

RESEARCH LETTERS

Consequences of Federal Patient Transfer Regulations: Effect of the 2003 EMTALA Revision on a Tertiary Referral Center and Evidence of Possible Misuse

Emergency department (ED) use has risen steadily over the past 20 years, in part because patients are guaranteed medical attention under the Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA requires ED physicians to evaluate and stabilize all patients regardless of ability to pay, and hospitals must provide specialist care or arrange transfer to a tertiary care center when specialist care is unavailable.^{1,2} Community hospitals have reported difficulty providing specialist coverage since the enactment of EMTALA, and the Centers for Medicare and Medicaid Services (CMS) published its "Final Rule" regarding EMTALA in September 2003, stating that hospitals with EDs are not required to guarantee specialist coverage at all times.³

It has been suggested that elimination of coverage requirements permits selective transfer of underinsured patients to centers with mandatory on-call specialists.^{4,5} This concern has not been validated, in part because data regarding EMTALA referrals are limited. Our institution has kept a log of transfer requests since 2000 that provides a unique opportunity to analyze trends in EMTALA transfer patterns.

Methods. Stanford University Hospital (SUH), Stanford, California, is a 566-bed tertiary care center with level I trauma designation. After receiving approval from our institutional review board, records of all transfer requests from September 2000 to January 2008 were analyzed. Patients were considered underinsured if they had Medi-Cal (Medicaid), county-based insurance, other insurance for low-income individuals, or no insurance. Deidentified records of all admissions to California hospitals for the years 2000 through 2006 were obtained from the California Office of Statewide Health Planning and Development. Data were collated by hospital to compare trends in insurance status and diagnosis volume for patients admitted to referring hospitals with the volume of patients transferred to our center. Transfer requests and discharge records were imported into a MySQL database (version 5.5.18) for integration and harmonization and then exported to the R statistical package for further analysis. Comparisons between groups of interest were evaluated using the Fisher exact test.

Results. Of 25 105 transfer requests made to our center during the study period, 10 584 were subject to EMTALA. The proportion of underinsured patients increased significantly from 24.9% (237 of 951) prior to September 1, 2003, to 32.4% (1292 of 3985) after September 1, 2003 (odds ratio [OR], 1.30; $P < .001$). The most common indications for transfer were for specialty or critical care services. The proportion of underinsured patients ranged from 15.1% to 55.7%, with gastrointestinal tract (GI) hemorrhage having the highest underinsured rate. The proportion of underinsured patients referred from the most common EMTALA referral sites also ranged widely from 15.6% to 69.7%. EMTALA transfers from 3 hospitals were associated with a significantly higher likelihood of underinsured status than EMTALA transfers from all other hospitals. Of these 3 hospitals, 1 (Hospital J) also reported significantly lower rates of underinsured patients discharged from their facility compared with those transferred to our center (OR, 0.4; $P < .001$).

The most common referral diagnosis from Hospital J was GI hemorrhage ($n = 77$). Most requests regarding GI hemorrhage cited lack of on-call gastroenterologist availability as the primary reason for transfer. Of the patients with GI hemorrhage transferred from Hospital J, 63.8% were underinsured, compared with 39.7% for all diagnoses from the same ED (OR, 2.64; $P = .02$). The annual change in percentage of underinsured patients with GI hemorrhage admitted to Hospital J through their ED was inversely proportional to the change in number of referrals for GI hemorrhage to our center (**Figure 1**). During the same period, Hospital J reported a 200% in-

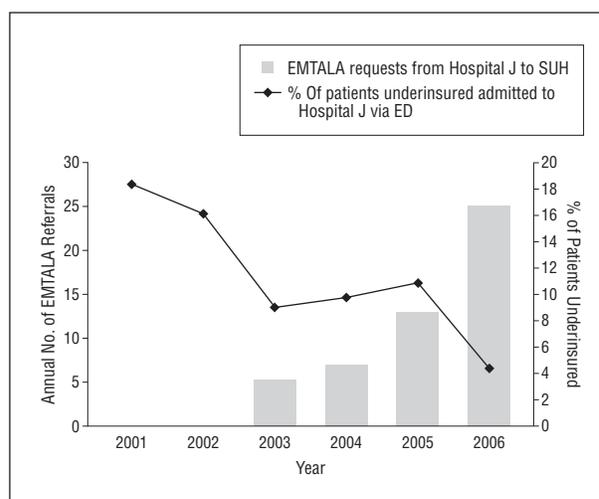


Figure 1. Trends in insurance status of patients with gastrointestinal (GI) bleeding admitted to Hospital J via emergency department compared with EMTALA (Emergency Medical Treatment and Active Labor Act) referral volume from Hospital J for GI bleeding. SUH indicates Stanford University Hospital.

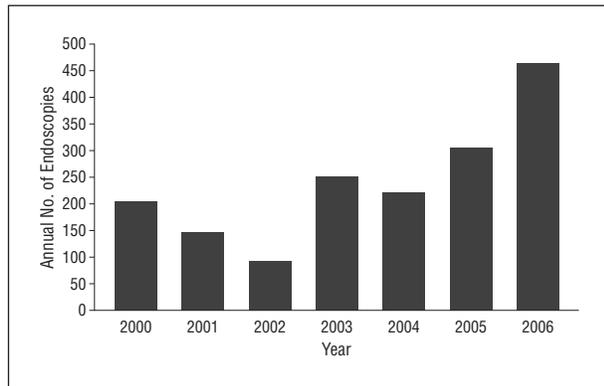


Figure 2. Annual number of endoscopies performed at Hospital J on patients admitted via emergency department.

crease in the number of inpatient endoscopic procedures performed per year starting in 2004 compared with 2000-2003 (**Figure 2**) despite nearly all of their transfers under EMTALA citing lack of gastroenterology coverage as the reason for transfer.

Comment. Our data suggest that the Final Rule may facilitate legal selective transfer of patients with emergency medical conditions based on insurance status. In the case of Hospital J, there was an increase following the Final Rule in the number of patients transferred to our center from their ED for GI hemorrhage, citing lack of gastroenterologist coverage despite an increase in the number of endoscopic procedures performed at their institution over the same period. Elimination of mandatory ED coverage for specialty providers allows hospitals to legally justify an EMTALA transfer request by saying they do not have guaranteed coverage in certain situations even when the facility has the capability to provide those services. Consequently, a selective coverage policy allowing specialists not to take call for the ED or to take only “elective” call (where the specialist is not obliged to see ED patients) is permissible under the Final Rule. Such arrangements have been observed in California as well as in Florida and Oregon.⁵⁻⁸ The absence of any formal requirement for record keeping of EMTALA requests makes estimating the scope and prevalence of these practices difficult even though such behavior would clearly violate the intent of EMTALA.

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Outcomes of Medical Malpractice Litigation Against US Physicians

The risk of medical malpractice varies substantially according to physician specialty.¹⁻³ Despite evidence regarding the frequency with which US physicians in different specialties face malpractice claims,^{2,3} there has been little study of the proportion of claims that result in litigation or the outcomes of the litigation process, in particular according to physician specialty.⁴ Malpractice claims that undergo litigation are an important source of concern to physicians,⁵ yet national data are lacking on the frequency of litigation, how litigation is typically resolved, and how long litigation takes to be resolved. Lengthier time to resolution affects physicians through lost practice time and added stress, work, and reputational damage. Patients are affected by anxiety as a result of a lengthy resolution process as well delays in the receipt of benefits. Using malpractice data from a nationwide professional liability insurer, we calculated the proportion of malpractice claims resulting in litigation, analyzed how litigated claims were resolved according to specialty, and calculated the time required to resolve claims of varying types.

Methods. We examined all claims closed between 2002 and 2005 that involved some defense cost (N=10 056). Cases without defense costs were excluded because they often reflected instances in which physicians reported a possible adverse event to the insurer but no allegation of malpractice was made.² Although our data included phy-