It’s not like "ER"-The scandal of patient dumping in US hospitals

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The television program “ER” is a perennially top-rated show, both in the US and in many countries worldwide. Viewers are accustomed to see, perhaps a half dozen times in every episode, a new patient being wheeled into the emergency room, where a team of doctors, nurses and other health care workers spring into action.

There is a rapid-fire flow of dialog, as the patient’s vital signs are shouted out and other key information is communicated. But there is one question you will never hear on “ER” that is an ever-present concern in the real-life American hospital emergency room, and increasingly determines what kind of treatment a patient receives—what kind of health insurance the person has.

If a person needs emergency medical treatment and rushes to a hospital for treatment, what happens may not be what he or she expects, that is, treatment based on how serious the signs and symptoms are. In hundreds of hospitals, treatment is based on money, not medicine.

Public Citizen’s Health Research Group recently published the sixth in a series of reports on US hospital emergency room practices, entitled “Questionable Hospitals: 527 Hospitals That Violated the Emergency Medical Treatment and Labor Act—A Detailed Look at ‘Patient Dumping.’” Passed by the United States Congress in 1986 as a section of the Social Security Act, the EMTALA provides that when a hospital emergency department denies medical screening, denies stabilizing treatment it has the capacity to provide, and/or inappropriately transfers an individual with an unstabilized emergency condition, that hospital is illegally “dumping” the patient.

Public Citizen examined the US government’s Department of Health and Human Services (DHHS) enforcement of the act. Through the Freedom of Information Act, the group obtained the names of hospitals that have violated the act. The violations were confirmed by the Health Care Financing Administration (HCFA), a federal agency within the DHHS. (HCFA was renamed and is now called the Centers for Medicaid and Medicare Services.)

The current report primarily covers the years 1997, 1998, and 1999, with some violations from 1996 (not covered in previous reports) and 2000. The data demonstrates:

* For-profit hospitals violate the act nearly twice as often as not-for-profit hospitals.

* A patient’s insurance status influences hospital compliance with the act. A patient may not be covered by insurance or may have coverage, such as an HMO, which requires preauthorization for treatment and frequently denies payment when the exam rules out an emergency condition.

* Over 90 percent of the hospitals guilty of violations had breached the screening, stabilizing treatment or transfer provisions of the act, the most serious categories of offenses.

* Less than one-third of the hospitals identified as engaging in illegal patient “dumping” were fined, and the total of such fines averages barely $1 million a year—a pittance for the trillion-dollar health care industry.

The EMTALA requires that all hospitals with emergency rooms medically screen everyone who “comes to” the ER and has a request for examination or treatment made on his or her behalf. Violations include: outright denials, “referrals” to other facilities, and requests for payment. In some cases patients are not told that they have a right to an exam regardless of their ability to pay, and thus “refuse” the exam when they are asked for payment. In some cases, a hospital’s screening standard can be so low that it amounts to no screening at all.

Several examples describe hospitals’ violation of the requirement for appropriate medical screening. A pregnant patient came to Arrowhead Community Hospital in Glendale, Arizona on July 10, 1997. The hospital’s own documentation stated: “This labor patient was in the care of an RN without any MSE [medical screening exam] by an MD.” She was discharged four hours later, and came back the following day in active labor and was admitted to the hospital. Her unborn child had died and the patient herself died the day after admission. An autopsy revealed that she died of internal hemorrhage because of the rupture of an aortic aneurysm (abnormal dilation of an artery). Staff members who were interviewed said: “The doctor may give labor instructions or discharge orders over the phone...” and “A physician is supposed to see all the patients, but they don’t always do it.”

In Baltimore, Maryland, on July 27, 1998, a 70-year-old man accompanied his daughter to the hospital with a sick child. When they arrived, the man told his daughter he didn’t feel well and would wait outside the hospital. Passersby noticed

something was wrong and called security. The security officer's log stated: "911 notified intoxicated male ... ER notified (refused)" An emergency medical technician with a private ambulance leaving the hospital initiated CPR while the officer contacted the emergency department for assistance. The emergency department again refused assistance. Another ambulance arrived and transported the man to the ER. About one-half hour after the man was first seen lying in the grass, he was pronounced dead of cardiac arrhythmia.

In New York City, a survey on January 29, 1999 showed that staff at St. Luke's-Roosevelt Hospital's ER informed uninsured patients seeking treatment that they would be responsible for a fee of over $400, before providing a screening exam. Many uninsured patients left without any examination.

If a patient has an emergency medical condition, the hospital ER must stabilize the condition to the best of its capability. A hospital may transfer an unstabilized patient if the patient or representative requests a transfer in writing and is informed of the risks.

Many times, however, hospitals try to transfer patients in cases where they believe the treatment will not be paid for. In Houston, Texas on August 10, 1996, a patient came to the ER at Doctor's Hospital with symptoms of acute appendicitis, a medical emergency. Because she had no insurance, she was discharged and told to drive to another hospital, where she underwent surgery.

It is also illegal for hospitals to refuse to accept an appropriate transfer of a patient who requires the specialized treatment it can provide. Nondiscrimination violations often occur when a hospital that can provide specialty care refuses to and instead transfers the patient to still another care center, a third stop on what can be a life-threatening runaround. For example, an ER physician tried to transfer a patient with a diagnosed brain injury to Cedars-Sinai Medical center in Los Angeles, California. Cedar-Sinai was the closest facility, had a trauma service, and had 24-hour neurosurgical on-call coverage. The ER physician refused to accept the transfer and the patient experienced a three-hour wait while arrangements were made for a transfer to a county facility.

The federal act says a hospital may not delay providing a screening or stabilizing treatment in order to ask about the patient's method of payment or insurance.

In Brooklyn, New York, Kings County Hospital's ER posted signs that the hospital required preauthorization or referral from a patient's Medicaid plan before treatment. As of April 2001, no civil monetary penalty had been imposed for this violation.

In Chicago, Illinois, a 19-year-old patient came to the ER of Provident Hospital of Cook County with symptoms of threatened miscarriage. The hospital sought HMO approval, which was denied. The young woman was not given an exam or treatment. Because of the delay, she began to deliver a nonviable fetus as she waited for a taxi to take her to another hospital.

Many Americans are enrolled in managed care health plans to cover the costs of health care. Some of these managed care organizations require preauthorization for examination and/or treatment. MCOs may also deny or reduce payment for exams if the patient is found not to have an emergency medical condition. These plans may try to control costs by directing patients to the least expensive place for treatment, limiting diagnostic procedures or requiring these to be preauthorized. So when a hospital complies with the EMTALA, but the MCO refuses to pay for emergency services, the hospital bears the cost of treatment and has a strong disincentive to comply with the act.

Thirteen states have enacted "prudent layperson" standards. These laws require that insurers pay for visits to the ER by their enrollees when symptoms would lead a prudent layperson to believe that an emergency condition existed. In a recent study, the University of North Carolina found that 86 percent of ER visits first denied by one insurer, and 62 percent of ER visits first denied by another insurer on grounds that the condition was not a medical emergency, did meet the state's prudent layperson standard.

Another result of the managed care regulation is that specialty physicians do not want to participate on hospitals on-call panels. One reason hospitals have difficulty filling these panels is that physicians fear they will not be reimbursed for the services they are required to provide.

While a number of factors contribute to patient dumping—race, gender, political or personal bias—the predominant factor is a patient's financial or insurance status. The report explains several factors that limit the scope of the study. Public Citizen has no means of estimating the number of violations that are unreported and does not have access to medical records surrounding each violation.

But based on the data and examples that the group was able to access, its report on patient dumping presents a picture of an emergency health care system in which decisions on whether to use the best treatment techniques are callously made based on payment prospects. Throughout the US, individuals with potentially life-threatening conditions are denied basic medical services when they arrive at the hospital emergency room.