The Emergency Medical Treatment and Active Labor Act of 1986: Providing Discrimination in Access to Emergency Medical Care

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THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT OF 1986: PROVIDING PROTECTION FROM DISCRIMINATION IN ACCESS TO EMERGENCY MEDICAL CARE

The practice of patient dumping is a by-product of the rising number of uninsured persons in the United States coupled with an increased focus by the health care industry on containing rising costs. In 1977, there

1. "The term 'patient dumping' is used to refer to the practice of those hospitals which, despite being capable of providing the needed medical care, send patients to other facilities or turn patients away because those patients are unable to pay." Reid v. Indianapolis Osteopathic Medical Hosp., Inc., 709 F. Supp. 853, 853-54 (S.D. Ind. 1989). One commentator defines patient dumping as:

   [T]he world of medical nonpractice, where economic reality shatter childhood images of kind, caring health care providers dedicated to saving lives. Patient dumping is the refusal of hospitals, usually private hospitals, to treat patients in need of emergency care (many of them women in labor) because of their inability to pay.


2. See generally Karen I. Treiger, Note, Preventing Patient Dumping: Sharpening the COBRA's Fangs, 61 N.Y.U. L. REV. 1186, 1192-96 (1986) (describing the underlying reasons for patient dumping). In 1984, over 35 million people under age 65 were without health insurance; between 1981 and 1985 over one million people were cut from Medicaid. Id. at 1193-94. By 1993, the number of uninsured in the United States had risen to 37 million. Rich Thomas, "A Walk in Space," NEWSWEEK, Oct. 4, 1993, at 46. Hospitals are now players in a competitive age where cost containment is caused by many factors. For example, Medicare's shift to diagnostic related groups (DRGs) in 1983 in place of cost-based reimbursements made hospitals more cost conscious and less willing to subsidize charity care. Treiger, supra, at 1194. In addition, the insurance industry increasingly holds hospitals accountable for the high costs of health care, and hospitals now compete for insured patients. Id. at 1195. These are the primary factors that contributed to the cost containment era in health care. Id. at 1193-96.
were twenty-five million uninsured persons in the United States; that number had risen to thirty-five million by 1988, and had reached thirty-seven million by 1993. Increasing numbers of uninsured patients force hospitals to make difficult choices between treating those in need and keeping operating costs down. In many cases, these choices result in denial of emergency treatment for the uninsured. Incidents of patient dumping range from outright denials of emergency care to transfers of unstable emergency patients for purely economic reasons.

Common law as well as state and early federal statutory attempts to address the problem of patient dumping had only a limited effect, prompting Congress to enact the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA or the Act) as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA). Responding to

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4. Thomas, supra note 2, at 46.
5. Treiger, supra note 2, at 1193-96. Two primary factors leading to patient dumping include "an increase in the number of uninsured people in the United States," id. at 1193, and "widespread cost containment efforts by the federal government." Id. at 1194. In addition, private health care facilities are likewise looking to contain costs, thus "[i]n the new era of competition with a price-driven marketplace, cost-shifting to subsidize charity care is impractical and bad business." Id. at 1195; see also McClurg, supra note 1, at 179-82 (discussing the reasons for patient dumping).

6. Group Charges Patient "Dumping" Widespread, UPI, May 19, 1993, available in LEXIS, Nexis Library, UPI File ("The problem of "patient dumping" will not go away so long as 37 million people remain uninsured and health care decisions are largely driven by concerns about who pays the bill." (quoting Dr. Sidney Wolfe, director of the Public Citizen Health Research Group)). "A permanent solution to the problem of patient dumping will occur only, as others have said, when the larger issue of health care financing, both for the individuals and the hospitals is addressed." Equal Access Hearings, supra note 1, at 154 (testimony of Dr. Ansell). While healthcare reform would be the best solution to the patient dumping dilemma, id., full implementation of healthcare legislation is still years away. Thomas, supra note 2, at 49.

7. See Equal Access Hearings, supra note 1, at 14-20. Testimony was presented at this hearing about a diabetic, unable to breath, who was refused treatment and physically removed from a hospital in Tennessee because he owed the hospital money and had no insurance. Id. at 14-16. He died the following day. Id. Further testimony concerned a young woman six-and-one-half months pregnant who sought emergency treatment at a hospital in Virginia. Id. at 43. She was bleeding and in severe pain. Id. After waiting several hours, the woman was instructed to go to another hospital because she did not have a private physician on staff. Id. The baby was born prematurly that afternoon and died within minutes. Id.


highly publicized incidents of patient dumping, Congress enacted EMTALA to prevent the denial of emergency care to uninsured and indigent patients.10

EMTALA incorporates two levels of treatment with which a hospital must comply to avoid violating the Act.11 First, a hospital must provide any individual who presents a potential emergency with a medical screening exam to determine if an emergency condition in fact exists.12 Second, a hospital is responsible for stabilizing any emergency patient prior to discharge or transfer to another hospital.13 In addition, any physician who negligently violates requirements of the Act is liable under EMTALA.14 Civil fines are imposed on hospitals and physicians for failing to comply with the statute's provisions.15 Any person directly harmed as a result of a violation of the Act may bring a civil suit against the violating hospital and obtain relief under the laws of the state where the violation occurred.16

10. See H.R. REP. No. 241, 99th Cong., 2d Sess. pt. 1, at 27, 42 (1986) (indicating that “[t]he 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”), reprinted in 1986 U.S.C.C.A.N. 579, 605; id., pt.3, at 5 (stating that “[i]n recent years there has been a growing concern about the provision of adequate emergency room medical services to individuals who seek care, particularly to the indigent and uninsured”), reprinted in 1986 U.S.C.C.A.N. 579, 726.

11. 42 U.S.C. § 1395dd(a)-(b) (1988 & Supp. III 1992). The Act requires that emergency patients be given an “appropriate medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition... exists.” Id. § 1395dd(a). If the hospital determines that the individual does have an emergency condition, then “the hospital must provide either—(A) ... for such further medical examination and such treatment as may be required to stabilize the medical condition or to provide for treatment of the labor, or (B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.” Id. § 1395dd(b)(1).

12. Id. § 1395dd(b)(A).

13. Id. A patient may be transferred only if the benefits of a transfer outweigh the risks to the patient. Id. § 1395dd(c)(1)(A)(ii).

14. Id. § 1395dd(d)(1)(B). A physician's violation can result from his or her authorization of a patient transfer where the benefits of the transfer do not outweigh the risks, or through a misrepresentation of either a patient's condition or of a hospital's obligations under the Act. Id. However, these illustrations are not the sole means of violating the Act. EMTALA clearly states that any negligent violation of the Act can result in imposition of a fine on the physician. Id.

15. Id. § 1395dd(d)(1)(A). "A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation.” Id. Physicians are likewise subject to civil monetary penalties of up to $50,000 for each violation. Id. § 1395dd(d)(1)(B).

16. Id. § 1395dd(d)(2)(A). Section 1395dd(d)(2)(A) provides:
Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against
A fundamental question regarding EMTALA is whether it applies broadly, to any individual, or more narrowly, to indigent and uninsured patients only. The statute's plain language provides that the Act applies to "any individual" without regard to the patient's ability to pay. However, EMTALA's legislative history indicates that Congress intended to protect those individuals without insurance or other means of payment from the denial of emergency medical care. While some courts have followed the legislative history and required that indigency be pled to establish an EMTALA violation, other courts, adhering to the express language of the statute, have extended EMTALA's protection to any individual regardless of economic means.

the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

Id. This section only provides for a civil suit against a violating hospital, not a physician. "See also Delaney v. Cade, 986 F.2d 387, 393 (10th Cir. 1993) (indicating that EMTALA only provides for a cause of action against a violating hospital, not a physician). However, the actions of a physician may result in liability for the hospital where a physician acts as an agent for the facility. See Abercrombie v. Osteopathic Hosp. Founders Ass'n, 950 F.2d 676, 678 (10th Cir. 1991) (involving potential liability on the part of the hospital resulting from conduct of the physicians acting as agents). Since the laws of the various states apply to the extent that there is no conflict with any of EMTALA's provision, suits brought in different states for similar violations could result in different relief for the parties depending on differences in the state statutes and whether they conflict with EMTALA. See 42 U.S.C. § 1395dd(f).

17. See Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 269-70 (6th Cir. 1990) (discussing whether EMTALA applies only to indigent individuals or to any person dumped by a health care facility); Lee v. Allegheny Regional Hosp. Corp., 778 F. Supp. 900, 902 (W.D. Va. 1991) (finding that the plain words of the statute should have effect, thus applying the Act to "any individual"); see also infra notes 113-40 and accompanying text.

18. 42 U.S.C. § 1395dd(a)-(b). Both of these provisions specifically reference "any individual" and give no indication that the statute should be interpreted differently. See id.


21. See, e.g., Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1040 (D.C. Cir. 1991) (indicating that EMTALA makes no distinction between the insured and the uninsured; its language is clear when it states "any individual," therefore, the Act applies to any person seeking emergency assistance); Burditt v. United States Dept. of Health & Human Servs., 934 F.2d 1362, 1371-72 (5th Cir. 1991) (dumping a patient because the risk of liability constitutes a violation of the statute); Cleland, 917 F.2d at 270 (holding that where the words of a statute are clear, and reading them as such does not lead to an absurd result, the facial reading of the statute must prevail). Other courts have recognized this controversy in dicta. See, e.g., Thornton v. Southwest Detroit Hosp., 895 F.2d 1131, 1132

Under this broad reading of EMTALA many suits brought under the Act resemble negligence claims involving damages for medical malpractice or wrongful death.\textsuperscript{22} One court examining the issue explicitly determined that the drafters of this antipatient dumping statute did not intend to create a federal malpractice statute, but intended to create a new cause of action for failure to treat.\textsuperscript{23} The facts giving rise to an EMTALA violation may nonetheless involve an allegation of negligence.\textsuperscript{24} The two causes of action, however, are distinct—EMTALA clearly provides an action for failure to treat emergency patients, independent of any negligent treatment.\textsuperscript{25}

This Comment examines the rise of the patient dumping problem and analyzes common law and early statutory attempts to address this problem. This Comment then explores the extension of EMTALA protection beyond the indigent to include all persons, and discusses its application beyond the confines of the emergency room. Next, this Comment analyzes several cases decided since the passage of EMTALA to determine whether a violation of the statute was truly alleged or whether the disputes were merely malpractice claims disguised as federal antidumping violations. Next, this Comment explores but rejects the suggestion that EMTALA should be limited to apply only to the indigent, as such a limitation provides insufficient protection from discriminatory emergency treatment to all persons. Finally, this Comment discusses the emerging characteristics that distinguish EMTALA violations from malpractice or negligence claims, and proposes that EMTALA would be strengthened by more accurate definitions of key terms and stricter reporting require-

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\textsuperscript{22} See, e.g., Collins v. DePaul Hosp., 963 F.2d 303, 304 n.2 (10th Cir. 1992) (alleging an EMTALA violation after an unsuccessful suit in state court for malpractice); Abercrombie v. Osteopathic Hosp. Founders Ass’n, 950 F.2d 676, 678 (10th Cir. 1991) (alleging both a violation of EMTALA and a pendent state claim for wrongful death); Gatewood, 933 F.2d at 1039 (involving allegations of malpractice and violations of EMTALA for failure to stabilize a patient prior to discharge).

\textsuperscript{23} See Gatewood, 933 F.2d at 1041. “The federal Emergency Act is not intended to duplicate preexisting legal protections, but rather to create a new cause of action, generally unavailable under state tort law, for what amounts to failure to treat.” \textit{Id.}

\textsuperscript{24} See infra notes 163-67 and accompanying text.

\textsuperscript{25} Violations of EMTALA include failure to stabilize prior to transfer or failure to provide an appropriate medical screening. See infra notes 163-69 and accompanying text. Although negligence could become an issue if the failure to stabilize was caused by negligent actions on the part of hospital personnel, failure to treat should be the thrust behind most EMTALA violations. See infra notes 163-69.
ments for hospitals that receive transfers in violation of EMTALA. This Comment concludes that EMTALA—a comprehensive antipatient dumping statute providing significant protection for patients—would provide more effective protection for patients and provide guidance for hospitals and physicians if a showing of discrimination by the hospital or physician were required.

I. EARLY ATTEMPTS TO CURB THE PROBLEM OF PATIENT DUMPING

The disparity between a public and a private hospital's duty to treat patients established the historical backdrop for the patient dumping controversy. At common law, private hospitals were under no obligation to treat any particular individual and, consequently, were not required to articulate any reason for refusing to provide treatment.\(^{26}\) Conversely, public hospitals often were established under charters requiring them to treat certain numbers or types of patients.\(^{27}\) Recognizing the harshness of the common law rule allowing a private hospital to refuse to treat any individual for any reason,\(^{28}\) courts established several exceptions to the rule in order to alleviate its severe effects.\(^{29}\)

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\(^{26}\) See Birmingham Baptist Hosp. v. Crews, 157 So. 224, 225 ( Ala. 1934) (holding that a private hospital is under no obligation to admit any patient and may deny admittance for whatever reason it sees fit); Le Juene Road Hosp., Inc. v. Watson, 171 So. 2d 202, 203 (Fla. Dist. Ct. App. 1965) ("[A] private hospital is under no obligation to admit any patient that it does not desire. . . . [I]t is permissible for a private hospital to reject for whatever reason, or no reason at all, any applicant for medical and hospital services."); see also 40 AM. JUR. 2d Hospitals and Asylums § 12, at 860 (1969) (noting that "a private hospital owes the public no duty to accept any patient not desired by it").

\(^{27}\) HEALTHCARE FACILITIES LAW, supra note 8, § 4.10.2., at 322-23 (describing the different duties imposed on public hospitals versus private hospitals).

\(^{28}\) See Le Juene, 171 So. 2d at 203 (discussing the harshness of the common-law rule); see also Birmingham Baptist, 157 So. at 225. The Birmingham court articulated the common law rule:

Defendant is a private corporation, and not a public institution, and owes the public no duty to accept any patient not desired by it. In this respect it is not similar to a public utility. It is not necessary to assign any reason for its refusal to accept a patient for hospital services.

\(^{29}\) See Mercy Medical Ctr., Inc. v. Winnebago County, 206 N.W.2d 198, 201 (Wis. 1973) (discussing dissatisfaction with the common law rule that led to the creation of exceptions).
A. Common Law Efforts to Impose a Duty to Treat on Health Care Facilities

Courts have carved out several exceptions to the common law rule, imposing a duty to treat upon public and private health care facilities alike in specific situations. These exceptions find their roots in basic tort law principles of reliance and abandonment.30

1. The "Reliance Exception"

One exception to the common law rule imposes a duty on private health care facilities to provide emergency medical care where an individual seeking treatment relied on the facility to provide care.31 The rationale for this exception is that, in an emergency situation, an individual relies on the existence of an emergency ward; to deny that individual access may further jeopardize the patient's emergency condition.32 In Wilmington General Hospital v. Manlove,33 an infant was denied emergency treatment because she was already under the care of a physician, and the hospital concluded that the medication she had been taking might conflict with any medication administered by the hospital.34 The child died shortly after being denied emergency assistance.35 The Delaware Supreme Court, recognizing the well-established common law rule, held that in a situation where an emergency patient relied on the existence of the medical facility and its custom of furnishing medical care, the facility must render emergency care to avoid potential liability.36 Accordingly, the court remanded the case to determine whether an actual emergency existed.37

30. See, e.g., Manlove, 174 A.2d at 140 ("[L]iability on the part of a hospital may be predicated on the refusal of service to a patient in case of an unmistakable emergency, if the patient has relied upon a well-established custom of the hospital to render aid in such a case."); Le Juene, 171 So. 2d at 203 (establishing a duty to treat based on a wrongful discharge standard where once a patient is admitted, a hospital cannot discharge the patient without potential liability); Stanturf v. Sipes, 447 S.W.2d 558, 561-62 (Mo. 1969) (applying the reliance principle of tort law that where an individual has relied on assistance, the denial of that assistance can result in liability).
31. See Manlove, 174 A.2d at 139 (establishing the reliance exception to the common law rule); see also Stanturf, 447 S.W.2d at 562 (adopting the Manlove exception and remanding the case to determine whether the requisite facts were established).
32. See Manlove, 174 A.2d at 136.
33. Id.
34. Id.
35. Id.
36. Id. at 140.
37. Id. at 140-41.
The Supreme Court of Missouri adopted this reliance principal in *Stanturf v. Sipes*, where a physician contacted the only area hospital to have his frostbitten patient admitted. The hospital refused to admit the patient without payment of a requisite $25.00 admission fee. Although the patient was unable to pay the fee, both his son-in-law and a local organization volunteered to pay it for him. Nonetheless, the hospital refused to admit the patient. The Missouri court, relying on *Manlove*, determined that the hospital was potentially liable for the patient’s injuries because it departed from its established custom of accepting any patient who paid the admission fee. The court remanded the case to determine if the facts met the requirements of the *Manlove* exception.

Thus, in order to reap the benefits of the reliance exception, an individual must establish two foundational prerequisites: (1) reliance upon the existence of the medical facility when seeking emergency assistance; and (2) the actual existence of a medical emergency. In *Fabian v. Matzko*, the failure to allege both an emergency condition and reliance on the custom of the hospital to treat emergencies resulted in an application of the common law rule and a denial of the exception.

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38. 447 S.W.2d 558 (Mo. 1969).
39. *Id.* at 559.
40. *Id.*
41. *Id.*
42. *Id.*
43. *Id.* at 561.
44. *Id.* at 562-63.
45. *See* Fabian v. Matzko, 344 A.2d 569 (Pa. Super. Ct. 1975) (holding that the *Manlove* exception can not apply where reliance on the custom of providing emergency assistance was not established and the patient did not actually go to the hospital to seek treatment); *see also* Wilmington Gen. Hosp. v. Manlove, 174 A.2d 135, 140-41 (Del. Super. Ct. 1961) (remanding the case to determine if an emergency actually existed).
46. *Fabian*, 344 A.2d at 569. Mrs. Fabian was diagnosed by her family physician, Dr. Matzko, as having a viral infection after she suffered an attack of severe neck pain and nausea. *Id.* at 570. When her condition worsened, her husband called the Geisinger Medical Center to consult with a physician, Dr. Cahill, who determined that Mrs. Fabian should be admitted. *Id.* However, in accordance with hospital procedures, Dr. Cahill asked Mr. Fabian if his wife had a family physician. *Id.* After discovering that Mrs. Fabian was in the care of another doctor, Dr. Cahill indicated that Dr. Matzko, her physician would have to make the arrangements for her admittance. *Id.* Mrs. Fabian was not admitted until several days later because Dr. Matzko was unavailable. *Id.* By then her condition had worsened, and she suffered a second attack before Dr. Matzko arranged for her admittance to the hospital. *Id.* This second attack was actually a cerebral hemorrhage and left Mrs. Fabian with “permanent brain damage, loss of speech, partial paralysis, loss of hearing, loss of vision and expressive and receptive aphasia.” *Id.*
47. *Id.* at 572. The court pointed out that the situation in *Fabian* was not analogous to *Manlove* or *Stanturf* because the patient did not “rely on the policy of rendering emergency care.” *Id.*; *see supra* notes 38-44 and accompanying text (discussing *Stanturf*).
The success of the Manlove "reliance" exception was limited by the necessary proofs. Once a party has established both the presence of an emergency condition and reliance on the established custom of the hospital of providing emergency care, the duty to provide care is established. Once the duty is established, however, the successful litigant also is required to prove all elements of the common law tort: breach of the duty, proximate cause, and damages. Although the Manlove exception alleviated the harsh effect of the common law no duty to treat rule, it failed to function as a final solution due to the burdensome proofs involved.

2. The Doctrine of Abandonment

Finding an alternative basis for imposing a duty to treat, the Supreme Court of New York, Trial Term, held a hospital liable in Barcia v. Society of New York Hospital. In Barcia, the parents of a two year-old child brought her to a New York hospital at the express instructions of their family physician. The hospital performed tests on the child, but did not admit her despite the admitting physician's observation that she "looked acutely ill to a mild degree." The following day, the parents returned to the hospital because their daughter's condition had worsened. The child died within twenty-four hours. The court held the hospital liable because the physician was negligent in his failure to admit the patient on the prior day. While this case does not expressly discuss the common

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48. McClurg, supra note 1, at 182-89 (discussing common law remedies to the no duty to treat rule); Karen H. Rothenberg, Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care, 26 Hous. L. Rev. 21, 40 (1989) (discussing the evolution of the duty of hospitals to provide care). The Manlove case established the "reliance" exception but was remanded to determine if the facts established that the exception should apply. Id.
49. Rothenberg, supra note 48, at 40.
[T]he plaintiff must prove the presence of an unmistakable emergency and reliance on a well-established custom. This factors, however, merely establish the duty to treat. Plaintiff must then prove the remaining elements of a common-law tort action: breach of duty, consequent harm and proximate cause. Id. (citations omitted).
50. See Fabian, 344 A.2d at 572 (holding that "a private hospital is presently under no duty to accept non-emergency patients that it does not desire"). The difficulties posed by the Manlove decision were its failure to include a definition of an "emergency," and its lack of guidelines for healthcare facilities on the type and extent of the duty to render emergency aid to the indigent. HEALTHCARE FACILITIES LAW, supra note 8, § 6.2.1, at 426-27.
52. Id. at 374.
53. Id. (quoting statements in record made by the admitting physician).
54. Id.
55. Id.
56. Id. at 376.
law rule or carve a specific exception, it indicates that a hospital can be held liable for injuries to a patient resulting from a failure to treat.\(^5\)

This type of judicial reasoning evolved into another exception to the common-law rule—a wrongful discharge standard.\(^5\) In *Le Juene Road Hospital, Inc. v. Watson*,\(^5\) a mother took her eleven year-old son to the hospital at their physician’s direction.\(^5\) Although a medical provider administered medication and placed the child in a hospital gown, the hospital discharged him prior to an appendectomy operation because his mother did not have the necessary money to pay for the operation.\(^6\) The Florida Supreme Court acknowledged the common law doctrine that the hospital had no duty to treat, but reasoned that once treatment commences, a patient should be able to rely on continued treatment.\(^6\) The court, therefore, held that discharging a patient after the commencement of treatment rendered the hospital liable for subsequent injuries resulting from the failure to continue treatment.\(^6\) The court was unconcerned that the proper paperwork had not been completed, finding that the treatment relationship had commenced based on the actions of the medical personnel.\(^6\)

Thus, once a professional relationship commences, a health care facility that terminates the relationship and “abandons” the patient risks liability.\(^6\) However, this exception to the no duty to treat rule carries its own burdens—not unlike the reliance exception.\(^6\) In order to utilize the abandonment doctrine, an individual must first establish the existence of a professional relationship.\(^6\)

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57. *Id.*
58. *See, e.g.,* *Le Juene Road Hosp., Inc. v. Watson,* 171 So. 2d 202, 203-04 (Fla. Dist. Ct. App. 1965) (holding that a private hospital is under no obligation to admit an emergency patient; however, once treatment has commenced, a patient may not be wrongfully discharged against his will).
59. *Id.*
60. *Id.* at 203.
61. *Id.*
62. *Id.* at 204. The court found little authority to rely on but was persuaded by a New York Court of Appeals decision, Meiselman v. Crown Heights Hospital, 34 N.E.2d 367 (N.Y. 1941), and a Pittsburgh hospital manual dealing with proper admitting and discharging. *Le Juene*, 171 So. 2d at 204.
63. *Le Juene*, 171 So. 2d at 204.
64. *Id.*
65. *See* *HEALTHCARE FACILITIES LAW,* *supra* note 8, § 4.9.2, at 320-21. “Because the healthcare facility is not liable until a professional relationship has been established, a threshold question that may arise in abandonment cases is whether a relationship was formed between the facility and the patient.” *Id.* at 321.
66. *See supra* notes 45-50 and accompanying text (discussing difficulties associated with the reliance exception).
67. *See, e.g.,* *Hill v. Ohio County,* 468 S.W.2d 306, 309 (Ky. 1970) (finding that no professional relationship was established where a pregnant woman was at the hospital for
The Kentucky Court of Appeals demonstrated in *Hill v. Ohio County* that establishing the existence of a professional relationship is more difficult than simply presenting oneself for treatment at an emergency ward. The *Hill* court offered no specific standard for determining when the existence of a professional relationship commences; however, in *Hill* the standard was slightly greater than the common procedure for accessing medical treatment through a hospital emergency ward. Given even this de minimis heightened standard, the abandonment doctrine did not fully remedy the patient dumping dilemma that resulted from private hospitals' continuing ability to deny emergency medical care.

These reliance and abandonment exceptions have lead to a limited common law duty of private medical providers to treat patients. However, the extent of this duty, where it begins, and when it can be terminated continued to be areas of litigation. Although the common law has had limited success in imposing a duty to treat, its application was haphazard and inconsistent, often resulting in no compensation in cases where necessary treatment was denied.

**B. Statutory Solutions to the Problem of Patient Dumping**

1. **State Statutory Attempts**

As a result of the inconsistent common law remedies, many states attempted to impose a duty to treat emergency patients by enacting statutes that require both public and private hospitals to treat individuals in emergency situations. These statutory schemes and the degree of protection

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68. 468 S.W.2d 306 (Ky. 1971), cert. denied, 404 U.S. 1041 (1972).
69. *Id.*
70. *Id.* at 307. Generally, a person is presented at an emergency ward and requests assistance for an emergency condition. However, in *Hill* a pregnant woman presented herself for emergency obstetrical care and was informed that since she had no attending physician on staff, and no one on duty wanted to handle her case, she could seek assistance at hospitals in two other cities. *Id.* She was at the hospital for over an hour before she took a taxi home and delivered her baby there. *Id.* The woman died the following day. *Id.* at 307-08. Ironically, Ohio County Hospital was constructed with Hill-Burton funds. *Id.* at 308; see infra notes 89-98 and accompanying text (discussing Hill-Burton's provisions and problems).
71. See *id.*
72. **HEALTHCARE FACILITIES LAW**, supra note 8, § 6.2.2, at 428.
73. *Id.*
74. See supra notes 45-50 (discussing the difficulties associated with the reliance exception because of the necessary proofs involved); supra notes 66-71 (discussing inconsistent treatment with respect to the abandonment exception).
75. See, e.g., **CAL. HEALTH & SAFETY CODE** §§ 1317, 1317.2-2a, (West Supp. 1992); **FLA. STAT. ANN.** § 395.1041 (West 1993); **GA. CODE ANN.** §§ 31-8-40 to -46 (Michie Supp.
vary, with some states offering comprehensive protection from a range of possible forms of discrimination,\textsuperscript{76} and other states limiting protection to the indigent.\textsuperscript{77}


\textsuperscript{76} \textit{See, e.g., Cal. Health & Safety Code} § 1317. California provides that emergency care must be rendered prior to inquiring about a patient's means of paying. \textit{Id.} § 1317(c). The statute explicitly states: "In 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 . . . ." \textit{Id.} § 1317(b).

\textsuperscript{77} \textit{See Haw. Rev. Stat.} § 321-232(b). This section provides:

No ambulance services, or any other emergency medical services available from or under the authority of this chapter shall be denied to any person 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. \textit{Id.}

\textsuperscript{78} \textit{Mass. Gen. Laws Ann.} ch. 111, § 70E(k). The Massachusetts statute outlines various rights of every patient, including the right to prompt life saving treatment in an emergency without discrimination on account of economic status or source of payment and without delaying treatment for purposes of prior discussion of the source of payment unless such delay can be imposed without material risk to his health, and this right shall also extend to those persons not already patients or residents or a facility if said facility has a certified emergency care unit . . . .

\textit{Id.} In the event that treatment is refused because of economic status, the statute also guarantees the right to prompt and safe transfer to a facility which agrees to receive and treat such patient. Said facility refusing to treat such patient shall be responsible for: ascertaining that the patient may be safely transferred; contacting a facility willing to treat such patient; arranging the transportation; accompanying the patient with necessary and appropriate professional staff to assist in the safety and comfort of the transfer, assure that the receiving facility assumes the necessary care promptly, and provide pertinent medical information about the patient's condition; and maintaining records of the foregoing.

\textit{Id.} § 70E(n).
disability, marital status, sexual preference, or source of payment.\textsuperscript{79} California,\textsuperscript{80} Florida,\textsuperscript{81} Idaho,\textsuperscript{82} and Louisiana\textsuperscript{83} all provide for broad antidiscriminatory care, while the Hawaii statute only prohibits discrimination when it is based on ability to pay.\textsuperscript{84}

Despite the efforts of these state legislatures to address the problems of patient dumping and discrimination in providing access to emergency care, their attempts have not been uniformly successful.\textsuperscript{85} The varying degrees of success\textsuperscript{86} of these statutes is due primarily to nonexistent or ineffective enforcement provisions.\textsuperscript{87} Additionally, most statutes lack

\textsuperscript{79} N.H. REV. STAT. ANN. \S 151:21. The statute provides that “[t]he 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.” \textit{Id.} \S 151:21(XVI). However, the statute does allow a hospital to transfer a patient for nonpayment of the hospital bill. \textit{Id.} \S 151:21(IV).

\textsuperscript{80} CAL. HEALTH \& SAFETY CODE \S 1317.

\textsuperscript{81} FLA. STAT. ANN. \S 395.1041.

\textsuperscript{82} IDAHO CODE \S 39-1391b. The Idaho statute does not require a hospital or its personnel to provide emergency care, however, if such care is provided, it should be in a nondiscriminatory fashion, and emergency care should therefore not be denied “to any person by reason of race, creed, national origin or financial ability to pay therefor.” \textit{Id.}

\textsuperscript{83} LA. REV. STAT. ANN. \S 40:2113.4. The Louisiana statute mandates that hospitals make emergency services 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.” \textit{Id.}

\textsuperscript{84} HAW. REV. STAT. \S 321-232(b) (indicating that emergency services should 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”).

\textsuperscript{85} Rothenberg, \textit{supra} note 48, at 54. For example, early statutory efforts to address the problem of patient dumping in Illinois were unsuccessful due to the lack of enforcement provisions in the state statute. \textit{Id.} The statute did not provide for a private right of action, nor were courts willing to imply one, thus limiting the statute’s effectiveness. \textit{Id.} As a result, incidents of dumping patients from private hospitals to Cook County Hospital in Chicago continue to be reported. \textit{Id.}

\textsuperscript{86} See, e.g., TENN. CODE ANN. \S 68-140-511 (1992) (providing that hospitals should not discriminate against emergency patients due to their uninsured status or their race, sex, religion, creed, national origin or ability to pay). Despite this statute, Dr. Kellermann, chief of the division of Emergency Medicine at the University of Tennessee at Memphis and director of the emergency department at the Regional Medical Center at Memphis, in his testimony before the House Subcommittee of the Committee on Government Operations, stated that the Tennessee statute was “frustrated by the power of the hospital lobby,” which “gutted the bill before it ever got out of the general assembly.” \textit{Equal Access Hearings, supra} note 1, at 118-19.

\textsuperscript{87} See HEALTHCARE FACILITIES LAW, \textit{supra} note 8, \S 6.2.2, at 428 (indicating that few state statutes “have effective enforcement provisions”); Rothenberg, \textit{supra} note 48, at 56. Professor Rothenberg noted:

[M]ost state laws have limited enforcement potential. First, many laws still lack implementing regulations. The definition of an emergency lacks clarity or is defined too narrowly. Many state laws do not address the problems of transfer that arise from a lack of appropriate services, and most laws allow transfer after “stabilization,” a term often used to justify economic, not medical, reasons. In addi-
regulations clarifying their function and impose minimal or no fines for violations. 88

2. The First Federal Statute

Congress' first attempt to discourage patient dumping appeared in 1946 with the enactment of the Hill-Burton Act (Hill-Burton). 89 Hill-Burton authorized the expenditure of federal funds for the construction and modernization of health care facilities. 90 In exchange for these federal monies, hospitals were required to provide medical treatment to individuals residing in the area surrounding the hospital 91 and to provide some below-cost and free medical treatment. 92 These services were generally required for a twenty-year period following construction of the health care facility. 93

Hill-Burton had a limited effect and consequently was widely criticized. 94 This federal legislation suffered from the same maladies as many of the state statutes. 95 Hill-Burton failed to grant an express right of action to persons denied the treatment required under the statute and courts were loathe to uphold an implied right of action under the statute, state laws experience little meaningful enforcement. Only a few states levy fines, usually minimal, for violations.

Id. at 56-57 (footnote omitted); see also McClurg, supra note 1, at 197. Professor McClurg concluded: "State emergency care statutes do not provide an effective remedy for patient dumping, most obviously because half the states have no such statutes. Moreover, all but a few of the statutes that do exist fail to expressly provide for a private right of action." Id.

88. Rothenberg, supra note 48, at 56-57; see, e.g., MD. HEALTH-GEN. CODE ANN. § 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 1989) (indicating that a violating hospital may be fined no more than $1000).


91. Id. § 291c(e)(1). In addition to ensuring adequate services for all people, Congress enacted Hill-Burton to promote research and development and to stimulate development of new and improved medical facilities. Id.

92. Id. § 291c(e)(2).

93. Id.

94. See HEALTHCARE FACILITIES LAW, supra note 8, § 4.10.3, at 325-26; Stricker, supra note 75, at 1126; Treiger, supra note 2, at 1198-1201; see also Hill v. Ohio County, 468 S.W.2d 306 (Ky. 1970) (involving patient dumping at a hospital constructed with Hill-Burton funds), cert. denied, 404 U.S. 1041 (1972).

95. See HEALTHCARE FACILITIES LAW, supra note 8, § 4.10.3, at 325-26. "Hill-Burton was criticized because it did not contain an express cause of action under which an individual could enforce its provisions, did not provide for punitive damages, and did not respond to the immediate needs of the uninsured." Id.
Cognizant of the shortcomings of both existing state statutes and Hill-Burton to address the patient dumping problem effectively, Congress eventually enacted EMTALA in 1986. EMTALA represented Congress' attempt to address comprehensively the patient dumping dilemma.

II. PROVISIONS OF THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT

A. EMTALA Violations

Under EMTALA, any hospital receiving Medicaid or Medicare reimbursements from the government must provide appropriate medical screening to any individual who comes to the hospital seeking treatment. The hospital must either stabilize the emergency condition or transfer the patient to a facility that is better equipped to care for the particular emergency. A transfer, however, can occur only if the patient gives written consent after being informed of EMTALA's provisions or a physician signs a certificate attesting that the benefits to the patient outweigh the risks of the transfer. Another qualified medical

96. Id.; Rothenberg, supra note 48, at 59 (discussing problems associated with Hill-Burton including the failure to provide for a private right of action, and its vague language).


100. Id. § 1395dd(b)(1)(A). An emergency medical condition is one which could result in (1) placing an individual's health in jeopardy, or (2) serious complications to the patient's condition. Id. § 1395dd(e)(1)(A). For example, if a pregnant woman is having contractions, an emergency medical condition exists when there is (1) insufficient time to safely transfer the woman prior to delivery or (2) such a transfer would risk the health or safety of the woman or her child. See id. § 1395dd(e)(1)(B).

101. Id. § 1395dd(b)(1)(B). Recently, in Burditt v. United States Department of Health and Human Services, 934 F.2d 1362, 1372 (5th Cir. 1991), the Fifth Circuit indicated that a lawful transfer of a pregnant woman in an emergency may need to include providing a physician to accompany her on the transfer as well as adequate equipment on the ambulance in case an emergency caesarean is necessary. Id. at 1373.

102. 42 U.S.C. § 1395dd(e)(1)(A)(i). The statute mandates that an unstabilized person can be transferred, only after "the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility." Id.

103. Id. § 1395dd(c)(1)(A)(ii). This section provides in part:

[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 medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer . . .
professional may certify the transfer, but only after the physician makes the necessary prior determination regarding the safety and necessity of the transfer.\footnote{Id. (footnote omitted).}

B. EMTALA Enforcement

The Act imposes civil monetary penalties of up to $50,000 on a violating hospital or physician.\footnote{Id. \S 1395dd(c)(1)(A)(iii). The statute provides: "[I]f a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person . . . has signed a certification . . . in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification . . . ." Id.} A physician violates EMTALA by certifying a transfer without sufficiently weighing the risks and benefits to the patient,\footnote{Id. \S 1395dd(d)(1)(B)(i). A physician violates the Act by certifying "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." Id.} or by misrepresenting a patient’s condition on the certificate of transfer.\footnote{Id. \S 1395dd(d)(1)(ii). In addition, fines can be imposed on a physician for any negligent violation of the Act. Id.}

The Act also provides for two types of private actions for damages when the Act is violated. First, an individual directly harmed as a result of an EMTALA violation may bring a civil suit against the hospital.\footnote{42 U.S.C. \S 1395dd(2)(A) (Supp. III 1991). Providing that: Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.} Damages in this type of suit are available according to the laws of the state in which the violation occurred.\footnote{Id.; \textit{see supra} note 16 (discussing Abercrombie v. Osteopathic Hospital Founders Ass’n, 950 F.2d 676 (10th Cir. 1991), involving hospital liability for the act of its agent physician).} In addition, a hospital that re-
ceives a patient who has been transferred in violation of EMTALA may recover for any financial losses that are attributable to the transfer.\textsuperscript{110} Again, these losses and damages are recoverable in civil actions under the laws of the state.\textsuperscript{111} All suits under EMTALA must be brought within the two year statute of limitations that runs from the date of the violation.\textsuperscript{112}

III. EMTALA—Providing Comprehensive Protection from Patient Dumping

A. The Erosion of the Requirement of Indigency

1. Congressional Intent Versus the Statute's Plain Language

EMTALA's legislative history clearly indicates that Congress was concerned principally with protecting indigent patients from the denial of emergency medical treatment.\textsuperscript{113} Despite this explicit concern, Congress drafted the statute to include "any individual" rather than limiting it to protecting only the uninsured and indigent.\textsuperscript{114} Due to this difference between the legislative history and the statutory language, courts have relied upon rules of statutory construction and interpretation to determine the proper application of EMTALA.\textsuperscript{115}

\textsuperscript{110} Id. § 1395dd(d)(2)(B). The statute requires:

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section 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.

\textsuperscript{111} 42 U.S.C. § 1395dd(d)(2)(B).

\textsuperscript{112} Id. § 1395dd(d)(2)(C).


\textsuperscript{114} Id. § 1395dd(a)-(b). Both of these sections refer to "any individual" and make no indication that the Act should be limited to the uninsured. \textit{id.} Despite explicit concern for the uninsured, the legislative history also references "any individual" when discussing the provision of an appropriate medical screening examination. H.R. Rep. No. 241, 99th Cong., 2d Sess., pt. 1, at 27 (1986), \textit{reprinted in} 1986 U.S.C.C.A.N. 579, 605.

\textsuperscript{115} See, e.g., Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 270 (6th Cir. 1990) (indicating that when a statute is unambiguous, the legislative history should not be relied upon for interpretation); Stewart v. Myrick, 731 F. Supp. 433, 435 (D. Kan. 1990)
When a statute is ambiguously written, its legislative history may be relied upon to assist in its interpretation. However, if a statute is not ambiguous, the facial reading of the statute must be followed, unless the result would be absurd. These rules of statutory construction are the basis for the debate concerning the interpretation of EMTALA.

Early decisions interpreting the statute follow its legislative history and apply the statute only to the uninsured. The United States District Court for the Southern District of Indiana, for example, determined in Evitt v. University Heights Hospital, that without the constraint of pleading indigency, any person could claim failure to stabilize or improper examination if they were harmed as a result of a discharge or transfer. That interpretation would render the hospital potentially liable for every diagnosis and discharge decision whether made for valid treatment purposes or not. Rejecting this expansive definition, the district court determined that the Act protected only the indigent from being dumped and thus required a showing of indigency in order to plead a violation of the Act.

In Stewart v. Myrick, the United States District Court for the District of Kansas followed Evitt and held that a showing of indigency is necessary for a violation of the Act. The Stewart court looked to EMTALA's legislative history to determine that indigent individuals who are denied emergency care possess a private right of action under EMTALA (relying on the legislative history to determine that EMTALA should only apply to the indigent).

116. See Wilderness Soc'y v. Morton, 479 F.2d 842, 855 (D.C. Cir.) (reversing district court's dismissal of complaint), cert. denied, 411 U.S. 917 (1973). "[W]here the language of a statute is clear and unambiguous on its face it cannot be controverted by seeking to show inconsistent legislative intent . . . ." Id.

117. Id. "[T]he “plain meaning” doctrine has always been subservient to a truly discernible legislative purpose . . . ." Id. (quoting District of Columbia v. Orleans, 406 F.2d 957, 959 (D.C. Cir. 1966)).


120. Id. at 497-98 (“Taking the plaintiff’s argument to its logical conclusion would lead to the result that any patient dissatisfied with an emergency room diagnosis and release could sue the hospital under the anti-dumping provision.”).

121. Id. at 498. The court explained: “This construction would, in effect, make the Hospital the guarantor of the physicians’ diagnosis and treatment . . . .” Id.

122. Id. The court determined that without a showing of indigency, the statute would merely duplicate state malpractice laws. Id. at 497-98.


124. Id. at 435-36. “Indigent persons denied emergency medical care possess a private federal cause of action under the Act.” Id. at 435.
that does not extend to the general population. The Stewart court concluded that nonindigent patients could seek a remedy in state court for medical malpractice, thus finding that only the uninsured possess a cause of action under EMTALA.

Using the same rules of statutory construction, however, other courts—including most courts of appeals that have heard the issue—have determined that the plain wording of EMTALA should prevail. These courts base their judgments on the fact that the statute is not ambiguous and that a broad interpretation of the statute does not produce an absurd result. The United States Court of Appeals for the Sixth Circuit reasoned in Cleland v. Bronson Health Care Group, Inc., that although the statute's intent and plain meaning are not identical, a facial reading of the statute was far from absurd. In fact, the Cleland court found that by allowing the statute to apply more broadly, EMTALA actually provided protection to other groups of people who may be discriminated against when seeking access to emergency care. Since the plain reading of the statute was neither absurd nor ambiguous, the Sixth Circuit determined that interpreting the statute did not require the court to scrutinize the legislative intent.

125. Id. at 435-36. The court indicated that the “case d[id] not present the type of evil that Congress sought to eliminate in the Act.” Id. at 436.
126. "The case therefore falls within the ambit of state negligence law, not the federal anti-dumping law." Id.
128. Gatewood, 933 F.2d at 1040 (“We conclude that we are bound by statutory language this clear, at least where, as here, it is not manifestly inconsistent with legislative intent.”); Cleland, 917 F.2d at 268 (“We hold Congress to its words, that this statute applies to any and all patients.”); Lee, 778 F. Supp. at 902 (“The statute is written plainly and does not contain any language that can reasonably be construed as limiting its application to indigents.”).
129. 917 F.2d 266 (6th Cir. 1990). The Clelands brought their 15-year-old son to the emergency room of Bronson Methodist Hospital in Kalamazoo, Michigan, where he was misdiagnosed with influenza and discharged within hours. Id. at 268. Within 24 hours the boy died of a cardiac arrest. Id.
130. Id. at 270. “The words of the statute on basic eligibility are quite plain, and interpreting them as such does not lead to an absurd result.” Id.
131. Id. at 272 (indicating that a physician could be prejudiced against an individual because of their “race, sex, or ethnic group . . . [or] distaste for the patient’s condition (e.g., AIDS patients)—all noneconomic reasons that would be remedied by applying the Act as it is written).
132. Id. at 270 (“[W]e do not need to make a dramatic choice between the two canons of construction.”).
In *Gatewood v. Washington Healthcare Corp.*, the United States Court of Appeals for the District of Columbia Circuit also extended EMTALA protection to insured individuals. The court of appeals reversed the district court’s decision denying protection to an insured person. While the district court found that the legislative history should prevail, the court of appeals held that it was bound by the statutory language because EMTALA is clear and unambiguous.

Similarly, in *Lee v. Allegheny Regional Hospital Corp.*, the district court was unpersuaded by the reasoning of the courts in *Stewart* and *Evitt*. The *Lee* court indicated that it was not the judiciary’s responsibility to rewrite statutes. Thus, the court agreed with the reasoning in *Cleland* and held that indigency need not be pled for EMTALA to apply.

2. **EMTALA: Providing Protection From Unforeseen Causes of Patient Dumping**

While a patient’s inability to pay for medical services is a primary motivation behind patient dumping, a hospital may dump a patient for reasons unrelated to economics, including prejudice by hospital personnel against the race, sex, or ethnicity of the person seeking treatment. In addition, hospital staff have been known to discriminate against patients

133. 933 F.2d 1037 (D.C. Cir. 1991). Mr. Gatewood presented himself at the hospital complaining of pain in his arm and chest. After being examined and having several tests run, he was diagnosed with musculoskeletal pain and discharged with instruction to use a heating pad, take Tylenol, and call his family physician in the morning. *Id.* at 1039. Mr. Gatewood died of a heart attack the following morning. *Id.*

134. *Id.* at 1040.

135. *Id.*

136. *Id.*

137. 778 F. Supp. 900 (W.D. Va. 1991). Ms. Wetzel was six months pregnant and complaining of severe stomach pain when she presented herself at the hospital and was misdiagnosed with appendicitis. *Id.* at 901-02. An emergency appendectomy was performed resulting in the premature birth of her daughter. *Id.* Ms. Wetzel was transferred several days following the operation. *Id.* at 902. She alleged that she was not stabilized before the transfer and thus, injuries resulted to herself and her daughter. *Id.*


140. *Id.* (indicating dissatisfaction with *Stewart* and *Evitt*, the court reiterated that it “cannot, and will not, rewrite a statute, based solely on legislative history, in the absence of any ambiguity”).

141. See Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 272 (6th Cir. 1990) (discussing possible noneconomic reasons for patient dumping, including discrimination based on race, sex, ethnicity, or condition).

142. *Id.*; see also Spencer, *supra* note 1, at 32 (discussing discriminatory treatment of African-Americans in accessing medical treatment).
with certain diseases by refusing to treat individuals with these particular, undesirable conditions. A major concern in the patient dumping debate is that the incidence of dumping patients with Acquired Immune Deficiency Syndrome (AIDS) appears to be on the rise.

Another unforeseen reason for patient dumping results from the fear of personal liability, illustrated by Burditt v. United States Department of Health & Human Services. In Burditt the physician was unconcerned with the patient’s ability or inability to pay, but rather was deterred from treating a pregnant woman because of his own potential financial liability in treating her highly unstable pregnancy. Dr. Burditt did not want to accept the woman “from a malpractice standpoint.” Under a narrow reading of EMTALA, and based on its legislative history, protection extends only to the indigent and uninsured. Therefore, a physician’s failure to treat a patient based on a concern for potential liability would obviously not be a violation of EMTALA. However, under a broader reading of EMTALA where the statute’s language encompasses all individuals, the patient in Burditt falls within the purview of the statute.

143. See Equal Access Hearings, supra note 1, at 111 (testimony of Dr. Relman). Dr. Relman indicated that tuberculosis was the undesirable disease in his day but today the disease that is avoided is AIDS. Id.


No otherwise qualified handicapped individual in the United States, . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service.

Id. § 794(a). This statute may provide protection to persons with AIDS. See Thomas v. Atascadero Unified Sch. Dist., 662 F. Supp. 376 (C.D. Cal. 1986) (finding that AIDS was covered as a disability under the Act). However, this protection may not be sufficient. See e.g., Healthcare Facilities Law, supra note 8, § 4.10.4., at 326-27 (indicating that protection from discrimination due to AIDS varies from state to state). The application of the Rehabilitation Act to persons with AIDS is, however, outside the scope of this Comment.

145. 934 F.2d 1362 (5th Cir. 1991).

146. Id. at 1367.

147. Id. Dr. Burditt made clear that “‘until DeTar Hospital pays my malpractice insurance, I will pick and choose those patients that I want to treat.’” Id. (quoting Dr. Burditt).


149. Id.

150. Regulations interpreting EMTALA are pending but have yet to be enacted. Medicare Program; Participation in CHAMPUS and CHAMPVA, Hospital Admissions for Veterans, Discharge Rights Notice, and Hospital Responsibility for Emergency Care, 53 Fed. Reg. 22,513 (1988) (to be codified at 42 C.F.R. pt. 489). The pending regulations, while not specifically recognizing these situations, apply the Act to all individuals, not just those who receive Medicare. Id. at 22,517.
While antidiscrimination laws may adequately protect persons from discriminatory dumping due to age, sex, ethnicity, or disease, such laws still would not protect the pregnant woman in *Burditt*. Thus, EMTALA’s protections should be applied broadly to protect the indigent and uninsured in addition to those who are at risk of receiving discriminatory treatment not otherwise protected by discrimination laws, including discrimination due to disease or medical condition.

**B. Patient Dumping Beyond the Emergency Room**

EMTALA specifically provides that any person who presents him or herself for treatment at an emergency room must be provided with an appropriate medical screening exam. However, with respect to the Act’s stabilization requirement, no restriction limits treatment to patients who present themselves at the emergency room. Thus, several cases that have been brought under EMTALA allege failure to stabilize before transfer despite lengthy prior hospitalizations.

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151. *Burditt*, 934 F.2d at 1366. In *Burditt*, there was no discrimination based on race, sex, ethnicity, or even unfavorable conditions. Instead, the discrimination had little to do with Ms. Rivera and much more to do with Dr. Burditt’s concern for his own financial liability. *Id.* at 1367.

152. *See id.* (providing EMTALA protection where the patient’s economic condition was not a factor); *see also* *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037 (D.C. Cir. 1991) (providing EMTALA protection regardless of the patient’s financial condition); *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 272 (6th Cir. 1990) (indicating that EMTALA should apply where the patient’s financial condition was not an issue because patients could be dumped by a hospital for a variety of reasons).

153. 42 U.S.C. § 1395dd(b) (1988 & Supp. III 1991); *see also* *Johnson v. University of Chicago Hosp.*, 982 F.2d 230 (7th Cir. 1992) (per curiam). The Seventh Circuit overruled its earlier decision, and determined that for an EMTALA violation, the patient must actually be presented at a hospital for treatment; diverting patients from one hospital to another while in an ambulance is not cognizable under the Act. *Id.* at 232.

154. 42 U.S.C. § 1395dd(c)(1). The text of the statute is plainly read to apply to “an individual at a hospital [with] an emergency medical condition which has not been stabilized.” *Id.*

155. *See, e.g.*, *Brooker v. Desert Hosp. Corp.*, 947 F.2d 412, 413-14 (9th Cir. 1991) (alleging a violation of EMTALA for failure to stabilize the patient prior to transferring her following a four day hospitalization where the patient gave her consent to the transfer); *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131, 1132 (6th Cir. 1990) (following a three-week stay in the hospital after a stroke, the patient alleged failure to stabilize prior to her transfer to a long term care facility); *Lee v. Allegheny Regional Hosp. Corp.*, 778 F. Supp. 900, 901 (W.D. Va. 1991) (following a four-day stay in the hospital after an emergency appendectomy, the patient claimed she was not stabilized when transferred); *Smith v. Richmond Memorial Hosp.*, 416 S.E.2d 689, 690 (Va.), *cert. denied*, 113 S. Ct. 442 (1992) (having spent five days in the hospital, the plaintiff alleged a violation of EMTALA for failure to stabilize her prior to transfer).
Basing its analysis upon statutory construction, the Supreme Court of Virginia in *Smith v. Richmond Memorial Hospital*\(^\text{156}\) determined that while EMTALA only requires an appropriate medical screening when an emergency patient seeks treatment, no such limitation exists under the Act's stabilization requirements.\(^\text{157}\) Thus, the court found that the stabilization requirement prior to transfer is not limited to patients in the emergency ward, but applies to any patient being transferred from the medical facility.\(^\text{158}\) This interpretation is consistent with the purpose of the Act—if EMTALA permitted a hospital to admit an emergency patient into the hospital, thus removing that patient from the emergency room, and immediately transfer that patient to another facility to avoid liability under the Act, EMTALA would be less effective.\(^\text{159}\)

EMTALA's goal is to ensure emergency care for the indigent; patient care does not become unnecessary once a patient leaves the emergency area or is admitted to the hospital.\(^\text{160}\) However, EMTALA was not intended to require long-term hospital care for the uninsured, but only

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\(^{156}\) 416 S.E.2d 689 (Va.), *cert. denied*, 113 S. Ct. 442 (1992). A private suit under EMTALA may be brought in an appropriate state or federal court. *Smith*, however, is exceptional in that it was a dispute brought in state court rather than federal court. In *Thornton v. Southwest Detroit Hospital*, 895 F.2d 1131 (6th Cir. 1990), the Sixth Circuit addressed the issue of whether such corresponding suits may be brought in federal court. The court relied on a two-tiered test set forth in *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983), where the Supreme Court held that such private civil actions are within the jurisdiction of the federal courts if the suit depends on the "resolution of a substantial question of federal law." *Id.* at 28. If the complainant cannot meet the "substantial question" standard, the court will consider whether Congress created a new, federal cause of action. *Thornton*, 895 F.2d at 1133. Fulfillment of either test is sufficient to grant federal jurisdiction. *Id.* The *Thornton* court determined that private civil suits alleging violation of EMTALA are subject to federal jurisdiction because EMTALA creates a federal cause of action and because these cases depend on the resolution of a question of federal law, not state law. *Id.* Thus, a private suit for an EMTALA violation can be brought in an appropriate state or federal court. *Id.; see also* H.R. Rep. No. 241, 99th Cong., 2d Sess., pt. 1, at 27-28 (1986), *reprinted in* 1986 U.S.C.C.A.N. 579, 606.

\(^{157}\) *Smith*, 416 S.E.2d at 692.

\(^{158}\) *Id.*

\(^{159}\) See id.; see also *Thornton*, 895 F.2d at 1135 (stating that "emergency care does not always stop when a patient is wheeled from the emergency room into the main hospital").

\(^{160}\) *Smith*, 416 S.E.2d at 692.

If an individual "comes to the emergency department," the hospital must provide an appropriate medical screening examination. If an individual "comes to a hospital" and the hospital determines that an emergency medical condition or active labor exists, the hospital must stabilize the condition or transfer the person. If a "patient at a hospital" has an emergency condition or is in active labor, the hospital may transfer that patient only under certain conditions.

emergency treatment for those in need. While the availability of EMTALA protection to all persons beyond the confines of the emergency room provides comprehensive protection from patient dumping, it also places hospitals and physicians at risk for EMTALA violations whenever a decision to discharge or transfer is made, since any patient transferred in an unstable condition has a potential cause of action.

IV. The Beneficial Effect of Comprehensive Anti-Patient Dumping Legislation

A. EMTALA: Prohibiting Failure to Treat

Without the necessity of pleading indigency, many suits brought under EMTALA have the same characteristics as state malpractice or wrongful death cases, or contain these types of state law claims as well. One suit brought under EMTALA involved a transfer where the patient gave her

161. Thornton, 895 F.2d at 1135 (Jones, J., concurring) ("The Act was designed to prevent hospitals from either turning down or 'dumping' indigent patients. It was not a measure to force hospitals to provide long-term care for uninsured patients.").

162. In testimony before the Subcommittee on Human Resources and Intergovernmental Relations of the House Committee on Government Operations in 1987, Dr. Relman, then head of the New England Journal of Medicine, proposed that no emergency patient should be transferred. Equal Access Hearings, supra note 1, at 106 (testimony of Dr. Relman). Dr. Kellermann, Chief of the division of Emergency Medicine at the University of Tennessee at Memphis, and Director of Emergency Services at the Regional Medical Center at Memphis, agreed with Dr. Relman but also suggested that a national standard of care might be sufficient in defining "stabilization." Id. at 120 (testimony of Dr. Kellermann). Dr. Kellermann similarly suggested that the doctrine of informed consent may be of assistance. Id. He suggested that the law could be strengthened by prohibiting patient transfers without informed consent to the transfer. Id.

163. See, e.g., Collins v. DePaul Hosp., 963 F.2d 303, 304 (10th Cir. 1992) (involving a patient who remained in the hospital for 26 days after an accident and based his claim on a violation of EMTALA for failure to perform an appropriate medical screening exam which would have diagnosed a serious hip injury); Abercrombie v. Osteopathic Hosp. Founders Ass'n, 950 F.2d 676, 678 (10th Cir. 1991) (involving a misdiagnosed heart attack where the patient was examined in the emergency room, subsequently sent home and instructed to contact her family physician if the pain persisted—the patient died within 24 hours); Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1039 (D.C. Cir. 1991) (following an emergency room examination and misdiagnosis of heart condition as musculo-skeletal pain, the hospital discharged the patient with treatment instructions, he died the next morning); Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 268 (6th Cir. 1990) (following an examination and misdiagnosis as having influenza, the patient was discharged and died within 24 hours). Many of these cases involved traditional state claims as well. See, e.g., Abercrombie, 950 F.2d at 678 (alleging both a violation of EMTALA and a state claim for wrongful death); Gatewood, 933 F.2d at 1038 (involving allegations of malpractice and violations of EMTALA for failure to stabilize prior to discharge); see also Collins, 963 F.2d at 304 n.2 (following an unsuccessful state malpractice suit, the plaintiff brought a federal EMTALA action).
consent to be transferred to another hospital for treatment purposes.\textsuperscript{164} Another case involved the discharge of a patient in need of long-term care following a long hospital stay after suffering from a stroke.\textsuperscript{165} The drafters of the statute did not intend EMTALA to extend to the point of infringing on legitimate treatment decisions concerning discharge or transfer.\textsuperscript{166} Rather than involving valid violations of EMTALA, some of these cases simply involved creative pleading of malpractice claims in order to allege an EMTALA violation as well.\textsuperscript{167} Not every discharge, transfer, or misdiagnosis is actionable under EMTALA: Congress intended to create a new federal cause of action for failure to treat a patient but did not intend to duplicate existing state negligence and malpractice laws.\textsuperscript{168} While many actions brought under EMTALA may also involve state claims, the causes of action are different.\textsuperscript{169}

For example, while traditional state malpractice cases apply a negligence standard,\textsuperscript{170} a strict liability standard is generally applied under EMTALA.\textsuperscript{171} In an early suit for violation of the statute, the United States District Court for the Southern District of Indiana\textsuperscript{172} indicated that

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164. Brooker v. Desert Hosp. Corp., 947 F.2d 412, 414 (9th Cir. 1991) (alleging both state claims and an EMTALA violation for transferring a patient to another facility for a medical procedure).

165. Thornton, 895 F.2d 1131 at 1132.

166. H.R. REP. No. 241, 99th Cong., 2d. Sess., pt. 1, at 27 (1986), reprinted in 1986 U.S.C.C.A.N. 579, 605. The legislative history states that “[t]he 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.” Id. This history makes it clear that the statute was drafted to address the refusal of hospital to treat certain emergency patients. Id.

167. Cleland, 917 F.2d at 268 (indicating that the plaintiffs had creatively pled their claim to include a violation of EMTALA).


169. Gatewood, 933 F.2d at 1041.


171. 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) (1988 & Supp. III 1991) impose a strict liability standard for EMTALA violations); Stevison v. Enid Health Sys., Inc., 920 F.2d 710, 713 (10th Cir. 1990); Reid v. Indianapolis Osteopathic Medical Hosp., Inc., 709 F. Supp. 853, 855 (S.D. Ind. 1989) (indicating that EMTALA “was based on a strict liability standard”).

\end{quote}
strict liability applies to private actions under the statute.\textsuperscript{173} That is, once a violation has been established, the defendant is liable for the resulting damages.\textsuperscript{174} In \textit{Stevison v. Enid Health Systems, Inc.},\textsuperscript{175} the United States Court of Appeals for the Tenth Circuit reached the same conclusion, finding that section 1395dd(a) contains mandatory language\textsuperscript{176} that creates a strict liability standard.\textsuperscript{177}

EMTALA is distinguishable from state malpractice claims in another respect—it preempts all state and local laws that conflict with its requirements.\textsuperscript{178} In \textit{Reid v. Indianapolis Osteopathic Medical Hospital, Inc.},\textsuperscript{179} Indiana's procedural limitations with regard to malpractice claims\textsuperscript{180} were considered inapplicable with respect to private actions under

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\item \textsuperscript{173} \textit{Id.} at 854-55 (holding that § 1395dd, which is based on a strict liability standard, "creates . . . a private cause of action against a hospital that improperly transfers a patient").
\item \textsuperscript{174} KEETON, supra note 170, at 534.
\item \textsuperscript{175} 920 F.2d 710, 713 (10th Cir. 1990) (finding that EMTALA contains "mandatory language" thus imposing a strict liability standard).
\item \textsuperscript{176} \textit{Id.} “Under the statute, the hospital must provide a medical screening if a request is made.” \textit{Id.}
\item \textsuperscript{177} \textit{Id.} (“We construe this statute as imposing a strict liability standard subject to those defenses available in the act.”). The Tenth Circuit reaffirmed \textit{Stevison} in \textit{Abercrombie v. Osteopathic Hospital Founders Ass'n}, 950 F.2d 676 (10th Cir. 1991), relying on the literal language of the Act as the basis for its decision that strict liability was the appropriate standard. \textit{Id.} at 681 (“Congress could have added the word 'negligently' in its civil enforcement provision, but it chose not to. In such circumstance, the courts should not rewrite the civil enforcement provision.”). The \textit{Abercrombie} court found it significant that the term "negligently," 42 U.S.C. § 1395dd(d)(1)(B) (Supp. III 1991), is used with respect to a physician's violation of the Act but the term is absent from the section regarding civil enforcement. \textit{Abercrombie}, 950 F.2d at 681; \textit{see also} 42 U.S.C. § 1395dd(d)(2). The court further noted that neither the medical screening requirement, nor the requirement of only transferring stable patients, incorporates a negligence standard. \textit{Abercrombie}, 950 F.2d at 681; \textit{see also} 42 U.S.C. § 1395dd(a), (c). The \textit{Abercrombie} court concluded that this construction supported a strict liability standard under EMTALA. \textit{Abercrombie}, 950 F.2d at 681.
\item \textsuperscript{178} 42 U.S.C. § 1395dd(f). “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.” \textit{Id.}
\item \textsuperscript{179} 709 F. Supp. 853 (S.D. Ind. 1989).
\item \textsuperscript{180} For example, the court explained that a complaint presented to a medical review panel is a state procedure. \textit{Id.} at 854. The court indicated that is was unaware of a single federal statute that "incorporated state procedural limitations on a federal cause of action brought in a federal court." \textit{Id.; cf} Wilson v. Atlanticare Medical Ctr., 868 F.2d 34, 35 (1st Cir. 1989) (“Doctors and hospitals, and, ultimately, their other patients, need screening protection against frivolous claims as much under the federal statute as they do for other malpractice charges.”). The \textit{Wilson} court dismissed the plaintiff's claim for failure to answer a motion referring the matter to the state court tribunal; a state procedure that the plaintiff argued was incompatible with EMTALA. \textit{Id.} The court indicated that because the plaintiff failed to answer this motion, the issue was moot, thus inferring the court's approval of the application of state procedures to a federal EMTALA action. \textit{Id.}
EMTALA. Such restrictions were found to conflict with the statute's preemption clause because congressional intent to incorporate state procedures is not evidenced whatsoever and because the state statute was based on a negligence standard which directly conflicts with the strict liability standard of EMTALA. However, the Reid court found that the state cap on medical malpractice damages applied in the private EMTALA action because EMTALA provides for a plaintiff to obtain the damages available "for personal injury under the law of a state." The court found that the state cap on damages did not violate the preemption clause because it did not conflict with the statute, and was in fact consistent with it.

In Power v. Arlington Hospital, the United States District Court for the Eastern District of Virginia determined that the federal statute's purpose was at odds with the purpose of the state statute that established procedural requirements and a damages cap for medical malpractice actions. The Virginia statute was concerned with ensuring that medical malpractice insurance was available to and affordable for health care providers—the Powers court found this purpose to be so different from the purpose of the federal statutory scheme, that it held that the state statutory requirements were preempted by the federal law. The Virginia Supreme Court has also held that state procedures for bringing a malpractice claim did not apply to an EMTALA action because they conflict with the Act's statute of limitations and are therefore preempted by the federal statute.

B. Limiting State Malpractice Claims in Federal Courts

One commentator has suggested that EMTALA should be interpreted according to its legislative history, thus requiring a showing of indi-
gency. This solution would avoid the present situation in which federal judicial resources are wasted adjudicating claims that are suited better for state courts. In fact, several federal district courts support this conclusion.

In *Stewart v. Myrick*, the plaintiff did not allege indigency; nevertheless, he claimed that EMTALA was violated. The patient sought medical assistance for chest pain and shortness of breath. Two days later, the patient returned to the hospital for tests, but was not admitted despite claims that he needed emergency treatment. The patient suffered a heart attack one week later and died shortly after arriving at the hospital. The district court determined that these facts gave rise to a state action for medical malpractice, not a federal cause of action for patient dumping, and indicated that indigency was an essential element for a violation of EMTALA.

The *Stewart* case represents a traditional state malpractice claim, not an action for the type of patient dumping Congress sought to curb in enacting EMTALA. Similarly, in *Evitt v. University Heights Hospital*, the district court held that pleading indigency was necessary to avoid a situation where any patient who is dissatisfied with an emergency room diagnosis and is subsequently released can sue under the patient dumping statute.

### C. Repercussions of Limiting EMTALA Based on Indigency

Limiting EMTALA to indigent patients may prevent situations where patients plead an EMTALA violation when in fact their claim is better

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189. Stricker, *supra* note 75, at 1158 (indicating that confusion and inconsistency would be reduced if indigency were required and stating that the state malpractice law is an appropriate remedy for persons who cannot sustain a showing of indigency).

190. *Id.* at 1122, 1158.


193. *Id.* at 434.

194. *Id.*

195. *Id.*

196. *Id.*

197. *Id.* at 436. "This case therefore falls within the ambit of state negligence law, not the federal anti-dumping law." *Id.*

198. *Id.* at 435 ("Indigent persons denied emergency medical care possess a private federal cause of action under the Act.").

199. *Id.* at 436.


201. *Id.* at 497-98.
recognized under a state negligence claim. A serious repercussion of this approach, however, would be the lack of protection for those who are discriminated against for noneconomic reasons. A supporter of the narrow interpretation for EMTALA indicates that discrimination by a hospital based on race, sex, or disease is specifically protected against by other federal statutes. Congressman Pete Stark, a major proponent of EMTALA, indicated in his statement before the House Subcommittee of the Committee on Government Operations that there are three ways in which a patient is protected from patient dumping: Hill-Burton, civil rights law, and EMTALA. Despite the availability of other protections, Congressman Stark nevertheless regarded EMTALA as an important and necessary piece of legislation.

If the protections of EMTALA were limited only to the indigent, the overall effectiveness of the statute would be abrogated. The purpose of EMTALA is to protect against patient dumping. Congress intended to protect the indigent; however, this legislation goes much further by creating a comprehensive statute, providing protection from discrimination in access to emergency care. To limit EMTALA to the uninsured would reduce protections for many in need.

202. Stricker, supra note 75, at 1158 (claiming state malpractice to be a more efficient forum for deciding claims that do not involve discrimination).
203. Supra notes 141-50 and accompanying text (discussing various reasons other than economic status for patient dumping).
204. See generally Stricker, supra note 75, at 1129. Arguably, by applying EMTALA only to the uninsured, congressional intent will be maintained and the statute will be most efficiently applied. Id. at 1158. Patients discriminated against for other reasons are protected under federal civil rights laws. Id. at 1145.
205. Equal Access Hearings, supra note 1, at 4 (testimony of Representative Pete Stark).
206. Id. Congressman Stark was particularly concerned with the potential for persons with AIDS being dumped by hospitals. Id.; see supra notes 143-44 and accompanying text (discussing the difficulties that AIDS patients encounter in the health system).
208. Clelland v. Bronson Health Care Group, Inc., 917 F.2d 266, 272 (6th Cir. 1990) (outlining a multiplicity of reasons that persons could be discriminated against in seeking emergency treatment and finding that the application of EMTALA in these situations is not wholly inconsistent with congressional intent).
V. MEANS OF STRENGTHENING EMTALA

A. Defining Stabilized and Appropriate Medical Screening

1. Stabilized

With the extensions of EMTALA beyond the confines of the emergency room, \(^{209}\) an increasing need exists to provide hospitals with concrete definitions, thus enabling them to comply adequately with EMTALA. For example, compliance with the Act would be more manageable if the term “stabilized”\(^{210}\) were more clearly defined.\(^{211}\)

The court in \textit{Cleland v. Bronson Health Care Group, Inc.}\(^{212}\) indicated that unless the emergency treatment given to stabilize a patient was somehow different from the treatment given to a paying patient, no violation of EMTALA could be established.\(^{213}\) The \textit{Cleland} court insisted that a showing of discrimination was necessary.\(^{214}\) Under the court’s reading of the statute, a patient should be considered “‘stabilized’” if the treatment was medically “reasonable” so that “no material deterioration of

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\(^{209}\) See supra notes 153-62 and accompanying text.

\(^{210}\) 42 U.S.C. § 1395dd(e)(3)(B) (Supp. III 1991). The Act defines “‘stabilized’” as “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 ... [of a pregnant woman], that the woman has delivered (including the placenta).” \textit{Id.} Similarly, the statute defines “‘to stabilize’” as requiring the provision of 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 from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition ... [of a pregnant woman], to deliver (including the placenta).

\(^{211}\) Equal Access Hearings, supra note 1, at 104 (testimony of Dr. Relman); \textit{id.} at 119 (testimony of Dr. Kellermann). Dr. Relman stated that “‘stabilization’ is hard to define and unreliable. The definition given in subsection (e)(4)(B) is deceptively oversimplified and potentially risky to the patient.” \textit{Id.} at 106. Dr. Kellermann noted that “‘stabilization’ ... is a loophole big enough to drive a tank through.” \textit{Id.} at 120. Dr. Kellermann, chief of the division of Emergency Medicine at the University of Tennessee at Memphis and director of the emergency department of the Regional Medical Center at Memphis, suggests that adopting a national standard of care for “stabilization” would be helpful. \textit{Id.}

\(^{212}\) 917 F.2d 266 (6th Cir. 1990); see supra notes 129-32 (discussing the \textit{Cleland} decision).

\(^{213}\) \textit{Cleland}, 917 F.2d at 271. Applying this standard to the facts before it, the court stated:

There is not the slightest indication that this outcome would have been any different for a patient of any other characteristics. Had his sex, race, national origin, financial condition, politics, social status, etc., been anything whatsoever, as far as can be gleaned from the complaint, the outcome would have been the same.

\textit{Id.} Thus, the complaint failed to allege a violation of EMTALA. \textit{Id.}

\(^{214}\) \textit{Id.} “In the hospital’s opinion, the patient was stable, and they would have believed that a patient with any differing characteristics would have been stable.” \textit{Id.}
the condition" would likely occur, and that patient received the same stabilizing treatment that a paying patient would have received.

2. Appropriate Medical Screening Examination

Not every medical misdiagnosis constitutes an inappropriate screening triggering an EMTALA violation. Therefore, the standards thus far enunciated with respect to the requirement of an appropriate medical screening are either a medical screening that a paying patient would have received or a screening that complies with the medical standards of the hospital. The subtle difference between these two approaches is significant only in theory because in practice the standards should be the same.

In Cleland v. Bronson Health Care Group, Inc., the United States Court of Appeals for the Sixth Circuit determined whether a medical screening was appropriate based on the motives of the hospital. More specifically, the court questioned whether the hospital was motivated by the economics of the patient when it conducted a screening exam. In Gatewood v. Washington Healthcare Corp., the United States Court of Appeals for the District of Columbia Circuit made no such distinction for

216. Cleland, 917 F.2d at 271.
217. See supra note 168 (citing cases indicating that EMTALA was a new federal cause of action and not intended to duplicate existing state causes of action).
218. 42 U.S.C. § 1395dd(a). The only restriction in the Act regarding "appropriate medical screening examination" is that it be "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." Id.; cf. id. § 1395dd(e) (defining "emergency medical condition," "participating hospital," "to stabilize," "stabilized," "transfer," and "hospital," but not providing a definition for "appropriate medical screening examination").
219. Cleland, 917 F.2d at 272. The court stated its belief that the terms of the statute, specifically referring to a medical screening exam by a hospital "within its capabilities" precludes resort to a malpractice or other objective standard of care as the meaning of the term "appropriate." Instead, "appropriate" must more correctly be interpreted to refer to the motives with which the hospital acts. If it 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.

Id.

220. Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1041 (D.C. Cir. 1991). "In our view, then, a hospital fulfills the 'appropriate medical screening' requirement when it conforms in its treatment of a particular patient to its standard screening procedures."

Id.

221. 917 F.2d 266 (6th Cir. 1990).
222. Id. at 272.
223. Id.
motives and established the criterion for an appropriate screening as standard hospital procedures. Since the practical differences between these two approaches are insignificant, they should provide the touchstone for the determination of an appropriate medical screening. Where a patient receives a screening that complies to standard hospital procedures, or is compatible to one given a nonindigent client, no violation of the medical screening provision of EMTALA should exist.

B. The Need To Report EMTALA Violations

Despite the creation of a broad antidumping statute, the effectiveness of EMTALA has been recently questioned. A report published by Public Citizen Health Research Group charges that EMTALA is not being enforced effectively. Instead of punishing violations by imposing sanctions under the statute, the United States Department of Health and Human Services (HHS), whose job it is to enforce the statute, usually forces violators only to change rules and training practices.

EMTALA does not require that violations of the Act be reported, but instead, provides that hospitals receiving transfers in violation of the Act are entitled to bring a private action against the transferring hospital. If hospitals were required to report violations, the actual number of incidents of patient dumping would be reported more realistically. In addition, more reported cases would provide guidance for hospitals and physicians to be better equipped to avoid future violations of EMTALA.

225. Id. at 1041.
226. Id.
227. Cleland, 917 F.2d at 272.
229. Lynn Wagner, Illegal Transfers Continue—Report, MODERN HEALTHCARE, May 24, 1993, at 8. "Public citizen charged HHS with being lax in enforcing the anti-dumping law because only 17 hospitals and three physicians were fined from 1986 to 1992." Id.
231. Id. “Final regulations spelling out all the terms for complying with the law have never been published. In addition, HHS has not required institutions to whom a patient was sent improperly by the ‘dumping’ hospital to report that fact to HHS." Id.; cf. FLA. STAT. ANN. § 395.1041(4) (West 1993) (requiring hospitals to maintain records of all transfers for five years and to report all violations).
232. 42 U.S.C. § 1395dd(d)(2)(B) (1988 & Supp. III 1991); see supra note 107 (quoting statutory language); see supra note 110 (discussing why hospitals do not voluntarily assert their rights under EMTALA when a transfer is received in violation of the Act).
C. A Showing of Discrimination Must Be Required

EMTALA should not create a cause of action only for the uninsured, but should be available whenever an individual is denied emergency care due to discrimination. In Cleland, the Sixth Circuit indicated that without a showing of some type of discrimination, no violation of EMTALA existed.\textsuperscript{235} The requirement that discrimination be pleaded for a cognizable violation of EMTALA would strengthen the Act by giving guidance to hospitals. As the Act presently is interpreted, hospitals must be wary of potential EMTALA violations whenever a patient is transferred or discharged, even if the patient provided informed consent to such action.\textsuperscript{236} Were a showing of discrimination of some type necessary, hospitals would be protected better where transfers or discharges were made for valid treatment reasons. Furthermore, the requirement that there be a showing of discrimination for a violation would conserve federal judicial resources and would not foreclose those parties with potential malpractice claims from bringing these actions in an appropriate state court. Many of the cases brought under EMTALA, as it is now drafted and broadly interpreted, would not be cognizable if a showing of discrimination, whether based on race, sex, ethnicity, religion, disease, or even potentially dangerous condition, were required for a violation.\textsuperscript{237}

\textsuperscript{235} Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 271 (6th Cir. 1990).

\textsuperscript{236} See, e.g., Brooker v. Desert Hosp. Corp., 947 F.2d 412, 414 (9th Cir. 1991). In that case, the plaintiff alleged a violation of EMTALA when she had consented to the transfer to another facility. \textit{Id.} Although the circuit court affirmed the district court's finding of no EMTALA violation, \textit{id.} at 415, if she had been required to include a showing of discrimination, the case would have been dismissed at the early stages, since the record did not indicate any type of discrimination. Rather, it illustrated that the decisions regarding the patient's care were made for treatment purposes. \textit{Id.} at 413-14.

\textsuperscript{237} See, e.g., Thornton v. Southwest Detroit Hosp., 895 F.2d 1131, 1132 (6th Cir. 1990). In \textit{Thornton}, the plaintiff alleged an EMTALA violation on the ground that the hospital failed to stabilize her prior to transferring her home for long term care. \textit{Id.} The Southwest Detroit Hospital had attempted to secure a bed for Ms. Thornton in the Detroit Rehabilitative Institute, a long-term care facility. Since this facility would not accept her due to her lack of medical insurance, she was transferred home. \textit{Id.} She eventually gained acceptance to the Detroit Rehabilitative Institute and subsequently brought suit against the Southwest Detroit Hospital for transferring her home in an unstabilized condition. Clearly, this type of transfer was outside the scope of EMTALA's legislative intent. \textit{Id.} at 1134 (quoting the Act's legislative history). With the requirement of pleading discrimination, this suit would have been dismissed at the early stages, or not brought at all, thus conserving judicial resources.
VI. Conclusion

The drafters of EMTALA envisioned a federal statute that would alleviate the problem of patient dumping and open the door to unfettered emergency care for those who need it. EMTALA currently provides for the comprehensive protection that Congress sought. The courts have extended EMTALA’s reach beyond the confines of the emergency room, however, and recognized private rights of action under the statute for any person who alleges an injury, rather than just the uninsured. This application of EMTALA to situations possibly unforeseen by the drafters offers broad protection for patients, but places hospitals and physicians at constant risk of violating EMTALA. To abrogate this risk, courts should instead require some showing of discrimination as a prerequisite for finding an EMTALA violation, however, that discrimination should be broader than just discrimination based upon inability to pay. EMTALA should protect against general discrimination in access to emergency care.

Furthermore, physicians and hospitals should not face liability under EMTALA when they comply with the standard hospital procedures in providing an appropriate medical screening exam and transferring a patient. As long as every patient receives standard care that would be given to a paying patient, no violation of the Act should be found. Despite the creation of this far reaching statute, violations rarely are reported. Until facilities receiving illegal transfers report these incidents, the practice of patient dumping will not subside.

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