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## The Intentional Tort of Patient Dumping: A New State Cause of Action to Address the Shortcomings of the Federal Emergency Medical Treatment and Active Labor Act (EMTALA)

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The Intentional Tort of Patient Dumping: A New State Cause of Action to Address the Shortcomings of the Federal Emergency Medical Treatment and Active Labor Act (EMTALA)

THE INTENTIONAL TORT OF PATIENT DUMPING: A NEW STATE CAUSE OF ACTION TO ADDRESS THE SHORTCOMINGS OF THE FEDERAL EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

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A man with a knife wedged against his spine was transferred from an emergency department because he did not have insurance.<sup>1</sup> The transferring hospital refused to remove the knife unless he paid \$1,000 cash in advance of treatment.<sup>2</sup>

A woman mistakenly identified as uninsured was turned away from two private hospitals during the early stages of giving birth—even though fetal monitoring indicated fetal distress. By the time the patient reached the county hospital, her child died.<sup>3</sup>

INTRODUCTION

Patient dumping<sup>4</sup> represents a cold, unconscionable disregard for human life. The act of patient dumping occurs when patients presenting in the emergency department are denied emergency medical care or stabilizing treatment based on economic<sup>5</sup> or non-

1. George J. Annas, *Your Money or Your Life: "Dumping" Uninsured Patients from Hospital Emergency Wards*, 76 AM. J. PUB. HEALTH 74, 74 (1986). For a critique on "anecdotal advocacy," see David A. Hyman, *Patient Dumping and EMTALA: Past Imperfect/Future Shock*, 8 HEALTH MATRIX 29, 53-54 (1998) (referring to "horror stories," the "anecdotal sword," and reliance on anecdotes as "intellectually sloppy"). But see Richard A. Posner, *Legal Narratology*, 64 U. CHI. L. REV. 737, 744 (1997) (explaining the possible value of anecdotal evidence while pointing to author Catherine MacKinnon who writes on pornography and includes stories of prostitutes, rape victims, and pornographic models and actresses).

2. Annas, *supra* note 1, at 74.

3. H.R. REP. NO. 100-531, at 6-7 (1988).

4. See *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 856 (4th Cir. 1994) (defining "patient dumping" as when hospitals refuse to provide emergency medical treatment to indigent, uninsured patients or when they transfer those patients before their emergency conditions are stabilized). "Patient dumping" is prohibited by federal legislation known as the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2000).

5. See David U. Himmelstein et al., *Patient Transfers: Medical Practice as Social Triage*, 74 AM. J. PUB. HEALTH 494, 495 (1984) [hereinafter *Harvard Medical School*].

economic<sup>6</sup> grounds, such as the patient's race, ethnicity, sexual orientation, or contraction of a socially unacceptable disease.<sup>7</sup> Evidence suggests that patient dumping is rising<sup>8</sup> and that it is 1.7

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*Study*] (noting that the financial interests of private hospitals and physicians motivated some transfers).

6. See *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 272 (6th Cir. 1990) (including the following reasons for discriminatory non-treatment of patients: "prejudice against the race, sex, or ethnic group of the patient; distaste for the patient's condition (e.g., AIDS patients); personal dislike or antagonism between the medical personnel and the patient; disapproval of the patient's occupation; or political or cultural opposition"); *Hines v. Adair County Pub. Hosp. Dist. Corp.*, 827 F. Supp. 426, 431 (W.D. Ky. 1993) (referring to characteristics such as age, race, sex, national origin, financial or insurance status, medical condition, social status, or politics as possible factors for discriminatory non-treatment). State statutes have also attempted to curb discriminatory medical care by including specific language prohibiting such discrimination. See, e.g., CAL. HEALTH & SAFETY CODE § 1317(b) (West 1990) (including non-discrimination provisions that "[i]n no event shall the provision of emergency services and care be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services . . ."); MICH. STAT. ANN. § 333.20201(2)(a) (Michie 2001) (stating that "[a] patient or resident will not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, sexual preference, or source of payment."); N.H. REV. STAT. ANN. § 151:21 (2001) (noting that "the patient shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, handicap, marital status, sexual preference, or source of payment . . ."); ID. CODE § 39-1391(b) (Michie 1987) (providing that, if emergency care is provided, it must not be denied "to any person by reason of race, creed, national origin or financial ability to pay therefore").

7. See Seth M. Manoach et al., *Social Bias and Injustice in the Current Health Care System*, 9 ACAD. EMERGENCY MED. 241, 242 (2002) (explaining that studies have indicated that Hispanic and African American emergency room patients face racial bias, even when the studies take patient preferences and socioeconomic differences into account). Manoach also notes that poor and minority patients are routinely subject to injustices in emergency care. *Id.* at 243. See generally Scott Burris, *Dental Discrimination Against the HIV-Infected: Empirical Data, Law and Public Policy*, 13 YALE J. ON REG. 1 (1996) (explaining a specific instance of discrimination involving HIV patients receiving inadequate dental care).

8. See *infra* notes 184-97 and accompanying text (describing the developing pattern of patient discrimination throughout the past decade); see also Manoach, *supra* note 7, at 241 (distinguishing between the care received by insured versus uninsured patients in the emergency room, despite the enforcement standards in the federal Emergency Medical Treatment and Active Labor Act (citing P. Braveman et al., *Insurance-related Differences in the Risk of Ruptured Appendix*, 331 NEW ENG. J. MED. 444, 444-49 (1994); J. Svenson & Carl W. Spurlock, *Insurance Status and Admission to Hospital for Head Injuries: Are We Part of a Two-tiered Medical System?* 19 AM. J. EMERGENCY MED. 19, 19-21 (2001)). Manoach also notes evidence in the press and academic medicine pointing to evidence of the double standard which discriminates against the poor, such as "attending supervision given to residents performing complicated procedures and referral for needed follow-up care." Manoach, *supra* note 7, at 241 (citations omitted); see also Knox H. Todd et al., *Ethnicity and Analgesic Practice*, 35 ANN. EMERGENCY MED. 11, 16 (2000) (detailing the problems shared by different ethnic groups in receiving emergency room care); Earl S. Ford & Richard S. Cooper, *Racial/Ethnic Difference in Health Care Utilization of Cardiovascular Procedures: A Review of the Evidence*, 30 HEALTH SERVICE RESEARCH 237, 237-52 (1997) (interpreting evidence of health care practices between ethnic and racial groups); Ronald J. Ozminkowski et al., *Minimizing Racial Disparity Regarding Receipt of a Cadaver Kidney Transplant*, 30 AM. J. KIDNEY DISEASE 749, 749-59 (1997) (noting a particular instance

times more likely to occur in for-profit hospitals than in not-for-profit hospitals.<sup>9</sup> Data from 1986 to 1999 indicates that there has been an approximately 100-fold increase in patient dumping hospital violators<sup>10</sup> and a 139-fold increase in patient dumping violations concerning the lack of performance of a “medical screening examination.”<sup>11</sup>

Congress had truly noble intentions when it addressed patient dumping through passage of federal legislation known as the Emergency Medical Treatment and Active Labor Act (EMTALA).<sup>12</sup> However, EMTALA has been described as “sloppy,” “silly,”<sup>13</sup> “hopelessly flawed from its inception,” and “doomed for failure.”<sup>14</sup>

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of discrimination with regard to a transplant operation).

9. KAJA BLALOCK & SIDNEY M. WOLFE, PUBLIC CITIZEN’S HEALTH RESEARCH GROUP, QUESTIONABLE HOSPITALS: 527 HOSPITALS THAT VIOLATED THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT: A DETAILED LOOK AT “PATIENT DUMPING” 4 (July 2001) [hereinafter PUBLIC CITIZEN’S HRG #1].

10. The actual number of hospital violators for the year 1986 was two. JOAN STIEBER & SIDNEY M. WOLFE, PUBLIC CITIZEN’S HEALTH RESEARCH GROUP, 140 HOSPITALS NAMED FOR PATIENT DUMPING VIOLATIONS 23 tbl.2, 24 tbl.3 (Apr. 1991) [hereinafter PUBLIC CITIZEN’S HRG #2]; JOAN STIEBER & SIDNEY M. WOLFE, PUBLIC CITIZEN’S HEALTH RESEARCH GROUP, PATIENT DUMPING CONTINUES IN HOSPITAL EMERGENCY ROOMS T-3 to T-11 tbl.3, T-17 to T-18 tbl.6 (May 1993) [hereinafter PUBLIC CITIZEN’S HRG #3]. The actual number of hospital violators for year 1999 was 198. PUBLIC CITIZEN’S HRG #1, *supra* note 9, at 33-59 tbl.1, 63-71 tbl.2, 127-40 tbl.3.

11. Medical screenings are required by the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd(a) (2000). The actual number of EMTALA violations in 1986 of the mandatory medical screening examination provision was zero. PUBLIC CITIZEN’S HRG #2, *supra* note 10, at 23 tbl.2, 24 tbl.3; PUBLIC CITIZEN’S HRG #3, *supra* note 10, at T-3 to T-11 tbl.3, and T-17 to T-18 tbl.6. The actual number of EMTALA violations of the mandatory medical screening examination provision of EMTALA in 1999 was approximately 139. PUBLIC CITIZEN’S HRG #1, *supra* note 9, at 33-59 tbl.1, 63-71 tbl.2, 127-40 tbl.3. There has also been a thirty-seven-fold increase in patient dumping violations for failing to provide “necessary stabilizing treatment” as required by 42 U.S.C. § 1395dd(b). PUBLIC CITIZEN’S HRG #2, *supra* note 10, at 23 tbl. 2, 24 tbl. 3; PUBLIC CITIZEN’S HRG #3, *supra* note 10, at T-3 to T-11 tbl.3, and T-17 to T-18 tbl.6. The actual number of EMTALA violations in 1986 for failure to provide necessary stabilizing treatment was two. *Id.* The actual number of EMTALA violations in 1999 for failure to provide necessary stabilizing treatment was seventy-four. PUBLIC CITIZEN’S HRG #1, *supra* note 9, at 33-59 tbl.1, 63-71 tbl.2, 127-40 tbl.3.

12. U.S.C. § 1395dd (2000).

13. See Hyman, *supra* note 1, at 30 (concluding that EMTALA is more flawed than useful and such flaws create judicial interpretations and amendments that ensure that no one benefits from the statute).

14. See Lawrence E. Singer, *Look What They’ve Done to My Law, Ma: COBRA’s Implosion*, 33 HOUS. L. REV. 113, 121 (1996) (reasoning that the Consolidated Omnibus Budget Reconciliation Act (COBRA), by presenting itself as a strict liability measure while simultaneously requiring a negligence-like analysis, creates judicial confusion sufficient to threaten the usefulness of the legislation); see also Maria O’Brien Hylton, *The Economics and Politics of Emergency Health Care for the Poor: The Patient Dumping Dilemma*, 199 BYU L. REV. 971, 973 (1992) (suggesting regulatory responses like EMTALA will not work, and Congress should focus on making insurance more affordable). Because EMTALA originated as part of the Consolidated Omnibus Reconciliation Act, it is alternatively referred to in the

EMTALA has required so many congressional amendments<sup>15</sup> that it has been described as worse than having no legislation at all.<sup>16</sup>

Inherent statutory ambiguity and widespread federal judicial discord compound the imperfections and shortcomings of EMTALA.<sup>17</sup> These ambiguities and inconsistent judicial opinions have precluded effective EMTALA compliance and government enforcement. For instance, although hospitals are strictly liable for EMTALA duties, it is the emergency physician's conduct which will be dispositive regarding EMTALA compliance.<sup>18</sup> However, the physician's conduct will likely be judged by an objective negligence standard—in most instances, that is, because the federal circuits are split on just what standards apply to various provisions of EMTALA.<sup>19</sup> Similarly, the federal circuits are split regarding whether provisions of EMTALA are to be interpreted conjunctively or disjunctively.<sup>20</sup> The confusion EMTALA has propounded, in both the legal and healthcare professions, has permitted an incentive for patient dumping,<sup>21</sup> which has resulted in significant patient morbidity and mortality.<sup>22</sup> Simply put, although EMTALA grants every person a

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literature either as “COBRA” or “OBRA.”

15. EMTALA has been amended at least seven times since being signed into law and significant amendments occurred in the Omnibus Budget Reconciliation Act (OBRA) of 1987, Pub. L. No. 100-203, § 4009(a), 101 Stat. 1330, 1330-56 to 1330-57 (codified as amended at 42 U.S.C. § 1395dd (2000)); OBRA of 1989, Pub. L. No. 101-239, § 6211, 103 Stat. 2106, 2245-49 (codified as amended at 42 U.S.C. § 1395dd (2000)); OBRA of 1990, Pub. L. No. 101-508, §§ 4008(b), 4207(a), 104 Stat. 1388, 1388-44, 1388-117 to 1388-118 (codified as amended at 42 U.S.C. § 1395dd (2000)).

16. See Mark A. Hall, *The Unlikely Case in Favor of Patient Dumping*, 28 JURIMETRICS J. 389, 396-97 (1988) (contending that amendments created to address COBRA's ineffectiveness in preventing patient dumping create a false sense that the problems of the poor and uninsured are being addressed, thus inhibiting the creation of truly effective legislative solutions).

17. Singer, *supra* note 14, at 120.

18. As with other corporate entities, the knowledge of the agents (physicians) is imputed to the principal (hospital). See ROBERT A. BITTERMAN, PROVIDING EMERGENCY CARE UNDER FEDERAL LAW: EMTALA 19 (American College of Emergency Physicians 2000) (explaining that, because physicians are agents of the hospital, EMTALA duties carry down to the physician). Therefore, every statutory violation of EMTALA by a physician, with regard to regulatory enforcement and civil liability, creates direct liability on the part of the hospital. See *Fed. Kemper Ins. Co. v. Brown*, 674 N.E.2d 1030, 1033 (Ind. Ct. App. 1997) (holding that an agent's knowledge is imputed to the principal, even if the principal does not have actual knowledge of the event).

19. See *infra* notes 549-58 and accompanying text (explaining judicial confusion).

20. See *infra* notes 602-43 and accompanying text (explaining judicial confusion).

21. See Annas, *supra* note 1, at 74 (examining the incentives to deny the indigent and uninsured emergency care, resulting from the transformation of healthcare as a social benefit to healthcare as an economic enterprise); see also Editorial, *Health and Hot Potatoes*, WASH. POST, Mar. 16, 1985, at A20 (reporting Professor Uwe Reinhardt's comments that economic incentives allow poor patients to “become the hot potatoes one hospital seeks to dump in the lap of another”).

22. See Robert L. Schiff et al., *Transfers to a Public Hospital: A Prospective Study of 467 Patients*, 314 NEW ENG. J. MED. 552, 555-556 (1986) [hereinafter *Cook County*

federal right to emergency medical care,<sup>23</sup> it has been reported that government enforcement has “tragically failed” to control patient dumping.<sup>24</sup>

Any proposed solution for patient dumping must consider the many complex issues of nationwide healthcare delivery, which include access to medical care for the indigent and underprivileged, financial compensation for emergency medical services provided by physicians and hospitals,<sup>25</sup> and the dignified delivery of medical care without discrimination based on non-medical grounds. Proposed solutions to patient dumping have included more federal legislation, segmental statutory resurrection of EMTALA, and even criminal actions against physicians and nurses.<sup>26</sup>

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*Hospital Study*] (showing that patient dumping results in significant increases in complications and mortality among the transferred patients); David A. Ansell, MD & Robert L. Schiff, MD, *Patient Dumping: Status, Implications, and Policy Recommendations*, 257 J. AM. MED. ASS'N 1500, 1501 (1987) (noting that patients transferred to Chicago's public Cook County Hospital suffered more than two times the mortality rate than those directly admitted).

23. See BITTERMAN, *supra* note 18, at 15 (explaining that EMTALA creates a federal right for emergency care and additional causes of action if the physician fails to comply with these regulations) (citing 42 U.S.C. § 1395dd); see also Troyen A. Brennan, *Review: Moral Imperatives Versus Market Solutions: Is Health Care A Right?*, 65 U. CHI. L. REV. 345, 353 (1998) (asserting that common law emergency care rights have been strengthened by courts' incorporation of state regulations, accreditation issues, and anti-discrimination law). *But see* Annas, *supra* note 1, at 77 (arguing that the limited common law right to treatment in an emergency room for emergency condition, which was secure in the 1970s, has become threatened throughout the past decades).

24. See PUBLIC CITIZEN'S HRG #2, *supra* note 10, at 18 (explaining that the Department of Health & Human Services has failed to effectively enforce COBRA patient dumping law because of its limited use of sanctioning authority); PUBLIC CITIZEN'S HRG #3, *supra* note 10, at 13 (noting the secrecy surrounding patient dumping activity within hospitals); JOAN STIEBER & SIDNEY M. WOLFE, PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, UPDATE ON PATIENT DUMPING VIOLATIONS 6 (Oct. 1994) [hereinafter PUBLIC CITIZEN'S HRG #4] (noting that the increased number of complaints about patient dumping is not reflected in the number of cases brought to the attention of the Health Care Financing Administration Agency); see also Mary Jean Fell, *The Emergency Medical Treatment and Active Labor Act of 1986: Providing Protection from Discrimination in Access to Emergency Medical Care*, 43 CATH. U. L. REV. 607, 608 (1994) (indicating that state regulatory and other early federal statutory attempts to address patient dumping have been ineffective); HEALTHCARE FACILITIES LAW § 6.2.2, at 428 (Anne M. Dellinger ed., 1991) (stating that few states provide adequate enforcement provisions for patient dumping). Dellinger also notes that early federal statutes were also ineffective in addressing patient dumping. *Id.* § 4.10.3.

25. The U.S. government's response to the financial strains experienced by hospitals has been disheartening. See OFFICE OF THE INSPECTOR GENERAL (OIG), DEP'T OF HEALTH AND HUMAN SERVICES (DHHS), THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT: SURVEY OF HOSPITAL EMERGENCY DEPARTMENTS 18 (Jan. 2001) [hereinafter DHHS, OIG EMTALA SURVEY] (noting that hospitals are increasingly burdened by the lack of reimbursement for certain medical services provided to uninsured patients).

26. See *infra* notes 777-82 and accompanying text (discussing how, in some cases, courts have looked to the standard of care of the attending physician in order to

This Article proposes that any effective remedy for patient dumping requires an understanding of its cause, and that more federal legislation or government agency regulation would likely only increase the diverse and inconsistent opinions of the federal judiciary. Rather, the time has come for state courts to recognize the true nature of patient dumping: it is *intentional*, not based on negligence, and *unrelated* to medical issues involving patient care. It exists in a zone *outside* the practice of medicine and within the realm of discrimination. Accordingly, in an attempt to right this civil wrong, this Article offers a proposal for courts to recognize a new intentional tort of patient dumping as a state cause of action. This Article proposes, however, that the recognition of such a tort be limited to circumstances where a patient's transfer is based *solely* on economic or non-economic, non-medical discriminatory reasons resulting in patient harm and *not* where the transfer is a part of a medical decision regarding patient care.

Although one intermediate state appellate court<sup>27</sup> has recently attempted to sustain such a cause of action, on review it was overturned with arguably sophistic reasoning.<sup>28</sup> Because there may be a reluctance to recognize a new intentional tort as part of our already burdened legal system, and rather an inclination to suggest segmental statutory resurrection of EMTALA, this Article examines the extensive imperfections, ambiguities, and inconsistencies of EMTALA which, in our opinion, lay to rest any hopes of meaningful resurrection.

This Article addresses the need for and elements of a new cause of action for patient dumping. Part I explains the basis for patient dumping, the incentive to dump, and congressional concerns. Part I also considers the epidemiology and persistence of patient dumping from 1986-2001. Part II reviews the statutory topography and components of EMTALA. Part III analyzes EMTALA on three fronts. First, we address inadequacies among emergency physicians, hospital staff, and the U.S. government in dealing with EMTALA. Second, we discuss the extensive judicial inconsistencies surrounding EMTALA, including the application of varied standards of care in evaluating

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implicate them in patient dumping suits).

27. See *Coleman v. Deno*, 787 So. 2d 446 (La. Ct. App. 2001) *aff'd in part, modified in part, and remanded* by 813 So. 2d 303 (La. 2002) (holding that a doctor's violation of the anti-dumping provision of EMTALA created a cause of action for an intentional tort of patient dumping).

28. *Coleman v. Deno*, 813 So. 2d 303 (La. 2002); see also *infra* Part III.E (recounting the court's reasoning for overturning a patient dumping claim and discussing why this logic is flawed).

hospital conduct, confusion over the objective-negligence standard governing physician conduct, and the federal circuit discord regarding conjunctive or disjunctive interpretations of EMTALA provisions. Part IV introduces the proposed new intentional tort of patient dumping by considering a prior judicial attempt to affirm such a tort in *Coleman v. Deno*. Finally, Part V considers the basis of such a tort in law and outlines substantive elements which ought to constitute such a tort. We conclude that creation of an intentional tort for patient dumping will be a more effective means of controlling patient dumping than the statutory provisions in EMTALA.

### I. THE BASIS FOR PATIENT DUMPING

Any proposed solution for patient dumping requires an understanding of the basis for its existence. This understanding comes from considering the incentives for, epidemiology of, congressional concerns about, and persistence of patient dumping.

#### A. Congressional Background

On April 7, 1986, President Ronald Reagan signed the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)<sup>29</sup> into law. COBRA contained a Medicare and Medicaid amendment now commonly known as EMTALA.<sup>30</sup> EMTALA was enacted during an era of escalation in the number of uninsured patients<sup>31</sup> that paralleled increasing reports of “patient dumping.”<sup>32</sup> Some emergency physicians and hospitals had reportedly denied emergency medical care to indigent and uninsured patients or transferred them to a public or charity hospital without first stabilizing their emergency medical condition.<sup>33</sup> Frequently, the transferred patients had medical or surgical conditions which rendered them unstable or critically ill, or were pregnant and in labor.<sup>34</sup>

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29. 42 U.S.C. § 1395dd (2000).

30. *Id.* § 9121(b).

31. See *Equal Access Hearings*, *supra* note 51, at 6-7 (explaining the congressional intent when enacting EMTALA to set up compliance standards for hospital regarding patient dumping).

32. *Cook County Hospital Study*, *supra* note 22, at 552; see also Ansell, *supra* note 22, at 1500 (noting that reports of patient dumping and denial of emergency medical were not just anecdotal); *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1039 (D.C. Cir. 1991) (finding that Congress intended EMTALA to address the patient dumping issue, and draws no distinction between insured and uninsured patients).

33. H.R. REP. NO. 99-241, at 27 (1986).

34. Ansell, *supra* note 22, at 1500; *Cook County Hospital Study*, *supra* note 22, at

Congress was concerned that hospitals were abandoning emergency care patients as a cost-cutting measure,<sup>35</sup> and knew that patient dumping decreased the quality of care received by the dumped indigent or uninsured patients.<sup>36</sup> This decreased care ultimately led to higher morbidity and mortality levels.<sup>37</sup> Congress created EMTALA to provide adequate emergency medical services to the indigent and uninsured who seek emergency care.<sup>38</sup>

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552.

35. See H.R. REP. NO. 99-241, at 27 (quoting the House Ways and Means Committee as saying that the patient dumping situation “has worsened since the prospective payment system [PPS] for hospitals became effective”). The Committee stressed that EMTALA’s purpose was to “provide a strong assurance that pressures for greater hospital efficiency are not to be construed as license to ignore traditional community responsibility and loosen historic standards.” *Id.*; see also *Brodersen v. Sioux Valley Mem’l Hosp.*, 920 F. Supp. 931, 939 (N.D. Iowa 1995) (noting that EMTALA was principally designed by Congress to prevent “patient dumping”); *Brooks v. Md. Gen. Hosp., Inc.*, 996 F.2d 708, 710 (4th Cir. 1993) (finding that Congress’s main concern was to insure that hospitals would not abandon the tradition of providing emergency care to everyone, in light to the increased pressure to decrease costs yet increase efficiency). Numerous congressional committees voiced concerns about these cost-cutting measures, such as the House Committee on Ways and Means, which reported:

The Committee is greatly concerned about the increasing number of reports that hospital emergency rooms are *refusing to accept or treat patients with emergency conditions* if the patient does not have medical *insurance*. The Committee wants to provide a strong assurance that pressures for greater hospital efficiency are *not* to be construed as *license to ignore* traditional responsibilities and loosen historic standards.

H.R. REP. NO. 99-241, at 27. The House Judiciary Committee agreed:

In recent years there has been a growing concern about the provision of adequate emergency room services to individuals who seek care, particularly as to the indigent and uninsured. Although at least twenty-two states have enacted statutes or issued regulations requiring the provision of limited medical services whenever an emergency situation exists, and despite the fact that many state court rulings impose a common law duty on doctors and hospitals to provide necessary emergency care, some are convinced that the problem needs to be addressed by federal sanctions . . . . The Judiciary Committee shares the concern of The Ways and Means Committee that appropriate emergency room care be provided to patients faced with medical emergencies and active labor.

*Id.*

36. *Equal Access Hearing*, *supra* note 51, at 6-7.

37. H.R. REP. NO. 99-241, at 27.

38. See *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 880 (4th Cir. 1992) (stating that “all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress” and stating that Congress enacted EMTALA to address its concern with the practice of patient dumping) (quoting 131 CONG. REC. S13904 (daily ed. Oct. 23, 1985) (statement of Sen. Durenberger)); see also *Bryan v. Rectors & Visitors of the Univ. of Va.*, 95 F.3d 349, 351 (4th Cir. 1996) (holding that the main intent of EMTALA is to provide an avenue for uninsured and poor patients to receive treatment and additionally provide an alternative remedy, if they do not receive treatment); H.R. REP. NO. 99-241, at 27 (stating that the concern was to ensure that the poor and uninsured received adequate emergency room care); 131 CONG. REC. S28569 (daily ed. Oct. 23, 1985) (statement of Sen. Dole) (quoting EMTALA co-sponsor Senator Robert Dole as denouncing “patient dumping” for “purely financial reasons”).

EMTALA requires that hospitals conduct a “medical screening examination”<sup>39</sup> and provide “necessary stabilizing treatment”<sup>40</sup> to any patient seeking emergency medical care in a hospital emergency department.<sup>41</sup> The examination’s purpose is to determine whether the person suffers from an “emergency medical condition.”<sup>42</sup> If an individual suffers from such a condition, either necessary emergency stabilizing care must be provided<sup>43</sup> or the patient must be transferred in accordance with EMTALA provisions.<sup>44</sup>

Although the clear legislative history<sup>45</sup> and purpose of EMTALA was to prevent indigent “patient dumping,”<sup>46</sup> the statute’s language is not narrowly tailored<sup>47</sup> and contains numerous undefined terms and ambiguities.<sup>48</sup> For example, there was initially great judicial confusion as to whether EMTALA applied to “all” individuals or

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39. 42 U.S.C. § 1395dd(a) (2000).

40. *Id.* § 1395dd(b).

41. *Equal Access Hearings*, *supra* note 51, at 6-7; *see also* *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1039, 1041 (D.C. Cir. 1991) (admitting that, although it does not create a federal cause of action for what has been considered malpractice claims in the past, the law does reach “any individual seeking emergency room care”) (internal quotations omitted).

42. 42 U.S.C. § 1395dd(a).

43. *Id.* § 1395dd(b)(1).

44. *See generally id.* § 1395dd(c).

45. *See Brooker v. Desert Hosp. Corp.*, 947 F.2d 412, 414 (9th Cir. 1991) (finding that the legislative history of EMTALA shows that Congress intended the act to prevent hospitals from refusing to treat the uninsured); *Gatewood*, 933 F.2d at 1039 (describing EMTALA as “designed principally to address the problem of ‘patient dumping’”); *see also* H.R. REP. NO. 99-241, at 27 (1986) (noting that, according to its legislative history, Congress enacted EMTALA to combat the growing problem of patient dumping).

46. H.R. REP. NO. 99-241, at 27; *see* *Power v. Arlington Hosp. Ass’n*, 42 F.3d 851, 856 (4th Cir. 1994) (defining “patient dumping” as “the practice of refusing to provide emergency medical treatment to patients unable to pay, or transferring them before emergency conditions were stabilized”); *Bryan v. Rectors & Visitors of the Univ. of Va.*, 95 F.3d 349, 351 (4th Cir. 1996) (holding that EMTALA’s primary purpose was to insure that patients who do not normally have access to emergency care are not neglected by hospitals).

47. *See Brooker*, 947 F.2d at 414 (finding that the language of EMTALA fails to specify specific economic criteria limiting the types of individuals covered by the Act); *Gatewood*, 933 F.2d at 1040 (noting that EMTALA does not distinguish between the insured or uninsured).

48. A three-tier court split occurred with respect to the conflict and relationship between EMTALA’s legislative history and the statute’s plain language. *Jones v. Wake County Hosp. Sys.*, 786 F. Supp. 538, 542-43 (E.D.N.C. 1991). First, some courts, relying heavily on legislative history, have required proof of an improper economic motive on the part of the hospital as an essential element of an EMTALA claim. *Evitt v. Univ. Heights Hosp.*, 727 F. Supp. 495 (S.D. Ind. 1989). Second, some courts have held that EMTALA does not require a plaintiff to prove an improper economic motive but does require a showing of some improper motive. *Cleland v. Bronson Healthcare Group, Inc.*, 917 F.2d 266, 266 (6th Cir. 1990). Third, other courts have rejected the motive requirement altogether, choosing to rely solely on the plain language of the statute. *Gatewood*, 933 F.2d at 1037.

solely to the poor.<sup>49</sup> More recently, EMTALA has been interpreted as applying to any person who “comes to an emergency department,” regardless of their financial status.<sup>50</sup>

### B. *Incentive to Dump Patients*

The incentive to dump patients has arisen from both economic and non-economic causes. Non-economic incentives for which some hospitals and physicians have been known to dump patients include discrimination based on a patient’s race, ethnicity, or sexual orientation, as well as a fear of personal liability.<sup>51</sup> Some physicians have even been known to discriminate against patients with certain diseases or undesirable conditions by refusing to treat them.<sup>52</sup>

Economic incentives for patient dumping typically revolve around four aspects of healthcare and its administration: the increasing number of uninsured;<sup>53</sup> healthcare cost containment measures; the

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49. Early in the evolution of the interpretation of EMTALA, some courts believed that EMTALA applied only to the poor. See *Cleland*, 917 F.2d at 268 (finding that EMTALA addresses care of poor patients, not “unfortunate consequences that occurred to any and all patients”); *Thornton v. S.W. Detroit Hosp.*, 895 F.2d 1131, 1132 (6th Cir. 1990) (stating that “[t]he Act requires hospitals to give emergency aid to indigent patients . . .”); *Stewart v. Myrick*, 731 F. Supp. 433, 435 (D. Kan. 1990) (“Indigent persons denied emergency medical care possess a private cause of action under the Act.”); *Evitt*, 727 F. Supp. at 498 (upholding summary judgment for the defendant hospital where the plaintiff presented no evidence that she was turned away from hospital for economic reasons); *Reid v. Indianapolis Osteopathic Med. Hosp.*, 709 F. Supp. 853 (S.D. Ind. 1989) (holding that EMTALA was designed to prevent hospitals from turning patients away because of inability to pay); *Thompson v. St. Anne’s Hosp.*, 716 F. Supp. 8, 10 (N.D. Ill. 1989) (explaining that EMTALA is aimed at preventing hospitals both from transferring and simply rejecting indigent patients); *Bryant v. Riddle Mem’l Hosp.*, 689 F. Supp. 490, 492 (E.D. Pa. 1988) (noting that EMTALA intended to address the problem of patient dumping).

50. See, e.g., *Cleland*, 917 F.2d at 268 (rejecting the lower court’s economic restriction on EMTALA because “this statute applies to any and all patients.”).

51. See *Burditt v. United States Dep’t of Health & Human Servs.*, 934 F.2d 1362, 1367 (5th Cir. 1991) (establishing that the physician was not concerned about the patient’s ability to pay, but rather transferred the woman for fear of malpractice liability); *Cleland v. Bronson Health Care Group*, 917 F.2d 266, 272 (6th Cir. 1990) (recognizing numerous non-economic reasons why a hospital might give substandard care, including, “prejudice against the race, sex or ethnic group of the patient”); *Hines v. Adair County Pub. Hosp. Dist. Corp.*, 827 F. Supp. 426, 431 (W.D. Ky. 1993) (asserting that race, national origin, sex, social status, financial status, and politics can be possible factors for an EMTALA claim based on discriminatory non-treatment); *Equal Access to Health Care: Patient Dumping: Hearing before a Subcommittee of the Committee on Government Operations*, 100th Cong. 1-2 (1997) (statement of Hon. Ted Weiss, Chairman, Subcommittee on Human Resources and Intergovernmental Relations) [hereinafter *Equal Access Hearings*] (establishing that patient dumping can result from discrimination based on race, ethnicity, or appearance).

52. *Equal Access Hearings*, *supra* note 51, at 111 (testimony of Dr. Relman) (indicating that the diseases and conditions avoided by physicians included tuberculosis and AIDS).

53. Any reference to uninsured individuals throughout this Article includes the underinsured as well.

common law no-duty rule; and ineffective state statutory responses.<sup>54</sup> Increases in the number of uninsured individuals have caused a significant strain on the ability of hospitals and physicians to provide care to the indigent while remaining solvent.<sup>55</sup> With an increase in the number of uninsured individuals, there has been a documented increase in the number of patients being dumped.<sup>56</sup>

Both governmental<sup>57</sup> and private<sup>58</sup> cost containment measures have

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54. See generally Karen I. Treiger, Note, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. REV. 1186, 1193-1204 (1986) (explicating the relationship of these four factors to the increase in patient dumping and noting that, despite a tradition of providing charity care, hospitals are more inclined than ever before to dump uninsured people who are unable to pay for medical costs).

55. See *id.* at 1192 (asserting that, due to the modern trend of providing healthcare as an employment benefit, millions of unemployed Americans are also uninsured). Furthermore, poor minorities and rural residents are more likely to be uninsured. 1 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE: A REPORT ON THE ETHICAL IMPLICATIONS OF THE DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES 94 (Mar. 1983). The number of uninsured was particularly important in setting the stage for patient dumping in the years immediately prior to enactment of EMTALA when cuts in the Medicaid program resulted in Medicaid covering less than forty percent of the poor in 1984, as compared to seventy percent in 1965. Robert Reinhold, *Treating an Outbreak of Patient Dumping in Texas*, N.Y. TIMES, May 25, 1986, at E4.

56. See Michael A. Dowell, *Hill-Burton: The Unfulfilled Promise*, 12 J. HEALTH POL., POL'Y & L. 153, 153 (1987) (documenting the rise in uninsured from 28.7 to 35.1 million between 1979 and 1984, which coincided with a new "competitive healthcare marketplace," creating greater incidents of patient dumping); see also Manoach, *supra* note 7, at 241-42 (remarking that the difference in care between insured and indigent patients will increase as more hospitals turn to managed care).

57. See Treiger, *supra* note 54, at 1194 (explaining how the prospective payment system under which Medicare now operates provides a predetermined sum to the hospital for given diagnoses). Congress adopted a prospective payment system in 1983 to curb Medicare expenditures. Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(c)(1), 97 Stat. 65 (codified as amended at 42 U.S.C. § 1395ww (2000)); see also Bruce C. Vladeck, Ph.D., *Medicare Hospital Payments by Diagnosis-Related Groups*, 100 ANNALS INTERNAL MED. 576, 576 (1984) (tracking the development of Medicare's current prospective payment system as a response to the widely varied charges of hospitals under the former "reasonable cost" reimbursement); Ronda Kotelchuck, *Poor Diagnosis, Poor Treatment: How the DRG System Affects Hospitals That Serve the Poor*, 16 HEALTH/PAC BULL. 7, 7 (1985) (critiquing Medicare's prospective payment system as one that has a "built in bias" against public hospitals that treat the overwhelming majority of Medicare patients); Eleanor D. Kinney, *Making Hard Choices Under the Medicare Prospective Payment Systems: One Administrative Model for Allocation of Medical Resources Under a Government Health Insurance Program*, 19 IND. L. REV. 1151, 1170 (1986) (explaining the prospective payment program, where Medicare pays hospitals a "fixed price for each Medicare case based on the DRG [diagnosis-related group] in which the patient's particular condition falls").

58. Examples of private cost containment measures include the growth of managed care and health maintenance organizations as payers for millions of insured. See Diane E. Hoffman, *Emergency Care and Managed Care—A Dangerous Combination*, 72 WASH. L. REV. 315, 327-40 (1997) (detailing the harm to both patients and providers resulting from the conflict between accessing emergency care and managed care cost-controlling restrictions on emergency room visits).

served as an incentive for patient dumping. While hospitals have struggled to maintain fiscal solvency with respect to various cost containment strategies, such strategies have served as an incentive to treat fewer poor patients, and have increased the likelihood of patient dumping.<sup>59</sup>

The common law no-duty rule also serves as a foundation for patient dumping. Under the common law, neither hospitals<sup>60</sup> nor physicians<sup>61</sup> have an affirmative duty to treat patients; therefore, either hospital or physician, or both, may acquiesce to economic pressures and refuse to treat individuals with emergency medical conditions.<sup>62</sup> Although numerous courts have attempted to reconsider the no-duty rule through theories of “undertaking,”<sup>63</sup>

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59. Kotelchuck, *supra* note 57, at 7 (declaring that private hospitals will adjust to new cost containment measures by “being highly selective in choosing . . . the patients they treat”); Treiger, *supra* note 54, at 1194 (noting that, despite a tradition of social responsibility, hospitals have more incentive to dump uninsured patients because of financial constraints of cost containment measures); Arnold S. Relman, *Economic Considerations in Emergency Care: What are Hospitals For?*, 312 NEW ENG. J. MED. 372, 373 (1985) (announcing that patient dumping will become more prevalent as hospitals seek to maintain their economic security in the face of cost containment provisions).

60. See *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1039 (D.C. Cir. 1991) (holding that hospitals commonly are not under any state common law duty to treat patients; when cost containment measures are forced upon them, patient dumping increases); *Birmingham Baptist Hosp. v. Crews*, 157 So. 224, 225 (Ala. 1934) (asserting that a private hospital does not have a duty to treat patients it deems unacceptable and need not give a reason for its refusal of treatment); WILLIAM L. PROSSER ET AL., PROSSER & KEETON ON THE LAW OF TORTS § 56, at 373-75 (5th ed. 1984) (explaining that liability is imposed for intentional or negligent misfeasance but not for nonfeasance, unless there is a special relationship between the parties).

61. See Wendy W. Brea, Comment, *Preventing “Patient-Dumping”: The Supreme Court Turns Away the Sixth Circuit’s Interpretation of EMTALA*, 36 HOUS. L. REV. 615, 621 (1999) (stating that a physician, under the common law, is not duty bound to treat a patient where no doctor-patient relationship exists); *Hurley v. Eddingfield*, 59 N.E. 1058, 1058 (Ind. 1901) (determining that, although defendant was the only available physician, he was free to refuse treatment and was not required by his state medical license to do so); *Childs v. Weis*, 440 S.W.2d 104, 107 (Tex. App. 1969) (holding that a physician-patient relationship had not been established and thus the physician had no duty to accept the person as a patient); cf. *Hiser v. Randolph*, 617 P.2d 774, 777 (Ariz. Ct. App. 1980) (determining that when a physician accepts payment to cover the services of an emergency department, the physician assents to the bylaws, rules, and regulations as a personal, contractual obligation; thus the physician’s duty to treat may arise derivatively from contract with hospital).

62. The common-law no-duty rule also may influence the non-economic discriminatory causes of patient dumping such as fear of personal liability. See *Burditt v. United States Dep’t of Health & Human Servs.*, 934 F.2d 1362, 1367 (5th Cir. 1991) (quoting Dr. Burditt: “until DeTar Hospital pays my malpractice insurance, I will pick and choose those patients that I want to treat.”).

63. See *Le Jeune Rd. Hosp., Inc. v. Watson*, 171 So. 2d 202, 203-04 (Fla. Dist. Ct. App. 1965) (deeming that initiation of treatment established a duty to the patient, thereby making the hospital liable for failure to treat); *O’Neill v. Montefiore Hosp.*, 202 N.Y.S.2d 436, 440 (App. Div. 1960) (finding that a mere phone call from nurse to doctor was enough evidence to find the hospital provided adequate attention to the deceased).

custom,<sup>64</sup> negligence,<sup>65</sup> reliance,<sup>66</sup> public policy,<sup>67</sup> federal legislation,<sup>68</sup> or through combinations of theories,<sup>69</sup> such attempts remain in the minority.<sup>70</sup>

Lastly, ineffective state statutory legislation also has provided an incentive for patient dumping.<sup>71</sup> Although numerous states have

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64. See *Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 135, 140 (Del. 1961) (finding that hospital liability may be imposed if the patient relied on the “well established custom of the hospital to render aid in such a case”).

65. See *Bourgeois v. Dade County*, 99 So. 2d 575, 578 (Fla. 1957) (holding that the hospital that released an unconscious man as a drunk without diagnosing or treating him was liable for negligence when the patient later died).

66. See *Wilmington Gen. Hosp.*, 174 A.2d at 140 (concluding that, due to patient’s reliance on a hospital custom to render care, withholding such care creates liability on the part of the hospital).

67. See *Guerrero v. Copper Queen Hosp.*, 537 P.2d 1329, 1331 (Ariz. 1975) (stating that state statutes create a public policy that a hospital must provide emergency care, and as such, may not deny emergency treatment without cause); *Thompson v. Sun City Cmty. Hosp.*, 688 P.2d 605, 610-11 (Ariz. 1984) (en banc) (determining that, as a matter of public policy, licensed hospitals must provide emergency treatment to those in need, and may not transfer the patient until all necessary emergency care has been rendered). See generally William J. Curran, *Economic and Legal Considerations in Emergency Care*, 312 NEW ENG. J. MED. 374, 374-75 (1985) (discussing the overall implications of the *Thompson* case and the impact it will have on hospital policy).

68. The no-duty rule was also a target of prior federal legislation in 1946 known as the Hill-Burton Act. Hospital Survey and Construction (Hill-Burton) Act, 42 U.S.C. §§ 291-291o-1 (1994). However, the Act was considered a failure in respect to assuring that the poor have access to care. Treiger, *supra* note 54, at 1198. In exchange for the provision of federal monies for construction and modernization of hospitals, Hill-Burton hospitals were required to make their services available to all persons residing in the immediate geographical hospital locus and were required to provide a reasonable volume of free or below-cost care to any person unable to pay. 42 U.S.C. § 291c(e)(1), (e)(2); 42 C.F.R. §§ 124.501-513, 124.601-607 (2001). The Hill-Burton Act was interpreted to require a certain level of annual uncompensated services to the poor, which was based on the financial status of the hospital, the nature and quantity of services provided by the hospital, and the need for uncompensated services within the area served by the hospital. *Corum v. Beth Israel Med. Ctr.*, 373 F. Supp. 558, 560 (S.D.N.Y. 1974); see also Treiger, *supra* note 54, at 1198-1201 (critiquing the failures of the Hill-Burton Act, with analogies to the infirmities of EMTALA and noting the lack of both incentives for hospital to be in compliance with the Hill-Burton Act and punishments for those hospitals found disregarding these statutory requirements).

69. See *Reeves v. N. Broward Hosp. Dist.*, 191 So. 2d 307, 309 (Fla. Dist. Ct. App. 1966) (combining of “undertaking” and negligence theory to find the hospital negligent for the misdiagnosis of hypertension that resulted in fatal blood clot on brain); *Stanturf v. Sipes*, 447 S.W.2d 558, 562 (Mo. 1969) (utilizing reliance theory and public policy to find duty-liability where the hospital had long-established the custom of accepting all persons for emergency treatment upon payment of a twenty-five dollar fee, and plaintiff relied on such custom).

70. See generally Leonard S. Powers, *Hospital Emergency Service and the Open Door*, 66 MICH. L. REV. 1455 (1968) (providing exceptions to the no-duty rule); Fell, *supra* note 24, at 613-17 (discussing the “reliance exception” and the doctrine of abandonment as common law efforts to impose a duty upon hospitals to treat indigent patients).

71. See HEALTHCARE FACILITIES LAW, *supra* note 24, § 6.2.2, at 428 (stating that few states provide effective enforcement provisions against patient dumping). See generally Andrew J. McClurg, *Your Money or Your Life: Interpreting the Federal Act Against*

enacted anti-patient-dumping statutes,<sup>72</sup> statutory patient transfer regulations,<sup>73</sup> or rules regarding the provision of emergency medical services to the poor,<sup>74</sup> when such laws are considered in light of increasing patient dumping, they have been considered notoriously “ineffective.”<sup>75</sup> The reasons underlying the ineffectiveness of state statutory anti-patient dumping regulations are similar to the reasons for the ineffectiveness of federal anti-patient dumping legislation: unclear definitions,<sup>77</sup> varied scope,<sup>78</sup> poor monitoring,<sup>79</sup>

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*Patient Dumping*, 24 WAKE FOREST L. REV. 173, 190-97 (1989) (analyzing state statutory attempts to address patient dumping); Thomas L. Stricker, Jr., Note, *The Emergency Medical Treatment & Active Labor Act: Denial of Emergency Medical Care Because of Improper Economic Motives*, 67 N.D. L. REV. 1121, 1124 n.16 (1992) (summarizing various state statutory schemes addressing patient dumping).

72. Typical state statute anti-patient dumping legislation include: CAL. HEALTH & SAFETY CODE §§ 1317, 1317.2-2a, (West 2000); COLO. REV. STAT. ANN. §§ 26-15-101 to 26-15-113 (West 1986); FLA. STAT. ANN. ch. 395.1041(3)(a) (Harrison 1998); GA. CODE ANN. §§ 31-8-40 to 31-8-46 (1996); HAW. REV. STAT. ANN. §§ 321-232(b) (Michie 2000); IDAHO CODE §§ 56-1011 to 56-1081B (Michie 2002); 210 ILL. COMP. STAT. ANN. 80/1 (West 2000); KY. REV. STAT. ANN. § 216B.400 (Banks-Baldwin 2001); LA. REV. STAT. ANN. §§ 40:2113.4-40:2113.6 (West 2001); MD. CODE ANN., HEALTH-GEN. § 19-307.1 to 19-308.2 (2000); MASS. ANN. LAWS ch. 111, §§ 51D, 70E(k) (Law. Co-op. 1995); MICH. STAT. ANN. § 333.20201(2)(a) (Michie 2001); MISS. CODE ANN. § 41-7-71 (2001); MO. REV. STAT. § 205.989(1) (1996); NEV. REV. STAT. ANN. §§ 439B.410(1)-(7) (Michie 2001); N.H. REV. STAT. ANN. § 151:21 (1996); N.J. STAT. ANN. § 26:2H-18.51c (West 1996); N.Y. PUB. HEALTH LAW §§ 2805-b, 2806(1) (McKinney 2002); R.I. GEN. LAWS §§ 23-17-19.1(13), 23-17-26(a) (1985); S.C. CODE ANN. § 44-7-345 (Law. Co-op. 2002); TENN. CODE ANN. § 68-140-511 (1992); TEX. HEALTH & SAFETY CODE ANN. § 311.022 (Vernon 2001); UTAH CODE ANN. § 26-8-8(1) (1998); WASH. REV. CODE ANN. §§ 36.62.100, 70.170.060(2) (West 2002); WIS. STAT. ANN. § 146.301(2) (West 1997).

73. See, e.g., CAL. HEALTH & SAFETY CODE §§ 1317-1317.6 (setting out specified requirements for patient transfer regulations, including a requirement that the hospital tell the patient the reason for the transfer).

74. *Id.*; CAL. WELF. & INST. CODE § 17000 (West 2001); N.Y. PUB. HEALTH LAW § 2805-b (McKinney 2002). Additionally, some states have enacted regulations prohibiting the denial of emergency medical care to uninsured patients. Dowell, *supra* note 56, at 154 n.4; *Summary of State Emergency Care: Statutes and Case Law*, 18 CLEARINGHOUSE REV. 494 (1984).

75. See McClurg, *supra* note 71, at 197 (noting that half of U.S. states do not have emergency care statutes and those that do fail to include a private right of action).

76. See HEALTHCARE FACILITIES LAW, *supra* note 24, § 4.10.3, at 324-26 (explaining that early federal statutes were also ineffective in addressing patient dumping).

77. See Michael A. Dowell, *Indigent Access to Hospital Emergency Room Services*, 18 CLEARINGHOUSE REV. 483, 485-87 (1984) (arguing that one weakness of state emergency care statutes is their failure to define what constitutes a medical emergency). For instance, there is no definition of “emergency” contained within the state statutes of KY. REV. STAT. ANN. §§ 216B.400(1) (Banks-Baldwin 2001); R.I. GEN. LAWS § 23-17-26(a) (2001); or N.J. ADMIN. CODE tit. 8, § 8:43-12.1 (2002).

78. State statutory schemes are extremely variable in the scope of their coverage. For example, California’s law is quite comprehensive as compared to other states, requiring the provision of emergency medical care to the indigent and a patient transfer section similar to EMTALA. CAL. WELF. & INST. CODE § 17000; CAL. HEALTH & SAFETY CODE § 1317-1317.6. The access to emergency medical care requires individual counties to provide medical assistance to the indigent through public hospitals or a social insurance program, and states:

[e]very county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, or by their own means, or by state hospitals or other state or private institutions.

CAL. WELF. & INST. CODE § 17000. With respect to patient transfers, the California statute requires that hospitals with emergency departments provide emergency services and care to any person who arrives with a condition in which the person is in danger of loss of life, or serious injury or illness. *Id.* § 1317(a). In addition to including specific patient transfer procedures, the California statute further forbids transfer unless hospital personnel can determine, within reasonable medical probability, that the transfer—or delay caused by the transfer—will not create a medical hazard to the person. CAL. HEALTH & SAFETY CODE § 1317.2(b)-(e).

Other state statutes exhibiting varied scope include: FLA. STAT. ANN. ch. 395.1041(3)(a) (Harrison 1999) (“Every general hospital which has an emergency department shall provide emergency services and care for any emergency medical condition when: (1) Any person requests emergency services and care, or (2) Emergency services and care are requested on behalf of a person . . .”); GA. CODE ANN. § 31-8-42 (2001) (“Any hospital which operates an emergency service shall be required to provide the appropriate, necessary emergency services to any pregnant woman who is a resident of this state and who presents herself in active labor to the hospital.”); HAW. REV. STAT. ANN. § 321-232(b) (Michie 2000) (providing that emergency medical services may not be denied on the “basis of the ability of the person to pay therefor or because of the lack of prepaid health care coverage or proof of such ability or coverage”); IDAHO CODE §§ 56-1011 to 56-1018B (Michie 2002); 210 ILL. COMP. STAT. ANN. 80/1 (West 2001) (“Every hospital . . . shall furnish such hospital emergency services to any applicant who applies for the same in case of injury or acute medical condition.”); LA. REV. STAT. ANN. § 40:2113.6 (West 2001) (stating that hospital emergency medical services must be available and “free from discrimination based on race, religion, or national ancestry and from arbitrary, capricious, or unreasonable discrimination based on age, sex, or physical condition and economic status”); MASS. ANN. LAWS ch. 111, § 51D (Law. Co-op. 1995) (“No acute hospital shall impose any discriminatory restrictions or conditions relating to admission, availability of services, treatment, transfer or discharge with respect to any patient.”); MICH. COMP. LAWS § 333.20201(2)(a) (2001); MISS. CODE ANN. § 41-7-71 (2001) (“No resident of this state shall be refused admission to or treatment in any of the institutions . . . because of his inability to pay all or any of said costs.”); NEV. REV. STAT. ANN. § 439B.410(1) (Michie 1991) (“[E]ach hospital in this state has an obligation to provide emergency services and care, including care provided by physicians and nurses, and to admit a patient where appropriate, regardless of the financial status of the patient.”); N.H. REV. STAT. ANN. § 151:21 (1996); N.J. STAT. ANN. § 26:2h-18.51c (West 1996) (“Access to quality health care shall not be denied to residents of this State because of their inability to pay for the care.”); TENN. CODE ANN. § 68-140-511 (2001) (providing broad based anti-discrimination protections by stating that hospitals should not discriminate against patients requiring emergency medical care due to their uninsured status or their race, sex, religion, creed, national origin or ability to pay); TEX. HEALTH & SAFETY CODE ANN. § 311.022 (Vernon 2001) (providing for criminal penalties if medical services are denied discriminatorily); WASH. REV. CODE ANN. § 70.170.060(2) (West 2002) (“No hospital shall adopt or maintain practices or policies which would deny access to emergency care based on ability to pay.”); WIS. STAT. ANN. § 146.301(2) (West 1997) (“No hospital providing emergency services may refuse emergency treatment to any sick or injured person.”); WYO. STAT. ANN. § 35-2-115(a) (Michie 1999) (“Emergency service and care shall be provided . . . to any person requesting such services or care, or for whom such services or care is requested.”). For a review of state statutes, see generally Hylton, *supra* note 14, at 1023.

79. See S. REP. NO. 93-1285, at 5 (1974), reprinted in 1974 U.S.C.C.A.N. 7842, 7900 (reporting that Hill-Burton’s implementation by state agencies had been a “sorry performance”); Kevin O’Neil, *Site Visits at 21 Hill-Burton Facilities Reveal Extensive*

“non-existent or ineffective enforcement,”<sup>80</sup> and minimal remedies.<sup>81</sup>

C. *Epidemiologic Basis of Patient Dumping*

That patient transfer from the emergency department disproportionately affects the poor and racial minorities and therefore inequitably reinforces racial and class inequalities of access to medical care has been well founded in three medical studies known as the: (1) Harvard Medical School Study;<sup>82</sup> (2) Cook County Hospital Study;<sup>83</sup> and (3) National Association of Public Hospitals Study.<sup>84</sup> These studies are briefly reviewed as they provide the context to understand the environment that led to the enactment of EMTALA, and furnish insight as to the type of EMTALA enforcement the American public should have expected.

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*Noncompliance*, 16 CLEARINGHOUSE REV. 404, 406-07 (1982) (noting that some form of non-compliance was uncovered in all but one of the twenty-one sites visited).

80. See Dowell, *supra* note 56, at 161-68 (1987) (stating that the Department of Health and Human Services has been criticized by the Senate, House, and General Accounting Office as “poorly enforcing uncompensated care compliance”); Dowell, *supra* note 77, at 487 (explaining specific state statutes and their lack of effectiveness in ensuring that everyone receives equal treatment in emergency rooms); Fell, *supra* note 24, at 619 (describing how the state statutes protecting emergency treatment have failed); Karen H. Rothenberg, *Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care*, 26 HOUS. L. REV. 21, 54-57 (1989) (asserting the limited potential of most state laws due to the fact that many laws still lack implementing regulations and those that do have such regulations impose only minimal fines for violations).

81. See Rothenberg, *supra* note 80, at 56-57 (remarking that, even if a state has passed these statutes protecting emergency room care, the statutes do not carry effective remedies if they are violated). For example, although the Texas statute carries criminal sanctions, it is mostly limited to misdemeanors, except that if, as a direct result of the offense the person denied emergency services dies, the offense then becomes a felony of the third degree. TEX. HEALTH & SAFETY CODE ANN. § 4438(a) (Vernon 2001). Most states impose minimal fines. See, e.g., MD. CODE ANN., HEALTH-GEN. I § 19-308.2(b)(2) (1990) (providing for a fine not to exceed \$1000 for transferring a patient in violation of this section of the code); WIS. STAT. ANN. § 146.301(7) (West 1997) (indicating that a violating hospital may be fined no more than \$ 1000).

82. *Harvard Medical School Study*, *supra* note 5, at 494. This study is referred to in the legal literature as the “Harvard Medical School” study; however, the patient population studied consisted of patient transfers to Highland General Hospital, the major public acute care facility in Alameda County, Oakland, California. *Id.* It was the researchers of the study, rather than the patients of the study, who were Harvard affiliated. *Id.*

83. *Cook County Hospital Study*, *supra* note 22, at 552.

84. DENNIS ANDRULIS & LARRY GAGE, NATIONAL ASS'N OF PUBLIC HOSPITALS, PATIENT TRANSFERS TO PUBLIC HOSPITALS: A NATIONAL ASSESSMENT (Apr. 1986).

1. *Harvard Medical School Study*

The Harvard Medical School Study reviewed 458 patient transfers<sup>85</sup> to Highland General Hospital Emergency Department during a six month period of time in 1981.<sup>86</sup> This study found that eighty-five percent of patients “imperiled by transfer”<sup>87</sup> were uninsured,<sup>88</sup> and thirty-three cases were judged as having received “substandard care” at the transferring hospital.<sup>89</sup> Although the reason for transfer was infrequently recorded,<sup>90</sup> no evidence was present that indicated any transfer occurred because of lack of beds,<sup>91</sup> and only one patient was explicitly transferred for a medical indication or service which was not provided at the original transferring hospital.<sup>92</sup> During the six months of the study, only thirteen patients with private insurance

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85. *Harvard Medical School Study*, *supra* note 5, at 494. Only the charts of twenty-two percent of the patients transferred were reviewed. *Id.* at 496. The study only excluded psychiatric patient transfers. *Id.* at 495. Demographic data was obtained from computerized billing records and patient medical charts. *Id.*

86. *Id.* at 494. The actual study period was from January 1, 1981, through June 30, 1981. *Id.* at 495. The Harvard Medical School Study suffered from a lack of definition of categories and criterion. *Id.* For instance, whereas four physicians reviewed patient charts for inclusion of patients into a “high risk” group, the patient transfer was “judged dangerous” if all four clinician-reviewers agreed that the patient was either (a) at risk of life-threatening complications in transit, or (b) that accepted medical practice would require immediate therapy that was delayed by the transfer. *Id.* However, what the clinician-reviewers considered as “life-threatening complications” was not defined in this study. *Id.* The criterion for what was “accepted medical practice” was similarly not defined. *Id.* Criteria for inclusion into “high risk” group of transferred patients were: (1) admission to the Intensive Care Unit (ICU), Operating Room, or Obstetrics suite; (2) pre-transfer diagnosis of stab wound, gun shot wound, motor vehicle accident, fracture or dislocation. *Id.*

Further, the study included “borderline cases.” *Id.* But exactly what the clinician-reviewers considered as “borderline cases” was not defined. *Id.* Although some “borderline cases” were identified in which continuous observation or immediate treatment might have been preferable (e.g., acute suppurative appendicitis, seizures other than status epilepticus, ingestion of undetermined substances), such cases were not categorized as “dangerous.” *Id.* Additionally, the study noted that in thirty-three cases, “transfer was judged to have jeopardized the patient;” and that such care was categorized as “substandard” care. *Id.* at 495-96. However, what the clinician-reviewers considered as “jeopardized” was not defined in the study. *Id.* The clinical conditions, which were the basis for judgment that “substandard care” (thirty-three transferred patients) fell into five categories: (1) cardiac or neurological disorders causing life-threatening emergencies; (2) inadequate evaluation or inadequate treatment of central nervous system (3) high risk of exhaustion during transfer; (4) undiagnosed traumatic pneumothoraces and/or hemothoraces requiring chest tube placement after transfer; (5) severe orthopaedic injuries for which immediate therapy was desirable. *Id.*

87. One can only imagine what was meant by “imperiled by transfer;” the term was not specifically defined in this study. *Id.* at 495.

88. *Id.*

89. *Id.*

90. *Id.* at 496.

91. *Id.* at 495.

92. *Id.*

were transferred,<sup>93</sup> and none of those patients jeopardized by transfer were privately insured.<sup>94</sup>

The authors of the Harvard Medical School Study concluded that “in some cases transfers were motivated by financial interests of private hospitals and physicians.”<sup>95</sup> Further, the study noted that “there is evidence that transfer was racially inequitable. Minority patients represented forty-five percent of all those transferred and fifty-eight percent of those jeopardized by transfer, although only thirty-three percent of the county’s population are “non-White.”<sup>96</sup> In the community studied, “transfer is a common and potentially dangerous medical intervention which appears to reinforce racial and class inequalities of access to medical care.”<sup>97</sup>

## 2. *Cook County Hospital Study*

The Cook County Hospital Study consisted of a review of 500 consecutive transfers during a six-week period from November 1983 to January 1984.<sup>98</sup> Eighty-nine percent of the transferred patients

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93. *Id.* at 496.

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.* at 494; *see Hyman, supra* note 1, at 45 (critiquing this medical study from a lawyer’s perspective by addressing the study’s limitations).

98. *Cook County Hospital Study, supra* note 22, at 552. During this time period, there were a total of 602 patient transfers, but only 500 patient admissions were included in the study. *Id.* at 553. Only those patients who were subsequently admitted to the medical or surgical service were included in the study; patients admitted to Ob/Gyn or Pediatrics, or who were discharged from the emergency department were excluded. *Id.* at 552. This study consisted of medical chart review and patient interviews. *Id.* at 552, 553. Methodologically, the Cook County Hospital Study analyzed the following factors: (1) patient demographics (age, gender, ethnicity, employment and insurance status); (2) number of transfers per year; (3) reason for transfer; (4) admission to ICU; (5) length of hospital stay; (6) patient charges; (7) clinical outcome; (8) stability of the patient’s condition at the time of transfer (assessment of stability required consensus among all four physician reviewers); (9) treatment delay caused by transfer; (10) informed consent; (11) costs incurred by Cook County Hospital; and (12) the number of hospitals which transferred to Cook County. *Id.* at 552.

In respect to the assessment of “stability,” patients whose conditions were classified as “unstable” had clear evidence of at least one of the following conditions at the transferring hospital: (1) shock (systolic blood pressure of < 100 mm Hg with clinical signs of shock); (2) acute cardiac or respiratory insufficiency (arterial partial pressure of oxygen < 60 mm Hg, respiratory acidosis, or evidence of severe respiratory distress); (3) severe acute metabolic abnormalities, such as diabetic ketoacidosis, other unexplained causes of metabolic acidosis, hypoglycemia, or severe hyponatremia; (4) abnormal mental status examination or focal neurological deficits caused by trauma; (5) abnormal mental status or acute complicated cerebrovascular accidents of nontraumatic origin; (6) severe anemia or active internal bleeding (with evidence of a dropping hematocrit (HCT) or HCT of less than 25% percent, shock, or blood loss of at least 500 ml), a low or dropping HCT, vital-organ or vascular injury, unstable spinal fractures, flail chest, or severe facial burns; (7) acute abdominal conditions with signs of peritonitis or perforation; (8)

were Black or Hispanic,<sup>99</sup> and eighty-one percent were unemployed.<sup>100</sup> Most of the patients—eighty-seven percent—were transferred because they lacked adequate medical insurance.<sup>101</sup> Twenty-four percent of the patients transferred were in an unstable clinical condition at the transferring hospital at the time of transfer.<sup>102</sup> Only six percent of the patients had given written informed consent for transfer.<sup>103</sup> Twenty-two percent required admission to an intensive care unit (ICU).<sup>104</sup>

This study concluded that patients were transferred to public hospitals predominately for economic reasons,<sup>105</sup> in spite of the fact that many of them were in an unstable condition at the time of transfer.<sup>106</sup> Patient transfers so disproportionately affected the poor and racial minorities that the study raised serious doubts as to the private health sector's ability to consider the condition and well-being of patients objectively,<sup>107</sup> given the strong economic incentives to transfer the uninsured.<sup>108</sup>

### 3. *National Association of Public Hospitals Study*

The National Association of Public Hospitals study surveyed twenty-six public hospitals over a two-week period in 1985.<sup>109</sup> This survey found that, of 1066 transfer patients, forty-seven percent were uninsured and eighteen percent were Medicaid patients.<sup>110</sup> The study noted that most of the transferred patients were in “serious”

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severe hypertension (blood pressure 200/130 mm Hg, with signs of end-organ damage); or (9) potentially life-threatening infections (e.g., meningitis, suspected sepsis, or complicated infections in diabetic patients or other compromised hosts). *Id.*

If a patient had a surgical condition, the concurrence of a fifth physician-reviewer (board-certified surgeon) was required for the patient to be denominated as unstable. *Id.* Treatment delay was defined as the time that elapsed from the transfer-request phone call to Cook County Hospital until the time the patient was discharged from the Cook County Hospital Emergency Department. *Id.*

99. *Id.* at 553.

100. *Id.*

101. *Id.* Forty-six percent of the transfer patients were public aid-Medicaid recipients; while another forty-six percent had no insurance at all. *Id.*

102. *Id.* at 554.

103. *Id.*

104. *Id.* at 553. The proportion of transferred medical-service patients who died was 9.4%, more than twice the proportion of medical-service patients who were not transferred. *Id.* at 552, 555.

105. *Id.* at 556.

106. *Id.* at 552.

107. *See id.* at 556 (finding that “economic reasons” were what prompted patient transfers from other hospital emergency departments to Cook County Hospital).

108. *Id.*

109. ANDRULIS, *supra* note 84.

110. *Id.*

condition: seventy-three percent of the transferred patients required emergency services at the receiving hospital, while fifty-four percent of uninsured patients requiring emergency treatment at the receiving hospital required admission.<sup>111</sup>

#### D. Persistence of Patient Dumping

Since the enactment of EMTALA in 1986, patient dumping has been the subject of little analysis.<sup>112</sup> To begin to appreciate the extent of penetration of patient dumping into the healthcare system, and to understand the extent to which EMTALA and government enforcement of EMTALA has been ineffective, one must understand the environment in which patient dumping occurs.

##### 1. The emergency department environment

In the United States there are approximately 3934 emergency departments.<sup>113</sup> Physicians who staff the emergency departments have varied training and educational backgrounds. In the year 2000, there were approximately 32,000 physicians practicing emergency medicine,<sup>114</sup> but only 17,300 were board certified by the American Board of Emergency Medicine.<sup>115</sup> Although board certification is not required by law for any physician to practice emergency medicine, such certification indicates that a physician has undergone at least

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111. *Id.*

112. See generally Lynn Healey Scaduto, Comment, *The Emergency Medical Treatment and Active Labor Act Gone Astray: A Proposal to Reclaim EMTALA for Its Intended Beneficiaries*, 46 UCLA L. REV. 943, 953-63 (1999) (noting that the courts have addressed patient dumping in EMTALA cases since its passage in 1986, but that little else has been done to address the problem).

113. LINDA F. MCCAIG & NGHI LY, NAT'L CTR. FOR HEALTH STATISTICS, NAT'L HOSPITAL AMBULATORY MEDICAL CARE SURVEY: 1999 EMERGENCY DEPARTMENT SUMMARY 2 (Apr. 2002). The American College of Emergency Physicians (ACEP) and the Center for Disease Control (CDC) differ in their assessment of how many emergency departments exist in the United States. *Id.* For instance, the CDC reports that there were 4005 hospitals with emergency departments in 1997, which decreased to 3934 in the year 2000. *Id.* However, the ACEP reported that in 1997 there was a total of 4945 U.S. hospitals which had emergency departments. AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, EMERGENCY MEDICINE STATISTICAL PROFILE (July 2001) [hereinafter ACEP], at <http://www.acep.org/1,381,0.html> (last visited Sept. 8, 2002). The drop in emergency departments seeing patients is also reflected by the fact that in 1994 there were as many as 4791 U.S. hospitals with emergency departments. *Id.*

114. ACEP, *supra* note 113, at 1. This figure was as of July 2001. *Id.*

115. *Id.* "The American Board of Emergency Medicine (ABEM) was [first] recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) as the 23rd medical specialty member board" in 1979. American Board of Emergency Medicine [hereinafter ABEM], at <http://www.abem.org/whatis/main.htm> (last visited Apr. 25, 2002). As of July 2001, there were approximately 1078 physicians board certified in emergency medicine by the American Osteopathic Board of Emergency Medicine. ACEP, *supra* note 113, at 1.

three years of post-graduate medical training.<sup>116</sup> This training includes education in emergency medicine as well as other medical disciplines.<sup>117</sup> Emergency physicians who are not board certified in emergency medicine may have as little as one post-graduate year of internship or residency training following completion of medical school, or may be trained in other specialties of medicine.<sup>118</sup>

The extent to which patient dumping occurs in emergency departments has not been well studied. However, while no one cumulative source of data is available,<sup>119</sup> a careful analysis of all available data sources indicates that patient dumping is on the rise.<sup>120</sup> While an accurate estimation of the incidence of patient dumping is unavailable,<sup>121</sup> one fifteen-year-old study estimated that 250,000 acts of patient dumping—in the form of patient transfers—occurred annually.<sup>122</sup> Despite being frequently cited,<sup>123</sup> that figure represents

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116. ACEP, *supra* note 113, at 1. Upon completion of an emergency medicine residency, the physician then must successfully pass both a written and oral examination to be recognized as board certified in emergency medicine. *Id.*

117. *Id.*

118. See Association of Emergency Physicians Membership Summary, at <http://www.emedicine.com/emerg/topic729.htm> (last visited Dec. 2, 2002). For example, emergency physicians may be trained, or partially trained, in other medical specialties such as internal medicine, pediatrics, family medicine, or surgery.

119. Remarkably, the Department of Health and Human Services (DHHS) does not maintain a centralized updated accounting of patient dumping EMTALA complaints or violations. Telephone Interview with Scott Hutchison, Project Analyst, Office of Inspector General, Office of Evaluation and Inspections, San Francisco Regional Office, Department of Health and Human Services, The Emergency Medical Treatment and Labor Act, The Enforcement Process (Jan. 2002; Feb. 27, 2002; Feb. 28, 2002); Telephone Interview with Doris Jackson, Centers for Medicare and Medicaid, Department of Health and Human Services, Washington, D.C. (Mar. 4, 2002).

120. See *supra* notes 183-97 and accompanying text (tracking date over the past two decades which illustrates the increase in many types of patient dumping activities).

121. See Scaduto, *supra* note 112, at 968-69 (describing the paucity of information on the subject).

122. Ansell, *supra* note 22, at 1500.

123. PUBLIC CITIZEN'S HRG #2, *supra* note 10, at 1 ("Four and a half years after the law went into effect, only 140 hospitals and three physicians responsible for approximately 165 violations of the law had been uncovered by government investigations, despite the 250,000 "dumping" incidents estimated to occur in American hospitals each year."); RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTHCARE? 100 (1997) ("There are no reliable studies of the rates of transfer out of emergency rooms since the passage of EMTALA, but one study guesses that some 250,000 illegal transfers have taken place."); PUBLIC CITIZEN'S HRG #3, *supra* note 10, at ii (explaining that studies conducted prior to enactment of the "patient dumping" law suggested that 250,000 patients a year were denied emergency medical care for economic reasons); Lauren A. Dame, *The Emergency Medical Treatment and Active Labor Act: The Anomalous Right to Health Care*, 8 HEALTH MATRIX 3, 8 (1998) ("Extrapolating from these studies and others, researchers estimated that as many as 250,000 patients a year in need of emergency care were being "dumped"—transferred from one hospital to another for economic reasons—by the late 1980s."); Scott E. Hamm, *Power v. Arlington Hospital: A Federal Court End Run Around State Malpractice Limitations*, 7 BYU J. PUB. L. 335, 338 (1993) ("In 1987, it

only an old estimation<sup>124</sup> that has never been correlated with either total emergency department visits or resulting patient transfers to other medical facilities.<sup>125</sup> More importantly, such an estimation has never been correlated with the lack of government enforcement.<sup>126</sup>

To be meaningful, any discussion of patient dumping must be placed in context. That is, patient dumping must be considered in light of the total emergency visits and transfers amongst medical facilities<sup>127</sup> throughout the United States. The emergency department visit and transfer data have been tabulated through the National Hospital Ambulatory Medical Care Survey (NHAMCS)<sup>128</sup> for the years

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was estimated that annually 250,000 emergency patients were transferred or discharged from health care facilities because of inability to pay for medical services.”); Hyman, *supra* note 1, at 50 (“The claim that 250,000 patients a year are dumped is impressive, but is based on generalizing from a skewed sample while simultaneously using an overbroad definition.”); Erik J. Olson, *No Room at the Inn: A Snapshot of an American Emergency Room*, 46 STAN. L. REV. 449, 465 (1994) (“One expert estimates that 250,000 Americans are wrongly transferred each year.”); Singer, *supra* note 14, at 128 (“One report estimated the incidence of dumping at 250,000 cases per year.”); Julia Ali, Note, *Does EMTALA Apply to Inpatients Located Anywhere in a Hospital?*, 32 RUTGERS L.J. 549, 581 n.4 (2001) (“Extrapolating from data in available studies, an estimated 250,000 patients were transferred for economic reasons.”); Bera, *supra* note 61, at 619 (“Some studies estimate that emergency facilities ‘dump’ at least 250,000 patients annually.”); Demetrios G. Metropoulos, Note, *Son of Cobra: The Evolution of a Federal Malpractice Statute*, 45 STAN. L. REV. 263, 266 (1999) (“One study estimated that 250,000 Americans were dumped annually.”); Scaduto, *supra* note 112, at 968 (“One 1987 article estimated that 250,000 acts of patient dumping occur annually.”); Clare Ansberry, *Dumping the Poor: Despite Federal Law, Hospitals Still Reject Sick Who Can’t Pay*, WALL ST. J., Nov. 29, 1988, at A1 (reporting that 250,000 patients are dumped annually).

124. Ansell, *supra* note 22, at 1500.

125. *But see* Hyman, *supra* note 1, at 49 (criticizing the study as overly expansive because it used a skewed sample and overbroad definitions).

126. *See* DHHS, OIG EMTALA SURVEY, *supra* note 25, at 15 (describing the poor state of data collection for EMTALA cases, which prohibits a comprehensive government enforcement program).

127. EMTALA applies to any “movement” of patients, which includes both patient transfer and discharge; however, as the 250,000 per year estimate relates to patient transfers, this Article will concentrate on the patient transfer application. Ansell, *supra* note 22, at 1500; *see also* 42 U.S.C. § 1395dd(e)(4) (2000) (defining the term “transfer” to mean, the movement (including the discharge) of an individual outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead or (B) leaves the facility without the permission of any such person.

*Id.*

128. National Hospital Ambulatory Medical Care Survey (NHAMCS) is a national probability survey of visits to hospital emergency and outpatient departments of non-Federal, short-stay, and general hospitals in the United States. LINDA F. MCCRAIG & CATHERINE W. BURT, NAT’L CENTER FOR HEALTH STATISTICS, NAT’L HOSPITAL AMBULATORY MEDICAL CARE SURVEY: 1999 EMERGENCY DEPARTMENT SUMMARY 320 (June 25, 2001) [hereinafter NHAMCS], available at <http://www.cdc.gov/nchs/data/ad/ad320.pdf>. NHAMCS, a part of the ambulatory care component of the National Health Care Survey that measures health care utilization across various types of providers, is conducted by the Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics for

of 1992-1999.

As noted in Table 1, during the period of 1992-1999, although emergency department visits increased from approximately 89.8 to 102.8 million visits per year, a fourteen percent increase, facility transfers increased from approximately 1.1 to 1.8 million transfers per year, or a sixty-four percent increase.<sup>129</sup>

TABLE 1

Emergency Department (ED) Visits 1992-1999			
	U.S. Population <sup>130</sup>	ED Visits <sup>131</sup>	Facility Transfers <sup>132</sup>
1992 <sup>133</sup>	255,029	89,796	1093
1993 <sup>134</sup>	257,782	90,266	1438
1994 <sup>135</sup>	260,327	93,402	1730
1995 <sup>136</sup>	262,803	96,545	1751
1996 <sup>137</sup>	265,228	90,347	1639
1997 <sup>138</sup>	267,783	94,936	1700
1998 <sup>139</sup>	270,248	100,385	1798
1999 <sup>140</sup>	272,690	102,765	1798

the years of 1992-1999. *Id.*

129. *Infra* notes 133-40 and accompanying table.

130. U.S. Census Bureau, *Monthly Estimates of the U.S. Population Division*, available at <http://eire.census.gov/popest/archives/national/nation1/inffile1-1.txt> (last visited Sept. 4, 2002).

131. NHAMCS, *supra* note 128 (representing data in thousands).

132. Number of visits in thousands that were transferred to other facilities. *Id.* Standard of error for facility transfers was calculated by the National Center for Health Statistics for the years of 1992, 1993, 1994 and 1999 only, and determined to be 85, 124, 141 and 181 respectively. *Id.*

133. Linda F. McCraig, Nat'l Center for Health Statistics, Nat'l Hospital Ambulatory Medical Care Survey: 1992 Emergency Department Summary 3 (Mar. 1994), at <http://www.cdc.gov/nchs/data/ad/ad245.pdf> [hereinafter, McCraig, 1992 Survey].

134. Barbara J. Stussman, National Center for Health Statistics, Case Survey: 1993 Emergency Department Summary 1 (Jan. 1996), at <http://www.cdc.gov/nchs/data/ad/ad271.pdf> [hereinafter Stussman, 1993 Survey].

135. Barbara J. Stussman, Nat'l Center for Health Statistics, Nat'l Hospital Ambulatory Medical Care Survey: 1994 Emergency Department Summary 3 (May 1996), at <http://www.cdc.gov/nchs/data/ad/ad275.pdf> [hereinafter Stussman, 1994 Survey].

136. Barbara J. Stussman, Nat'l Center for Health Statistics, Nat'l Hospital Ambulatory Medical Care Survey: 1995 Emergency Department Summary 3 (Apr. 1997), at <http://www.cdc.gov/nchs/data/ad/ad285.pdf> [hereinafter Stussman, 1995 Survey].

137. Linda F. McCraig & Barbara J. Stussman, Nat'l Center for Health Statistics, Nat'l Hospital Ambulatory Medical Care Survey: 1996 Emergency Department Summary 4 (Dec. 1997), at <http://www.cdc.gov/nchs/data/ad/ad293.pdf>

Accordingly, the estimate of 250,000 illegal patient transfers, made in 1987 based on data from 1982 through 1984,<sup>141</sup> may have historical significance, but it must be considered within the context of government efforts to curtail patient dumping. The number of patients transferred from emergency departments as facility transfers each year, when compared with the yearly number of actual government confirmed EMTALA violations, is most revealing.<sup>142</sup>

**TABLE 2**

<b>Emergency Department Facility Transfers and DHHS EMTALA Violations</b>				
	<b>Facility Transfers<sup>143</sup></b>	<b>EMTALA Investigations<sup>144</sup></b>	<b>EMTALA Violations<sup>145</sup></b>	<b>% EMTALA Viol. / Transfers<sup>146</sup></b>
<b>1992<sup>147</sup></b>	1093	315	86	<b>.008</b>
<b>1993<sup>148</sup></b>	1438	340	76	<b>.005</b>
<b>1994<sup>149</sup></b>	1730	370	137	<b>.008</b>
<b>1995<sup>150</sup></b>	1751	457	163	<b>.009</b>
<b>1996<sup>151</sup></b>	1639	349	199	<b>.012</b>
<b>1997<sup>152</sup></b>	1700	448	230	<b>.013</b>
<b>1998<sup>153</sup></b>	1798	412	262	<b>.014</b>
<b>1999<sup>154</sup></b>	1798	n/a	322	<b>.018</b>

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[hereinafter McCraig, 1996 Survey].

138. Parivash Nourjah, Nat'l Center for Health Statistics, Nat'l Hospital Ambulatory Medical Care Survey: 1997 Emergency Department Summary 3 (May 6, 1999), at <http://www.cdc.gov/nchs/data/ad/ad304.pdf>.

139. Linda F. McCraig, Nat'l Center for Health Statistics, Nat'l Hospital Ambulatory Medical Care Survey: 1998 Emergency Department Summary 3 (May 2000), at <http://www.cdc.gov/nchs/data/ad/ad313.pdf> [hereinafter McCraig, 1998 Survey].

140. NHAMCS, *supra* note 128.

141. Ansell, *supra* note 22, at 1500.

142. See *infra* Table 2 (observing that the data in Table 2 documents the miniscule number of actual government confirmed EMTALA violations as compared to the large number of patients transferred from emergency departments as facility transfers).

143. Representing the number of facility transfers in thousands.

144. DHHS, OIG EMTALA SURVEY, *supra* note 25, at 8 fig. 3.

145. *Id.*

146. This value represents the percent of confirmed EMTALA violations with respect to the total of facility transfers as calculated by the National Center for Health Statistics for the years of 1992-1999. *Id.* This number is calculated using data presented in the "EMTALA Violations" column and the data presented in the "Facility Transfers" column. *Id.*

147. McCraig, 1992 Survey, *supra* note 133.

148. Stussman, 1993 Survey, *supra* note 134.

149. Stussman, 1994 Survey, *supra* note 135.

150. Stussman, 1995 Survey, *supra* note 136.

As noted in Table 2, although the average number of emergency department facility transfers from 1992-1999 was approximately 1.6 million patients per year, there was only an average of 384 EMTALA investigations and 184 EMTALA violations per year.<sup>155</sup> Accordingly, government enforcement efforts were only able to detect patient dumping in an average of approximately 0.01% of emergency department facility transfers.<sup>156</sup>

## 2. *Patient dumping EMTALA violations 1986-1999*

No national data bank exists to monitor and track cumulative occurrences of patient dumping or EMTALA violations.<sup>157</sup> Two sets of studies, however, provide insight into the magnitude of patient dumping and EMTALA violations: the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) studies (DHHS-OIG),<sup>158</sup> and the reviews conducted by the Public Citizen Health Research Group (PCHRG).<sup>159</sup>

Between 1991-2001, the PCHRG published six studies which considered the incidence of EMTALA patient dumping violations with respect to DHHS and the Health Care Financing Administration Agency (HCFA) government investigations and enforcement.<sup>160</sup> The

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151. McCraig, 1996 Survey, *supra* note 137.

152. Nourjah, *supra* note 138.

153. McCraig, 1998 Survey, *supra* note 139.

154. NHAMCS, *supra* note 128.

155. *See supra* notes 143-54 and accompanying table.

156. *Supra* notes 143-54 and accompanying table.

157. *See* DHHS, OIG EMTALA SURVEY, *supra* note 25, at 15 (reporting that there is no uniform data collection format or complete database for EMTALA violations).

158. The mission of the OIG, a division of the DHHS, is to protect the integrity of the DHHS, as well as the health and welfare of beneficiaries served by them. *Id.* at 1. The Office of Evaluation and Inspections ("OEI") is one of several components of the OIG which conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the DHHS, the United States Congress, and the public. *Id.* In that regard, the OIG conducted an inspection to evaluate the enforcement process for EMTALA, which was published in January 2001. *Id.*

159. *See generally* PUBLIC CITIZEN, ABOUT PUBLIC CITIZEN, at <http://www.citizen.org/about> (last visited Sept. 13, 2002) (noting that the Public Citizen is a national, nonprofit consumer advocacy organization founded by Ralph Nader in 1971 to represent consumer interests in Congress, the executive branch and the courts). The Public Citizen Health Research Group (PCHRG), headed by Dr. Sidney M. Wolfe, is a division of Public Citizen which promotes research-based, system-wide changes in health care policy and provides government oversight concerning drugs, medical devices, doctors and hospitals and occupational health. The Health Research Group, *About the Health Research Group*, Public Citizen, at <http://www.citizen.org/hrg/about> (last visited Sept. 13, 2002).

160. PUBLIC CITIZEN'S HRG #1, *supra* note 9; PUBLIC CITIZEN'S HRG #2, *supra* note 10; LAUREN DAME & SIDNEY M. WOLFE, PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, PATIENT DUMPING IN HOSPITAL EMERGENCY ROOMS: AN UPDATE BASED ON COMPLAINTS RECEIVED BY HHS BETWEEN APRIL 1, 1994 AND MARCH 31, 1995 1 (Mar. 1996)

six PCHRG studies were consistent in respect to nine conclusions.

First, the PCHRG studies noted that complaints to HCFA of EMTALA patient dumping violations continued to increase,<sup>161</sup> and that the agency's attention to such complaints "clearly underrepresented"<sup>162</sup> the frequency with which patient dumping continued to occur.<sup>163</sup> Second, the PCHRG studies identified that DHHS's enforcement record was consistently characterized as "meager,"<sup>164</sup> "poor,"<sup>165</sup> or "lax."<sup>166</sup> The PCHRG studies noted that even OIG's own analysts criticized the enforcement scheme employed by the federal government.<sup>167</sup> In that regard, the studies noted that there continued to be "vast discrepancies"<sup>168</sup> in the rate of incidents reported and violations confirmed by each of HCFA's ten regional

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[hereinafter PUBLIC CITIZEN'S HRG #5]; LAUREN DAME & SIDNEY M. WOLFE, PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, HOSPITAL VIOLATIONS OF THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT: A DETAILED LOOK AT "PATIENT DUMPING" 6 (Dec. 1997) [hereinafter PUBLIC CITIZEN'S HRG #6]; PUBLIC CITIZEN'S HRG #3, *supra* note 10; PUBLIC CITIZEN'S HRG #4, *supra* note 24.

Although the name of the HCFA has been changed to Center for Medicaid and Medicare Services (CMS), because this Article uses data and information obtained from previous HCFA publications, we will continue to use the reference to HCFA, rather than CMS. CENTERS FOR MEDICARE AND MEDICAID SERVICES, INTRODUCING CMS, available at <http://cms.hhs.gov/about/reorg.asp> (last visited Sept. 12, 2002).

161. See PUBLIC CITIZEN'S HRG #2, *supra* note 10, at 26 tbl.5 (confirming EMTALA violations by 139 different hospitals); *id.* at 24 tbl.3 (noting the violation of EMTALA laws in twenty-four states and the District of Columbia); PUBLIC CITIZEN'S HRG #3, *supra* note 10, at T3-T11tbl.3 (reporting that, from 1986 through 1992, patient dumping violations had occurred in a total of thirty-two states, the District of Columbia, and Puerto Rico); PUBLIC CITIZEN'S HRG #4, *supra* note 24, at 6 (noting increased complaints of patient dumping incidents received by HCFA each year, and explaining that the number of cases brought to the agency's attention "clearly underrepresents" the frequency with which patient dumping occurs); PUBLIC CITIZEN'S HRG #5, *supra* note 160, at 2 (stating that hospital EMTALA violators were located in thirty states and Puerto Rico); PUBLIC CITIZEN'S HRG #5, *supra* note 160, at 5 (describing that EMTALA complaints to HCFA continued to increase, again noting that this was indicative of the fact that the agency's attention "clearly underrepresented" the frequency with which patient dumping continued to occur); PUBLIC CITIZEN'S HRG #6, *supra* note 160, at 6 (noting 256 hospitals in forty-one states and Puerto Rico which were named as being responsible for patient dumping violations); PUBLIC CITIZEN'S HRG #6, *supra* note 160, at 12 (reporting the "ever-increasing" numbers of EMTALA violations each year); PUBLIC CITIZEN'S HRG #1, *supra* note 9, at 1 (observing EMTALA violations in forty-six states as well as the District of Columbia and Puerto Rico).

162. PUBLIC CITIZEN'S HRG #5, *supra* note 160, at 2; PUBLIC CITIZEN'S HRG #4, *supra* note 24, at 6.

163. PUBLIC CITIZEN'S HRG #5, *supra* note 160, at 2; PUBLIC CITIZEN'S HRG #4, *supra* note 24, at 6.

164. See PUBLIC CITIZEN'S HRG #2, *supra* note 10, at 2, 7 (noting that DHHS's "meager enforcement record represented a serious failure of its responsibility to punish and deter [EMTALA] violations").

165. PUBLIC CITIZEN'S HRG #4, *supra* note 24, at 9.

166. PUBLIC CITIZEN'S HRG #2, *supra* note 10, at 2.

167. *Id.*

168. PUBLIC CITIZEN'S HRG #4, *supra* note 24, at 6.

offices.<sup>169</sup>

Third, repeat hospital offenders were persistent throughout the PCHRG studies.<sup>170</sup> Fourth, the DHHS consistently fined, but did not penalize hospitals for hospital EMTALA violations.<sup>171</sup>

Fifth, HCFA's policy of disclosing only a limited number of EMTALA violations to the public<sup>172</sup> "kept [the public] largely in the dark about patient dumping violations"<sup>173</sup> in their own community.<sup>174</sup> Sixth, DHHS had "tragically failed" to meet the challenge posed by congressional anti-patient dumping legislation.<sup>175</sup> Seventh, the healthcare reform measure of universal health coverage<sup>176</sup> was a key to ending the "unconscionable and deadly practice [of patient dumping]."<sup>177</sup>

Eighth, the PCHRG studies consistently noted that regional HCFA offices were lopsided in their enforcement of EMTALA.<sup>178</sup> For

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169. *Id.*

170. See PUBLIC CITIZEN'S HRG #4, *supra* note 24, at 4-5 (referring to the eighty-five hospitals not penalized for their violations, including fourteen hospitals which had repeated EMTALA violations); PUBLIC CITIZEN'S HRG #6, *supra* note 160, at 6 (noting that twenty-three, or nine percent, of the hospitals were repeat offenders); PUBLIC CITIZEN'S HRG #1, *supra* note 9, at 31 (reporting that out of the 527 hospitals in the study period 12.9% were repeat dumping offenders).

171. See PUBLIC CITIZEN'S HRG #2, *supra* note 10, at 2 (identifying that 121 hospitals which violated EMTALA were never penalized by DHHS); PUBLIC CITIZEN'S HRG #3, *supra* note 10, at 6 (noting ninety-one percent of the 244 offending hospitals, including twenty-three repeat patient dumping offenders, were never penalized); PUBLIC CITIZEN'S HRG #4, *supra* note 24, at 2 (reporting only twenty-four hospitals, or nine percent, were penalized). EMTALA sanctions may include either monetary fines and/or a civil penalty of excluding a hospital from the Medicare program.

172. See PUBLIC CITIZEN'S HRG #2, *supra* note 10, at 7 (observing that HCFA had a policy of disclosing only a limited number of EMTALA violations to the public); PUBLIC CITIZEN'S HRG #3, *supra* note 10, at ii (noting that in approximately sixty percent of cases wherein hospitals were penalized, the DHHS accepted a settlement term by which it agreed not to affirmatively publicize or to dicourtose the agreement).

173. PUBLIC CITIZEN'S HRG #3, *supra* note 24, at 13.

174. *Id.* at 4.

175. PUBLIC CITIZEN'S HRG #2, *supra* note 10, at 18; PUBLIC CITIZEN'S HRG #3, *supra* note 10, at 23-24; see also PUBLIC CITIZEN'S HRG #5, *supra* note 160, at 6 (explaining that the economically-motivated patient dumping of uninsured patients that prompted the passage of EMTALA will continue to occur for economic—not medical—reasons which could result in harm to patients requiring emergency medical care); PUBLIC CITIZEN'S HRG #6, *supra* note 160, at 13 (remarking that patient dumping from American hospital emergency departments is a "dangerous, disgraceful but predictable accompaniment to the market-driven health care system in the richest nation in the world").

176. PUBLIC CITIZEN'S HRG #4, *supra* note 24, at 8.

177. See *id.* at 6 (arguing that healthcare reform inclusive of uncompromised universal coverage "is needed to put a stop to this unconscionable and deadly practice [of patient dumping]").

178. PUBLIC CITIZEN'S HRG #2, *supra* note 10, at 10, 11. As noted in the table below, both HCFA Regions I and II, which had previously not confirmed any EMTALA violations during the first four and one-half years following the effective

instance, HCFA Regions I and II found *no* patient dumping violations in the first four and one-half years that EMTALA was in effect.<sup>179</sup> Ninth, the PCHRG studies revealed that for-profit hospitals were “greatly overrepresented” amongst patient dumping hospital EMTALA offenders.<sup>180</sup>

date of EMTALA, during the PCHRG study years from 1991 through 1992, confirmed only one and nine violations, respectively. PUBLIC CITIZEN’S HRG #3, *supra* note 10, at 17. In similar fashion, Regions III, VII, IX, and X continued to confirm low numbers of EMTALA violations. *Id.* Regions IV, V and VI, however, continue to lead the regions in both number of completed investigations and confirmed violations of patient dumping. *See id.* (noting HCFA regional enforcement of EMTALA remained lopsided); PUBLIC CITIZEN’S HRG #4, *supra* note 24, at 6 (finding that there continued to be “vast discrepancies” in the rate of incidents reported and violations confirmed by each of HCFA’s ten regional offices); PUBLIC CITIZEN’S HRG #5, *supra* note 160, at 5 n.14 (reporting “vast differences” continued in the regional HCFA offices with respect to rate of incidents reported and violations confirmed).

As noted in the following table, cumulative data for the first six and one-half years since the effective date of EMTALA (mid-1986 through 1992) also revealed persistent lopsided HCFA enforcement of EMTALA.

<i>HCFA Region Patient Dumping Enforcement 1986-1992</i>			
<b>HCFA Region</b>	<b>Completed Investigations</b>	<b>Confirmed Violations</b>	<b>Investigations/ Violations</b>
I	20	1	5%
II	46	9	20%
III	83	18	22%
IV	305	67	22%
V	96	30	31%
VI	414	112	27%
VII	39	12	31%
VIII	11	3	27%
IX	149	36	24%
X	52	11	21%
Totals	1215	299	25%

PUBLIC CITIZEN’S HRG #3, *supra* note 10, at T-14 fig. 1.

179. PUBLIC CITIZEN’S HRG #2, *supra* note 10, at 11.

180. PUBLIC CITIZEN’S HRG #5, *supra* note 160, at 2; *see also* PUBLIC CITIZEN’S HRG #3, *supra* note 10, at v, 3 (explaining that, although only 742 of 5704, or thirteen percent, of general hospitals were for-profit, 23.5% of hospitals which violated EMTALA (63 of 268) were for-profit). Furthermore, 8.5% of for-profit hospitals were caught dumping patients, as compared to 4.1% of not-for-profit hospitals. PUBLIC CITIZEN’S HRG #4, *supra* note 24, at 3 (showing that for-profit hospitals were “greatly overrepresented” amongst patient dumping hospital offenders (citing U.S. DEP’T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES tbl. 179 (1993))). Twenty-nine percent of hospitals cited for EMTALA violations were for-profit hospitals while only fourteen percent of all general hospitals in the United States were for-profit. PUBLIC CITIZEN’S HRG #5, *supra* note 160, at 2 n.7 (citing U.S. DEP’T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES tbl. 182, tbl. 183 (1995) (showing that even though for-profit hospitals represented eighteen percent of all hospitals in 1993, those for-profit hospitals accounted for twenty-seven percent of hospitals cited for patient dumping EMTALA violations); PUBLIC CITIZEN’S HRG #1, *supra* note 9, at 32 (concluding that for-profit hospitals were 1.7 times more likely

Notwithstanding discrepancies in nomenclature<sup>181</sup> utilized by the various reporting organizations<sup>182</sup> concerning the number of patient dumping EMTALA violations per year, the reported trend is clear: not only does patient dumping continue to exist throughout U.S. emergency departments, but there is overwhelming evidence that it is increasing.<sup>183</sup> For instance, in relying upon the DHHS-OIG data, the number of EMTALA investigations between fiscal years 1994 and 1998 averaged approximately 400 a year,<sup>184</sup> and as of January 2001, the OIG had processed 677 dumping cases.<sup>185</sup> When data from the DHHS-OIG is considered along with the PCHRG studies, a more comprehensive pattern regarding patient dumping is depicted: a continued increase in patient dumping occurred from 1987 through 1998.<sup>186</sup> Figure 1 indicates that from 1987 to 1998, there had been approximately a 390% increase in EMTALA investigations<sup>187</sup> and a 683% increase in EMTALA violations.<sup>188</sup>

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than not-for-profit hospitals to violate EMTALA patient dumping provisions).

181. For instance, differences in data between the DHHS-OIG and the PCHRG often can be accounted for on whether (a) an EMTALA violation is reported as "reported," "confirmed," or the hospital has been "out of compliance;" (b) whether a hospital is reported and categorized as "fined," "not fined," "violating," or "penalized;" (c) whether, in accounting for an EMTALA violation, the date used is the date "out of compliance," "fined," or "settled"; (d) whether an investigation is started and reported or "confirmed"; (e) whether the OIG has "processed" cases, "settled cases," or whether cases remain "pending" or (f) whether a fiscal year, calendar year, or unequal study period (which may include portions of a fiscal year, calendar year, or quarter) are utilized for reporting. *Supra* notes 69-90 and accompanying text.

182. PUBLIC CITIZEN'S HRG #1, *supra* note 9, at 79.

183. *See supra* Table 2 (documenting an overall trend in increasing EMTALA violations from 1992 through 1999).

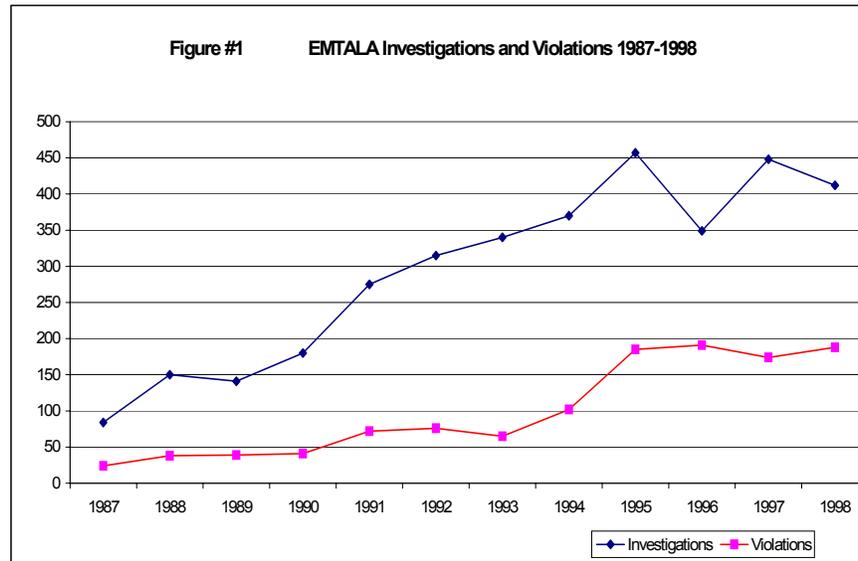
184. DHHS, OIG EMTALA SURVEY, *supra* note 25, at 8.

185. *Id.* The cases which have been processed include cases from fiscal year 2000 and January 2001.

186. *See infra* Figure 1. Data for the creation of Figure 1 was obtained from the following sources: for years 1987-1992, data was taken from PUBLIC CITIZEN'S HRG #3, *supra* note 10, at T-13 tbl.4; for year 1993, data was taken from PUBLIC CITIZEN'S HRG #4, *supra* note 24, at 6 n.12; for years 1994-1998, data was taken from DHHS, OIG EMTALA SURVEY, *supra* note 25, at 8 fig.3.

187. The actual data indicates that in 1987 there were approximately eighty-four investigations conducted. PUBLIC CITIZEN'S HRG #3, *supra* note 10, at T-13 tbl.4. The actual data indicates that in 1998 there were approximately 412 investigations conducted. DHHS, OIG EMTALA SURVEY, *supra* note 25, at 8 fig.3. The highest documented number of investigations, according to the DHHS-OIG, was in 1995, when 457 investigations were recorded. *Id.* The highest documented number of violations, according to the DHHS-OIG, was in 1996, when 191 EMTALA violations were recorded. *Id.*

188. *Id.*



This increase in patient dumping can also be evidenced from examining the actual number of EMTALA hospital violators, number of violations, and specific type of major hospital EMTALA violation.<sup>189</sup> For instance, when examining the number of actual EMTALA hospital violators, a similar pattern of increased patient dumping activity is exhibited.<sup>190</sup> Figure 2 illustrates from 1986 to 1999, there

189. *Supra* Figure 1.

190. *See infra* Figure 2. Data for the creation of Figure 2 to depict hospital EMTALA violators on a yearly basis was taken from the PCHRG studies as follows: data for years 1986-1990 was taken from PUBLIC CITIZEN’S HRG #2, *supra* note 10, at 23 tbl.2, 24 tbl.3; data for year 1991 was taken from *id.* 23 tbl.2, 24 tbl.3, and PUBLIC CITIZEN’S HRG #3, *supra* note 10, T-3 to T-11 tbl.3, T-17 to T-18 tbl.6; data for year 1992 was taken from *id.* at T-3 to T-11 tbl.3, T-17 to T-18 tbl.6; data for year 1993 was taken from *id.* at T-3 to T-11 tbl.3, T-17 to T-18 tbl.6, and PUBLIC CITIZEN’S HRG #4, *supra* note 24, at 11-13 tbl.2, 15 tbl.3; data for year 1994 was taken from *id.* at 11-13 tbl.2, 15 tbl.3; PUBLIC CITIZEN’S HRG #5, *supra* note 160, at 8-13 tbl.1, 14 tbl.2; PUBLIC CITIZEN’S HRG #6, *supra* note 160, 15-24 tbl.1, 25-27, tbl.2; data for year 1995 was taken from PUBLIC CITIZEN’S HRG #5, *supra* note 160, at 8-13 tbl.1, 14 tbl.2; PUBLIC CITIZEN’S HRG #6, *supra* note 160, at 25-27 tbl.1, tbl.2; data for years 1996 and 1997 was taken from *id.* at 25-27 tbl.1, tbl.2; PUBLIC CITIZEN’S HRG #1, *supra* note 9, at 33-59 tbl.1, 63-71 tbl.2, 127-140 tbl.3; data for years 1998 and 1999 was taken from *id.* at 33-59 tbl.1, 63-71 tbl.2, 127-140 tbl.3. In taking data from the various PCHRG studies, variations in nomenclature were taken into account, such that both hospitals which were fined and not-fined were considered; and, where applicable, a preference for inclusion into the accounting of a particular year was made for (a) an EMTALA violation which was “confirmed,” (b) a hospital which was reported or categorized as either “fined,” “not fined,” “violating,” or “penalized;” (c) the date given as “settled” or “confirmed,” when available, was preferred for an EMTALA violation; (d) the date an investigation was “confirmed,” when available, was preferred; and (e) when available, the date a case was “settled” was preferred.

was a 100-fold increase in the total of hospital EMTALA violators.<sup>191</sup>

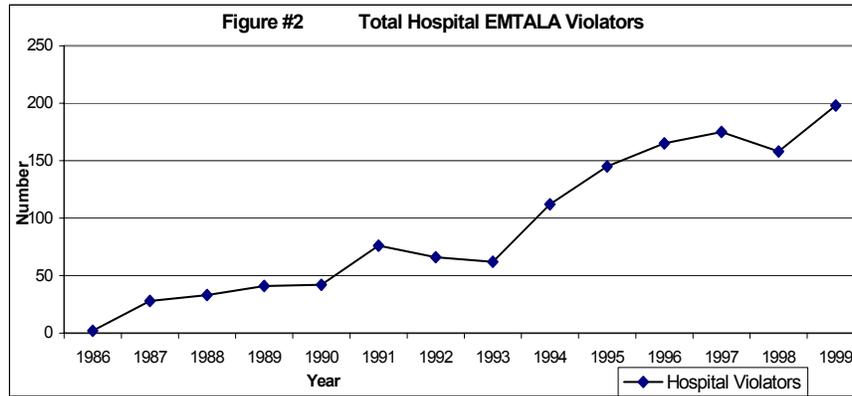
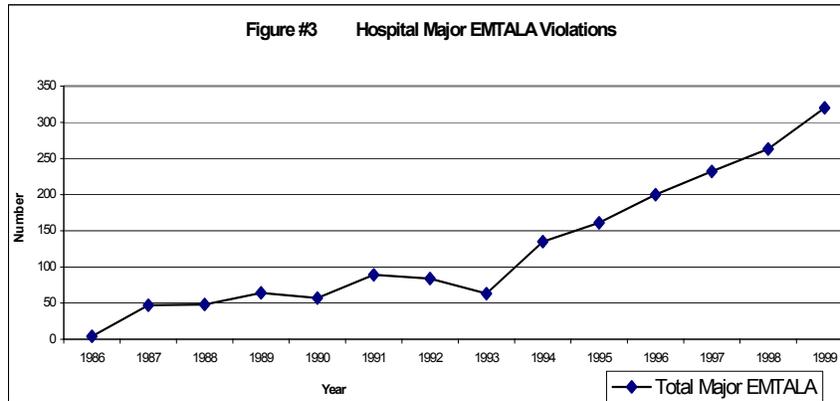


Figure 3 examines the incidence of major hospital EMTALA violations; again, a similar pattern of increased patient dumping activity is exhibited.<sup>192</sup> There was an eighty-fold increase in major hospital EMTALA violations from 1986 to 1999.<sup>193</sup>

191. The actual number of hospital violators for the year 1986 was two. PUBLIC CITIZEN’S HRG #2, *supra* note 10, at 23, tbl.2, 24 tbl.3; PUBLIC CITIZEN’S HRG #3, *supra* note 10, at T-3 to T-11 tbl.3, T-17 to T-18 tbl.6. The actual number of hospital violators for year 1999 was 198. PUBLIC CITIZEN’S HRG #1, *supra* note 9, at 33-59 tbl.1, 63-71 tbl.2, 127-40 tbl.3.

192. See *infra* Figure 3. Data to create Figure 3, depicting the incidence of major EMTALA violations by hospitals, on a yearly basis, was taken from the PCHRG studies as follows: data for years 1986-1992 was taken from PUBLIC CITIZEN’S HRG #2, *supra* note 10, 23 tbl.2, 24 tbl.3; PUBLIC CITIZEN’S HRG #3, *supra* note 10, at T-3 to T-11 tbl.3, T-17 to T-18 tbl.6; data for year 1993 was taken from PUBLIC CITIZEN’S HRG #4, *supra* note 24, T-3 to T-11 tbl.3, T-17 to T-18 tbl.6; *id.* at 11-13 tbl.2, 15 tbl.3; data for year 1994 was taken from *id.* at 11-13 tbl.2, 15 tbl.3; PUBLIC CITIZEN’S HRG #5, *supra* note 160, at 8-13 tbl.1, tbl.2; PUBLIC CITIZEN’S HRG #6, *supra* note 160, at 25-27 tbl.1, tbl.2; data for year 1995 was taken from PUBLIC CITIZEN’S HRG #5, *supra* note 160, at 8-13 tbl.1, tbl.2; PUBLIC CITIZEN’S HRG #6, *supra* note 160, at 15-24 tbl.1, 25-27 tbl.2; data for years 1996 and 1997 was taken from *id.* at 25-27 tbl.1, tbl.2; PUBLIC CITIZEN’S HRG #1, *supra* note 9, at 33-59 tbl.1, 63-71 tbl.2, 127-140 tbl.3; data for years 1998 and 1999 was taken from *id.* at 33-59 tbl.1, 63-71 tbl.2, 127-40 tbl.3. In taking data from the various PCHRG studies, variations in nomenclature were taken into account, such that both hospitals which were fined and not-fined were considered; and, where applicable, a preference for inclusion into the accounting of a particular year was made for (a) an EMTALA violation which was “confirmed,” (b) a hospital which was reported or categorized as either “fined,” “not fined,” “violating,” or “penalized;” (c) the date given as “settled” or “confirmed,” when available, was preferred for an EMTALA violation; (d) the date an investigation was “confirmed,” when available, was preferred; and (e) when available, the date a case was “settled” was preferred.

193. The actual number of major EMTALA violations by hospitals for the year of 1986 was four. PUBLIC CITIZEN’S HRG #2, *supra* note 10, at 23 tbl.2, 24 tbl.3; PUBLIC CITIZEN’S HRG #3, *supra* note 10, at T-3 to T-11 tbl.3, T-17 to T-18 tbl.6. The actual number of major EMTALA violations by hospitals for the year of 1999 was 320. PUBLIC CITIZEN’S HRG #1, *supra* note 9, at 33-59 tbl.1, 63-71 tbl.2, 127-40 tbl.3.



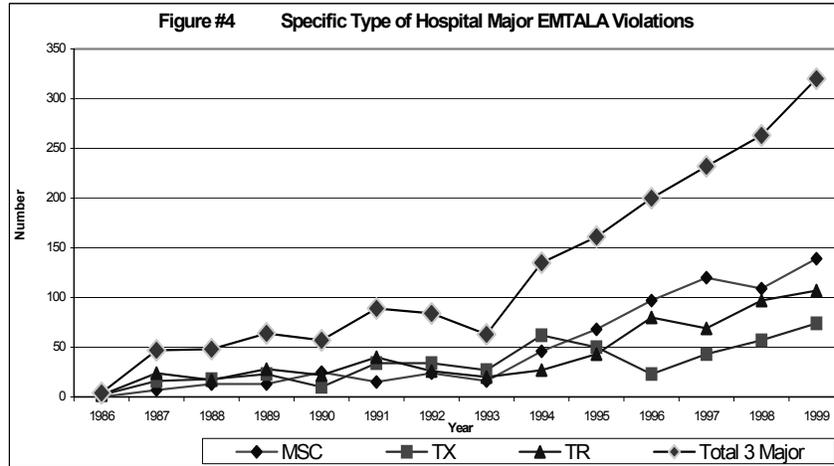
Lastly, Figure 4 shows that, when examining the incidence of the specific type of major EMTALA violation by hospitals, the increased pattern of patient dumping activity persists.<sup>194</sup> In fact, from 1986 to 1999, there was a 139-fold increase in violations of the performance of a medical screening examination requirement,<sup>195</sup> an approximate thirty-seven-fold increase in violations of the requirement of the provision of necessary stabilizing treatment,<sup>196</sup> and approximately a

194. See *infra* Table 5. The data used to create Figure 4, depicting the incidence of the specific type of major EMTALA violations by hospitals on a yearly basis, was taken from the PCHRG studies. Specifically, data for years 1986-1992 was taken from PUBLIC CITIZEN'S HRG #2, *supra* note 10, 23 tbl.2, 24 tbl.3; PUBLIC CITIZEN'S HRG #3, *supra* note 10, at T-3 to T-11 tbl.3, T-17 to T-18 tbl.6; data for year 1993 was taken from *id.* at T-3 to T-11 tbl.3, T-17 to T-18 tbl.6; PUBLIC CITIZEN'S HRG #4, *supra* note 24, at 11-13 tbl.2, 15 tbl.3; data for year 1994 was taken from *id.* at 11-13 tbl.2, 15 tbl.3; PUBLIC CITIZEN'S HRG #5, *supra* note 160, at 8-13 tbl.1, 14 tbl.2; PUBLIC CITIZEN'S HRG #6, *supra* note 160, at 25-27 tbl.1, tbl.2; data for year 1995 was taken from PUBLIC CITIZEN'S HRG #5, *supra* note 160, at 8-13 tbl.1, 14 tbl.2; PUBLIC CITIZEN'S HRG #6, *supra* note 160, at 25-27 tbl.1, tbl.2; data for years 1996 and 1997 was taken from *id.* at 25-27 tbl.1, tbl.2; PUBLIC CITIZEN'S HRG #1, *supra* note 9, at 33-59 tbl.1, 63-71 tbl.2, 127-40 tbl.3; data for years 1998 and 1999 was taken from *id.* at 33-59 tbl.1, 63-71 tbl.2, 127-40 tbl.3. In taking data from the various PCHRG studies, variations in nomenclature were taken into account, such that both hospitals which were fined and not-fined were considered; and, where applicable, a preference for inclusion into the accounting of a particular year was made for (a) an EMTALA violation which was "confirmed," (b) a hospital which was reported or categorized as either "fined," "not fined," "violating," or "penalized;" (c) the date given as "settled" or "confirmed," when available, was preferred for an EMTALA violation; (d) the date an investigation was "confirmed," when available, was preferred; and (e) when available, the date a case was "settled" was preferred. *Supra* note 192.

195. The actual number of violations of EMTALA's mandatory medical screening examination provision in 1986 was zero. PUBLIC CITIZEN'S HRG #2, *supra* note 10, 23 tbl.2, 24 tbl.3; PUBLIC CITIZEN'S HRG #3, *supra* note 10, at T-3 to T-11 tbl.3, T-17 to T-18 tbl.6. In 1999, the actual number of EMTALA violations in respect to the mandatory medical screening examination provision of EMTALA was approximately 139. PUBLIC CITIZEN'S HRG #1, *supra* note 9, at 33-59 tbl.1, 63-71 tbl.2, 127-40 tbl.3.

196. In 1986, the actual number of violations of the EMTALA provision of

fifty-four-fold increase in violations of the provision regulating illegal or inappropriate transfers.<sup>197</sup>



Having considered the incentives for, epidemiology of, and persistence of patient dumping, along with the congressional background of EMTALA, this Article now considers the general statutory topography of this Act.

## II. EMTALA STATUTORY TOPOGRAPHY

To further appreciate how EMTALA has been ineffective in curbing patient dumping, it is important to understand its statutory topography. Two factors are critical in this understanding: (a) the relation of EMTALA to state medical malpractice causes of action and (b) the core statutory EMTALA provisions.

### A. State vs. Federal Medical Malpractice

Any meaningful solution to patient dumping must address the relationship between patient dumping and medical malpractice.

necessary stabilizing treatment was two. PUBLIC CITIZEN'S HRG #2, *supra* note 10, 23 tbl.2, 24 tbl.3; PUBLIC CITIZEN'S HRG #3, *supra* note 10, at T-3 to T-11 tbl.3, T-17 to T-18 tbl.6. The actual number of 1999 violations of the EMTALA provision of necessary stabilizing treatment was seventy-four. PUBLIC CITIZEN'S HRG #1, *supra* note 9, at 33-59 tbl.1, 63-71 tbl.2, 127-40 tbl.3.

197. In 1986, the actual number of violations regarding illegal or inappropriate transfer provisions was two. PUBLIC CITIZEN'S HRG #2, *supra* note 10, 23 tbl.2, 24 tbl.3; PUBLIC CITIZEN'S HRG #3, *supra* note 10, at T-3 to T-11 tbl.3, T-17 to T-18 tbl.6. In 1999, the actual number of violations of illegal or inappropriate transfer provisions was approximately 107. PUBLIC CITIZEN'S HRG #1, *supra* note 9, at 33-59 tbl.1, 63-71 tbl.2, 127-40 tbl.3.

This relationship has confused both state and federal judicial and legislative branches of government.<sup>198</sup> Such confusion has hampered EMTALA statutory compliance and thereby permitted patient dumping persistently to increase.

To be sure, Congress did not intend EMTALA to serve as a federal medical malpractice statute.<sup>199</sup> Rather, by enacting EMTALA,

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198. See *Coleman v. Deno*, 813 So. 2d 303 (La. 2002) (providing an example of a state court misunderstanding the nature of patient dumping). From a federal point of view, Congress, and the resultant federal judicial opinions in accord, further confuse the relationship between patient dumping and medical practice; for instance, while some state courts have held that patient dumping is included within the practice of medicine, therefore subject to a state's medical malpractice act, Congress and the federal courts have indicated that EMTALA is not a federal malpractice statute, suggesting that patient dumping is not a subject of malpractice. Compare *Burks v. St. John's Hosp.*, 596 N.W.2d 391, 396-98 (Wis. 1999) (concluding that medical malpractice can include "failure to treat," and therefore, the failure to provide health care services can be negligent and violate the state-imposed standard of care for hospitals and physicians), and *Coleman*, 813 So. 2d at 303 (allowing a claim of patient dumping to be heard under state medical malpractice law), with *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996) (en banc) (stating that claims of misdiagnosis fall squarely under state tort law while patient dumping falls solely under EMTALA), and *Holcomb v. Monahan*, 30 F.3d 116, 117 (11th Cir. 1994) (noting that no federal malpractice claims are created under EMTALA and the Act is designed to address an area of law, specifically failure to treat, that is not covered by state medical malpractice law).

199. See *Marshall v. E. Carroll Parish Hosp.*, 134 F.3d 319, 322 (5th Cir. 1998) (agreeing that EMTALA was not created to be a federal malpractice statute); *Summers*, 91 F.3d at 1136-37 (disagreeing with the notion that EMTALA creates a federal cause of action for malpractice); *Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139, 145 (4th Cir. 1996) (holding that EMTALA liability analysis should not be done in "hindsight"); *Correa v. Hosp. S.F.*, 69 F.3d 1184, 1192 (1st Cir. 1995) (declaring that no cause of action for malpractice was created by the passage of EMTALA); *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995) (noting that EMTALA was not designed as a national standard of care for screening patients); *Holcomb*, 30 F.3d at 117 (observing that EMTALA was not intended to remedy negligent treatment or diagnosis); *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 856 (4th Cir. 1994) (asserting that EMTALA cannot be substituted for traditional areas of state law, such as malpractice); *Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519, 522 (10th Cir. 1994) (explaining that neither malpractice nor negligence causes of action can be derived from EMTALA); *Urban ex rel. Urban v. King*, 43 F.3d 523, 525 (10th Cir. 1994) (concluding that EMTALA creates neither a malpractice nor negligence cause of action); *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1040 (D.C. Cir. 1991) (acknowledging that new protections found under EMTALA are not duplications of legal protections existing under state law); *Cleland v. Bronson Healthcare Group, Inc.*, 917 F.2d 266, 268 (6th Cir. 1990) (noting that it is unlikely that EMTALA was intended by Congress to be a general malpractice statute); *Lebron v. Ashford Presbyterian Cmty. Hosp.*, 995 F. Supp. 241, 243 (D.P.R. 1998) (announcing that EMTALA was only intended as an anti-dumping statute and was not intended to create federal causes of action for negligence or malpractice); *Torres Nieves v. Hosp. Metropolitano*, 998 F. Supp. 127, 132 (D.P.R. 1998) (restating that EMTALA does not create a cause of action for either misdiagnosis or malpractice); *Scott v. Hutchinson Mem'l Hosp.*, 959 F. Supp. 1351, 1357 (D. Kan. 1997) (affirming previous holdings refusing to recognize a cause of action for malpractice derived from EMTALA); *Tank v. Chronister*, 941 F. Supp. 969, 972 (D. Kan. 1996) (clarifying that EMTALA was intended to create a new cause of action separate from malpractice and negligence); *Hart v. Mazur*, 903 F. Supp. 277, 280

Congress intended to create a new federal cause of action for “failure to treat” a patient, which it recognized as patient dumping.<sup>200</sup> EMTALA was “not intended to duplicate preexisting legal protections.”<sup>201</sup> However, holding that EMTALA is not a subject of federal malpractice permits the inference that patient dumping is a subject of state medical malpractice.<sup>202</sup> We contend that courts and

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(D.R.I. 1995) (emphasizing that Congress did not intend for EMTALA to expose hospitals to new causes of action for malpractice). *But see* Metropoulos, *supra* note 123, at 263 (reviewing the implications of COBRA as a federal malpractice law).

Thus, questions that related to the adequacy of a hospital’s medical standard screening procedure were intended to “remain the exclusive province of local negligence law.” *Vickers*, 78 F.3d at 143 (concluding that the accuracy of diagnosis is a matter strictly in the province of state tort law rather than a concern under EMTALA); *Power*, 42 F.3d at 856 (reiterating that EMTALA is not a substitute for other medical torts); *Gatewood*, 933 F.2d at 1041 (agreeing that malpractice and negligence claims remain causes of action under state law); *Cleland*, 917 F.2d at 271-72 (noting that EMTALA is not intended to determine what ‘adequate’ screening procedures would be in emergency rooms); *Stewart v. Myrick*, 731 F. Supp. 433, 436 (D. Kan. 1990) (asserting that improper emergency department diagnosis and treatment do not fall under federal anti-dumping provisions but rather under state negligence law); *Evitt v. Univ. Heights*, 727 F. Supp. 495, 497 (S.D. Ind. 1989) (determining that claims regarding treatment and diagnosis are to remain within the areas regulated by state law). Also, presumably, an EMTALA claim is not to be judged by the accuracy of diagnosis or the quality of treatment but rather whether treatment was provided equitably to all patients with similar conditions. *See Marshall*, 134 F.3d at 322 (clarifying that ‘appropriateness’ under EMTALA results when the hospital provides equitable screening to all patients with similar symptoms); *Summers*, 91 F.3d at 1138-39 (noting that faulty screening does not fall within the realm of EMTALA provision); *Vickers*, 78 F.3d at 143-44 (disagreeing with the contention that EMTALA imposes a duty on hospitals requiring that screening procedures result in the correct diagnosis); *Correa*, 69 F.3d at 1192-93 (calling for regular screening procedures under EMTALA, violation of which results if those procedures are not followed in specific instances); *Eberhardt*, 62 F.3d at 1258 (holding that failure to detect decedent’s suicidal tendency is not actionable under EMTALA but it is likely actionable under state malpractice law); *Holcomb*, 30 F.3d at 117 (asserting that hospitals must apply the same screening procedure to all patients including those without insurance); *Repp*, 43 F.3d at 522 (directing that hospitals must follow established screening procedures with each patient that enters the emergency room); *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 879-80 (4th Cir. 1992) (contending that claims arising from physician or hospital personnel misdiagnosis or negligent treatment should be brought under state malpractice theories of recovery); *Gatewood*, 933 F.2d at 1041 (agreeing that a hospital violates EMTALA when it departs from its standard screening procedures, regardless of the reasons for the deviation); *Torres Nieves*, 998 F. Supp. at 132 (ruling that, in order to comply with EMTALA, a hospital must conduct screening of all persons who seek medical attention).

200. *See* H.R. REP. NO. 241, pt. 3, at 5 (1986), *reprinted in* 1986 U.S.C.C.A.N. 579, 727 (describing a “new federal cause of action”).

201. *Gatewood*, 933 F.2d at 1041 (holding that EMTALA was enacted to create a remedy for “failure to treat” that was not previously available under state tort law as opposed to overlapping with preexisting legal protections); *see also* *Thornton v. S.W. Detroit Hosp.*, 895 F.2d 1131, 1133 (6th Cir. 1990) (acknowledging that the cause of action created under EMTALA is not analogous to traditional state medical torts because it created a remedy for “failure to treat,” which state law does not address).

202. *See Burks*, 596 N.W.2d at 399 (holding that the tests used to determine if one of EMTALA’s regulations was violated are “effectively indistinguishable” from state

legislatures cloud the relationship between patient dumping and patient care by addressing whether EMTALA is a federal malpractice statute, which improperly implies patient dumping is in fact a medical malpractice tort.

Confusion regarding the relationship of EMTALA to state medical malpractice also stems from the fact that EMTALA and state medical malpractice suits frequently coexist.<sup>203</sup> Often this is because there are strategic advantages in filing both an EMTALA and a state medical malpractice cause of action. These advantages have included: (1) skirting state tort reform,<sup>204</sup> (2) multiple recovery for both state

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malpractice laws, lending to the inference that if certain conduct by the treating hospitals and physicians are not covered under EMTALA it would likely be allowed as a cause of action under state law).

203. See Hamm, *supra* note 123, at 348 (noting that further analysis of state causes of action, such as personal injury and medical malpractice, substantiate the notion that EMTALA and malpractice damages are closely related). The relationship between medical negligence and possible resultant EMTALA liability was discussed in one state court that not only analogized an EMTALA claim with a malpractice claim, but it also applied comparative fault principles. See *Clark v. Baton Rouge Gen. Med. Ctr.*, 657 So. 2d 741, 746-47 (La. Ct. App. 1995) (looking at a scenario in which the patient was transferred into the hospital, and as a result, whether a 'failure to treat' remedy is appropriate); *cf. Griffith v. Mt. Carmel Med. Ctr.*, 842 F. Supp. 1359, 1365 (D. Kan. 1994) (holding that comparative fault is not applicable because a plaintiff is not required to prove negligence in order to recover under EMTALA).

204. See Robert A. Bitterman, *A Critical Analysis of the Federal COBRA Hospital "Antidumping Law": Ramifications for Hospitals, Physicians, and Effects on Access to Healthcare*, 70 U. DET. MERCY L. REV. 125, 172-75 (1992) (noting this legislation may effectively "dismantle state malpractice tort reforms" that have been previously passed). The skirting of state "tort reform" limitations might include state malpractice screening panels; unfavorable state limits, or "caps" on liability damages. *Id.* However, whether state caps on medical malpractice damages apply to EMTALA cases is another area exhibiting judicial confusion, where some courts have held that state caps on medical malpractice damages apply to EMTALA damages. See *Reid v. Indianapolis Osteopathic Med. Hosp., Inc.*, 709 F. Supp. 852, 855 (S.D. Ind. 1989) (deciding on a case of first impression that the \$100,000 cap on malpractice damages applied to an EMTALA action); *Lee ex rel. Wetzel v. Alleghany Reg'l Hosp. Corp.*, 778 F. Supp. 900, 903-04 (W.D. Va. 1991) (holding limitation on malpractice recoveries applies to EMTALA claims, as failing to read incorporation clause as including malpractice caps would render clause meaningless); *Barris v. County of Los Angeles*, 972 P.2d 966, 974-76 (Cal. 1999) (holding that California's medical injury cap of \$250,000 for non-economic losses was applicable to an EMTALA failure to stabilize claim, because if the claim were brought under state law the cap would have been applied); *Diaz v. CCHC-Golden Glades, Ltd.*, 696 So. 2d 1346, 1347 (Fla. Dist. Ct. App. 1997) (concluding that EMTALA intended to incorporate the "vagaries of state medical malpractice" when determining damages).

Not unexpectedly, some courts have held that state caps on medical malpractice damages do not apply to EMTALA damages. See *Power v. Arlington Hosp.*, 800 F. Supp. 1384, *aff'd in part and rev'd in part sub nom.* 42 F.3d 851, 869 (4th Cir. 1994) (announcing that an EMTALA plaintiff may recover damages above a state malpractice damage cap); *Cooper v. Gulf Breeze Hosp., Inc.*, 839 F. Supp. 1538, 1542-43 (N.D. Fla. 1993) (following *Power* and holding that U.S.C. § 1395dd(d)(2)(A) did not incorporate Florida's medical malpractice law); *Spradlin v. Acadia-St. Landry Med. Found.*, 711 So. 2d 699, 702-03 (La. Ct. App. 1998) (holding state caps do not apply to EMTALA); see also *Power*, 42 F.3d at 869 (Ervin, C.J., concurring in part, dissenting in part) (endorsing "excellent and lucid opinion"

and federal claims,<sup>205</sup> and (3) strategic leverage.<sup>206</sup>

However, although EMTALA and state causes of action for medical negligence may coexist,<sup>207</sup> they are different.<sup>208</sup> For example, while traditional state malpractice cases apply a negligence standard,<sup>209</sup> a strict liability standard is commonly applied under EMTALA.<sup>210</sup> Another difference is that EMTALA preempts all state and local laws that conflict with its requirements.<sup>211</sup>

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of the district court in *Power*, and finding no evidence of congressional intent to limit EMTALA damages with state malpractice caps).

205. See Bitterman, *supra* note 204, at 170-75 (noting that plaintiffs' attorneys may add COBRA violation claims to their malpractice actions to recover civil monetary penalties).

206. See *id.* at 164-69 (arguing that strategic leverage over a defendant hospital may be achieved by raising the hospital's potential loss of its Medicare participation and tax exemption status, which could follow a finding of violation).

207. PUBLIC CITIZEN'S HRG #4, *supra* note 24, at 2 n.4 (finding that patient dumping and medical malpractice claims are usually combined involving emergency services); Bitterman, *supra* note 204, at 170-75 (noting COBRA violation are often coupled with state medical malpractice causes of action).

208. See *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991) (acknowledging that there may be overlap between EMTALA causes of action and traditional state law causes of action, but that EMTALA is intended to provide a separate remedy while leaving the adequacy of hospital procedure, screening, and diagnosis under the province of state law).

209. See PROSSER ET AL., *supra* note 60, § 30, at 164-65 (articulating the necessary elements of a negligence cause of action: duty, breach, causation, and damages).

210. See *Abercrombie v. Osteopathic Hosp. Founders Ass'n*, 950 F.2d 676, 681 (10th Cir. 1991) (finding that the requirements of 42 U.S.C. § 1395dd(a),(c), impose a strict liability standard for EMTALA violations); *Stevison v. Enid Health Sys., Inc.*, 920 F.2d 710, 713 (10th Cir. 1990) (holding that it was the literal "mandatory language" of EMTALA that imposes a strict liability standard); *Reid v. Indianapolis Osteopathic Med. Hosp.*, 709 F. Supp. 853, 855 (S.D. Ind. 1989) (indicating that strict liability principles were the basis for EMTALA); see also discussion *infra* Part II.G (discussing preemption between EMTALA and state medical malpractice standards).

211. See 42 U.S.C. § 1395dd(f) (2000) ("The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section."). Although some believe that EMTALA creates neither a statutory duty of care nor standard of care. See Jack E. Karns, *Hospital Screening Procedures and the Emergency Medical Treatment and Active Labor Act (EMTALA): Proof of "Improper Intent" Not Necessary in Failure to Stabilize Cases*, 9 WIDENER J. PUB. L. 355, 357 (2000) (arguing that the purpose of EMTALA is to give all patients comparable care and that EMTALA does not set out to create either a statutory duty of care or a standard of care for physicians).

*B. Core EMTALA Provisions*

The core provisions of EMTALA include the following requirements: (1) medical screening,<sup>212</sup> (2) necessary stabilizing treatment,<sup>213</sup> (3) no delay in examination or treatment,<sup>214</sup> (4) transfer standards,<sup>215</sup> (5) refusal to consent<sup>216</sup>/refusal to transfer,<sup>217</sup> (6) preemption,<sup>218</sup> (7) nondiscrimination,<sup>219</sup> and (8) civil enforcement.<sup>220</sup> As noted in Table 3, some EMTALA provisions have pertinent subcomponents affecting both hospital and physician understanding and compliance, as well as government enforcement.

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212. 42 U.S.C. § 1395dd(a).

213. *Id.* § 1395dd(b).

214. *Id.* § 1395dd(h).

215. *Id.* § 1395dd(c).

216. *Id.* § 1395dd(b)(2).

217. *Id.* § 1395dd(b)(3).

218. *Id.* § 1395dd(f).

219. *Id.* § 1395dd(g).

220. *Id.* § 1395dd(d)(2); *see infra* Table 3.

TABLE 3

EMTALA Core Provision	EMTALA Subcomponent	Federal Code
Medical Screening Examination	Emergency Medical Condition	42 USC § 1395dd(a)
	Comes to the emergency department	
	Appropriate medical screening examination	
Necessary Stabilizing Treatment (Actual knowledge rule)		42 USC § 1395dd(b)
No Delay		42 USC § 1395dd(h)
Transfer Requirement	Transfer of unstable patients	42 USC § 1395dd(c)(1)
	Appropriate transfer	42 USC § 1395dd(c)(2)
Refusal of Treatment		42 USC § 1395dd(b)(2)
Refusal to Transfer		42 USC § 1395dd(b)(3)
Preemption		42 USC § 1395dd(f)
Nondiscrimination		42 USC § 1395dd(g)
Enforcement	Civil Monetary Penalties	42 USC § 1395dd(d)(1)
	Civil Enforcement	42 USC § 1395dd(d)(2)

Since federal courts have viewed the language of EMTALA disparately, the major EMTALA components and subcomponents are reviewed briefly below.

1. *Medical screening examination*

A common area of confusion leading to statutory EMTALA violations<sup>221</sup> and litigation, occurs in § 1395dd(a) of EMTALA, known as the “medical screening examination” requirement.<sup>222</sup> The section contains three subcomponents: “emergency medical condition,”<sup>223</sup> “comes to the emergency department,”<sup>224</sup> and “appropriate medical

221. See PUBLIC CITIZEN’S HRG #1, *supra* note 9, at 1 (noting that 90.1% of violating hospitals violated the screening, stabilizing treatment or transfer provisions of EMTALA subcomponents).

222. *Id.* at 13 (noting that hospitals often incorrectly assume that providing a “Triage” exam to a patient by a nurse satisfies the EMTALA provision).

223. 42 U.S.C. § 1395dd(a).

224. *Id.*

screening examination.”<sup>225</sup> Section 1395dd(a) of EMTALA specifically provides:

In the case of a hospital that has a hospital emergency department, if any individual . . . *comes to the emergency department* and a request is made on the individual’s behalf for examination or treatment for a medical condition, the hospital must provide for an *appropriate medical screening examination* within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an *emergency medical condition* . . . exists.<sup>226</sup>

*a. “Emergency Medical Condition”*

Healthcare providers often have difficulty understanding what actually constitutes an “emergency medical condition.”<sup>227</sup> Many healthcare providers believe an “emergency medical condition” is, or should be, defined in terms of medical practice.<sup>228</sup> However, EMTALA defines an “emergency medical condition” by federal statute and not by medical practice.<sup>229</sup> Section 1395(e)(1)(A) specifically defines an emergency medical condition as:

a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could *reasonably be expected* to result in:<sup>230</sup>

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in *serious jeopardy*;<sup>231</sup>

(ii) serious *impairment* to bodily functions;<sup>232</sup> or serious *dysfunction* of any bodily organ or part.<sup>233</sup>

225. *Id.*

226. *Id.* (emphasis added).

227. See DHHS, OIG EMTALA SURVEY, *supra* note 25, at 15 (noting providers’ difficulty understanding the “emergency medical condition” requirement of 42 U.S.C. § 1395dd(e)(1)(A)). In respect to pregnant women, the statute defines “an emergency medical condition to exist in a *pregnant woman*, who is *having contractions*, if: (i) there is *inadequate* time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a *threat* to the *health* or *safety* of the woman or the unborn child.” 42 U.S.C. § 1395dd(e)(1)(B)(i)-(ii) (emphasis added).

228. See DHHS-OIG EMTALA Survey, *supra* note 25, at 13-14 (noting that providers often find the definition of “emergency medical condition” unclear).

229. See *id.* at 6 n.2 (defining “emergency medical condition” by federal statute).

230. 42 U.S.C. § 1395dd(e)(1)(A) (emphasis added).

231. *Id.* § 1395dd(e)(1)(A)(i) (emphasis added).

232. *Id.* § 1395dd(e)(1)(A)(ii) (emphasis added).

233. *Id.* § 1395dd(e)(1)(A)(iii) (emphasis added).

b. “Comes to the Emergency Department”

The phrase “comes to the emergency department”<sup>234</sup> in § 1395dd(a) provides a source of confusion and litigation for health care providers. The case of *Arrington v. Wong*<sup>235</sup> demonstrates a common judicial interpretation of the meaning of the EMTALA phrase.<sup>236</sup>

*Arrington*<sup>237</sup> involved the diversion of an ambulance carrying a patient experiencing severe respiratory distress<sup>238</sup> to the emergency department of one hospital to a more distant hospital.<sup>239</sup> The patient

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234. *Id.* § 1395dd(a).

235. 237 F.3d 1066 (9th Cir. 2001).

236. *See infra* notes 245-46 and accompanying text (discussing several court decisions in relation to the *Arrington* decision).

237. In *Arrington*, Harold Arrington (“Arrington”), on May 5, 1996, while working as a security guard, experienced difficulty breathing while driving to his job. *Arrington*, 237 F.3d at 1066. Upon arrival to his work site, an ambulance was summoned, which took Arrington to the closest medical facility, Queen’s Medical Center (Queen’s hospital). *Id.* While in route to the Queen’s Hospital emergency department, the ambulance personnel contacted the hospital by radio. *Id.* Ambulance personnel informed Dr. Norbert Wong, the emergency physician on duty that evening, that Arrington was “in severe respiratory distress speaking 1-2 words at a time and . . . breathing about fifty times a minute.” *Id.* After being informed of Arrington’s medical condition, ambulance personnel notified Dr. Wong that the patient was a “Tripler [Army Medical Center] patient, being that he was in severe respiratory distress we thought we’d come to a close facility.” *Id.* at 1070. Dr. Wong responded: “I think it would be okay to go to Tripler.” *Id.* Accordingly, ambulance personnel drove the patient to Tripler, which was approximately five miles further than Queen’s Hospital. *Id.* By the time the ambulance arrived at Tripler, Arrington’s condition had deteriorated. *Id.* Arrington was pronounced dead approximately thirty-seven minutes after his arrival at Tripler. *Id.*

In a suit against Queen’s Hospital, the plaintiffs’ complaint asserted that the plaintiff suffered a heart attack on the way to work, and that the emergency physician (Dr. Norbert Wong) at the initial designated receiving hospital (Queen’s) redirected the ambulance to a more distant hospital (Tripler), and that as a result, Mr. Arrington dies soon after arrival. included four allegations. *Id.* at 1068.

The district court granted defendants’ motions to dismiss plaintiffs’ complaint on the ground that in light of EMTALA, Arrington had never “come to” Queen’s emergency department. *Id.* at 1069. The district court concluded that EMTALA applied only in the case of a patient’s “physical presence” in the emergency department. *Id.* Plaintiffs appealed to the Court of Appeals for the Ninth Circuit. *Id.* The dispositive issue for the court of appeals concerned the legislative construction of “come to the emergency department.” *Id.* at 1070.

The *Arrington* court concluded that the patient, Arrington, was in a non-hospital-owned ambulance en route to Queen’s hospital, and the ambulance personnel contacted the hospital’s emergency department on his behalf and requested treatment. *Id.* at 1072-73. Accordingly, the plain language of the DHHS’s rules required the hospital to treat Arrington unless the hospital maintained “diversionary status.” *Id.* at 1073. Queen’s hospital did not contend that it maintained “diversionary status” at the time Dr. Wong directed Arrington to the more distant Tripler facility. The judgment of the district court was reversed and remanded to the district court. *Id.*

238. *Id.* at 1069.

239. *Id.*

died within thirty-seven minutes of arrival at the second hospital.<sup>240</sup> The *Arrington* court found the meaning of “comes to an emergency room” ambiguous.<sup>241</sup> Accordingly, the court relied on principles of statutory construction and interpretation,<sup>242</sup> as well as the DHHS interpretive regulations for EMTALA<sup>243</sup> as a basis for its holding.

Recognizing the DHHS’s expansive interpretation of “comes to the emergency department,” the *Arrington* court reasoned that individuals in non-hospital-owned ambulances have unquestionably “come to the hospital” when the ambulance is on hospital property.<sup>244</sup> Furthermore, the court noted that, if ambulance personnel contact the hospital to request permission to transport the individual to the hospital for examination and treatment, the hospital may *not* deny

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240. *Id.*

241. *See id.* at 1071 (recognizing the confusion surrounding Congress’s requirements regarding when an emergency patient’s location, with respect to the hospital, triggers a hospital’s EMTALA obligation).

242. *See id.* at 1070 (noting four basic canons of statutory construction and interpretation relevant to the court’s holding). First, the court noted that, ordinarily, courts simply apply the unambiguous terms of a statute to the case before them. *Id.* (citing *Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984) for the proposition that both courts and administrative agencies must follow the unambiguous intent of Congress regarding statutory language). The court noted, where the language of the statute is clear on its face, courts are only permitted to examine the specific and general statutory context in which the phrase is used in order to discern a determinate meaning. *See id.* at 1070 (citing *Robinson v. Shell Oil Co.*, 519 U.S. 337, 441 (1997) for the proposition that ambiguous statutory language is deciphered by evaluating the specific context of the language, the language’s everyday use and the context of the statute as a whole); *see also* *Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. 469, 476 (1992) (noting that where the intent of Congress is expressed in unambiguous terms, the reviewing court should not defer to an agency’s interpretation of a statute); *McCarthy v. Bronson*, 500 U.S. 136, 139 (1991) (stating that statutory language must always be viewed in the correct context); *Brown v. Gardner*, 513 U.S. 115, 118 (1994) (stating that statutory context clarifies ambiguous language of a statute); *King v. St. Vincent’s Hosp.*, 502 U.S. 215, 221 (1991) (citing *Shell Oil Co. v. Iowa Dep’t of Revenue*, 488 U.S. 19, 26 (1988) for the proposition that the meaning of statutory language often depends on the situation’s context).

243. *See Arrington*, 237 F.3d at 1071 (citing *Village of Hoffman Estates v. Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 504 (1982) for the proposition that administrative agency regulations interpreting a rule “will often suffice to clarify a standard with an otherwise uncertain scope”). The DHHS had promulgated regulation 42 C.F.R. § 489.24, which interpreted EMTALA section 1395dd(a)’s “comes to the emergency department” language as follows:

An individual in a non-hospital-owned ambulance *off hospital* property is *not* considered to have come to the hospital’s emergency department, *even if* a member of the ambulance staff contacts the hospital by telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and treatment. In such situations, the hospital *may deny* access *if* it is in “*diversionary status*,” that is, it does not have the staff or facilities to accept any additional emergency patients.

Special Responsibilities of Medicaid Hospitals in Emergency Cases, 42 C.F.R. § 489.24(b) (2001) (emphasis added).

244. *Arrington*, 237 F.3d at 1072.

the individual access *unless* it “is in ‘diversionary status,’”<sup>245</sup> or *unless* it has a valid treatment-related reason for denying access.<sup>246</sup> The *Arrington* court further noted that, even if a hospital maintained diversionary status, if an ambulance continued to the hospital in spite of an instruction to take a patient elsewhere, the patient still “comes to” the hospital and emergency treatment must be provided.<sup>247</sup>

*c. “Appropriate Medical Screening Examination”*

The third subcomponent of the medical screening examination EMTALA section is the phrase “appropriate medical screening examination.”<sup>248</sup> Federal courts are split widely on the meaning of this phrase and the standard of care which should be applied in order to achieve compliance.<sup>249</sup> Such confusion, again, promotes EMTALA non-compliance and poor government enforcement.<sup>250</sup> The meaning cannot be sufficiently described without understanding its accompanied standard of care; the meaning of the “appropriate medical screening examination” is discussed below.<sup>251</sup>

Federal courts utilize an objective,<sup>252</sup> subjective,<sup>253</sup> and a burden-shifting<sup>254</sup> standard of care to define the meaning of “appropriate medical screening examination.” Some federal circuits, such as the Ninth Circuit, are split within their own circuit.<sup>255</sup> For instance, as

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245. *See id.* (defining diversionary status as a hospital that “does not have the staff or facilities to accept any additional emergency patients” (citing 42 C.F.R. § 489.24)) (emphasis added).

246. *Id.*

247. *Id.* (citing 42 C.F.R. § 489.24). The court stressed that the DHHS “clearly recognized” that hospitals could abuse the Act by simply diverting all persons in emergency straits before they arrive on hospital property. *Id.* Accordingly, under 42 C.F.R. § 489.24, a hospital must show that it maintains diversionary status in order to divert emergency patients. *Id.* A hospital maintains diversionary status when it lacks either the staff or facilities to treat a patient. *Id.*

248. 42 U.S.C. § 1395dd(a).

249. *See infra* notes 398-510 and accompanying text (discussing the contrasting applicable standards of care for EMTALA).

250. *See DHHA, OIG EMTALA Survey, supra* note 25, at 13 (discussing providers’ confusion surrounding EMTALA requirements).

251. *See infra* notes 399-495 and accompanying text (contrasting the objective with the subjective standard of care applied to various EMTALA provisions).

252. *See infra* notes 425-33 and accompanying text (discussing the objective standard of care applied to the “appropriate medical screening examination” component of EMTALA).

253. *See infra* notes 434-50 and accompanying text (explaining the subjective standard of care applied to the “appropriate medical screening examination” component of EMTALA).

254. *See infra* notes 451-55 and accompanying text (describing the burden-shifting standard of care to be applied to the appropriate medical screening examination component of EMTALA).

255. *See infra* notes 259-61 and accompanying text (discussing the contrasting viewpoints of the Ninth Circuit Court’s opinions). By no means is the Ninth Circuit the only federal circuit with an internal split regarding the meaning or standard of

discussed below,<sup>256</sup> the Ninth Circuit, in *Eberhardt v. City of Los Angeles*,<sup>257</sup> propounded an objective standard of care when defining the meaning of “appropriate medical screening examination.”<sup>258</sup> In contrast, in *Jackson v. East Bay Hospital*,<sup>259</sup> the Ninth Circuit adopted the “comparative test.”<sup>260</sup> The court noted 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.<sup>261</sup> Following this reasoning, the *Jackson* court adopted an equitable or subjective standard.<sup>262</sup>

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care applied to the phrase “appropriate medical screening examination.” *Compare* *Power v. Arlington Hosp. Ass’n*, 42 F.3d 851, 858 (4th Cir. 1994) (advocating a burden-shifting standard in respect to the “appropriate medical screening examination” component), *with* *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 879 (4th Cir. 1992) (advocating a subjective or equitable standard explaining that EMTALA requires hospitals to implement a uniform screening examination, but that it does not guarantee the accuracy of the emergency personnel’s diagnosis).

256. See *infra* notes 429-31 and accompanying text (discussing *Eberhardt v. City of Los Angeles*, 62 F.3d 1253 (9th Cir. 1995) in detail).

257. 62 F.3d 1253 (9th Cir. 1995).

258. *Id.* at 1257.

259. 246 F.3d 1248 (9th Cir. 2001). The *Jackson* case involved a patient with a history of psychiatric and psychological illnesses who was treated with numerous psychiatric medications. *Id.* at 1252. After being evaluated in an emergency department and psychiatric specialty service on several occasions over a period of a few days, the hospital determined that the patient lacked a diagnosed emergency medical condition. *Id.* at 1252-53. After ultimately being admitted to a psychiatric facility, the patient experienced a cardiac arrest and died. *Id.* at 1253. An autopsy determined that Jackson died from sudden cardiac arrhythmia, caused by acute psychotic delirium, initially caused by clomipramine (Anafranil) toxicity. *Id.* The doctors and nurses that monitored Jackson at Redbud failed to diagnose him as suffering from Anafranil (or other drug) toxicity. *Id.* The *Jackson* court held that the district court correctly concluded that no genuine issue of material fact existed when Jackson received initial screening examinations that satisfied Redbud’s EMTALA obligations. *Id.* at 1256. Further, the *Jackson* court upheld the district court’s rejection of the argument that Jackson required different treatment from other patients because he exhibited psychiatric, and not just physical, symptoms as groundless. *Id.*

260. See *id.* (citing the objective standard language of *Eberhardt*, 62 F.3d at 1258). The *Jackson* court also stated that the central issue surrounding EMTALA procedures is whether a procedure is designed to identify acute and severe symptoms indicating an “emergency medical condition.” *Id.* at 1255.

261. See *id.* at 1256 (stating that the court affirmatively adopted the comparative test used by several other circuits). But see *id.* (citing *Eberhardt*, 62 F.3d at 1257, for an exception for examinations that are so short that they cannot identify symptoms that alert physicians to a patient’s immediate need for medical attention).

262. See *id.* at 1255 (citing several different circuit opinions for the proposition that a hospital is only required to provide a screening examination “comparable to that offered to other patients with similar symptoms”); see also *Marshall v. E. Carroll Parish Hosp. Serv. Dist.*, 134 F.3d 319, 323-24 (5th Cir. 1998) (identifying that “a treating physician’s failure to appreciate the extent of the patient’s injury or illness . . . may constitute negligence or malpractice, but cannot support an EMTALA claim for inappropriate screening . . . . It is the plaintiff’s burden to show that the Hospital treated her differently from other patients . . . .”); *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1139 (8th Cir. 1996) (en banc) (holding that

## 2. “Necessary Stabilizing Treatment” and the “Actual Knowledge” rule

EMTALA imposes a duty of stabilization on both the hospital and the emergency physician.<sup>263</sup> The duty of stabilization, unlike the duty to perform an appropriate medical screening examination,<sup>264</sup> does not arise unless the hospital obtains “actual knowledge” of the patient’s unstable emergency medical condition.<sup>265</sup> The actual knowledge rule has expressly served as a condition precedent to the stabilization requirement in at least six of the federal circuits.<sup>266</sup>

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improper screenings of patients for discriminatory reasons, failure to screen patients or treating patients differently from other patients violate EMTALA provisions but mere negligent or faulty screenings by the hospital do not violate EMTALA); *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1040 (D.C. Cir. 1991) (explaining that, in order for hospitals to meet the ‘appropriate medical screening’ standard set up by EMTALA, the hospital must conform “its treatment of a particular patient to its standard screening procedures”); *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 272 (6th Cir. 1990) (stating that a screening is appropriate within the meaning of EMTALA if a hospital treats a patient in the same manner as paying patients).

263. 42 U.S.C. § 1395dd(c)(1)-(2) (2000). *See id.* § 1395dd(e)(3)(A) (defining “to stabilize” as providing medical treatment of a condition that may be necessary to assure, “within reasonable medical probability,” that no material deterioration of the condition is likely to occur during a transfer); *id.* § 1395dd(e)(3)(B) (defining “stabilized” as a state where no material deterioration of a condition is likely “within reasonable medical probability,” to result from a transfer).

264. *See* discussion *infra* Part III.D (noting that an “actual knowledge” requirement is not associated with the medical screening examination). A conjunctive or disjunctive interpretation of EMTALA, with respect to the relationship of the necessary stabilizing treatment provision, actual knowledge rule, and medical screening examination requirement, is interpreted by the federal circuits with wide variation resulting in significant confusion amongst healthcare providers. Discussion *infra* Part III.D.

265. *See* *Battle v. Mem’l Hosp. at Gulfport*, 228 F.3d 544, 558 (5th Cir. 2000) (noting that the duty to stabilize does not arise unless the hospital has actual knowledge of the patient’s unstable condition); *see also* *Brenord v. Catholic Med. Ctr. of Brooklyn & Queens, Inc.*, 133 F. Supp. 2d 179, 185 (E.D.N.Y. 2001) (articulating that EMTALA’s stabilization transfer requirements are only triggered after a hospital’s determination of an emergency medical condition (citing *Gatewood*, 933 F.2d at 1041)); *Fuentes Ortiz v. Mennonite Gen. Hosp.*, 106 F. Supp. 2d 327, 332 (D.P.R. 2000) (“If ‘any individual . . . comes to a hospital and the hospital determines that the individual has an emergency medical condition,’ the hospital must try to stabilize that condition, and can shift the patient to another institution only in accordance with EMTALA’s transfer provisions. . . . [I]f no emergency condition is detected, there is no duty to stabilize.” (quoting 42 U.S.C. § 1395dd(b))); *Otero v. Hosp. Gen. Menoita, Inc.*, 115 F. Supp. 2d 253, 259 (D.P.R. 2000) (explaining that “[t]he duty to stabilize arises with respect to any individual who comes to a hospital after the hospital determines that the patient has an emergency medical condition” (citing 42 U.S.C. § 1395dd(b)(1) and *Lopez-Soto v. Hawayek*, 175 F.3d 170, 173 (1st Cir. 1999))); *Pagan v. Hosp. San Pablo, Inc.*, 97 F.Supp. 2d 199, 202 (D.P.R. 2000) (“The duty to stabilize is triggered if the patient arrives at the hospital and the hospital determines that the patient has an emergency medical condition.” (citing 42 U.S.C. § 1395dd(b))).

266. *See* *Jackson*, 246 F.3d at 1257 (noting that the Ninth Circuit rule requiring a showing of actual knowledge as a condition precedent to the stabilization requirement adheres to the rule in five other circuits); *see, e.g., Summers*, 91 F.3d at 1140 (finding that a hospital must determine that a patient has an emergency

EMTALA, in fact, contains parallel yet separate definitions of the terms “to stabilize”<sup>267</sup> and “stabilized.”<sup>268</sup> The term “to stabilize” indicates what the hospital must do to a patient who has an emergency medical condition and requires necessary stabilizing treatment, but who is not transferred in accordance with 42 U.S.C. § 1395dd(c).<sup>269</sup> “Stabilized,” on the other hand, refers to the condition in which the patient must be to transfer him or her, other than in accordance with the restrictions of § 1395dd(c).<sup>270</sup>

If a hospital has actual knowledge of the emergency medical condition, it then must provide either “within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or for transfer of the individual to another medical facility . . . .”<sup>271</sup> Under EMTALA, “to stabilize” means “to provide such medical treatment of the emergency medical condition as may be necessary to assure, within *reasonable medical probability*, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.”<sup>272</sup>

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medical condition before the EMTALA stabilization requirement applies (citing *Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139, 145 (4th Cir. 1996)); *Gatewood*, 933 F.2d at 1041 (stating that a hospital’s diagnosis of an individual’s emergency medical condition triggers the stabilization and transfer provisions of EMTALA); *Vickers*, 78 F.3d at 145 (observing that a hospital must have actual knowledge of an emergency medical condition and that EMTALA does not apply even if the hospital should have diagnosed such a condition). Only one court has held that a hospital has a duty to stabilize an emergency medical condition even under circumstances where it had no knowledge of such condition. *See Carodenuto v. New York City Health & Hosp. Corp.*, 593 N.Y.S.2d 442, 446 (Sup. Ct. 1992) (requiring stabilization of an emergency medical condition even if the hospital does not diagnose the condition). This reasoning relies, however, on the language of the transfer provisions, which, unlike the stabilization requirements of EMTALA, do not contain a knowledge requirement. *Id.*

267. 42 U.S.C. § 1395dd(e)(3)(A).

268. *Id.* § 1395dd(e)(3)(B).

269. *See id.* § 1395dd(e)(3)(A). This section provides that “to stabilize,” with respect to an emergency medical condition, means:

to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result or occur during from the transfer of the individual from a facility, or, with respect to an emergency medical condition, to deliver (including the placenta).

*Id.*

270. *See id.* § 1395dd(e)(3)(B). This section also provides that “stabilized,” with respect to an emergency medical condition, means:

that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition, that a woman has delivered (including placenta).

*Id.*

271. *Id.* § 1395dd(b)(1)(A)-(B).

272. *Id.* § 1395dd(e)(3)(A) (emphasis added).

The court in *Burditt v. United States Department of Health & Human Services*<sup>273</sup> further clarified that such treatment consists of “treatment that *medical experts agree* would prevent the threatening and severe consequences of the patient’s emergency medical condition while in transit.”<sup>274</sup> In that regard, professional medical standards, rather than standards established by each hospital, determine the adequacy of a particular patient stabilization,<sup>275</sup> thereby making such a legal determination patient-specific, contextual, and situational,<sup>276</sup> yet commensurate with an objective standard of care.<sup>277</sup>

### 3. *No-delay requirement*

The EMTALA “no delay in examination or treatment”<sup>278</sup> requirement provides that “[a] participating hospital may not delay provision of an appropriate medical screening examination required under 42 U.S.C. § 1395dd(a),”<sup>279</sup> or delay necessary stabilizing treatment required under subsection 42 U.S.C. § 1395dd(b),<sup>280</sup> “in order to inquire about the individual’s method of payment or insurance status.”<sup>281</sup> Frequently, emergency departments will delay a patient’s medical screening examination or stabilization treatment in order to inquire about the patient’s payment status—EMTALA expressly forbids this delay.<sup>282</sup> After stabilization of the emergency medical condition, EMTALA no longer applies and prior authorization for further services is permitted.<sup>283</sup> Some states also

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273. 934 F.2d 1362 (5th Cir. 1991).

274. *Id.* at 1369 (emphasis added).

275. *See Cherukuri v. Shalala*, 175 F.3d 446, 454 (6th Cir. 1999) (applying a flexible standard to determine the sufficiency of stabilization treatments and finding that the standard varies based on the reasonableness of treatment under the immediate circumstances).

276. *See id.* at 449-50 (stating that the definition of “stabilize” requires a “fast on-the-spot risk analysis” by the transferring physician based on the particular situation).

277. *See* notes 399-495 and accompanying text (comparing the objective versus the subjective standard of care with respect to physician liability).

278. 42 U.S.C. § 1395dd(h).

279. *Id.*

280. *Id.*

281. *Id.*; *see also* HCFA Interpretive Guidelines § 489.24(c)(3), *available at* [http://www.hcfa.gov/pubforms/07\\_som/somap\\_v\\_013\\_to\\_034.htm](http://www.hcfa.gov/pubforms/07_som/somap_v_013_to_034.htm) (last visited Sept. 2, 2002) [hereinafter HCFA Interpretive Guidelines] (stating that all individuals, whether or not they are insured, must be served if they have an emergency medical condition). As such, a hospital should not delay its provision of a medical screening examination or necessary stabilizing treatment by inquiring about a patient’s ability to pay for the care. *Id.* In addition, although a hospital may register new patients by following reasonable processes, which may include asking patients about insurance coverage, a hospital may not delay the screening or treatment of patients with emergency medical conditions in order to follow such registration processes. *Id.*

282. 42 U.S.C. § 1395dd(h).

283. *See id.* (prohibiting delays in the provision of a medical screening

prohibit prior authorization calls until after the patient receives a medical screening examination and any necessary stabilizing treatment.<sup>284</sup>

#### 4. *Transfer requirements*

EMTALA regulates patient transfers, and states that a “transfer” occurs when a hospital employee directs the movement, including discharge, of a patient outside a hospital’s facilities.<sup>285</sup> However, EMTALA only governs transfers of patients who have unstabilized emergency medical conditions.<sup>286</sup> Thus, if a medical screening examination is “appropriate” and does not reveal an emergency medical condition, or indicates that an emergency medical condition has been stabilized, EMTALA does not govern a transfer.<sup>287</sup> Accordingly, EMTALA provisions apply in two scenarios where unstable patients are commonly transferred: (1) transfers of unstable

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examination and any necessary stabilization treatment only).

284. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1317 (West 2000) (requiring the provision of emergency services and care prior to inquiring about the payment therefore); FLA. STAT. ANN. ch. 395.1041(3)(h) (Harrison 1999) (providing that a Florida hospital may ask a patient about insurance or other financial information provided that the questioning does not delay emergency services or care).

285. 42 U.S.C. § 1395dd(e)(4). This provision includes movement directed by any person employed by, or directly or indirectly affiliated, or associated with the hospital. *Id.* It does not include, however, any movement of a patient who has been declared dead or who leaves the hospital without a hospital employee’s permission. *Id.*

286. *Id.* § 1395dd(c)(1). EMTALA does not restrict hospitals concerning the treatment or transfer of individuals with stabilized emergency conditions. Hospital Responsibility for Emergency Care, 59 Fed. Reg. 32,086, 32,104 (June 22, 1994) (to be codified at 42 C.F.R. pt. 489).

287. *See* Hospital Responsibility for Emergency Care, 59 Fed. Reg. at 32,104 (stating that, under EMTALA, hospitals may transfer an individual with stabilized emergency medical conditions without meeting the requirements of an appropriate transfer); *see* Cherukuri v. Shalala, 175 F.3d 446, 449 (6th Cir. 1999) (observing that EMTALA does not limit the transfer of stabilized patients); *Green v. Truro Infirmary*, 992 F.2d 537, 539 (5th Cir. 1993) (finding that the treating hospital met its responsibility under EMTALA, and could discharge the patient, when the hospital stabilized the patient’s condition); *Delaney v. Cade*, 756 F. Supp. 1476, 1486 (D. Kan. 1991) (stating that a hospital does not violate the statute when it releases or transfers a patient whose condition is stabilized prior to the release or transfer); *Clark v. Baton Rouge Gen. Med. Ctr.*, 657 So. 2d 741, 744 (La. Ct. App. 1995) (holding that EMTALA does not require a hospital to cure a patient’s emergency medical condition and that a hospital’s responsibility under EMTALA ends when it stabilizes such a condition); *see also* HCFA Interpretive Guidelines, *supra* note 281, at V-29 (noting that certification of the transfer is not required if the individual no longer has an emergency medical condition). Although not covered by EMTALA, transfers of stabilized patients may be governed by state transfer laws. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1317.2 (West 2000) (delineating the requirements for transferring a patient for nonmedical reasons); NEV. REV. STAT. 439B.410 (2001) (specifying the conditions that a hospital must satisfy prior to transferring a patient to another hospital); TEX. HEALTH & SAFETY CODE ANN. § 241.027 (Vernon 2001) (regulating patient transfers).

patients which are medically necessary and (2) transfers of unstable patients which are at the request of the patient.<sup>288</sup>

*a. Transfer of unstable patients*

A hospital may legally transfer unstable patients to another hospital where (1) the transfer is medically necessary, or (2) the patient requests the transfer.<sup>289</sup> Medical indications for transfer of patients generally arise out of the necessity for a higher level of care which is not available at the initial treating hospital.<sup>290</sup> These inadequacies

288. 42 U.S.C. § 1395dd(c)(1).

289. *Id.* Naturally, when a physician and hospital transfer a patient to obtain a higher level of care, but cannot stabilize the patient prior to the transfer, the transfer should occur only when the initial treating hospital first minimizes the risks of transfer to the unstabilized patient. See 42 U.S.C. § 1395dd(c)(2) (defining an appropriate transfer as one in which the transferring hospital minimizes the risks to the patient's health). This would include, for example, control of blood pressure, perfusion, and ventilation. See, e.g., *Cherukuri*, 175 F.3d at 449, 451 (finding that where the physician stabilized the patient's blood pressure, even though the physician did not have the resources available to immediately stabilize all the patient's emergency medical conditions, the physician stabilized the patient to the best of his ability for transfer to another facility). If a patient requests a medically unstable transfer, EMTALA provides that if the individual has an unstabilized emergency medical condition, the hospital may not transfer the individual unless the individual, "after being informed of the hospital's obligations under [EMTALA] and of the risk of the transfer, in writing requests transfer to another medical facility." 42 U.S.C. § 1395dd(c)(1)(A)(i). In patient-requested unstable transfers, as well as medically-necessary unstable transfers, the transfer must satisfy EMTALA criterion for an "appropriate" transfer. See *id.* § 1395dd(c)(2) (listing the requirements of an appropriate transfer). Under EMTALA, an appropriate transfer is a transfer:

- (A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;
- (B) in which the receiving facility—
  - (i) has available space and qualified personnel for the treatment of the individual, and
  - (ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;
- (C) in which the transferring hospital sends to the receiving facility all medical records . . . related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or legal certification . . . and the name and address of any on-call physician . . . who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;
- (D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and
- (E) which meets such other requirements as the Secretary [of DHHS] may find necessary in the interest of the health and safety of individuals transferred.

*Id.*

290. Such a transfer may result, for example, where the initial treating hospital

include insufficient resources, capabilities, or expertise at the initial treating hospital, and may preclude the transferring hospital's ability to completely stabilize a patient's emergency medical condition.<sup>291</sup> Thus, where the benefits of transfer outweigh the risks of transfer, EMTALA specifically requires the transfer of unstable patients<sup>292</sup> in an appropriate manner.<sup>293</sup>

1) *Legal certification*

When an individual at a hospital has an unstabilized emergency medical condition, as defined by the statute,<sup>294</sup> the hospital may not transfer the individual unless a physician has signed a legal certification.<sup>295</sup> The legal certification indicates that "based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child."<sup>296</sup>

This legal certification process implies that the transferring emergency physician believes that the receiving facility has the

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does not provide orthopedics, neurosurgery, OB, neonatal, or pediatric wards. See 42 U.S.C. § 1395dd(g) (listing "burn units, shock-trauma units, [and] neonatal intensive care units" as examples of specialized capabilities).

291. See *Cherukuri*, 175 F.3d at 449 (finding a transfer appropriate where the transferring hospital did not have an anesthesiologist immediately available to perform a medically-necessary surgery).

292. 42 U.S.C. § 1395dd(b)(1)(B).

293. See *infra* notes 294-309 and accompanying text. As noted earlier, EMTALA does not govern the transfer of stable patients. Hospital Responsibility for Emergency Care, 59 Fed. Reg. 32,086, 32,104 (June 22, 1994) (to be codified at 42 C.F.R. pt. 489). The court in *Cherukuri v. Shalala* clearly found that the act does not impose any requirements on hospitals with respect to the treatment or transfer of individuals whose emergency condition has been stabilized. 175 F.3d at 446, 449. In *Cherukuri*, the court further noted that, where a physician believes that a transfer will not materially deteriorate a patient's condition, the physician may transfer the patient without a certification or the consent of the receiving hospital. *Id.* at 450. However, state statutes may govern transfers of stable patients. See, e.g., CAL. HEALTH & SAFETY CODE § 1317.2 (West 2000) (stating a hospital's responsibilities in transferring a patient); NEV. REV. STAT. 439B.410 (2001) (detailing the conditions precedent to a patient transfer); TEX. HEALTH & SAFETY CODE ANN. § 241.027 (Vernon 2001) (discussing the necessary steps for transferring a patient).

294. 42 U.S.C. § 1395dd(e)(3)(B)(ii).

295. *Id.* § 1395dd(c)(1)(A)(ii). Thus, only medically-necessary transfers of unstabilized patients require a legal certification. See *id.* (prohibiting the transfer of patients with unstabilized medical conditions unless a physician signs a legal certification). Although hospitals may have preexisting "transfer agreements" amongst themselves, EMTALA requires that all transfers of patients with unstabilized emergency medical conditions satisfy the requirements of legal certification. See *id.* (failing to provide an exception for preexisting transfer agreements); *cf. id.* § 1395dd(f) (noting that EMTALA preempts state laws that directly conflict with EMTALA requirements, thereby indicating that EMTALA will prevail over hospital agreements that create similar discrepancies).

296. *Id.* § 1395dd(c)(1)(A)(ii).

necessary resources, capabilities, and expertise to stabilize the patient's emergency medical condition.<sup>297</sup> The legal certification must weigh, not merely mention, the medical risks and benefits associated with the transfer of the unstable patient.<sup>298</sup>

The standard for determining the legal sufficiency of the certification—that is, whether a transferring emergency physician, or hospital, “negligently”<sup>299</sup> completed the certification—is the objective standard of reasonableness under ordinary negligence standards.<sup>300</sup> This same standard would apply to evaluating the conduct of either the hospital or the emergency physician.<sup>301</sup> The dispositive legal issue is whether, under the specific patient's circumstances, the certifying “physician *knew or should have known* that the benefits [of transfer] did not outweigh the risks [of transfer].”<sup>302</sup>

## 2) Patient informed consent

A patient's informed consent is a key concept in EMTALA. A hospital has fulfilled its obligations to a patient who refuses to consent to the treatment of an emergency medical condition when the hospital offers the individual further treatment and informs the patient of the risks and benefits of such treatment, and yet the patient still refuses treatment.<sup>303</sup>

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297. *Cf. id.* § 1395(c)(1) (stating that the certification must contain a summary of the risks and benefits underlying the certification, thereby implying that the physician must be aware of the benefits that the patient will receive at the other facility). If a physician is not immediately available to sign the legal certification, the EMTALA statute provides that a “qualified medical person” (e.g., a nurse, physician assistant, etc.) may sign the legal certification, so long as they previously consulted with a physician who will later countersign the certification. *Id.* § 1395(c)(1)(A)(iii).

298. *Burditt v. United States Dep't of Health & Human Servs.*, 934 F.2d 1362, 1362 (5th Cir. 1991) (finding that EMTALA requires the signer of a certification to deliberate and weigh the risks and benefits of a transfer prior to signing the certification).

299. 42 U.S.C. § 1395dd(d)(1) (noting that a hospital may face civil damages if it “negligently” violates a requirement of EMTALA).

300. *Cherukuri v. Shalala*, 175 F.3d 446, 449-51 (6th Cir. 1999) (discussing a treating physician's need to make quick determinations regarding the stabilization and transfer of a patient and applying an objective standard of reasonableness to those decisions).

301. 42 U.S.C. § 1395dd(d)(1)(A)-(B) (applying the standard of negligence to the actions of both a participating hospital and a physician responsible for the examination, treatment, or transfer of a patient in a participating hospital).

302. *Id.* § 1395dd(d)(1)(B)(i) (emphasis added). If a physician signs a certification that the medical benefits of a transfer to another facility outweigh the risks that the physician “knew or should have known” otherwise, or if the physician misrepresents a patient's medical condition or other information, the physician may face civil monetary penalties. *Id.* § 1395dd(d)(1)(B)(i)-(ii).

303. *Id.* § 1395dd(b)(2). A person acting on the patient's behalf can also refuse to consent to recommended examination and treatment. *Id.*

3) “Appropriate” transfer

Under EMTALA, there are five conditions precedent to an “appropriate” transfer of an unstable patient.<sup>304</sup> A transfer to a medical facility is “appropriate” where (1) the transferring hospital provides the patient medical treatment within its capabilities which minimizes the risks to the individual’s health, or the health of the unborn child for a woman in labor; (2) the receiving facility has space and qualified personnel to treat the individual, and agrees to accept and treat the individual; (3) the transferring hospital sends the receiving facility all relevant, available medical records; (4) the individual is transferred by qualified personnel and transportation equipment; and (5) other requirements established by the Secretary of DHHS, in the interest of the individual’s health and safety, are satisfied.<sup>305</sup>

Where a hospital “has reason to believe” that it received a transferred patient in violation of EMTALA, it must report the transferring hospital to the Health Care Financing Administration (“HCFA”)<sup>306</sup> or the state survey agency.<sup>307</sup> A hospital has an obligation to report a possible EMTALA violation regardless of whether the receiving hospital believes the sending hospital violated the law intentionally or with any ill motive.<sup>308</sup> Either physicians or hospitals may violate the statute, but physicians do not have a corresponding obligation to report a suspected EMTALA obligation.<sup>309</sup>

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304. *Id.* § 1395dd(c)(2).

305. *Id.*

306. *See supra* note 160 (noting that although the Health Care Financing Administration changed its name to Center for Medicaid and Medicare Services (CMS), because this Article uses data and information obtained from previous HCFA publications, this Article will continue to use the reference to HCFA rather than CMS).

307. Provider Agreements and Supplier Approval, 42 C.F.R. § 489.20(m) (2001).

308. *See* Hospital Responsibility for Emergency Care, 59 Fed. Reg. 32,086, 32,107 (June 22, 1994) (to be codified at 42 C.F.R. pt. 489) (observing that hospitals that suspect cases of dumping are “in the best position to discern when an inappropriate transfer has taken place in violation of the statute”).

309. *See* 42 C.F.R. § 489.20(m) (requiring a hospital to report suspected transfer violations by another hospital); Hospital Responsibility for Emergency Care, 59 Fed. Reg. at 32,106-07 (discussing a hospital’s duty to report suspected violations). However, for EMTALA purposes, a physician may be considered the agent of the hospital such that a receiving hospital must report his actions if the receiving hospital suspects that the physician violated the statute. *See* BITTERMAN, *supra* note 18, at 19 (stating that EMTALA duties attach to physicians as agents of the hospital when the physicians accept hospital medical staff privileges or on-call duties, making the hospital directly liable for physicians’ violations); *Burditt v. United States Dep’t of Health & Human Servs.*, 934 F.2d 1362, 1374 (5th Cir. 1991) (“[H]ospital physicians who treat patients in fulfillment of their contractual responsibilities are the hospital’s agents for purposes of such treatment.”).

*b. Transfer of stable patients*

EMTALA does not govern the transfer of stable patients;<sup>310</sup> however, such transfer may be governed by state statutes.<sup>311</sup> The terms “to stabilize”<sup>312</sup> and “stabilized”<sup>313</sup> are defined under EMTALA.

5. *Refusal to consent to treatment/refusal to consent to transfer*

EMTALA does not thwart patient autonomy or patient decision-making. Although hospitals and physicians must perform various activities and provide various services under EMTALA, a patient’s refusal to consent to treatment,<sup>314</sup> or refusal to consent to transfer,<sup>315</sup> will not subject a hospital or physician to liability under EMTALA.<sup>316</sup>

6. *Preemption*

Congress anticipated that matters relating to the governance of patient dumping would concern both state and federal matters.<sup>317</sup>

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310. 42 U.S.C. § 1395cc(a)(1)(I)(ii) (restricting transfer of medically unstable patients only).

311. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1317.5 (West 2000); NEV. REV. STAT. 439B.410(4) (2001); TEX. HEALTH & SAFETY CODE ANN. § 241.027 (Vernon 2001), as examples of states which have enacted patient transfer laws which *do* apply to stable transfers.

312. 42 U.S.C. § 1395dd(e)(3)(A); *see supra* note 264 (defining both “to stabilize” and “stabilized”).

313. 42 U.S.C. § 1395dd(e)(3)(B). The court in *Cerukuri v. Shalala* was clear in noting that “[t]he act does not impose any requirements on hospitals with respect to the treatment or transfer or individuals whose emergency condition has been stabilized.” 175 F.3d 446, 449 (6th Cir. 1999).

314. *See* 42 U.S.C. § 1395dd(b)(2) (stating that a hospital fulfills its duty to provide medical screening examinations and medical treatment, as may be required to stabilize a patient’s medical condition, if the hospital offers the individual further medical examinations and treatment and informs the individual of the risks and benefits of such examinations and treatment, but the individual refuses to consent).

315. *Id.* § 1395dd(b)(3) (providing that a hospital meets its obligations to provide medical screening examinations and medical treatment if the hospital offers to transfer the individual to another medical facility and informs the individual of the risks and benefits of such a transfer, but the individual refuses to consent).

316. Under either of these circumstances, the hospital must take all reasonable steps to obtain a “written informed consent to refuse” from the individual. *Id.* § 1395dd(b)(2)-(3). With respect to a refusal to consent to medical examination or treatment, the patient’s medical records must contain a description of the refused examination or treatment and the written informed refusal should indicate that the hospital informed the person of the risks and benefits of such procedures. Provider Agreements and Supplier Approval, 42 C.F.R. § 489.24(c)(2) (2001). For a refusal to consent to transfer, the patient’s medical record must indicate that the hospital informed the patient of the risks and benefits of the transfer, state the reasons for the patient’s refusal, and contain a description of the refused transfer. *Id.* § 489.24(c)(4).

317. *See Reid v. Indianapolis Osteopathic Med. Hosp.*, 709 F. Supp. 853, 855 (S.D. Ind. 1989) (commenting on Congress’s awareness of state concerns during its drafting of EMTALA provisions). *Reid*, a seminal case which tested the extent to which COBRA preempts state law, involved the allegedly inappropriate transfer of the victim of an automobile accident. *Id.* at 853. The patient died shortly after the

Accordingly, Congress provided that the provisions of EMTALA do not preempt the requirements of any state or local law except where a state or local requirement directly conflicts with EMTALA.<sup>318</sup> Thus, EMTALA specifically envisions that some procedural matters are better left to state discretion.<sup>319</sup> Often concerns of EMTALA preemption arise under (a) circumstances of private rights of action by the victim or survivors against the hospital or emergency physician, (b) issues of capping recovery awards under a state's medical

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transfer. *Id.* The hospital defendant attempted to invoke the protection of Indiana law that required review of malpractice cases by a medical review panel and limited damages to \$100,000. *Id.* at 854. The court held that Indiana law, which states that a cause of action does not arise against a hospital until a state medical review panel renders an opinion, "directly conflicts with section 1395dd's provision that such a cause of action arises whenever '[a]ny individual . . . suffers personal harm as a direct result of a requirement of [EMTALA].'" *Id.* at 855. The court did find, however, that the \$100,000 damage cap applied to COBRA cases. *Id.* at 855-56.

318. 42 U.S.C. § 1395dd(f). This preemption provision relies on the familiar principle of *unius est exclusio alterius* (the mention of one thing implies the exclusion of the other). See *Cipollone v. Liggett Group*, 505 U.S. 504, 517 (1992) (noting that where Congress includes a provision that defines a statute's pre-emptive reach, the statute does not preempt any matter beyond that reach). To determine whether federal law preempts a state statute, a court must ascertain Congress's intent. *Cal. Fed. Sav. & Loan Ass'n v. Guerra*, 479 U.S. 272, 280 (1987); see also *Burgio & Campofelice, Inc. v. New York State Dep't of Labor*, 107 F.3d 100, 108 (2d Cir. 1997) (stating that Congress's intent controls a preemption analysis). When Congress expressly defines a statute's preemptive reach, and the statute provides "a reliable indicium of congressional intent" regarding the reaches of state authority, there is a "reasonable inference" that Congress did not intend to preempt matters beyond that reach. *Freightliner Corp. v. Myrick*, 514 U.S. 280, 288 (1995); see also *Toy Mfrs. of Am., Inc. v. Blumenthal*, 986 F.2d 615, 623 (2d Cir. 1993) (discussing the application of the rule in *Cipollone*). A state statute directly conflicts with federal law when compliance with both federal and state regulations is a "physical impossibility." See also *Fla. Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142-43 (1963) (noting that a court does not have to examine congressional intent where compliance with both state and federal is a "physical impossibility"); *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941) (determining preemption by considering whether a state law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress"); *Env'tl. Encapsulating Corp. v. City of New York*, 855 F.2d 48, 53 (2d Cir. 1988) (listing several ways in which a federal law preempts state law).

319. See *Bryan v. Rectors & Visitors of the Univ. of Va.*, 95 F.3d 349, 352 (4th Cir. 1996) (holding EMTALA is not intended to preempt state tort law except where absolutely necessary). Also, state law generally will control in respect to the issue of preemption and punitive damages related to EMTALA violations. See *Taylor v. Dallas County Hosp. Dist.*, 976 F. Supp. 437, 438 (N.D. Tex. 1996) (denying punitive damages based on Texas law which precluded punitive damages); see also *Griffith v. Mt. Carmel Med. Ctr.*, 826 F. Supp. 382, 385 (D. Kan. 1993) (denying punitive damages based on Kansas law that precludes punitive damages in wrongful death cases). Similarly, state tort law controls the effect and applicability of intervening agency or superceding causes in respect to liability. See *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 944 (6th Cir. 1995) (denying EMTALA damages because under state law the plaintiff was unable to prove proximate cause in a state wrongful death claim); see also *Williams v. Birkeness*, 34 F.3d 695, 697-98 (8th Cir. 1994) (denying EMTALA damages because the plaintiff was unable to prove negligence under state law due to an intervening event).

malpractice regulatory scheme,<sup>320</sup> or (c) as may relate to statutes of limitations<sup>321</sup> or other state procedural formalities often related to medical malpractice causes of action.<sup>322</sup>

#### 7. *Enforcement and private causes of action*

Within DHHS, EMTALA is enforced by the HCFA and the Office of Inspector General (“OIG”).<sup>323</sup> The HCFA authorizes state survey agencies to investigate complaints of patient dumping in order to determine if there was a violation.<sup>324</sup> The OIG’s Office of Counsel to the Inspector General levies monetary fines against violating hospitals and physicians and removes physicians from the Medicare program.<sup>325</sup> However, before the HCFA can send a case to the OIG that deals with the medical judgment of a hospital or physician, they must refer the case to a medical peer review organization (PRO).<sup>326</sup>

EMTALA did not create a private cause of action against physicians,<sup>327</sup> although such private action is permitted against a

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320. See *Barris v. County of L.A.*, 972 P.2d 966, 976 (Cal. 1999) (concluding, like other federal courts, that damages awarded under EMTALA were subject to California Civil Code § 3333.2, that includes a cap of “\$250,000 on the liability of a health care provider for noneconomic damages in an action based on professional negligence”).

321. See *Draper v. Chiapuzio*, 9 F.3d 1391, 1393 (9th Cir. 1993) (holding that the state’s one-year limitation period for filing notice of a tort claim is not preempted by the two-year statute of limitations under 42 U.S.C. § 1395dd(f) because compliance with both the federal and state statute of limitations is not a physical impossibility due to the lack of direct conflict, thus allowing the plaintiff to file the required notice under the state statute within one year and file suit under the federal statute within two years); *Reyes Santana v. Hosp. Ryder Mem’l Inc.*, 130 F. Supp. 2d 270, 274 (D.P.R. 2001) (holding the two year statute of limitations under 42 U.S.C. § 1395dd(d)(2)(C), instead of the one year state statute of limitations, applied to the plaintiff’s EMTALA claim, thus denying the defendants motion for summary judgment); *HCA Health Servs. of Ind. v. Gregory*, 596 N.E.2d 974, 977 (Ind. Ct. App. 1992) (holding EMTALA’s two year statute of limitations preempts the Indiana provision which requires the claimant file with the Department of Insurance for a medical review panel opinion); see also *Vogel v. Linde*, 23 F.3d 78, 80 (2d Cir. 1994) (barring the EMTALA claim because 42 U.S.C. § 1395dd(d)(2)(C) did not expressly provide that the claimant’s infancy and incompetency would toll the two year statute of limitations, thus making the plaintiffs claim time barred).

322. See *Brooks v. Md. Gen. Hosp., Inc.*, 996 F.2d 708, 714-15 (4th Cir. 1993) (finding that arbitration, as required under the Maryland Malpractice Act, was not necessary to bring an EMTALA claim).

323. See DHHS, OIG EMTALA SURVEY, *supra* note 25, at 1 (explaining EMTALA’s enforcement as bifurcated between the HCFA and the OIG).

324. See *id.* at 7-8 (stating the HCFA authorized state survey agencies to investigate complaints, conduct on-site inspections, discover repeated violations, and review EMTALA implementation plans).

325. See *id.* at 7 (describing OIG’s enforcement of the EMTALA).

326. See *id.* at 8 (stating that, without a PRO review, the OIG can enforce monetary penalties only if a delay may jeopardize an individual’s well being or a screening exam was not conducted).

327. See *Delaney v. Cade*, 986 F.2d 387, 394 (10th Cir. 1993) (holding that EMTALA does not create a private cause of action against a physician); *Baber v.*

hospital.<sup>328</sup> Rather, there are two arms of EMTALA enforcement: civil monetary penalties<sup>329</sup> and civil enforcement.<sup>330</sup>

*a. Civil monetary penalties*

EMTALA empowers the DHHS, upon the authorization of the Attorney General of the United States, to initiate administrative proceedings for civil penalties against hospitals and physicians that negligently violate EMTALA.<sup>331</sup> EMTALA specifically states that “[a] participating hospital that negligently violates a requirement of [EMTALA] is subject to a civil money penalty of not more than \$50,000<sup>332</sup> for each such violation.”<sup>333</sup> The aggrieved hospital or physician has a right of appeal to the U.S. Court of Appeals.<sup>334</sup>

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Hosp. Corp. of Am., 977 F.2d 872, 876 (4th Cir. 1992) (same); Gatewood v. Wash. Healthcare Corp., 933 F.2d 1037, 1041 (D.C. Cir. 1991) (holding that EMTALA does not create negligence or malpractice causes of action); Urban v. King, 783 F. Supp. 560, 563 (D. Kan. 1992) (holding that the EMTALA does not create a private cause of action against a physician); Lavignette v. W. Jefferson Med. Ctr., No. 89-5495, 1990 U.S. Dist. LEXIS 14966, at \*4 (E.D. La. Nov. 7, 1990) (dismissing a 42 U.S.C. § 1395dd complaint against a physician because the language and the legislative history of the act indicated that it was not intended to create a private cause of action against physicians); Verhagen v. Olarte, No. 89 Civ. 0300, 1989 U.S. Dist. LEXIS 13881, at \*17 (S.D.N.Y. Nov. 17, 1989) (holding the EMTALA statutory scheme does not include a private right of action against a physician); Richardson v. S.W. Miss. Reg'l Med. Ctr., 794 F. Supp. 198, 201-02 (S.D. Miss. 1992) (determining from the language and drafter's intent that the statute does not create a private cause of action against a physician).

328. See *Delaney*, 986 F.2d at 393 (stating that EMTALA creates a cause of action against hospitals); *Barber*, 977 F.2d at 877 (finding that EMTALA's legislative history indicates that the statute allows for causes of action against hospitals); *Gatewood*, 933 F.2d at 1040 n.1 (stating that the EMTALA provides a cause of action against hospitals not physicians).

329. 42 U.S.C. § 1395dd(d)(1) (2000).

330. *Id.* § 1395dd(d)(2).

331. *Id.* § 1395dd(d)(1)(A)-(B); see *Burditt v. United States Dep't of Health & Human Servs.*, 934 F.2d 1362, 1367 (5th Cir. 1991) (describing how the DHHS, the government agency responsible for enforcing the Medicare provider agreement, filed an administrative claim for civil penalties against a physician for EMTALA violations pursuant to § 1395dd(d)(1)).

332. This figure is not more than \$25,000 in the case of a hospital with less than 100 beds. *Id.* § 1395dd(d)(1)(A)-(B).

333. *Id.* § 1395(d)(1)(A); see *Burditt*, 934 F.2d at 1367 (referring an EMTALA claim against a violating physician to an administrative hearing in front of an administrative law judge in order to recover civil monetary penalties which are contingent upon weighing the aggravating or mitigating circumstances).

334. See *id.* § 1395dd(d)(1)(A) (“The provisions of section 1320a-7a of this title . . . shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320a-7a(a) of this title.”); see also *id.* § 1320a-7a(e) (“Any person adversely affected by a determination of the Secretary under this section may obtain a review of such determination in the United States Court of Appeals for the circuit in which the person resides, or in which the claim was presented . . .”); *Burditt*, 934 F.2d at 1367-68 (reviewing Departmental Appeals Board decision against a physician pursuant to 42 U.S.C. § 1320a-7a(e)).

Additionally, EMTALA provides that physicians who examine or transfer a patient and who “negligently” violate a requirement of EMTALA, are also subject to civil monetary penalties.<sup>335</sup> Specifically, a physician who:

signs a [legal] certification that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks,<sup>336</sup> or (2) misrepresents a patient’s condition or other information, including a hospital’s obligations,<sup>337</sup> is subject to a civil money penalty of not more than \$50,000 for each such violation.<sup>338</sup>

Also, if the physician’s violation is found to be “gross and flagrant, or is repeated,”<sup>339</sup> the physician can be excluded from participating in Medicare and State healthcare programs.<sup>340</sup>

*b. Civil enforcement*

Under EMTALA civil enforcement,<sup>341</sup> if a patient suffers harm because a hospital violated EMTALA requirements, that patient can sue the hospital for damages under the personal injury law of that state or seek equitable relief.<sup>342</sup> There is no corresponding EMTALA civil enforcement provision under which an individual who suffers personal harm may directly proceed in a civil action against an emergency physician.<sup>343</sup> When a medical facility<sup>344</sup> suffers financial loss, relief is also available.<sup>345</sup> Under either circumstance, whether a suit by a person harmed or by a medical facility, no action may be brought more than two years after the date of the violation.<sup>346</sup>

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335. 42 U.S.C. § 1395dd(d)(1)(B)(i) (emphasis added).

336. *Id.* § 1395dd(d)(1)(B)(i).

337. *Id.* § 1395dd(d)(1)(B)(ii).

338. *Id.* § 1395dd(d)(1)(B).

339. *Id.* § 1395dd(d)(1)(B)(ii).

340. *Id.* § 1395dd(d)(1)(A).

341. *Id.* § 1395dd(d)(2).

342. *Id.* § 1395dd(d)(2)(A).

343. *See id.* (limiting an individual’s civil enforcement action against a participating hospital).

344. *Id.* § 1395dd(d)(2)(B).

345. *Id.* The statute states:

Any medical facility that suffers a financial loss as a direct result of a participating hospital’s violation of an EMTALA requirement may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

*Id.*

346. *Id.* § 1395dd(d)(2)(C).

### 8. *Nondiscrimination*

EMTALA is a nondiscriminatory congressional act as evidenced by its attempts to preclude a receiving hospital from limiting the transfer of patients to its medical facility.<sup>347</sup> EMTALA provides that, if a hospital has specialized capabilities, those hospitals may not refuse transfers of patients requiring the specialized capabilities, if the hospital has the capacity to treat the individual.<sup>348</sup> The government defines "capacity" broadly as "the ability of [a] hospital to accommodate [an] individual requesting examination or treatment of the transferred individual."<sup>349</sup> Capacity, therefore, encompasses many factors, such as numbers and availability of qualified staff, beds and equipment,<sup>350</sup> and a review of the hospital's past practices of accommodating additional patients in excess of its occupancy limits.<sup>351</sup>

## III. EMTALA IMPERFECTIONS AND THE RESULTANT INCONSISTENCIES IN INTERPRETATION AND ENFORCEMENT

Our proposed new cause of action is based, in part, upon the extensive confusion, ambiguities, and inconsistencies which have hampered EMTALA compliance and enforcement. This Part outlines some of the major EMTALA infirmities which have hampered effective monitoring and control of patient dumping, and have made government enforcement virtually impossible. Those infirmities include inadequacies of understanding, compliance, and enforcement on the part of emergency physicians, hospital staff, and the federal government; conflicting standards of care regarding hospital conduct; confusion regarding the standard of care under which a physician's conduct is judged; and conjunctive and disjunctive interpretations of EMTALA.

### A. *EMTALA Imperfections*

Emergency physicians, hospital staff and the federal government have exhibited significant inadequacies with respect to EMTALA

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347. *See id.* § 1395dd(g) (describing EMTALA's non-discrimination provisions).

348. *See id.* (stating that specialized capabilities include burn units, shock trauma units, neonatal intensive care units, or in rural areas, regional referral centers which are identified by the Secretary of DHHS).

349. Special Responsibilities of Medicaid Hospitals in Emergency Cases, 42 C.F.R. § 489.24(b) (2001).

350. *Id.*

351. *Id.* Thus, a medical facility will not be able to evade a transfer of a potential patient, nor evade the spirit of EMTALA, by merely claiming that its capacity has been reached prior to the anticipated transfer. *Id.*

implementation.<sup>352</sup> The inadequacies were shown clearly in two recent studies conducted by the DHHS and the OIG.<sup>353</sup>

1. *Emergency department physician and staff inadequacies*

In January 2001, the OIG released a study which was conducted to determine whether emergency department medical directors, emergency physicians, and hospital emergency department staff were aware of the various provisions of EMTALA.<sup>354</sup> The DHHS study survey revealed that emergency physicians and hospital emergency department staff possess an inadequate understanding of EMTALA.<sup>355</sup>

First, the OIG study revealed that emergency department directors and emergency physicians are often unaware of EMTALA policy changes.<sup>356</sup> Emergency department directors and physicians have insufficient knowledge regarding policy changes and the proper interpretation and application of EMTALA because they do not obtain their information on EMTALA directly from government agencies.<sup>357</sup> This lack of information especially has caused delays in

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352. See Annas, *supra* note 1, at 74 (identifying the critical nexus between healthcare professionals and the government by noting that “[i]t is not just the rise of for-profit medicine that has challenged our traditional social commitment to provide emergency services to rich and poor alike, but the *erosion* of this social commitment *on the part of the government itself.*”) (emphasis added).

353. DHHS, OIG EMTALA SURVEY, *supra* note 25, at 1 (tracking the violations of hospitals and noting the increase of violations over the past decade).

354. See *id.* (stating that the purpose of the survey was “[t]o determine whether staff and directors of hospital emergency departments are aware of the various provisions of the Emergency Medical Treatment and Labor Act (EMTALA) and find out how they believe the Act affects them, their hospitals and their patients”). At 121 randomly selected hospitals, the OIG conducted telephone interviews with the directors of the emergency departments. *Id.* at 9. At the same hospitals, the OIG received a thirty-seven percent response to mail surveys sent to emergency department physicians, nurses, specialists and staff. *Id.* The OIG also reviewed articles and interviewed representatives from the national and California chapter of the American College of Emergency Physicians. *Id.* at 8.

355. See *id.* at 2 (finding that the answer given by respondents was that “aspects of EMTALA are unclear and questionable”).

356. *Id.* at 2 (noting that emergency department personnel are familiar with EMTALA requirements, but many are unaware of recent policy changes).

357. See *id.* at 10 (explaining that over ninety percent of the directors obtain their EMTALA information from other sources such as “staff, professional associations, newsletters or the Internet”). The survey suggests that a consequence of only eleven percent of directors receiving information directly from the HCFA is that thirty-five percent were unaware of the 1998 Interpretive Guidelines and sixty-three percent were unaware of the HCFA EMTALA Advisory Bulletin. See *id.* at 10-11 (finding that “[o]nly 65 percent of directors are aware of HCFA’s Interpretive Guidelines, published in June 1998, and only twenty-seven percent knew of the proposed EMTALA Advisory Bulletin issued by HCFA and the OIG in November 1998.”). Examples of just three years of EMTALA policy changes (e.g., 1996, 1998, and 1999) illustrate the potential lack of knowledge emergency directors and physicians would face. See *id.* at 9 (describing EMTALA policy developments in 1996 which addressed enforcement issues and defined key terms; in 1998 which expanded State surveyor instructions; and in 1999 which recommended best practices to assist hospital

issuing regulations and resolving issues relating to the impact of managed care and the application of the EMTALA to different hospital departments.<sup>358</sup> Second, the OIG study confirmed that emergency department staff training remains a problem.<sup>359</sup> High-volume emergency department staff are less likely to receive EMTALA training than their counterparts in lower-volume emergency departments.<sup>360</sup> Further, only seventy-five percent of emergency department on-call specialists are trained on EMTALA guidelines.<sup>361</sup>

Third, surveyed hospital emergency departments continue to express concerns about EMTALA compliance.<sup>362</sup> Although, under EMTALA, a medical screening examination cannot be delayed in order to inquire about an individual's method of payment,<sup>363</sup> up to thirty percent of emergency department staff *continue* to inquire about health insurance information before providing a medical screening examination.<sup>364</sup> Sadly, fifteen percent of staff in those hospitals that seek authorization for medical screening exams, and ten percent in those that seek insurance authorization for [necessary] stabilizing treatment, believed that screening or treatment is *not provided* when authorization is denied.<sup>365</sup> Furthermore, "five percent of respondents believed an inappropriate transfer from their hospital has taken place in the past year,"<sup>366</sup> whereas eight percent [of all hospitals], including almost eighteen percent of hospitals with a large proportion of Medicaid beneficiaries, believed that decisions regarding medical screening *are* influenced by a patient's ability to

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compliance).

358. *See id.* at 9 (explaining that the evolution of the implementation of the EMTALA resulted from "delay[s] before final regulations were issued[;] . . . concerns about the impact of managed care on access to emergency department services[;] . . . [and] issues . . . over the application of EMTALA to different hospitals departments and operations").

359. *See id.* (finding that the staff that is less likely to receive EMTALA training are those working in high-volume emergency departments).

360. *Id.* at 11.

361. *Id.* at 2.

362. *See id.* at 2 (explaining that participants in the survey reported that, generally, hospitals comply with EMTALA but there are still overall concerns regarding compliance).

363. *See* 42 U.S.C. § 1395dd(h) (2000) (disallowing hospitals to delay a medical screening examination to ask about the patient's insurance status or payment method).

364. *See* DHHS, OIG EMTALA SURVEY, *supra* note 25, at 12 (stating that seventy percent of registration staff report that payment information is collected only after a patient has undergone a screening exam).

365. *Id.* at 13. Twenty-five percent of registration staff said that authorization is sought for necessary stabilizing treatment. *Id.* at 19.

366. *Id.*

pay.<sup>367</sup>

Fourth, OIG survey respondents found aspects of EMTALA “unclear” or “questionable.”<sup>368</sup> Over forty percent of emergency physicians<sup>369</sup> and over sixty percent of emergency department directors<sup>370</sup> believe parts of EMTALA are unclear.<sup>371</sup> Also, many respondents believed that interpretations of EMTALA exceed legislative intent.<sup>372</sup>

Fifth, survey respondents believed that EMTALA effects both quality of patient care and a hospital’s administrative and financial condition.<sup>373</sup> Directors at forty-four percent of emergency departments believed the patient protection provided in EMTALA increased the standard of care,<sup>374</sup> whereas twenty-five percent of directors believed EMTALA has had a negative impact upon hospital finances and administration.<sup>375</sup>

Sixth, the OIG survey revealed that “managed care” causes particular problems for hospital emergency departments when the hospitals comply with EMTALA.<sup>376</sup> Although EMTALA implementation guidelines warn hospitals against obtaining insurance authorization prior to patient screening, emergency departments argue that without previous authorization, private managed care plans will not refund emergency services.<sup>377</sup> The hospitals are left with the Hobson’s choice of either: contacting the health plan before the required medical screening examination to

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367. *Id.* Also, the survey suggested that, if a hospital had a high percentage of Medicaid patients, then staff was more likely to seek authorization for stabilizing treatments. *Id.*

368. *Id.* at 2, 13.

369. *Id.* at 13.

370. *Id.*

371. *See id.* (stating that emergency department staff believed terms such as “emergency medical condition,” “medical screening exam” and “stable for discharge” require clarification).

372. *See id.* at 14 (explaining EMTALA interpretation problems and concerns with legislative intent when a patient admitted through another department develops an emergency medical condition).

373. *See id.* at 3 (stating that some respondents believed that EMTALA creates administrative complications and financial problems by requiring that hospitals treat patients without providing funding).

374. *Id.* at 15.

375. *Id.* Respondents specifically believed that EMTALA creates layers of unnecessary bureaucracy; complicates routine procedures; contributes to financial problems; and promotes over utilization of the emergency department (especially by managed care patients who do not or cannot obtain an office visit with their primary care physician). *Id.* The problems created included: (1) EMTALA mandating medical screening and stabilization of emergency conditions without providing a source of funding for such services; and (2) having to provide screening exams for non-emergency patients who lack insurance or whose insurance will not pay. *Id.*

376. *Id.* at 3.

377. *Id.* at 16.

secure payment, and therefore, suffering an EMTALA violation; or risking that the health plans will deny payment if they obtain authorization after the medical screening examination is provided, and thereby, remaining in compliance with EMTALA.<sup>378</sup>

## 2. *Federal government inadequacies*

The OIG also conducted a study to evaluate government enforcement processes relating to EMTALA.<sup>379</sup> The OIG study revealed four significant governmental inadequacies regarding EMTALA enforcement.<sup>380</sup> First, respondents noted the “long delays and inadequate feedback” in the EMTALA enforcement process.<sup>381</sup> Not only was timely processing of EMTALA cases found to be a longstanding problem,<sup>382</sup> but HCFA regional offices often failed to communicate their decisions to state survey agencies, hospitals, and the Peer Review Organizations regarding specific EMTALA violations thereby resulting in inadequate feedback.<sup>383</sup>

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378. *See id.* (explaining that hospitals are left with this choice because the HCFA and OIG could not resolve the issue as EMTALA did not give them the authority to amend non-Medicare and non-Medicaid managed care plans).

379. *See id.* at 11 (explaining the diverse methodology for the DHHS enforcement study). Interviews were conducted at four HCFA regional offices that have jurisdiction over a majority of the nation’s hospitals and many EMTALA cases, eight state survey agencies, five PROs and emergency department nurses, physicians and healthcare providers. *Id.* The OIG also reviewed HCFA manuals, guidelines and logs of EMTALA complaints and law journals. *Id.* Previous studies conducted by the OIG revealed prior inadequacies in governmental EMTALA oversight. *See id.* at 10 (discussing the conclusions of a 1998 study which found coordination among components of the investigation process needed improvements and a 1995 study which found inconsistencies in the enforcement of EMTALA).

380. *See id.* at 2 (finding inadequacies in the enforcement process; EMTALA investigations; EMTALA case tracking; and the peer review process).

381. *Id.*

382. The HCFA requires state survey agencies to complete investigations within five working days of authorization and submit their reports ten to fifteen working days after the investigation is complete. *Id.* at 12. Although strict time frames apply to state survey agencies that investigate complaints of patient dumping, HCFA itself is not subject to any. *Id.* The logs that we obtained for purposes of the Enforcement Survey from the HCFA central office confirmed long delays in processing EMTALA claims. *Id.* For instance, between 1994 and 1998, regional offices took an average of sixty-five days after the state’s investigation to determine if an EMTALA violation occurred. Seven of the ten HCFA regional offices sometimes took as long as one year or more to decide whether a hospital violated EMTALA. *Id.* Staff in one state informed the survey investigators that in some cases two years or more elapsed before the hospital was made aware of status. *Id.* In one case, a hospital was not cited until four years after the EMTALA investigation occurred. *Id.*

383. *See id.* at 13 (stating state survey agencies and PROs are not informed by the HCFA of the results of their investigations).

Second, the number of EMTALA investigations<sup>384</sup> and their ultimate disposition was found to vary widely by HCFA region and year.<sup>385</sup> Although nationally the study identified one EMTALA investigation for every fifteen hospitals between 1994 and 1998, because of the widespread inconsistency of EMTALA investigations and dispositions, some hospitals may have a higher or lower chance of being investigated, depending in large part on their geographic location and assignment to a particular regional HCFA office.<sup>386</sup> The percentage of investigations that confirm a patient dumping EMTALA violation also was found to vary greatly by region throughout the United States.<sup>387</sup> For instance, although nationally forty percent of EMTALA investigations substantiated a violation between 1994 and 1998,<sup>388</sup> one HCFA region found violations in twenty-two percent of its investigations, whereas another region found violations in sixty-eight percent of its investigations.<sup>389</sup>

Third, poor tracking of EMTALA cases impeded HCFA oversight.<sup>390</sup> The government's data collection for EMTALA cases historically has been inconsistent and incomplete.<sup>391</sup> Upon examination, HCFA's

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384. *Id.* at 13. The Enforcement Study noted:

In 1994, for example, one of the largest HCFA regions [which the study did not name] handled 119 EMTALA cases, the second highest total nationally. [However, t]he workload has since dropped precipitously, and in 1998 the same region handled only three [3] EMTALA cases. Another region [also unnamed] logged 42 cases in 1996 and only 7 in 1998. Conversely, 7 of the 10 regional offices have seen a rise in their EMTALA caseloads since 1994. One region's caseload climbed from eighteen cases in 1994 to seventy-four cases in 1998. Another region's caseload jumped from thirteen cases in 1994 to 48 in 1998.

*Id.*

385. *Id.* at 2, 13.

386. *Id.* at 13. In one region, however, the study found that there was one EMTALA investigation for every eight hospitals in that region during the same period; in another region, there was an average of one investigation for every forty hospitals. *Id.*

387. *Id.* at 14 (noting that variance between states could be due to multiple reasons including inconsistency in data collection methods and also the number and size of the agency's staff).

388. *Id.*

389. *Id.* Substantial inconsistencies regarding EMTALA investigations have also been found in state agencies that investigate patient dumping. *Id.* at 15. In 1997, the Enforcement Process and Procedures Subgroup of the EMTALA Work Group found "substantial inconsistencies" between state agencies and regions both in understanding and application of EMTALA guidelines. *Id.*

390. *Id.* at 2.

391. *Id.* at 15. Inconsistencies in data collection formats between regions and the central HCFA office were found by the Enforcement Study. *Id.* Offices used different software applications to track cases. *Id.* Regional office staff reported that they had lost EMTALA files. *Id.* Another region developed its own spreadsheet, and noted that they had received no guidance from central office about tracking cases. *Id.*

own investigation logs were found to contain numerous errors and to have omitted key information about patient dumping complaints and EMTALA investigations.<sup>392</sup> The historical absence of an accurate, complete, central database was believed to have limited HCFA's ability to oversee regional offices and effectively monitor patient dumping.<sup>393</sup>

Fourth, peer review was not always obtained before HCFA considered terminating a hospital for medical reasons.<sup>394</sup> Although the HCFA instructs states to obtain professional medical review during an EMTALA investigation, such a medical review does not always occur.<sup>395</sup>

EMTALA imperfections—due to emergency physician, hospital staff, and federal government inadequacies—have been fostered by conflicting standards imposed on hospitals or emergency physicians.<sup>396</sup> Not only may the standards of care be different as applied to either the hospital or emergency physician, but judicial interpretations of EMTALA have resulted in different standards of care being applied to the same EMTALA provision by different federal circuits.<sup>397</sup>

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392. *Id.* at 2. For instance, although HCFA's central office implemented a particular software for tracking EMTALA cases, some regional offices continued to use their own methods for data collection which were distinct from the methods of the HCFA central office. *Id.* The Enforcement Study requested EMTALA investigation logs from HCFA's central office, and found the logs contained numerous errors and omissions. *Id.* at 15.

Key information was absent. Details were missing concerning the complaints that did not result in an investigation, the dates investigations were authorized, and the nature of the violations, which can range from technical violations involving a failure to complete necessary paperwork to more serious infractions such as failure to perform a medical screening exam. Common errors in the 1998 logs include illogical dates (e.g., dates of investigation precede dates of complaint) and incorrect provider numbers.

*Id.* at 16.

393. *Id.* at 15. The HCFA central office cannot track regional workloads and address longstanding problems because the regional offices continue to use their own methods for data collection. *Id.*

394. *Id.* at 2.

395. *Id.* After state investigations occur, the regional offices have discretion to ask the local PRO to perform another review, lasting five days, in order to obtain evidence from additional medical experts. *Id.* at 16. The PRO review becomes mandatory if the OIG assesses civil penalties. *Id.* In this review, the PRO determines if the patient "had an emergency medical condition that was not stabilized." *Id.* After this review, the PRO is required to discuss the incident with the physicians and hospitals involved where they have an opportunity to submit additional information. *Id.*

396. See Michael J. Frank, *Tailoring EMTALA to Better Protect the Indigent: The Supreme Court Precludes One Method of Salvaging a Statute Gone Awry*, 3 DEPAUL J. HEALTH CARE L. 195, 206-09 (2000) (describing the different Federal Circuit opinions regarding a standard of care under EMTALA).

397. *Id.*

*B. Hospital Conduct: Conflicting Standards of Care*

The three duties imposed by EMTALA (appropriate medical screening examination,<sup>398</sup> necessary stabilizing treatment,<sup>399</sup> and appropriate transfer<sup>400</sup>) carry with them separate, and often conflicting, standards of care.<sup>401</sup> That is, although each duty requires medical compliance, whether such compliance has been satisfied turns on a legal, not a medical, determination.<sup>402</sup> The legal determination of compliance will consider whether the standard of care for each duty has been legally satisfied.<sup>403</sup> Because the federal circuit courts are frequently divided as to what standard of care should be used to determine legal compliance, compliance with EMTALA suffers and patient dumping continues.<sup>404</sup>

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398. 42 U.S.C. § 1395dd(a) (2000).

399. *Id.* § 1395dd(b).

400. *Id.* § 1395dd(a).

401. *See infra* Table 4 (listing the differences in standards of care among the federal circuits).

402. *See* Frank, *supra* note 396, at 195-205 (providing a general overview of the EMTALA statute).

403. *Id.*

404. *See infra* Table 4 (describing that the standards of care used by courts when evaluating whether the transfer or screening procedure performed by the hospital constituted a violation of EMTALA).

TABLE 4<sup>405</sup>

<u>EMTALA Component</u>	<u>Federal EMTALA Liability</u>			<u>State Malpractice Liability</u>
	EMTALA Sub-component	Hospital	Physician	Physician
<b>Medical Screening Examination (MSE)</b>	<b>MSE</b>	<u>Objective Standard</u> 1st Cir. 9th Cir. 11th Cir. <u>Subjective Standard</u> 6th Cir. 8th Cir. 10th Cir. D.C. Cir. <u>Burden-Shifting Standard</u> 4th Cir.	Objective Standard	Objective Standard
	<b>Emergency Medical Condition</b>	Objective Standard	Objective Standard	Objective Standard
<b>Stabilization</b>	<b>To Stabilize</b>	Objective Standard	Objective Standard	Objective Standard
	<b>Stabilized</b>	Objective Standard	Objective Standard	Objective Standard
<b>Transfer</b>		Objective Standard	Objective Standard	Objective Standard

Traditionally, the standard of care with which most physicians are familiar with is the standard of care used in state medical malpractice or professional negligence actions.<sup>406</sup> State medical negligence actions are litigated under, and are based upon, the objective, reasonable prudent person standard.<sup>407</sup> According to this standard, a practicing physician is held to a level of care exercised by a same or similarly practicing reasonable physician, under same or similar

405. See Frank, *supra* note 396, at 205-12 (describing the split in the standards of care promulgated by the different federal circuits for the EMTALA screening exam requirement).

406. See *generally id.* at 232-41 (discussing malpractice standards as they apply to hospitals and to individual physicians in an analysis of a Sixth Circuit EMTALA case).

407. *Id.*

conditions.<sup>408</sup> Under most state medical malpractice laws, expert medical testimony is necessary to show what the standard of care is and precisely how it was violated.<sup>409</sup>

In the realm of EMTALA-patient dumping liability, however, the emergency physician's conduct is subject to multiple standards of care, and hospital EMTALA liability and physician negligence liability constitute different prongs of liability analysis.<sup>410</sup> First, in considering a hospital's EMTALA liability, the emergency physician's conduct will be imputed to the hospital in such a way that a determination may be made as to whether there was sufficient *hospital* compliance with EMTALA.<sup>411</sup> Here, the emergency physician's conduct, although it may fall below the negligence standard of care, may be satisfactory to satisfy some, but not all, of a hospital's EMTALA-imposed duties.<sup>412</sup> It should be noted, however, that this same conduct may not satisfy other aspects of liability exposure.<sup>413</sup>

Second, notwithstanding any imputation of physician conduct to a hospital, the emergency physician's conduct also may be evaluated from a "negligence" perspective to determine physician EMTALA liability, under an objective standard of care.<sup>414</sup> For instance, although an emergency physician's conduct may satisfy a subjective standard of care for the satisfaction of a hospital's "appropriate medical screening examination," that same conduct may not be viewed as immune from physician EMTALA liability, or physician state negligence liability, which adhere to an objective standard of care.<sup>415</sup>

There have been instances in which the emergency physician's conduct is sufficient to satisfy some of the hospital EMTALA obligations, yet below the objective standard of care reasonably

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408. *Id.* In contrast, the subjective standard is where an actor's conduct is judged according to his own conduct, and not as against a similarly situated acted in same or similar circumstances. *Id.*

409. *Id.*

410. *See supra* Table 4 (illustrating that courts will consider different standards of care depending on whether the court is evaluating hospital or physician actions).

411. *See BITTERMAN, supra* note 18, at 19 (stating that, legally, physicians are viewed as agents of the hospital and that hospitals are directly liable for all its physician's actions under EMTALA).

412. *See generally* Frank, *supra* note 396, at 232-41 (discussing the range of malpractice standards as they apply to both physicians and hospitals, and how the same action in different states could result in different findings of liability).

413. *Id.*

414. *See BITTERMAN, supra* note 18, at 19 (noting the practical implications of the principle/agent relationship between hospitals and physicians when determining liability under EMTALA).

415. *See id.* (explaining how the different standards between state and federal laws can impose different liabilities on the physician, even when a court evaluates the same action).

expected of physicians, therefore subjecting physicians to personal civil liability. Thus, the federal circuits' approach to such standards of care will now be considered.<sup>416</sup>

*1. Medical screening examination: multiple standards of care*

Many of the violations and much of the litigation involving EMTALA concern the appropriate medical screening examination provision.<sup>417</sup> This provision sends a mixed signal: it requires "appropriate"<sup>418</sup> (suggestive of an objective standard) screening, but one which is "within the capability of the . . . emergency department" (suggestive of a subjective standard).<sup>419</sup> The Sixth Circuit Court of Appeals commented on this statutory ambiguity and noted that "[a]ppropriate" is one of the most wonderful weasel words in the dictionary.<sup>420</sup> The First Circuit, quoting Ralph Waldo Emerson, noted that "appropriateness," like nature, is a "mutable cloud which is always and never the same."<sup>421</sup>

Thus, difficulties for healthcare providers who wish to comply with EMTALA consist, in part, of a lack of consensus by both the medical and legal community, with respect to the various EMTALA obligations—such as what constitutes "appropriate" medical screening.<sup>422</sup> Indeed, the federal circuits have employed varied standards of care, sending physicians and hospitals mixed messages regarding their responsibilities, and thereby complicating and threatening EMTALA compliance and government enforcement.<sup>423</sup> There are three separate applicable standards of care with respect to the "appropriate medical screening examination" EMTALA duty: (1) the objectively reasonable standard; (2) the subjective standard; and (3) the burden-shifting standard.<sup>424</sup> These standards will be discussed briefly to illustrate the varied foci and resultant confusion

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416. See generally *supra* Table 4 (illustrating the differences of standards of care regarding EMTALA violations between federal circuit courts).

417. 42 U.S.C. § 1395dd(a) (2000).

418. *Id.*

419. *Id.*

420. *Cleland v. Bronson Healthcare Group, Inc.*, 917 F.2d 266, 271 (6th Cir. 1990).

421. See *Correa v. Hosp. S.F.*, 69 F.3d 1184, 1192 (1st Cir. 1995) (discussing EMTALA's requirement for an appropriate medical screening but the lack of definition for what constitutes one).

422. Frank, *supra* note 396, at 205-06 (explaining that some federal courts find liability if no examination is given, while other circuits are only concerned that the screening examination is uniform for all patients).

423. See *id.* at 232 (noting that the ambiguity in EMTALA's language creates dilemmas for both hospitals and the intended beneficiaries of the act).

424. See *supra* Table 4 (identifying these three standards and explaining how the standards are applied differently to hospitals and physicians).

of the federal courts.

*a. The objectively reasonable standard*

The federal courts within the First, Ninth, and Eleventh Circuits have reached beyond EMTALA's plain textual meaning and have developed an objective standard for determining compliance with EMTALA's appropriate medical screening examination duty.<sup>425</sup> Although in the minority, these jurisdictions import greater obligations to this ambiguous "appropriate" duty.<sup>426</sup>

For instance, in *Correa v. Hospital San Francisco*,<sup>427</sup> the First Circuit held that a hospital fulfills its statutory duty to screen patients in its emergency department "if it provides screening examination *reasonably calculated* to identify critical medical conditions that *may be affecting* symptomatic patients *and* provides that level of screening uniformly to all those who present substantially *similar complaints*."<sup>428</sup> The Ninth Circuit, in *Eberhardt v. City of Los Angeles*,<sup>429</sup> held that if a

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425. See Caroline J. Stalker, Comment, *How Far Is Too Far?: EMTALA Moves From the Emergency Room to Off-Campus Entities*, 36 WAKE FOREST L. REV. 823, 830-34 (2001) (comparing the standard used by various federal circuits in interpreting the meaning of "appropriate medical screening examination"); see also Frank, *supra* note 396, at 206 (noting the similar approach taken by the First and Ninth Circuits in determining what is meant by an "appropriate medical screening" under EMTALA).

426. See Stalker, *supra* note 425, at 830-34 (contrasting the First, Ninth, and Eleventh Circuits' standard for determining what is an appropriate medical screening with the standard of the Fourth, Sixth, Eighth and Tenth Circuits).

427. 69 F.3d 1184 (1st Cir. 1995). In *Correa*, a sixty-five year-old female, Ms. Gonzalez, complained of "feeling real bad," experiencing "chills, cold sweat, dizziness, [and] chest pains." *Id.* at 1188. Ms. Gonzalez had her son take her to Hospital San Francisco at approximately 1:00 p.m. on September 6, 1991. *Id.* After the hospital staff "continued blithely to ignore her" for approximately two hours, Ms. Gonzalez left the hospital and went to the offices of a local physician. *Id.* at 1188-89. By the time she arrived at the doctor's office her blood pressure was 90/60. *Id.* at 1189. Ms. Gonzalez began vomiting, did not respond to fluid resuscitation, and expired from hypovolemic shock. *Id.* The defendant hospital in *Correa* did not follow its own hospital policies and procedures during the treatment of Ms. Gonzalez. *Id.* at 1193. Specifically, the hospital neither recorded her vitals signs nor referred Ms. Gonzalez immediately to a physician, as would have been consistent with the hospital's own policy regarding the evaluation of a patient with chest pain. *Id.* The court in *Correa* held the defendant's failure to provide appropriate screening to the decedent and the act of merely assigning her a number upon being told she was experiencing chest pain was so egregious and lacking in justification that it amounted to an effective denial of the screening examination required by EMTALA. *Id.* Accordingly, the First Circuit affirmed the \$700,000.00 verdict. *Id.* at 1188.

428. *Id.* at 1192 (emphasis added). Reference to the "reasonable" provision in identifying critical medical conditions is an objective approach to the determination of a standard of care for the duty of medical screening examinations.

429. 62 F.3d 1253 (9th Cir. 1995). In *Eberhardt*, Allan Eberhardt was taken to a hospital emergency department because of a heroin overdose. *Id.* at 1254. The emergency physician gave Eberhardt two two-milligram doses of Narcan and discharged the patient. *Id.* at 1255. The emergency physician testified that Eberhardt told him right before he walked out of the hospital that he was experiencing a feeling of "impending doom" and that he "was upset because we

medical screening examination is “designed to identify *acute* and *severe* symptoms that alert the physician of the need for *immediate* medical attention to prevent serious bodily injury,”<sup>430</sup> then the examination is “appropriate.”<sup>431</sup> The Eleventh Circuit, in *Gardner v. Elmore Community Hospital*,<sup>432</sup> stressed that a hospital fulfills its statutory duty to screen patients in its emergency department if it provides for a screening examination “reasonably calculated to identify *critical medical conditions* that may be afflicting symptomatic patients . . . .”<sup>433</sup>

*b. The subjective standard*

The subjective standard of care for the medical screening examination is followed primarily by the Sixth, Eighth, Tenth, and D.C. Circuits.<sup>434</sup> These circuits utilize a plain-text statutory analysis and consider the legislative purpose of EMTALA<sup>435</sup> in attempting to determine what is meant by “appropriate medical screening examination.” This type of textual analysis generally employs five legal axioms: (1) EMTALA is not a federal malpractice statute and it

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saved his life.” *Id.* Thirty hours after discharge from the emergency department, Eberhardt was found with a machete, breaking the windows of a private residence. *Id.* When the police arrived, Eberhardt charged at them shouting “kill me” and “put me out of my misery.” *Id.* The police shot and killed Eberhardt, after which Eberhardt’s survivors brought suit against the hospital, claiming the hospital negligently failed to detect Eberhardt’s suicidal tendency. *Id.* The Ninth Circuit held that because Eberhardt’s symptoms were not acute or severe, the hospital did not bear any EMTALA liability. *See id.* at 1258 (holding that absent a proffer of any evidence showing manifestation of “acute” or “severe” symptoms, the hospital fulfilled its responsibility to provide an appropriate medical screening examination comparable to that offered other patients with similar symptoms).

430. *Id.* at 1257 (emphasis added).

431. *See id.* at 1257-58. The Ninth Circuit did not focus on the capabilities of an emergency department nor whether a particular medical screening examination was applied equitably, but rather relied upon an objective interpretation of the statutory language. *Id.*

432. 64 F. Supp. 2d 1195 (M.D. Ala. 1999). In *Gardner*, plaintiffs filed a cause of action under EMTALA alleging, in part, violation of the medical screening provisions. *Id.* at 1198-1200. Plaintiffs were victims of motor vehicle accidents who were initially evaluated at Elmore Community Hospital (“Elmore”), and later evaluated at Baptist Medical Center. *Id.* Plaintiffs alleged that Elmore violated EMTALA’s medical screening examination by not detecting various facial and rib fractures which were in fact diagnosed at Baptist. *Id.* at 1200. The *Gardner* court, considering both the purpose and rationale behind EMTALA, noted that the “First Circuit has defined the ‘appropriate medical screening requirement’ more thoroughly” than its own circuit. *Id.* at 1201. The court held that the plaintiffs failed to meet their burden of production regarding defendant’s motion to dismiss and thereby granted the defendant’s motion. *Id.* at 1202.

433. *Id.* at 1202.

434. Frank, *supra* note 396, at 206-07. Although Frank includes the Eleventh Circuit in the subjective interpretation category, I include the Eleventh Circuit under the objective category for reasons stated above.

435. *Id.*

does not set a national emergency health care standard;<sup>436</sup> (2) “appropriate medical screening examination” is not judged by its proficiency in accurate diagnosis; rather what is dispositive is whether the examination was performed equitably in comparison to other patients with similar symptoms;<sup>437</sup> (3) a misdiagnosis, failure to properly diagnose, or failure to order additional diagnostic tests does not bring liability under EMTALA for inappropriate medical screening, but rather may constitute negligence or malpractice under a state tort action;<sup>438</sup> (4) a key issue is whether a hospital’s procedures

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436. *Marshall v. E. Carroll Parish Hosp.*, 134 F.3d 319, 322 (5th Cir. 1998) (agreeing with other circuits which have held that EMTALA “*was not intended to be used as a federal malpractice statute*” but rather was passed to prevent patient dumping) (emphasis added); *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996) (en banc) (holding that EMTALA is not a federal malpractice statute, does not establish a national emergency health care screening standard, and claims of misdiagnosis or inadequate treatment should be the province of state malpractice law); *Urban v. King*, 43 F.3d 523, 525 (10th Cir. 1994) (stating clearly that EMTALA “is neither a malpractice nor a negligence statute”); *see Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139, 142 (4th Cir. 1996) (noting that other circuits universally agree with the idea that EMTALA should be distinguished from standard claims of negligence and misdiagnosis); *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995) (stating that the language of EMTALA declines to impose a national standard of care upon hospitals’ screening of patients); *Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519, 522 (10th Cir. 1994) (asserting that § 1395dd(a) specifically precludes the establishment of a federal standard for malpractice); *Holcomb v. Manahan*, 30 F.3d 116, 117 (11th Cir. 1994) (stating that § 1395dd(a) does not create a basis for federal malpractice claims resulting from misdiagnosis); *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 879-80 (4th Cir. 1992) (stating that the language of EMTALA clearly indicates that it was not intended to establish a national standard for screening emergency room patients); *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991) (holding that EMTALA does not create a sweeping federal cause of action for medical malpractice claims which are traditionally covered by state law); *see also Correa v. Hosp. S.F.*, 69 F.3d 1184, 1192 (1st Cir. 1995) (holding that EMTALA does not create a federal cause of action for medical malpractice).

437. *Marshall*, 134 F.3d at 322 (stating an appropriate medical screening is one performed equitably among all patients with similar symptoms); *see Vickers*, 78 F.3d at 144 (contending EMTALA is only violated when patients *perceived* to have the same symptoms receive disparate screening, not when patients who *in fact* have the same symptoms receive disparate treatment); *Summers*, 91 F.3d at 1138 (noting that inappropriate treatment occurs when patients with similar symptoms receive different treatment within the hospitals capabilities; EMTALA does not create a rule that patients are entitled to non-negligent or correct treatment, but rather they are entitled to be treated as other similarly situated patients); *Correa*, 69 F.3d at 1192-93 (holding that faulty or negligent screening does not contravene EMTALA, but rather EMTALA is violated by disparate screening and the refusal to follow established procedures); *Holcomb*, 30 F.3d at 117 (stating that a hospital is in compliance with EMTALA as long as it screens paying and indigent patients in the same manner); *Repp*, 43 F.3d at 522 (noting that the required standard of “appropriate medical screening” varies with each hospital and a hospital, therefore, violates § 1395dd(a) when it does not follow its own established practices and procedures for screening emergency room patients).

438. *See Marshall*, 134 F.3d at 322 (noting that while a misdiagnosis may constitute malpractice or negligence, it can not support a claim of inappropriate screening under EMTALA); *Vickers*, 78 F.3d at 143 (stating EMTALA does not establish a duty of care for hospitals requiring a correct diagnosis during emergency room screening,

were uniformly followed, or would have been offered to any other patient in a similar condition with similar symptoms;<sup>439</sup> and (5) an inappropriate medical screening examination concerns disparate treatment or impact upon a patient which then will constitute an EMTALA violation.<sup>440</sup>

Individual circuits, however, have focused on different aspects of these principles to formulate their subjective standard. In *Gatewood v.*

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but rather, that is a matter of state malpractice law); *Eberhardt*, 62 F.3d at 1258 (maintaining that state law, not EMTALA, would be the appropriate authority to settle whether the hospital was liable for failure to identify suicidal tendencies of a patient); *Baber*, 977 F.2d at 880 (declaring that issues of misdiagnosis and negligent treatment are best resolved under state malpractice theories of recovery); *Gatewood*, 933 F.2d at 1039 (affirming the district court's ruling that as long as the hospital in question did not deviate from its own established procedures in screening patients, issues relating to diagnosis remain within the exclusive domain of state malpractice law); *see also Summers*, 91 F.3d at 1139 (agreeing with the district court that faulty screening alone is not a cause of action under EMTALA).

439. *Marshall*, 134 F.3d at 323 (affirming that an "appropriate medical screening examination" is an examination that a "hospital would have offered to any other patient in a similar condition with similar symptoms"); *see Summers*, 91 F.3d at 1137 (holding that EMTALA requires patients to be treated as other similarly situated patients, but EMTALA does not require correct or non-negligent treatment); *Eberhardt*, 62 F.3d at 1258 (stating that the test for an EMTALA violation is "whether the challenged procedure was identical to that provided similarly situated patients as opposed to whether the procedure was adequate as judged by the medical profession"); *Correa*, 69 F.3d at 1192 (noting that the "essence" of the medical screening requirement is that there be some screening procedure that is administered even-handedly); *Holcomb*, 30 F.3d at 117 (holding that EMTALA "only requires a hospital to provide indigent patients with a medical screening similar to one which they would provide any other patient"); *Repp*, 43 F.3d at 522 (stating that § 1395dd(a) requires a hospital to provide a medical screening "that is appropriate within the capability of the hospital's emergency department"; this requirement is, therefore, hospital-specific, "varying with the specific circumstances of each provider"); *Baber*, 977 F.2d at 879 (holding the plain language of EMTALA requires a screening procedure that is applied "uniformly to all patients with similar complaints"); *Gatewood*, 933 F.2d at 1041 (maintaining EMTALA is intended to ensure each patient is accorded the same level of treatment as other patients in similar circumstances, not to ensure a proper diagnosis); *Cleland v. Bronson Healthcare Group, Inc.*, 917 F.2d 266, 268 (6th Cir. 1990) (interpreting the phrase "appropriate medical screening" to mean an examination that would have been offered to any paying patient); *see also Vickers*, 78 F.3d at 143 (stating that the "appropriate medical screening" provision is aimed at disparate treatment) (citing *Brooks v. Md. Gen. Hosp.*, 996 F.2d 708, 713 (4th Cir. 1993)).

440. *See Vickers*, 78 F.3d at 144 (maintaining a claim under EMTALA exists only when patients who are *perceived* to have the same conditions receive disparate treatment, not when patients who *in fact* have the same conditions receive disparate treatment); *Summers*, 91 F.3d at 1138 (stating that an emergency room screening that has a disparate impact on the plaintiff should be considered inappropriate for EMTALA purposes); *Repp*, 43 F.3d at 522 (holding that a hospital violates § 1395dd(a) when it does not follow its own established screening procedures); *see also Marshall*, 134 F.3d at 323-24 (observing that the plaintiff bears the burden of showing that the hospital treated the plaintiff differently from other patients; the burden is not on the hospital to show that it had a uniform screening); *Williams v. Birkeness*, 34 F.3d 695, 697 (8th Cir. 1994) (emphasizing plaintiffs must prove the hospital treated one patient "differently from other patients" to have a claim under EMTALA).

*Washington Healthcare Corp.*,<sup>441</sup> for instance, the D.C. Circuit Court of Appeals reasoned that what constitutes an “appropriate” screening is properly determined not by reference to particular outcomes, but instead by reference to a hospital’s own standard screening procedures.<sup>442</sup> The Sixth Circuit, in *Cleland v. Bronson Health Care Group, Inc.*,<sup>443</sup> and the Tenth Circuit, in *Repp v. Anadarko Municipal*

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441. 933 F.2d 1037 (D.C. Cir. 1991). In *Gatewood*, the victim, Mr. Gatewood died of a heart attack after being discharged from the emergency department of Washington Hospital Center (“WHC”) with a diagnosis of suffering from “musculoskeletal pain.” *Id.* at 1038. Mr. Gatewood complained of pain radiating down his left arm and into his chest. *Id.* at 1039. Mr. Gatewood was evaluated by Dr. Mehlman, a resident, who examined him and performed blood tests, a chest x-ray and an EKG. *Id.* Dr. Laygo, the attending physician, also examined Mr. Gatewood. *Id.* Mr. Gatewood was discharged from the hospital with instructions to use a heating pad and over-the-counter analgesics for his pain. *Id.* Mr. Gatewood died the next morning from a heart attack. *Id.* Mrs. Gatewood filed a suit alleging EMTALA violations and a state malpractice action. *Id.* at 1038. The district court held that EMTALA was intended to prohibit “dumping” of patients for economic reasons, and that it provided no cause of action for fully insured patients presenting typical claims of “failure to properly diagnose.” *Id.* at 1039 (summarizing the district court’s May 23, 1990 ruling). The D.C. Circuit Court of Appeals ruled that whether a patient carries health insurance is not critical to a claim under EMTALA, which by its own terms covers “any individual” who presents at an emergency department. *Id.* However, the court of appeals affirmed the dismissal of the complaint for failure to state a claim upon which relief can be granted. *Id.* Similarly, the court noted, any departure from standard screening procedures constitutes inappropriate screening in violation of EMTALA. *Id.* at 1041. The court made clear that the motive for such departure is not important to this analysis, which applies whenever and for whatever reason a patient is denied the same level of care provided others and guaranteed him or her by § 1395dd(a). *Id.* at 1041. “Absent some allegation of differential treatment,” then, no claim can be stated under § 1395dd(a). *Id.* The D.C. Circuit found that the appellant failed to state a cognizable claim under the federal statute and absent a viable federal cause of action the district court’s dismissal of the case was affirmed for lack of jurisdiction. *Id.* at 1041-42.

442. *Id.* at 1042. The *Gatewood* court also relied on the plain text meaning of the federal statute to hold that it “unambiguously extends” protections to “any individual” who seeks emergency department assistance. *Id.* at 1040. Here, the D.C. Circuit relied on the canons of statutory interpretation, citing courts are bound by statutory language when it is so clear that where, as here, “it is not manifestly inconsistent with legislative intent.” *Id.* (citing *United Mine Workers of Am. v. Federal Mine Safety & Health Review Comm’n*, 671 F.2d 615, 621 (D.C. Cir. 1982); *Aviation Consumer Action Project v. Washburn*, 535 F.2d 101, 106-07 (D.C. Cir. 1976)). The court noted its history makes clear that EMTALA is intended not to ensure each emergency department patient a correct diagnosis, but rather to ensure each patient “is accorded the same level of treatment regularly provided to patients in similar medical circumstances.” *Id.* at 1041.

443. 917 F.2d 266 (6th Cir. 1990). The Clelands took their fifteen-year-old son to the Bronson Methodist Hospital emergency department (“Bronson”) complaining of lower abdominal cramps and vomiting. *Id.* at 268. The child was diagnosed as having influenza and was discharged four hours later. *Id.* However, the child was actually suffering from intestinal intussusception, a condition where a part of the intestine telescopes within itself. *Id.* Less than twenty-four hours after his discharge from Bronson, the child suffered a cardiac arrest and died. *Id.* The parents of Cleland filed a cause of action under EMTALA, alleging, in part, that defendants failed to provide for an appropriate medical screening. *Id.* The district court dismissed the Clelands’s complaint for failure to state a cause of action, based on its

*Hospital*,<sup>444</sup> also focused on the peculiarities of a particular hospital. The *Cleland* court referred to an appropriate medical screening examination by a hospital as being “within its capabilities,”<sup>445</sup> whereas the *Repp* court interpreted EMTALA’s requirement as being “hospital-specific, varying with the specific circumstances of each provider.”<sup>446</sup> The Eighth Circuit, in *Summers v. Baptist Medical Center Arkadelphia*,<sup>447</sup> reasoned that “something more than, or different

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interpretation that EMTALA applied only to indigent and uninsured patients. *Id.* The Sixth Circuit Court of Appeals affirmed, but on different grounds. *Id.* Because there was no allegation that the screening was in any way different than would have been offered to any other patient, or was deficient in any way peculiar to the patient’s characteristics, the judgment of the district court dismissing the case was affirmed. *Id.* at 272.

444. 43 F.3d 519 (10th Cir. 1994). In *Repp*, Mr. Repp sought emergency care from the Anadarko Municipal Hospital (“Anadarko”) for pain throughout his left arm. *Id.* at 521. Mr. Repp informed the nurses he had previously undergone cardiac bypass surgery. *Id.* While in the emergency department, Mr. Repp’s doctor was contacted, who prescribed two different injections of medications. *Id.* After receiving the injections, Mr. Repp returned home, where he died in his sleep from a cardiac arrest. *Id.* Plaintiffs, who were Mr. Repp’s survivors, brought suit under EMTALA alleging that defendants (Anadarko, Dr. Jay Belt, Anadarko Medical Clinic, P.C., and C. Bilyeu, L.P.N.) violated their own policies and did not provide Mr. Repp with a proper medical screening examination. *Id.* Plaintiffs additionally brought a state malpractice action against all defendants. *Id.* at 521 n.2. The district court granted summary judgment for all defendants and plaintiffs appealed. *Id.* at 521. Although the Sixth Circuit Court of Appeals found “appropriate medical screening” to be an ambiguous phrase, the court believed the language of § 1395dd(a) precluded the adoption of a standard tantamount to a federal malpractice statute. *See id.* at 522 (emphasizing that Congress did not intend EMTALA to serve as a medical malpractice statute). The Sixth Circuit Court of Appeals held that a hospital violates § 1395dd(a) when it does not follow its own standard procedures. *Id.* Accordingly, the Sixth Circuit affirmed the district court’s grant of summary judgment for defendants. *Id.* at 523.

445. *Cleland*, 917 F.2d at 272. The *Cleland* court stated that to resort to a malpractice or other objective standard of care for the meaning of the term “appropriate” was precluded by the terms of the statute. *Id.* Rather, “appropriate,” the court believed, “must more correctly be interpreted to refer to the motives with which the hospital acts”—thereby establishing a subjective standard. *Id.* Motives the court considered, without limitation, included race, sex, politics, occupation, education, personal prejudice, and drunkenness. *Id.* Although the “motive” aspect of *Cleland* was overturned by *Roberts v. Galen of Virginia, Inc.*, 525 U.S. 249, 253 (1999), motive is the essence of subjectivity. The *Cleland* court believed if a hospital acts in the same manner as it would have for the usual paying patient, then the screening provided is “appropriate” within the meaning of the statute. *Cleland*, 917 F.2d at 272.

446. *Repp*, 43 F.3d at 522. The *Repp* court reasoned that EMTALA does not require a hospital to provide a medical screening in the abstract, but one that is appropriate “within the capability” or within the “particular conditions of each individual emergency room,” including ancillary services routinely available to the emergency department. *Id.*

447. 91 F.3d 1132 (8th Cir. 1996) (en banc). In *Summers*, Harold Summers fell out of a tree stand while deer hunting after which he was taken by ambulance to Baptist Medical Center Arkadelphia (“Baptist”). *Id.* at 1135. The emergency physician ordered four x-rays of the patient’s spine as well as other routine tests. *Id.* Although Baptist conceded that Summers complained of chest pain, the emergency doctor testified that Summers did not complain of pain in the front part of his chest. *Id.* No x-rays of the chest were taken. *Id.* The emergency physician at Baptist

from,”<sup>448</sup> ordinary negligence in the emergency department screening process must be shown to make out a federal claim under EMTALA.<sup>449</sup> The court held that the “something” required was a “lack of uniform treatment.”<sup>450</sup>

*c. The burden-shifting standard*

The Fourth Circuit, in *Power v. Arlington Hospital Ass’n*,<sup>451</sup>

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believed the spinal x-rays showed only an old break at the eighth thoracic vertebra. *Id.* Summers was told he was suffering from mucourte spasms. *Id.* Although Summers requested to be admitted to the hospital, he was given pain injections and discharged. *Id.* The next day Summers went by ambulance to St. Bernard’s Regional Medical Center in Jonesboro, Arkansas, where he underwent a chest x-ray and computerized tomography. *Id.* Multiple fractures to the rib, vertebra, and sternum were revealed from the scan. *Id.* at 1135-36. Summers was subsequently hospitalized at Jonesboro for fourteen days, some of that time in intensive care. *Id.* at 1136. Summers filed an EMTALA claim alleging Baptist had “failed to provide for an appropriate medical screening examination within the capability of [its] . . . emergency department . . .” *Id.* The lower court granted Baptist’s motion for summary judgment and dismissed the complaint. *Id.* at 1135. Summers sought review in the appeals court. *Id.* The court concluded:

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.

*Id.* at 1139.

448. *Id.* at 1138.

449. *Id.* Thus, a medical screening examination is deemed inappropriate if it has any type of “disparate impact on the patient.” *Id.* The court held that patients are entitled to be treated as “other similarly situated patients are treated, within the hospital’s capabilities.” *Id.* The court noted further that once a hospital determines on its own what its screening procedures will be, it must apply them uniformly to all patients. *Id.* (citing *Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139, 143 (4th Cir. 1996); *Correa v. Hosp. S.F.*, 69 F.3d 1184, 1192-93 (1st Cir. 1995); *Repp*, 43 F.3d at 522; *Holcomb v. Monahan*, 30 F.3d 116, 117 (11th Cir. 1994)).

450. *Id.* The court also held, with respect to determining the appropriateness of a medical screening examination, that an emergency physician is only required by EMTALA to screen and treat a patient for those conditions the physician “perceives the patient to have.” *Id.* at 1139.

451. 42 F.3d 851 (4th Cir. 1994). In *Power*, Susan Power was evaluated at the Arlington Hospital (“Arlington”) emergency department for pain in her left hip, lower abdomen, and back running down her leg; inability to walk; shaking; and severe chills. *Id.* at 853. She was evaluated by two physicians and was given a prescription for pain medication, the name of an orthopedist, and was discharged. *Id.* The following day, Power again appeared at the Arlington emergency department in an unstable condition and with barely existent blood pressure. *Id.* Upon diagnosing her with septic shock, Arlington admitted Power without delay to the intensive care unit (“ICU”). *Id.* During her four month stay in the ICU, Power was maintained on life support, suffered the amputation of both legs below the knee, became blind in one eye, and was stricken with severe and permanent lung damage. *Id.* After five months of hospitalization she was eventually transferred from Arlington to another hospital in her hometown of London, England. *Id.*

Power sued Arlington under EMTALA, alleging that it failed to give her an “appropriate medical screening” during her first visit to the emergency department. *Id.* at 853-54. Power also argued that Arlington violated EMTALA by moving her to the hospital in London while her condition was unstable. *Id.* at 854. The district

formulated yet a different standard which consisted of a three-step, burden-shifting process to determine the correct standard of care to be utilized in the determination of whether the EMTALA “appropriate medical screening examination” obligation was satisfied.<sup>452</sup> First, the plaintiff has the burden of making a threshold showing of differential treatment (subjective standard).<sup>453</sup> Second, the hospital is permitted to offer rebuttal evidence indicating either that the patient was provided the same degree of care afforded to all patients, or that a test or procedure was bypassed because the treating physician determined that the individual circumstances of the patient

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court denied Arlington’s motion for summary judgment on Power’s EMTALA claim, finding that there were genuine issues of material fact. *Id.* The district court ruled that Power’s EMTALA causes of action were not controlled by the Virginia cap on medical malpractice damages, VA. CODE ANN. § 8.01-581.15 (Michie 1992), or the Virginia liability limits for tax-exempt hospitals, *id.* § 8.01-38. *Power*, 42 F.3d at 854. A jury returned a verdict in favor of Power on the screening claim and awarded actual damages of five million dollars. *Id.* The jury found in favor of Arlington on the EMTALA transfer claim. *Id.*

On appeal, Arlington’s main issue concerned the appropriate legal standard for recovery in an EMTALA claim. *Id.* at 854. Other issues on appeal included: EMTALA’s interrelationship with the two Virginia statutes, medical malpractice suit caps, and the limits on liability for tax-exempt hospitals. *Id.* The court noted that Power had plainly provided sufficient evidence to meet the threshold requirement of an EMTALA claim from which a jury could conclude that she was evaluated differently from other patients treated at the Arlington emergency department, and that Arlington did not uniformly apply its standard screening procedure. *Id.* at 856. Arlington had the chance to present evidence that the emergency department treated Power no differently than other patients, or that any deviation from standard procedures was based on the determination of the treating physician as to what was medically required. *Id.* at 859. In response, Power submitted evidence from qualified medical experts who testified that, for a patient with Power’s symptoms, a blood test was an essential part of a medical screening examination at Arlington’s emergency department. *Id.* The Fourth Circuit upheld the jury’s verdict in favor of Powers and her claim under EMTALA. *Id.* at 869. However, the court reversed the holding that Virginia’s medical malpractice damages cap and limit on liability for tax-exempt hospitals were inapplicable to EMTALA claims. *Id.* The court stated that the state’s limitation on damages was applicable, and recovery should have been limited to one million dollars under VA. CODE ANN. § 8.01-581.15. *Power*, 42 F.3d at 861. In addition, the liability limit for the tax-exempt hospital should have applied, under VA. CODE ANN. § 8.01-38, because the action was one for negligence or other tort. *Power*, 42 F.3d at 864-65.

452. *Power*, 42 F.3d at 856. The Fourth Circuit noted it previously held that “[t]he plain language of [EMTALA] requires a hospital to develop a screening procedure designed to identify such critical conditions that exist in symptomatic patients and to apply that screening procedure uniformly to all patients with similar complaints.” *Id.* The court relied on *Barber v. Hospital Corp. of America*, 977 F.2d 872, 879 (4th Cir. 1992), which stressed that EMTALA requires more than simply having a screening procedure in place. *Power*, 42 F.3d at 859 (citing *Barber*, 977 F.2d at 879). Rather, adherence to EMTALA requires hospitals to *uniformly* apply screening procedures. *Id.* In *Power*, two emergency room physicians testified that Arlington lacked written guidelines detailing appropriate medical screening procedures for emergency department doctors to follow when evaluating patients. *Id.* at 855.

453. *Id.* at 858. This initial burden of the plaintiff is more akin to the objective standard of care.

(objective standard) did not necessitate the test or procedure.<sup>454</sup> Third, if a hospital submits such rebuttal evidence, the plaintiff is then given the opportunity to use the his own medical testimony (subjective standard) to challenge the physicians' medical opinions.<sup>455</sup>

2. *Stabilization: objective standard of care*

Although multiple standards of care may be imposed in evaluating an appropriate medical screening examination, the duty of stabilization employs an objective standard. Stabilization involves two considerations: actual patient stabilization and stabilization during transfer.<sup>456</sup> To be sure, according to the plain text of EMTALA, stabilization has occurred when such treatment has been provided as may be necessary to assure "within *reasonable medical probability*"<sup>457</sup> that "no material deterioration of the condition is likely."<sup>458</sup> Thus, a professional (objective) standard, rather than the standard of a particular hospital, is used.<sup>459</sup>

Some flexibility, however, is provided for within the objective standard of care of EMTALA's duty of stabilization, as shown in

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454. *Id.* This rebuttal evidence of the hospital is more akin to the subjective standard of care.

455. *Id.* The court stressed that this is particularly true in a case like *Power* where a hospital has denied that it maintains any standard emergency protocols or procedures, noting that there, the Fourth Circuit ruled that EMTALA's plain language dictates that hospitals must create screening procedures and apply them consistently. *Id.* (citing *Barber*, 977 F.2d at 879).

456. See 42 U.S.C. § 1395dd(e)(3)(A)-(B) (2000) (explaining that the difference between "to stabilize" and "stabilized" is that "to stabilize" a patient involves the provision of the medical treatment required for a patient to be considered "stabilized" such that the likelihood of "material deterioration" during transfer to another medical facility is practically non-existent).

457. *Id.*

458. *Id.*; accord *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1259 n.3 (9th Cir. 1995) (asserting that the stabilization mandate requires hospitals to provide care tailored to meet the needs of each patient's emergency medical condition—not to dispense "uniform stabilizing treatment"); *In re Baby K*, 16 F.3d 590, 596 (4th Cir. 1994) (stating that rather than providing merely "uniform treatment," the hospital must provide the requisite treatment to avoid material deterioration of the individual patient's emergency medical condition); *Thornton v. S.W. Detroit Hosp.*, 895 F.2d 1131, 1134 (6th Cir. 1990) (explaining that, once the hospital becomes aware that a patient is suffering from an emergency medical condition, it must stabilize the specific condition detected before the patient can be transferred or discharged). In cases of maternal labor, the stabilization process involves the time at which the mother has delivered the child and the placenta. 42 C.F.R. § 489.24(b)(ii)(B) (1998).

459. BARRY R. FURROW ET AL., *HEALTH LAW* 546 (1995); accord *Delaney v. Cade*, 986 F.2d 387 (10th Cir. 1993); *Green v. Touro Infirmary*, 992 F.2d 537 (5th Cir. 1993); *Burditt v. United States Dep't of Health & Human Servs.*, 934 F.2d 1362 (5th Cir. 1991); see also *Brooker v. Desert Hosp. Corp.*, 947 F.2d 412, 415 (9th Cir. 1991) (explaining that the hospital's responsibility under EMTALA ends when it has stabilized a patient's emergency medical condition).

*Cherukuri v. Shalala*.<sup>460</sup> The court in *Cherukuri* reasoned that

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460. 175 F.3d 446 (6th Cir. 1999). The main issue in *Cherukuri* was whether Dr. Cherukuri, an emergency department on-call surgeon, violated the "stabilization" requirement of EMTALA because he transferred two critically ill patients with head injuries to a regional trauma center before operating on their abdominal injuries to stop suspected internal bleeding. *Id.* at 448. In response to this violation, the Inspector General initiated an enforcement action seeking suspension of the doctor's license and \$100,000 maximum "civil penalty." *Id.* An administrative law judge working for the Secretary of the Department of Health and Human Services ruled that the surgeon was guilty and imposed the maximum fine. *Id.*

The complex facts of *Cherukuri* are quite interesting. At about 3:30 a.m. on September 15, 1991, five severely injured auto accident victims were brought to Williamson Hospital ("Williamson"), a small rural hospital in the Appalachian Mountains of Kentucky. *Id.* at 451. The Williamson emergency department consisted of an emergency physician and a registered nurse. *Id.* Upon arrival of the five trauma victims to Williamson, Dr. Cherukuri was immediately summoned to the emergency department. *Id.* Two of the five patients, Crum and Mills, had severe head injuries, internal abdominal injuries and evidence of internal bleeding. *Id.* Williamson had no trauma center and no equipment for monitoring the effect of anesthesia on the brain during surgery, and maintained a longstanding policy of refraining from performing neurosurgery on brain injuries. *Id.* at 448. Rather, as on the evening of the events in question, its protocol was to transfer such patients to other larger and better equipped hospitals. *Id.*

Dr. Cherukuri's evaluation of Crum revealed extensive brain injury and severely low blood pressure which he believed to be indicative of near-brain death. *Id.* at 451. When a small incision in Crum's stomach revealed internal bleeding, Dr. Cherukuri tentatively concluded that Crum might not survive. *Id.* However, Crum would need immediate blood and other liquid transfusions to stabilize his blood pressure. *Id.* After implementing initial resuscitative treatment, Dr. Cherukuri concluded that he would have to operate on Crum's abdomen to locate and stop the bleeding before transferring him to another hospital for brain surgery. *Id.* at 451-52. Dr. Cherukuri found patient Mills to be responsive but unconscious with an acute head injury and low blood pressure. *Id.* at 451. A small incision in his stomach indicated that Mills was also bleeding internally. *Id.*

Dr. Cherukuri attempted to arrange for anesthesia in order to operate on Crum and Mills. *Id.* The anesthesiologist on call advised strongly against operating on the patients with cranial injury and refused to provide anesthesia for any such anticipated surgery on the accident victims. *Id.* at 452. The anesthesiologist repeatedly advised that administering anesthesia for the abdominal surgery was too dangerous because Williamson lacked the equipment to monitor the anesthesia's effect on brain pressure. *Id.* No other anesthesiologists were available to Dr. Cherukuri. *Id.*

Because Dr. Cherukuri could not find an anesthesiologist to provide anesthesia that would allow him to perform intraabdominal surgery on the two patients with head injuries, both patients were transferred to St. Mary's Hospital ("St. Mary's") in Huntington, West Virginia. *Id.* at 451. Upon learning that the two patients were transferred, St. Mary's staff became irate and reported their suspicions that Dr. Cherukuri had violated EMTALA by transferring unstable patients without the receiving hospital's consent. *Id.* at 454. Based on St. Mary's report of a suspected incident of improper transfer, the U.S. government undertook an investigation and prosecution of Dr. Cherukuri. *Id.*

The administrative law judge ("ALJ") held that in cases of internal bleeding, "stabilization" "necessarily require[s]" the surgeon to perform abdominal surgery prior to transfer. *Id.* at 449. Although the ALJ acknowledged that the on-call anesthesiologist had asserted very plainly that he did not intend to administer anesthesia to the patients because of the high risk that it would result in their deaths, the ALJ nevertheless held that EMTALA "required" the surgeon "to force" the anesthesiologist to administer anesthesia by "expressly ordering him to do so." *Id.* at 452. According to the ALJ, EMTALA "necessarily required" Dr. Cherukuri to force

EMTALA's statutory definitions regarding stabilization are "not given a fixed or intrinsic meaning."<sup>461</sup> Rather, the meaning of stabilization "is purely contextual or situational."<sup>462</sup> Thus *Cherukuri* held that "to stabilize" requires a "flexible standard of reasonableness" that depends on the circumstances.<sup>463</sup>

### 3. *Transfer: objective standard of care*

EMTALA is silent as to the applicable standard of care to be used to determine statutory compliance with the patient transfer provision.<sup>464</sup> Because patient dumping litigation resulting from EMTALA transfer violations involves the interrelationship<sup>465</sup> of

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the anesthesiologist "against his will" to administer anesthesia. *Id.*

The Sixth Circuit Court of Appeals declined to enforce the order of the ALJ, and set aside the administrative decision. *Id.* at 449. The Sixth Circuit noted that EMTALA in no way mandated such a "confrontation" as proposed by the ALJ. The Sixth Circuit found the ALJ's conclusions erroneous. *Id.* at 452.

461. *Id.* at 449. In this regard, the capabilities of a particular hospital, as well as a patient's specific circumstances, remain pertinent issues of law and medicine. *See also In re Baby K*, 16 F.3d at 596 (emphasizing that meeting the standard of dispensing reasonable treatment under the circumstances may require the provision of a hospital or its standard practices); *Burditt*, 934 F.2d at 1369 (explaining that EMTALA requires treatment that would prevent material deterioration of the patient's emergency medical condition during transfer); *Deberry v. Sherman Hosp. Ass'n*, 741 F. Supp. 1302, 1305 (N.D. Ill. 1990) (noting that the term "to stabilize" involves a factual question about whether the medical care was reasonable in light of the circumstances).

462. *Cherukuri*, 175 F.3d at 449. The *Cherukuri* court explained that in determining stabilization, factors that ought to be balanced include the relative weights of: (1) what the emergency physician can do for the patient at the receiving hospital; (2) what services would be available to the patient at the receiving hospital; (3) the patient's current condition; and (4) the risk that the patient's condition will deteriorate during the transfer. *Id.* at 450. Here, the *Cherukuri* court cited *Bryan v. Rectors & Visitors of the University of Virginia*, 95 F.3d 349, 352 (4th Cir. 1996), noting that the Fourth Circuit also held that in terms of transfer, "stabilize" is a relative concept that varies with the circumstances. *Cherukuri*, 175 F.3d at 450.

463. *Cherukuri*, 175 F.3d at 454. Also, the *Cherukuri* court affirmatively cited the position set forth in the brief filed by the Solicitor General of the United States in *Roberts v. Galen of Virginia, Inc.*, 525 U.S. 249 (1999), in which the Solicitor General, on behalf of the United States Secretary of Health and Human Services (the "Secretary"), explained that the definition of "stabilization" establishes an "objective" standard of "reasonableness," based on the specific circumstances at hand and "requires merely that a hospital stabilize patients within the staff and facilities at the hospital." *Cherukui*, 175 F.3d at 450. The court also cited the Solicitor General's reference to a statement of Senator Bob Dole, a co-sponsor of EMTALA, who had stated that "a hospital is charged *only* with the responsibility of providing an adequate first response to a medical crisis" which "means the patient must be evaluated and, at a minimum, provided with whatever medical support services and/or transfer arrangements that are consistent with the capability of the institution and the well-being of the patient." *Id.* at 451 (citing 131 CONG. REC. 28,569 (1985)).

464. *See* 42 U.S.C. § 1395dd(a)-(c) (2000) (detailing the medical treatment that hospitals are required to provide to emergency room patients in terms of transfer, but containing nothing about the necessary standard of care).

465. Litigation concerning patient transfer generally involves three questions.

medical and legal principles of patient stabilization and transfer, the U.S. Solicitor General's position in *Roberts v. Galen of Virginia, Inc.*,<sup>466</sup>

First, courts consider issues which relate back to sufficiency determinations of whether necessary stabilizing treatment of an emergency medical condition was in fact adequate for stabilization. *See, e.g., Roberts*, 525 U.S. at 252. Although the main issue in *Roberts* focuses on whether improper motive is a required element to establish an EMTALA violation, the fact pattern and subsequent discussion of patient transfer is a prime example of the interrelationship between the issue of transfer raising the sufficiency consideration of prior necessary stabilizing treatment of the patient's emergency medical condition. *Id.*

Second, courts determine whether the transfer involved an unstable medical condition where the physician completes a legal certification indicating that the "medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual." 42 U.S.C. § 1395dd(c)(1)(A)(ii). *See Burditt*, 934 F.2d at 1371-72 (concluding that the physician's testimony as to his weighing the benefits and risks of transfer was incredible because he made an "immediate and unwavering decision" to transfer the patient when he learned of her condition over the phone); *Owens v. Nacogdoches County Hosp. Dist.*, 741 F. Supp. 1269, 1279 (E.D. Tex. 1990) (noting the physician's testimony that he weighed the benefits and risks of transfer was incredible, where he risked sending a sixteen year old pregnant girl with labor pains to a hospital four hours away without providing transportation, rather than risk stunting the growth of the baby).

Third, courts must decide whether the transfer was "appropriate" under EMTALA. 42 U.S.C. § 1395dd(c)(2). *See Owens*, 741 F. Supp. at 1276 (asserting that the patient's private automobile did not satisfy EMTALA's requirements for adequate transportation where a physician's direction for the patient to go to another hospital qualified as a transfer); *Burditt*, 934 F.2d at 1372-73 (describing the transfer of a high risk hypertensive labor patient to a hospital three hours away, where neither the medical personnel nor the equipment in the ambulance were considered satisfactory under EMTALA); *Wey v. Evangelical Cmty. Hosp.*, 833 F. Supp. 453, 466 (M.D. Pa. 1993) (finding in favor of the hospital ordering a transfer, where no expert medical testimony was offered to indicate that a private automobile transfer of a patient who was not able to comply with directions to keep the injured limb elevated and continued to suffer from pain, was medically inappropriate and violative of EMTALA).

466. 525 U.S. 249 (1999). Accordingly, a review of the facts in *Roberts* is helpful. In *Roberts*, Wanda Y. Johnson sustained injuries when she was struck by a vehicle in May 1992. Brief of Amicus Curiae United States at 5, *Roberts v. Galen of Va., Inc.*, 525 U.S. 249 (1999) (No. 97-53) [hereinafter Solicitor General Brief]. Her injuries were life-threatening, and she was taken to the Galen of Virginia hospital ("Galen") (formerly DBA Humana Hospital, University of Louisville) in Louisville, Kentucky, where she was treated for two months. *Id.* at 5. She suffered multiple infections and complications. *Id.* (citing Pet. App. at A27). In July 1992, Galen transferred Johnson, who lacked medical insurance, to Crestview Health Care Facility, a licensed nursing facility in Indiana. *Id.* (citing Pet. App. at A27). At the time of transfer, Johnson was being treated for an active infection. *Id.* at 5 (citing Pet. App. at A27). The day after Johnson's transfer to the nursing facility, Johnson's condition worsened and she was transferred to Midwest Medical Center, a nearby Indianapolis hospital, where she was treated for several months. *Id.* (citing Pet. App. at A27). Petitioner, Johnson's guardian, filed a federal suit on August 30, 1993, singularly alleging that Galen had violated EMTALA 42 U.S.C. § 1395dd(b) by transferring Johnson to the nursing facility before stabilizing her condition. *Id.* at 5 (citing Pet. App. at A27).

The district court initially denied Galen's motion for summary judgment on the EMTALA claim because it concluded that a genuine issue of material fact existed as to whether Johnson was stabilized at the time of transfer. *Id.* at 6. The district court also held, citing the Sixth Circuit's decision in *Cleland v. Bronson Health Care Group*,

with respect to the analysis of the standard of care applicable to necessary stabilizing treatment, again is informative. In *Roberts*, the Solicitor General comprehensively dissected all provisions of EMTALA which pertain to an objective standard of care.<sup>467</sup> Notably, the government identified four key loci within EMTALA that pointed strongly to an objective standard.

First, the government inter-related the standard of care of 42 U.S.C. § 13295dd subsection (a) with (b).<sup>468</sup> In *Roberts*, the government relied upon the statutory definition of the term “emergency medical condition,”<sup>469</sup> indicating that a “reasonableness

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*Inc.*, 917 F.2d 266, 271 (1990), that “the presence of an improper motive [is] an essential element in a claim for relief under § 1395dd,” and that there was also a disputed issue of material fact as to whether the hospital transferred Johnson with an improper motive. Solicitor General Brief, *supra*, at 7. The court’s ruling on improper motive was based on evidence that a hospital social worker was pressured to discharge Johnson because the hospital was not receiving payment for her treatment. *Id.* (citing Pet. App. at A37-38). On a motion for reconsideration, although the district court did not alter its earlier conclusion, it granted summary judgment to Galen because “the plaintiff presented no evidence that either the medical opinion that Johnson was stable or the decision to authorize her transfer was caused by an improper motive[.]” *Id.* at 6-7 (citing Pet. App. at A50-51).

The Sixth Circuit Court of Appeals affirmed the district court’s judgment, declaring that the district court “properly interpreted the *Cleland* holding as requiring that a plaintiff prove a hospital acted with an improper motive in order to recover under the EMTALA.” *Id.* at 7 (citing Pet. App. at A10). The Sixth Circuit reasoned that proof of an improper motive is necessary for distinguishing between an EMTALA claim and a state law claim for malpractice. *Id.* at 7-8 (citing Pet. App. at A11). The Sixth Circuit did acknowledge, however, that the issue in *Cleland* was whether the hospital had complied with 42 U.S.C. § 1395dd(a) by providing the patient with an “appropriate medical screening,” whereas the issue in *Roberts* was whether the hospital violated § 1395dd(b) by neglecting to stabilize a patient with an emergency medical condition. *Id.* at 8. As such, the court of appeals concluded that *Cleland*’s improper motive requirement also pertains to cases, such as the one at hand, arising under § 1395dd(b). *Id.* The Sixth Circuit affirmed the district court’s award of summary judgment for Galen, holding that the district court correctly concluded that petitioner had not met the burden of proving an improper motive served as the impetus for discharging Johnson. *Id.* However, on certiorari, the United States Supreme Court overturned the Sixth Circuit holding, thereby establishing that proof of an improper motive is neither a necessary nor required factor for finding an EMTALA violation. *Roberts*, 525 U.S. at 250.

467. The government’s strategy was to identify as many instances as possible within the EMTALA statute which relied upon, or either directly or indirectly imposed, an objective standard, thereby showing that the opposition’s contention of EMTALA involving a subjective standard was inconsistent with the statute.

468. See Solicitor General Brief, *supra* note 466, at 2-3 (explaining that 42 U.S.C. § 1395dd(a) requires hospitals to provide patients with a proper medical examination to evaluate whether they are suffering from an emergency medical condition and, if such a condition is found to exist, § 1395dd(b) obligates the hospital to stabilize the patient within the means available at the hospital or to transfer the patient in compliance with § 1395dd(c), whereby transfer can be performed at a patient’s or legal representative’s written request).

469. See *id.* at 14-15. “Emergency medical condition” was defined as:  
a condition ‘manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could *reasonably be expected* to result in: (i) placing the health of

standard”<sup>470</sup> is yet again integrated into EMTALA.<sup>471</sup> That is, the government asserted that according to the statutory language of EMTALA, a failure to provide an adequate medical examination to a patient who had an emergency medical condition “could reasonably be expected”<sup>472</sup> to result in danger to the health or damage to bodily function in that patient.<sup>473</sup> Here, referring to the use of the “familiar”<sup>474</sup> “reasonableness standard,”<sup>475</sup> the government indicated that this definition reinforces and makes apparent that, at a minimum, hospitals are required to stabilize the conditions of those patients whose health could “reasonably be expected” to be in peril without such care, as with the transfer of a patient.<sup>476</sup>

In conjunction with this analysis, the government noted that the statutory definition of “to stabilize”<sup>477</sup> includes two requirements: (1) the hospital must guarantee “within reasonable medical probability”<sup>478</sup> that deterioration of the patient’s condition during transfer is unlikely; and (2) the term “emergency medical condition” refers to a condition that could “reasonably be expected” to put a patient’s health in significant danger.<sup>479</sup> As a result, the government concluded that “[b]oth of those ‘reasonableness’ standards support the conclusion that EMTALA imposes an ‘objective standard of care.’”<sup>480</sup>

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the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part).  
*Id.* (citing 42 U.S.C. § 1395dd(e)(1)(A)) (emphasis added).

470. *Id.* at 15.

471. *See id.* at 15-16 (insisting that the use of a reasonableness standard not be misconstrued as meaning that a hospital “will be liable only if it *intends* to treat a patient improperly or . . . with an improper motive”).

472. *Id.* at 15.

473. *Id.*

474. *Id.*

475. *Id.*

476. *Id.*

477. *Id.*

478. *Id.* at 9 (citing 42 U.S.C. § 13295dd(e)(1)(A), (3)(A) (2000)).

479. *Id.*

480. *Id.* The Solicitor General also noted that 42 U.S.C. § 1395dd(a) (requiring a hospital to provide “an appropriate medical screening examination within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department . . .”) has a *standard of care similar* to that required under 42 U.S.C. § 1395dd(b), i.e., a *reasonableness*—but not purely objective—standard, as a hospital, therefore, *cannot* be held liable under § 1395dd(b)(1)(A) on the ground that it “‘negligently’ failed to have more specialized staff or facilities at the hospital.” *Id.* at 14 n.4 (citing 42 U.S.C. § 1395dd(b)(1)(A)).

Second, the government also considered “mental state”<sup>481</sup> in its analysis of EMTALA’s standard of care.<sup>482</sup> Specifically, the government noted that the definition of “to stabilize”<sup>483</sup> elucidates the “mental state”<sup>484</sup> required of the hospital in making transfer decisions: it must make certain, “within reasonable medical probability”<sup>485</sup> that the odds of the patient’s condition worsening are low.<sup>486</sup> Consequently, the hospital is not strictly liable for a patient’s condition when it makes a transfer through such an objective standard of care analysis.<sup>487</sup>

Third, the government relied on legislative history<sup>488</sup> in arguing that Congress dealt with “patient dumping”<sup>489</sup> by imposing a “substantive standard of medical care.”<sup>490</sup> This position was substantiated by noting that all pertinent congressional committee reports and floor debate statements<sup>491</sup> express the hospital’s EMTALA duties in “objective terms.”<sup>492</sup>

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481. *Id.* at 13 (citing 42 U.S.C. § 1395dd(b)).

482. *See id.* (clarifying that the term “mental state” referred to that of the individual committing the EMTALA violation).

483. *Id.*

484. *Id.*

485. *Id.* at 14.

486. *Id.*

487. *See id.* (stating that if the hospital acts “within reasonable medical probability” (i.e., an objective standard) to ensure that any “material deterioration” of the patient’s condition is unlikely, the hospital has fulfilled its duties under such an objective standard).

488. *Id.* at 10.

489. *Id.* Here the government defined patient dumping as “refusing treatment to or transferring patients who could not pay for care.” *Id.*

490. *See id.* (stating that the substantive standard was chosen over a proscription against “acting with an improper (non-medical) [subjective] motive”). The Conference Report on EMTALA made clear that it was adopting the House proposal that “all participating hospitals must . . . provide further examination and treatment within their competence to stabilize the medical condition or provide treatment for the labor.” H.R. CONF. REP. NO. 99-453, at 473 (1985). Although the House bill required provision of “medical treatment . . . to assure that no material deterioration of the [emergency medical] condition is likely to result from the transfer of the individual,” *id.* at 477, the Senate bill added that the treatment must only provide such assurance “within reasonable medical probability.” *Id.* The Conference Committee adopted the House provision, but modified it with the Senate’s “within reasonable medical probability” standard. *Id.* Thus, the adopted compromise indicates that Congress focused on the precise standard of care to be embodied in EMTALA, and concluded that a medical reasonableness standard would provide sufficient protection against patient dumping. *Id.* at 478.

491. Solicitor General Brief, *supra* note 466, at 10.

492. *Id.* Senate floor debate and commentary concerning EMTALA support the notion that Congress chose to address the problem of emergency treatment and stabilization by imposing a medical standard of care. *See* 131 CONG. REC. 29,829, 29,835 (1985) (announcing that hospital emergency rooms are required to provide a medical evaluation and stabilize any patient presenting for care). For instance, Senator Durenberger, the bill’s floor manager, stated that the bill would “make it clear that the Medicare Program will not do business with any institution which

Lastly, the government relied on sanction provisions to bolster its identification of an objective standard.<sup>493</sup> Here, the government noted that a participating hospital that “negligently”<sup>494</sup> violates a requirement of EMTALA is subject to a civil money penalty for each such violation.<sup>495</sup>

### C. *Physician Conduct: Objective Standard of Care*

Much confusion exists in both the legal and medical professions concerning the standard of care that should be applied to emergency physicians’ conduct with respect to EMTALA obligations.<sup>496</sup> Such confusion threatens EMTALA compliance and fosters patient dumping. For instance, physicians are placed in a difficult position when they are expected to follow a particular standard of care regarding one EMTALA provision on behalf of the hospital, but their own conduct with respect to that same provision may be judged against an altogether different standard.<sup>497</sup> Because such a divergent set of standards may exist for the same EMTALA obligation, we briefly explore the basis for physician liability under EMTALA.

#### 1. *Strict liability vs. negligence*

Although traditional state medical malpractice causes of action are governed by a negligence standard, and it is commonly misperceived that EMTALA is governed by a strict liability standard,<sup>498</sup> judicial

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willfully and knowingly, or through negligence, turns its back on an emergency medical situation.” *Id.* at 28,568. Senator Kennedy, a co-sponsor, similarly stated that “every patient who has a bona fide emergency must receive stabilizing care.” *Id.* at 28,569. Senator Dole, another co-sponsor, referred to the problem of patient dumping, and added that “a hospital is charged only with the responsibility of providing an adequate first response to a medical crisis,” which “means that a patient must be evaluated and, at a minimum, provided with whatever medical support services and/or transfer arrangements that are consistent with the capability of the institution and the well-being of the patient.” *Id.*

493. See Solicitor General Brief, *supra* note 466, at 16 (indicating that “[i]f, as the Sixth Circuit held, violations of EMTALA require proof of improper motive, there could be no possibility of a ‘negligent’ violation of the Act . . .”).

494. See *id.* at 4 (stating the use of the term “negligence” in the sanction provisions allows sanctioning a hospital that is at fault regardless of whether an improper motive can be proven).

495. See *id.* (explaining a physician may also be excluded from Medicare participation and federally funded state health care programs for “gross and flagrant or repeated” violations) (citing 42 U.S.C. § 1395dd(d)(1)(A)-(B) (2000)).

496. See Frank, *supra* note 396, at 205-10 (noting schism existing between the interpretations of the circuits regarding the standard of care required by EMTALA).

497. See *id.* at 204, 213-14 (noting that “hospitals but not physicians are subject to private suits” for EMTALA violations, yet “knowledge of a medical condition is imputed to the hospital through its physicians” and thus physicians become responsible for two divergent sets of standards).

498. See *Abercrombie v. Osteopathic Hosp. Founders Ass’n*, 950 F.2d 676, 681 (10th Cir. 1991) (finding that the requirements of 42 U.S.C. § 1395dd(a) and (c)

decisions have been notably unclear as to which standard should be used to judge a physician's conduct. For instance, in *Abercrombie v. Osteopathic Hospital Founders Ass'n*,<sup>499</sup> the court specifically found that it was significant that the word "negligently" was used with respect to a physician's violation of EMTALA, but that the term was absent from the section regarding civil enforcement.<sup>500</sup> Noting further that neither the appropriate medical screening requirement, nor the requirement of only transferring stable patients incorporates a negligence standard, the court concluded that a strict liability standard applied under EMTALA.<sup>501</sup>

However, it is misleading to denominate EMTALA as a strict liability statute, especially when considering the standard against

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impose a strict liability standard for EMTALA violations); *Stevison ex rel. Collins v. Enid Health Sys., Inc.*, 920 F.2d 710, 713 (10th Cir. 1990) (finding that EMTALA contains "mandatory language" thus imposing a strict liability standard, subject to the defenses provided by the statute); *Reid, Inc. v. Indianapolis Osteopathic Med. Hosp.*, 709 F. Supp. 853, 855 (S.D. Ind. 1989) (indicating EMTALA "was based on a strict liability standard"); *Fell, supra* note 24, at 631 (noting that EMTALA generally carries a strict liability standard while state malpractice claims employ a negligence standard).

499. 950 F.2d 676, 681 (10th Cir. 1991). In *Abercrombie*, a patient who presented to an emergency department with chest pain was treated and sent home. *Id.* at 677-78. Later, on the same day of discharge, the patient was seen by her family physician who diagnosed her as having a myocardial infarction. *Id.* The patient returned to the hospital where she suffered a massive infarction and died. *Id.* at 678.

500. *Id.* at 681 (citing 42 U.S.C. § 1395dd(d)(1)(B)).

501. *Id.* Even more bizarre, the *Abercrombie* court also found that jury instructions that included reference to a negligent violation of EMTALA, rather than imposing strict liability, were impermissible, yet merely constituted harmless error. *Id.* at 680-81. Some cases have held that EMTALA does not impose a strict liability standard. *See, e.g., Barris v. City of Los Angeles*, 972 P.2d 966, 972 (Cal. 1999) (stating EMTALA requires "actual knowledge by the hospital" and is, therefore, not a strict liability statute); *Stevison v. Enid Health Syst., Inc.*, 920 F.2d 710, 713 (10th Cir. 1990) (construing EMTALA as imposing a strict liability standard. Most of what is published regarding the relationship of strict liability to EMTALA is directed at hospitals, rather than physicians. *See Terry J. Wechsler, Tenth Circuit Survey: Health Law*, 73 DENV. U. L. REV. 767 (1996) (stating that EMTALA imposes strict liability on hospitals, and further, that the hospital carries the burden of proof in refuting an alleged EMTALA violation). Some authors have noted that the strict liability standard has been inappropriately applied as an "exceedingly strict liability" standard, and has only been applied to certain provisions of EMTALA. *See Frank, supra* note 396, at 212-13 (asserting that, in order to most faithfully preserve the meaning of the text, courts should refrain from interpreting the stabilization provision in isolation, and accordingly, should employ a conjunctive reading of the various provisions); *Caroline J. Stalker, How Far is Too Far?: EMTALA Moves From the Emergency Room to Off-Campus Entities*, 36 WAKE FOREST L. REV. 823, 824 (positing that judicial interpretations of EMTALA substantially expanded liability under the statute). Additionally, with respect to the actual knowledge rule, *see supra* Part II.B, most courts have ruled that EMTALA's stabilization requirement does not impose strict liability on the hospital. *See Frank, supra* note 396, at 213 (commending courts for holding that EMTALA's duty to stabilize does not arise unless the hospital is aware of a patient's emergency medical condition).

which physician conduct is to be judged.<sup>502</sup> That is, whereas strict liability automatically imposes responsibility for acts regardless of the care utilized during the act, EMTALA requires hospitals to adhere to a certain level of care.<sup>503</sup> Similarly, EMTALA itself contains numerous indications that an objective standard of care is to be used in evaluating physician conduct.<sup>504</sup> In fact, much of the language of EMTALA is based on the common negligence, or objective, standard which would evaluate whether a reasonable physician, under the same or similar circumstances, would have acted in the same manner as the physician in question acted.<sup>505</sup>

## 2. *Basis for physician EMTALA liability*

To appreciate the standard against which physician conduct must be judged, it is important to understand how physicians are liable under EMTALA. This is an area of additional confusion, because EMTALA is believed by many to be primarily a hospital-oriented statute<sup>506</sup> which “imposes no responsibilities directly on physicians; it unambiguously requires hospitals to examine and stabilize, treat or appropriately transfer all who arrive requesting treatment.”<sup>507</sup> This is a misconceived paradox.<sup>508</sup> Physician EMTALA duties are imposed on the basis of two separate underpinnings. First, physician duties are imposed through the historical persistence of the notion of a “responsible physician,”<sup>509</sup> and second, through “voluntariness.”<sup>510</sup>

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502. See Alicia K. Dowdy et al., *The Anatomy of EMTALA: A Litigator's Guide*, 27 ST. MARY'S L.J. 463, 489 (1996) (arguing that it is incorrect to refer to EMTALA as a strict liability statute, even though courts sometimes do so); see also Joan M. Stieber et al., *EMTALA In The 90's—Enforcement Challenges*, 8 HEALTH MATRIX 57, 67 n.39 (1998) (arguing that the imposition of strict liability under EMTALA is “inappropriate in the inexact realm of emergency medical care”).

503. Stieber, *supra* note 502, at 67 n.39.

504. See *id.* (identifying the use of statutory language such as “reasonable medical probability” and “reasonable physician” as probative of an intended objective test).

505. *Id.*

506. *Burditt v. United States Dep't of Health & Human Servs.*, 934 F.2d 1362, 1376 (5th Cir. 1991) (acknowledging EMTALA imposes no responsibilities directly on physicians).

507. *Id.*

508. See BITTERMAN, *supra* note 18, at 84 (noting it is paradoxical that “the law does not directly create any physician duties or liabilities.”).

509. Historically, a “responsible physician,” as originally defined by EMTALA, included: “one who (A) is employed by, or under contract with, the participating hospital, and (B) acting as such an employee or under such contract, has professional responsibility for the provision of examinations or treatment for the individual, or transfers of the individual, with respect to which the violation occurred.” 42 U.S.C. § 1395dd(d)(2) (Supp. IV 1987), *amended by* 42 U.S.C.A. § 1395dd(d)(1)(B)-(C) (West Supp. 1991).

510. See BITTERMAN, *supra* note 18, at 19 (noting that duties attach to on-call, admitting, and consulting physicians by virtue of their voluntarily accepting medical staff privileges or accepting on-call duties).

The language of EMTALA is unambiguous with respect to physician liability: any “responsible physician” who negligently violates an EMTALA requirement is subject to civil monetary penalties.<sup>511</sup> A “responsible physician” is one who is “responsible for the examination, treatment, or transfer of an individual in a participating hospital who has sought emergency medical care.”<sup>512</sup>

“Voluntariness” also provides for physician EMTALA duties. First, EMTALA, as a federal law, was written as one of the Conditions of Participation in the Medicare program.<sup>513</sup> Thus, to participate in Medicare, a hospital must require its medical staff, *in toto*, to comply with the Medicare Conditions of Participation, which include all the provisions of EMTALA.<sup>514</sup> Therefore, all physicians who treat patients in a Medicare-participating hospital, especially emergency physicians, are subject to the legal duties of EMTALA.<sup>515</sup> It is the mere attainment of clinical hospital privileges, at a Medicare-participating hospital, which subjects a physician to the obligations, responsibilities, and duties of EMTALA.<sup>516</sup>

### 3. *Physician EMTALA liability: objective-negligence standard of care*

The U.S. government has taken the clear position that EMTALA is governed by an objective-negligence standard, and not a strict liability standard of care.<sup>517</sup> The evidence supporting the government’s

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511. 42 U.S.C. § 1395dd(d)(1)(B) (2000).

512. *Id.*

513. *Burditt v. United States Dep’t of Health & Human Servs.*, 934 F.2d 1362, 1366 (5th Cir. 1991) (“Hospitals that execute Medicare provider agreements with the federal government pursuant to 42 U.S.C. § 1395cc must treat all human beings who enter their emergency departments in accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd.”); BITTERMAN, *supra* note 18, at 15.

514. BITTERMAN, *supra* note 18, at 84.

515. *Id.* at 19.

516. *Id.* at 84. Thus, all members of a hospital’s medical staff become liable under the EMTALA definition of a “responsible physician.” *Id.*; *Burditt*, 934 F.2d at 1371 n.10 (stating that physicians “may not obligate themselves to hospitals receiving federal funds without accepting EMTALA’s obligations”).

517. See Solicitor General Brief, *supra* note 466. The government’s position and understanding of the applicable standard of care in respect to EMTALA duties is best reflected in the Amicus Curiae Brief of the Solicitor General of the United States, on behalf of the Secretary, in *Roberts v. Galen of Virginia, Inc.*, 525 U.S. 249 (1999). The interpretation of an EMTALA objective standard of care is also consistent with the rulings of various federal circuits citing an objective standard for the interpretation of 42 U.S.C. § 1395dd(a)’s “appropriate medical screening examination” requirement imposing a *substantive minimum standard of care*. See *Correa v. Hosp. S.F.*, 69 F.3d 1184, 1192 (1st Cir. 1995) (screening must be “reasonably calculated to identify critical medical conditions”); *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995) (“The touchstone is whether . . . the [screening] procedure is designed to identify an ‘emergency medical condition,’ that is manifested by ‘acute’ and ‘severe’ symptoms.”).

position is overwhelming and includes at least five specific loci.<sup>518</sup>

First, the statutory language that subjects a physician to liability is clear in providing that a physician who “negligently”<sup>519</sup> violates a requirement of EMTALA is subject to enforcement proceedings.<sup>520</sup> The use of “negligently” in forming the basis of physician liability clearly imports an objective standard of care based in negligence, rather than in strict liability.<sup>521</sup> This negligence standard finds support in additional, specific statutory language also based on an objective framework.<sup>522</sup> For instance, “reasonableness standards”<sup>523</sup> are enunciated within statutory definitions of “emergency medical condition,”<sup>524</sup> “to stabilize,”<sup>525</sup> and “stabilized,”<sup>526</sup> and are augmented

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518. Because hospital EMTALA duties and obligations are essentially the duties of an emergency physician, the provisions outlining EMTALA hospital duties are, by definition, imputed upon the physicians on staff at participating hospitals. Accordingly, arguments in favor of an objective standard of care for hospitals, as outlined in the section on Transfer Standard of Care, *supra* Part II.B.4, are equally supportive of an objective standard of care for physicians and will not be repeated in this section concerning physician EMTALA liability.

519. 42 U.S.C. § 1395dd(d)(1)(B) (2000).

520. *Id.* (providing that “any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section” will be liable for civil monetary penalties). The government also has noted that if an EMTALA violation is “gross and flagrant or is repeated,” then the physician is also subject to exclusion from participation in Medicare and federally funded state health care programs. Solicitor General Brief, *supra* note 466, at 4; *see also* 42 U.S.C. § 1395cc(b)(2) (stating the Secretary may refuse to enter into an agreement with the provider). The Secretary may also impose civil money penalties and exclusions pursuant to 42 U.S.C. § 1320a-7a, as incorporated into 42 U.S.C. § 1395dd(d)(1)(A)-(B). Solicitor General Brief, *supra* note 466, at 4.

521. Solicitor General Brief, *supra* note 466, at 15 (asserting that the inclusion of the word “negligent” indicates that the statutory duty turns on objective factors rather than strict liability).

522. *Id.*

523. The government, in *Roberts*, strongly advocated the position that “both of th[e] ‘reasonableness standards’ [referring to the standards used in the definition of “emergency medical condition” and “to stabilize”] support the conclusion that EMTALA imposes an ‘objective standard of care.’” Solicitor General Brief, *supra* note 466, at 9 (citing 42 U.S.C. § 1395dd(e)(1)(A), (3)(A)).

524. 42 U.S.C. § 1395dd(e)(1)(A) defines an “emergency medical condition” as follows:

[A] medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could *reasonably be expected* to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part . . . (emphasis added).

525. 42 U.S.C. § 1395dd(e)(3)(A) defines the term “to stabilize” as follows:

[T]o provide such medical treatment of the condition as may be necessary to assure, *within reasonable medical probability*, that no material deterioration of the condition is likely to result or occur during from the transfer of the individual from a facility, or, with respect to an emergency medical condition

by similar statutory use of the phrases “could reasonably be expected”<sup>527</sup> and “within reasonable medical probability”<sup>528</sup> within certain definitions.<sup>529</sup>

A second factor supporting the notion that an objective standard of care should be used with respect to physician conduct is found in the Omnibus Budget Reconciliation Act of 1990 (“OBRA 1990”),<sup>530</sup> in which Congress provided that, when considering allegations of violations of EMTALA, the Secretary shall “request the appropriate utilization and quality control peer review organization (“PRO”).”<sup>531</sup> The role of the PRO is to address “quality of care,”<sup>532</sup> which relates to a medical standard of care, whereby the PRO is to provide an “expert medical opinion.”<sup>533</sup> Congress’s provision for the use of a PRO further affirms that physician EMTALA liability is based on “adherence to a medical standard of care.”<sup>534</sup>

Third, the use of an alternative to the stabilization requirement also indicates that the physician EMTALA duty turns on objective factors.<sup>535</sup> Specifically, under the appropriate transfer provisions of EMTALA,<sup>536</sup> a hospital may transfer a patient whose condition has *not*

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described in paragraph (1)(B), to deliver (including the placenta) (emphasis added).

526. 42 U.S.C. § 13295dd(e)(3)(B) defines the term “stabilized” as follows:

[T]hat no material deterioration of the condition is likely, *within reasonable medical probability*, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta) (emphasis added).

527. See Solicitor General Brief, *supra* note 466, at 15 (arguing that the use of such statutory language confers an objective duty upon physicians).

528. *Id.* at 9 (citing use of objective language as precluding a strict liability interpretation of EMTALA) (citing 42 U.S.C. § 1395dd(e)(3)(A)).

529. *Id.*

530. Pub. L. No. 101-508, Tit. IV, § 4027(a)(1)(A), 104 Stat. 1388-117 (codified at 42 U.S.C. § 1395dd(d)(3) (1994)).

531. 42 U.S.C. § 1395dd(d)(3).

532. See 42 C.F.R. § 489.24(g)(2)(v) (2001) (identifying quality of care as one factor to be considered in evaluating the EMTALA liability of physicians and hospitals).

533. A medical expert opinion is generally provided regarding (a) whether an individual had an emergency medical condition, (b) whether an individual’s emergency medical condition was stabilized, (c) whether an individual was transferred appropriately, and (d) whether there were any medical utilization or quality of care issues involved in the case. *Id.*

534. The objective standard is further substantiated by the fact that Medicare providers generally have an obligation to provide services of “a quality which meets *professionally recognized standards of health care.*” 42 U.S.C. § 1320c-5(a)(2) (emphasis added).

535. Solicitor General Brief, *supra* note 466, at 16 n.6 (articulating exception to the no-transfer rule when medical benefits “reasonably expected” from treatment at another facility outweigh increased risk to the individual) (citing 42 U.S.C. § 1395dd(c)(1)(A)(ii)).

536. 42 U.S.C. § 1395dd(c)(1).

been stabilized<sup>537</sup> if a physician “has signed a certification that[,] based upon the information available at the time of transfer, the medical benefits *reasonably expected* from the provision of appropriate medical treatment at another facility outweigh the increased risks to the individual . . . from effecting the transfer.”<sup>538</sup>

Fourth, the government has relied, in part, upon 42 U.S.C. § 1395dd(d)(1)(B)(i), which imposes liability on a physician who signed such a legal certification “if the physician knew or should have known” that the benefits did not outweigh the risks.<sup>539</sup> The “should have known” standard suggests that the physician’s duty is “not merely” to refrain from acting on subjective grounds, but rather invokes obligations based upon objective standards.<sup>540</sup>

Lastly, subsequent congressional amendments to OBRA 1990<sup>541</sup> concerning the imposition of civil penalty provisions also support an EMTALA objective standard.<sup>542</sup> Under EMTALA, as originally enacted, the Secretary could impose civil monetary penalties on physicians who “knowingly violate[d] a requirement of [EMTALA].”<sup>543</sup> In OBRA 1990, Congress substituted the term “negligently” for the term “knowingly,”<sup>544</sup> which is compatible with an objective standard of care.

#### D. *Conjunctive versus Disjunctive Interpretations of EMTALA*

Another area in which hospital and physician conduct may conflict, and thereby lead to poor EMTALA compliance, is in the determination of whether the medical screening examination, stabilization, and transfer provisions of EMTALA are interdependent or independent of each other. Here, again, the federal courts are split in their conjunctive and disjunctive interpretations of EMTALA.

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537. *Id.*

538. Solicitor General Brief, *supra* note 466, at 16 n.6 (noting that the EMTALA statutory duty is, therefore, based on an analysis of what is “*reasonably expected*,” which is compatible with an objective standard) (citing 42 U.S.C. § 1395dd(c)(1)(A)(ii)) (emphasis added).

539. Solicitor General Brief, *supra* note 466, at 16 n.6.

540. *Id.*

541. Pub. L. No. 101-508, Tit. IV, § 4008(b)(3)(A) and (B), 104 Stat. 1388-44 (codified at 42 U.S.C. § 1395dd(d)(2)(A) (1994)).

542. *See* 42 U.S.C. § 1395cc(a)(1), (b)(2) (employing “reasonableness” standard in enumerating grounds for termination and non-renewal of agreements).

543. *Id.* § 1395dd(d)(2).

544. OBRA 1990 § 4008(b)(1), 104 Stat. at 1388-44; *see also* Solicitor General Brief, *supra* note 466, at 18 (“[C]anon[s] of statutory construction requir[e] a change in language to be read, if possible, to have some effect.”) (internal citations omitted) (quoting *Am. Nat’l Red Cross v. S.G.*, 505 U.S. 247, 263 (1992)).

### I. *Conjunctive interpretations*

A conjunctive interpretation of EMTALA limits the scope of EMTALA to patients evaluated in the emergency department only, and thereby precludes its application to inpatients.<sup>545</sup> Under such an interpretation, the liability exposure for physicians is more limited.

Naturally, the conjoining of subsections (b) and (c) of 42 U.S.C. § 1395dd finds explicit support in the plain text of § 1395dd(b)(1), which “ties the need for stabilization of discerned emergency medical conditions to the transfer restrictions imposed by subsection (c).”<sup>546</sup> Therefore, § 1395dd(c) can be interpreted to impose liability only upon a prior § 1395dd(b) determination that a transferee patient suffers from an emergency medical condition.<sup>547</sup> Further, because 42 U.S.C. § 1395dd(b)(1)(B) provides that if a hospital determines that an emergency medical condition exists, it either must stabilize the individual or transfer him “in accordance with subsection (c),” there is “sound reason, embedded in the statute’s text, to read subsection (c)’s qualified prohibition on unstabilized transfers in tandem with subsection (b)’s requirement that the hospital actually detect the emergency medical condition.”<sup>548</sup> The conjunctive interpretation of EMTALA is followed by the Fourth and Ninth Circuits.

The Fourth Circuit endorsed the conjunctive interpretation of EMTALA through two separate methodologies. In *Bryan v. Rectors & Visitors of the University of Virginia Medical Center*,<sup>549</sup> the Fourth Circuit assessed the temporal duration of EMTALA obligations; whereas in

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545. See *Lopez-Soto v. Hawayek*, 175 F.3d 170, 176-77 (1st Cir. 1999) (favoring a disjunctive reading of EMTALA so as not to limit liability to the emergency room only).

546. *Id.* at 175 (finding that such a linkage of subsections (b) and (c) therefore makes “*linguistic and structural sense*”) (emphasis added). Such a proposition finds support in case law through linkage of the actual knowledge of the hospital in respect to the presence of an emergency medical condition with the stabilization of such a condition. See *Urban v. King*, 43 F.3d 523, 526 (10th Cir. 1994) (joining three other federal circuit courts in requiring proof of actual knowledge on the part of the hospital in a § 1395dd(c) claim regarding patient transfer); *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 883 (4th Cir. 1992) (noting a hospital determination that the patient suffers from an emergency medical condition is a prerequisite for application of EMTALA’s transfer requirements); *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991) (noting that the 42 U.S.C. § 1395dd(b) (stabilization) and § 1395dd(c) (transfer) provisions “are triggered only after the hospital determines that [an] individual has an emergency medical condition.”) (citing 42 U.S.C. § 1399dd(b)(1), (c)); *Cleland v. Bronson Health Care Group*, 917 F.2d 266, 271 (6th Cir. 1990) (stating that “[i]f the emergency nature of the condition is not detected, the hospital can not be charged with failure to stabilize a known emergency condition”).

547. *Lopez-Soto*, 175 F.3d at 175; accord *Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139, 145 (4th Cir. 1996); *Gatewood*, 933 F.2d at 1041.

548. *Lopez-Soto*, 175 F.3d at 175.

549. 95 F.3d 349, 350 (4th Cir. 1996).

*Hussain v. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.*,<sup>550</sup> the Fourth Circuit considered the ability of EMTALA to reach into a patient's hospital room. Under either methodology, hospital and emergency physician EMTALA obligations are quite diverse. In *Bryan*,<sup>551</sup> the court identified a hospital's obligation under EMTALA as pertaining to "immediate, emergency stabilizing treatment,"<sup>552</sup> rather than having to provide treatment indefinitely.<sup>553</sup> Thus, the court narrowly interpreted the scope of the temporal duration of the EMTALA obligation by declaring that "the stabilization requirement was intended to regulate the hospital's care of the patient only in the immediate aftermath of the act of admitting a patient for emergency treatment."<sup>554</sup> In *Hussain*,<sup>555</sup> the Eastern District of Virginia, relying on

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550. 914 F. Supp. 1331, 1335 (E.D. Va. 1996).

551. In *Bryan*, Cindy Bryan, as administratrix of the estate of Shirley Robertson, brought a cause of action under EMTALA against the University of Virginia Medical Center ("UVA"). *Bryan*, 95 F.3d at 349. The complaint alleged that UVA failed to provide Mrs. Robertson with the stabilizing treatment that EMTALA required and she died as a result. *Id.* at 350. The district court granted the defendant's motion to dismiss for failure to state a claim under Rule 12(b)(6) of the Federal Rules of Civil Procedure. *Id.* Mrs. Robertson was transferred to UVA because of severe respiratory distress. *Id.* UVA was given clear instructions to take all necessary measures to keep her alive. *Id.* After twelve days of treating Mrs. Robertson, UVA entered a "do not resuscitate" ("DNR") order against the family's wishes. *Id.* Eight days after the DNR order, Mrs. Robertson suffered a heart attack and was allowed to die. *Id.* at 351. The *Bryan* court affirmed the dismissal of the administratrix's action for failure to state a claim under which relief could be granted, as no recoverable cause of action arising under EMTALA could be identified. *Id.* at 353.

552. *Id.* at 351.

553. *Id.* The *Bryan* court specifically noted that "once EMTALA has met that purpose of ensuring that a hospital undertakes stabilizing treatment for a patient who arrives with an emergency condition, the patient's care becomes the legal responsibility of the hospital and the treating physicians." *Id.* The court identified the limited purpose of EMTALA by requiring that the hospital provide limited stabilizing treatment to or an appropriate transfer of "any patient that arrives" with an emergency condition. *Id.* at 352.

554. *Id.*

555. 914 F. Supp. 1331 (E.D. Va. 1996). In *Hussain*, Uzma Hussain, presented to Fairfax Hospital emergency department for evaluation. *Id.* at 1332. After being diagnosed and treated for acute recurrent pancreatitis, Ms. Hussain was admitted to the hospital. *Id.* In the early morning on the date following her admission to the hospital, the nursing staff requested a medical examination for Ms. Hussain for unspecified reasons. *Id.* The physician staff did not comply with this request and Ms. Hussain died shortly thereafter. *Id.* The plaintiff filed a cause of action under EMTALA, alleging that Fairfax failed to provide an appropriate medical screening examination and that Fairfax violated 42 U.S.C. § 1395dd(b)(1)(A) by failing to stabilize Ms. Hussain's medical condition. *Id.* Evidence indicated that Ms. Hussain's complications of acute pancreatitis were not diagnosed and her life threatening condition was not stabilized. *Id.* Fairfax filed a motion for summary judgment and asserted that it had in fact treated and admitted Ms. Hussain for her emergency medical condition upon presentation to the emergency department. *Id.* at 1335. The district court indicated that the plaintiff's proof did not establish or permit an inference that Fairfax failed to stabilize the original emergency medical condition of acute recurrent pancreatitis to such a point that it would not materially deteriorate during, or as a result of, transfer to another hospital. *Id.* As such, the court granted

42 U.S.C. § 1395dd(b)(1)(A), explained that the statutory language clearly refers back to the emergency medical condition “observed upon the patient’s initial appearance at the hospital’s emergency department.”<sup>556</sup> Accordingly, the court noted that “neither in its text nor its avowed purpose does EMTALA reach into the hospital room of a patient admitted for several hours to redress the failure of hospitals to follow standard medical procedures in connection with in-patient hospital treatment.”<sup>557</sup>

In *James v. Sunrise Hospital*,<sup>558</sup> the Ninth Circuit utilized a three-way conjunctive statutory construction for the interpretation of EMTALA. The Ninth Circuit interpreted subsections (a), (b), and (c) of 42 U.S.C. § 1395dd as if each subsection related to a single course of events. Thus, the *James* court reasoned that careful examination of the plain statutory text supports the proposition that § 1395dd(c) regulates transfers made pursuant to §§ 1395dd(a) and (b) and did not create an alternative basis for hospital liability.<sup>559</sup> Specifically, the court reasoned that because Congress did not use “and” or “or” to connect § 1395dd subsections (a), (b), and (c),<sup>560</sup> the transfer duty in § 1395dd(c) was interpreted to deal with people who have emergency

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the defendant’s motion for summary judgment. *Id.*

556. *Id.* at 1334.

557. *Id.* at 1335.

558. 86 F.3d 885 (9th Cir. 1996). Ms. James challenged the dismissal of her complaint for failure to state a claim upon which relief could be granted. *Id.* at 886. Her complaint alleged that she developed an emergency medical condition while hospitalized in Sunrise Hospital (“Sunrise”) and was subsequently discharged in violation of EMTALA. *Id.* Ms. James was admitted to Sunrise with acute renal failure. *Id.* While an inpatient, she underwent insertion of a synthetic graft into her arm. *Id.* The procedure was followed by numerous complications, including pain, numbness of her forearm, wrist, and hand, coolness of her hand, bluish discoloration of her hand, and weakening of her pulse. *Id.* Nevertheless, Sunrise discharged Ms. James without any evaluation of the condition of her vasculature. *Id.* Ms. James alleged that the condition she developed post-operatively was not stabilized prior to her discharge, which ultimately caused her hand to be amputated. *Id.* Ms. James asserted that Sunrise violated 42 U.S.C. § 1395dd(c) of EMTALA. *Id.* at 887. Sunrise asserted that there was no such thing as a claim under § 1395dd(c) not implicating § 1395dd(b). *Id.* at 888. Its theory was that, unless and until the hospital “determines that the individual has an emergency medical condition” under § 1395dd(b), the transfer restrictions of § 1395dd(c) do not operate. *Id.* The court noted its prior holding in *Eberhardt v. City of Los Angeles*, 62 F.3d 1253 (9th Cir. 1995), that screening at less than an appropriate level will not satisfy EMTALA, and that the hospital’s duty to stabilize the patient under § 1395dd(b) does not arise until the hospital detects the emergency condition. *James*, 86 F.3d at 889. The court concluded that the transfer restrictions of § 1395dd(c) only apply when an individual comes to the emergency room, and when the hospital determines that the individual has an emergency medical condition after an appropriate medical screening examination. *Id.* As a result, the Ninth Circuit affirmed the judgment that dismissed Ms. James’s complaint, concluding that EMTALA only applied to treatment decisions made in the emergency department. *Id.*

559. *James*, 86 F.3d at 888, 889.

560. *Id.* at 888.

medical conditions under § 1395dd(b),<sup>561</sup> and that because § 1395dd(b) states that the transfer must be “in accordance with subsection (c),”<sup>562</sup> § 1395dd(c) regulates the transfers made in accordance with § 1395dd(b).<sup>563</sup>

## 2. *Disjunctive interpretations*

The First,<sup>564</sup> Sixth,<sup>565</sup> Seventh,<sup>566</sup> and Tenth<sup>567</sup> Circuits, as well as the

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561. *Id.*

562. *Id.*

563. *Id.* The court failed to understand why Congress would indicate that in § 1395dd(b), the transfer has to be in accordance with § 1395dd(c), unless it meant for § 1395dd(c) to regulate the transfers made in accordance with § 1395dd(b). *Id.* Therefore, the court held that § 1395dd(c) was designed to deal with people who are found to have emergency medical conditions under § 1395dd(b). *Id.* In support of its logic, the court noted the absence of inter-circuit conflict among four circuits utilizing such a conjunctive analysis to hold that there is no liability under § 1395dd(c) unless there has been a determination under § 1395dd(b). *Id.* (citing *Urban v. King*, 43 F.3d 523, 525-27 (10th Cir. 1994); *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 883 (4th Cir. 1992); *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991); *Cleland v. Bronson Health Care Group*, 917 F.2d 266, 271 (6th Cir. 1990)).

564. *Lopez-Soto v. Hawayek*, 175 F.3d 170 (1st Cir. 1999); *see infra* note 575 (describing the facts of *Lopez-Soto*).

565. In *Thornton v. Southwest Detroit Hospital*, 895 F.2d 1131 (6th Cir. 1990), the Sixth Circuit relied on rules of statutory construction and legislative history as a basis for its disjunctive interpretation of EMTALA. The court considered the appeal of a district court's grant of summary judgment to defendant Southwest Detroit Hospital (“Southwest Detroit”) under a claim of EMTALA violation. *Id.* at 1132. The issue in *Thornton* was whether the initial treating hospital violated EMTALA by releasing Ms. Thornton before her condition “stabilized.” *Id.* After suffering a stroke, Elease Thornton spent a protracted course at a hospital but her recovery necessitated being transferred to the Detroit Rehabilitation Institute (“DRI”) for post-stroke rehabilitation therapy. *Id.* However, the DRI refused to accept Ms. Thornton because she lacked health insurance coverage. *Id.* Consequently, Ms. Thornton was discharged from the hospital and sent to her sister's home for basic nursing care. *Id.* After discharge from Southwest Detroit, Ms. Thornton's condition deteriorated until she finally gained admission to the DRI. *Id.* Ms. Thornton brought suit under EMTALA, alleging that she suffered from an “emergency medical condition” when she entered Southwest Detroit and that Southwest Detroit failed to stabilize her condition before discharging her as required by EMTALA. *Id.*

The district court found that no genuine issue of material fact existed as to whether, after a three week stay in Southwest Detroit, Ms. Thornton's condition had stabilized sufficiently for release. *Id.* at 1134. The district court had stated that EMTALA was not intended to require hospitals to bring patients to complete recovery, but to require hospitals to give emergency department treatment. *Id.* The Sixth Circuit affirmed the district court's holding, concluding that the district court correctly found that Ms. Thornton's condition had stabilized at the time of her release and that no genuine issue of material fact existed. *Id.* at 1135.

The *Thornton* court's analysis centered on changes in construction between 42 U.S.C. § 1395dd(a) [medical screening examination] and 42 U.S.C. § 1395dd(b) [stabilization], noting that changes in wording support varied interpretations as well as changes in meaning. The court reasoned that, because of the change in wording between the screening requirement for patients that come to a “hospital emergency room” in § 1395dd(a), and the stabilization requirement in § 1395dd(b) that applies to the “hospital,” a disjunctive interpretation was thereby warranted. *Id.* at 1135. The court noted that EMTALA's legislative history supports a literal [and therefore

Supreme Court of Virginia,<sup>568</sup> favor a disjunctive interpretation of the

disjunctive] interpretation, and that such history is clear that Congress intended to prevent hospitals from dumping patients who suffered from an emergency medical condition because they lacked insurance to pay the medical bills. *Id.* at 1134. The *Thornton* court reasoned that notwithstanding the repeated use of the phrase, “emergency room,” in comments of the congressional Judiciary Committee (citing H.R. REP. NO. 241(III) (1986), *reprinted in* 1986 U.S.C.C.A.N. 726-27) and The Ways and Means Committee (citing H.R. REP. NO. 241(I) (1986), *reprinted in* 1986 U.S.C.C.A.N. 605), Congress sought to ensure that patients with medical emergencies would receive emergency care. *Thornton*, 895 F.2d at 1134-35. Noting that, although “emergency care often occurs, and almost invariably begins, in an emergency room,” the court reasoned that emergency care does not always stop when a patient is transported from the emergency department into other areas of the hospital. *Id.* at 1135.

566. At least one district court in the Seventh Circuit has applied a disjunctive interpretative analysis to EMTALA. In *Loss v. Song*, No. 89C 6952, 1990 WL 159612, \*1 (N.D. Ill. Oct. 16, 1990), Tracy Loss presented to defendant St. Joseph Hospital (“St. Joseph”) in active labor. On the day of her admission, Tracy gave birth to a son, Brent Loss. *Id.* at \*1. From the time of his birth, Brent suffered from severe congenital cardiac disease. *Id.* On the day after his birth, St. Joseph discharged both mother and infant. *Id.* In her complaint against her doctor for violations of the discharge provision of EMTALA, 42 U.S.C. § 1395dd(c)(1) (2000), Tracy alleged that, prior to and at the time of his discharge, her child exhibited blue discoloration from his waist and thighs to his toes, ate poorly, and was lethargic. *Loss*, 1990 WL 159612, at \*1. Tracy alleged that these symptoms indicated an emergency medical condition, and that Brent was not stabilized at the time of his discharge. *Id.*

The defendants argued that a child born at a hospital with an emergency medical condition was precluded from bringing an EMTALA action because the child could not plead that he was admitted to or through the emergency department. *Id.* However, the court in *Loss* noted that the complaint met all elements of an anticipated EMTALA claim, except for the fact that the infant did not “go to an emergency room.” *Id.* at \*3. In so doing, the court relied on *Deberry v. Sherman Hospital Ass’n*, 741 F. Supp. 1302, 1305 (N.D. Ill. 1990), which provided guidance to the court regarding the elements of an EMTALA claim. *Loss*, 1990 WL 159612, at \*3. The *Loss* court noted that the claim was not brought as a typical case of emergency department presentment, but rather was with respect to an infant who “*came into legal existence after admittance.*” *Id.* (emphasis added). Relying upon the type of disjunctive interpretation employed by *Thornton*, as well as congressional intent and plain statutory language, the court held that the plaintiff’s allegations that her child suffered from a severe congenital cardiac disease at birth were sufficient to state a claim under COBRA. *Id.* That is, the fact that the claim substantiated an emergency medical condition which required immediate treatment, irrespective of the manner or locus in which the patient arrived at the hospital where the treatment was provided, was sufficient to state a valid claim under EMTALA. *Id.*

567. The Tenth Circuit also endorses the disjunctive interpretation of EMTALA as noted in both *Urban v. King*, 43 F.3d 523 (10th Cir. 1994), and *Robbins v. Osteopathic Hospital Founders Ass’n*, 178 F. Supp. 2d 1221 (N.D. Okla. 2000). Although *Urban* primarily involves the “actual knowledge” component of § 1395dd(c), and *Robbins* concerns the “informed consent” of a patient by a hospital in respect to its recommended transfer in satisfaction of 42 U.S.C. § 1395dd(c)(1)(A)(i), both cases implement and support the disjunctive interpretation of EMTALA.

568. The Supreme Court of Virginia relied upon the plain language and unambiguous words of Congress to form its disjunctive interpretation of EMTALA in *Smith v. Richmond Memorial Hospital*, 416 S.E.2d 689 (Va. 1992). *Smith* involved a woman who, at thirty-three weeks gestation, had premature rupture of the uterine membranes. *Id.* at 690. During the subsequent four days of her stay at Richmond Memorial Hospital (“Richmond”), the plaintiff experienced abdominal cramping, greenish vaginal leakage, and progressive abdominal discomfort. *Id.* The plaintiff subsequently experienced cold chills and her body temperature dropped to 95.3

interrelationship of EMTALA provisions. Under the disjunctive approach, courts treat the three duties of EMTALA as if they are independent of each other. In other words, the duty to provide an appropriate medical screening examination,<sup>569</sup> the duty to stabilize,<sup>570</sup> and the duty to appropriately transfer<sup>571</sup> are not viewed as interdependent, but rather, they represent separate and distinct duties and causes of action.<sup>572</sup> Such a disjunctive interpretation of the EMTALA provisions mandates that EMTALA is triggered wherever an individual located within a hospital develops an emergency medical condition, giving rise to the duty to medically screen, stabilize, and/or transfer.

Cases which raise the conjunctive and disjunctive interpretation issue commonly involve instances in which those who have suffered harm “come into legal existence after admittance.”<sup>573</sup> In *Lopez-Soto v. Hawayek*,<sup>574</sup> the First Circuit addressed a newborn’s entrance to the hospital via the operating room.<sup>575</sup> The court’s analysis relied heavily

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degrees Fahrenheit. *Id.* At one point, Richmond called a physician, who was not Ms. Smith’s regular attending physician. Without ever examining her, the physician ordered that Ms. Smith be transferred to the Medical College of Virginia Hospital (“MCV”). *Id.* Several hours after arriving at MCV, Ms. Smith underwent emergency Cesarean section. *Id.* At first, two ambulances refused to transport Ms. Smith to MCV. *Id.* Ms. Smith sued Richmond claiming violation of COBRA [EMTALA], which caused her child to experience severe injuries. *Id.* The trial court held that COBRA did not cover “emergency conditions arising from medical neglect during a stay in a hospital.” *Id.* Smith appealed.

In propounding the disjunctive interpretation, the Supreme Court of Virginia reasoned in *Smith* that the language used in each subsection of EMTALA describes distinct patient circumstances requiring different treatment protocols. *Id.* at 692. Specifically, the court held that if an individual “comes to the emergency department” and requests examination or treatment, the hospital must provide an appropriate medical screening examination; whereas, if an individual “comes to a hospital” and the hospital determines that an emergency medical condition or active labor exists, the hospital must either stabilize the condition or transfer the person. *Id.* If the “patient [is] at a hospital,” the hospital may transfer that patient only under certain conditions. The court noted that there was “nothing in the language of the Act which limits application of these subsections solely to a patient who initially arrives at the emergency room and who has not been stabilized . . . .” *Id.*

569. 42 U.S.C. § 1395dd(a).

570. *Id.* § 1395dd(b).

571. *Id.* § 1395dd(c).

572. See, e.g., *Smith*, 416 S.E.2d at 692 (using the disjunctive interpretation in holding that nothing in the language of EMTALA limits application of each subsection to a patient who initially arrives at an emergency room and who has not been stabilized).

573. See *Loss v. Song*, No. 89C 6952, 1990 WL 159612, at \*3 (N.D. Ill. Oct. 16, 1990) (involving a child whose birth was delayed and who was alleged to have been injured as a result); see also *Smith*, 416 S.E.2d at 689 (involving birth of a child which was born with cardiac problems at time of birth); *Lopez-Soto v. Hawayek*, 175 F.3d 170 (1st Cir. 1999) (involving the birth of a child in an operating room).

574. 175 F.3d 170 (1st Cir. 1999).

575. *Id.* Mayda Lopez-Soto, experiencing labor pains, was admitted at Auxilio Mutuo Hospital (“Auxilio”) for the delivery of her child. *Id.* at 171. When Dr. Jose

on the plain text of the statutory language.<sup>576</sup>

The *Lopez-Soto* court held that EMTALA “unambiguously imposes”<sup>577</sup> certain duties in the emergency care of an individual “regardless of how that person enters the institution or where within the walls he may be when the hospital identifies the problem.”<sup>578</sup> Further, the court explained that nothing in the provisions of EMTALA suggests a “necessary relationship”<sup>579</sup> between a hospital’s obligations and the identity of the department within the hospital to which the afflicted individual presents himself.<sup>580</sup> The First Circuit

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Hawayek, an obstetrician, induced her water to break and immediately discovered the presence of thick “pea soup” meconium in the amniotic fluid, he ordered a Cesarean section. *Id.* Roughly fifteen minutes after the operation commenced, Lopez-Soto gave birth to a baby boy who suffered from severe respiratory distress due to meconium aspiration, constituting a medical emergency. *Id.* A pediatrician determined that the baby suffered not only from meconium aspiration, but also had a collapsed lung in the form of a pulmonary pneumothorax and that the baby required specialized neonatal intensive care unit. *Id.* The pediatrician elected to send the infant to the receiving hospital without first attempting to stabilize the patient or to treat the exigent condition of pneumothorax. *Id.* The baby was transferred to the San Juan Pediatric Hospital where he died the next day. *Id.*

Plaintiff, Lopez-Soto, filed a cause of action against the physicians and Auxilio, alleging violations of EMTALA. *Id.* Lopez-Soto asserted that Auxilio violated EMTALA because her baby was born “with a severe pulmonary condition that required emergency and immediate medical care and treatment,” but Auxilio nonetheless transferred him to another institution without stabilizing this condition. *Id.* at 172. The defendants denied the allegations, contested jurisdiction, and asserted that EMTALA did not apply. *Id.*

The district court had adopted a conjunctive interpretation of all three subsections of EMTALA and precluded the independent reading of the provisions, fearing that applying EMTALA outside the emergency department would extend the statute beyond its scope and beyond Congressional intent. *Id.* The district court dismissed plaintiff’s EMTALA claim. *Id.* The First Circuit reversed the district court’s order, ordered the reinstatement of the pendent EMTALA claims, and remanded the case for further proceedings. *Id.* at 177.

576. *Id.* at 172. The First Circuit began by considering “the meaning of the words that Congress wrote with an appraisal of the statutory text and structure . . . mindful that if the plain language of the statute points unerringly in a single direction, an inquiring court ordinarily should look no further.” *Id.*

577. *Id.* at 173.

578. *Id.* (citing *Helton v. Phelps County Reg’l Med. Ctr.*, 794 F. Supp. 332, 333 (E.D. Mo. 1992); *Smith*, 416 S.E.2d at 692).

579. *Id.* The court further explained that “a disjunctive approach draws strength from the fact that subsection (b) mentions neither an emergency department locus nor a medical screening as a precursor to a hospital’s stabilization obligations. Rather, those obligations attach as long as an individual enters any part of the hospital and the hospital determines that an emergency medical condition exists.” *Id.* at 174. The court believed that Congress “structurally [chose] to disconnect the three subsections [of EMTALA], closing them off from each other by periods, without any conjunctive links.” *Id.* The court reasoned that Congress’s use of punctuation supported its disjunctive interpretation of EMTALA. *Id.*

580. *Id.* at 173. By relying on the tenet that “all words and provisions of statutes are intended to have meaning and are to be given effect, and no construction should be adopted which would render statutory words or phrases meaningless, redundant, or superfluous,” the court rejected the district court’s attempt to meld the duties of § 1395dd subsections (a), (b) and (c). *Id.* (citing *United States v. Ven-Fuel, Inc.*, 758

held that a plain language approach was also good public policy.<sup>581</sup> That is, interpreting § 1395dd(b) to obligate hospitals to stabilize individuals when emergency medical conditions arise, regardless of their location in the hospital, is key to ensuring the health of those already admitted to the hospital who develop an emergency medical condition.<sup>582</sup>

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F.2d 741, 751-52 (1st Cir. 1985)). The court also relied on canons of statutory construction concerning the selection of language, noting that the fact that Congress used the “comes to an emergency department” language in § 1395dd(a), while employing different phraseology (“comes to a hospital”) in § 1395dd(b), serves to emphasize the “separateness of the statutory commands.” *Id.* at 173. The court reasoned that Congress is presumed to have acted intentionally and purposely when it includes particular language in one section of a statute but omits it in another. *Id.* (citing *BFP v. Resolution Trust Corp.*, 511 U.S. 531, 537 (1994)). Otherwise, under a conjunctive approach, the implementation of the § 1395dd(b) phrase “comes to a hospital” would be meaningless in respect to the § 1395dd(a) phrase “comes to the emergency department.” *Id.*

581. *Id.* at 176. The First Circuit was quite critical of the conjunctive reasoning used by the district court. *Id.* The court noted that the district court unduly “fretted” over legislative purpose and was erroneous in its belief that allowing EMTALA’s stabilization and transfer obligations to apply outside the context of an emergency department (i.e., via a disjunctive interpretation) would extend the statute’s reach beyond Congress’s perceived limited goal of patient dumping. *Id.* The First Circuit cited three reasons why the district court’s reasoning was faulty and cramped. *Id.*

First, the *Lopez-Soto* court held that courts should interpret statutes primarily through detailed analysis of concrete statutory language, not by reference to *abstract notions* of generalized legislative intent. *Id.* (reiterating “that courts must presume that a legislature says in a statute what it means and means in a statute what it says there”) (citing *Conn. Nat’l Bank v. Germain*, 503 U.S. 249, 253-54, (1992)). The First Circuit explained that while an examination of legislative purpose can shed light upon congressional intent, it cannot serve as the baseline for statutory construction. *Id.*

Second, the First Circuit emphasized that the narrow conjunctive interpretation of the district court did not account for the fact that statute explicitly embraces women in labor who typically go to maternity wards, not emergency departments, when they are ready to give birth. *Id.* at 176-77.

Third, the court noted that a disjunctive interpretation, not a conjunctive interpretation, best serves Congress’s preoccupation with patient dumping. *Id.* Here, the court pointed out that patient dumping is not a practice that is limited to an emergency department, and that where a hospital determines that a patient on a ward has developed an emergency medical condition, it may fear that the costs of treatment will outstrip the patient’s resources, and seek to move the patient elsewhere. *Id.* at 177. The court opined that this form of patient dumping is “equally as pernicious” as the dumping that occurs in emergency departments, and the court was not prepared to say that Congress did not seek to curb it. *Id.* Although the district court was concerned that EMTALA might be converted into a federal medical malpractice statute without an emergency department arrival limitation commensurate with a conjunctive interpretation, the First Circuit found this concern to be overblown. *Id.*

582. *Id.* at 175.

IV. THE FAILED ATTEMPT AT CREATING A NEW TORT OF PATIENT DUMPING: *COLEMAN V. DENO*<sup>583</sup>

Having considered the shortcomings of EMTALA and how they preclude effective healthcare provider compliance and government enforcement, a new approach to patient dumping will be considered—a state cause of action in the form of an intentional tort of patient dumping. One failed attempt to sustain such a cause of action opens the door for consideration of this new remedy.

A. *Case Facts*

*Coleman* concerned a medical malpractice and patient dumping general tort cause of action involving the loss of the plaintiff's arm.<sup>584</sup> On June 7, 1988, the plaintiff went to the emergency department of JoEllen Smith Hospital ("JESH"), where he complained of chest wall pain as a result of lifting.<sup>585</sup> The plaintiff had a fever of 100.3 degrees Fahrenheit.<sup>586</sup> He was examined by the attending emergency physician and discharged.<sup>587</sup>

The following day, swelling and aching<sup>588</sup> in the plaintiff's left arm caused him to return to the emergency department.<sup>589</sup> At that time the plaintiff had a heart rate of 120 beats per minute and a fever of 102.8 degrees Fahrenheit.<sup>590</sup> An attending nurse noted that the plaintiff's left arm was "swollen and warm with bullae in the left antecubital space."<sup>591</sup> On this visit, the plaintiff was examined by Dr. Richard Deno,<sup>592</sup> who ordered a white blood cell count on the plaintiff that returned a reading of 27,100.<sup>593</sup> Dr. Deno diagnosed the plaintiff with left arm cellulitis and found that the plaintiff's

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583. 787 So. 2d 446 (La. Ct. App. 2001), *aff'd in part, modified in part, and remanded by* 813 So. 2d 303 (La. 2002).

584. *Id.* at 454.

585. *Id.* Mr. Coleman arrived at the emergency department at 1:44 a.m., also complaining of chest pain during deep breathing. *Id.*

586. *Id.* Normal body temperature is 98.6 degrees Fahrenheit.

587. *Id.* Dr. Ivan Sherman, the attending emergency physician, found chest wall tenderness. *Id.* Dr. Sherman diagnosed plaintiff with chest pain and costochondritis and prescribed various anti-inflammatory medications. *Id.* The plaintiff was discharged at 3:45 a.m. *Id.* Coleman was instructed to "apply heat to his chest and to see his personal physician for a follow up examination." *Id.* After filling his prescription, the plaintiff returned home. *Id.*

588. *Id.*

589. *Id.* Mr. Coleman returned to the JoEllen Smith Hospital on June 8, 1988, at 8:10 p.m. *Id.*

590. *Id.* Normal heart rate range is 60-80 beats per second.

591. *Id.*

592. *Id.* at 455. Dr. Deno noticed track marks consistent with intravenous drug use on the swollen left arm of the plaintiff. *Id.*

593. *Id.* at 454. Normal range for a white blood cell count is approximately 6-10,000.

condition necessitated inpatient intravenous antibiotics.<sup>594</sup>

Dr. Deno felt that transferring the patient was feasible and would be advantageous for the patient.<sup>595</sup> The Charity Hospital of New Orleans ("Charity") possessed superior and immediately available laboratory facilities necessary to treat the patient.<sup>596</sup> Dr. Deno arranged for the plaintiff to be transferred to Charity,<sup>597</sup> but determined that the plaintiff was stable and could transport himself to Charity.<sup>598</sup> Dr. Deno did not administer antibiotics to the plaintiff.<sup>599</sup>

The plaintiff arrived at Charity over two and one-half hours after his discharge from the JESH emergency department.<sup>600</sup> Examination at Charity revealed that the plaintiff had a swollen left upper extremity which was extremely painful.<sup>601</sup> His arm was swollen and warm from the mid arm to lower forearm.<sup>602</sup> Since the transfer to Charity, the patient's white blood cell count had risen to 29,900.<sup>603</sup> Left arm x-rays revealed significant soft tissue swelling.<sup>604</sup>

Antibiotics were not started until seven hours after the plaintiff arrived at Charity.<sup>605</sup> A surgical consultation on June 11 revealed that the plaintiff had crepitus, "indicating gas in the tissues of his left arm."<sup>606</sup> Subsequent left arm X-rays confirmed "air" within the soft tissues of plaintiff's left arm.<sup>607</sup> The plaintiff was then taken to the operating room,<sup>608</sup> where the skin, fat, and bulk of the muscles of his left arm were found dead.<sup>609</sup> An open left shoulder disarticulation

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594. *Id.*

595. *Id.*

596. *Id.* at 455.

597. *Id.* Dr. Deno contacted the emergency resident at Charity, whereupon the resident accepted the plaintiff for immediate admission to the emergency department. *Id.*

598. *Id.* at 456. The plaintiff alleged in his original petition that Dr. Deno gave him express permission to go first to his home to pick up certain belongings before going to Charity. *Id.* at 461.

599. *Id.* at 455.

600. *Id.* The plaintiff arrived at 12:21 a.m. on June 9, 1988. *Id.*

601. *Id.*

602. *Id.* at 456.

603. *Id.*

604. *Id.*

605. *Id.* The physician determined that the plaintiff should be admitted for "intravenous antibiotics (Nafcillin, 2 grams every four hours), tetanus toxoid administration, elevation of warm compresses to the left arm, and additional blood studies." *Id.* The patient was admitted to the Hospital's LSU Medicine Service at 6:00 p.m., June 9, 1988. *Id.*

606. *Id.* at 457. "Crepitus" is a crackling sensation which is felt by an examiner when palpating soft tissue.

607. *Id.*

608. *Id.*

609. *Id.* Tissue death was believed to be due to compartment syndrome, a condition whereby infection-swelling become so great in magnitude that the blood

and amputation of the plaintiff's left arm at the level of the left shoulder was preformed.<sup>610</sup> Tissue cultures were positive for the gas-forming organism, peptostreptococcus, and on June 28, 1988, the plaintiff was discharged from Charity.<sup>611</sup>

*B. Trial Court and Procedural History*

The plaintiff filed a request for a medical panel review pursuant to Louisiana law,<sup>612</sup> wherein he alleged that both emergency physicians who evaluated him at JESH were negligent, that JESH and Charity hospitals were negligent, and that their negligence caused the loss of his left arm.<sup>613</sup> The plaintiff claimed that the defendants failed to properly diagnose or treat his left arm condition.<sup>614</sup> The medical malpractice panel concluded that there was "no breach of the applicable medical standard of care" by either JESH emergency physician.<sup>615</sup> The plaintiff subsequently filed suit in civil district court,<sup>616</sup> alleging both negligence and violation of COBRA's anti-dumping provision<sup>617</sup> against the defendants.

A jury trial<sup>618</sup> was held, during which Dr. Deno filed various motions attempting to preclude any reference to COBRA/EMTALA's anti-dumping provision, or to the race or socioeconomic status of the plaintiff.<sup>619</sup> The trial court granted Dr. Deno's exception of no cause

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supply of the arm is completely compromised and, as a result of a lack of blood flow to the tissues, the tissues die. *Id.*

610. *Id.* at 456.

611. *Id.*

612. *Id.* This review was made pursuant to LA. REV. STAT. ANN. § 40:1299.41 and § 40:1299.39 (West 2001); *Coleman*, 787 So. 2d at 456. The plaintiff filed individually and as the father of Louis Frank Coleman. *Id.*

613. *Id.*

614. *Id.* With respect to Jo Ellen Smith Hospital, Coleman alleged negligence during the June 7 and June 8, 1988, emergency department visits. *Id.* With respect to Charity, Coleman alleged negligence during the Charity hospital stay between June 9 and June 12, 1988. *Id.*

615. *Id.*

616. The suit was filed on July 27, 1990, against Dr. Sherman, Dr. Deno, and Jo Ellen Smith Hospital. *Id.* The Louisiana Patients' Compensation Fund ("Compensation Fund" or "Fund") was an intervenor in the suit. *Id.*

617. The COBRA violation was filed as a supplemental petition on March 27, 1991. *Id.* at 456-57.

618. The jury trial was conducted on March 1-5, March 8-12 and March 15, 1999. *Id.* at 457. Plaintiff settled his claim against JoEllen Smith Hospital for \$10,000, and the hospital was dismissed from the action on October 10, 1991. *Id.* at 458. Plaintiff settled his separately filed claim against Charity in March, 1993, for \$25,000, and Charity was dismissed from the action. *Id.*

619. Dr. Deno filed peremptory exceptions of no cause of action and/or prescription on plaintiff's COBRA/EMTALA anti-patient-dumping claim and a motion *in limine* for an order precluding any reference to COBRA/EMTALA. *Id.* at 457.

of action.<sup>620</sup> After hearing multiple medical expert witnesses for the plaintiff and the defense, the jury found both of the JESH emergency physicians were negligent and that their negligence contributed to the loss of plaintiff's left arm.<sup>621</sup> The jury awarded \$4,400,000 to the plaintiff,<sup>622</sup> but the court subsequently issued multiple annotated judgments<sup>623</sup> significantly reducing the plaintiff's award.<sup>624</sup> The trial

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620. *Id.*

621. *Id.* The jury apportioned twenty percent of fault to Dr. Sherman and eighty percent to Dr. Deno. *Id.* The jury found that Charity and plaintiff were not negligent. *Id.*

622. *Id.* This included "lost wages, diminished earning capacity and the cost of replacing personal services." *Id.* The jury found that the amount for future medical care and related benefits was \$500,000. *Id.* The damages sustained by plaintiff's son, Louis Frank Coleman, for loss of society and services was \$1 million. *Id.* The March 18, 1999 judgment was rendered in favor of the plaintiffs and against Dr. Ivan Sherman and Dr. Richard Deno, *in solido*. *Id.* The judgment awards were restricted for each defendant to \$100,000 plus interest based on statutory limits. LA. REV. STAT. ANN. § 40:1299.42(B)(2); *Coleman*, 787 So. 2d at 457.

623. On March 18, 1999, the court issued an annotated judgment that maintained the award rendered against defendants, Dr. Ivan Sherman and Dr. Richard Deno, *in solido*: Louis Coleman, individually, \$4,900,000.00; Louis Coleman, as natural tutor of his minor son, Louis Frank Coleman, \$1,000,000.00. *Coleman*, 787 So. 2d at 457. This judgment, as previously mentioned, was limited to \$100,000 plus interest for both plaintiffs. *Id.* at 457. Further, judgment was rendered against the Louisiana Patients' Compensation Fund Over-Sight Board ("LPCF") in the sum of \$300,000.00 for both plaintiffs. *Id.* The annotated judgment awarded legal interest from the date the claim was filed with the LPCF. *Id.* The award for expert fees remained the same. *Id.*

Accordingly, the trial court found that Louis Coleman would recover judgment against each defendant doctor in the sum of \$79,591.84 plus interest. *Id.* The LPCF owed the balance of \$238,775.51 plus interest. *Id.* The trial court held that Louis Coleman on behalf of his minor son, Louis Frank Coleman, would recover from each defendant doctor the sum of \$20,408.16 plus interest. *Id.* The LPCF owed the balance of \$61,224.49 plus interest. *Id.*

On June 24, 1999, after hearing post-trial motions, the trial court rendered a final amended judgment which provided that the parties stipulated that Louis Coleman settled with Charity for \$25,000, and settled with JoEllen Smith Hospital for \$10,000. *Id.* at 458. The court granted the defendant Dr. Ivan Sherman's motion for judgment notwithstanding the verdict ("JNOV"). *Id.* The court granted remittitur regarding the claim of Louis Coleman as natural tutor of his minor son, Louis Frank Coleman, to \$10,000.00. *Id.* Although the trial court noted that the jury found Louis Coleman in need of future medical care and related benefits in the amount of \$500,000.00, the trial court did not enter a judgment on this sum. *Id.* The trial court denied the post-trial motions except as follows: the trial court reiterated that it granted Dr. Ivan Sherman's motion for JNOV, dismissing all claims against Dr. Sherman by Louis Coleman, individually and on behalf of his minor son, Louis Frank Coleman, with prejudice, each party to bear their own costs. *Id.* at 459. Sole fault was assigned to Dr. Richard Deno. *Id.* In the amended judgment, the trial court held that the award to Louis Coleman on behalf of his minor son, Louis Frank Coleman, was remitted from \$1,000,000 to \$10,000. *Id.* The trial court found that the award to Louis Coleman does not pre-empt the claim of the minor son. *Id.*

The trial court ordered that the award to the minor son, Louis Frank Coleman, against Dr. Richard Deno was \$1,018.30 and interest from April 1, 1991, with the LPCF paying all other interest thereon [\$10,000.00 divided by \$4,910,000.00 = .0020366%, which means that the minor son, Louis Frank Coleman's award on a total limitation of \$500,000.00 is \$1,018.30 (\$500,000

court's judgment was appealed<sup>625</sup> by the plaintiff, defendant Dr. Deno, and the Louisiana Patients' Compensation Fund (LPCF) as an intervenor.<sup>626</sup>

### C. Louisiana Appellate Court Opinion

The main issues the plaintiff alleged on appeal included: (1) the trial court erred in not allowing the plaintiff to disclose to the jury that Dr. Deno directed plaintiff to Charity because plaintiff lacked finances or hospitalization insurance;<sup>627</sup> and (2) Dr. Deno's fault in directing plaintiff to Charity because of the lack of finances or insurance is beyond the scope of the Louisiana Medical Malpractice Act (LMMA), and (3) because Dr. Deno's conduct was beyond the scope of the Louisiana Medical Malpractice Act (LMMA), application of the LMMA's limit on damages was impermissible.<sup>628</sup> On appeal, defendant Dr. Deno claimed that the jury was prejudiced by plaintiff's witnesses' references to race and socio-economic status.<sup>629</sup>

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x .0020366% = \$1,018.00).].

*Id.* The trial court decreed that the judgment in favor of plaintiff, Louis Coleman, against Dr. Richard Deno was \$98,971.70 with interest from April 1, 1991, with the LPCF paying all other interest. *Id.* at 458. The trial court ordered that the LPCF should receive credit of \$100,000 for the judgment rendered against Dr. Richard Deno, and awarded \$400,000 plus interest in favor of the plaintiff Louis Coleman against the LPCF. *Id.*

624. *Id.* at 458-59.

625. *Id.*

626. The intervenor, the Louisiana Patients' Compensation Fund, argued on appeal that:

(1) the trial court erred in denying Dr. Deno and the Fund's motions for new trial as well as JNOV, and the jury erred in finding that Dr. Deno was negligent; (2) there was no expert evidence to prove that Dr. Deno was negligent or caused or contributed to plaintiff's loss of his left arm; (3) the jury erred in failing to apportion fault to Charity; (4) the jury award was excessive; (5) the jury erred in awarding \$500,000 in special damages for lost wages or diminished earning capacity; (6) the trial court and jury erred in rendering an award to the minor son, Louis Frank Coleman, for loss of consortium; (7) the trial court erred in permitting plaintiff's witnesses to testify regarding the cost of plaintiff's future medical care and including \$500,000 for future medical care and related expenses in a lump sum; and (8) the trial court erred in failing to give the Patients' Compensation Fund a credit of \$110,000 for plaintiff pretrial settlements with JoEllen Smith and Charity Hospitals.

*Id.*

627. *Id.* at 459.

628. *Id.*

629. Dr. Deno also argued on appeal that:

(1) the jury charges were erroneous and confusing; (2) the verdict was contrary to the law and evidence; (3) the trial court erred in failing to apportion any fault to Charity; (4) the trial court verdict was manifestly erroneous because there was no credible evidence that the plaintiff was in need of future medical care; (5) the trial court abused its discretion in allowing testimony concerning the cost of a prosthesis device where there

Chief Appellate Justice, William H. Byrnes, III, delivered the opinion for the court.<sup>630</sup> Justice Byrnes held that Dr. Deno's fault in directing plaintiff's transfer to Charity for lack of finances or insurance created a timely action beyond the scope of the LMMA, thereby entitling plaintiff to the full amount of the jury award.<sup>631</sup> Justice Byrnes noted that the Supreme Court of Louisiana had previously held that provisions of the LMMA apply only to "malpractice" as defined in the LMMA, and any other liability faced by health care providers is governed by general tort law.<sup>632</sup> The court noted that the federal anti-dumping statute fails to provide a civil remedy against physicians,<sup>633</sup> and that Louisiana state law imposes upon hospitals the obligation to render emergency services to all persons regardless of insurance or economic status, but does not expressly impose or decline to impose the same obligation on physicians.<sup>634</sup>

Justice Byrnes stressed that as public policy the LMMA must be strictly construed against limiting the tort claimant's rights against the wrongdoer.<sup>635</sup> The court noted that, were the health care provider to commit an intentional tort against a patient or negligently injure that patient in a manner unrelated to medical treatment, the LMMA's limitation of liability would not be available.<sup>636</sup>

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was no expert testimony establishing that the device was medically necessary; (6) the jury verdict was manifestly erroneous because there was no evidence to support an award to the son, Louis Frank Coleman, for loss of consortium; and (7) the damage award to the minor son, Louis Frank Coleman, was extinguished by the award to his father, Louis I. Coleman.

*Id.*

630. *Id.* at 454.

631. *Id.* at 459.

632. *Id.* Justice Byrnes stated that this included those provisions of the LMMA that limited liability of qualified health care providers by providing a "maximum amount of damages, a mandatory pre-suit review by a medical review panel, and special prescriptive and preemptive periods." *Id.*

633. *Id.* (citing *McDougal v. Blanch*, 672 So. 2d 398, 400 n.3 (La. Ct. App.), *writ denied*, 674 So. 2d 973 (La. 1996)).

634. *Id.* (citing LA. REV. STAT. ANN. § 40:2113.4 (West 2001)). The appellate court also emphasized Dr. Deno's express granting of permission to the plaintiff to first go home, and then go to Charity hospital, noting:

Although he actually recognized, or should have recognized, the severe nature and seriousness of the plaintiff's arm infection, Dr. Deno nevertheless failed to hospitalize the plaintiff for immediate care and attention at JoEllen Smith Hospital, and instead instructed plaintiff to go to Charity Hospital, while at the same time giving him express permission to go first to his home to pick up certain belongings before going to Charity.

*Coleman v. Deno*, 787 So. 2d 446, 460 (La. Ct. App. 2001).

635. *Id.* at 461 (citing *Johns v. Agrawal*, 748 So. 2d 514 (La. Ct. App. 1999), *writ denied*, 754 So. 2d 944 (La. 2000); *Clark v. Baird*, 714 So. 2d 840 (La. Ct. App.), *writ denied*, 726 So. 2d 31 (La. 1998)).

636. *Coleman*, 787 So. 2d at 462 (citing *Descant v. Adm'rs of Tulane Educ. Fund*, 639 So. 2d 246 (La. 1994)).

Justice Byrnes specifically noted that intentional tort allegations do *not* fall within the province of the LMMA.<sup>637</sup> The court noted that the LMMA, as with medical malpractice acts of most states, governs only *unintentional* acts of *negligence* and contractual issues.<sup>638</sup> The court also noted that even JESH's policy provided that "every emergency room patient must receive appropriate treatment before discharge or transfer, regardless of financial status."<sup>639</sup> Justice Byrnes made clear that the "patient dumping" cause of action was not prohibited under the LMMA because of its status as an intentional tort, even though Dr. Deno's decision to transfer the plaintiff to Charity for lack of finances or insurance violated JESH's written policy.<sup>640</sup>

The appellate court concluded there was "no express state law that excludes recovery under [Louisiana Civil Code article 2315], general tort law [Louisiana Revised Statutes section 40:2113.4 to 40:2113.6], or against physicians for the intentional tort of patient dumping."<sup>641</sup> Justice Byrnes held that "[p]laintiff's reference to anti-dumping states a cause of action against the physician under Louisiana law."<sup>642</sup> Further, Justice Byrnes concluded that the nature of patient dumping precluded application of the LMMA, and that the plaintiff's amended petition stated a cause of action against defendant Dr. Deno, *beyond* the scope of the LMMA, thereby entitling the plaintiff to the jury award which would not be subject to the damage cap.<sup>643</sup>

Accordingly, Justice Byrnes, in recognizing the intentional tort of patient dumping, reinstated the jury's verdict against Dr. Deno and in favor of plaintiff.<sup>644</sup> The cause of action of patient dumping was permitted to exist even where EMTALA provisions were satisfied.<sup>645</sup>

#### D. *Supreme Court of Louisiana Opinion—Majority Opinion*

After an extensive rendition of the facts in *Coleman*, the Supreme Court of Louisiana's opinion consisted of three parts. The first part of the opinion addressed the nature of the plaintiff's patient dumping claim.<sup>646</sup> The second part addressed the standards for defining a medical malpractice, claim which consisted of an analysis

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637. *Id.* at 462 (citing LA. REV. STAT. ANN. § 40:1299.41A(8); *Richardson v. Advanced Cardiovascular Sys. Inc.*, 865 F. Supp. 1210 (E.D. La. 1994)).

638. *Id.*

639. *Id.*

640. *Id.*

641. *Id.*

642. *Id.*

643. *Id.* The LMMA has a \$500,000 damage cap. *Id.*

644. *Id.*

645. *Id.*

646. *See infra* notes 649-68 and accompanying text.

of six factors.<sup>647</sup> The third part of the Supreme Court of Louisiana's opinion addressed both plaintiff's and defendant's arguments with respect to the medical malpractice claim.<sup>648</sup>

The court characterized the plaintiff's patient dumping claim, as the intentional tort of improper transfer.<sup>649</sup> The court held that the nature of the claim of improper transfer (patient dumping) in this case was "really a claim of failure to properly diagnose, failure to stabilize, or both."<sup>650</sup> The court noted that "the court of appeal, with little analysis and citing no authority, characterized such a claim as outside the scope of 'malpractice' under the LMMA and thus justified the entire \$4,900,000 jury award."<sup>651</sup> The Supreme Court of Louisiana held that the appellate court erred both procedurally and substantively in this regard.<sup>652</sup>

The Louisiana Supreme Court recited the court of appeal's reasoning that "the 'patient dumping' cause of action refers to an intentional tort where Dr. Deno directed plaintiff's transfer to Charity for lack of finances or insurance although it conflicted with JoEllen Smith Hospital's written policy."<sup>653</sup> The supreme court utilized a two-prong approach to determine whether the patient's claim of patient dumping was outside the scope of "malpractice" under the LMMA and hence correct.<sup>654</sup> First, the supreme court distinguished the *Coleman* case from its prior two decisions, *Spradlin v. Acadia-St. Landry Medical Foundation*<sup>655</sup> and *Fleming v. HCA Health*

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647. See *infra* notes 670-94 and accompanying text.

648. See *infra* notes 695-703 and accompanying text.

649. *Coleman v. Deno*, 813 So. 2d 303, 313 (La. 2002).

650. *Id.*

651. *Id.*

652. *Id.* Procedurally, the Supreme Court of Louisiana held that neither *Coleman's* original nor amended petition alleged an intentional tort, and that the court of appeal thus crafted an intentional tort that "was not plead [sic], not prayed for in relief, not argued, not tried, and not submitted to the jury." *Id.* The court specifically noted that the plaintiff's original petition alleged only medical malpractice; the amended petition alleged only negligence *per se* based on EMTALA; and the pleadings were not expanded at trial, as provided for in LA. CIV. CODE ANN. art. 1154 (West 1997), to include such an alleged intentional tort. *Coleman*, 813 So. 2d at 313. The Supreme Court of Louisiana significantly noted that the court of appeal did not overrule the trial court's grant of Dr. Deno's exception of no cause of action as to the EMTALA claim and that *Coleman* did not contest that ruling. *Id.* at 313 n.13.

653. *Coleman*, 813 So. 2d at 313 (citing the lower court's opinion at 787 So. 2d 446, 463 (La. Ct. App. (2001))). The court also held that, because the JESH's policy was never introduced into evidence and was not even implemented until several months after *Coleman* presented there, the hospital policy was not relevant. *Id.* at 313 n.12.

654. See *id.* at 314 (noting that the court of appeal found that plaintiff's reference to anti-patient-dumping statutes in his amended petition sufficed to state a cause of action under Louisiana tort law).

655. 758 So. 2d 116 (La. 2000).

*Services of Louisiana, Inc.*,<sup>656</sup> in which it addressed patient dumping claims under the EMTALA and the Louisiana statutory counterpart.<sup>657</sup> Second, it added *sui generis* three factors to the previous list of three factors it had created in *Sewell v. Doctors Hospital*,<sup>658</sup> which may be used by courts in determining whether certain conduct by a qualified health care provider constitutes “malpractice” as defined by the LMMA.<sup>659</sup>

The Supreme Court of Louisiana distinguished *Coleman* from the two prior decisions by noting that the defendant in the case at bar was an emergency room physician as opposed to a hospital.<sup>660</sup> The court outlined two reasons for which it believed such a distinction was of importance. First, the court noted that the “statutory duties imposed by EMTALA . . . apply only to participating hospitals, not physicians . . . .”<sup>661</sup> Second, “hospitals are distinct legal entities that do not, in the traditional sense of the term, ‘practice’ medicine; whereas, physicians do ‘practice’ their profession, and their negligence in providing such professional services is termed ‘malpractice.’”<sup>662</sup> The court explained that attempts to imply a private cause of action against a physician have been rejected as inconsistent with both EMTALA’s congressional history<sup>663</sup> and with the Louisiana anti-dumping statutory scheme.<sup>664</sup> In addition, the LMMA applies

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656. 691 So. 2d 1216 (La. 1997).

657. *See id.* at 414 n.15 (distinguishing *Spradlin* from the case at bar, where the Supreme Court of Louisiana defined the term “patient dumping” as “the refusal to treat patients with emergency medical conditions who are uninsured and cannot pay for medical treatment or the transfer of such patients to a public hospital”).

658. 600 So. 2d 577, 579 n.3 (La. 1992); *see also infra* text accompanying note 670.

659. *See Coleman*, 813 So. 2d at 315-16 (citing Holly P. Rockwell, Annotation, *What Patient Claims Against Doctor, Hospital, or Similar Health Care Provider Are Not Subject to Statutes Specifically Governing Actions and Damages for Medical Malpractice*, 89 A.L.R.4TH 887 (1991)).

660. *See id.* at 314.

661. *Id.* (recognizing that the same reasoning applies to the Louisiana statutory counterpart to EMTALA).

662. *Id.* at 314-15 (explaining that the significance of the term “malpractice” is that it is used to “differentiate professionals from nonprofessionals for purposes of applying certain statutory limitations of tort liability” which was at issue in *Coleman* under the LMMA) (citing FRANK L. MARAIST & THOMAS C. GALLIGAN, JR., LOUISIANA TORT LAW § 21-2 (1996)).

663. *See id.* at 314 n.15 (citing *Eberhardt v. City of Los Angeles*, 62 F.3d 1253 (9th Cir. 1995)).

664. *Id.* (maintaining that the statutory scheme was designed to overcome common law, which failed to allocate a duty to *hospitals* to give emergency treatment to all persons) (citing LA. REV. STAT. ANN. §§ 40:2113.4 to :2113.6 (West 2001)). Additionally, the Supreme Court of Louisiana noted that in *Coleman*, it declined for the third time to decide whether the Louisiana statutory scheme, which includes its own penalty provisions, can form the basis for a private cause of action under general tort law. LA. CIV. CODE ANN. art. 2315 (West 1997). *See, e.g.*, *Spradlin v. Acadia-St. Landry Med. Found.*, 758 So. 2d 116 (La. 2000); *Fleming v. HCA Health Servs. of La.*, 691 So. 2d 1216 (La. 1997).

only to “malpractice” and all other tort liability on the part of a qualified health care provider is governed by general tort law.<sup>665</sup>

The court clarified that “‘malpractice’ means any *unintentional* tort or any breach of contract based on health care or professional services rendered, or which should have been rendered, by a health care provider, to a patient.”<sup>666</sup> The court reasoned that both statutory patient dumping claims and medical malpractice claims are simply particularized forms of torts that often overlap; even though all medical malpractice claims are personal injury claims, not every personal injury claim is a medical malpractice claim.<sup>667</sup> Consequently, “[i]t follows then that the court of appeal in this case legally erred in characterizing a claim for patient ‘dumping’ as always giving rise to an intentional tort and in reasoning that a bright line can be drawn between medical malpractice claims and patient ‘dumping’ claims.”<sup>668</sup>

The second part of the Supreme Court of Louisiana’s opinion addressed the standards for defining a medical malpractice claim.<sup>669</sup> The court listed three factors that have been used in Louisiana to determine whether certain conduct by a health care provider constitutes “malpractice” as defined under the LMMA: “(1) whether the particular wrong is ‘treatment related’ or caused by a dereliction of professional skill, (2) whether the wrong requires expert medical evidence to determine whether the appropriate standard of care was breached, and (3) whether the pertinent act or omission involved assessment of the patient’s condition.”<sup>670</sup> The court then adopted three additional factors: “(4) whether an incident occurred in the context of a physician-patient relationship, or was within the scope of activities which a hospital is licensed to perform, (5) whether the injury would have occurred if the patient had not sought treatment, and (6) whether the tort alleged was intentional.”<sup>671</sup> The court reasoned that application of the six factors to the evidence in *Coleman* led to the “inescapable conclusion” that Coleman’s claim of improper transfer (patient dumping) against Dr. Deno was within the ambit of the statutory definition of “malpractice,” and therefore within the

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665. *Coleman*, 813 So. 2d at 315 (defining “malpractice,” “tort,” and “health care” as referenced in Louisiana tort law); *see also infra* note 672 (providing specific definitions of these terms).

666. *Coleman*, 813 So. 2d at 315.

667. *Id.* (citing Scott E. Hamm, Note, *Power v. Arlington Hospital: A Federal Court End Run Around State Malpractice Limitations*, 7 BYU J. PUB. L. 335, 347-48 (1993)).

668. *Id.* at 315.

669. *See id.*

670. *Id.*; *see also* Sewell v. Doctors Hosp., 600 So. 2d 577, 579 n.3 (La. 1992) (citing Rockwell, *supra* note 659).

671. *Coleman*, 813 So. 2d at 316.

scope of the LMMA.<sup>672</sup>

In its analysis of the first factor, the Supreme Court of Louisiana disagreed with the plaintiff's assertion that Dr. Deno's conduct did not involve a breach of professional duty that was beyond the realm of professional treatment because Dr. Deno's decision to transfer Coleman was for economic reasons and not ordered for medical reasons.<sup>673</sup> Rather, the court reasoned that Dr. Deno's conduct consisted of properly diagnosing and treating, distinguishable from any decision to transfer him to Charity based on economic grounds.<sup>674</sup> The court's analysis relied on two prior Louisiana cases: *Spradlin v. Acadia St. Landry Medical Foundation*,<sup>675</sup> and *Bolden v. Dunaway*.<sup>676</sup> In noting that a decision to transfer a patient cannot easily be divorced from other treatment decisions, the court relied upon *Vachon v. Broadlawns Medical Foundation*<sup>677</sup> to conclude that Dr. Deno's decision as to where Coleman should be treated, Charity or JES, was a part of his medical treatment.<sup>678</sup> The court noted that in *Vachon*, a decision

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672. *Id.* at 316-18 (applying the six factors to the facts of the case, and concluding that the statutory definition of "malpractice," which expressly includes refusal to provide treatment that the plaintiff asserted "should have been performed or furnished" pursuant to LA. REV. STAT. ANN. § 40:1299.41A(8) and (9) (West 2001)). LA. REV. STAT. ANN. § 40:1299.41A(8) provides:

"Malpractice" means any *unintentional tort* or any breach of contract based on health care or professional services rendered, or which should have been rendered, by a health care provider, to a patient . . . (emphasis added).

LA. REV. STAT. ANN. § 40:1299.41A(9) provides:

"Health care" means any act, or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical care, treatment or confinement.

LA. REV. STAT. ANN. § 40:1299.41A(7) provides:

"Tort" means any breach of duty or any negligent act or omission proximately causing injury or damage to another. The standard of care required of every health care provider, except a hospital, in rendering professional services or health care to a patient, shall be to exercise the degree of skill ordinarily employed, under similar circumstances, by the members of his profession in good standing in the same community or locality, and to use reasonable care and diligence, along with his best judgment, in the application of his skill.

673. *Coleman*, 813 So. 2d at 316 (rejecting Coleman's argument that his transfer was directly related to his lack of insurance and ability to pay medical bills).

674. *Id.* at 316-17 n.17 (refuting Coleman's argument that relied heavily on the court of appeal decision in *Spradlin v. Acadia-St. Landry Medical Foundation*, 711 So. 2d 699 (La. App. 3d Cir. 1998), *aff'd*, 758 So. 2d 116 (La. 2000)).

675. 758 So. 2d 116, 122 n.10 (La. 2000) (repudiating broad statements of dicta made by the court of appeal—the same statements relied upon by Coleman).

676. 727 So. 2d 597, 601 (La. 1998), *writ denied*, 739 So. 2d 801 (La. 1999) (stating that the "legislature did not intend for applicability of the medical malpractice act to depend on the motives of the doctors, be it greed or philanthropy, at the time of the alleged wrongful acts"); *Coleman*, 813 So. 2d at 317.

677. 490 N.W.2d 820 (Iowa 1992).

678. *Coleman*, 813 So. 2d at 317 (holding that the decision to transfer a patient who had developed compartment syndrome to a charity hospital, or to a private

of whether a patient should be “transferred for care to charity hospital,” was part of the “treatment” of a patient who developed compartment syndrome.<sup>679</sup>

Analyzing the second malpractice-determinative factor concerning expert medical evidence to determine whether the appropriate standard of care was breached, the court noted that it was necessary to use expert medical testimony when the facts of the case involved a professional act of medical practice.<sup>680</sup> The Supreme Court of Louisiana bolstered its support for this factor by highlighting the “sheer number of experts that were called to testify,”<sup>681</sup> and that the type of evidence was beyond the common recognition of “obvious negligence.”<sup>682</sup>

The third factor considered was whether the pertinent act or omission involved assessment of the patient’s condition.<sup>683</sup> The court relied upon the evidence at trial that “the receiving facility [Charity] had better access to laboratory and radiology at the time of the transfer (in the middle of the night), and was better able to care for Coleman’s condition.”<sup>684</sup> The court reasoned that access to resources for the plaintiff’s care was related to the assessment of the patient’s condition.<sup>685</sup>

The fourth factor addressed was whether the incident in question was within the context of a physician-patient relationship.<sup>686</sup> Here, the Supreme Court of Louisiana determined that the transfer decision “clearly occurred” in the context of a physician-client relationship, and any attempt to divorce transfer decisions from treatment decisions was without merit.<sup>687</sup>

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hospital that was closer, was considered “treatment”) (citing *Vachon v. Broadlawns Med. Found.*, 490 N.W.2d 820 (Iowa 1992)).

679. *Id.*

680. *See id.* (reasoning that expert testimony was necessary to determine whether there was a breach of care on the part of an emergency physician at a Level II trauma center, and if so, the extent of that breach).

681. *Id.*

682. *Id.* (citing *Pfiffner v. Correa*, 643 So. 2d 1228, 1234 (La. 1994) (giving examples of “obvious negligence” as the “[f]ailure to attend a patient when the circumstances demonstrate the serious consequences of this failure, and failure of an on-call physician to respond to an emergency when he knows or should know that his presence is necessary”).

683. *Id.* at 318.

684. *Id.*

685. *See id.* (noting, however, that Dr. Deno’s inquiry into Coleman’s financial status did not “remove this matter from the arena of medical malpractice”).

686. *See id.* (stating that an incident within the scope of activities which a hospital is licensed to perform is also within the scope of the inquiry).

687. *Id.*

Fifth, the court considered whether the injury would have occurred if the patient had not sought treatment.<sup>688</sup> The court discounted an analogy to the transfer decision as “the cashier at the hospital’s window,” by an amicus party in this case.<sup>689</sup> The court concluded that “common sense indicates that a claim based on failure to provide enough treatment is clearly linked to treatment.”<sup>690</sup>

Lastly, the Supreme Court of Louisiana considered whether the tort alleged was intentional.<sup>691</sup> It found the court of appeal’s characterization of Coleman’s dumping claim as an intentional tort “both procedurally and substantively flawed,”<sup>692</sup> and concluded that the conduct in this case did not consist of “obvious negligence,” but instead required expert testimony.<sup>693</sup> Consequently, it determined that the tort alleged cannot exist as intentional.<sup>694</sup>

The third part of the court’s opinion addressed the plaintiff’s and defendant’s arguments in respect to the medical malpractice claim.<sup>695</sup> The court responded to Dr. Deno’s medical malpractice arguments, stating that “[w]hile we admit it is a close call, the evidence sufficiently supports a finding of some fault by Dr. Deno, although not 100 percent of the fault. In failing to allocate any fault to CHNO [Charity], we find that the jury manifestly erred.”<sup>696</sup> The Supreme Court of Louisiana, however, then relied upon the same arguments to attribute fault to Charity.<sup>697</sup> As a result, the court attributed

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688. *Id.*

689. *Id.*

690. *Id.* (recognizing that Dr. Deno had, in fact, provided Coleman with treatment, including the correct diagnosis of cellulitis and his need for antibiotics).

691. *Id.*

692. *Id.*

693. *See id.* (finding the facts in this case to be outside the definition of negligence as set forth in *Pfiffner v. Correa*, 643 So. 2d 1228, 1234 (La. 1994)); *see supra* note 682 (providing examples of negligence).

694. *See Coleman*, 813 So. 2d at 318-21 (determining that Coleman’s claims are entirely governed by the LMMA, and citing with approval the appellate court’s reasoning and granting of the JNOV in respect to Dr. Sherman, and remanded the matter to the court of appeal on the issues of quantum and application of the LMMA’s limitations to the ultimate damage award).

695. *Id.* at 319-21.

696. *Id.* at 319.

697. *Id.* at 319-21 (supporting the court’s decision using the plaintiff’s two medical experts: Dr. Paul Blaylock and Dr. Neil Crane). Dr. Paul Blaylock, board-certified in both emergency and legal medicine, testified that,

no valid medical reason existed for Dr. Deno to send the plaintiff to Charity, a Level I Trauma Center, at a time when his severe arm infection required immediate attention . . . [and] Dr. Deno should never have discharged Coleman without treatment because “the risk of the infection getting worse, much worse, was very high.”

*Id.*

Dr. Blaylock further testified that Dr. Deno should have initiated antibiotic treatment, taken both blood and infection site cultures, and transferred the patient

seventy-five percent of the fault to Charity and twenty-five percent to Dr. Deno.<sup>698</sup>

Accordingly, the Supreme Court of Louisiana reversed the intentional tort finding of patient dumping by the court of appeal,<sup>699</sup> affirmed the finding of malpractice liability on the part of Dr. Deno,<sup>700</sup> but modified the fault allocation and held that Dr. Deno was only twenty-five percent liable.<sup>701</sup> The Supreme Court of Louisiana remanded the matter to the court of appeal for a quantum review of damages and to render a judgment in accordance with the limitations of the LMMA.<sup>702</sup> On remand, the court of appeal was instructed both to conduct a meaningful quantum review and to render judgment in accordance with the limitations of the LMMA.<sup>703</sup>

#### *E. Supreme Court of Louisiana Opinion—Minority Opinion*

Justice Knoll and Justice Johnson wrote dissenting opinions in *Coleman*.<sup>704</sup> Justice Knoll concurred with the majority opinion, finding

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by ambulance. *Id.* at 320. Dr. Blaylock testified that “the sooner you diagnose the infection; the sooner you treat it, the better the progress.” *Id.* Dr. Blaylock surmised that the plaintiff’s arm “would have been saved had proper medical treatment been provided [by Dr. Deno].” *Id.*

Dr. Neil Crane, board-certified in both internal and infectious disease medicine, testified that Dr. Deno was confronted with a “necrotizing cellulitis”—an infection which progresses exponentially. *Id.* Accordingly, Dr. Crane testified that, the earlier treatment was provided, the better the chance of achieving a good result. *Id.* Dr. Crane further testified that when Coleman was presented to Dr. Deno, his condition was both “limb threatening and life threatening,” and required immediate emergency treatment. *Id.*

While the plaintiff settled with Charity pre-trial for \$25,000, the issue of Charity’s fault was put before the jury by way of special interrogatory. *Id.* at 311.

698. *Id.* at 321.

699. *Id.*

700. *Id.* (affirming, in addition, the grant of judgment notwithstanding the verdict dismissing the malpractice claim against Dr. Sherman).

701. *Id.* The court’s final decree was concurred by Justices Knoll (in part), Johnson (in part), Victory (in part) and Traylor (in part), and was dissented by Justices Knoll (in part), Johnson (in part), Victory (in part for the reasons assigned by Justice Knoll) and Traylor (in part for the reasons assigned by Justice Knoll). *See id.* at 321-25. Justices Knoll and Johnson published the dissenting opinions. *Id.*

702. *See id.* at 321 (finding that the “most glaring error in the appellate court’s analysis is in the treatment of damages, especially general damages”). The court held that:

[T]he appellate court’s one paragraph analysis of this sizeable general damage award was not sufficient to constitute a meaningful review of general damages. Indeed, the appellate court failed to make even the initial inquiry required for a meaningful review of a general damage award of “whether the particular effects of the particular injuries to the particular plaintiff are such that there has been an abuse of the ‘much discretion’ vested in the judge or jury.”

*Id.* at 321 (citing 1 FRANK L. MARAIST & HARRY T. LEMMON, LOUISIANA CIVIL LAW TREATISE: CIVIL PROCEDURE § 14.14 (1999)).

703. *Id.*

704. *Id.* at 322-25.

that the lower courts erred in finding an intentional tort of “patient dumping.”<sup>705</sup> Justice Johnson joined the majority in affirming the finding of medical malpractice liability on the part of Dr. Deno, but dissented from the majority’s finding that the plaintiff’s claim of patient dumping was one of medical malpractice.<sup>706</sup> Rather, Justice Johnson believed that Dr. Deno’s conduct constituted an intentional tort.<sup>707</sup>

Justice Johnson based his dissent upon the Supreme Court of Louisiana’s previous holding that patient dumping is governed by general tort law and not by the LMMA.<sup>708</sup> Relying upon *Spradlin v. Acadia-St. Landry Medical Foundation*,<sup>709</sup> Justice Johnson reasoned that despite the fact that the federal and state anti-dumping statutes prohibit action by hospitals and not physicians, “a hospital can only act through agents/employees and can be held accountable under a theory of vicarious liability.”<sup>710</sup> Justice Johnson agreed with the reasoning of the court of appeal that the LMMA only encompasses *unintentional* acts of negligence and contractual issues.<sup>711</sup> He emphasized that “it is *impossible* for a physician to negligently or *unintentionally* transfer an uninsured patient from a private hospital to a public hospital because of an inability to pay.”<sup>712</sup> Accordingly, Justice Johnson concluded that “it is clear that plaintiff’s claim for ‘patient dumping’ falls outside the scope of the Medical Malpractice Act.”<sup>713</sup>

Further, Justice Johnson surmised that Dr. Deno’s testimony, referring to the transfer of the plaintiff from JESH to Charity because it had a better trauma center, is “clearly pretextual and not worthy of belief.”<sup>714</sup> Justice Johnson pointed out that the plaintiff was diagnosed with cellulitis of the arm and “was not in need of trauma treatment. He simply needed to be admitted to the hospital for intravenous

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705. *Id.* at 322. While Justice Knoll concurred with the majority opinion finding that the lower courts erred in finding an intentional tort of “patient dumping,” he disagreed with the majority’s conclusion that there was no manifest error in the jury’s finding of malpractice against Dr. Deno. *Id.* Justice Knoll believed the record clearly supported that Dr. Deno was not negligent in his medical treatment of Coleman, and consequently, Coleman’s allegations against Dr. Deno should be dismissed for lack of causation. *Id.*

706. *Id.*

707. *Coleman*, 813 So. 2d at 322.

708. *Id.*

709. 758 So. 2d 116 (La. 2000).

710. *Coleman*, 813 So. 2d at 322.

711. *Id.*

712. *Id.* (first emphasis added and second emphasis in the original).

713. *Id.*

714. *Id.*

antibiotic treatment.”<sup>715</sup> Thus, he concluded that “Dr. Deno decided to transfer plaintiff to Charity Hospital *because* he determined that plaintiff *could not afford to pay* for inpatient treatment at JoEllen Smith, not because he wanted plaintiff to have the benefit of a superior treatment facility. He therefore made an economic and not a medical decision.”<sup>716</sup>

*F. Analysis of Supreme Court of Louisiana Opinion*

Utilizing sophistic logic, the Supreme Court of Louisiana opinion in *Coleman v. Deno* represents a strenuous effort to avoid recognition of reprehensible physician conduct known as patient dumping, and to avoid remedy of that conduct through tort law. The court chose to lose sight of its legal duty to “resolve all reasonable inferences or factual questions in favor of the plaintiff,”<sup>717</sup> which resulted in a flawed, yet outcome determinative, opinion. There are at least eleven problems with the Supreme Court of Louisiana opinion.

First, the Supreme Court of Louisiana re-casted the facts of the case in a manner most conducive with its desired outcome. For instance, the court, as well as Dr. Deno, passed off quite lightly the significantly abnormal physical signs of the distress Coleman experienced. They stated “[w]ith the exception of an elevated temperature (102.8 degrees Fahrenheit), and heart rate (120 beats per minute), [Coleman’s] vital signs were normal.”<sup>718</sup> However, a temperature of 102.8 degrees Fahrenheit and a heart rate of 120 beats per minute are not so easily discounted, as demonstrated by the medical outcome of this matter—the amputation of an arm through shoulder articulation. Remarkably, the court based its opinion, in part, upon its understanding that “Coleman was stable” and “in good condition.”<sup>719</sup> Furthermore, to bootstrap its finding that transfer was permissible, the court appears to have adopted Dr. Deno’s characterization of Coleman’s condition as a “complicated

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715. *Id.*

716. *Id.* (emphasis added).

717. *Id.* at 319 (approving the court of appeal’s reasoning that even construing reasonable inferences and factual questions in a light most favorable to the plaintiff, a reasonable person still could not find, based on the evidence, that Dr. Sherman proximately caused the plaintiff’s loss). The Supreme Court of Louisiana, therefore, affirmed the court of appeal’s grant of JNOV in favor of Dr. Sherman. *Id.*

718. *Id.* at 308.

719. *Id.* at 309. The court believed Dr. Deno’s testimony that the decision to transfer Coleman was made after a complete medical evaluation. *Id.* at 318; *see supra* notes 683-85 and accompanying text (discussing the third malpractice-determinative factor considered by the court—whether the pertinent act or omission involved assessment of the patient’s condition).

infection.”<sup>720</sup> In fact, while his infection represented a serious threat to life [and limb], it is of the type which responds to antibiotics—assuming they are administered in the first instance.<sup>721</sup>

Second, the court misunderstood the application of EMTALA to physicians. The court relied on its distinction of the facts of *Coleman* with case precedents that concerned defendant hospitals.<sup>722</sup> The significance of that distinction, the court believed, was two-fold. First, the Supreme Court of Louisiana was under the impression that EMTALA’s statutory duties “apply only to participating hospitals, not physicians.”<sup>723</sup> Second, the court noted that “hospitals are distinct legal entities that do not, in the traditional sense of the term, ‘practice’ medicine; whereas, physicians do ‘practice’ their profession, and their negligence in providing such professional services is termed ‘malpractice.’”<sup>724</sup> The court explained that attempts to imply a private cause of action against a physician have been rejected as inconsistent with EMTALA’s congressional history<sup>725</sup> and the court declined to say whether it was consistent with Louisiana anti-patient-dumping statutory scheme.<sup>726</sup>

By misunderstanding that EMTALA duties in fact become physician duties, the court missed the point as to how physicians are duty bound—and legally bound—by EMTALA.<sup>727</sup> It is precisely because hospitals do not practice medicine that the EMTALA duties of “appropriate medical screening examination”<sup>728</sup> and “necessary

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720. *Id.* at 308.

721. *See id.* at 319-320 (relying upon the medical testimony of plaintiff’s two expert witnesses, Dr. Blaylock and Dr. Crane); *see supra* note 697 (describing the plaintiff’s expert witness testimony).

722. *See Coleman*, 813 So. 2d at 314 (relying on *Spradlin v. Acadia-St. Landry Med. Found.*, 758 So. 2d 116 (La. 2000); *Fleming v. HCA Health Servs. of La., Inc.*, 691 So. 2d 1216 (La. 1997)).

723. *Id.* The court held the same for the Louisiana statutory counterpart to EMTALA. *Id.*

724. *Id.* at 314-15 (citing FRANK L. MARAIST & THOMAS C. GALLIGAN, JR., LOUISIANA TORT LAW § 21-2 (1996)). The Supreme Court of Louisiana further explained that the significance of the term “malpractice” was that it is used to “differentiate professionals from nonprofessionals for purposes of applying certain statutory limitations of tort liability” which was at issue in *Coleman* under the LMMA. *Id.*

725. *See id.* at 314 n.15 (declaring that the plain text of 42 U.S.C. § 1395dd(d)(2) allows a civil action against only the participating hospital, not the physician) (citing *Eberhardt v. City of Los Angeles*, 62 F.3d 1253 (9th Cir. 1995)).

726. *Id.* (noting that even though the Louisiana “anti-dumping” statutory scheme, LA. REV. STAT. ANN. § 40:2113.4 to :2113.6 (West 2001), establishes a duty for hospitals to provide emergency treatment, the issue of whether the scheme can form the basis of a private cause of action under general tort law was factually not before the court because the defendant in *Coleman* was a physician and not a hospital).

727. *See supra* Part III.C.2 (describing EMTALA duties and physician duties).

728. 42 U.S.C. § 1395dd(a) (2000) (defining “appropriate medical screening examination”).

stabilizing treatment”<sup>729</sup> become duties of the physician.<sup>730</sup> By concentrating on the fact that the remedy for failures to perform those duties are in the form of a private action against the hospital, and not the physician, the court misunderstood the essence and purpose of EMTALA. Indeed, it is because there is no private action against physicians, either through EMTALA or through state law, that patient dumping flourishes.<sup>731</sup>

Third, with respect to the nature of a medical malpractice claim, the Supreme Court of Louisiana used flawed logic to suggest that the court of appeal erred in deciding that claims of patient dumping always give rise to an intentional tort and in claiming that a “bright line can be drawn between medical malpractice claims and patient ‘dumping’ claims.”<sup>732</sup> The court reasoned that although both statutory patient dumping claims and medical malpractice claims are particularized forms of torts that often overlap, and even though all medical malpractice claims are personal injury claims, not every personal injury claim is a medical malpractice claim.<sup>733</sup> By such a characterization, the court evidences its misunderstanding of what patient dumping is. That is, although the particularities of patient dumping may overlap with medical malpractice and personal injury claims, the nature of the tort of patient dumping is non-medical decision-making founded upon discrimination based on non-medical factors, e.g., race, ethnicity, sexual orientation, socially unacceptable disease, financial status, etc.<sup>734</sup>

Fourth, in considering whether the particular wrong in *Coleman* was a “treatment related” dereliction of professional skill, the Supreme Court of Louisiana simply re-characterized the plaintiff’s denomination of Dr. Deno’s conduct into one of properly diagnosing-treating rather than one based on economic grounds.<sup>735</sup>

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729. *Id.* § 1395dd(b) (defining “necessary stabilizing treatment”).

730. *See supra* notes 540-83 and accompanying text (discussing the establishment of physician duties and obligations, and therefore liability, under EMTALA).

731. *See* H.R. REP. NO. 241 (III) (1986), *reprinted in* 1986 U.S.C.C.A.N. 728 (noting that “the ability to assess this fine against the responsible physician as well as the hospital will be a strong incentive for both to respond to the medical needs of individuals with emergency medical conditions and women in active labor”).

732. *Coleman v. Deno*, 813 So. 2d 303, 316 (La. 2002).

733. *Id.* at 315.

734. *See Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 272 (6th Cir. 1990) (noting that a “hospital that provides a substandard (by its standards) or nonexistent medical screening for any reason (including, without limitation, race, sex, politics, occupation, education, personal prejudice, drunkenness, spite, etc.) may be liable under EMTALA”).

735. *Coleman*, 813 So. 2d at 316 (citing *Spradlin v. Acadia-St. Landry Med. Found.*, 711 So. 2d 699 (2000); *Bolden v. Dunaway*, 727 So. 2d 597 (1999)). The court in *Spradlin* held that the LMMA was not applicable to suits against physicians or

Such reasoning by the court is odd, as the court admitted that Dr. Deno's reason, in part, to transfer the plaintiff to Charity was based on "economic grounds."<sup>736</sup> In order to support its re-characterization of the plaintiff's assertions regarding Dr. Deno's conduct being beyond the realm of the LMMA, the court discounted the *Coleman* plaintiff's reliance on *Spradlin v. Acadia-St. Landry Medical Foundation*.<sup>737</sup> Although *Spradlin* was affirmed,<sup>738</sup> the Supreme Court of Louisiana reasoned that the language in *Spradlin* relied on by the *Coleman* plaintiff was merely dicta, as the court did not address the nature of the EMTALA claim in *Spradlin*.<sup>739</sup> Even the dissent by Justice Johnson identified the supreme court's reasoning as strained.<sup>740</sup> Additionally, in relying on *Bolden v. Dunaway*<sup>741</sup> to defeat plaintiff's characterization of Dr. Deno's conduct,<sup>742</sup> the court's logic again was flawed. In *Bolden*, a physician's decision to leave the hospital and not operate on his patient who had been prepped for surgery, because his fee was not in his pocket, was not deemed a non-medical related intentional act, but rather an act based on rendering professional health care services *because* such a decision was a breach of contract based on a failure to render professional services that the physician had *previously agreed* to provide.<sup>743</sup> The facts in *Coleman* do

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hospitals for damages resulting from economic decisions. *Spradlin*, 711 So. 2d at 701. The court in *Bolden* held that the LMMA applied to a suit in which a physician refused to perform surgery on a patient who had not made appropriate financial arrangements. *Bolden*, 727 So. 2d at 602.

736. *Coleman*, 813 So. 2d at 308 n.3 (admitting that Dr. Deno's reason for transfer was financially-based, but that Dr. Deno would have arranged for the plaintiff's treatment at JESH if he was not able to transfer the plaintiff to Charity).

737. 711 So. 2d 699, 699-700 (La. Ct. App. 1998) (*Spradlin I*). In *Spradlin I*, the Court of Appeal of Louisiana, Third Circuit, affirmed the judgment of the trial court on the issue of whether a cause of action alleging the failure of a hospital's emergency department to treat and stabilize a patient based on *lack of means* bypasses the procedural and substantive limitations imposed by the LMMA. *Spradlin I*, 711 So. 2d at 699-700. The court in *Spradlin I* held that, while the LMMA governs suits involving malpractice, it does "not control suits for damages not contemplated by the LMMA," including indigent patient dumping. *Id.* at 699.

738. *Spradlin v. Acadia-St. Landry Med. Found.*, 758 So. 2d 116 (La. 2000) (*Spradlin II*). Although the court affirmed *Spradlin I* in *Spradlin II*, the Supreme Court of Louisiana in *Coleman* noted that it had "repudiated" various "broad statements" of the dicta in *Spradlin I*. *Coleman*, 813 So. 2d at 316 n.17.

739. *Coleman*, 813 So. 2d at 316. In *Spradlin II*, on petition for certiorari, the judgment of the court of appeal was affirmed, holding claims under EMTALA and the state anti-patient-dumping statute, when joined with medical malpractice claims, were subject to the pre-suit medical review panel requirement of the LMMA. *Spradlin II*, 758 So. 2d at 124.

740. *Coleman*, 813 So. 2d at 322 (Johnson, J., concurring in part and dissenting in part).

741. 727 So. 2d 597 (La. Ct. App.), *writ denied*, 739 So. 2d 801 (La. 1998).

742. *Coleman*, 813 So. 2d at 317.

743. See *Bolden*, 727 So. 2d at 600 (stating that the plaintiffs' restructuring of their claims does not escape the fact that there was a contractual relationship with the

not support the Supreme Court of Louisiana's contractual theories of *Bolden*.

Fifth, the court's interpretation of and reliance on *Vachon v. Broadlawns Medical Foundation*,<sup>744</sup> with respect to the location where the plaintiff should have been treated, was disheartening.<sup>745</sup> The court either misunderstood *Vachon*, or its implications regarding *Vachon* are disingenuous for at least three reasons. First, the phrase "charity hospital" does not appear in the *Vachon* decision; rather, "Charity" was the name of the hospital in *Coleman*.<sup>746</sup> This was as an improper characterization of the facts of *Vachon* by the Supreme Court of Louisiana in an attempt to make it analogous to *Coleman*. The transfer in *Vachon* was to the University Hospital in Iowa City.<sup>747</sup> Second, the decision in *Vachon* was not merely a decision to transfer to a "charity" hospital or to a "closer hospital," as implied by the court.<sup>748</sup> Rather, the patient in *Vachon* had "severe multiple trauma injuries,"<sup>749</sup> and as such the transfer obviously involved the decision to send the patient to a facility which had a higher level of care so the patient could receive treatment for the "multiple trauma" that was not otherwise available.<sup>750</sup> Third, the University hospital in *Vachon* was not just the only Level I full tertiary care center in the area; it also was the only center for specialized treatment of orthopaedic trauma in the entire state of Iowa.<sup>751</sup> As Justice Johnson's dissent pointed out, the plaintiff in *Coleman* did not have multiple traumas—he had a simple infection, uncared for due to economic grounds.<sup>752</sup> Even if, *arguendo*, the plaintiff's infection in *Coleman* were due to trauma,

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defendant). The court of appeal also noted that the motives of the physician at the time of the alleged wrongful act are not dispositive in deciding whether LMMA applies. *Id.* at 601.

<sup>744</sup> 490 N.W.2d 820 (Iowa 1992).

<sup>745</sup> *Coleman*, 813 So. 2d at 317.

<sup>746</sup> *See id.* (stating the *Vachon* court held that the "decision of whether patient should be transferred for care to *charity* hospital, which was the only Level I full tertiary care center, or to private a hospital that was closer was part of 'treatment' of patient who developed compartment syndrome") (emphasis added).

<sup>747</sup> *Vachon*, 490 N.W.2d at 823.

<sup>748</sup> *Coleman*, 813 So. 2d at 317.

<sup>749</sup> *Vachon*, 490 N.W.2d at 823.

<sup>750</sup> *Coleman*, 813 So. 2d at 317. The Supreme Court of Louisiana is obviously unaware that most Emergency Medical Systems throughout the nation utilize various treatment protocols wherein patients with multiple trauma are taken by paramedics preferentially to regional trauma center. ADVANCED TRAUMA LIFE SUPPORT FOR DOCTORS, AMERICAN COLLEGE OF SURGEONS, COMMITTEE ON TRAUMA, INSTRUCTOR COURSE MANUAL 23, 25 (1997). Alternatively, also per most Emergency Medical Systems treatment protocols throughout the nation, where a multiple injured trauma patient is first taken to a non-trauma treatment facility, the patient generally is stabilized and then transferred to the trauma center. *Id.*

<sup>751</sup> *Vachon*, 490 N.W.2d at 823.

<sup>752</sup> *Coleman*, 813 So. 2d at 322-23.

there is no indication of “multiple trauma” as in *Vachon*. Additionally, *Vachon* involved a patient being transferred because medical services were not available at the initial treating hospital.<sup>753</sup> However, in *Coleman*, the opposite was true—antibiotics were available, but Dr. Deno did not administer them for economic reasons.<sup>754</sup> Such services—the administration of intravenous antibiotics—are commonly available to patients in any hospital emergency department in the United States.

Sixth, the court’s opinion again was logically and legally inconsistent with respect to whether a wrong requires expert medical evidence to determine if the appropriate standard of care was breached.<sup>755</sup> Oddly, the court based the need for expert testimony on the fact that a large number of experts had testified.<sup>756</sup> Thus, the Supreme Court of Louisiana mistakenly decided that expert testimony was legally required simply because many experts in fact testified.

Seventh, the court’s opinion is heavily burdened with reliance on Dr. Deno’s arguably pretextual statements.<sup>757</sup> The court adopted the defendant’s assertion that the decision to transfer was made after an assessment of Coleman’s condition.<sup>758</sup> However, in its attempts to make medical determinations, the court erred. The court assumed that “the receiving facility [Charity] had better access to laboratory and radiology at the time of the transfer (in the middle of the night) and was better able to care for Coleman’s condition.”<sup>759</sup> However, the court apparently forgot that the patient did not want for “better access to laboratory and radiology;”<sup>760</sup> the patient required something as simple as the administration of intravenous antibiotics.<sup>761</sup> After all, as the court notes, Dr. Deno determined that the patient’s medical status was stable.<sup>762</sup> If the necessity of transfer was truly dependent upon the need for access to laboratory and radiology services, then Dr. Deno’s conclusion regarding stability, upon which the court depended, would have been illogical. The court’s acceptance of Dr. Deno’s pretext was also addressed by Justice Johnson’s dissent, which

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753. *Vachon*, 490 N.W.2d at 822.

754. *Coleman*, 813 So. 2d at 308. In fact, Dr. Deno testified that he would have treated the plaintiff at JESH if he was not accepted at Charity. *Id.* at 308 n.3.

755. *Coleman*, 813 So. 2d at 317.

756. *Id.*

757. *Id.* at 318.

758. *Id.*

759. *Id.*

760. *Id.*

761. *Id.* at 308.

762. *Id.* at 318.

noted that Dr. Deno's testimony in regard to his reasons for transfer was "clearly pretextual and not worthy of belief."<sup>763</sup>

Eighth, the court, with little inquiry and citing no authority, addressed the issue of whether the incident occurred in the context of a physician-patient relationship, or was within the scope of activities which a hospital is licensed to perform.<sup>764</sup> Here, the court summarily deemed the transfer decision to have occurred in the context of a physician-client relationship, and that any attempts to divorce transfer decisions from the treatment decisions are, *ipso facto*, made without merit.<sup>765</sup>

Ninth, the court's analysis disregarded the crux of patient dumping when it considered whether the injury would have occurred if the patient had not sought treatment.<sup>766</sup> The court concluded that "common sense indicates that a claim based on failure to provide enough treatment is clearly linked to treatment."<sup>767</sup> The court failed to perceive that, in patient dumping, the critical inquiry is not necessarily what was done for a patient, but rather what was not done.<sup>768</sup> Here, the plaintiff did not receive the simple administration of intravenous antibiotics, inaction that was based on non-medical, economic motivating factors.<sup>769</sup>

Tenth, the Supreme Court of Louisiana, with strained logic and little analysis, summarily concluded that because the "court of appeal's characterization of Coleman's dumping claim as an intentional tort is both procedurally and substantively flawed," and because the conduct in this case does not consist of obvious negligence, but rather requires expert testimony, the tort alleged cannot exist as intentional.<sup>770</sup> However, only a sophist's logic would require a matter to be first denominated as "obvious negligence" as a condition precedent to its classification as an "intentional tort." By such logic, the Supreme Court of Louisiana is apparently advocating that for a matter to be considered an intentional tort, there must be first, *a priori*, a determination of negligence. Furthermore, apparently

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763. *Id.* at 322.

764. *Id.* at 318.

765. *Id.*

766. *Id.*

767. *Id.*

768. See Robert M. Ey, *Establishing Hospital Liability Under the Emergency Medical Treatment and Active Labor Act for "Patient Dumping"*, 62 AM. JUR. TRIALS 119, § 6, at 135-36 (1997) (noting that the typical screening violation will be established "by identifying some component of the defendant's standard or usual screening procedure that was omitted in the plaintiff's case").

769. *Coleman*, 813 So. 2d at 308.

770. *Id.* at 318 (citing *Pfiffner v. Correa*, 643 So. 2d 1228, 1234 (La. 1994)).

the Court proposes that because expert testimony is required, the matter cannot be denominated as an intentional tort, but rather must, therefore, be classified as negligence.

Finally, the court used the strong arguments that were employed to find fault with Dr. Deno<sup>771</sup> as a way to attribute fault to Charity—a non-party defendant.<sup>772</sup> The court relied heavily on the strong testimony of both plaintiff's experts, who opined that Dr. Deno breached the standard of care for an emergency physician at a Level II Trauma Center by failing to provide immediate antibiotic treatment,<sup>773</sup> and that such a breach led to the subsequent amputation of the plaintiff's arm.<sup>774</sup> However, the Supreme Court of Louisiana re-casted the import of such expert testimony. Whereas the expert testimony severely ridiculed the *lack* of treatment by Dr. Deno in his *failure* to provide *any* antibiotics to the plaintiff,<sup>775</sup> the court relied on the importance of the use of such antibiotics in proclaiming that the *delay* of such antibiotics by Charity was commensurate with an appropriation of seventy-five percent fault to Charity and only twenty-five percent to Dr. Deno.<sup>776</sup> In that way, the Supreme Court of Louisiana attributed seventy-five percent fault to a non-party defendant and achieved the result it desired.

#### V. THE NEW INTENTIONAL TORT OF PATIENT DUMPING

Over the past sixteen years, numerous suggestions have been made to resurrect the sloppy EMTALA legislation to curb the rise of patient dumping. Some have suggested even more federal legislation.<sup>777</sup> Others have suggested segmental statutory resurrection by either

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771. *Id.* at 320.

772. *Id.* at 320-21. The plaintiff settled with Charity pre-trial for \$25,000; however, the issue of Charity's fault was put before the jury by way of special interrogatory. *Id.* at 311.

773. *Id.* at 319.

774. *Id.* at 320.

775. *Id.*

776. *Id.* at 321.

777. *See, e.g.*, Access to Emergency Medical Services Act of 1999, S. 517, 106th Cong. § 2 (1999) (incorporating by reference the vague language of EMTALA); Patient Access to Responsible Care Act of 1997, S. 644, 105th Cong. § 2771, H.R. 1415, 105th Cong. § 2771 (1997) (providing that health insurance providers establish care for enrollees); Quality Health Care and Consumer Protection Act, H.R. 1222, 105th Cong. § 2 (1997) (stating that the purpose of the proposed legislation is to ensure that managed health care services provide enrollees with access to adequate health services); Health Insurance Bill of Rights Act of 1997, S. 373, 105th Cong. § 2771, H.R. 820, 105th Cong. § 2771 (1997) (prohibiting specified restrictions on access to emergency services); Managed Care Consumer Protection Act of 1997, H.R. 337, 105th Cong. (1997) (providing for access to health care services and protections for enrollees of such services generally by amending the Internal Revenue Code Act of 1986 and the Social Security Act).

including new phrases,<sup>778</sup> providing definitions for clarity,<sup>779</sup> including the language of tort,<sup>780</sup> or even by having Congress attempt to repair curatively the mis-match between its original congressional intent and the final statutory language.<sup>781</sup> Some have suggested criminal action against hospitals, physicians, and nurses.<sup>782</sup> Although complex, our solution is the creation of a new<sup>783</sup> state cause of action:<sup>784</sup> the

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778. See GEORGE J. ANNAS, *SOME CHOICE: LAW, MEDICINE, AND THE MARKET* 85 (Oxford Univ. Press 1998) (asserting that emergency care legislation should hold treating hospitals and physicians to a legal standard that is “consistent with reasonable medical standards”).

779. See Mark Strasser, *The Futility of Futility?: On Life, Death, and Reasoned Public Policy*, 57 MD. L. REV. 505, 509 (1998) (suggesting that Congress amend the Act to “clarify what it intends EMTALA to include” such as “specifying that the Act is intended to apply only to indigent care”).

780. See Singer, *supra* note 14, at 160 (suggesting that Congress should amend EMTALA to “define an appropriate screening examination as one that is free from gross misconduct”). Singer comprehensively dissects the judicial schizophrenia interpreting what an “appropriate medical screening examination” means (or should mean) by identifying three schools of thought amongst the federal courts: (1) the use of a “*comparability test*,” (uniform, non-disparate treatment standard) which holds that a particular hospital must give all patients the same screening based on particular procedures and standards developed by the hospital, *id.* at 139-43; (2) the use of a “*bad motive test*,” which interprets “appropriate” as referring to the motive behind the particular screening given rather than the actual procedures, *id.* at 143-46; and (3) the use of a “*capability test*,” whereby courts define “appropriate” in terms of hinging liability on whether or not the hospital personnel screened the patient to the extent of the hospital’s capability. *Id.* at 146-52.

781. See Scott B. Smith, Note, *The Critical Condition of the Emergency Medical Treatment and Active Labor Act: A Proposed Amendment to the Act After In the Matter of Baby K*, 48 VAND. L. REV. 1491, 1528-29 (1995) (noting that “Congress should amend its sloppy legislation” by “eliminat[ing] the inconsistency between the Act’s original intent and its statutory language”).

782. See Annas, *supra* note 1, at 76 (discussing a New York statute that imposes fines and jail time upon doctors, nurses, and hospital employees who deny emergency medical treatment to patients) (citations omitted).

783. Although time will tell, this introduction of the new tort of intentional dumping is made with the understanding of the cautionary admonitions in respect to the paradox of novelty, the paradox of agency, and the tort paradox as described by Professor Anita Bernstein. See Anita Bernstein, *How to Make a New Tort: Three Paradoxes*, 75 TEX. L. REV. 1539, 1544 (1997) (discussing the three forms of opposition tort reformers might face when they attempt to introduce a new cause of action in tort).

784. For a thorough discussion of federalism, tort remedies involving constitutional rights, and policy considerations affecting federal tort legislation, and the Commerce Power, see Robert M. Ackerman, *Tort Law and Federalism: Whatever Happened to Devolution?*, 14 YALE L. & POL’Y REV. 429, 456-57 (1996) (asserting that both the practice of medicine and the practice of law remain local, stating, “[d]espite the growth of tertiary care facilities, medical practice remains largely local [not federal] . . . . Despite the globalization of legal practice, regulation of the legal profession remains largely a state matter . . . .”). Additionally, in choosing a state law remedy, rather than resurrecting segmental, federal statutory EMTALA infirmities, we are mindful of Justice Posner’s remarks in *Great Central Insurance Co. v. Insurance Services Office, Inc.*, 74 F.3d 778, 785-86 (7th Cir. 1996) (Posner, C.J.) (“[W]hat Great Central really wants . . . is for us to create in the name of Illinois law a new tort . . . . We keep warning the bar that a plaintiff who needs a common law departure or innovation to win should bring his suit in state court rather than in federal court.”).

intentional tort of patient dumping.<sup>785</sup>

In making our proposal, we rely, in part, upon the axiom that while the main purpose of tort law is to provide a remedy for individuals wrongly harmed, it also must serve to deter wrongful behavior.<sup>786</sup> We are mindful that “without potential tort liability, profit driven entities may find it cost-effective to engage in behaviors that pose unreasonable threats to human society.”<sup>787</sup> As one commentator has noted, the lack of compliance with prior federal legislation involving medical care is due to the following fact:

[T]here is little incentive for hospital compliance with HHS enforcement of Hill-Burton; neither the statute nor the regulations provide punitive measures for violations. *Without fear of punishment, hospitals feel free to disregard their obligations.* If they get caught cutting corners, they are merely reprimanded and told to do better next time.<sup>788</sup>

New causes of action are generally proposed to right a neglected wrong and adjust the fit and balance between injuries and remedies in a modern society.<sup>789</sup> In this regard, the law enters the fluidity of balance between life and the ongoing recognition of legally cognizable rights, duties, interests, and injuries which intersect such a balance.<sup>790</sup> Tort law is at the heart of such recognition and as such

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We are further mindful that the law permits a particular conduct to be actionable under more than one legal theory. See *Togstad v. Vesely*, 291 N.W.2d 686, 693 (Minn. 1980) (stating that a claim for legal malpractice against an attorney is legally cognizable as either a tort or contract action).

785. We purposefully do not call this the intentional tort of improper patient transfer as “patient transfer” implies a medical decision based on medical criteria falling within the duties and obligations of a physician with the doctor-patient relationship—the antithesis of the nature of patient dumping.

786. See Tamsen Douglass Love, *Detering Irresponsible Use and Disposal of Toxic Substances: The Case for Legislative Recognition of Increased Risk Causes of Action*, 49 VAND. L. REV. 789, 796 (1996) (asserting that well-defined laws on increased risk causes of actions will deter irresponsible behavior).

787. *Id.* at 793.

788. Treiger, *supra* note 54, at 1199-1200 (emphasis added) (citations omitted).

789. See S.F.C. Milsom, *A Pageant in Modern Dress*, 84 YALE L.J. 1585, 1585 (1975) (book review) (commenting that this attempt of adjustment between injuries and remedies is ever changing and that the attempts of law to correct this fit may render the law as a “reiterated failure to classify life”).

790. See *Smith v. Superior Court*, 198 Cal. Rptr. 829, 832 (Cal. Ct. App. 1984) (noting that the law of torts is fluid) (quoting PROSSER ET AL., *supra* note 60, § 1, at 3-4); E.F. Albertsworth, *Recognition of New Interests in the Law of Torts*, 10 CAL. L. REV. 461, 461-62 (1922) (discussing the evolution of tort law from remedy-duty-right-interest to interest-right-duty-remedy); Robert F. Blomquist, “*New Torts*”: *A Critical History, Taxonomy, and Appraisal*, 95 DICK. L. REV. 23, 36-37 (1990) (describing new tort development in modern and judicial society); Rory Lancman, *Protecting Speech from Private Abridgement: Introducing the Tort of Suppression*, 25 SW. U. L. REV. 223, 238-43 (1996) (discussing the policies and continuous evolution of tort law).

continues to grow,<sup>791</sup> notwithstanding that newly recognized torts may not necessarily fit standard denominations.<sup>792</sup>

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791. See Lancman, *supra* note 790, at 239 (asserting that the growth of tort law reflects “personal, social, and economic rights”); see also PROSSER ET AL., *supra* note 60, § 1, at 4:

The law of torts is anything but static, and the limits of its development are never set. When it becomes clear that the plaintiff’s interests are entitled to legal protection against the conduct of the defendant, the mere fact that the claim is novel will not of itself operate as a bar to the remedy.

*Id.*

792. See PROSSER ET AL., *supra* note 60, § 1, at 3-4 (listing torts that did not fit into standard categories when they were first introduced “but nevertheless have been held to be torts,” including:

the intentional infliction of mental suffering, the obstruction of the right to go where the plaintiff likes, the invasion of the right of privacy, the denial of the right to vote, the conveyance of land to defeat a title, the infliction of prenatal injuries, the alienation of the affections of a parent, and injury to a person’s reputation by entering the person in a rigged television contest . . .

*Id.* (citations omitted); see also Bernstein, *supra* note 783, at 1545 n.30 (citing Chamberlain v. Chandler, 5 F. Cas. 413 (C.C.D. Mass. 1823) (No. 2,575) (awarding monetary damages to a woman passenger and her husband for the “habitual obscenity, harsh threats, and immodest conduct’ of a ship captain”).

For other “new” torts that don’t quite fit the traditional pigeon-holes of tort law categorization, see Buckley v. Metro-N. Commuter R.R., 79 F.3d 1337, 1346 (2d Cir. 1996) (allowing a claim for emotional distress for fear of cancer based on asbestos exposure); Best Place, Inc. v. Penn. Am. Ins. Co., 920 P.2d 334, 346 (Haw. 1996) (holding that an independent tort cause of action exists where an insurer fails to act in good faith towards its insured); Guar. Nat’l Ins. Co. v. Potter, 912 P.2d 267, 272 (Nev. 1996) (recognizing that an insurer’s tortious breach of the implied covenant of good faith is not limited to unreasonable denial or delay of payments for valid claims); Madrid v. Lincoln County Med. Ctr., 923 P.2d 1154, 1163 (N.M. 1996) (recognizing an emotional distress claim for fear of developing AIDS from a “medically sound channel” due to negligence); Blomquist, *supra* note 790, at 41-52 (providing an overview of “new tort” litigation, including negligent infliction of emotional distress, wrongful life, and wrongful birth); Lancman, *supra* note 790, at 242-43 (introducing the tort of suppression to prevent an individual from infringing on another’s right to speech); Jane E. Larson, “Women Understand So Little, They Call My Good Nature ‘Deceit’”: A Feminist Rethinking of Seduction, 93 COLUM. L. REV. 374, 453 (1993) (describing the tort of sexual fraud where one “fraudulently makes a misrepresentation of fact, opinion, intention, or law, for the purpose of inducing another to consent to sexual relations in reliance upon it”); William L. Prosser, *Intentional Infliction of Mental Suffering: A New Tort*, 37 MICH. L. REV. 874, 874 (1939) (discussing the development of intentional infliction of emotional distress as a redressible harm); William L. Prosser, *Privacy*, 48 CAL. L. REV. 383, 389 (1960) (identifying four “new” torts in the law of privacy: “intrusion upon . . . [an individual’s] private affairs”; “public disclosure of . . . private facts [about an individual]”; “publicity which places [an individual] in a false light in the public eye”; and “appropriation . . . of [an individual’s] name or likeness”); Krista J. Schoenheider, *A Theory of Tort Liability for Sexual Harassment in the Workplace*, 134 U. PA. L. REV. 1461, 1485-94 (1986) (proposing tort liability for sexual harassment in the workplace when, based on a reasonable woman standard, an individual unreasonably interferes with another individual’s “right to work in an environment free from sex-based intimidation or hostility”); Samuel D. Warren & Louis D. Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 192, 197 (1890) (discussing whether the law in 1890 protected an individual’s privacy and noting that the laws of libel and slander did not adequately cover against invasions of privacy).

The intentional tort of patient dumping is based in public policy, although influenced by antecedents in the law of contract, medical malpractice tort, the constitutional right to be free from discrimination, and the federal statutory right to emergency medical care.<sup>793</sup> Clearly, however, although influenced by other bodies of law, the true nature of patient dumping has not been duly recognized by contract, tort, constitutional or federal law. Thus, without duly recognizing the nature of the act and harm of patient dumping, current law does not fit the circumstances of patient dumping and therefore is unable to provide proper redress. And, notwithstanding influences from other branches of law, because the nature and harm of patient dumping remains unredressed, it continues to grow and cause harm to thousands of unsuspecting individuals at their moments of greatest need and reliance upon those expert in emergency care.<sup>794</sup>

Conceptually, the basis for our proposal of a new intentional tort of patient dumping is taken from the teachings of Justice Holmes, which include the organization of tort law into the three categories of liability without fault, negligence, and intentional tort.<sup>795</sup> Holmes' categorizations of law either imposed an absolute duty to avoid causing injury, imposed a duty to avoid only harm that was foreseeable (negligence), or imposed a duty to avoid harm that was foreseeable with substantial certainty (intentional tort).<sup>796</sup> In that regard, intentional tort law has rested on the outer limits of tort liability, but attempts to define the line between duty and no-duty.<sup>797</sup> That is, in the balance of injuries and remedies, where negligence law addresses recognized duties to avoid foreseeable harm, intentional tort law reaches beyond the line of traditional duty into an expanding

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793. See 42 U.S.C. § 1395dd (2000) (codifying requirements for emergency medical care and creating remedies for statutory violations); see also BITTERMAN, *supra* note 18, at 15 (stating that EMTALA created a federal cause of action for individuals denied emergency medical care).

794. In this regard there are no non-tort protections for the act of patient dumping. See *supra* note 22 (describing the increase in health complications and mortality when patient dumping occurs).

795. See OLIVER WENDELL HOLMES, *THE COMMON LAW* 104 (M. Howe ed., Harvard Univ. Press 1963) (asserting that tort liability was not derived by reasoning from principle, but rather imposed by the state for policy reasons).

796. See *id.* at 128 (stating that, although the law began with liability for intentional harms, it grew to include liability for "conduct [that] would have been wrong in the fair average member of the community, whom he is expected to equal at his peril").

797. See *id.* ("In general, this question will be determined by considering the degree of danger attending the act or conduct known under the circumstances. If there is danger that harm to another will follow, the act is generally wrong in the sense of the law.")

sphere of harm and liability, which exists concomitant with the growth of a modern society. It is within this sphere where, although no duties may have been imposed, intentional tort law grows to further avoid harm that may be foreseeable with substantial certainty. The intentional tort of patient dumping will attempt to define further an imposed duty to avoid harm that is foreseeable with substantial certainty when a patient is transferred *solely* for economic or non-economic, non-medical discriminatory reasons.<sup>798</sup>

Lastly, we define the nature and act of patient dumping as completely distinct from a patient's medical care or medical transfer decision. That is, it is an intentional act of depriving a person of emergency medical care not based upon any medical reason, but rather based on discrimination; either economic<sup>799</sup> or non-economic<sup>800</sup> non-medical grounds.<sup>801</sup> Accordingly, we anticipate that its use will be strictly reserved for application to patient transfers that are the result of shameful acts of discrimination.

#### A. *Elements of the Intentional Tort of Patient Dumping*

The general premise for the intentional tort of patient dumping is that one who intentionally causes injury to another is subject to liability to the other for that injury, if his conduct is without justification under the circumstances.<sup>802</sup> Accordingly, the intentional tort of patient dumping will exist only where a physician, or other person(s), organization, or entity, causes a patient with an emergency medical condition<sup>803</sup> to be transferred to another healthcare facility without first having stabilized the patient's emergency medical

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798. See *supra* note 51 (discussing several reasons why a hospital might engage in patient dumping).

799. See *Harvard Medical Study*, *supra* note 5, at 495 (discussing study of hospital transfers and providing statistics on insurance held by transferred patients).

800. See *Cleland v. Broson Health Care Group, Inc.*, 917 F.2d 266, 272 (6th Cir. 1990) (noting factors that result in discriminatory treatment by hospitals may include "prejudice against the race, sex, or ethnic group of the patient; distaste for the patient's condition (e.g., AIDS patients); personal dislike or antagonism between the medical personnel and the patient; disapproval of the patient's occupation; or political or cultural opposition"); see also *Hines v. Adair County Pub. Hosp. Dist. Corp.*, 827 F. Supp. 426, 431 (W.D. Ky. 1993) (referencing the *Cleland* factors for discriminatory non-treatment).

801. This represents a partial list and is not intended to be limiting.

802. Cf. PROSSER ET AL., *supra* note 60, § 9, at 39 (explaining that the premise of the tort of battery is that one who harmfully contacts another, with the intent to cause such contact, will be liable for any injury unless the batterer is justified in the intent behind that contact).

803. The term "emergency medical condition" is to be defined using an objective (reasonable person) standard, and in that regard, will depend on medical expert testimony and evidence, whereby common law, statutory, or professional medical standards may be relied upon.

condition.<sup>804</sup> The patient transfer must be on the basis of either economic status (e.g., the patient's financial status),<sup>805</sup> non-economic status (e.g., race, ethnicity, sexual orientation, socially unacceptable disease),<sup>806</sup> or any other reason not based on professional medical standards related to the medical care of the patient.<sup>807</sup> The elements which should, therefore, serve as the foundation for the intentional tort of patient dumping include: (1) intent to injure; (2) absence of justification; (3) causation; and (4) injury.

1. *The intent to injure*

The first element of the intentional tort of patient dumping is an intent to injure the plaintiff. Satisfaction of this element occurs when the defendant knows or should have known that the consequences of his act were certain, or substantially certain, to result from his act.<sup>808</sup> Thus, this element does not require that the defendant acted with a purpose of causing injury to the plaintiff, but rather only requires that the defendant have acted with substantial certainty that injury would occur.<sup>809</sup> An objective standard should be used to determine whether there was a substantial certainty that the injury would occur. The plaintiff should bear the burden of proving that the defendant, as a reasonable person, knew or should have known that the consequences were certain, or substantially certain, to result from his act.<sup>810</sup>

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804. The term "stabilized" is to be defined using an objective (reasonable person) standard, and in that regard, will depend on medical expert testimony and evidence, whereby common law, statutory or professional medical standards may be relied on.

805. This represents but one example of economic causes; others might include no insurance, under insurance, etc.

806. This represents only a partial list; other non-economic causes may also be included as discussed in the text of this Article.

807. For instance, this may include political, religious, or other non-medical or non-treatment related reasons.

808. See RESTATEMENT (SECOND) OF TORTS § 870 cmt. b (1979) (describing the concept of intentionally causing harm).

809. See *id.* § 8A cmt. b ("Intent is not, however, limited to consequences that are desired."); PROSSER ET AL., *supra* note 60, § 8, at 36 ("The intent with which tort liability is concerned . . . is an intent to bring about a result which will invade the interests of another in a way the law forbids.");

810. See PROSSER ET AL., *supra* note 60, § 41, at 269 ("The plaintiff must introduce evidence which affords a reasonable basis for the conclusion that it is more likely than not that the conduct of the defendant was a cause in fact of the result."); see also HOLMES, *supra* note 795, at 108 (noting that using an objective standard for this basis ensures the evidence is looked at from the view of a reasonable person, rather than any subjective standards the defendant may have had as a measure of his own conduct).

## 2. *Absence of justification*

The second element of the intentional tort of patient dumping is that the defendant has acted in the absence of justification. This factor is influenced by public policy such that, where public policy seeks to discourage a defendant's conduct, that defendant's conduct will likely be deemed unjustified.<sup>811</sup> This element should be evaluated by an objective standard of conduct; that is, tort theory and tort liability, especially with respect to the nature and harm of patient dumping, should be based upon public policy and not the individual defendant's moral blameworthiness.<sup>812</sup> As such, an objective standard should apply, and the particular defendant's state of mind should serve neither as a measure of his conduct nor of his justification, thereby making state of mind irrelevant.<sup>813</sup> Accordingly, conduct will be actionable only where it falls below the standard demanded by the reasonable person on public policy grounds.<sup>814</sup> The plaintiff should bear the burden of proving that the defendant's conduct was not

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811. Public policy demands justification for a defendant's conduct because there are certain behaviors that are discouraged in society. See PROSSER ET AL., *supra* note 60, § 3, at 16 ("There is good reason, therefore, to make a conscious effort to direct the law along lines which will achieve a desirable social result.").

812. See HOLMES, *supra* note 795, at 116 (noting that the objective standards by which intentional torts are reviewed are based on public policy issues rather than any individual moral blameworthiness of a defendant).

813. An objective standard was selected here, rather than a subjective or combination of objective—subjective standard (*Restatement (Second) of Torts* approach) to avoid recasting the nature of patient dumping with every judicial balancing act which would be required under either a subjective or combination of objective-subjective standard. For instance, although in *prima facie* tort, the *Restatement* adopts a standard which is both objective and subjective, it then requires re-evaluation of the defendant's conduct to determine if it was "generally culpable and not justifiable under the circumstances." RESTATEMENT (SECOND) OF TORTS § 870 (1979). Thus, a determination must be made whether the defendant's conduct is generally culpable where it is "improper or wrongful," or "blameworthy" or "not in accord with community standards of right conduct." *Id.* § 870 cmt. e. This re-evaluation of the defendant's conduct in patient dumping denigrates the nature of the tort and harm suffered by the patient. In *prima facie* tort, for instance, factors such as the nature and seriousness of the harm, the means used by the defendant, and the defendant's motive may be used by the court to make the determination of justifiability. This is avoided under an objective standard. See also HOLMES, *supra* note 795, at 116 (advocating tort liability is based on public policy, not individual moral blameworthiness, and therefore a particular defendant's actual state of mind was not the measure of his conduct).

814. Acceptable forms of justification, which would avoid defendant liability, include, but are not limited to, (a) patient consent; (b) lack of facility capacity, evidenced by insufficient bed capacity, nursing capacity, or other medical resources; or (c) availability of a higher level of care, where a particular form of medical therapy, treatment, specialist or specialty care is unavailable at the originating hospital. See PROSSER ET AL., *supra* note 60, § 16, at 109 (noting that justification "signifies that the defendant has acted to further an interest of such social importance that it is entitled to protection, even at the expense of damage to the plaintiff").

justified, and the defendant may rebut.<sup>815</sup> If the defendant intends to rely upon privilege or other forms of justification, then the defendant shall have the burden of proving his justification as to this element.<sup>816</sup>

### 3. Causation

The third element necessary to establish the intentional tort of patient dumping is that of causation. Causation requires that the defendant's act of patient dumping cause injury to the plaintiff, such that the injury to the plaintiff would not have occurred in the absence of the defendant's act of patient dumping.<sup>817</sup> In that regard, as Dean Keeton makes clear, causation is a required element of any tort.<sup>818</sup> The plaintiff should bear the burden of proving the element of causation.<sup>819</sup>

### 4. Injury

The fourth element requires that the plaintiff has suffered some damage, actual loss, injury, or legally cognizable harm as a result of the defendant's act.<sup>820</sup> Further, the injury that the plaintiff suffered must not have been able to occur without the defendant's act or conduct.<sup>821</sup> The plaintiff should bear the burden of proving damage, actual loss, injury or legally cognizable harm suffered.<sup>822</sup> Damages should include compensatory,<sup>823</sup> special,<sup>824</sup> and punitive damages.<sup>825</sup>

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815. See 21 CHARLES ALAN WRIGHT & KENNETH W. GRAHAM, JR., FEDERAL PRACTICE AND PROCEDURE § 5122 (1977) (justifying the placing of the burden on the plaintiff by the fact that "it is the plaintiff who is asking the court to alter the status quo and it is therefore fair that he should have the burden of proving the facts in support of his demand.").

816. See PROSSER ET AL., *supra* note 60, § 16, at 108 (noting that, as it is impractical to require a plaintiff to negate all possible justifications at the outset, matters that may be asserted as justification for defendant's conduct that would ordinarily be actionable are left for the defendant to prove).

817. See *id.* §§ 41, 42 (noting that an essential element for any tort is that there be a reasonable connection between the act or omission of the defendant and the damage which the plaintiff suffered).

818. *Id.*

819. See RESTATEMENT (SECOND) OF TORTS § 433B(1) (1979) (stating that the plaintiff bears the burden of proof to show that the defendant's tortious conduct caused the plaintiff's harm).

820. See *Appalachian Power Co. v. Am. Inst. of C.P.A.*, 177 F. Supp. 345, 349 (S.D.N.Y. 1959) (noting that an essential element of prima facie tort is that "[t]here must be an intent to injure plaintiff, at least to the extent of infliction of *wrongful* harm upon plaintiff without just cause or excuse.").

821. See PROSSER ET AL., *supra* note 60, §§ 41, 42 (stating there must be a connection between the defendant's act or omission and the plaintiff's damage or injury).

822. See *id.* at 239 (noting that this burden "is quite uniformly on the plaintiff, since he is asking the court for relief, and must lose if his case does not outweigh that of the defendant's").

823. RESTATEMENT (SECOND) OF TORTS § 903 ("Compensatory damages are the

Because the nature of patient dumping involves intentional non-negligence based conduct, when it occurs as the result of the physician's act, recovery should not be subject to the limitations of state medical malpractice tort reform.<sup>826</sup>

### B. Limitations

We are aware that the introduction of any new tort will raise premonitions of triviality, unmanageability, and "opening of the flood gates" of litigation.<sup>827</sup> Although these issues must be addressed, courts must meet the demands of a changing society where the existing law does not adequately address a particular harm.<sup>828</sup> We

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damages awarded to a person as compensation, indemnity, or restitution for harm sustained by him."). For example, awarding a person lost wages for time missed from work because of an injury.

824. *Id.* § 904(2) ("Special damages are compensatory damages for a harm other than one for which general damages are given."). For example, "in personal injury cases, harm to earning capacity, expenses for medical treatment and similar items are ordinarily treated as bases for special damages." *Id.* § 904(2) cmt. b.

825. *Id.* § 908(1) ("Punitive damages are damages, other than compensatory or nominal damages, awarded against a person to punish him for his outrageous conduct and to deter him and others like him from similar conduct in the future."). For example, imposing punitive damages on a drunk driver beyond injuries caused is both a punishment to the driver, and a deterrent to other persons who may consider the same behavior.

826. *See, e.g., Sewell v. Doctors Hosp.*, 600 So. 2d 577, 578 (La. 1992) (noting that "[t]he [Louisiana] Medical Malpractice Act's limitations on the liability of a health care provider are special legislation in derogation of the rights of tort victims" and, therefore, liability limitations under the Act should be strictly construed to "apply only in cases of liability for malpractice as defined in the Act," and not to "any other liability of the health care provider").

827. *See, e.g., Miller v. Balt. & Ohio S.W. R.R. Co.*, 85 N.E. 499, 502 (Ohio 1908) (discussing the concern that a "flood of litigation" would "naturally" result should the court recognize a right of recovery on a novel basis of "fright").

828. For instance, this may occur where either the law fails to redress fully the harms of a certain type of wrongful conduct, or where the current law simply does not fit the circumstances of the wrongful conduct or harm. *See Nees v. Hocks*, 536 P.2d 512, 514 (Or. 1975) (noting that the creation of new tort law, where necessary, would avoid the "rigidities of existing causes of action"); Jane Byeff Korn, *The Fungible Woman and Other Myths of Sexual Harassment*, 67 TUL. L. REV. 1363, 1379 (1993) (noting that, when the state of the law did not recognize a cause of action for sexual harassment, plaintiffs were forced to attempt to fit their sexual harassment claims into a tort claim that was never designed to address the problem of sexual harassment); Krista J. Schoendhelder, Comment, *A Theory of Tort Liability for Sexual Harassment in the Workplace*, 134 U. PA. L. REV. 1461, 1463, 1481-85 (1986) (noting that federal law and state tort law fail to redress fully the harms of sexual harassment). We believe, with respect to patient dumping, that the law has failed to redress fully the harm of such wrongful conduct and that the current law does not fit the circumstances of the wrongful conduct that continues to persist and increase. *See Porter v. Crawford & Co.*, 611 S.W.2d 265, 268 (Mo. Ct. App. 1981) ("It is clear that modern legal thought considers that 'there exists a residue of tort liability which has not been explicated in specific forms of tort action and which is available to the courts to develop as common law actions as the needs of society require such development.") (citing Brown, *The Rise and Threatened Demise of the Prima Facie Tort Principle*, 54 NW. U. L. REV. 563, 573 (1959-60); *see, e.g., Tate v. Browning-Ferris, Inc.*,

believe that the data presented herein suggest that the shortcomings of EMTALA have precluded the control of patient dumping and that the harm of patient dumping has not been properly redressed.

In considering the various concerns associated with the introduction of any new tort, we first reiterate that the intentional tort of patient dumping is to be limited to instances of explicitly egregious behavior outside the practice of medicine; the tort does not involve substantive issues of patient care or medical decision-making (e.g., transfer of a patient for higher level of care not available in the transferring hospital).<sup>829</sup> Thus, it is to be applied only in circumstances where the sole basis for transferring a patient is discrimination due to race, ethnicity, sexual orientation, socially unacceptable disease, or other socioeconomic factors.

Second, with respect to fraudulent or fictitious claims, as Dean Prosser points out, “the problem is one of adequate proof, and it is not necessary to deny a remedy in all cases because some claims may be false.”<sup>830</sup> The general standard of proof required to support each element of a claim of the intentional tort of patient dumping will provide a sufficient degree of guarantee of genuineness under the circumstances of each case.<sup>831</sup> If the plaintiff can prove each element of the intentional tort of patient dumping, the reliability and reasonableness of the claim is assured.<sup>832</sup> Further, we are mindful that “factual, legal and medical charlatans are unlikely to emerge from a trial unmasked.”<sup>833</sup>

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833 P.2d 1218 (Okla. 1992) (affirming non-statutory public policy wrongful discharge claim based on race discrimination and racially motivated retaliatory discharge); *Alcorn v. Anbro Eng'g, Inc.*, 468 P.2d 216 (Cal. 1970) (permitting an intentional infliction of emotional distress claim based in part on racial epithets); Richard Delgado, *Words That Wound: A Tort Action for Racial Insults, Epithets, and Name-Calling*, 17 HARV. C.R.-C.L. L. REV. 133, 134 (1982) (noting the limitations of current law with respect to protection from racial insults, and proposing a new cause of action based on defendant's intent to demean through reference to race); John T. Nockleby, *Hate Speech in Context: The Case of Verbal Threats*, 42 BUFF. L. REV. 653, 699-711 (1994) (proposing a tort of racial intimidation).

829. See *supra* note 814 (noting that the substantive issues of patient care and medical decision making are acceptable forms of justification, which would allow the defendant to avoid liability).

830. PROSSER ET AL., *supra* note 60, § 47, at 327-28.

831. Cf. *Rodrigues v. State*, 472 P.2d 509, 520 (Haw. 1970) (claiming the “general standard of proof required to support a claim of mental distress is some guarantee of genuineness in the circumstances of the case”).

832. Cf. *Devlin v. Johns-Manville Corp.*, 495 A.2d 495, 499 (N.J. Super. Ct. Law Div. 1985) (setting forth each element the plaintiffs would need to prove in order to recover under an emotional distress claim, and stating that should the plaintiffs meet these standards, the “reliability and reasonableness” of their claims would be assured).

833. *Niederman v. Brodsky*, 261 A.2d 84, 88 (Pa. 1970) (refusing to accept the proposition that the judicial system cannot, in general, deal with fraudulent claims).

Third, as to each element of the tort, we rely heavily on the objective test of reasonableness through use of the reasonably prudent person standard. We believe the combination of strict application of the reasonable person standard, judicial scrutiny of the pleadings,<sup>834</sup> and charging the plaintiff with the burden of proof as to each element of the cause of action will properly limit the application of the intentional tort of patient dumping and will provide sufficient protection against unlimited defendant liability.<sup>835</sup>

Fourth, we believe that any notion that the recognition of the intentional tort of patient dumping may encourage litigation and expand liability will be unjustified. This is especially true in light of the fact that neither the recognition of prima facie tort, nor the emotional distress torts, have led to an increase in litigation.<sup>836</sup> Similarly, the feared flood of litigation, resultant increasing costs of insurance, and untold impact upon the healthcare industry has not occurred with respect to the recognition of any link between toxic torts and emotional distress.<sup>837</sup> Further, we find the words of Dean Prosser instructive:

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834. In fact, in *Coleman*, the Supreme Court of Louisiana specifically noted that the tort of patient dumping was not initially specifically pled, but was merely submitted as a supplemental pleading. *Coleman v. Deno*, 813 So. 2d 303, 313 (La. 2002). Specifically, the Supreme Court of Louisiana noted,

Procedurally, neither *Coleman's* original nor amended petition alleges an intentional tort. The original petition alleges only medical malpractice; the amended petition alleges only negligence *per se* based on EMTALA. Nor were the pleadings expanded at trial, as provided for in [LA. CIV. CODE ANN. art. 1154 (West 1997)], to include such an alleged intentional tort. To the contrary, the effect of the trial court's granting of Dr. Deno's combined exception of no cause of action and motion in limine was to exclude any mention before the jury of either the financial reasons for the transfer or the EMTALA claim. The court of appeal thus crafted an intentional tort that was not plead, not prayed for in relief, not argued, not tried, and not submitted to the jury.

*Id.* (citations omitted).

835. *Rodrigues*, 472 P.2d at 519 (noting that strict application of the reasonable person standard is sufficient protection against unlimited defendant liability).

836. See Leslie Benton Sandor et al., *Recovery for Negligent Infliction of Emotional Distress Attendant to Economic Loss: A Reassessment*, 37 ARIZ. L. REV. 1247, 1253-59 (1995) (discussing erroneous fears about triviality, fraudulent claims, and unmanageability that accompanied resistance to the recognition of the new emotional distress torts); Kenneth J. Vandeveld, *The Modern Prima Facie Tort Doctrine*, 79 KY. L.J. 519, 544-46 (1991) (noting that the experience in New York, despite the recognition of the prima facie tort doctrine, was not in any discernible way found to be an increase in the number of legal actions filed).

837. See Kenneth W. Miller, Note, *Toxic Torts and Emotional Distress: The Case for an Independent Cause of Action for Fear of Future Harm*, 40 ARIZ. L. REV. 681, 691 (1998) (noting that "the predictions about a flood of litigation have been unpersuasive to many jurists and commentators" and the predictions have failed, in any case, to materialize).

It is the business of the law to remedy wrongs that deserve it, even at the expense of a “flood of litigation”; and it is a pitiful confession of incompetence on the part of any court of justice to deny relief upon the ground that it will give the courts too much work to do.<sup>838</sup>

Thus, when justice calls for a remedy for a patient who has been wrongfully withheld emergency medical care or necessary stabilizing treatment solely because of race, ethnicity, sexual orientation, socially unacceptable disease, or socioeconomic factors, the doors to the courthouse should always be open.

#### CONCLUSION

Patient dumping is a dangerous but predictable accompaniment to the market-driven health care system in the richest nation in the world.<sup>839</sup> As there is little incentive for compliance with EMTALA, some healthcare professionals and facilities have disregarded their obligations and engaged in patient dumping, on the basis of purely economic or non-economic, non-medical discriminatory grounds, without apparent fear of punishment.<sup>840</sup> Indeed, no measure in law currently exists to provide punitive measures for patient dumping. Both state and federal government performance in enforcing anti-patient-dumping law have been recognized as disgraceful, especially when considering that although the average emergency department facility transfers from 1992 to 1999 were approximately 1.6 million patients per year, the federal government initiated an average of only 384 (0.02%) EMTALA investigations and found an average of only 184 (0.01%) EMTALA violations per year.<sup>841</sup>

The American public has every right to be outraged at a healthcare system that fails to properly treat a patient with an emergency medical condition just because the patient is of a particular race/ethnicity or is poor. Congress, as early as 1988, anticipated such abhorrent and grave circumstances—then a reality as well—and enacted EMTALA specifically to deter patient dumping and attempt to save the lives of patients with emergency medical conditions.<sup>842</sup>

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838. William L. Prosser, *Intentional Infliction of Mental Suffering: A New Tort*, 37 MICH. L. REV. 874, 877 (1939), cited in *Schultz v. Barberton Glass Co.*, 447 N.E.2d 109, 111 (Ohio 1983).

839. PUBLIC CITIZEN'S HRG #6, *supra* note 166, at 11 (noting that patient dumping from American hospital emergency departments is a “dangerous, disgraceful but predictable accompaniment to the market-driven health care system in the richest nation in the world”).

840. Treiger, *supra* note 54, at 1200 (noting that “[w]ithout fear of punishment, hospitals feel free to disregard their obligations.”).

841. See *supra* Table 2.

842. See *supra* note 38 (stating that Congress enacted EMTALA to address its

However, extensive ambiguities and inconsistent interpretations have frustrated EMTALA's effectiveness in preventing patient dumping.<sup>843</sup> Nationwide, as demonstrated above, there continues to be evidence indicating that the reprehensible patient dumping conduct persists on the part of some emergency physicians and healthcare facilities.<sup>844</sup> Although relatively uncommon,<sup>845</sup> such behavior contributes to the increase in patient dumping.

As state regulatory and federal legislation have been unsuccessful in their attempt to thwart patient dumping, and because the federal government simply cannot regulate patient transfers in distant emergency departments, we believe it is time for state courts to recognize the intentional tort of patient dumping and place civil actions in the hands of the victims, rather than in the hands of a federal prosecutor. Because such a cause of action recognizes that patient dumping is intentional, not negligence based, and occurs in a zone outside the practice of medicine and professional medical care decision making, it should sound in intentional tort. It should not be constrained by state medical malpractice recovery limitations, which specifically are concerned with the practice of medicine and not the shameful practice of discrimination.<sup>846</sup>

We believe that permitting a jury to know that a patient has been seriously harmed or died solely because of the patient's race, ethnicity, socioeconomic status, or other non-medical discriminatory reasons, will likely be more effective in controlling patient dumping than the continued manipulation of federal legislation and regulation, which will invariably lead to further judicial discord. Accordingly, an intentional tort of patient dumping would have a strong and beneficial effect on the attention and care provided those who present to emergency departments with emergency medical conditions. Finally, justice requires that the ongoing harm caused by patient dumping be properly redressed.

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concern with the practice of patient dumping).

843. See Singer, *supra* note 14, at 121 (noting that the law threatens to implode upon itself as contrary and harmful interpretations threaten the law's utility).

844. *Supra* note 183 and accompanying text (summarizing findings with respect to patient dumping incidents between 1992 and 1999).

845. *Supra* note 21.

846. *Supra* note 826 and accompanying text.