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To: Attending Physician Staff, Departments of Emergency Medicine, Mercy Hospital of Pittsburgh and Mercy Providence Hospital

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From: Keith Conover, M.D., FACEP
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Subject: **Psychiatry Transfers**

*Based on input from many people, especially the detailed review and comments by Becky O'Connor, Bruce Wright, and Patty Neumeyer (thanks!), I wished to revise my previous memo on this topic. Since the original is still a useful reference, and the changes and clarifications, though significant, are few, I am sending you the entire document but with changes marked with ~~standard word processing notation~~ **standard word-processing notation**. This is available online, as are the relevant portions of the Pennsylvania Mental Health Act and related regulations, on the PMHS DEM Intranet site at: http://www.pitt.edu/~kconover/DEMweb/DEM_Intranet.htm.*

This memo outlines guidelines for attending emergency physicians when transferring psychiatric patients. It is not an exhaustive consideration of psychiatric transfers. It is not official policy. It is not designed for any audience except the attending emergency physicians at PMHS Emergency Departments – although others may find it helpful. It is just a memo with a simple set of guidelines. It is my attempt to provide practical advice for psych transfers, integrating local practice patterns, Allegheny County Medicaid policies, Commonwealth of Pennsylvania and Federal regulatory law, and common law principles. A formal guideline for physicians regarding psychiatric transfers seems worthwhile, and I will work with Dr. Kaveh Ilkhanipour, Physician Quality Manager of the Department of Emergency Medicine, to develop such a document. Please forward any comments or suggestions to Dr. Ilkhanipour and myself care of the Department of Emergency Medicine at Mercy Hospital of Pittsburgh. My thanks to all the people who have reviewed and improved this over the past six months. However, any errors are my own and should not be attributed to any other person.

The “catchment area” plan for care of Medicaid psychiatric admissions in Allegheny County, as flawed as it might be, nonetheless had the advantage of making the process of psychiatry transfers and admissions simple. With the demise of this system, uncertainty about how to manage such patients has caused concern, confusion, and even occasionally conflict among the staff.

Having had to deal with such situations over the past few months, and having to wake two of the administrators on call in the wee hours of the morning to obtain clarification, I thought it would be best to summarize my understanding of the situation – in terms of the specific situations faced by the emergency physician staff.



Background: the original system defined “catchment areas” based on postal Zip code, and any Medicaid (“DPA” “welfare” “Medicaid HMO” “Access”) patients who lived in a particular catchment area, and who required psychiatric admission, would have to be transferred to the psychiatric facility in that area – regardless of patient choice or other considerations. In about May of last year this system was terminated. This was reportedly for a variety of reasons – possibly including transferring of a patient who might not be “stabilized” (in legal EMTALA/COBRA terms) based on insurance/financial status, violating the core tenet of the EMTALA “anti-dumping” law.

Here are several clinical scenarios to consider.

1. A physician at a hospital without psychiatric facilities wishes to transfer a psych patient to Mercy Hospital or Mercy Providence Hospital. Regardless of whether the physician mentions “catchment areas” or not, if we have psych beds of an appropriate type, we are obligated under EMTALA to accept the transfer. “Appropriate beds” is not a simple term to define, see below. However, you should know that a hospital has been, under EMTALA, fined \$25,000 for not accepting transfers within its special capabilities: <http://www.medlaw.com/oklacase.htm>. *Comment/Question: “There needs to be clarification regarding the transfer of patients from a facility that does not have a psychiatric unit to either Mercy or Mercy Providence Hospital. For example, what if the patient has insurance that our hospital or physicians do not participate with?”* The answer to this is fairly straightforward. Under Federal EMTALA law, if their hospital doesn’t have appropriate psych beds and we do, and they want to transfer the patient, we have to accept the patient. This is true, even if the patient had already been provided a Medical Screening Exam, and is “stable” in EMTALA terms, regardless of insurance or physician acceptance of the patient. It would be appropriate, however, to tactfully suggest to the transferring facility that the patient might be better off at a facility who accepts the patient’s insurance -- without, however, in any way suggesting that we are refusing the transfer. We can, of course, accept the patient for transfer, admit the patient, start appropriate treatment (admitting and starting appropriate treatment are important, we *should not* hold the patient in the ED) and then work on a transfer to a place with appropriate beds *and* that takes the patient’s insurance. And it would be OK to indicate to the patient and the transferring facility that we will start working on a transfer to a place that takes the patient’s insurance as soon as the patient is here and admitted. And if they want to take that into account in deciding whether to send the patient here or to the place that takes the patient’s insurance, that’s well and good. But we still can’t refuse the transfer, refuse to start caring for the patient, or hold the patient in the ED pending transfer to another facility.

2. A physician at a hospital WITH psychiatric capability wishes to transfer a psych patient to Mercy Hospital or Mercy Providence Hospital. *Background:*

Mercy Hospital and Mercy Providence Hospital both have psychiatric units, as do many other area hospitals. However, some patients require special psych units. The “specialties” of Mercy Hospital and Mercy Providence Hospital are as follows.

Mercy Hospital:

- Generic adult non-violent psych patients
- Geriatric psych patients

Mercy Providence Hospital:

- Generic adult non-violent psych patients
- Generic adult violent psych patients
- Geriatric psych patients
- “Dual-diagnosis” patients – those with significant psych problems *and* with significant drug and alcohol problems.

Neither Mercy Providence Hospital nor Mercy Hospital have the capacity to take care of

- Detox: people with primary drug and alcohol problems who do not also have a major psychiatric diagnosis.

- Adolescent Patients (Mercy Hospital and Mercy Providence Hospital can take patients who are over 18, or who are emancipated minors no longer in high school). Addendum from Bruce Wright and Patty Neumeyer: We can accept patients on the Unit here at Mercy who are over 18 or through the approval of the attending physician under special circumstances (regardless of whether or not the patient is an emancipated minor).

2a: Catchment transfers. If the physician says “We have beds of the appropriate type, but I want to transfer the patient because he’s from your catchment area” this is an inappropriate transfer and you should, gently and tactfully, refuse the transfer and explain that the catchment system is no longer operative. Additional information: the state, via the county, pays a bulk yearly sum to some but not all hospitals (e.g., Mercy Providence Hospital but not Mercy Hospital) for the care of indigent psychiatric patients in their “catchment area.” Based on this contract, some hospitals are obligated to care for such patients in return for the payment. The state mental health regulations (Pennsylvania Code, Title 55 - Public Welfare, Part VII - Mental Health Manual [Regulations], Chapter 5100 - Mental Health Procedures) say:

5100.86. Involuntary emergency examination and treatment not to exceed 120 hours.

...

(g) If the person is determined to be severely mentally disabled and in need of immediate treatment:

(1) The examining physician shall make certain that the person has received a copy of forms MH-782, Bill of Rights, and MH-783-A, Explanation of Rights Under Involuntary Emergency Commitment.

(2) The facility shall notify the administrator, if applicable, that:

(i) No warrant has been issued and there is reasonable probability that a previous application, based upon the same behavior, had been sought;

(ii) A bed is needed at another facility; or

(iii) Public funding will be involved.

(3) When the examining facility recommends emergency involuntary treatment and has no bed available, the administrator in designating a facility for treatment, shall also authorize transportation between facilities.

(h) The administrator shall designate an appropriate treatment facility which may be the examining facility or, if no bed is available there, the nearest appropriate facility which is capable of immediately providing such treatment. If county OMH funding is not involved, the patient's choice of facilities is to be respected whenever an appropriate bed is available.

However, the question of **transferring** such a patient is a much more thorny issue, involving Federal EMTALA law, and common law principles of consent, which overrule any contractual obligations. Some additional legal opinions are appropriate here, and will have repercussions throughout the other cases discussed below.

Per Barbara Blackman of the law firm Horty, Springer, Mattern, which specializes in health care law, and per Rebecca O’Connor, legal counsel for Pittsburgh Mercy Health System, the following apply:

If a patient is subject to involuntary (“302”) commitment, the patient may be transferred to another facility against his or her will **only** if the receiving facility can better care for the patient than the sending facility. Insurance status and “catchment” areas are, in this case, completely overruled by Federal and common law principles. However, if the patient **has the capacity and consents** to the transfer, then it’s OK. This is a very sticky point, though -- getting **informed consent** from a patient who is so mentally disabled to require a 302 involuntary commitment would be **very** difficult and would probably be difficult to defend in court unless documented very well.

2b: Known to your hospital. If the physician says “We have beds, but I want to transfer the patient because his psychiatrist is there and he’s been admitted to the psych floor there 30 times in the past year” or “His psychiatrist is there and requests the transfer” it’s appropriate to accept the transfer. Per Bruce Wright and Patty Neumeier: “Any decision regarding the acceptance of a patient who is known here [Mercy Hospital -- KC] should be made by the attending psychiatrist on-call.” Note though that at Mercy Providence Hospital the current policy is that the emergency physician can accept the patient for the psychiatrist on call, see below.

2c: Detox. If the physician says “We have beds, but the patient doesn’t really have any psych problems, just needs detox” you should, gently and tactfully, refuse the transfer and suggest that they transfer to a facility that does detox, such as St. Francis, Braddock, Jefferson, or the VA.

2d: Dual-Diagnosis: If the physician, especially in the detox case above, says “Well, the patient needs detox but really does have a major depression,” or it definitely sounds like a true dual-diagnosis patient, you should accept the patient to Mercy Providence Hospital. But, if it’s questionable whether the patient really needs anything more than detox, make the patient a 23-hour admission. This allows the psychiatrist, if necessary, to enter a primary diagnosis other than a major psychiatric disorder, and discharge to an outpatient detox program, or transfer to an inpatient detox program.

3. No appropriate beds at Mercy Hospital or Mercy Providence Hospital. If you are at Mercy Providence Hospital or Mercy Hospital and have a psych patient who needs to be admitted, but there are no appropriate beds, you will need to transfer the patient to an appropriate facility. Choosing a facility to call is simple. If the patient is well-known to another facility, see if that facility will accept the transfer.

If the facility has beds but refuses the transfer based on “catchment area,” please refer the case to Drs. MacLeod or Hodgdon for investigation for possible COBRA/EMTALA violation and try to find another facility. Note that reporting to the appropriate Chair doesn’t mean that it IS a COBRA/EMTALA violation, only that it might be and needs to be investigated.

If the patient or the patient’s primary physician has a strong preference for one facility, or a strong aversion to some other facility, use this as your guide to picking facilities to call, regardless of “catchment area.”

If the patient has some sort of commercial insurance (NOT “Access” “DPA” “welfare” “Medicaid HMO” “Gateway” “Three Rivers” or “Best”) and the patient is stable in legal terms (beyond the scope of this memo), then it may be appropriate to transfer to the facility requested by the insurance company, with the patient’s or surrogate’s guardian’s consent, but only with the patient or guardian’s informed consent (and note the above caveat about getting consent in a psychiatrically-disabled patient).

If the patient is uninsured, or has Medicaid (“Access” “DPA” “welfare” “Medicaid HMO” “Gateway” “Three Rivers” or “Best”), we have no beds, and the patient has no preference, use the “catchment area” book to determine which facility to call first. The catchment area facility is generally close to the patient, making subsequent outpatient care coordination easier. All psych hospitals in the county can be paid for any Medicaid HMO patients, which makes things simpler.

From my understanding, the county will pay hospitals for the care of uninsured indigent psych patients *if* they are at their “catchment” hospital, but not at other hospitals. Thus there is a financial incentive to transfer indigent patients to such “catchment” hospitals. However, such transfers for insurance reasons are “dumps” and are the reason EMTALA was enacted in the first place. If the patient is “stable” in EMTALA terms, the transfer is OK – but “stable” in EMTALA legal terms is quite different than “stable for psychiatric admission” as the patient will receive a complete medical history and physical exam and complete psychiatric exam and labwork as part of the admission.

I, personally, rarely consider any psych patient I transfer “stable” in EMTALA terms. Most patients with severe enough psychiatric illness to require admission have an “emergency medical condition” that is psychiatric, and we are required to provide stabilizing care prior to transfer. If the courts decide that “stabilizing care” for a psychiatric condition is merely sedation (if needed) and a 24-hour guard to prevent suicide, and you transfer with orders to the EMTs to restrain as needed, you may be OK with such transfers.

However, if the courts decide that stabilizing emergency psychiatric conditions requires evaluation and a treatment plan by a psychiatrist, such transfers may be unlawful. Please note that in this regard, I am not talking about a court ruling on your patient's transfer. What I mean that if a court takes a case of the transfer of a psych patient and rules on what constitutes "stabilize" in a patient with a psychiatric problem but no medical problems, then we will have guidelines on when to consider a psych patient "stable for transfer." If you are intimately familiar with the current court decisions regarding "stable" in EMTALA terms and are sure the patient is "stable" then transferring to the catchment hospital would be legal. I've tried to follow these court cases and have decided I will seldom if ever transfer a psych patient to a catchment hospital solely for financial reasons, I will leave this to the psychiatrists after they've evaluated the patient.

"Stabilizing" a psych patient is a grey area. What it means is that the patient won't get worse during transport to the other facility. Does this mean that as long as the EMTs prevent the patient from committing suicide en route the patient was stable? What if the patient decompensates from the psychological stress of being thrown in the back of an ambulance for a ride in rush-hour traffic?

Certainly if the psychiatrist has seen the patient in the ED and determines that the patient is stable for transfer I would have no qualms about transferring. Your mileage may vary. Here is some information from www.emtala.com:

5. What are the implications under EMTALA for a "single entry" method of evaluation of mental health recipients?

Under systems in place in some states, psychiatric patients and other recipients of public mental health services are referred automatically to a central screening location (under the auspices of a Community Mental Health system) for evaluation and placement for treatment, as part of a comprehensive plan for community-based mental health services. The issue may be raised whether such a system is permissible under EMTALA.

The regulations under EMTALA specify that the term "emergency medical condition" includes "psychiatric disturbances and/or symptoms of substance abuse". The EMTALA requirements would probably be interpreted to require that both a medical and a psychiatric evaluation be undertaken in this circumstance, and that intervention be provided if either the medical or the psychiatric condition is considered to be "unstable". As is the case with other specialty hospitals, it is likely that a medical determination, supported by a written certification, that the necessary care can be provided more suitably in a designated psychiatric facility and thus that a transfer is "appropriate" under EMTALA would be given some degree of deference by the courts. The certifying physician should be careful to specify the types of facilities and services which the specialized psychiatric facility can provide as part of his detailed transfer certification.

These considerations would not apply if the specialty psychiatric hospital does not have medical facilities sufficient to attend to the patient's medical needs other than psychiatric care. In that case, the medical needs and the need to stabilize the medical condition would have to be addressed first.

Note that the sloppy use in the regulation of the term "symptoms of substance abuse" may be argued to mean that any intoxicated person who comes to an emergency room must be kept and observed until he has sobered up. This interpretation would, if accepted, turn many large hospitals into drunk tanks without locks and keys.

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Backup 302: when transferring a patient who had signed a 201 voluntary commitment, it used to be common for various staff to request or complete a "backup 302" (involuntary commitment). It was said that "a 201 is hospital-specific and not valid at another hospital." And, it is common knowledge (whether true or not) that EMTs and paramedics are not "allowed" to restrain a suicidal patient who has signed a 201

voluntary commitment, but can restrain a suicidal patient who has been involuntarily committed under section 302 ("302'd").

There never was any real legal basis for this oral tradition, and by a clear reading of the Pennsylvania law, signing a 201 voluntary commitment is a legal bar to a 302 involuntary commitment. This has recently been popularized, including an October 25, 1999 memo from the Patricia L. Valentine, Deputy Director of the Allegheny County Department of Human Services' Office of Behavioral Health, to "Hospital Administrators of Designated Psychiatric Units, Emergency Department Directors and Social Service Directors." Now, most if not all institutions will accept a 201 commitment from another institution. So, backup 302's are "out" now at least by common current understanding. And under Section 201, psychiatric patients who "sign a 201" **do** give their consent to be restrained for up to 72 hours if needed. If you think the patient may need a "backup" 302, consider if the patient truly meets the requirements for a 201 (informed consent, etc.), and if not, it might be better to complete a 302. ~~However, it is never appropriate to complete a 302 if the patient has signed a 201.~~ If it turns out that a patient has signed a 201 voluntary commitment, but you find out that the patient really was not appropriate for a voluntary admission and fits better under the provisions of a 302 involuntary commitment (e.g., questions about the patient's ability to give informed consent to the 201, or the patient attempted suicide and thus fits better under the provisions for a 302 and a petitioner is available), it is appropriate to dispose of the 201 paperwork and complete a 302. However, it still isn't appropriate to have the 302 paperwork done but not called in to the county as a "backup."

There really is very little difference between a 201 and a 302 commitment in terms of being able to restrain the patient -- **As long as you have made sure that the front of the form has "72 hours" written in the blank on the front that says ("up to 72 hours."** Always check any 201 you sign and make sure **72 hours** is written on the form.) There is one advantage of having someone petition a 302: it will makes the 303 (long-term commitment) easier later on. The decision whether to use a 201 or 302 is a social clinical one, based on the patient's willingness and capacity to sign a 201, and whether you have a petitioner. (Note that our policy is that ED nurses or social workers, rather than a physician, should be the petitioner if an outside petitioner isn't available).

Nonetheless, this word has certainly not gotten to most EMTs and paramedics. And, it would certainly be bad if a suicidal patient jumped out of an ambulance on the Fort Pitt bridge and jumped off the bridge – as happened once in the past. So if the patient is a danger to him- or herself, but has signed a 201 voluntary commitment rather than "302'd", there is a simple solution: write on a prescription for "restrain patient if necessary during transport." EMTs and paramedics are then happy that they have written authorization from a physician to restrain the patient if needed – even if not truly necessary, given that common law **requires** medical professionals of all levels to act "in loco parentis" and restrain suicidal patients to protect them – whether committed under section 302 or section 201 – indeed, any medical professional who becomes aware a patient is suicidal is obligated to restrain the patient as needed, starting immediately.

4. Psychiatrist on call at Mercy Hospital refuses admission. Assume a patient is in Mercy Hospital's ED, needs a psych admission, psych beds are available, and the patient is appropriate for Mercy Hospital's psych area. Unless the patient is "legally" stable and the insurance company requests a transfer elsewhere, or the patient requests a transfer elsewhere, we are obligated to admit the patient – regardless of the patient's insurance status. If, for any reason, the psychiatrist on call refuses to accept the patient – although theoretically this should never happen – the emergency physician should (1) call the Chair of Psychiatry or designate to admit the patient, or if this fails within a reasonable time (half an hour is considered a reasonable time in such situations), (2) contact the administrator on call.

This also raises questions related to the involuntary transfer of patients who have been committed for psychiatric reasons. See the notes above, also here is a quote from Pittsburgh Mercy Health System Legal Counsel Rebecca O'Connor:

"For patients on a 302 who refuse to consent to a transfer to a more appropriate facility that can provide more or better services we can still transfer the pt but we need to document that we are transferring them so that they can receive more or better services. We also need to document the stabilization of the pt for transfer. There should be no documentation of any financial incentive to transfer."

“For patients who are either voluntary or involuntary who would have better financial coverage of their care (either by insurance or catchment area) if they were transferred but refuse to transfer and we can provide the services that they need then we should provide the services.. We can advise them of the financial consequences of their decision but we MUST emphasize that we are more than willing to provide any and all of the emergency medical care that they need.”

5. Accepting Transfers at Mercy Providence Hospital. Our current policy, to quote Dr. Hodgdon’s February 27, 1996 memo (in the Communication Book in the doctor’s call room in the Mercy Providence Hospital ED): “There is always a psychiatrist on call for the ERC. Whenever you have questions, or need to discuss a case with a psychiatrist prior to making a decision, just call the psychiatrist on-call. **You do not need to call a psychiatrist to admit patients. We have carte blanche to admit to their services.**”

Federal law (COBRA/EMTALA) does not require that a physician accept a transfer on behalf of the hospital. And, although some states require that transfers be accepted by a physician, this is not the case in Pennsylvania. However, PMHS policy, as evidenced by the current transfer policies and forms, requires that transfers be based on physician to physician contact, and physicians speak for the hospital when they accept transfer patients.

Therefore, if you, the emergency physician on duty, admit a patient or accept a patient for transfer, the patient *is* admitted or accepted for transfer. However, the psych nurses will usually call the psychiatrist on call about all transfers. If the psychiatrist on call disagrees with your decision to accept the patient, it is appropriate for the psychiatrist to call you and discuss the case, however, given that you have already accepted the patient, it would be rude, crude and socially unacceptable for the psychiatrist on call to refuse the transfer without discussing the case with you. (I mention this not on theoretical grounds, it has happened more than once.) If the **ERC nursing staff** have issues with your accepting a transfer, they should discuss it with you, and if you believe it’s necessary, **you** should consult the psychiatrist on call -- nonetheless, the decision is yours and not that of the ERC nursing staff.

A note about transfers in general. It’s unlawful for a hospital to refuse a transfer, when it has appropriate capabilities, unless on formal divert status. And, if a patient shows up anyway while the hospital is on divert, the hospital has to accept the patient and provide appropriate care.

The following legal questions and answers may also be of interest as far as accepting transfers (From Stephen A. Frew, J.D., who specializes in COBRA/EMTALA issues, <http://www.medlaw.com>):

QUESTION: “Assume that a psychiatric patient is brought to an acute care hospital that does not offer inpatient psych services, receives an MSE and is certified for inpatient admission--but the hospital does not have the capability to treat the patient on an inpatient basis and seeks authorization for transfer the patient to a neighboring facility with inpatient psych capabilities and an open bed.”

“Are you familiar with any state regulations under which a psychiatric patient with no insurance must be transferred to a state-run facility, rather than to a closer facility that offers inpatient psychiatric services? Or must the closer facility take the patient because it offers a "specialized capability"? Is there a distinction between patients who come through the ER and direct admits?”

ANSWER: “Any requested facility with the specialized capabilities to provide care that the sending hospital cannot must accept transfers from anywhere within the US if they have capacity. Many states attempt to regulate where patients go for psych care by payment regulations, but EMTALA requires any facility with the capability to accept the patient if requested, regardless of means or ability to pay. EMTALA care, stabilization, transfer, and acceptance rules apply to all patients at the hospital, not just ED patients, per the US Supreme Court decision in Roberts v. Galen 1999 interpretation of the Section a vs Section b language”

QUESTION: “A neighboring hospital has no psychiatric services. Our hospital has a psychiatric unit. Recently there was a request for transfer made by the other hospital's ER. Our on-call psychiatrist refused to speak with the transferring physician in the ER until insurance information could be obtained. Rather than risk an allegation of EMTALA violation, we had our ER physician speak with the referring ER physician and accept the patient for further evaluation in our ER. Our ER physician was very unhappy with the psychiatrist's handling of this case.”

"If this psychiatrist continues this practice and a complaint is filed, how likely is it that we would be cited with an EMTALA violation?"

ANSWER: "Highly likely, if it gets reported."

6. Alcohol and Drug Intoxication and Psych Transfers A common cause of dissent about psych transfers is alcohol and drug intoxication. First, let's address the question of family or friends who bring someone with alcohol or drug problems into the ED and they say "we need to commit him, he's drinking himself to death." Well, slowly committing suicide by drinking excessively is not recognized as suicidal behavior by the common law. And, specifically for Pennsylvania, the state mental health law says:

"Persons who are mentally retarded, senile, alcoholic, or drug dependent shall receive mental health treatment only if they are also diagnosed as mentally ill, but these conditions of themselves shall not be deemed to constitute mental illness." Which means you cannot use section 201 or section 302 commitment procedures for someone who is just an alcoholic (or drug addict).

The second topic under this head is of "interviewability" -- some psych facilities and physicians refuse to take patients unless the patient is "interviewable" and some refuse to take anyone with a blood alcohol of over 100 (the legal limit). I can find no basis in Federal, state, or common law for this practice, or to use this as a basis for refusing a transfer. Yes, some of these patients are fine once they sober, and this frustrates the accepting staff, which is the basis for these policies (which, as far as I can tell, are all oral tradition and not written policy anywhere).

There **are** many people ("maudlin drunks") who say things when drunk that they wouldn't say when sober. Yes, saying "I want to end it all (sob)" when drunk may be an indication of an underlying depression, but it may not be an indication of a severe enough depression that the patient requires involuntary commitment. If the patient made such comments while drunk, but really did nothing that makes it seem likely the patient would actually act on this suicidal ideation, while sober or drunk, it seems reasonable to allow the patient to sober and then re-interview. If the patient really is fine, then discharge the patient rather than transferring (or admitting).

But, if the patient, even while drunk, has done something suggesting a potential for suicide -- slit his or her wrist, gotten up on the edge of a bridge -- then the patient is suicidal, and a danger to himself or herself, and needs to be 302'd and admitted (or transferred) regardless of alcohol level or "interviewability." If a facility or physician that would otherwise be obligated to accept the patient, based solely on alcohol level or "interviewability" refuses to accept (or admit) the patient, or demands that you keep the pt until sober, then this has a high likelihood of being a COBRA/EMTALA violation. Do your best to find an appropriate place for the patient, and report the case to Dr. MacLeod or Dr. Hodgdon as a potential COBRA/EMTALA violation. You should, as a matter of courtesy, inform the refusing physician that you will be reporting this to your superior as a potential COBRA/EMTALA violation. and that the refusing physician should report this fact to his or her superior. Please document in your note to Dr. MacLeod or Dr. Hodgdon the patient name and medical record number, date and details of the occurrence, name of the refusing physician and facility, and that you informed the physician that you would be reporting the incident.

My understanding is surely flawed and incomplete, and clarification from those more knowledgeable about the situation is welcomed. Nonetheless, I hope an articulation and focus on specific clinical situations is valuable and a useful guide to the clinical staff. Clarifications or corrections should address the above situations in terms that will be of use to the clinical staff in their decision-making – often at 4 AM.

Thank you.