No. 25-22

In the Supreme Court of the United States

RICKY KOEL,

Petitioner,

v.

CITIZENS MEDICAL CENTER, INC., ET AL,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

BRIEF OF AMICI CURIAE CALIFORNIA ACADEMY OF EYE PHYSICIANS AND SURGEONS (CAEPS) AND THE NORTH DAKOTA SOCIETY OF EYE PHYSICIANS AND SURGEONS (NDSEPS) IN SUPPORT OF PETITIONER

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INTEREST OF THE AMICI CURIAE[1]

The CALIFORNIA ACADEMY OF EYE PHYSICIANS AND SURGEONS (CAEPS) represents the interests of ophthalmologists in various forums including legislative, regulatory, and legal forums. Similarly, The NORTH DAKOTA SOCIETY OF EYE PHYSICIANS AND SURGEONS (NDSEPS) is the statewide organization that represents ophthalmologists and their patients in matters relating to patient care. Of considerable concern to both organizations are attempts by optometrists to expand their scope of practice into areas that are more properly within the medical discipline of ophthalmology. *Koel v. Citizens Medical Center, Inc.*, *et al* is a case in which two Federal Courts (The District Court of Kansas and the Tenth Circuit Court of Appeals) sanctioned the participation of a non-physician optometrist in an emergency medical screening of a patient who suffered a traumatic eye injury. The participation of the non-medical optometrist was in direct contravention of a hospital policy, consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd regulations, which provided that *only* physicians (medical doctors or doctors of osteopathy, resident physicians, nurse practitioners, and physician assistants were qualified to conduct an emergency medical screening exam. CAEPS and NDSEPS are filing an *amici curiae* brief

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[1] Pursuant to Sup. Ct. R. 37.2, all parties received notice of the intention to file this brief at least ten days prior to the due date. Pursuant to Sup. Ct. R. 37.6, no counsel for any party authored this brief in whole or in part, or made a monetary contribution intended to fund the preparation or submission of this brief.

in support of Plaintiff's Petition for a Writ of Certiorari, in the hope that this Court will review and reverse the decisions of the District and Circuit Courts.

INTRODUCTION

Ophthalmologists are highly trained physicians who can competently perform delicate eye surgeries, address traumatic eye injuries, and diagnose and treat both simple and complex diseases of the eye, far beyond the scope of practice for optometrists. "After four years of medical school and one year of internship, every ophthalmologist spends a minimum of three years of residency (hospital-based training) in ophthalmology. During residency, ophthalmologists receive special training in all aspects of eye care, including prevention, diagnosis and medical and surgical treatment of eye conditions and diseases. Often, an ophthalmologist spends an additional one to two years training in a subspecialty, that is, a specific area of eye care (for example, glaucoma or pediatric ophthalmology.)"[2] In Kansas, physicians are licensed and regulated by the State Board of the Healing Arts. By contrast, optometrists are licensed and regulated by the State Board of Examiners in Optometry. Optometrists are not physicians. Kansas Statutes Annotated (K.S.A.) § 65-1501(a) sets forth the meaning of the practice of optometry:

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[2] https://www.aao.org/eye-health/tips-prevention/ophthalmology-training-certification

> The practice of optometry means: (1) The examination of the human eye and its adnexae and the employment of objective or subjective means or methods (including the administering, prescribing or dispensing, of topical pharmaceutical drugs) for the purpose of diagnosing the refractive, muscular, or pathological condition thereof; (2) the prescribing, dispensing or adapting of lenses (including any ophthalmic lenses which are classified as drugs by any law of the United States or of this state), prisms, low vision rehabilitation services, orthoptic exercises and visual training therapy for the relief of any insufficiencies or abnormal conditions of the human eye and its adnexae; and (3) the prescribing, administering or dispensing of topical pharmaceutical drugs and oral drugs for the examination, diagnosis and treatment of ocular conditions and any insufficiencies or abnormal conditions of the human eye and its adnexae including adult open-angle glaucoma.

In addition, that statute specifically states what the practice of optometry does not include:

> The practice of optometry shall not include: (1) The management and treatment of glaucoma, except as provided in subsection (a); (2) the performance of surgery, including the use of lasers for surgical purposes, except that licensees may remove non-perforating foreign bodies from the cornea, conjunctiva or eyelids; remove eyelashes; scrape the cornea for diagnostic tests, smears or cultures; dilate,

> probe, irrigate or close by punctal plug the tear drainage structures of the eye; express conjunctival follicles or cysts; debridement of the corneal epithelium and co-management of post-operative care; or (3) the performance of procedures requiring anesthesia administered by injection or general anesthesia.

K.S.A. § 65-1501(b).

K.S.A. § 65-1505(a) sets forth the minimum qualifications for licensure as an optometrist:

> Persons entitled to practice optometry in Kansas shall be those persons licensed in accordance with the provisions of the optometry law. A person shall be qualified to be licensed and to receive a license as an optometrist: (1) Who is of good moral character; and in determining the moral character of any such person, the board may take into consideration any felony conviction of such person, but such conviction shall not automatically operate as a bar to licensure; (2) who has graduated from a school or college of optometry approved by the board; and (3) who successfully meets and completes the requirements set by the board and passes an examination given by the board.

K.S.A. § 65-1505(a). The Kansas State Board of Examiners in Optometry promulgates the rules and regulations governing approval of optometry schools and colleges to operate in the state. K.S.A. § 65-1505(a).

In the instant case, knowing and understanding the significant difference between the disciplines of ophthalmology and optometry is crucial for

appreciation of the extent to which Citizens Medical Center, Inc. deviated from the clear mandates of EMTALA.

SUMMARY OF ARGUMENT

Respondent Citizens Medical Center, Inc. (CMCI), is a hospital in Colby, Kansas that operates an Emergency Department that conducts medical screening examinations of patients presenting at the Emergency Department to determine whether the patient is suffering from an emergency medical condition as defined in 42 U.S.C. 1395dd(e)(1). According to CMCI's Bylaws, only physicians, resident physicians, nurse practitioners and physician assistants are qualified to conduct medical screening exams. On April 10, 2019, Petitioner Ricky Koel presented at the Emergency Department with severe symptoms from being struck with a metal wire in his right eye. The Emergency Department did not have the capabilities to have Mr. Koel examined under anesthesia in the operating room by an ophthalmologist to rule out an open globe injury. Instead of transferring Mr. Koel to a facility that had such capabilities, the acting Emergency Department Chief, Dr. Kuhlman, a family medicine physician, enlisted the services of an optometrist, Dr. Funk, who performed certain tests which did not involve an examination under anesthesia of the entirety of Mr. Koel's eye and concluded that Mr. Koel did not have an open globe injury. An optometrist is not a physician. Under CMCI's Bylaws, he was not qualified to perform an emergency medical examination.

1. Under EMTALA and case law, a hospital is strictly liable for violations of its own policies and procedures. The District Court erroneously determined that Dr. Kuhlman did not violate CMCI's policies by enlisting Dr. Funk's active participation in the medical screening examination of Mr. Koel, and his providing Dr. Kuhlman with an incorrect diagnosis that Mr. Koel did not have an open globe injury. The District Court erroneously characterized Dr. Funk's role as a mere consultant. Dr. Funk, is not a physician, and is not qualified to conduct an emergency medical screening examination, and yet, he was the individual who performed the most significant testing on Mr. Koel's eye and was entirely responsible for the diagnosis that resulted in Mr. Koel's discharge from CMCI with instructions to see an ophthalmologist a hundred miles away the next day. The District Court's finding that enlisting Dr. Funk's active participation in Mr. Koel's medical screening examination and providing the basis of Mr. Koel's diagnosis did not violate CMCI policy, and its grant of summary judgment to CMCI was erroneous.

The Circuit Court's analysis in affirming the District Court's grant of summary judgment suffers from an even more glaring defect: The Circuit Court found that Dr. Funk's active participation in Mr. Koel's medical screening examination did not violate CMCI's Bylaw 10.4 because Dr. Funk was a physician. The Circuit Court panel's erroneous belief that Dr. Funk was a medical doctor critically affected its ability to evaluate; 1) the propriety of CMCI's EMTALA medical screening examination under its Bylaws and, 2) the District Court's grant of summary judgement against Mr. Koel. The Tenth Circuit panel's error warrants

reversal of its order affirming the District Court's grant of summary judgment in favor of CMCI.

2. Both the District Court and the Tenth Circuit panel held that in order for CMCI to be held liable under EMTALA for improperly failing to stabilize or transfer a patient, CMCI must have had actual knowledge of a specific, emergency medical condition in the patient. That holding is inconsistent with the plain language of 42 U.S.C. § 1395dd(e)(1)(A) which defines "emergency medical condition." The definition of an "emergency medical condition" is couched in terms of the foreseeability of serious harm to the patient or unborn child. The statute provides that a patient who has a condition (not necessarily an identified or diagnosed condition) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in serious harm, has an emergency medical condition. The Tenth Circuit's interpretation of 42 U.S.C. § 1395dd(e)(1)(A) is entirely inconsistent with the language of the statute, which focuses on the type and severity of symptoms and not their etiology. The instant case presents an important question of statutory construction under EMTALA: Whether, for the purposes of stabilizing or transferring a patient manifesting acute severe symptoms, the definition of "emergency medical condition" means a specific, identifiable medical condition which the hospital must have knowledge of?

ARGUMENT

I. Both the District Court and the Circuit Court Panel Erred in Finding That the Active Participation of an Unqualified, Non-Medical Consultant in the Emergency Medical Screening Exam of Mr. Koel Did Not Violate EMTALA.

In 1986, Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd. Congress enacted EMTALA to address the problem of "dumping" patients in need of medical care. but lack health insurance. *See Abercrombie v. Osteopathic Hosp. Founders Ass'n,* 950 F.2d 676, 680 (10th Cir. 1991) "Under EMTALA, a participating hospital [footnote omitted] has two primary obligations. *See Ingram v. Muskogee Reg'l Med. Ctr.,* 235 F.3d 550, 551 (10th Cir. 2000). First, the hospital must conduct an initial medical examination to determine whether the patient is suffering from an emergency medical condition. *See Abercrombie,* 950 F.2d at 680. The second obligation requires the hospital, if an emergency medical condition exists, to stabilize the patient before transporting him or her elsewhere. *See Urban v. King,* 43 F.3d 523, 525 (10th Cir. 1994)." *Phillips v. Hillcrest Medical Center*, 244 F.3d 790 at 796 (10th Cir. 2001).

The precise statutory language pertaining to the initial medical examination is as follows:

(a)Medical screening requirement

> In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.

42 U.S.C. § 1395dd(a).

Although not specifically defined in the EMTALA statute, the term "appropriate medical screening examination" is to be considered in the context of the "capability of the hospital's emergency department, including ancillary services routinely available to the emergency department." Thus, the Tenth Circuit Court of Appeals in *Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519 (10th Cir. 1994) held that where a hospital promulgates a standard screening policy with respect to patients entering its emergency department, it defines which procedures are within its capabilities. "Indeed, hospitals, and not reviewing courts, are in the best position to assess their own capabilities. Thus, a hospital violates section 1395dd(a) when it does not follow its own standard procedures.[5] *Accord Baber,* 977 F.2d at 881 ('[A] hospital satisfies the requirements of § 1395dd(a) if its standard screening procedure is applied uniformly to all

patients in similar medical circumstances."); *Gatewood,* 933 F.2d at 1041 ('[A] hospital fulfills the 'appropriate medical screening requirement' when it conforms in its treatment of a particular patient to its standard screening procedures.'). [footnote omitted]" *Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519, 522 In footnote 5 of the court's opinion, the Tenth Circuit pointed out that EMTALA imposes a strict liability on a hospital that violates its own rules. However, the Circuit Court also allowed that any "slight deviation" by a hospital from its standard screening policy would not violate EMTALA. "Mere *de minimus* variations from the hospital's standard procedures do not amount to a violation of hospital policy. To hold otherwise would impose liabilities on hospitals for purely formalistic deviations when the policy had been effectively followed." *Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519, 523 (10th Cir. 1994)

In the instant case, CMCI's deviation from its own established policy was profound. According to CMCI's Bylaws, the only individuals qualified to conduct an emergency medical screening examination are: 1) Physicians (Medical Doctors or Doctors of Osteopathy), 2) Resident Physicians, 3) Nurse Practitioners, 4) Physician Assistants. (Pet.App.143a). Dr. Funk is none of these. He is an optometrist, who is specifically limited in his scope of practice. As demonstrated in the Interest of the Amici and Introduction sections above, the vast difference in education, training, and experience between an ophthalmologist and an optometrist is striking. In order to properly address the emergency medical condition (*See*, Point II *infra.*) that Mr. Koel presented with at the emergency room, *i.e.* a severely damaged right eye that was caused

by the application of trauma directly to the eye, the appropriate course would have been to have Mr. Koel seen by an ophthalmologist who could perform an examination, under anesthesia in the operating room, of the entirety of Mr. Koel's eye in order to rule out an open globe injury. That procedure was not within CMCI's capabilities and consequently would have triggered the transfer provisions of 42 U.S.C. § 1395dd(c). Dr. Kuhlman testified that if tests, including a CT scan, definitively established an open globe injury, he would have transferred Mr. Koel for an ophthalmologic exam. (Pet.App.249a-250a). Instead, Dr. Kulman, who was board certified in family medicine with no training in ophthalmology (Pet.App.30a), enlisted the assistance of optometrist Funk and allowed Dr. Funk to examine Mr. Koel's injured eye in the emergency room. Dr. Funk performed at least two examinations or tests on Mr. Koel; first, he examined Mr. Koel's eye using a slit lamp, and second, he performed a Seidel test. Dr. Funk testified that after performing these tests, he concluded that Mr. Koel did not have an open globe injury. (Pet.App.165a). Dr. Funk did not conduct, nor was he qualified to conduct a surgical examination of the entirety of Mr. Koel's eye. Dr. Funk recommended topical steroids and antibiotic drops which were ordered by Dr. Kuhlman.

Clearly, Dr. Funk's active participation in Mr. Koel's examination made Dr. Funk more than a curbside consultant on Mr. Koel's case. Dr. Funk was acting as a diagnostician because Dr. Kuhlman lacked the necessary background to operate a slit lamp. Dr. Kuhlman engaged Dr. Funk to perform a very significant portion of Mr. Koel's medical screening exam, notwithstanding the fact that O.D. Funk was not a

physician, and was not, according to a Corporate Representative of CMCI, Jenny Niblock, qualified to perform an emergency medical treatment exam. (Pet.App. 217a). Dr. Funk's active participation in Mr. Koel's medical screening examination came dangerously close to practicing medicine without a license.

Nevertheless, the District Court rejected Mr. Koel's claims that 1) CMCI (acting through Dr. Kuhlman) violated its own procedures by not referring Mr. Koel to a specialty physician and instead asked Dr. Funk to examine [Mr. Koel], and 2) Dr. Kuhlman delegated the responsibility to identify Mr. Koel's medical condition to Dr. Funk who was not qualified under CMCI rules. The District Court, in evaluating Mr. Koel's claims acknowledged that Mr. Koel's EMTALA expert, Dr. John Richard Ludgin, M.D., J.D., had opined that CMCI violated a number of its policies, but had not opined whether such violations were more than slight deviations from policy. (Pet.App.43a). Thus, the District Court framed the issue before it as follows:

> The question is whether any of the deviations Dr. Ludgin identified are more than slight deviations from policy or practice. This is not a situation where Plaintiff received no medical screening examination at all. To the contrary, Plaintiff was seen by multiple health professionals who administered multiple tests in an effort to diagnose the injury and determine the recommended treatment. But despite these tests, Dr. Kuhlman was unable to confirm a diagnosis other than "possible globe rupture." Plaintiff's federal claim for failing to provide an appropriate medical screening thus stands or falls on

> whether any deviations from policy and practice were de minimis. The Court concludes they were as would every reasonable jury."

Pet.App.44a.

The District Court then set forth its reasoning with respect to each of the claims raised by Mr. Koel.

> First, Dr. Kuhlman's recruitment of Dr. Funk's assistance did not violate CMCI's policies or bylaws. And it did not differ from his ordinary practice. Dr. Kuhlman testified that he often called an optometrist to help before talking with an ophthalmologist for eye injuries. Nothing in CMCI's rules prohibits CMCI from using additional resources to help in its screening process."

Pet.App.44a.

To characterize Dr. Funk's active participation in Mr. Koel's medical screening exam as merely "helping" in the process is thoroughly disingenuous. Citing to Dr. Kuhlman's testimony that he often "called an optometrist for help before calling an ophthalmologist for eye injuries" suggests that the optometrist was consulted to answer questions in the abstract, before Dr. Kuhlman spoke to a physician and surgeon. The record shows unequivocally that Dr. Funk actively participated in Mr. Koel's medical screening exam. Indeed, the record demonstrates that it was Dr. Funk's testing and examination of Mr. Koel's eye that served as the basis for the missed open globe. The ER report, which Dr. Kuhlman signed. recites "per optometry-right corneal laceration, temporal side, past pupil, no globe rupture." (Pet.App. 122a). Dr. Funk's actions were in direct contravention

of black letter hospital policy that only Physicians (Medical Doctors or Doctors of Osteopathy), Resident Physicians, Nurse Practitioners, and Physician Assistants are qualified to conduct a medical screening exam.

The District Court's legal contortions to excuse Dr. Kuhlman's, and consequently, CMCI's clear EMTALA violations found their full effect in the Court's finding that Dr. Kuhlman did not delegate the responsibility identify Plaintiff's medical condition to Dr. Funk, who was not qualified under CMCI rules. The Court found:

> Fourth, Plaintiff claims Dr. Kulhman delegated the responsibility to identify Plaintiff's medical condition to Dr. Funk, who was not qualified under CMCI rules. But Dr. Kuhlman still took full responsibility for Plaintiff's screening. He signed the emergency Room record. This is not a situation in which he or P.A. Keller were not involved in the examination at all. No reasonable jury could find that consulting Dr. Funk violated policy.

Pet.App.46a.

The District Court's conclusion that no reasonable jury could find that Dr. Kuhlman, in enlisting an unqualified, non-medical "consultant", who was by all accounts not qualified to perform an emergency medical screening exam, to examine Mr. Koel, perform two tests on his eye, opine, *incorrectly*, that Mr. Koel did not suffer from a particular medical condition, *i.e.*, an open globe, recommend a care plan which Dr. Kuhlman adopted and ordered, in direct contravention of a fun-

damental bylaw of the hospital, violated policy is nothing short of risible. In an effort to glaze over the damning facts of what occurred, the Court characterizes Dr. Kuhlman's conduct as "consulting Dr. Funk." In an attempt to shore up the Court's wobbly legal analysis, the Court added this gem of a footnote:

> [Fn 7] It seems illogical to discourage ERs from using available outside resources to help with specialty medicine. Having Dr. Funk respond was a benefit and not a detriment to Plaintiff when Dr. Kuhlman was less familiar with the proper tests to utilize.

Pet.App.46a.

Apparently, the Court believed that Mr. Koel should be appreciative that Dr. Kuhlman enlisted the assistance of a non-physician to "help with specialty medicine" with which Dr. Kuhlman had no familiarity. Dr. Kuhlman's reliance on a non-physician to conduct an examination of Mr. Koel's eye resulted in the missed diagnosis of an open globe. The operative facts of the instant case are so egregious, it is more accurate to say that no reasonable jury could have possibly found that Dr. Kuhlman, and consequently, CMCI did not violate the hospital's policy.

On appeal, the Tenth Circuit affirmed the District Court's grant of summary judgement against Petitioner. The Tenth Circuit panel made the following findings:

> Similarly, Section 10.4 of Citizens' Bylaws, titled "Emergency Medical Treatment Exam," provides that a medical screening examination may be conducted by *physicians* (*i.e.*, Drs. Kuhlman and Funk), resident physicians,

> nurse practitioners, or *physicians' assistants.* App. Vol. III, 200. Again, there is no requirement that a specialist be available to conduct an individual's medical screening examination. (italics in original)

Pet.App.9a.

The Tenth Circuit panel's finding is significant because it cites to Section 10.4 of CMCI's Bylaws, a policy of the hospital that helps define its capabilities. As the Tenth Circuit stated unequivocally in *Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519 (10th Cir. 1994): "Thus, a hospital violates section 1395dd(a) when it does not follow its own standard procedures. [footnote omitted]" *Repp* 43 F.3d at 522 And as previously discussed above, EMTALA imposes strict liability on a hospital that violates its own rules. In the instant case, the record is replete with facts establishing beyond cavil that Dr. Funk is not a licensed physician. Yet, the Tenth Circuit panel's decision discussing who may conduct a medical screening exam lists *physicians* in italics for emphasis and uses the abbreviation *i.e.*, meaning "that is" followed by "Dr. Kuhlman and Dr. Funk." Clearly, the Circuit Court panel's erroneous belief that Dr. Funk was a medical doctor critically affected its ability to evaluate; 1) the propriety of CMCI's EMTALA medical screening examination under its bylaws and, 2) the District Court's grant of summary judgement against Mr. Koel. The Tenth Circuit panel's error warrants reversal of its order affirming the District Court's grant of summary judgment in favor of CMCI.

II. Both the District Court and the Circuit Court Panel Erred in Applying an Overly Restrictive Interpretation of What Constitutes an Emergency Medical Condition.

In *Urban v. King*, 43 F.3d 523 (10th Cir. 1994) the Tenth Circuit held that in order for a hospital to be held liable for violating EMTALA's provisions relating to transferring patients who have an unstabilized emergency medical condition, the hospital must have actual knowledge of such unstabilized medical condition. The Court stated:

> A plain reading of the statute reveals actual knowledge of an unstabilized emergency medical condition as a requirement to establish liability. Subsection (c) requires the hospital to meet certain transfer conditions if the individual's emergency medical condition is not stabilized. The hospital cannot be held to stabilize an emergency situation without knowing an emergency exists. The Emergency Medical Treatment and Active Labor Act is neither a malpractice nor a negligence statute.

Urban v. King, 43 F.3d 523, 525

In *Urban,* the plaintiff was pregnant with twins and was deemed have a high-risk pregnancy. Plaintiff went to the obstetrics department of the Central Kansas Medical Center for a stress test. The test showed no fetal movement. However, fetal heart tones were identified for each twin and Ms. Urban's vital signs were normal. The nurse who conducted the test, after consulting with a doctor, but without informing Ms. Urban of the test results, instructed Ms. Urban

to come back to the Medical Center the next morning for another stress test. Ms. Urban returned the next day for the repeat test. During the repeat stress test, the morning nurse realized that something was wrong and called in another obstetrician/gynecologist, who ordered a biophysical profile, which revealed no movement or breathing in either fetus and the absence of fetal heart rate motion in one of the fetuses. A caesarian section was performed that day. One baby was delivered stillborn and the other was born with brain damage.

Ms. Urban, her husband, and the surviving infant child sued the Central Kansas Medical Center in District Court for violating the Emergency Medical Treatment and Active Labor Act, specifically 42 U.S.C. § 1395dd(c)(1)(A)(i) & (iii) , by sending her home after the first non-reactive stress test. The hospital moved for summary judgment and the District Court granted the motion holding that § 1395dd(c) requires a hospital have actual knowledge of an emergency medical condition before liability attaches pursuant to that section of the statute.

In affirming the District Court's grant of summary judgment, the Tenth Circuit employed the following analysis in determining that the hospital did not have actual knowledge that Ms. Urban had an emergency medical condition as defined in 42 U.S.C. § 1395 dd(e)(1).

> An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

> (i) placing the health of the individual . . . in serious jeopardy,
>
> (ii) serious impairment to bodily functions, or
>
> (iii) serious dysfunction of any bodily organ or part. . . .
>
> 42 U.S.C. § 1395dd(e)(1)(A); *Delaney v. Cade*, 986 F.2d 387, 392 (10th Cir. 1993). For Ms. Urban an emergency medical condition had not manifested itself. She was not in pain, and she had not displayed acute symptoms of severity at the time she was sent home from the obstetrics department. A facial reading of § 1395dd(e)(1) requires some manifestation of acute symptoms so the hospital would know of the condition.

Urban v. King, 43 F.3d 523 at 525-526.

The clear import of the Court's detailing the absence of pain, or other acute symptoms of severity is that if Ms. Urban had displayed such symptoms, the hospital would have known that she suffered from an emergency medical condition.

The Court's analysis make sense, because the definition of an "emergency medical condition" is couched in terms of the foreseeability of serious harm to the patient or unborn child. 42 U.S.C. § 1395dd (e)(1)(A) provides:

> The term "emergency medical condition" means—
>
> (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence

> of immediate medical attention could reasonably be expected to result in—
>
> (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
>
> (ii) serious impairment to bodily functions, or
>
> (iii) serious dysfunction of any bodily organ or part;

A patient having a medical condition (not necessarily an identified or diagnosed condition) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that *the absence of immediate medical attention could reasonably be expected to result* in serious harm has an emergency medical condition. It is certainly not an oversight on Congress' part that the statutory definition of emergency medical condition does not require the hospital to diagnose or identify a specific medical condition before the hospital is required to stabilize or transfer the patient. Rather, Congress mandated that hospitals, when a patient presents manifesting acute severe symptoms that, in the absence of immediate medical attention could reasonably be expected to result in serious harm, stabilize, or transfer such patient regardless of the patient's ability to pay.

In the instant case, Ricky Koel was the barely walking embodiment of an emergency medical condition. He had suffered severe trauma to his right eye. He was vomiting due to the severity of his pain. He had a laceration of the cornea and was bleeding from the eye. The average functioning adult could reason-

ably foresee that if Mr. Koel did not receive immediate medical attention, he could end up losing his sight in that eye or worse, losing the eye. Since time is of the essence in open globe injuries, an examination under anesthesia of the eye by an ophthalmologist (which was beyond the capabilities of CMCI to stabilize) as soon as possible was indicated. Had the Tenth Circuit employed in this case, the same analysis it employed in *Urban v. King*, 43 F.3d 523 (10th Cir. 1994), it would have recognized that Mr. Koel presented at the CMCI emergency room with an emergency medical condition that was beyond the capabilities of CMCI to stabilize. That finding would have implicated the transfer provisions of EMTALA.

Instead, the Circuit Court panel, erroneously believing that Dr. Funk was a medical doctor, put its imprimatur on a medical screening that was conducted in violation of CMCI's Bylaws (*See*, Point I, *supra*) and EMTALA regulations and affirmed the District Court's grant of summary judgment.

When the Circuit panel considered the claim that CMCI improperly discharged Mr. Koel and sent him home without stabilizing him, it made the following findings:

> Mr. Koel argues that he was improperly discharged under EMTALA because he was not stabilized before the discharge. This issue turns on whether Citizens had actual knowledge of Mr. Koel's occult globe rupture. Based on the record, we find no reasonable jury could find Citizens had actual knowledge of Mr. Koel's specific emergency medical condition—an occult globe rupture. Dr. Funk opined that Mr. Koel did not have an open

> globe rupture but had a closed globe, for which Citizens provided stabilizing measures. Importantly, as noted above, Citizens did not have the capability (*i.e.*, surgical exploration) to affirmatively identify whether Mr. Koel had an occult globe rupture. Accordingly, Citizens could not have had actual knowledge of Mr. Koel's specific, unstabilized emergency medical condition. And in turn, Citizens could not have been under an obligation to stabilize Mr. Koel for an occult globe rupture before discharging or transferring him because Citizens did not have actual knowledge of Mr. Koel's specific, unstabilized emergency medical condition.

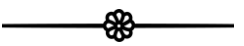
Pet.App.11a-12a.

The Tenth Circuit panel decision, by imposing a requirement that in order for a hospital to have "actual knowledge" of an emergency medical condition, the hospital must have knowledge of the specific medical condition causing the manifested symptoms, unreasonably restricts the scope of the definition of "emergency medical condition" set forth in 42 U.S.C. § 1395dd(e)(1)(A). Such a requirement is entirely inconsistent with the language of the statute, which focuses on the type and severity of symptoms and not their etiology. A patient presenting with severe, acute symptoms that if left untreated could foreseeably result in serious harm to the patient or the patient's unborn child, has an emergency medical condition regardless of the cause of the symptoms. It is the foreseeable harm that should dictate the hospital's action. Dr. Kuhlman testified that if Mr. Koel's diagnosis was an open globe Dr. Kuhlman would have transferred

Mr. Koel out for an ophthalmologic examination and recommended treatment. But on the state of the information Dr. Kuhlman had, Mr. Koel had an emergency medical condition that was beyond the capabilities CMCI to properly stabilize. Mr. Koel should have been immediately transferred to a facility that could properly address his condition.

The Tenth Circuit's requirement that the hospital have actual knowledge of the specific medical condition causing symptoms before stabilizing or transferring the patient, allows the hospital avoid any costs associated with a transfer, or treatment or any liability for an EMTALA violation by conducting a medical screening examination arguably within its capabilities, and if the hospital cannot confirm the existence of a specific medical condition discharge the patient. This is exactly what happened to Mr. Koel. The Tenth Circuit's "specific medical condition rule" flies in the face of the Congress' main purpose in enacting EMTALA, and is inconsistent with the clear language of 42 U.S.C. § 1395dd(e)(1)(A).

The instant case presents an important question of statutory construction under EMTALA: Whether for the purposes of stabilizing or transferring a patient manifesting acute severe symptoms, the definition of "emergency medical condition" means a specific, identifiable medical condition which the hospital must have knowledge of? The Amici submit that it does not.



CONCLUSION

For the reasons stated, Mr. Koel's petition for a writ of certiorari should be granted.

Respectfully submitted,

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