Filed 10/28/19 Simich v. Henry Mayo Newhall Memorial Hospital CA2/8

**NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS**



IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION EIGHT

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| ANITA SIMICH et al.,<br><br>Plaintiffs and Appellants,<br><br>v.<br><br>HENRY MAYO NEWHALL MEMORIAL HOSPITAL,<br><br>Defendant and Respondent. | B291317<br><br>(Los Angeles County Super. Ct. No. BC543363) |

APPEAL from a judgment of the Superior Court of Los Angeles County. Melvin D. Sandvig, Judge. Affirmed.

Law Office of Kevin G. Little and Kevin Gerard Little for Plaintiffs and Appellants.

Reback, McAndrews & Blessey, Thomas F. McAndrews, Beth Ann Neri and Joseph M. Radochonski for Defendant and Respondent.

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## SUMMARY

On April 22, 2014, Anita Simich and Gerhard Wutti sued Henry Mayo Newhall Memorial Hospital (defendant or the hospital) for medical negligence and other claims after the death of their mother at the hospital on December 22, 2012. The trial court granted summary judgment for defendant.

We affirm the judgment.

## FACTS

### 1. Events on December 22, 2012

The decedent, 81 years old, came to the emergency room of the hospital at 1:34 p.m. of the day she died, complaining of severe chest pain. Emergency physician Seth Sushinsky (who is not a named defendant) examined her at 1:45 p.m. He ordered an initial round of testing, including "a Troponin assay, a CBC [complete blood count], a metabolic panel, a lipid panel, a chest x-ray, CT scans of the head, chest and abdomen, and an EKG."

An elevated troponin value indicates that heart muscle is being damaged. The result of decedent's initial troponin test, available by 2:30 p.m., was "0.082 ng/ml," which the laboratory report stated was "indeterminate but may indicate myocardial damage." Dr. Sushinsky's notes state that decedent's history is "worrisome for acute coronary syndrome," and that the troponin was elevated, but was decreased from an earlier troponin test (prior to this hospitalization).

The hospital's protocol for chest pain and ruling out myocardial infarction includes, among many other things, an initial troponin test immediately, and then two additional tests over the next six hours. Dr. Sushinsky did not order repeat testing. At 6:40 p.m., decedent was admitted to the hospital for observation by Dr. Jong Lee of Facey Medical Group, who ordered

"[s]erial troponin and serial EKG," respiratory therapy and various pain medications.

At 8:27 p.m., decedent's troponin value was 57, a "critical result." This result was reported to a nurse and then to Dr. Saber Patrus, the doctor on duty, at 9:05 p.m. At 9:20 p.m., the family at bedside reported "seizure like" activity, and the decedent was noted to have episodes of long pauses between heartbeats. At 9:22 p.m. the nurse called for a rapid response team. At 9:32 p.m. Dr. Patrus initiated an emergency transfer to Providence Holy Cross Medical Center, because defendant's cardiac catheterization facility was not open on weekends. At 9:40 p.m., decedent's troponin value was 103.

Decedent was taken to an ambulance to be transported to Providence Holy Cross at 10:05 p.m., but her condition worsened, and the emergency room (ER) nurse accompanying her summoned an ER physician to assist with resuscitation efforts. Decedent was taken back to the ER to obtain a stable airway, and the ER staff began resuscitative efforts. These failed and decedent died at 10:44 p.m.

A private autopsy on December 26, 2012, reported the cause of death as "acute myocardial infarction, anterior wall, left ventricle, ventricular free wall rupture and associated hemopericardium."

**2. The Ensuing Litigation**

On April 22, 2014, one year and four months after their mother died, plaintiffs filed this lawsuit against the hospital. Plaintiffs also named Dr. Jong Lee and Facey Medical Group as defendants, but their motion for summary judgment was granted and is not at issue.

The operative complaint alleged causes of action for medical negligence, elder abuse, wrongful death, and violation of federal and state statutes on emergency medical care. The complaint alleged in substance that the ER physician (Dr. Sushinsky) performed a minimal initial screening, after which decedent was left unattended for the next five hours, and staff ignored her and her daughter's repeated pleas for assistance. When Dr. Lee finally saw her, he administered morphine and refused Ms. Simich's requests for a cardiac specialist, saying that was "too premature." By the time the rapid response team was called, decedent was in the midst of a massive heart attack. It was not until the staff sought to transfer decedent to Providence Holy Cross that hospital personnel disclosed the hospital was not equipped to handle cardiac interventions, and decedent's only chance of survival was a transfer to Providence Holy Cross.

Defendant moved for summary judgment or alternatively summary adjudication. Defendant argued, among other things, that the medical negligence and wrongful death claims were barred by a one-year statute of limitation; plaintiffs could not establish an elder abuse claim by clear and convincing evidence; and decedent received an appropriate medical screening.

Defendant's evidence included decedent's medical records, Ms. Simich's deposition testimony, and an expert opinion from Dr. David L. Schriger. Dr. Schriger opined that the care and treatment provided by defendant's nursing and ancillary staff complied with the standard of care, and nothing they did or failed to do was a substantial factor in causing the decedent's death.

Plaintiffs opposed defendant's motion, submitting expert declarations from Dr. Jared Strote (emergency medicine), Dr. Bradley Monash (hospital medicine), Dr. Jonathan M. Tobis

(cardiology), and Dr. Eugene R. Dorio (a member of defendant's medical executive committee from 2011 to 2015 and a member of its medical staff for over 25 years). A declaration from Ms. Simich (we will refer to her as plaintiff) explained she had no reason to believe her mother's care and treatment at the hospital on December 22, 2012, caused her death until "within a year of filing suit" (on April 22, 2014).[1]

The trial court granted defendant's motion for summary adjudication on each of the claims, as described at the outset. (Another claim was resolved by a later summary judgment ruling that is not at issue.) Judgment was entered on June 18, 2018, and plaintiffs filed a timely notice of appeal.

**DISCUSSION**

A defendant moving for summary judgment must show "that one or more elements of the cause of action . . . cannot be established, or that there is a complete defense to the cause of

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[1] Defendant filed numerous objections to plaintiffs' declarations, including objections to the entirety of the Simich, Monash, Tobis, and Dorio declarations, on the ground they did not state they were made under penalty of perjury in the State of California (Code Civ. Proc., § 2015.5). That same day, plaintiffs filed further declarations from each declarant, complying with section 2015.5 and stating that the earlier declaration was incorporated by reference and was truthful and accurate. The court found the four declarations did not comply with section 2015.5, but the record does not show whether the court was aware of the corrected declarations. We need not resolve the parties' dispute over the admissibility of the declarations, because they do not in any event create triable issues of material fact affecting the reasons why summary judgment is proper in this case.

action." (Code Civ. Proc., § 437c, subd. (p)(2).) Summary judgment is appropriate where "all the papers submitted show that there is no triable issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." (*Id.,* subd. (c).)

Our Supreme Court has made clear that the purpose of the 1992 and 1993 amendments to the summary judgment statute was " 'to liberalize the granting of [summary judgment] motions.' " (*Perry v. Bakewell Hawthorne, LLC* (2017) 2 Cal.5th 536, 542.) It is no longer called a "disfavored" remedy. (*Ibid.*) "Summary judgment is now seen as a 'particularly suitable means to test the sufficiency' of the plaintiff's or defendant's case." (*Ibid.*) On appeal, we take the facts from the record before the trial court and review its decision de novo. (*Yanowitz v. L'Oreal USA, Inc.* (2005) 36 Cal.4th 1028, 1037.)

**1. The medical negligence and wrongful death claims are barred by the statute of limitation.**

An action for injury or death against a health care provider based on professional negligence must be brought within "three years after the date of injury or one year after the plaintiff discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first." (Code Civ. Proc., § 340.5; see *Jolly v. Eli Lilly & Co.* (1988) 44 Cal.3d 1103, 1109 ["The discovery rule provides that the accrual date of a cause of action is delayed until the plaintiff is aware of her injury and its negligent cause."].) Thus, the statute of limitation begins to run "when the plaintiff has reason to suspect an injury and some wrongful cause . . . ." (*Fox v. Ethicon Endo-Surgery, Inc.* (2005) 35 Cal.4th 797, 803.) "A plaintiff need not be aware of the specific 'facts' necessary to establish the claim; that is a process

contemplated by pretrial discovery. . . . So long as a suspicion exists, it is clear that the plaintiff must go find the facts; she cannot wait for the facts to find her." (*Jolly,* at p. 1111.) "[W]e look to whether the plaintiffs have reason to at least suspect that a type of wrongdoing has injured them." (*Fox*, at p. 807.)

The evidence on the accrual of the statute of limitation comes from plaintiff's own testimony and is reflected in her complaint. She contends nothing in her deposition "is so conclusive such that reasonable minds must conclude that she 'almost immediately' suspected medical negligence on the date of death." As we will explain, we do not agree. Despite plaintiff's protestations to the contrary, the only objectively reasonable interpretation of everything plaintiff has said is that she had reason to suspect some wrongful cause of her mother's death on the day she died, so that the statute began to run on that date.

We begin with plaintiff's complaint. She alleged that, after an initial contact with an emergency physician (later identified as Dr. Sushinsky), who "performed a minimal initial screening exam," her mother "was left unattended for approximately 5 more hours," "even though she was in great pain and was repeatedly pleading for assistance." Plaintiff alleged she herself made "repeated pleas for assistance for her mother and for a specialist to come and examine her." When her mother was "finally seen by Dr. Lee," Dr. Lee "refused [their] requests for a cardiac consultation" as premature, and "repeatedly refused [her and the decedent's] pleas to consult with a cardiac specialist and ignored [decedent's] complaints that she remained in pain, despite the Morphine he had given her." The complaint alleged that after decedent was admitted for observation, and stopped breathing, hospital staff sought to transfer her to another hospital, and "[f]or

the first time, [defendant] personnel disclosed that its facility was not equipped to handle cardiac interventions and that [decedent's] only chance at survival was if she was transferred," to which plaintiff immediately agreed.

Plaintiff's declaration opposing summary judgment stated that while she was "unhappy with what I, as a layperson, considered delays in my mother's care at Henry Mayo on December 22, 2012, I had no reason to believe, and did not then believe, that anything that had been done or had not been done caused her death." She declared that her "belief of suspected causation certainly was acquired within a year of filing suit [April 22, 2014]; indeed, I was still investigating this issue post-filing." At her deposition, plaintiff testified she retained an attorney "[a]pproximately the time the complaint was filed," and she believed Dr. Lee had committed malpractice "at the time that I obtained counsel." She "didn't discover that [her mother's care at Henry Mayo in any way contributed to her death] until I got close to getting the attorney [Mr. Gambardella]."
Mr. Gambardella notified defendant of plaintiff's intention to sue by letter dated November 22, 2013.

The question, however, is not when plaintiff obtained evidence she deemed sufficient to demonstrate causation; the question is when she had reason to suspect a wrongful cause for her mother's death. Her deposition testimony shows she clearly had reason to (and did) suspect a wrongful cause on the date her mother died.

At her deposition, plaintiff testified that after Dr. Lee arrived, she told him her mother's "chest pain was getting more extreme, radiating down . . . her left arm, her neck, her shoulder," and plaintiff "wanted to . . . have her referred to a cardiologist."

Plaintiff "asked for a cardio consult, and he denied it," based on "his theory that she had indigestion." She testified that, after the rapid response team arrived, Dr. Patrus advised her that her mother "needed emergency cardiac intervention." She testified Dr. Patrus told her that "she needs an immediate angiogram and possibly an angioplasty, and she needs to be seen by a cardiologist." She testified Dr. Patrus "[s]pecifically . . . stated that there's no one here to run the cardiac center" and that "they were not staffed."

Plaintiff also testified that Dr. Patrus, together with an emergency room physician who had worked on resuscitating the decedent after she "coded," told plaintiff (that day) that her mother had suffered a massive heart attack and they could not revive her. They (Dr. Patrus and the ER physician) "responded to my questions." Specifically: "I asked them why wasn't anything done. Why wasn't I notified. That they didn't have the staff to take care of cardiac patients. I asked them why didn't they inform me sooner instead of waiting ten hours until she's dead, and they had no answer. They wouldn't respond."

Plaintiff was then taken to a room where her deceased mother was "still hooked up to everything" and a nurse came in and said, " 'How did this happen?' " Plaintiff's interpretation of the nurse's question was: "She said she didn't understand why my mom died."

Plaintiff testified that she ordered a private autopsy (which was performed a few days later), because she "wanted answers" to "[w]hy she died." (In her declaration, plaintiff stated the family decided to order a private autopsy "not because we suspected that my mother's care and treatment caused her death

but because we simply did not know and felt that we owed it to her memory to determine as best we could why she died.")

To summarize: Plaintiff knew her mother was complaining of severe chest pain throughout her time at the hospital. She was present with her mother at all pertinent times, and her declaration states that her mother complained of high levels of pain (contrary to hospital records). Her complaint and interrogatory responses state her mother was left unattended for five hours after Dr. Sushinsky's initial screening. She asked for and was refused a cardiac consultation. A few hours later, Dr. Patrus told her decedent needed emergency cardiac intervention and defendant had no staffing to provide those services. Dr. Patrus told her that her mother died of a massive heart attack, and plaintiff questioned the doctors that very day about why the hospital did not "inform me sooner instead of waiting ten hours until she's dead" that the hospital "didn't have the staff to take care of cardiac patients." Plaintiff ordered a private autopsy that was performed a few days after her mother's death. From this evidence, we can see no objectively reasonable conclusion other than that plaintiff had reason to suspect, on the day her mother died, a wrongful cause for her death.

Accordingly, the one-year statute of limitation began to run on December 22, 2012.

In this case, the one-year limit was extended for an additional 90 days, to March 22, 2014. Under Code of Civil Procedure section 364, "[n]o action based upon the health care provider's professional negligence may be commenced unless the defendant has been given at least 90 days' prior notice of the intention to commence the action." (*Id.*, subd. (a).) And, "[i]f the notice is served within 90 days of the expiration of the applicable

statute of limitations, the time for the commencement of the action shall be extended 90 days from the service of the notice." (*Id.*, subd. (d).) Plaintiff's lawyer gave notice of her intent to sue by letter dated November 22, 2013. This was "within 90 days of the expiration of the applicable statute of limitations" (*ibid.*), as one year would expire on December 22, 2013.

Plaintiff's notice gave plaintiff one year and 90 days in which to file this action, that is, to March 22, 2014. (*Russell v. Stanford University Hospital* (1997) 15 Cal.4th 783, 788 [section 364, subdivision (a) tolls rather than merely extending the one-year statute of limitation, so that plaintiff has one year and 90 days in which to file a lawsuit].)

Because plaintiff's complaint was not filed until April 22, 2014, her claims for medical negligence and wrongful death, which rested on professional negligence, were time barred.

**2. There is no triable issue that defendant's conduct amounted to the reckless neglect necessary to establish an elder abuse claim.**

The Elder Abuse and Dependent Adult Civil Protection Act (the Act; Welf. & Inst. Code, § 15600 et seq.) includes a provision that "makes available, to plaintiffs who prove especially egregious elder abuse to a high standard, certain remedies 'in addition to all other remedies otherwise provided by law.' " (*Covenant Care, Inc. v. Superior Court* (2004) 32 Cal.4th 771, 779 (*Covenant Care*), quoting § 15657.) "Specifically, a plaintiff who proves 'by clear and convincing evidence' that a defendant is liable for physical abuse [or] neglect . . . (as these terms are defined in the Act), and that the defendant has been guilty of 'recklessness, oppression, fraud, or malice' in the commission of such abuse, may recover attorney fees and costs." (*Covenant*

*Care,* at p. 779, quoting § 15657, subd. (a).) Damages up to $250,000 for emotional distress suffered by the decedent prior to death may also be recovered. (*Covenant Care,* at pp. 779-780; see also § 15657, subd. (b).)

"In order to obtain the Act's heightened remedies, a plaintiff must allege conduct essentially equivalent to conduct that would support recovery of punitive damages." (*Covenant Care, supra,* 32 Cal.4th at p. 789; see *id.* at p. 785 [citing the legislative judgment that the requirement for clear and convincing evidence "adequately protects health care providers from liability under the statute for acts of simple or even gross negligence"].)

Plaintiffs contend their expert declarations (Drs. Strote, Tobis and Monash) "raised triable issues of fact that the care decedent received was negligent and below the standard of care." We agree, but as just stated and as plaintiffs themselves point out, a plaintiff must show much more than negligence. Plaintiffs must show the neglect was committed "with recklessness, oppression, fraud or malice." (*Delaney v. Baker* (1999) 20 Cal.4th 23, 41 (*Delaney*).) And recklessness, unlike negligence, involves conduct that "rises to the level of a 'conscious choice of a course of action . . . with knowledge of the serious danger to others involved in it.' " (*Id.* at pp. 31-32; see *id.* at p. 27 [referring to this as "reckless neglect"].)

We do not see clear and convincing evidence that would allow a reasonable factfinder to conclude there was anything other than professional negligence in this case. The Strote, Tobis and Monash declarations all identify alleged breaches in the standard of care by emergency room personnel (failure to consult a cardiologist, failure to repeat EKG and troponin studies, failure

to transfer decedent to a hospital with 24-hour catheterization capability). That is not evidence of the kind of "egregious" conduct that constitutes reckless neglect. "[T]he Elder Abuse Act's goal was to provide heightened remedies for, as stated in the legislative history, 'acts of egregious abuse' against elder and dependent adults [citation], while allowing acts of negligence in the rendition of medical services to elder and dependent adults to be governed by laws specifically applicable to such negligence. That only these egregious acts were intended to be sanctioned . . . is further underscored by the fact that the statute requires liability to be proved by a heightened 'clear and convincing evidence' standard." (*Delaney, supra,* 20 Cal.4th at p. 35.)

To fill the evidentiary gap, plaintiffs rely on Dr. Dorio's declaration. Dr. Dorio had been on the hospital's medical executive committee from 2011 to 2015, and opined that defendant's administration "began to bypass the [committee] with respect to patient and physician complaints," and that "sentinel events" such as an unexpected death required in-depth examination under defendant's policy and were supposed to be brought to the attention of the committee. "[B]y chance and after the fact," he learned there were two elderly cardiovascular patients in late 2012 who came to the hospital on the weekends with cardiovascular complications and, after significant delays, died before they were transferred (decedent and one other in September 2012). Dr. Dorio was "reasonably certain" that these deaths were not reported to the executive committee, and opined that both should have been reported. The failure to make the committee aware of the September 2012 event "deprived the [committee] of an opportunity to recommend a change in hospital

practices, so that the December 2012 recurrence could have been avoided."

Dr. Dorio's declaration says nothing about reckless neglect by the hospital's doctors or other staff. His assertion that a report of the September 2012 event to the medical executive committee could have resulted in a change in hospital practices that could have avoided "the December 2012 recurrence" is entirely speculative. Certainly, it is not clear and convincing evidence of "especially egregious elder abuse" (*Covenant Care, supra,* 32 Cal.4th at p. 779) in the care and treatment of decedent.

Plaintiffs describe several cases finding triable issues as to whether a defendant's employees acted with the necessary reckless neglect. None of them involves facts remotely similar to this case. (See, e.g., *Stewart v. Superior Court* (2017) 16 Cal.App.5th 87, 91, 101, 105 [a reasonable jury could find the hospital "recklessly and/or fraudulently failed to meet its custodial obligations" in a case where the hospital authorized doctors to sign a consent for surgery without the elder's consent and over the objection of his designee]; *Sababin v. Superior Court* (2006) 144 Cal.App.4th 81, 90 ["A trier of fact could find that when a care facility's employees ignore a care plan and fail to check the skin condition of a resident with Huntington's chorea, such conduct shows deliberate disregard of the high degree of probability that she will suffer injury."].) There are no comparable circumstances here.

### 3. There are no triable issues on the claimed violations of federal and state statutes on emergency medical treatment.

A federal statute requires a hospital with an emergency department to provide an appropriate medical screening for anyone who comes there for examination or treatment. (42 U.S.C. § 1395dd, the Emergency Medical Treatment and Active Labor Act (referred to in the cases as EMTALA).) The statute "was not intended to be used as a federal malpractice statute, but instead was enacted to prevent 'patient dumping', which is the practice of refusing to treat patients who are unable to pay." (*Marshall v. East Carroll Parish Hosp. Serv. Dist.* (5th Cir. 1998) 134 F.3d 319, 322 (*Marshall*).)

"Accordingly, an EMTALA 'appropriate medical screening examination' is not judged by its proficiency in accurately diagnosing the patient's illness, but rather by whether it was performed equitably in comparison to other patients with similar symptoms." (*Marshall, supra,* 134 F.3d at p. 322.) "It is the plaintiff's burden to show that the Hospital treated her differently from other patients; a hospital is not required to show that it had a uniform screening procedure." (*Id.* at pp. 323-324.)

Health and Safety Code section 1317 is California's version of the federal statute, "impos[ing] on California hospitals an obligation to tend to all patients requesting emergency care." (*Jackson v. East Bay Hospital* (9th Cir. 2001) 246 F.3d 1248, 1258 (*Jackson*).) Emergency care includes "medical screening, examination, and evaluation by a physician and surgeon." (§ 1317.1, subd. (a)(1).)

Plaintiffs contend they raised a triable issue of fact that defendant violated the federal and state statutes by failing to provide an appropriate medical screening. We think not.

Shortly after decedent presented in the emergency room, Dr. Sushinsky examined her and ordered an initial round of testing that included a troponin assay, a complete blood count, an EKG, a radiograph of the chest, a CT examination of the head, a CT examination of the abdomen and pelvis, and a CT angiography of the chest, all of which were performed. About five hours later, she was admitted to the hospital for observation (6:40 p.m.) by Dr. Lee, who ordered "[s]erial troponin and serial EKG," respiratory therapy and various pain medications.

Plaintiffs' opposing evidence included the hospital's own "Chest Pain / Rule Out MI [myocardial infarction] Protocol." The protocol includes, among many other things, "Troponin STAT then every 6 hours x 2." (This means two tests over the next six hours.) In decedent's case, more than six hours passed between the first troponin test result and the second result (which was highly elevated and indicated significant myocardial injury).

Plaintiffs contend that because the hospital did not comply with the troponin testing required by its own chest pain protocol, "a trier of fact could infer that decedent received a disparate screening from similarly situated patients." The law does not support that view.

There are, as plaintiffs point out, circumstances under which "[e]vidence that a hospital did not follow its own screening procedures can support a finding of EMTALA liability for disparate treatment." (*Battle v. Memorial Hospital* (5th Cir. 2000) 228 F.3d 544, 558; see *ibid.* [judgment as a matter of law on

EMTALA screening claim was error; hospital's explanations for failure to follow its own published standards in the plaintiff's case required credibility determinations, and there was evidence of an alleged motivation for the disparate treatment, namely that the plaintiff was black, poor and uninsured].) This is not such a case.

The Ninth Circuit has stated the rule we follow. "We hold that a hospital satisfies EMTALA's 'appropriate medical screening' requirement if it provides a patient with an examination comparable to the one offered to other patients presenting similar symptoms, unless the examination is so cursory that it is not 'designed to identify acute and severe symptoms that alert the physician of the need for immediate medical attention to prevent serious bodily injury.' [Citation.] This standard is consistent with Congress's purpose in enacting EMTALA, which was to limit the ability of hospitals to avoid treating poor or uninsured patients." (*Jackson, supra,* 246 F.3d at p. 1256.)

Here, plaintiffs did not present evidence that decedent received a materially different screening than that provided to others in her condition. The failure to comply with the troponin protocol may well have been professional negligence, but the evidence does not show a "cursory" medical screening examination within the rule enunciated in *Jackson*. The battery of tests performed on decedent in the emergency room cannot be described as "cursory." As *Marshall* tells us: "If the Hospital provided an appropriate medical screening examination, it is not liable under EMTALA even if the physician who performed the examination made a misdiagnosis that could subject him and his employer to liability in a medical malpractice action brought

under state law." (*Marshall, supra,* 134 F.3d at p. 322.) "Therefore, a treating physician's failure to appreciate the extent of the patient's injury or illness, as well as a subsequent failure to order an additional diagnostic procedure, may constitute negligence or malpractice, but cannot support an EMTALA claim for inappropriate screening." (*Id.* at p. 323.)

This is not a case, like most of those plaintiffs cite, where a patient is released from the emergency room after an inadequate medical screening; decedent was admitted to the hospital for observation. There is no evidence of disparate treatment vis-à-vis other patients. There is only the failure to comply with the troponin protocol. That was faulty screening with disastrous results, but it was not disparate screening. (See *Summers v. Baptist Medical Center Arkadelphia* (8th Cir. 1996) 91 F.3d 1132, 1139 ["In sum, we hold that instances of 'dumping,' or improper screening of patients for a discriminatory reason, or failure to screen at all, or screening a patient differently from other patients perceived to have the same condition, all are actionable under EMTALA. But instances of negligence in the screening or diagnostic process, or of mere faulty screening, are not."].)

**DISPOSITION**

The judgment is affirmed. Defendant shall recover costs on appeal.

GRIMES, J.

WE CONCUR:

BIGELOW, P. J. WILEY, J.