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The Elderly and Patient Dumping

by George P. Smith II

Although patients in "right to refuse medical treatment" cases have trouble terminating their medical care, many persons have difficulty obtaining medical care in the first place because they are refused admission to hospitals. This problem is termed "patient dumping." Also known as "demarketing of services" or "management of patient mix," patient dumping refers to the hospital practice of transferring or refusing to treat persons who are indigent, uninsured, or otherwise undesirable to admit. Patient dumping has origins in the common law no-duty rule. This rule provides that hospitals have no duty to admit and treat all patients who seek care and, in some cases, have no duty even to specify reasons for rejecting patients. Hospitals often "dump" patients who arrive at hospital wards either without any health insurance or with only Medicaid insurance—a program which physicians know provides low reimbursement payments.

The economic pressures placed upon hospitals over the past decade increased the frequency of patient dumping in cases falling under the no-duty rule. This rule and the ability of hospitals to refuse medical treatment have been limited by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986, 42 U.S.C. §1396dd (1994) and the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. §1395dd (1994)—an amendment to COBRA.

In the final analysis, it will be seen that the elderly will be secure from the indignity of patient dumping only when society and the health care industry acknowledge their inherent value as an important segment of contemporary American life.

EMTALA: Patient Dumping and the Federal Response

Before COBRA and EMTALA limited a hospital's right to refuse medical treatment to patients, the common law's no-duty rule was restricted only by four exceptions: 1) once a hospital provides medical care, it must do so nonnegligently; 2) once a person gains "patient" status, the caregiver must aid and protect that patient; 3) where a person relies upon a caregiver's custom of providing emergency care, a duty to provide that care exists; and 4) true "emergency" cases obviate the no-duty rule. Although it has been asserted that the no-duty rule was applied narrowly, its application was apparently widespread enough to provoke Congress to pass EMTALA. Before EMTALA, experts estimated that hospitals dumped up to 250,000 patients a year.

Congress recognized the public need to reduce the incidence of patient dumping when it enacted COBRA and EMTALA's anti-dumping provisions. Section 1395 of EMTALA provides in pertinent part: "If a patient at a hospital has an emergency medical condition which has not been stabilized... the hospital may not transfer the patient unless—the transfer is an appropriate transfer to that facility." (42 U.S.C. §1395 (c)(1)(B) (1994)). EMTALA applies to hospitals that receive federal funds from the Medicare and Medicaid programs, and provides for civil monetary fines against participating hospitals and physicians who violate it.

Hospitals and physicians will violate §1395 either "by failing to detect the nature of the emergency condition through inadequate screening procedures, [or after detecting the emergency nature of the patient's condition,] by failing to stabilize the condition before releasing the patient." However, a threshold requirement needed to protect a patient under EMTALA is
that the patient must arrive at a hospital's emergency room in an emergency condition.\textsuperscript{14} In sum, then, to plead a §1395 claim, a patient must prove: 1) that he or she arrived at a defendant hospital's emergency room in an emergency condition; and 2) either that the hospital failed to screen the patient adequately in order to determine an emergency condition or that the hospital discharged or transferred the patient before the emergency condition had passed.\textsuperscript{15}

EMTALA's powers are broad. It requires hospitals which execute Medicare provider agreements with the federal government to treat “all human beings who enter their emergency departments” in accordance with the act’s provisions.\textsuperscript{16} The act is alleged to have such a “landslide potential” that its reach in the area of health law has been compared to the pervasive Racketeering Influenced and Corrupt Organization statute in the area of business fraud and corporate law.\textsuperscript{17}

Statutory and Administrative Shortcomings

EMTALA should serve to prevent hospitals’ dumping of uninsured and underinsured persons who enter emergency wards of hospitals. Despite its provisions, however, patient dumping continues, and judicial enforcement of EMTALA appears to be waning. Only nine percent of the hospitals cited by the Health Care Financing Administration (HCFA) for violating EMTALA were punished.\textsuperscript{18} Between 1986 and 1992, HCFA investigated 268 hospitals for 302 EMTALA violations, but only fined 17 of them.\textsuperscript{19}

It has been suggested that EMTALA is ineffective because it has definitional flaws and enforcement shortcomings.\textsuperscript{20} Specifically, because the statute’s key words are either defined vaguely or not defined at all, courts juggle testimonies of medical experts and extract their own definitions.\textsuperscript{21} Oftentimes, the legislative history of EMTALA has been of value to judicial decisionmaking—but it has also provided a basis for broadening the statute’s reach.\textsuperscript{22}

Judicial constructions of EMTALA’s language remain problematic because the courts must interpret the statute’s undefined terms and also apply those terms to a particular hospital’s practice. For example, in Baber v. Hospital Corporation of America, 977 F.2d 872 (1992), the Fourth Circuit Court of Appeals had to interpret and apply the undefined term, “appropriate medical screening examination,” to determine whether a hospital violated EMTALA’s §1395dd(e)(1)(A).\textsuperscript{23} It determined that because Congress left this term undefined, it would scrutinize the phrase on a case-by-case basis and, thus, not create an a priori definition or structure a reasonableness standard for interpreting the phrase, itself.\textsuperscript{24}

The Baber case illustrates how EMTALA’s statutory faults have hampered its effectiveness. Other courts have criticized EMTALA for being plagued by “weasel words.”\textsuperscript{25} EMTALA fails to define—or defines only vaguely—other key statutory terms such as “emergency medical condition” (42 U.S.C. §1395dd(e)(1)(A) (1994)), “to stabilize” (42 U.S.C. §1395dd(c)(1)(A) (1994)), and “reasonable transfers.”\textsuperscript{26} These terms, then, become EMTALA’s so-called Achilles’ heels. EMTALA’s flexible statutory language may well be the central reason why only nine percent of hospitals that HCFA cites for EMTALA violations receive actual punishment.\textsuperscript{27}

EMTALA’s protections do not sufficiently reassure those uninsured elderly patients who seek hospital care that they will be protected against patient dumping. Although elderly persons who have neither Medicare nor private insurance may have an increased risk of being dumped, these individuals also may be denied adequate emergency medical treatment for other reasons.\textsuperscript{28} For example, some unethical physicians discriminate against persons with diseases such as AIDS\textsuperscript{29} and other physicians favor treating patients with simple ailments over patients with complex ones in order to reduce their risks of malpractice.\textsuperscript{30}

Irregularities Within DHHS

While Congress created EMTALA in order to curb the number of patients dumped by hospitals and physicians, it unfortunately provided this statute with a faulty enforcement mechanism. (42 U.S.C. §1395dd(d) (1994)). To compound EMTALA’s inherent weaknesses, the U.S. Department of Health and Human Services (DHHS) has established a record of very limited enforcement against hospitals and physicians who violate it.\textsuperscript{31}

One of EMTALA’s most powerful provisions included the right of DHHS to suspend or terminate the Medicare contract of a hospital found to dump patients. (42 U.S.C. §1395dd(d)(1)). Yet, when it realized that suspending a hospital’s Medicare contract would harm disproportionately those persons who depend solely on Medicare, Congress revoked this power.\textsuperscript{32} Congress did, however, leave intact the DHHS’s authority to fine ($50,000 per incident) physicians who violate knowingly EMTALA and hospitals who violate negligently EMTALA. (42 U.S.C. §1395dd(d)(1)). Nevertheless, it has been suggested that hospitals faced with EMTALA fines continue to dump indigent patients because the fines issued by DHHS often are less than the costs of the medical care they refuse to give.\textsuperscript{33}

Strengthening EMTALA

To strengthen EMTALA’s effectiveness, Congress must clarify its definitions and broaden its enforcement mechanisms and the DHHS must improve its own enforcement procedures. Congress should model EMTALA after state and local antidumping programs. For example, in California, a state law penalizes hospitals which receive dumped patients but which fail to report the dumping hospitals.\textsuperscript{34} Congress could improve EMTALA enforcement by developing a similar “failure to report dumping hospitals” penalty for those hospitals which accept the dumped patients.

Congressional efforts could also be undertaken to require hospitals to follow the practice of a Texas pub-
lic hospital which requires other hospitals to telephone and secure the acceptance of any patient they wish to transfer to the public hospital.\textsuperscript{36} The hospital monitors the transfers by recording all incoming telephone calls.\textsuperscript{36} This hospital’s practice has reduced the number of unstable patient transfers and deaths related to transfers.\textsuperscript{37}

Crucial to the whole issue of EMTALA coverage is whether hospitals should retain both admitting and exclusion powers or relinquish the prerogative to an inept and insensitive federal bureaucracy.\textsuperscript{38} Linked inextricably to this concern is the ultimate question of whether EMTALA will — over time — “increase the number of lives saved, or — more properly — raise them to a level that justifies the public expenditures.”\textsuperscript{38}

**Ethical Obligations to Treat the Elderly**

In a society where the elderly are more susceptible to illness and disability than any other age group,\textsuperscript{40} they “ought to command special attention in matters pertaining to health care.”\textsuperscript{41} Clearly, access to hospitals and health care resources is an important concern to them.\textsuperscript{42} Many in fact have Medicare, or private insurance, or both; but many others have neither. As with society as a whole, the elderly population is composed of persons having various income levels, interests, and needs.\textsuperscript{43} Even if society’s ethical consensus advocated unlimited access to health care, health care providers still would be unlikely to provide health care to persons unable to pay for it.\textsuperscript{44} Patient dumping and access to health care remain prominent issues for the elderly because elderly persons typically are not economically productive.\textsuperscript{45} Indeed, the population of elderly is impoverished disproportionately and disadvantaged economically.\textsuperscript{46}

Some physicians and patients have adopted a consumerist image of the physician as an independent contractor who sells his or her knowledge and skill to patients who demand care.\textsuperscript{47} This contractual model of medical care\textsuperscript{48} overlooks the moral and ethical considerations inherent within an emergency patient-physician situation and belittles the idea that a doctor should make “a correct technological (medical) choice consonant with a patient’s needs and desires.”\textsuperscript{49} In addition, for-profit hospitals face an inelastic demand for services, which contribute ultimately to their being unresponsive to altruistic social winds.\textsuperscript{50}

Americans should be offended particularly by hospitals dumping elderly patients because the elderly are characterized as recruited to poverty after relatively decent working lives.\textsuperscript{51} An elderly person’s “social worth” and corresponding health care resource allocation should not be determined by his or her ability to be a rational consumer\textsuperscript{25} who has saved money to purchase healthful retirement years. Instead, health care should be allocated by considering the fairness to the persons who need care the most—specifically, the sick and indigent elderly.

**Conclusion**

When society allows health care providers to operate and profit in any community, an ethic of fairness—which respects the wisdom,\textsuperscript{53} self respect,\textsuperscript{54} and achievement of the elderly—should be in place and, indeed, controlling.\textsuperscript{55} Respect for the dignity and autonomy of elderly patients, as well as the underlying motive to help them, must replace the all consuming profit motive held by both hospitals and physicians as the lodestar for American health care delivery. In order to reach this goal, society should restrict medical licenses to health care providers who will care for the indigent elderly as a condition for doing business with the rest of society. Only then might the incidence of dumping elderly patients be diminished significantly.\footnote{See Daniel N. Rosenstein, Emergency Stabilization for a Wounded COBRA, 9 Issues L. & Med. 255 (1993).}

\textsuperscript{2} Id. at 256.
\textsuperscript{3} Id.
\textsuperscript{5} Id.
\textsuperscript{8} See id. at 184.
\textsuperscript{9} See Hines, 827 F. Supp. at 428.
\textsuperscript{11} See Rosenstein, supra note 1, at 256.
\textsuperscript{12} Abercombie v. Osteopathic Hosp. Founders Ass'n, 950 F.2d 676, 680 (10th Cir. 1991).
\textsuperscript{14} See id. at 1305.
\textsuperscript{15} See id.
\textsuperscript{16} Burditt v. United States Dep't. of Health & Human Services, 934 F.2d 1392, 1366 (6th Cir. 1994).
\textsuperscript{17} See Gary Taylor, Cracking Down on Patient Dumping, Nat'l L. 2 (June 6, 1998).
\textsuperscript{20} See Rosenstein, supra note 1, at 278 n.146.
\textsuperscript{21} See id. at 278–89.
\textsuperscript{22} See id. at 278.
\textsuperscript{23} Baber, 977 F.2d 872, 878–85 (4th Cir. 1992).
\textsuperscript{24} See id. at 878 n.7.
\textsuperscript{25} See Rosenstein, supra note 1, at 278–79.
\textsuperscript{26} Cleland v. Bronson Health Care Group, 917 F.2d 226, 271 (6th Cir. 1990).
\textsuperscript{27} See Libit, supra note 15, at A16.
\textsuperscript{30} See Burditt, 934 F.2d at 1366.
\textsuperscript{31} See Treiger, supra note 4, at 1209.
\textsuperscript{32} See id. at 1217.
\textsuperscript{33} See Rosenstein, supra note 1, at 288 n.208.
\textsuperscript{34} See id. at 289 n.214.
\textsuperscript{36} See id.
\textsuperscript{37} See id.
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This column is submitted on behalf of the Elder Law Section, Mary Alice Ferrell, chair, and Juliana R. Osterhout, editor.

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39 Id.
41 Id. at 679.
45 See Caplan, supra note 40, at 668–73.
46 See id. at 675.
48 See Bruce Jennings et al., Ethical Challenges of Chronic Illness, HASTINGS CTR. REP. 51, 58 (Feb./Mar. 1988).
51 See Ronald Bayer & Daniel Callahan, Medicare Reform: Social and Ethical Perspectives, 10 J. HEALTH POLITICS, POL’Y & L. 533, 536 (1986).
52 See Caplan, supra note 40, at 668.
54 See Smith, supra note 43, at ch. 1.
55 See id. at ch. 2 & 12.