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IN THE

UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

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Case No. # 97-4464

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THEODORE CHERUKURI, MD,	PETITIONER
v. DONNA E. SHALALA, PHD, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CAROL WEIL, SENIOR COUNSEL, OFFICE OF COUNSEL TO THE INSPECTOR GENERAL,	RESPONDENTS

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ON APPEAL FROM A FINAL DECISION
ON REVIEW OF AN ADMINISTRATIVE LAW JUDGE
DECISION BY THE DEPARTMENTAL APPEALS BOARD OF
THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

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BRIEF OF PETITIONER

Final Brief

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Respectfully submitted by:

Mr. G. Chad Perry, III
Mr. John David Preston
POD C
Paintsville, KY 41240
606-789-5395
(FX) 16067893976
Attorneys for the Petitioner

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==========**I. TABLE OF CONTENTS**

SECTION	HEADING	PAGE
I.(B)	STATEMENT REGARDING ORAL ARGUMENT	i
II.	STATEMENT OF SUBJECT MATTER AND APPELLATE JURISDICTION	ii
	(i) STATEMENT OF BASIS FOR SUBJECT MATTER JURISDICTION	

(ii) Statement of Basis for Jurisdiction in the Court of Appeals, Sixth Circuit ii
III. Issues Presented for Review 1
IV. Statement of the Case 2
(A) Brief nature of the case / procedural history 2
(B) Brief overview of the relevant medical facts 3
(C) standard of review 5
(D) Facts relevant to the issues presented for review 8
V. Summary of Argument 13
VI. An Argument 18
Issue I. The Secretary erred in the application of the EMTALA statute to Dr. Cherukuri since the uncontroverted evidence demonstrated that Dr. Cherukuri toiled all night to save two patients' lives and did save the patients. 18
Issue II. The ALJ committed legal error where she ignored in excess of sixty federal cases in which courts have interpreted the Act beyond the DHHS's own regulations and beyond the Act's organic language. 25
Issue II.A. If Dr. Cherukuri is found blameless where he provided good faith medical care, the decision would be consistent with all other DHHS cases and with all case law. 30
Issue II.B. Other inconsistencies in the decision's logic require that the decision should be remanded for analysis consistent with the facts. 31
(i) St. Mary's Status 31
(ii) Who Ordered Transfer 32
(iii) Order Dr. Thambi to Perform Anesthesia 33
(iv) Objection to CMP 34

Table of Contents, continued

	ISSUE III. THE ALJ ERRED WHEN SHE DID NOT PERMIT DR. CHERUKURI THE AFFIRMATIVE DEFENSE THAT HIS INABILITY TO COMPLY WITH THE STATUTE WAS DUE TO ESTABLISHED HOSPITAL POLICY AND DR. THAMBI'S REFUSAL TO PROVIDE ANESTHESIA SERVICES.	35
	ISSUE IV. THE ALJ ACTED UNREASONABLY WHEN SHE IMPOSED A CMP UPON DR. CHERUKURI WHICH WAS DISPROPORTIONATE TO THE CONDUCT PROVEN BY THE IG AND INCONSISTENT WITH OTHER DECISIONS.	41
	(i) THE FINE IS UNREASONABLE	41
	(ii) IF NO NEGLIGENCE, THEN NO FINE	43
	(iii) MITIGATING CIRCUMSTANCES	44
VII.	CONCLUSION	44
VIII.	APPENDIX TO THE BRIEF	
	(A). INDEX TO APPENDIX	

(A) TABLE OF AUTHORITIES

Case	**Page**
Baber v. Hospital Corp. of Am., 977 F.2d 872 (4th Cir. 1992)	22, 23, 27, 32
Brodersen v. Sioux Valley Memorial Hospital, 902 F. Supp. 931 (Iowa 1995)	20, 21, 23, 24, 25
Brooks v. Maryland Gen. Hosp., Inc., 996 F.2d 708 (4th Cir. 1993)	22, 23
Burditt v. United States Department of Health And Human Services, 934 F.2d 1362 (1991)	ii,8,29,42, 43, 44
Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266 (6th Cir. 1990)	22, 23, 24, 27,
Coleman v. McCurtain Memorial Medical Management, 771 F. Supp. 343 (E.D. Okla. 1991)	24
Deberry v. Sherman Hosp. Ass'n, 769 F. Supp. 1030, 1034 (N.D. Ill. 1991)	24
Delaney v. Cade, 986 F.2d 387 (10th Cir. 1993)	27
Evitt v. University Heights Hosp., 727 F. Supp. 495 (S.D. Ind. 1989)	24
Florida Power & Light Co. v. Lorion, 470 U.S. 729 (1985)	5
Gatewood v. Washington Healthcare Corp., 933 F.2d 1037 (D.C. Cir. 1991)	22, 23, 30, 32
Holcomb v. Monahan, 30 F.3d 116 (11th Cir. 1994)	22
Hudson Transit Lines. Inc. v. United States of America Interstate Commerce Comm'n., 765 F.2d	7

329 (2nd Cir. 1985)
Magnuson v. Video Yesteryear, 85 F.3d 1424 (9th Cir. 1996) 8
New York v. Shalala, 1996 U.S. Dist. LEXIS 2261 (1996) 5,6,7,8, 25
Nichols v. Estabrook, 741 F. Supp. 325 (D.N.H. 1989) 24
N.L.R.B. v. Springfield Hosp., 899 F.2d 1305 (2d Cir. 1990) 8
N.Y.S.D.S.S. v. Shalala, 21 F.3d 485 (1994) 5
Repp v. Anadarko Municipal Hosp., 43 F.3d 519 (10th Cir. 1995) 27
Stewart v. Penny, 238 F. Supp. 821 (D.C. Nev. 1965) ii

TABLE OF AUTHORITIES, CONTINUED

Stewart v. Myrick, 731 F. Supp. 433 (D. Kan. 1990)	24
Thornton v. Southwest Detroit Hospital, 895 F.2d 1131 (6th Cir. 1990)	19, 27
Vargas v. Del Puerto Hospital, 98 F.3d 1202 (9th Cir. 1996)	8,28
Weeks v. Quinlan, 838 F.2d 41 (2d Cir. 1988)	6
Williams v. Birkeness, 34 F.3d 695 (8th Cir. 1994)	23, 27
ACTS, STATUTES AND OTHER AUTHORITY	
Social Security Act of 1964, §1867	2
42 C.F.R. 489.24	2
42 C.F.R. § 1003	2
42 C.F.R. § 1003.106(a)(4)	13
42 C.F.R. § 1003.106(b)(5)	44
42 C.F.R. § 1005.21(k)(2)	ii
5 U.S.C.S. § 702 (1997)	ii
5 U.S.C. § 706(2)(A) (1982)	7
5 U.S.C. § 706(2)(E.)	7
28 U.S.C. §1296	ii
28 U.S.C. §1331	ii
28 U.S.C. §1391	ii
42 U.S.C.A. §1320a-7a(e) (1997)	ii
42 U.S.C.A. §1320a-7a(f) (1997)	ii
42 U.S.C. §1395dd	ii,2, 27, 28, 29, 32, 43
HR Rep. No. 241, 99th Cong., 2nd Sess., 27, reprinted in U.S. Code Cong. & Ad. News 42, 605-06, 726-55	19
H.R.Rep. No. 241(III), 99th Cong., 1st Sess. 6, reprinted in 1986 U.S.C.C.A.N., 42, 726-727	22
131 Cong. Rec. § 13904, October 23, 1985	20
ARTICLES	
Robert J. Levine, et al., Analysis of Federally Imposed Penalties for Violations of the Consolidated Omnibus Reconciliation Act, 28(1) Annals of Emergency Medicine 45 (1996)	32, 41
Elliott B. Oppenheim, EMTALA: Its First Decade; A Retrospective Analysis of 42 U.S.C. § 1395dd, 43(4) MED. TRIAL TECH. Q. 77, 112-115 (1997)	16,24, 30
MANUALS	
Comprehensive Accreditation Manual for Hospitals, Joint Commission on Accreditation of Healthcare Organizations (1996)	33, 39

(B) STATEMENT REGARDING ORAL ARGUMENT

Dr. Cherukuri respectfully seeks 30 minutes per side for oral argument. This case is the most important EMTALA case to come before any court since it challenges the paradoxical imposition of disproportionate fines by the Department of Health and Human Services against a physician who should be hailed as a hero. No practitioner has ever been fined so much under the Act's provisions or held accountable where he provided good faith medical care. The opportunity to address the court on these matters is integral to Petitioner's legal and factual advocacy.

The Court's decision will guide national medical policy and the decision will influence emergency medical care in every trauma facility from Bangor, Maine to Bangor, Washington. If the Court sustains the Departmental Appeals Board's determination, surgeons throughout the nation will be less likely to attend emergency patients who present with catastrophic injuries.

This case would be difficult to resolve without oral argument since there may remain important factual questions or interpretations of case law about which the honorable justices may need to speak with counsel directly. For these reasons, Petitioner requests this opportunity to be heard.

II. Statement of Subject Matter and Appellate Jurisdiction

(i) Statement of Basis for Subject Matter Jurisdiction

This Court maintains subject matter jurisdiction under 42 U.S.C.A. §1320a-7a(e) (1997) and 42 U.S.C.A. §1320a-7a(f) (1997); Burditt v. United States Department of Health And Human Services, 934 F.2d 1362, 1367 (1991). The Court maintains appellate jurisdiction under 42 C.F.R. §1005.21(k)(2) and 28 U.S.C. §1296.

There is federal question jurisdiction, 28 U.S.C. §1331, since this case involves the interpretation of the federal statute, 42 U.S.C. §1395dd.

(ii) Statement of Basis for Jurisdiction in the Court of Appeals, Sixth Circuit

The conduct alleged took place at Williamson Appalachian Regional Hospital located in Williamson, Kentucky. Both jurisdiction over the parties and venue are proper in this Court of Appeals. 28 U.S.C. §1391. Appeal comes after a final determination from the Secretary of Health and Human Services. A final determination of the Department of Health and Human Services is reviewable under the Administrative Procedure Act, , 5 U.S.C.S. § 702 (1997); Stewart v. Penny, 238 F. Supp. 821 (D.C. Nev. 1965). By these statutory authorities Dr. Cherukuri is entitled to judicial review both in this court and at this time.

III. Issues Presented For review

I. **Whether the Secretary erred in the application of the EMTALA statute to Dr. Cherukuri when the uncontroverted evidence demonstrated that Dr. Cherukuri toiled all night to save two patients' lives and he did save the patients.**

Petitioner answers: Yes. No physician has ever been fined when he delivered good-faith medical care.

IV. **Whether the ALJ acted unreasonably when she imposed a CMP upon Dr. Cherukuri which was disproportionate to the conduct proven by the IG and inconsistent with other decisions.**

Petitioner answers: Yes. No physician has ever been fined over $20,000 and Dr. Cherukuri's conduct did not merit a fine five times greater than the most stringent treatment ever meeted out to a provider under this Act.

IV. Statement of the Case

(A) Brief Nature Of The Case; Procedural History

The OIG prosecuted Dr. Theodore Cherukuri for alleged violations of the "anti-dumping" statute, EMTALA. Dr. Cherukuri has been fined $100,000 by the Department of Health and Human Services [DHHS]. This matter arose through the Office of Inspector General in a civil prosecution under The Social Security Act § 1867(a); 42 C.F.R. 489.24 and 42 C.F.R. Part 1003; 42 U.S.C. § 1395dd, *et seq*..

On September 20, 1995 the Inspector General (IG) of the Department of Health and Human Services (DHHS) by letter informed Dr. Theodore Cherukuri of the IG's determination.

Respondent appeared before the ALJ in hearings lasting four days. Dr. Cherukuri argued no case law and cited no legal authorities for his position.

The Honorable Administrative Law Judge Mimi Hwang Leahy imposed fines on each violative count.

Dr. Cherukuri appealed the adverse decision on 24 July 1997 and DAB declined to review the case and by letter dated 17 November 1997, the Department informed Dr. Cherukuri. The ALJ's initial decision of May 1997 became a final determination. Appeal of the ALJ's final determination was then filed in this Court in a timely manner.

(B) BRIEF OVERVIEW OF THE RELEVANT MEDICAL FACTS

Sean Crum, 19 years old, and Delmar Mills, 22 years old were involved in a violent auto accident in the early hours of 15 September 1991. There were three other persons injured although none were as severely injured as Crum and Mills. All **five victims** were taken to Williamson Appalachian Regional Hospital (Williamson), a small hospital with a 75-80 bed capacity. Of the five original trauma victims, the two patients, Crum and Mills, were then transported by ambulance to St. Mary's Hospital (St. Mary's); 400 beds.

Mr. Crum, Inspector General exhibit 2, sustained profound injuries including an head injury and Mr. Mills sustained, Inspector General exhibit 3, severe injuries including an head injury. Both patients required the **full**

services of a sophisticated trauma team. This level of care was not present at Williamson.

Williamson does not have the ability to handle neurosurgery in the context of abdominal trauma. Dr. Theodore Cherukuri he responded to the E.R. physician's call promptly and arrived at 3:30 AM.

Dr. Cherukuri performed a peritoneal lavage on both Mills and Crum and determined that both were bleeding in the abdomen. Dr. Cherukuri stabilized the two patients' physiologic problems and decided to operate. He summoned anesthesiologist Dr. Thambi but he refused to perform anesthesia.

Dr. Cherukuri asked the nurses to call others who could perform anesthesia but none were available and Dr. Cherukuri attempted to contact the hospital administrator, Mr. C.D. Glover. The administrator was not available.

Dr. Cherukuri then called Dr. Arya at St. Mary's Hospital who told Dr. Cherukuri that if he couldn't get anesthesia, then he should transfer the patients. Dr. Cherukuri or the nurses called **Dr. Thambi six times but this on-call doctor** arrived at the hospital some **2 ¾ hours** after the initial call. At that time, Dr. Thambi examined at least one patient and he then left the hospital.

In the face of Dr. Thambi's refusal to perform anesthesia, Dr. Cherukuri could not perform surgery on these boys and Dr. Cherukuri was forced to do nothing definitive at Williamson or to transfer both boys to St. Mary's Hospital by helicopter, a level one major trauma facility of 400 beds located nearby. Dr. Cherukuri, through the nurses, arranged to transfer both patients to St. Mary's Hospital by ambulance.

Neither patient suffered any deterioration as a consequence of Dr. Cherukuri's treatment.

(C) STANDARD OF REVIEW

The Administrative Procedure Act applies to proceedings before the DHHS, New York v. Shalala, 1996 U.S. Dist. LEXIS 2261 (1996), and the Act specifies that judicial review is "narrow." 1996 U.S. Dist. LEXIS 2261, *15. The Court's remedy if the administrative record "'does not support the agency action . . . is to remand to the agency for additional investigation or explanation'" rather than to admit new evidence. New York v. Shalala, 1996 U.S. Dist. LEXIS 2261, *17 (citing N.Y.S.D.S.S. v. Shalala, 21 F.3d 485, 493 (1994) (quoting Florida Power & Light Co. v. Lorion, 470 U.S. 729, 744 (1985).

Where the reviewing court is called upon to determine whether an agency's construction of a statute is contrary

to federal law, the Court must first inquire whether Congress has spoken to the precise question at issue. New York v. Shalala, 1996 U.S. Dist. LEXIS 2261, *23-24. If so, the Court must give effect to Congressional intent as discerned from the language and legislative history of the statute. Id.

If, however, the statute is "silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute," Id. at 23, that is not at odds with a "definitive contrary legislative command." Id.

In its review, an Agency must be reasonable and must interpret statutes in accordance with its own regulations. While the Agency's interpretation need not be the only interpretation possible or the one which the reviewing court would adopt, a Court may not sustain the Agency's interpretations where they are plainly wrong. Weeks v. Quinlan, 838 F.2d 41, 43 (2d Cir. 1988).

The APA is consistent with Fed. R. Civ. Proc. 52 which provides that "findings of fact … shall not be set aside unless clearly erroneous." With regard to plain error, The Administrative Procedure Act provides that a "Court reviewing a decision made by an administrative agency shall 'hold unlawful and set aside agency action, findings, and

conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.'" Hudson Transit Lines. Inc. v. United States of America Interstate Commerce Comm'n., 765 F.2d 329, 336 (2nd Cir. 1985) (quoting 5 U.S.C. § 706(2)(A) (1982)).

In determining whether agency action is arbitrary or capricious under the Administrative Procedure Act, a court must examine whether the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problmm, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise. New York v. Shalala, 1996 U.S. Dist. LEXIS 2261, *34.

A court may overturn an agency's interpretation of its own regulation only if that interpretation is "**plainly erroneous**." New York v. Shalala, 1996 U.S. Dist. LEXIS 2261, *34. Similarly, DAB's formal findings of fact may not be overturned unless they are unsupported by **substantial evidence in the record**. See 5 U.S.C. § 706(2)(E). Thus, the agency's factual findings will not be disturbed unless the Court determines after examining the record that "no rational trier of fact could reach the conclusions drawn by

the [agency]." N.L.R.B. v. Springfield Hosp., 899 F.2d 1305, 1310 (2d Cir. 1990). In addition, any issues a party contests on an appeal from the agency action must have been raised at the proper time before the agency. New York v. Shalala, 1996 U.S. Dist. LEXIS 2261, *36-37.

Finally, the controlling, and only, case with respect to the applicable standard of review to be applied in an EMTALA case where CMP's have been imposed against a physician is Burditt v. U.S. Department of Health and Human Services, 934 F.2d 1362 (1991). The reviewing court in Burditt stated, "We will uphold DAB's fact findings if they are 'supported by substantial evidence on the record considered as a whole." Id. And a "court of appeals can only invalidate an administrator's interpretation [of a statute imposing a civil monetary penalty] if that interpretation is unreasonable." Burditt, 934 F.2d 1362, 1367-68.

In a recent EMTALA case in California, Vargas v. Del Puerto Hospital, 98 F.3d 1202, 1204 (9th Cir. 1996), the appellate court reviewed the trial court's findings of fact for clear error and its conclusions of law de novo. In accord and relied upon by the Vargas court, Magnuson v. Video Yesteryear, 85 F.3d 1424, 1427 (9th Cir. 1996).

(D) FACTS RELEVANT TO THE ISSUES PRESENTED FOR REVIEW

Dr. Cherukuri objects to the Findings of Fact and Conclusions of Law entered by the honorable Judge Leahy in a number of respects.

The decision includes no preliminary analysis to justify the application of the proceedings or decision to Dr. Cherukuri. FFCL 2.

In FFCL pages 32-34, findings VI, 29-31, the ALJ concluded that the transfers were not appropriate. The ALJ stated that it was "immaterial whether St. Mary's Hospital was a tertiary care facility or had the capacity to treat the emergency medical conditions of Sean Crum and Delmar Mills without advance notice."

In section VIII, conclusions 37-41, FFCL 36-40, the ALJ denied the affirmative defense under section 1867(d)(1)(C) of the Act. Her denial was based upon the findings of fact that the affirmative defense is not available "to a physician in Respondent's situation who has not only denied having ever ordered either of the transfers at issue, but who has also never signed or counter-signed the transfer forms to certify that he was the physician who made the risk-benefit evaluation specified by law."

Further, in the record, Id. ¶ 7 - Id. at 38, ¶ 1-2, the ALJ noted that Dr. Cherukuri contemporaneously wrote in the

chart, "Anesthesiologist not willing to put the pt to sleep. He advised transfer immediately to Cable Huntington Hospital. (IG Ex 2, at 17); and "Dr. Thambi refused to give anesthesia." (IG Ex.3 at 2).

Then the ALJ concluded that this affirmative defense was not available to Dr. Cherukuri since, after the fact, in the hearings, according to the ALJ, Dr. Cherukuri denied ordering the transfers, that he never signed or counter-signed the transfer orders. The ALJ then concluded that Dr. Cherukuri "caused the transfer to occur under the circumstances discussed above" and then the ALJ wrote the footnote:

> **It is not necessary that I decide in this case which doctor, if any, ordered the transfer of Sean Crum or Delmar Mills.** [emphasis added]

FFCL 38, n.. 28.

After denying Dr. Cherukuri the affirmative defense, the ALJ evaluated the issue of the anesthesiologist's unavailability. FFCL 39-40. Here, she neglected to analyze the testimony with respect to Dr. Thambi's presence or absence in the E.R. other than in footnote 29: "… Respondent [Dr. Cherukuri] testified to having to search for an anesthetist for surgery after he advised Dr. Hani and the nurses at 4:00 AM, to transfer the patients

immediately. FFCL 39 n.29. (citing IG Ex.2 at 17; IG Ex. 3; Tr.857-59).

In Section IX, FFCL 40-55, Judge Leahy then provided her analysis on the issue why Dr. Cherukuri should not receive the benefits of an affirmative defense basing this in her sense that Dr. Cherukuri was not a credible witness. FFCL 40, items 42-44. Then, Judge Leahy concluded that since Dr. Cherukuri believed surgery was appropriate that for Dr. Cherukuri to "direct Dr. Thambi to administer anesthesia and to eliminate any misunderstanding that may have existed" over whether Dr. Thambi wanted to proceed with surgery.

The ALJ rested her analysis on the **IG's medical experts'** opinions. FFCL 42, ¶ 3. The ALJ then concluded that "if a surgeon decides that surgery should be performed, it is the surgeon's duty to tell the anesthesiologist to administer anesthesia, and it is the surgeon's responsibility to resolve any misunderstandings that may exist with the anesthesiologist." (citing Tr. 980T, 1009T).

The ALJ then noted the "conflicting version of the events" and resolved the "conflict" in favor of the IG wher she found "insufficient credible evidence to support" Dr. Cherukuri's contention that "he … directed Dr. Thambi" to

administer anesthesia and "that Dr. Thambi refused to administer anesthesia." FFCL 42-43. The ALJ then examined the apparently conflicting renditions, and noted Pat White's statement, FFCL 44, ¶ 3, then interpreted White's version as lacking a preponderance of credibility.

The ALJ did not find credible the fact that Dr. Thambi did not come to the E.R. for nearly three hours as evidence of his unwillingness to perform anesthesia. FFCL 45 ¶ 1. The ALJ could not find in the record any evidence that Dr. Thambi "uttered any outright refusal to administer anesthesia." FFCL 45, ¶ 1.

Further, the ALJ concluded that the hospital's long-standing policy NOT to anesthetize these types of patients, did not "substantially" contribute to the delay and to Dr. Thambi's reluctance to perform anesthesia. FFCL 45 ¶ 2. The ALJ did not find that Dr. Thambi was **told** to administer anesthesia.

The ALJ then cited the **long-standing policy** to transfer, the testimony by White, Glover, Smith, and Thambi, in this regard, FFCL 45, ¶ 3, the fact that Dr. Thambi had **never** performed "surgery of any type at Appalachian Regional Hospital on a patient with head injury." The ALJ then concluded that she would "expect" some documentation of these matters, FFCL 46, ¶ 3, in this

"chaos" had the facts transpired the way Dr. Cherukuri contended.

The ALJ concluded that an "hospital official" can be reasonably expected to "affirmatively support a surgeon's orders to an anesthesiologist." FFCL 50, ¶ 3. Testimony of Pat White then supported the fact that the administrator was unavailable. Id.

In order to reach her ultimate conclusion, Judge Leahy discounted competent testimony by Pat White, FFCL 50, ¶ 2. The ALJ did not find this testimony credible due to a documentation defect rather than finding some internal inconsistency with the witness' testimony. Further, she did not find Dr. Cherukuri credible even though she was not able to "determine with certainty the contents of the conversations held between Dr. Thambi and Dr. Cherukuri. FFCL 52, ¶ 2.

Next, in arriving at the CMP under 42 C.F.R. § 1003.106(a)(4), FFCL 55, the ALJ referenced the fact that Dr. Cherukuri did not submit any argument "to show the amount of the CMP" was unreasonable. Further, Judge Leahy found "reasonable" the face amounts of $50,000 for each violation. FFCL page 55, section X, item 55. However, the ALJ did not provide any comparison to other cases where the DHHS fined other physicians nor did she consider whether

there were any extenuating circumstances and, finally, DAB never read Dr. Cherukuri's brief on appeal to DAB.

V. SUMMARY OF ARGUMENT

Congress did not intend the DHHS to apply the Act to Dr. Cherukuri, a physician who provided good-faith medical care. The record reflects that the Inspector General did not establish that Dr. Cherukuri departed from the standard of care in any instance. Without a departure from the standard of care, at a minimum, there can not be an EMTALA violation. Further, where there is no disparate treatment shown, there can not be an EMTALA violation.

Dr. Cherukuri provided excellent medical care within the capabilities of the recipient hospital. That is what the Act mandates and Dr. Cherukuri met that standard. EMTALA does not regulate the situation where physician has **substantially complied** with the intent of the Act. The Act does not apply where there are merely questions involved with medical care and treatment decisions which remain wholly within the province of the practitioners.

The patients received an appropriate medical screening, were stabilized prior to transfer, and appropriate transfers were achieved. No patient suffered any form of harm as a consequence of Dr. Cherukuri's care and treatment.

No facts witness stated that Dr. Cherukuri did anything wrong. Both adverse expert witnesses failed to criticize Dr. Cherukuri if anesthesia were actually unavailable. The preponderance of the evidence supports the fact that there was no anesthesia available.

Dr. Cherukuri is entitled to the affirmative defense since he was prevented from administering care due to the unavailability of another on-call practitioner, Dr. Thambi. **Dr. Cherukuri was unable to comply with the Act's provisions due to the conduct of another physician, the rules and regulations of the hospital, and the practice patterns prevailing in the rural mountain community.**

No facts witness who knew about the capabilities at Appalachian Regional Hospital testified that there was the availability of safe anesthesia at Williamson. **Dr. Cherukuri was precluded from performing surgery through the acts of another person and by hospital policy.**

Only the ALJ saw this issue otherwise. In a contorted misunderstanding of medical practice the ALJ reached a decision which **ignored all testimony from fact witnesses**, ignored the plain language of the statute, and adopted the view expressed by the OIG's expert witnesses. Here she illogically concluded that Dr. Cherukuri was not credible and that he somehow should have **forced** a licensed

independent practitioner, Dr. Thambi, to perform anesthesia in violation of his professional judgment and established hospital policy.

No rational trier of fact could reach such a conclusion; the Act does not mandate such measures, and as a national rule for trauma care, such conduct would result in irrational confrontations in emergency rooms through America.

Dr. Cherukuri was further sandbagged by fog. Nevertheless, even without helicopter evacuation and after ground ambulance transport, neither patient sustained any harm from the transfer. Because Dr. Cherukuri was "up to his neck in alligators" and the staff was "overwhelmed," some important paperwork was not appropriately completed and there are some questions about whether the transfers were expressly approved in advance. Despite these impediments, Dr. Cherukuri saved the patients and substantially complied with the Act's provisions.

EMTALA is an example of a statute with drafting imprecision but to give sense to the Act, to bring fairness to litigants, to implement Congressional intent to prevent dumping, the Act's literal organic language has been remodeled by case law. JA 001; and JA 003, Elliott B. Oppenheim, EMTALA: Its First Decade; A Retrospective

Analysis of 42 U.S.C. § 1395dd, 43(4) MED. TRIAL TECH. Q. 77, 112-115 (1997) (hereinafter OPPENHEIM).

In her decision, the **ALJ cited no case law** despite the existence of in excess of sixty federal decisions which have interpreted the literal organic language of the Act. Dr. Cherukuri is entitled to have his case decided to include the generous and favorable body of case law. For the ALJ to ignore these cases is plain error. There are, additionally, three internal inconsistencies within the decision which must be addressed in remand.

Further, the CMP imposed, in view of the fact that the Act does not regulate this medical conduct, and its face amount, is unreasonable.

The policy of the Department must be to prosecute and to fine only those practitioners who do not provide medical care in good faith. Dr. Cherukuri did exactly what he should have done in the Hippocratic tradition and to fine this practitioner makes no sense.

This Court's decision will be pinned to bulletin boards in every trauma facility in America and the decision must be consistent with other decisions. DAB has gone too far in applying the Act to Dr. Cherukuri's treatment decisions made in good faith medical care. No practitioner has ever been fined where he provided good- faith care.

The Cherukuri decision is the most important decision in EMTALA's history since it tests the reach of the Act's regulatory powers. Dr. Cherukuri implores this court, on his behalf and on the behalf of those patients who will need medical care after traumatic injury not to perpetuate a wrong and illogical decision which would cause the hands that cure to tremble in fear of unreasonable federal government second guessing at the very moment those hands must remain ready and steady to cure.

VI. An Argument: Issue I

The Secretary misapplied this Act to Dr. Cherukuri's conduct. If Dr. Cherukuri did not "dump" the statute does not apply to him. To "dump," a physician must deny access to medical care where the physician has a duty to provide care and there must exist a non-medical motive.

The standard of review here is *de novo* since the question is one of pure law. Here, this Court must give effect to Congress' intent as discerned from the plain language of the statute and from the legislative history. The court must decide whether the Agency failed to consider an important aspect of the problem. Here, the Department wrongly applied the Act.

Dr. Cherukuri provided good, appropriate medical care in a time of "chaos" in an emergency room in rural West

Virginia. Mr. Crum hovered near death, and Mr. Mills was similarly injured although is condition was less severe. Both patients required the full services of a complete trauma team. The "trauma team" at Appalachian Regional Hospital consisted of two doctors and two nurses who were called upon to treat five critically injured patients. To criticize Dr. Cherukuri or any of those who helped that night is cruel, humanly indecent, and contrary to the law in America.

Legislative intent of the Act guides how the Act is to be implemented. In Thornton v. Southwest Detroit Hospital, 895 F.2d 1131 (6th Cir. 1990), in this Circuit, the court reviewed the legislative intent of the Act with respect to the social ill the Act was intended to correct. The Act requires hospitals to give emergency aid to indigent patients who suffer from an "emergency medical condition." The Court reasoned that Congress enacted EMTALA to prevent hospitals from dumping patients; refusing to treat patients who lack insurance to pay for their claims by either refusing treatment or transferring them to other hospitals. Id. at 1132, 1135 (Judge Jones concurring opinion).

The economic motive to shunt patients away from a facility was paramount to The Honorable United States Senator Kennedy (D-Mass.). JA 036: 131 Cong. Rec. § 13904,

October 23, 1985 (statement of Senator Kennedy). Senator Kennedy defined "dumping" as a denial of emergency medical care based upon indigency or upon racial discrimination. Id.

There is no question that Dr. Cherukuri **wanted** to provide medical care and he confronted the bloody terror of a lonely E.R. and a foggy night. Dr. Cherukuri **did not dump; this Act does not regulate Dr. Cherukuri's conduct.**

In Brodersen v. Sioux Valley Memorial Hospital, 902 F. Supp. 931 (Iowa 1995), the Court analyzed the legislative intent of the statute. Id. at 935-36. The attending physician examined the patient in the E.R., prescribed medicine, and **then left the E.R.**, abandoning his patient. The patient went into cardiac arrest, was transferred by air ambulance, went into cardiac arrest while aloft, then died. Id. at 1136. Anyone would readily identify that leaving a patient in such condition was heartless conduct. This conduct exemplifies medical behavior the Act was intended to regulate. Brodersen's doctor "dumped" his patient.

Contrast Dr. Cherukuri's conduct to the physician in Brodersen, Dr. Cherukuri stayed all night long at the bedside in hand to hand combat with death. He did not abandon these patients.

After reviewing the social ills the Act was intended to remedy, the same as those cited in Thornton, *supra*, the Brodersen court, provided various examples of "dumps." Brodersen, 902 F. Supp. 931, 940 n.8. JA 040. According to the Congressional intent as expressed in Brodersen, Dr. Cherukuri's care and treatment does not fall within the Act.

Dr. Cherukuri (1) came to the E.R. in the middle of the night, (2) examined five patients, (3) admitted three to Williamson; for two he (4) placed chest tubes, (5) placed breathing tubes, (6) inserted intravenous lines, (7) placed a tube into both injured man's belly to diagnose whether there was bleeding, (8) he called the transferee hospital, (9) he negotiated with Dr. Thambi, he (10) tried to call the hospital administrator, (11) he arranged or caused to be arranged transfers to St. Mary's. he denied the patients nothing. Dr. Cherukuri transferred only when he had no medical alternative. His conduct did not constitute "dumping."

Physicians who refuse good faith medical care when they have a duty to provide care must be punished but it is obvious that **there is no medical parallel** between the medical care dished out to these unfortunate patients and the compassionate care and treatment Dr. Cherukuri provided

Sean Crum and Delmar Mills. **Dr. Cherukuri provided safe medical care within the resources available and, when he encountered obstacles, he transferred these boys safely.**

In footnote 9, the Brodersen court observed that the concern of the Committee which wrote that the Act intended "appropriate emergency room care be provided to patients faced with medical emergencies …" (citing H.R.Rep. No. 241(III), 99th Cong., 1st Sess. 6, reprinted in 1986 U.S.C.C.A.N., 42, 726-727.). 902 F. Supp. 931, 940. Further, here, EMTALA "is not a federal malpractice statute," Id. at 940.

Thus, **EMTALA was not designed to provide a federal remedy for misdiagnosis or general malpractice.** See Holcomb v. Monahan, 30 F.3d 116, 117 (11th Cir. 1994); Baber v. Hospital Corp. of Am., 977 F.2d 872, 880 (4th Cir. 1992) Even if Dr. Cherukuri had departed from the standard of care, the Act, by clear Congressional intent and case law precedents, does not regulate that conduct.

EMTALA requires that all patients who come to the E.R. receive the same care according to that hospital's capabilities, nothing more. "… EMTALA requires a hospital's emergency room to screen all patients with the same level of treatment which that hospital would normally provide to patients in similar medical circumstances, and to stabilize

any emergency condition discovered." Brodersen, 902 F. Supp. 931, 940-41.

"Disparate treatment" is a term not defined in the Act yet case law amply demonstrates that EVERY EMTALA violation must contain an element of disparate treatment. **Disparate treatment goes to the heart of the Congressional intent.** The term means to provide to one patient a level of care which differs from the care given to other patients on some basis **other than** on a medical basis. In the case at bar, no disparate treatment was shown and that is a requirement under the statute. For that reason, the Act does not apply to Dr. Cherukuri's conduct.

Again, the court in Brodersen engaged in an analysis where it determined whether there was disparate treatment and examined whether the denial of care "was the result of an economic motive or bias." Id. at 945. In Brodersen, there was a non-medical motive to a denial of medical care; in Cherukuri there was no denial of care and there was no non-medical motive involved in the transfers.

Additionally on this point, in Brodersen, the court noted a split with the Eighth circuit on whether economic motive or bias must be demonstrated as a prerequisite. Id. The Sixth Circuit follows the analysis presented in

Cleland, 917 F.2d 266,and **requires a showing of improper economic motive before EMTALA is triggered.**

The Court must distinguish the medical facts in Burditt from those in Cherukuri. Dr. Burditt was more concerned with lessening his medical negligence liability than he was with helping a mother-to-be in a dangerous medical situation. Id. at 1367. Dr. Cherukuri, in contrast, practiced on this occasion in the same way as he would have done on any other occasion and the hospital functioned to its maximum potential. In Dr. Cherukuri's case, **no testimony supported disparate treatment; there was no triggering of the EMTALA statute.**

This Court must not permit an ALJ who misunderstands medicine and law to succeed in devastating a physician and his reputation where he provided exemplary medical care.

If the Court applies the Act to caregivers who deliver good-faith medical care the national consequences will devastate medical care delivery to the gravely injured.

Issue II.

The standard of review is that of plain error and for the Agency to fail to include an analysis of not one case is plainly erroneous. New York v. Shalala, 1996 U.S. Dist. LEXIS 2261, *34. Further, the Agency is limited to a "permissible construction of the statute," Id. at 23. A

permissible construction would be an interpretation that is not at odds with a "definitive contrary legislative command." Id.

It is imperative to understand the case law to understand the Act. As mentioned, EMTALA is a flawed piece of legislation in the respect that many important terms are not defined within the Act's organic language. The most superficial survey discloses that there have been nearly two-hundred cases brought nationwide and about 60 have reached the appellate level. JA 001. For the ALJ to blatantly ignore this avalanche of legal authority can not satisfy the standards of review.

To fail to include case law in the analysis is unfair, arbitrary and capricious. Further, to engage in the case law analysis, to which Dr. Cherukuri is entitled, would have exonerated Dr. Cherukuri. This case law analysis, which Dr. Cherukuri provided to DAB on appeal, was wholly ignored by the Agency.

In her opinion, the ALJ's **only** citation, other than to plain statute, was to Dorland's Illustrated Dictionary, p.10 n.8. There is not one citation to any case law whatsoever. **A judge must know the law.** Numerous cases demonstrate that if the ALJ would include case analysis,

then the results would support complete exoneration of Dr. Cherukuri.

For instance, **case law does not require that emergency conditions are cured**. Thornton, 895 F.2d 1131, 1135. The Act requires only **that the patient's condition is made as safe as possible under the circumstances**. Brodersen, 902 F. Supp. 931, 939 n.6. The Act contains no requirement which forced Dr. Cherukuri to perform surgery when, in his **medical judgment**, this was an impossibility. Thornton, 895 F.2d 1131, 1134. Thornton also stands for the premise that **the Act does not insert itself into medical practice decisions between and among health care professionals.** Id.

Had the ALJ read Thornton she would have quickly learned that her interpretation of the statute placed her interpretation of medical care between the doctor and the patient, a position Congress did not contemplate or intend. ALJ's do not practice medicine even when they have the power to review medical care.

Further, the medical records, Inspector General exhibits 2 and 3, reflect that the patients **were stabilized** in a medical sense when they were transferred. This fulfills the requirements of the Act's organic language. The term "stabilization", 42 U.S.C. § 1395dd (e)(3)(B, is further defined in Thornton v. Southwest Detroit Hospital,

895 F.2d 1131, 1135 (6th Cir. 1990). Id. at 1135. See also Delaney v. Cade, 986 F.2d 387, 388 (10th Cir. 1993). Dr. Cherukuri stabilized both of these patients in a medical sense; therefore the transfers were appropriate.

Repp v. Anadarko Municipal Hosp., 43 F.3d 519, 522 n.6 (10th Cir. 1995), footnote 6, points out that the **hospital** defines what is a standard screening in terms of the hospital's capabilities. In the case at bar, under Repp, the DHHS must show that Dr. Cherukuri treated his patients differently from other patients who are similarly situated. See also Williams v. Birkeness, 34 F.3d 695, 697 (8th Cir. 1994); Cleland v. Bronson Health Care Grp., Inc., 917 F.2d 266, 272 (6th Cir. 1990). 43 F.3d 519, 522.

Case law requires the rational medically contextual approach found in Baber v. Hospital Corporation of America, 977 F.2d 872, 881 (4th Cir. 1992). Baber stands for the proposition that the Act does not guarantee a correct diagnosis but only provides a satisfactory first response to medical crises. Further, on the subject of paperwork, failure to complete paperwork did not violate the Act's provisions. 42 U.S.C.A. §§ 1395dd(b) & (c); 977 F.2d 872, 878.

In Vargas v. Del Puerto Hospital, 98 F.3d 1202 (9th Cir. 1996) the court concluded that an hospital is not

liable under EMTALA when it permits a stable patient to be transferred but fails to comply fully with the Act's requirement that a physician include in the transfer certificate a written summary of the specific risks to the patient of effecting the transfer. **The trial court refused to premise EMTALA liability on the hospital's failure to comply strictly with the certification requirement.**

In Vargas the physician failed to appropriately complete the paperwork. The court engaged in de novo review and "concluded that [the doctor] … genuinely weighed the risks and benefits to the child before deciding to transfer her, and rejected [the plaintiff's] … argument that the inadequate completion of the certificate itself violated EMTALA." Id.

The court's analysis in Vargas recognized the imperfections found in medical practice; EMTALA does not insert itself into the intimate decisions made between a doctor and a patient. The main component of good-faith medical care does not hinge on paperwork. **Intent, good-faith in the medical care, is everything.**

The Vargas court's rationale here is persuasive and controlling; it does not permit mindless application of the literal words of the statute on the issue of completing forms Id. at 1204-05. The Vargas court, in reliance upon

Burditt, analyzed that where the practitioner has engaged in the **mental process** but has not completed the paperwork, this lapse is a scrivener's error for which no liability should be assessed.

In footnote 9, the Burditt court stated: "… Congress has expressly provided that medical personnel must make a determination regarding medical risks and benefits, not just sign a paper stating as much." See 42 U.S.C.A. § 1395dd(c)(1)(A)(iii) (West Supp.1991). Burditt, 934 F.2d 1362, 1371 n.9. **Congress favored substance over form and Dr. Cherukuri provided substantive medical care.**

The ALJ not only ignored the fact that Dr. Cherukuri did engage in the requisite mental processes, she ignored the case law which would have lead her to an **opposite** decision. Since Dr. Cherukuri engaged in the mental analysis required by the Act, he has committed no wrong under the Act. See JA 012, OPPENHEIM at 95.

The theory of disparate treatment also eluded the ALJ. In short, under Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1041 (D.C. Cir. 1991), where a patient is screened consistent with hospital protocols or capabilities, where the practitioner adheres to the applicable standard of care, there is no EMTALA violation. Id. at 1041; JA 0013, OPPENHEIM at 97. Dr. Cherukuri provided

these two boys the best Williamson had to offer and that was what the Act required.

Issue II.A.

If the Court remands in accord with the petitioner's arguments, the Cherukuri decision fits with other cases decided and with existing DHHS policies. **There is no line of dissent opinions for the Court to reconcile.** The Department is charged with public responsibility, overall enforcement posture and precedential effects. Dr. Cherukuri may obtain the relief he seeks without disrupting legitimate administrative interests and procedures. The ALJ's position represents an anomaly.

In the overall pattern of enforcement, the Cherukuri decision is incongruent with Department decisions but the decision for which Dr. Cherukuri argues **is absolutely consistent with all other decisions and departmental policies and procedures**.

If the Court decides in Dr. Cherukuri's favor, there is no disruption to other decisions or to DHHS policies or procedures. In the alternative, as illustrated in the case law analysis, to sustain the Department's position would be inconsistent with all case law and the Department's other decisions.

Issue II.B.

Four inconsistencies in the ALJ's opinion are not harmless:

(i) St. Mary's Status: At FFCL pages 32-34, findings VI, 29-31, the ALJ concluded that the transfers were not appropriate and that St. Mary's status was "immaterial." In fact, St. Mary's status **is** material. The fact that St. Mary's was a 400 bed facility with full trauma team care and **did not have an ability to refuse a transfer** made it the **only** facility to which Dr. Cherukuri could send his patients.

A course of medical dealing and customary medical practice supported the fact that Dr. Cherukuri's conduct **met** the Act's requirements. Gatewood supplies the authority for the premise that when the patient is screened consistent with hospital protocols or the practitioner adheres to the applicable standard of care, then it does not violate EMTALA. Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1041 (D.C. Cir. 1991).

That such a course of medical dealing existed which permitted Dr. Cherukuri to transfer without express consent was further corroborated by both Nurse Hatfield, Tr. 557 ll. 20-25; Tr. 558 ll. 1-4, and Nurse White, Tr. 527 ll. 9-15. This is the way medicine is practiced at Williamson and this course of dealing defined the capability of that

facility for purposes of 42 U.S.C. §1395dd(a). Baber, 977 F.2d 872, 883 n.10. (citing 42 U.S.C. 1395dd(c)(2)). **St. Mary's status and the course of dealing between the facilities and the medical staff was of paramount importance.**

(ii) Who Ordered Transfer: The ALJ's statement, FFCL page 38, footnote 28, that who ordered the transfer is immaterial is inconsistent with the rest of her analysis where she eventually found that Dr. Cherukuri was the responsible party and that he deserved the harshest treatment in the history of the Act for any physician ever prosecuted under the Act. See JA 041, Robert J. Levine, et al., Analysis of Federally Imposed Penalties for Violations of the Consolidated Omnibus Reconciliation Act, 28(1) Annals of Emergency Medicine 45, 46 [table 1], 47 (1996). [Hereinafter LEVINE]. **Who ordered the transfer is dispositive of who the IG should have prosecuted and who is the responsible party**. FFCL page 38, ¶ 2. Then in the next paragraph, the ALJ decided that it was Dr. Cherukuri who did order the transfers.

(iii) Dr. Cherukuri Should Not Order Dr. Thambi to Perform Anesthesia: The ALJ found authority in the Act which required that Dr. Cherukuri should have ordered Dr. Thambi to perform anesthesia. The Act contains no such

requirement and this finding and conclusion constitutes legal error. **No case law supports these notions of medical practice.**

JCAHO standards control here. The regulations promulgated by the Joint Commission on Accreditation of Healthcare Organizations [JCAHO] clearly provide autonomy for each and every independently licensed practitioner. See JA 045, Comprehensive Accreditation Manual for Hospitals, Joint Commission on Accreditation of Healthcare Organizations (1996).

JCAHO standards define a licensed independent practitioner and JCAHO standards do not permit or provide for a praktitioner or hospital administrator to have authority to "force" a licensed independent practitioner to do anything.

(iv) Objection to CMP: In another example of flawed logic and justice denied, in assessing her CMP, the judge claimed Dr. Cherukuri never objected to the imposition of the CMP. **Dr. Cherukuri objected but DAB ignored the objection.** On appeal to DAB, according to Departmental regulations, Dr. Cherukuri addressed this issue most clearly but DAB ignored the argument completely. While DAB has the authority to decline review, where a party who has been adversely affected raises legitimate points for review

on appeal, DAB may not act in an arbitrary and capricious manner and deny review out of hand. **Dr. Cherukuri was due a reading of his brief, at a minimum.**

In Dr. Cherukuri's Brief on Appeal to DAB, JA 048, RBR-DAB 222-23, he objected to the ALJ's FFCL's 53-57 inclusive, stating that no penalty was proper and he further cited persuasive legal authority to support his position.

Burditt requires that the IG must assess reasonable penalties. As Departmental policy, it would be illogical to maximally fine all violators no matter what was the substance of their violation. The ALJ unreasonably assessed Dr. Cherukuri the largest fine in the statute's decade long history yet his conduct was wholly consistent with good medical practice. This is another example how case law would have caused the ALJ to reach an opposite decision.

Issue III.

Anesthesia was unavailable by hospital policy. Hospital policy absolutely prohibited anesthesia in these cases. **There were no intra-cranial pressure monitors at this facility.** In this case, to preclude an affirmative defense is arbitrary and capricious and is not supported by substantial evidence on the record. Dr. Cherukuri is

entitled to this defense as a matter of law and *de novo* review applies.

Dr. Cherukuri's position here is founded in the plain reading of the statute, plain logic, and plain fairness. The ALJ cited section 1867(d)(1)(C), FFCL page 37, ¶6, then she then went on to deny Dr. Cherukuri the benefit of the defense. Every witness stated that Dr. Thambi refused treatment and every witness stated that hospital policy precluded the administration of anesthesia in this clinical context.

The testimony upon which the ALJ based her conclusion here is from Mr. Glover, not a physician, from a person not present that night, and pulled out of context to suit the ALJ's needs. It is hard to see why the ALJ would prefer the testimony of a lay witness over all of the medical witnesses.

The other witness the ALJ cites on this issue is Dr. Aaron, a physician not present that night and who was the prosecution's expert witness. The ALJ's opinion, section IX. numbers 42-52, pages 40-42, are not supported by substantial evidence on the record and on this point.

Further, as a matter of hospital policy and procedure, Dr. Thambi could not have performed anesthesia. Dr. Thambi

testified that anesthesia was impossible. **Dr. Thambi's actual availability is consequently irrelevant.**

To consider this, however, since the ALJ did engage in this availability analysis, the best evidence on the issue whether Dr. Thambi was available would come from the witnesses who **were** present that night. Dr. Cherukuri is eminently clear in his testimony that Dr. Thambi refused to come to the E.R. or, after he arrived 2 ¾ hours late, he then, by his actions, refused to provide anesthesia.

Nurse White stated:

> [H]e [Dr. Thambi] said … no, I cannot give this patient anesthesia … And he was just … waving his hands and telling him, shaking his head no … And Dr. Cherukuri was saying, John … I have to do surgery. I have to have anesthesia. I have to do surgery. And Dr. Thambi said no, he could not do it, he couldn't put him to sleep. So he left, he left out the door … he left the hospital.

Tr. 487 ll. 1-6. See also, Nurse White's testimony Tr. 488 ll. 14-18; Tr. 489 l. 11 - Tr. 491 l. 23; Tr. 492 ll. 11 - Tr. 493 l. 14. Finally on Dr. Thambi's refusal she testified:

> Dr. Thambi "**said he couldn't put them to sleep, he wouldn't put them to sleep**," Tr. 528 ll. 23-24, leaving no question, "**that was a flat refusal. He said he wouldn't, he couldn't, he left. He left the hospital. He left us … he left us**." [emphasis added] Tr. 529 ll. 1-8. Dr. Thambi was not in the hospital "very long", 10-15 minutes.

Tr. 535 ll. 1-2. Nurse Hatfield testified in exact congruence with Nurse White on the issue of Dr. Thambi's refusal to perform anesthesia. Tr. 544 ll. 1-8; Tr. 545 ll.7-25; Tr. 546 ll. 1-6. Further, this testimony was then corroborated by another facts witness, the floor supervisor, Denise Smith, RN. Tr. 744 ll. 1-8.

Dr. Thambi relied upon mysterious psychic inferences on whether Dr. Cherukuri wanted to perform surgery. Tr. 257 ll. 24-25 - Tr. 258 ll. 1; Tr. 258 ll. 17-20; Tr. 259 ll. 6-10. **Then, in this desperate situation Dr. Thambi merely walked away.** Tr. 259 ll. 11-14. The court should recall Dr. Burditt's callous indifference as a parallel to Dr. Thambi's conduct on that night.

Could witnesses make a more clear statement that Dr. Thambi refused to perform anesthesia? Only two conclusions are reasonable based upon the facts and the statute's language:(1) Dr. Thambi refused to perform anesthesia and (2)Dr. Cherukuri is entitled to the affirmative defense under the Act's provisions.

Nevertheless, all of this confusion over Dr. Thambi's intent and state of mind aside, it was **against hospital policy** for Dr. Thambi to anesthetize these patients. Tr. 285 ll.22-25; Tr. 286 ll. 1-2. Moreover, even had Dr. Thambi wanted to perform anesthesia, the patients'

conditions precluded him from performing surgery: **Anesthesia was too dangerous at that hospital**. Tr. 294 ll. 11-19; Tr. 875 T ll. 8-13.

Dr. Siryous Arya, the recipient surgeon, recalled that Dr. Cherukuri stated that Dr. Thambi would not perform surgery. Tr. 303 ll. 2-4; Tr. 303 ll. 14-16. Mr. C.D. Glover, Williamson Hospital administrator, Tr. 971T ll. 25- Tr. 972 T ll. 1-8, investigated and determined that Dr. Thambi refused anesthesia and Mr. Tom Jones, hospital administrator at St. Mary's reached the same conclusion. Tr. 805 ll. 5-7; Tr. 805 ll. 12-15.

No reasonable trier of fact could conclude here that Dr. Thambi was available to perform anesthesia; that he wanted to perform anesthesia; and that hospital policy permitted him to administer anesthesia in these circumstances. Yet, incomprehensibly, the ALJ concluded that Dr. Cherukuri should have forced Dr. Thambi to perform anesthesia. ALJ's item 46 is not founded in law and was confabulated by the ALJ without medical or legal authority. FFCL page 40.

As above explained, **under JCAHO standards, Dr. Thambi is an independently licensed practitioner over whom Dr. Cherukuri had no authority.** The IG did not show that the authority the ALJ suggests exists, did exist. There was no

evidence to support this conclusion introduced from the medical licensure laws in the Commonwealth of Kentucky or in the hospital bylaws. Aside from evidence not present in this record, no jurisdiction anywhere in this nation recognizes such authority.

Further, the ALJ's notion that where a surgeon decides surgery is necessary he must **force** the anesthesiologist to give anesthesia is unsupported by substantial evidence on the record or by any medical practice standard anywhere in the nation. FFCL 42, ¶ 3. The reason the medical record does not show that Dr. Thambi was "told" to perform anesthesia is that no person or physician has power to exert such authority over an independently licensed practitioner. FFCL 45, ¶ 3; JA 046, JCAHO standards MS.1-MS.1.1.2.

The same is true with the nursing staff. Nurses have no authority to demand that a physician do anything. This is impermissible by the bylaws and JCAHO standards. FFCL page 50.

The statute framers contemplated a situation where health care professionals would speak by actions rather than by words; that's how medicine is practiced sometimes. The Act does not require, nor does any case law support, health care professionals forcing or coercing one another into treatment or that they "order" one another; that's not

how medicine is practiced, ever. Such conduct is not medically desirable and it would be legally untenable to premise medical care on the concept of verbal abuse and assault. For these reasons, FFCL's IX.42-51, pages 40-54, including the supporting analysis, are illogical.

If, as the ALJ contends, Dr. Thambi's refusal were "driven by Appalachian Regional Hospital's long-standing policy to transfer all patients with head injuries" then whether Dr. Thambi refused to perform anesthesia is nugatory. To perform anesthesia here would have violated hospital policy. (1) **Dr. Thambi was prevented from doing so by hospital policy.** (2) **Dr. Cherukuri was prevented from performing surgery because there was no anesthesia available.**

Dr. Cherukuri's affirmative defense is embedded in hospital policy, Medicare standards, and stands independently of Dr. Cherukuri's credibility. Dr. Cherukuri's **credibility had no effect** on what appears as an iron clad hospital policy: no anesthesia for severely head injured patients. FFCL page 51.

BOTH DR. CHERUKURI'S AND DR. THAMBI'S HANDS WERE TIED BY HOSPITAL POLICY. All of the other points the ALJ has made on this topic must fail in the face of this fact. FFCL pages 45-50. For the ALJ to then conclude that she did not

lessen Dr. Cherukuri's culpability due to the unavailability of anesthesia is illogical. **Dr. Cherukuri had no choice; anesthesia was unavailable by hospital policy.**

Issue IV.

(i) The Fine is Unreasonable: In the ten years since Congress passed EMTALA, no practitioner has been so heavily fined. **No practitioner who has provided good faith medical care has ever been prosecuted or fined.** It is incongruous to fine a surgeon who comes to the hospital in the middle of the night, who delivers good faith medical care to five patients, and who succeeds in his mission. He saved every patient! The IG made no showing that any patient was in any way injured by Dr. Cherukuri.

The case law and administrative decisions offer a small statistical series for comparison but even with the paucity of experience, there is no struggle here. JA 41-42, Robert J. Levine, et al., Analysis of Federally Imposed Penalties for Violations of the Consolidated Omnibus Reconciliation Act, 28(1) Annals of Emergency Medicine 45-47 (1996).

Since its enactment in 1986, there have only been **six fines** imposed against physicians ranging between $2,500 to $20,000 with a mean of $8,500, a median of $7,500 and a

standard of deviation of $8,612. No physician has ever been terminated from Medicare for an EMTALA violation. JA 41-42, LEVINE at 45, 46. In view of this precedent and the requirement that the Department is bound by its own precedents, the amount of the fine is wildly disproportionate and unreasonable.

The controlling appellate case, and the only appellate case involving DHHS against a physician, is Burditt. It is the only case heard at the appellate level which took up the issue of the CMP against a physician.

The reviewing court in Burditt concluded that a "court of appeals can only invalidate an administrator's interpretation [of a statute imposing a civil monetary penalty] if that interpretation is unreasonable." Burditt, 934 F.2d 1362, 1367-68.

Petitioner contends that the fine is unreasonable on its face. Petitioner argues that no fine is proper since he provided good faith medical care according to the level of the care given to all patients in his geographic locale. Vargas, Baber, and Burditt support this conclusion for the reasons above indicated.

The IG showed no disparate treatment or any violation of any standard of care and Dr. Cherukuri provided good

faith medical care, doing the best he could have done without any showing of malicious intent.

NO CASE LAW, NO DEPARTMENTAL PRECEDENT SUPPORTS A FINE OF $100,000. THAT AMOUNT IS UNREASONABLE. Some case, some time, may justify such a large fine but not this case, not this time. In this case, there should be no fine. This doctor should be praised for admirable courage in the face of daunting disaster.

(ii) If No Negligence, then No Fine: Dr. Burditt objected to the imposition of a fine on the basis that he was not the responsible physician, 934 F.2d 1362, 1373, and that the hospital must be found culpable, Id. ; see JA 051, the Court's full discussion of CMP in Burditt, that the violation by the health care provider must be a "knowing violation," Id. at 1374.

The Burditt court noted that "Congress has since amended EMTALA to allow the federal government to fine physicians who *negligently* violate EMTALA's requirements. 42 U.S.C.A. § 1395dd(d)(1)(B) (West Supp.1991)." Id. at 1375.

In contrast to Dr. Burditt, who acted at least negligently, Dr. Cherukuri did not act negligently. **NO TESTIMONY SUPPORTS THAT DR. CHERUKURI ACTED NEGLIGENTLY.** No witness identified a standard of care in this entire matter. No

witness testified that Dr. Cherukuri departed from the standard of care. No witness testified that Dr. Cherukuri's medical conduct caused any harm to any patient. Unless the Department is able to show that Dr. Cherukuri acted negligently, under Burditt, 934 F.2d 1362, 1375, Dr. Cherukuri may not be fined at all.

(iii) Mitigating Circumstances: Dr. Cherukuri asks this honorable court to take notice of what he did right. Dr. Burditt was a wrongdoer; Dr. Cherukuri was a rightdoer. In its analysis of the mitigating circumstances in Burditt, Id. at 1375, the court stated that the statute itself provided NO standard for deciding civil sanction amounts. Instead, the Burditt court agreed with DAB that 42 C.F.R. §1003.106(b)(5) controls here. There are no parallels between these two physicians' conduct and despite egregious conduct in the Burditt case, the ALJ found mitigating circumstances. For the ALJ to not find mitigating circumstances with Dr. Cherukuri constitutes plain error in view of the eleven affirmative acts he performed to save these boys. No fine is proper for Dr. Cherukuri.

VII. Conclusion

The Cherukuri case tests whether EMTALA covers good faith medical care. Dr. Cherukuri argues that the government may not prosecute a provider who toiled all

night and saved five patients. The statute was not intended to regulate such conduct. Further, the ALJ's decision is fatally flawed where it does not consider one case in the face of in excess of 60 decisions. Had the ALJ included these cases, she would have reached a favorable decision to the Petitioner.

To find in favor of Dr. Cherukuri is consistent with all case law and with all Departmental cases. Dr. Cherukuri could not have performed surgery since hospital policy precluded provision of anesthesia under these circumstances. It is illogical, and should be illegal, to fine a doctor who did not depart from the standard of care and who worked all night long to save two lives.

The ALJ imposed an unreasonable CMP in view of case law, Dr. Cherukuri's good-faith medical conduct, and Departmental precedent. Every trauma surgeon and E.R. doc in America will read the Cherukuri decision and for this Court to sustain DAB, it will adversely affect medical care in this nation.

Petitioner asks this honorable Court to remand the decision of the DHHS for a decision consistent with the facts in the case and to include case law analysis which will lead to the conclusion that Dr. Cherukuri should be fully exonerated.

Respectfully submitted this 16th day of June 1998.

Mr. John David Preston; and Mr. Chad G. Perry, III
POD C; Paintsville, KY 41240; 606-789-5395
Signed by Elliott B. Oppenheim, MD/JD/LLM Health Law on behalf of Mr. G. Chad Perry, III, and Mr. John David Preston, with the attorneys' express permission.

Index for Joint Appendix
Vol. I Pages 001-258
Vol. II Pages 259-517

PETITIONER'S DOCUMENTS DESIGNATED IN THE BRIEF AS "JA PAGE"

Doc. #	Description of Each Document	Appendix Page
	Major EMTALA Cases from U.S.C.A.	001
	Elliott B. Oppenheim, EMTALA: *Its First Decade; A Retrospective Analysis of 42 U.S.C. § 1395dd*, 43(4) MED. TRIAL TECH. Q. 77 (1997).	003
	Congressional Record § 13903-13905 (October 23, 1985)	036
	List of "dumps" from Brodersen v. Sioux Valley Memorial Hospital, 902 F. Supp. 931, 940 n.8. (Iowa 1995)	040
	Robert J. Levine, et al., Analysis of Federally Imposed Penalties for Violations of the Consolidated Omnibus Reconciliation Act, 28(1) Annals of Emergency Medicine, 45 (1996).	041
	Comprehensive Accreditation Manual for Hospitals, Joint Commission on Accreditation of Healthcare Organizations 484 (1996).	045
	Petitioner's Brief on Appeal to DAB, pages 222-225, submitted to DAB on Appeal	048
	Burditt v. U.S. Department of Health and Human Services, 934 F.2d 1362, 1373-1376 1991 U.S. App. LEXIS 14376 (1991).	051

RESPONDENTS' DOCUMENTS

Doc. #	Description of Each Document	Appendix Page
	May 23, 1997 Decision by Administrative Law Judge Leahy	**055**
	November 18, 1997 Determination to Decline Review by the Departmental Appeals Board	**0118**
	Inspector General Exhibit (I.G. ex. 1)	**0120**

I.G. ex. 2	0128
I.G. ex. 3	0145
I.G. ex. 4	0166
I.G. ex. 5	0170
I.G. ex. 6	0178
I.G. ex. 16	0185
Respondent's Exhibit 3	0204
Record (R) at 3-6 (September 10, 1995 letter to Dr. Cherukuri).	0209
R 212-216 (Brief for the Respondent)	0213
R 376-77 (Reply Brief for respondent)	0218
R at 40, 520-22 (Respondent's Brief in Support of Appeal to the Departmental Appeals Board).	0220
R 647, 670-671 (Inspector General's Response to Appeal and Cross-Appeal).	0224
Transcript Pages	0227
*Transcript Pages	0479

CERTIFICATE OF SERVICE
Final Brief

I hereby certify that on the 16th day of June 1998 the **original** of the Petitioner's Final Brief prepared by the Petitioner and **six copies** were sent by United States Mail, postage pre-paid, to Mr. Leonard Greene, Deputy Clerk of the Court, United States Court of Appeals for the Sixth Circuit, 100 E. 5th St., Cincinnati, OH 45202.

IN ADDITION, BY FIRST CLASS U.S. MAIL, POSTAGE PREPAID, I sent **two copies** of the identical materials to the Respondents: Mr. Carl E. Goldfarb, Attorney, Appellate Staff; U.S. Department of Justice; Civil Division, Appellate Staff; 601-"D" Street N.W., Room 9541; Washington, DC 20530-0001.

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Mr. Chad G. Perry, III
POD C
Paintsville, KY 41240
606-789-5395
(FX) 16067893976
Signed by Elliott B. Oppenheim, MD/JD/LLM HEALTH LAW
on behalf of Mr. G. Chad Perry, III, attorney for the
Petitioner, with Mr. Perry's express permission.