

## EMTALA: ALL BARK AND NO BITE

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*In the modern era of managed healthcare, the number of indigent and uninsured patients continues to rise, placing greater strain on hospitals to provide adequate treatment to patients requiring emergency medical care. In response, Congress enacted the Federal Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986 in an effort to prevent hospitals from denying emergency medical treatment as a way of cutting costs. EMTALA was intended to guarantee health care access to all. In practice, however, EMTALA's functionality has been diminished by ineffective monitoring and enforcement and a lack of uniformity among courts interpreting the statute. This note delves into the myriad problems plaguing EMTALA's effectiveness as a deterrent to patient dumping by focusing on the statute's amended regulations which became effective in November 2003. After an analysis of the weakening effect the amended regulations have on access to health care, the author concludes that courts must make an effort to increase the burden of proof hospitals must meet in order to avoid compliance with EMTALA. In addition, the author advances the proposition that Congress needs to reexamine the conundrum of providing emergency medical treatment to the poor and, accordingly, amend EMTALA to better achieve Congress's original intent.*

## I. INTRODUCTION

On March 21, 1974, Hattie Mae Campbell gave birth to her third child in a parking lot outside the Marshall County Hospital.<sup>1</sup> When Ms. Campbell unexpectedly went into labor early that morning, she and her sister asked a neighbor to take them to the nearest hospital.<sup>2</sup> Upon arriving at the emergency room, a nurse informed Ms. Campbell that she should travel some thirty miles to a hospital in Oxford, Mississippi, where she had received prenatal care, and deliver the baby there.<sup>3</sup> An emergency room doctor who never examined Ms. Campbell agreed with

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1. Campbell v. Mincey, 413 F. Supp. 16, 18 (N.D. Miss. 1975).

2. *Id.*

3. *Id.*

the nurse's directive.<sup>4</sup> Ms. Campbell left the emergency room and proceeded to the parking lot, where she gave birth to her son in the front seat of her neighbor's car.<sup>5</sup> When Ms. Campbell's sister returned to the emergency room and asked the nurse to admit Ms. Campbell and her newborn son, the nurse refused.<sup>6</sup> The doctor was never notified of the birth, and Ms. Campbell and her son were not provided any postnatal care.<sup>7</sup>

When Ms. Campbell brought suit against the hospital for breaching a common-law duty owed to her,<sup>8</sup> the court found that the hospital's refusal to admit Ms. Campbell was in accordance with its policy not to admit patients who are not referred by a local physician.<sup>9</sup> The court deferred to the nurse's determination that Ms. Campbell's impending delivery did not constitute an emergency situation.<sup>10</sup> Additionally, the court also refused to entertain Ms. Campbell's claim that her race and financial status had anything to do with the hospital's refusal to admit her.<sup>11</sup>

Ms. Campbell's plight illustrates the profound need for federal regulations prohibiting hospitals from refusing to treat patients who are indigent or uninsured. Accordingly, in 1986, Congress passed the Federal Emergency Medical Treatment and Active Labor Act (EMTALA)<sup>12</sup> amid growing concern about hospitals denying emergency care to individuals or prematurely transferring patients who could not pay their hospital costs.<sup>13</sup> Individuals without health insurance generally do not receive regular medical attention either because they cannot afford to pay for it or because doctors refuse to treat them.<sup>14</sup> Without access to routine preventative treatment, people like Ms. Campbell generally turn to

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4. *Id.* at 19.

5. *Id.*

6. *Id.*

7. *Id.*

8. *Id.* at 19–20. The court noted the existence of “a ‘trend’ in the common law of this country toward imposing liability upon a hospital which refuses to admit and treat, on an emergency basis, a seriously injured person.” *Id.* at 20.

9. *Id.* at 20–21 (“While the court is disturbed by the seemingly cursory examinations performed on Ms. Campbell by the staff nurse and by the fact that Ms. Campbell was never examined by the emergency room physician, the court must conclude that plaintiffs suffered no tortious injury at the hands of the defendants . . .”).

10. *Id.* at 21.

11. *Id.* at 22.

12. 42 U.S.C. § 1395dd (2003). EMTALA was passed as part of the Consolidated Omnibus Budget Reconciliation Act during a time of increasing numbers on uninsured patients. Thomas A. Gionis, *The Intentional Tort of Patient Dumping: A New State Cause of Action to Address the Shortcomings of the Federal Emergency Medical Treatment Act (EMTALA)*, 52 AM. U. L. REV. 173, 181 (2002).

13. Gionis, *supra* note 12, at 181 (noting that often these transferred patients were medically unstable, critically ill, pregnant, or in labor); see *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1039–40 (D.C. Cir. 1991).

14. Walter L. Stiehm, *Poverty Law: Access to Healthcare and Barriers to the Poor*, 4 QUINNIPIAC HEALTH L.J. 279, 289 (2001).

emergency departments as their primary source of healthcare,<sup>15</sup> which cost far more than physicians' office visits.<sup>16</sup> Since hospitals are often not reimbursed for emergency care, they attempt to shift the cost to those who can pay and limit the amount of uncompensated care provided to uninsured and indigent patients.<sup>17</sup> As one commentator noted, "[t]he increase in managed healthcare makes it increasingly difficult to shift costs to payers who are unwilling to pay the added expense of the uninsured. As cost shifting becomes more difficult, providers are not compensated for much of the care they provide to the poor."<sup>18</sup>

Since EMTALA's passage, courts have struggled with the Act's inherent ambiguity,<sup>19</sup> resulting in inconsistent opinions that have limited its effectiveness.<sup>20</sup> To better define the scope and boundaries of EMTALA,<sup>21</sup> and in response to growing pressure from hospitals and physicians,<sup>22</sup> the Centers for Medicare & Medicaid Services (CMS), of the Department of Health and Human Services (HHS), and the Office of the Inspector General (OIG) revised the regulations governing the Act. The final regulations for EMTALA were released on August 29, 2003, and went into effect on November 10, 2003.<sup>23</sup> The revised version of EMTALA significantly clarifies and limits the scope of a hospital's obligations to provide emergency medical care to all people.<sup>24</sup>

This note argues that the recently revised regulations to EMTALA<sup>25</sup> will have a negative effect on uninsured and underinsured persons' access to emergency medical care. Part II considers the background of EMTALA and the roots of its recent regulations.<sup>26</sup> It also examines the

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15. *Id.* at 288–89.

16. *Id.* at 289. "Emergency room overhead costs are many times higher than those of a simple clinic, due to both expensive equipment and the additional staff required in the emergency room." *Id.* at 289 n.46 (citing Erik J. Olson, *No Room at the Inn: Snapshot of an American Emergency Room*, 46 STAN. L. REV. 449, 467 (1994)).

17. *Id.* at 289–90; *see also* RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 48 (1997) ("Hospital administrators argue that it is difficult for a hospital to operate efficiently if it must serve every person who appears at its door.").

18. Stiehm, *supra* note 14, at 289. "This increased financial strain on hospitals and physicians may ultimately lead to reduced availability of healthcare services for the poor as some hospitals go out of business or relocate to more affluent areas where there is less likelihood of over-utilization by the poor." *Id.* at 290.

19. *Dollard v. Allen*, 260 F. Supp. 2d 1127, 1131 n.3 (D. Wyo. 2003) ("It is safe to assume that § 1395dd has not made its way into any textbooks on statutory construction as a model of Congress' ability to draft a plain and unambiguous statute."); Gionis, *supra* note 12, at 183 ("[T]he statute's language is not narrowly tailored and contains numerous undefined terms and ambiguities.").

20. Gionis, *supra* note 12, at 178.

21. *Id.*

22. Robert Pear, *Emergency Rooms Get Eased Rules on Patient Care*, N.Y. TIMES, Sept. 3, 2003, at A1 ("The administration drafted the new rule after hearing complaints from scores of hospitals and doctors who said the old standards were onerous and confusing, exposed them to suits and fines and encouraged people to seek free care in emergency rooms."), available at <http://www.nytimes.com/2003/09/03/politics>.

23. *See* 42 C.F.R. §§ 413, 482, 489 (2003).

24. Pear, *supra* note 22, at A1.

25. 42 U.S.C.A. § 1395dd (West Supp. 2003).

26. *See infra* text accompanying notes 30–118.

legislative history of the original Act to illuminate the underlying congressional intent, and also explores the courts' treatment of the Act and difficulty in interpreting Congress's language. Part III considers the weaknesses of the law and focuses on how the new regulations address some controversies while creating others.<sup>27</sup> Part IV concludes that courts should strictly construe the language of the statute and impose greater burdens on hospitals to provide uncompensated care to uninsured and indigent patients. At the same time, Congress should reexamine the issue and ultimately amend EMTALA in order to better effectuate its original intent.<sup>28</sup>

## II. BACKGROUND

### A. *The Evolution of EMTALA*

In 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA), which included provisions amending the Medicare statute.<sup>29</sup> These amendments required all hospitals receiving Medicare payments to examine and provide minimal treatment to all patients seeking emergency medical care, regardless of their ability to pay or their Medicare status.<sup>30</sup> These amendments are now generally known as EMTALA.<sup>31</sup> The Act applies to all persons seeking an emergency screening exam,<sup>32</sup> but its primary impact is on uninsured and underinsured people who cannot otherwise afford medical care.<sup>33</sup>

Congress enacted EMTALA to address "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."<sup>34</sup> One study showed that eighty-seven percent of hospitals transferring patients conceded that lack of health insurance was the sole motivation for transfer.<sup>35</sup> Another study found that, of those patients transferred, over seventy-two percent required emergency medical care at the second hospital.<sup>36</sup>

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27. See *infra* text accompanying notes 119–77.

28. See *infra* text accompanying notes 128–87.

29. ROSENBLATT ET AL., *supra* note 17, at 65.

30. *Id.*

31. *Id.* (noting that sometimes EMTALA is also called "COBRA").

32. *Cooper v. Gulf Breeze Hosp. Inc.*, 839 F. Supp. 1538, 1541 (N.D. Fla. 1993).

33. *Id.* at 1540; see also Stiehm, *supra* note 14, at 280 ("As a consequence of the high costs of healthcare, the poor are the least able to receive medical treatment unless the government subsidizes or provides free care.").

34. H.R. REP. NO. 99-241, pt. 1, at 27 (1986) ("The Committee is most concerned that medically unstable patients are not being treated appropriately. There have been reports of situations where treatment was simply not provided. In numerous other instances, patients in unstable condition have been transferred improperly, sometimes without the consent of the receiving hospital.").

35. *Arrington v. Wong*, 237 F.3d 1066, 1074 n.10 (9th Cir. 2001) (citing Karen I. Treiger, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. REV. 1186, 1190–91 (1986)).

36. *Id.*

Congress's purpose in enacting EMTALA was to prevent the practice known as "patient dumping."<sup>37</sup> "The act of patient dumping occurs when patients [who seek care] in an emergency department are denied emergency medical care or stabilizing treatment based on economic or noneconomic grounds, such as race, ethnicity, sexual orientation, or contraction of a socially unacceptable disease."<sup>38</sup> Congress was concerned that hospitals were dumping patients in order to cut costs and therefore decreasing the quality of care given to indigent or uninsured patients.<sup>39</sup> In turn, this inadequate care ultimately led to higher rates of morbidity and mortality.<sup>40</sup>

Hospitals have economic incentives for patient dumping related to the increasing number of uninsured patients.<sup>41</sup> The rising number of uninsured people places a strain on the ability of hospitals to provide uncompensated care while remaining solvent.<sup>42</sup> Emergency departments are often overutilized due to people seeking treatment for what they believe are medical emergencies that, in reality, are far less than life-threatening.<sup>43</sup> Additionally, other people go to the emergency department with nonurgent conditions because they have no place else to go.<sup>44</sup> As one commentator noted, "[e]mergency departments provide a health-care safety net for these people."<sup>45</sup>

Further, the government's limitations on reimbursement rates for Medicare and Medicaid patients make it even more difficult for hospitals to provide services to uninsured or underinsured individuals.<sup>46</sup> This financial burden causes decreased availability of healthcare services for the uninsured or underinsured population because some hospitals are forced to close or relocate to more affluent areas where there is likely to be less overutilization of emergency department resources.<sup>47</sup> When hospitals close, it puts more financial pressure to contain costs on those hos-

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37. *Dollard v. Allen*, 260 F. Supp. 2d 1127, 1131 (D. Wyo. 2003) (noting that patient dumping is "the practice of refusing to treat uninsured patients").

38. *Gionis*, *supra* note 12, at 175-76; *see also Arrington*, 237 F.3d at 1069 ("Congress enacted . . . EMTALA . . . to prevent 'hospitals . . . 'dumping' [indigent] patients . . . by either refusing to provide emergency medical treatment or transferring patients before their conditions stabilized." citing *James v. Sunrise Hosp.*, 86 F.3d 885, 886 (9th Cir. 1996))).

39. *Gionis*, *supra* note 12, at 182.

40. *Id.*

41. *Id.* at 184.

42. *Id.* at 185.

43. Douglas M. Hill, *Emergency Care under Pressure*, ROCKY MOUNTAIN NEWS (Denver), Jan. 4, 2004, at 7E.

44. *Id.* (providing examples of such conditions including bladder infections, pneumonia, high fevers, and extremity injuries). However, Hill also notes that according to the Centers for Disease Control and Prevention, only nine percent of the 108 million patients who sought emergency medical treatment in 2001 were classified as "nonurgent." *Id.*

45. *Id.*

46. *Stiehm*, *supra* note 14, at 289-90.

47. *Id.* at 290; *see also Hill*, *supra* note 44 (noting that a lack of resources has led many emergency departments to close over the past ten years).

pitals that remain.<sup>48</sup> Moreover, the increase in the number of patients being refused care coincides with the increase in the number of uninsured individuals seeking emergency medical treatment.<sup>49</sup>

Known as the “anti-dumping” statute,<sup>50</sup> the purpose of EMTALA was to guarantee health care access to all, including the uninsured or underinsured.<sup>51</sup> In the past, Congress addressed the patient dumping<sup>52</sup> phenomenon with the passage of the Hill-Burton Act of 1946.<sup>53</sup> That Act gave states federal grants to construct hospitals with the proviso that those hospitals offer a “reasonable” amount of uncompensated care to patients unable to pay.<sup>54</sup> However, the Hill-Burton Act only applied to those hospitals that received federal funding. Also, the government rarely enforced the provision requiring that community and uncompensated care be provided to a certain percentage of patients.<sup>55</sup> Hospitals claimed this provision was not a legal requirement.<sup>56</sup> Consequently, the Hill-Burton Act taught Congress that a statute mandating care must be more specific as to the duties and obligations of hospitals and must clearly establish a mechanism for enforcing those duties and obligations.

### B. EMTALA's Requirements

Under EMTALA, Medicare-provider hospitals<sup>57</sup> have a duty to provide appropriate medical screening and stabilization before transferring patients who seek care in a hospital emergency room.<sup>58</sup> EMTALA provides:

In the case of a hospital that has a hospital emergency department, if any individual . . . comes to the emergency department . . . for examination or treatment for a medical condition, the hospital must provide for an *appropriate medical screening examination* within the capability of the hospital's emergency department . . . to determine whether or not an emergency medical condition . . . exists.<sup>59</sup>

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48. J. B. Orenstein, *State of Emergency*, WASH. POST, Apr. 22, 2001, at B01.

49. Gionis, *supra* note 12, at 185.

50. Arrington v. Wong, 237 F.3d 1066, 1069 (9th Cir. 2001).

51. *Id.*

52. Gionis, *supra* note 12, at 177.

53. ROSENBLATT ET AL., *supra* note 17, at 64.

54. *Id.* Hill-Burton was passed prior to the restructuring of hospital financing under prospective payment systems. Thus, hospitals were better able to shift the costs of uncompensated care to those with the ability to pay for treatment.

55. *Id.*

56. *Id.*

57. 42 U.S.C. § 1395dd(e)(2) (2003) (a participating hospital is one that has entered into a provider agreement under 42 U.S.C. § 1395cc). EMTALA “applies to any hospital that receives Medicare payments and has an emergency department.” *Abercrombie v. Osteopathic Hosp. Founders Ass'n*, 950 F.2d 676, 680 (10th Cir. 1991). Thus, the Act effectively applies to all hospitals because virtually every hospital receives Medicare funding.

58. 42 U.S.C. § 1395dd(a)–(c).

59. *Id.* § 1395dd(a) (emphasis added).

If any individual . . . comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required *to stabilize* the medical condition, or (B) *for transfer* of the individual to another medical facility in accordance with subsection (c) of the section.<sup>60</sup>

If an individual at a hospital has an emergency medical condition which has not been stabilized . . . the hospital may not transfer the individual unless, the individual . . . requests transfer to another facility, and the transfer is appropriate . . . to that facility.<sup>61</sup>

Thus, hospitals are only required to provide screening to the extent necessary to determine whether an emergency condition exists.<sup>62</sup> If such a condition does not exist, a hospital complies with EMTALA's requirements upon completion of the medical screening.<sup>63</sup> If an emergency medical condition is found, then the hospital must satisfy EMTALA's stabilization and treatment requirements.<sup>64</sup>

The HHS's Health Care Financing Administration (HCFA) and the OIG have the power to enforce EMTALA.<sup>65</sup> They may impose fines of up to \$50,000 against hospitals found to be in violation of the Act<sup>66</sup> and against physicians who negligently violate the Act's requirements.<sup>67</sup>

In addition, patients may bring claims against hospitals and physicians for EMTALA violations.<sup>68</sup> To state a claim, the plaintiff must allege that she went to the emergency room of a Medicare-provider hospital seeking treatment, and the hospital either failed to screen her in the same way as other patients, or the hospital discharged or transferred her before the medical condition was stabilized.<sup>69</sup> This provides a remedy for individuals in situations where a claim under state medical malpractice law may not be available.<sup>70</sup> For example, courts routinely reject the argument that plaintiffs bringing claims under EMTALA must meet the procedural restrictions necessary for state malpractice claimants.<sup>71</sup>

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60. *Id.* § 1395dd(b) (emphasis added).

61. *Id.* § 1395dd(c).

62. Decanda M. Faulk, *EMTALA: The Real Deal*, 16 (2) THE HEALTH LAW. 10, 70 (2003).

63. *Id.*

64. *Id.*

65. *St. Anthony Hosp. v. HHS*, 309 F.3d 680, 693 (10th Cir. 2002).

66. 42 U.S.C. § 1395dd(d)(1)(A).

67. *Id.* § 1395dd(d)(1)(B).

68. *See Sorrells v. Babcock*, 733 F. Supp. 1189, 1194 (N.D. Ill. 1990) (holding that a patient may bring a private cause of action under EMTALA against the emergency room physician who discharged her). *But see ROSENBLATT ET AL.*, *supra* note 17, at 90 ("While it is clear that HHS may institute actions against physicians who violate EMTALA requirements, several courts have held that the federal agency remedy is exclusive and that EMTALA does not authorize a private cause of action against individual physicians.").

69. *Brenord v. Catholic Med. Ctr.*, 133 F. Supp. 2d 179, 185 (E.D.N.Y. 2001).

70. *Reynolds v. MaineGeneral Health*, 218 F.3d 78, 83 (1st Cir. 2000).

71. *ROSENBLATT ET AL.*, *supra* note 17, at 89 (noting "State requirements that malpractice plaintiffs pursue remedies before a medical review panel prior to filing suit are preempted by federal

*C. The Legislative History of EMTALA*

Congress's avowed purpose in passing EMTALA was to prevent patient dumping,<sup>72</sup> but the legislative history of the Act provides guidance as to the particular trends Congress intended to avert. The committee notes of the House of Representatives reveal that Congress's primary concern was that medically unstable patients were not being treated appropriately, if at all.<sup>73</sup> According to one committee report, "[t]here have been reports of situations where treatment was simply not provided. In numerous other situations, patients in an unstable condition have been transferred improperly, sometimes without the consent of the receiving hospital."<sup>74</sup>

Congress was also concerned that patient dumping had worsened since the prospective payment system for hospitals to receive reimbursement became effective, and hospitals were under greater pressure to contain costs.<sup>75</sup> The House Committee on Ways and Means reported that "[t]he Committee wants to provide a strong assurance that pressures for greater hospital efficiency are not to be construed as licenses to ignore traditional community responsibilities and loosen historic standards."<sup>76</sup>

*D. The State of EMTALA from 1986 to November, 2003**1. Ineffective Monitoring and Enforcement*

Although there have been no comprehensive data monitoring patient dumping since EMTALA was enacted, two sets of studies suggest the practice continues to rise.<sup>77</sup> One set shows that patient-dumping violations have continued to increase and that HCFA has inadequately responded to these violations.<sup>78</sup> This set also shows that HCFA's enforcement of EMTALA has been "lax" and that hospitals often have not been penalized for violations.<sup>79</sup> In addition, a 2001 study done by the OIG showed that many physicians and emergency room directors did not

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law," while the question of "whether state caps on the amount of malpractice awards limit damages available under EMTALA" is still open).

72. Dollard v. Allen, 260 F. Supp. 2d 1127, 1131 (D. Wyo. 2003).

73. H.R. REP. NO. 99-241, pt. 1, at 27 (1985).

74. *Id.*

75. *Id.*

76. *Id.*

77. Gionis, *supra* note 12, at 199.

Evidence suggests that patient dumping is rising and that it is 1.7 times more likely to occur in for-profit hospitals than in not-for-profit hospitals. Data from 1986 to 1999 indicates that there has been an approximately 100-fold increase in patient dumping hospital violators and a 139-fold increase in patient dumping violations concerning the lack of performance of a 'medical screening examination.'

*Id.* at 176-77.

78. *Id.* at 200.

79. *Id.* at 200-01.



know about various provisions of EMTALA and continued to ask patients about health insurance information before providing them with a medical screening examination.<sup>80</sup> Taken together, these studies seem to indicate that EMTALA has not been effective in terms of its original goal of reducing patient dumping.<sup>81</sup>

Furthermore, as one court noted, “[a]lthough a hospital’s violation of EMTALA’s provisions theoretically can result in the termination of that hospital’s provider agreement . . . termination generally does not occur in practice so long as the hospital takes corrective action.”<sup>82</sup> Between 1986 and 1995, HCFA found 507 EMTALA violations and, of these, only eleven resulted in the termination of the hospital’s Medicare provider status, and only fifty-two resulted in the assessment of fines to either hospitals or doctors.<sup>83</sup>

In addition, EMTALA has been minimally effective as a deterrent to patient dumping because HCFA and the OIG rarely enforce penalties for EMTALA violations.<sup>84</sup> Civil penalties are infrequently imposed and over half of the cases the OIG reviews are closed without the assessment of any penalties.<sup>85</sup>

Moreover, some commentators have criticized HCFA for failing to properly oversee the administration of EMTALA. The OIG’s own study found that poor data collection and the absence of an accurate and complete database to track EMTALA violations and patient dumping complaints greatly impeded HCFA’s oversight of EMTALA.<sup>86</sup> Furthermore, HCFA only discloses a limited number of EMTALA violations to the public, which makes it difficult to inform the public about patient dumping occurrences in their own community.<sup>87</sup>

## 2. *Lack of Uniformity Among the Courts*

The lack of judicial uniformity among the federal circuits also has likely interfered with EMTALA compliance. For instance, courts have disagreed over whether they should read the medical screening, stabilization, and transfer provisions of the Act conjunctively or disjunctively.<sup>88</sup>

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80. *Id.* at 233–34.

81. *Id.* at 178–79 (“The confusion EMTALA has propounded, in both the legal and healthcare professions, has permitted an incentive for patient dumping, which has resulted in significant patient morbidity and mortality. Simply put, although EMTALA grants every person a federal right to emergency medical care, it has been reported that government enforcement has ‘tragically failed’ to control patient dumping.”).

82. *St. Anthony Hosp. v. HHS*, 309 F.3d 680, 693 (10th Cir. 2002).

83. *ROSENBLATT ET AL.*, *supra* note 17, at 91.

84. *See St. Anthony Hosp.*, 309 F.3d at 693.

85. *Id.*

86. *Gionis*, *supra* note 12, at 236–38.

87. *Id.* at 201.

88. *Id.* at 264. Under the conjunctive approach, the three duties of EMTALA set forth in §1395dd(a)–(c), including an appropriate medical screening examination, stabilization, and appropriate transfer, are treated as interdependent, sequential requirements. Under the disjunctive approach,

Under the conjunctive approach, followed by the Fourth, Sixth, Ninth, and Eleventh Circuits, the obligations of EMTALA only attach to those patients evaluated in the emergency room.<sup>89</sup> Using this interpretation, the threshold issue is whether a patient came to the hospital's emergency room, since only patients examined in the emergency room must be appropriately screened and stabilized before a possible transfer.<sup>90</sup> Therefore, under this approach, hospitals do not have to comply with EMTALA once the patient is admitted. In support of this interpretation, the Fourth Circuit noted that "the stabilization requirement was intended to regulate the hospital's care of the patient only in the immediate aftermath of the act of admitting [a patient] for emergency treatment."<sup>91</sup>

Conversely, under the disjunctive approach adhered to by the First and Tenth Circuits, the duty to provide an appropriate medical screening and the duty to stabilize are viewed as independent.<sup>92</sup> Thus, EMTALA attaches when an individual located anywhere within the hospital develops an emergency medical condition.<sup>93</sup> The First Circuit reasoned that "[n]othing in the subsection's text suggests a necessary relationship between the hospital's obligations and the identity of the department within the hospital to which the afflicted individual presents himself."<sup>94</sup> Additionally, the Tenth Circuit has held that although a disjunction exists between the medical screening and stabilization requirements, a plaintiff must show a violation of the stabilization requirement before recovering under EMTALA's transfer provision.<sup>95</sup> Thus, under this approach, EMTALA's transfer provision does not apply where the defendant hospital never determined that the patient had an emergency medical condition.<sup>96</sup>

Many courts agree that Congress did not design EMTALA to operate as a federal malpractice statute or to replace state law medical mal-

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EMTALA is interpreted as setting forth distinct causes of action under the medical screening requirement in section 1395dd(a) and the stabilization requirement in section 1395dd(b).

89. Gionis, *supra* note 12, at 265; see *Harry v. Marchant*, 291 F.3d 767, 770 (11th Cir. 2002); *Bryan v. Rectors & Visitors of the Univ. of Va. Med. Ctr.*, 95 F.3d 349, 352 (4th Cir. 1996); *James v. Sunrise Hosp.*, 86 F.3d 885, 889 (9th Cir. 1996); *Thornton v. S.W. Detroit Hosp.*, 895 F.2d 1131, 1134 (6th Cir. 1990).

90. *Dollard v. Allen*, 260 F. Supp. 2d 1127, 1132 (D. Wyo. 2003).

91. *Bryan*, 95 F.3d at 352.

92. Gionis, *supra* note 12, at 269-70; see *Lopez-Soto v. Hawayek*, 175 F.3d 170, 173-74 (1st Cir. 1999); *Dollard*, 260 F. Supp. 2d at 1131.

93. Gionis, *supra* note 12, at 270.

94. *Lopez-Soto*, 175 F.3d at 173.

Congress's preoccupation with patient dumping is served, not undermined, by forbidding the dumping of any hospital patient with a known, unstabilized, emergency condition. After all, patient dumping is not a practice that is limited to emergency rooms. If a hospital determines that a patient on a ward has developed an emergency medical condition, it may fear that the costs of treatment will outstrip the patient's resources, and seek to move the patient elsewhere.

*Id.* at 177.

95. *Dollard*, 260 F. Supp. 2d at 1134.

96. *Id.*

practice claims.<sup>97</sup> One court noted that “EMTALA . . . was not intended to guarantee proper diagnosis or to provide a federal remedy for misdiagnosis or medical negligence.”<sup>98</sup> The congressional notes support this inference:

The avowed purpose of EMTALA was not to guarantee that all patients are properly diagnosed, or even to ensure that they receive adequate care, but instead to provide an “adequate first response to a medical crisis” for all patients and “send a clear signal to the hospital community . . . that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress.”<sup>99</sup>

Subscribing to the notion that EMTALA is not meant to provide a remedy for negligence, some courts reject EMTALA claims involving levels of medical care that seem “shockingly low,” provided the hospital did not deviate from its own screening procedures.<sup>100</sup> As a result, the Act only guarantees nondiscriminatory emergency medical treatment.<sup>101</sup>

Some courts have interpreted EMTALA as a strict liability statute.<sup>102</sup> For example, the Tenth Circuit noted that under EMTALA the hospital must provide medical screening after the patient requests it, and once a request for emergency care has been made, the burden is on the hospital to show that the patient either refused to consent to treatment or withdrew the request.<sup>103</sup> In a different case, the Tenth Circuit held that the trial court erred in instructing the jury to determine whether the hospital was negligent in screening and discharging the plaintiff because EMTALA imposes strict liability on a hospital that violates the requirements mandating appropriate screening and stabilization.<sup>104</sup>

Courts have also split as to the appropriate standard of care with respect to the duty to perform an appropriate medical screening. The First, Ninth, and Eleventh Circuits have applied an objectively reasonable standard for determining compliance with this requirement, calling for a larger obligation on the part of the physician and importing a reason-

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97. *Id.* at 1131.

98. *Power v. Arlington Hosp. Ass’n*, 42 F.3d 851, 856 (4th Cir. 1994).

99. *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 880 (4th Cir. 1992) (quoting 131 CONG. REC. S13904 (Oct. 23, 1985) (statement of Sen. Durenberger)).

100. *ROSENBLATT ET AL.*, *supra* note 17, at 85.

101. *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1138 (8th Cir. 1996) (holding that “[p]atients are entitled under EMTALA, not to correct or non-negligent treatment in all circumstances, but to be treated as other similarly situated patients are treated, within the hospital’s capabilities”); *Hutchinson v. Greater S.E. Cmty. Hosp.*, 793 F. Supp. 6, 8 (D.D.C. 1992) (“[A] negligent misdiagnosis does not state a claim under the Act.”); *see also Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139, 143 (4th Cir. 1996).

102. *ROSENBLATT ET AL.*, *supra* note 17, at 84.

103. *Stevison v. Enid Health Sys., Inc.*, 920 F.2d 710, 713–14 (10th Cir. 1990).

104. *ROSENBLATT ET AL.*, *supra* note 17, at 84 (citing *Abercrombie v. Osteopathic Hosp. Founders Ass’n*, 950 F.2d 676, 681 (10th Cir. 1991)).

ableness requirement into EMTALA.<sup>105</sup> Moreover, the First Circuit noted that a hospital fulfills its duty to screen patients in the emergency room “if it provides for a screening examination reasonably calculated to identify critical medical conditions that may be afflicting symptomatic patients and provides that level of screening uniformly to all those who present substantially similar complaints.”<sup>106</sup> Conversely, the Sixth, Eighth, Tenth, and D.C. Circuits apply a subjective standard, drawing from legislative intent and the plain text of the Act to determine the meaning of “appropriate medical screening examination.”<sup>107</sup> The Tenth Circuit interpreted this requirement as being “hospital-specific, varying with the specific circumstances of each provider.”<sup>108</sup>

Finally, courts are divided over whether EMTALA applies after the patient has been initially stabilized<sup>109</sup> and admitted to the hospital.<sup>110</sup> Several courts have upheld EMTALA causes of action where the patient claimed the hospital failed to stabilize the patient prior to transfer to another facility.<sup>111</sup> For example, in *Thornton v. Southwest Detroit Hospital*, the court allowed the patient’s claim that the hospital failed to stabilize him before transferring him to a long-term care facility after he was admitted and hospitalized for three weeks following a stroke.<sup>112</sup> Similarly, another court held that “[p]atient dumping is not limited to a refusal to provide emergency room treatment. It occurs, and is equally reprehensible, at any time a hospital determines that a patient’s condition may result in substantial medical costs and the hospital transfers the patient because it fears it will not be paid for those expenses.”<sup>113</sup>

On the other hand, some courts have focused on EMTALA’s purpose of providing emergency medical treatment to uninsured or indigent patients.<sup>114</sup> These courts have rejected EMTALA claims where patients have been appropriately screened, admitted to the hospital, stabilized, and subsequently transferred to another facility.<sup>115</sup> Accordingly, in *Bry-*

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105. See *Correa v. Hosp. S.F.*, 69 F.3d 1184, 1192 (1st Cir. 1995); *Eberhardt v. Los Angeles*, 62 F.3d 1253, 1257–58 (9th Cir. 1995); *Gardner v. Elmore Cmty. Hosp.*, 64 F. Supp. 2d 1195, 1202 (M.D. Ala. 1999).

106. *Correa*, 69 F.3d at 1192.

107. See *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1138 (8th Cir. 1996); *Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519, 522 (10th Cir. 1994); *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991); *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (6th Cir. 1990).

108. *Repp*, 43 F.3d at 522.

109. The term “stabilized” means that no material deterioration in the medical condition “is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.” 42 U.S.C. § 1395dd(e)(3)(B) (2001).

110. ROSENBLATT ET AL., *supra* note 17, at 86.

111. *Id.*; see *Brooker v. Desert Hosp. Corp.*, 947 F.2d 412, 413–14 (9th Cir. 1991); *Lee v. Alleghany Reg’l Hosp. Corp.*, 778 F. Supp. 900, 902–03 (W.D. Va. 1991).

112. *Thornton v. S.W. Detroit Hosp.*, 895 F.2d 1131, 1132 (6th Cir. 1990).

113. *Smith v. Richmond Mem’l Hosp.*, 416 S.E.2d 689, 692 (Va. 1992).

114. ROSENBLATT ET AL., *supra* note 17, at 87.

115. *Id.*

*ant v. Adventist Health System*,<sup>116</sup> the court held that EMTALA's stabilization requirement ends when an individual is admitted for inpatient care.<sup>117</sup>

### III. ANALYSIS

#### A. *The Need for New Regulations*

The lack of effective monitoring and judicial uniformity underscores the need for improved regulations interpreting EMTALA. The Centers for Medicare and Medicaid Services (CMS) of the HHS and the OIG recently promulgated such new rules.<sup>118</sup> Thomas A. Scully, the Administrator of CMS since 2001, acknowledged, "[w]e've methodically tried to go through the statute and find ways to rationalize and straighten up EMTALA."<sup>119</sup> Mr. Scully noted that the changes in the rule are "modest" saying, "[w]e tried to suggest ways to apply EMTALA in a 'real world' context."<sup>120</sup> CMS also intended the new rule to aid hospitals and courts in adhering to and interpreting EMTALA.<sup>121</sup> Mr. Scully agreed, stating, "I think EMTALA has been over-interpreted in many cases. People are begging for clarity and, accordingly, we're trying to give them clarity."<sup>122</sup> However, he also noted that CMS attempted to stay true to Congress's original intent of avoiding patient dumping and guaranteeing access to emergency room care.<sup>123</sup>

Moreover, CMS was facing pressure from healthcare providers to amend the regulations.<sup>124</sup> CMS claims it heard numerous complaints from hospitals and doctors arguing that the old regulations were "onerous and confusing," exposed them to litigation and monetary fines, and encouraged people to seek uncompensated care in emergency depart-

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116. 289 F.3d 1162 (9th Cir. 2002).

117. *Id.* at 1168. However, the court also noted that hospitals cannot avoid liability under EMTALA by ostensibly "admitting" a patient without intending to treat her, and then discharging or transferring her without having met the stabilization requirement. *Id.* at 1169.

118. *A Conversation with Thomas Scully*, 35 J. HEALTH L., 449, 449 (2002). The article derived from a teleconference between Mr. Scully and the American Health Lawyers Association on May 25, 2002. *Id.*

119. *Id.*

120. *Id.*

121. *Id.*

122. *Id.* at 450.

123. *Id.* Mr. Scully reiterated,

EMTALA is extremely important to make sure that low-income people have access to emergency rooms, and we're very focused on preventing patient dumping. On the other hand, I don't think EMTALA should drive perverse decisions in the healthcare system. So, we're going to try to fix EMTALA, without melting down the hospital emergency room situation.

*Id.* at 449.

124. Pear, *supra* note 22, at 1-2. For example, one doctor claimed that hospital duties under the older version of EMTALA grew because of court decisions and the "layering of regulation on regulation." *Id.*

ments.<sup>125</sup> Additionally, in the past, courts often sided with patients who brought EMTALA claims against hospitals.<sup>126</sup>

*B. Amended Regulations to EMTALA*

The final rule, published on September 9, 2003 and made effective on November 10, 2003, attempts to clarify the responsibilities of Medicare-participating hospitals under EMTALA.<sup>127</sup> Specifically, the final rule reiterates and clarifies changes regarding

emergency patients presenting to off-campus clinics that do not routinely provide emergency services, the applicability of the EMTALA provisions to hospital inpatients and outpatients, the circumstances under which physicians must serve on hospital medical staff "on-call" lists, and the responsibilities of hospital-owned ambulances.<sup>128</sup>

Under the new regulations, EMTALA obligations attach when individuals "come to a hospital emergency department" and make a request for examination or treatment for a medical condition.<sup>129</sup> Thus, when a patient enters the hospital via a department other than the emergency department and subsequently develops an emergent medical condition, the obligations of EMTALA do not attach.<sup>130</sup> Under the current regulations, "[t]he standard that applies to presentations on hospital property outside the Dedicated Emergency Departments is whether the patient is requesting emergency services, or the patient would appear to a normal prudent layperson to be in need of emergency treatment, based on his appearance or behavior."<sup>131</sup> Consequently, when a patient requests services other than emergency medical treatment, including outpatient treatment, the obligations of EMTALA are not triggered.<sup>132</sup> This contrasts with the old rule, which provided that the obligations of EMTALA applied whenever a patient sought emergency medical treatment anywhere on the entire main hospital campus.<sup>133</sup>

The new regulations provide guidance as to what qualifies as a "dedicated emergency department."<sup>134</sup> Previously, there had been confusion amongst hospitals about whether EMTALA obligations applied to off-campus, provider-based entities that do not hold themselves out to

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125. *Id.* at 1.

126. *Id.* at 1–2.

127. Faulk, *supra* note 62, at 10.

128. Ctr's for Medicare & Medicaid Servs., 68 Fed. Reg. 53,222, 53,222 (Sept. 9, 2003) (to be codified at 42 C.F.R. pts. 413, 482, 489) [hereinafter 68 Fed. Reg. 53,222].

129. *Id.* at 53,223.

130. *Id.* at 53,238.

131. *Id.* at 53,240–41.

132. *Id.* at 239–40.

133. Pear, *supra* note 22, at A1.

134. See *A Conversation with Thomas Scully*, *supra* note 118, at 449.

the public as offering emergency services.<sup>135</sup> The final rule states that a “dedicated emergency department” includes any department or facility licensed by the State as an emergency department, held out to the public as a place that provides emergency care without a previously scheduled appointment, or based on a representative sample of patient visits in the last year which provided at least one-third of all its outpatient visitors with emergency medical treatment.<sup>136</sup> CMS rejected the notion that the standard for determining what constitutes a dedicated emergency department should be the nature of the care provided.<sup>137</sup> In this respect, the regulations extend the meaning of emergency departments beyond those that are specifically licensed by the State to include other facilities that regularly provide a substantial amount of emergency medical care.<sup>138</sup> Now, if a facility such as an urgent care center holds itself out as a place that treats emergency medical conditions without an appointment, EMTALA applies.<sup>139</sup>

Further, the final rule offers two different tests to determine whether an individual presenting to a dedicated emergency department must be treated according to EMTALA’s obligations.<sup>140</sup> The first is whether the individual makes a specific request, or a request is made on the individual’s behalf, for examination or treatment of an emergency medical condition.<sup>141</sup> The second is whether the individual’s appearance or behavior would cause a “prudent layperson” to believe that examination or treatment for an emergency medical condition is needed and that the individual would request such if he or she were able to do so.<sup>142</sup> Thus, the “prudent layperson” is now the legal standard to be used on EMTALA reviews or investigations.<sup>143</sup>

Under the recent amendments to EMTALA, when a patient comes to the emergency department, the initial medical screening can be more cursory than under the original version of the Act.<sup>144</sup> Hospitals can meet the screening requirement through a qualified medical person, rather

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135. For example, a dialysis center located blocks away from a hospital emergency room would have employees trained to administer emergency medical treatment, although it was not itself an emergency department. Pear, *supra* note 22, at A1 (citing an example from Thomas A. Scully).

136. Faulk, *supra* note 62, at 13.

137. *Id.* at 13–14.

138. *Id.* at 14.

139. *Id.* (noting that “CMS believes that the formula it included in the definition of a dedicated emergency department strikes a balance between (1) the overly broad definition of those off-campus departments that will be included in the definition of a dedicated emergency department based on the department’s intended use, and (2) an individual’s perception of the department as an appropriate place to seek emergency care”).

140. *Id.* at 15.

141. *Id.*

142. *Id.* CMS stated that the standard set forth in this test should not be applied so broadly so as to require EMTALA screenings for those individuals who are perfectly capable of making a request for emergency medical treatment, but who chose not to do so. *Id.* at 16.

143. *Id.*

144. 68 Fed. Reg. 53,222, *supra* note 128, at 53,235.

than an emergency room physician, by simply asking a patient several questions if the patient verifies she does not need emergency care.<sup>145</sup>

The new regulations also clarify what constitutes a “medical screening examination.” The final rule clearly states that triage and vital signs alone do not satisfy the medical screening requirement under EMTALA.<sup>146</sup> However, vital signs accompanied by the individual’s statement that she is not seeking emergency medical care, along with brief questioning by a qualified medical professional, are sufficient to establish that no emergency medical condition exists under EMTALA.<sup>147</sup>

In addition, CMS addressed an issue that courts continually struggled with regarding whether the obligations of EMTALA continue once the patient has been admitted to the hospital. The final rule clearly provides that EMTALA does not apply once the emergency department patient becomes an inpatient.<sup>148</sup> Thus, once an individual becomes an inpatient, the stabilization requirement of EMTALA has been satisfied.<sup>149</sup>

Further, the new regulations provide that a hospital does not have to place a physician who provides emergency care on-call, twenty-four hours a day, if the hospital cannot reasonably do so.<sup>150</sup> The only requirement is that there must be someone available to appraise emergencies and give referrals during the hours of operations and within the usual staffing capabilities of the facility.<sup>151</sup> In addition, doctors can now render specialty coverage by means other than a specialist physically coming to the emergency room.<sup>152</sup> As a result, a patient may receive a referral to a specialist’s office instead of receiving such care within the hospital’s emergency department.<sup>153</sup>

Finally, the regulations attempt to clarify the applicability of EMTALA to hospital-owned ambulances. The final rule states that “comes to the emergency department” includes all hospital-owned ambulances that transport patients.<sup>154</sup> Thus, the obligations of EMTALA attach even if the ambulance is not yet on hospital grounds. The regulations also provide that an individual in a non-hospital-owned ambulance

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145. *Id.*

146. *Id.* at 53,236.

147. Faulk, *supra* note 62, at 15 (“CMS agrees that the medical screening examination, the extent and quality thereof, is generally within the judgment and discretion of the qualified medical personnel performing the examination but remains subject to review by Quality Improvement Organizations and State surveyors if a complaint is filed.”).

148. *Id.* at 16 (“[A]n inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services.” (citing Section 210 of the Medicare Hospital Manual, CMS Publication Number 10) (1989))).

149. *Id.*

150. *Id.*

151. *Id.* at 13.

152. Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare—Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 Fed. Reg. 174, 53,223 (Sept. 9, 2003) (to be codified at 42 C.F.R. pts. 413, 482, 489).

153. *Id.*

154. Faulk, *supra* note 62, at 13.



off hospital property has not “come to the emergency room” for the purposes of EMTALA, even if a member of the ambulance staff contacts hospital personnel and informs them that they want to transport the individual to the hospital for emergency medical treatment.<sup>155</sup> Additionally, a hospital-owned ambulance may transfer the individual to the nearest appropriate facility, other than that hospital, if it is directed to do so by community emergency medical services protocol or by a physician aboard the ambulance not affiliated with the hospital.<sup>156</sup>

*C. Effect of the Amended Regulations on Access to Health Care*

Mr. Scully, administrator of CMS, claims that the amended regulations will “reduce the costs of compliance for hospitals and doctors without weakening patients’ protections.”<sup>157</sup> It is apparent that the new regulations relax the obligations previously imposed on hospitals and emergency department physicians and specialists and expand the exemptions from the Act available to providers.<sup>158</sup> Nonetheless, under the final rule, patients may now find it more complicated to obtain various emergency medical treatments at some hospitals and hospital-owned clinics.<sup>159</sup> Additionally, some patients may find it more difficult to win damages in court for injuries caused by EMTALA violations.<sup>160</sup>

The relaxed screening requirement may cause patients with medical emergencies to be overlooked. The effect of allowing the hospital to meet the screening requirement merely by asking a patient several questions is that patients who experience an emergency, but do not convey this to the medical professional quickly enough, may not receive the necessary medical treatment prior to being discharged from the emergency department. For example, it is possible to imagine a scenario where a patient may come to the emergency department seeking care and be seen by a qualified medical professional, but not receive a thorough medical screening examination because the patient did not clearly state that he or she was seeking emergency medical care. Thus, a patient may be inappropriately screened by virtue of the fact that he or she failed to recognize the need to make the proper request.

In addition, CMS noted in the final rule that individuals who arrive at the hospital’s emergency department with a non-emergency medical condition should be referred to their own private physician’s office for further treatment and not simply sent away from the emergency depart-

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155. 42 C.F.R. § 489.24(b) (2000).

156. *Id.*

157. Pear, *supra* note 22.

158. *Id.*

159. *Id.*

160. *Id.* (“Patients turned away or refused emergency care can still sue, but hospitals will, in many cases, have stronger defenses.”).

ment.<sup>161</sup> However, this directive provides little help to those who are uninsured and cannot afford to pay out-of-pocket for private medical treatment in a physician's office.

The changes to the on-call obligations are equally troubling. If a hospital does not need to provide twenty-four-hour, on-call specialists, then patients who require specialized care in the emergency department may not receive it. As one physician noted,

[t]he new rule could aggravate the existing problem. Specialists are not accepting on-call duties as frequently as we would like. As a result, hospital emergency departments lack coverage for various specialties like neurosurgery, orthopedics and ophthalmology. The new rule could make it more difficult for patients to get timely access to those specialists.<sup>162</sup>

Moreover, the new amendments leave open the question whether a hospital is excused from EMTALA's obligations if it can show that it did not have the capability to provide on-call physicians.<sup>163</sup>

The new regulations also provide that doctors can have simultaneous on-call duties at two or more hospitals and can schedule elective surgery while on-call.<sup>164</sup> For example, if a physician is in surgery when an emergency arises at the hospital's emergency department, it is questionable how quickly the physician will be able get to the department and provide the patient with appropriate medical screening and stabilization. It is even more doubtful that a physician on-call at one hospital will be able to effectively provide on-call emergency services at another hospital concurrently. In all likelihood, this regulation will give hospitals an excuse not to provide round-the-clock coverage or eliminate coverage for specialties that are more costly.<sup>165</sup> As a result, more patients requiring specialty care will be transferred to teaching hospitals that have the largest variety of medical specialists, thus increasing the burden on those facilities which are already serving a large population of indigent patients.<sup>166</sup>

In addition, the new application of the "prudent layperson" standard in the test of whether an individual presented to a dedicated emergency department must be treated leaves open several questions. Under this standard, it is unclear whether a hospital needs to inquire if a patient is seeking or desires medical treatment in order to fully comply with

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161. Faulk, *supra* note 62, at 13.

162. Pear, *supra* note 22.

163. Faulk, *supra* note 62, at 16.

164. Pear, *supra* note 22.

165. Marsha Austin, *Change Limits Specialty Care in ER, Clinics On-Call 24/7 Service Not Required*, DENV. POST, Sept. 4, 2003, at A-01; *see also* Leslie Berenstein, *New Rules for Hospitals Raise Some Concerns*, SAN DIEGO UNION-TRIB., Sept. 19, 2003, at C-1 (quoting an executive healthcare director who claimed, "[t]oo much discretion . . . could hurt patients [and] flexibility in an environment like that means space to cut back on care")

166. Austin, *supra* note 165, at A-01.

EMTALA's obligations.<sup>167</sup> The regulations make clear that the hospital must have notice of an individual coming to the emergency department with an emergency medical condition for EMTALA to apply.<sup>168</sup> However, once the hospital has notice, it is conceivable that the prudent layperson standard would require the hospital to treat the individual, regardless of whether she made a request for medical treatment.<sup>169</sup> If EMTALA's obligations attach at this point, then the hospital would be required to ask the individual whether she is seeking emergency medical treatment, and, if the answer is "yes," the hospital must comply with EMTALA's requirements. Because EMTALA does not apply without notice, this creates an incentive for the hospital to claim it did not have notice of the individual presenting an emergency medical condition. Additionally, if the prudent layperson's observations are sufficient to give the hospital notice, it is likely many will claim that the obligations of EMTALA do not attach in this scenario. Consequently, the prudent layperson standard seems to create yet another loophole for hospitals to avoid EMTALA.

Ironically, CMS amended the temporal and geographical requirements of the Act in a way that guarantees uninsured patients even less access to emergency medical care. When a patient has an emergency in a doctor's office, outpatient clinic, or operating room of the hospital, the obligations of EMTALA do not attach, even if the patient is subsequently transferred to the emergency department.<sup>170</sup> Moreover, the staff at hospital-owned facilities is not required to transport the patient to the emergency department of the main hospital, but can merely call 911.<sup>171</sup> Additionally, hospital-owned ambulances are not required to take patients to a particular facility.<sup>172</sup> Rather, they can transport the patient to another hospital.<sup>173</sup>

This regulation allows the emergency department to circumvent its duties under the Act based solely upon the fact that the patient did not initially present herself to the emergency department. This gives the hospital a way of avoiding the EMTALA obligations without any valid reason or justification other than hospital geography. If the purpose of EMTALA is to ensure emergency medical treatment to everyone, including uninsured and indigent patients, it makes little sense to excuse hospitals from the duties of the Act when an emergent patient happens to arrive at an outpatient clinic or physician's office adjacent to the hospital prior to arriving at the emergency room.

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167. Faulk, *supra* note 62, at 16.

168. *Id.* at 15.

169. *Id.* at 16.

170. 68 Fed. Reg. 53,222, *supra* note 128, at 53,223.

171. Berenstein, *supra* note 165, at C1.

172. *Id.*

173. *Id.*

Taken together, the new regulations will likely save hospitals money<sup>174</sup> but will have a negative effect on those who depend on EMTALA the most—the uninsured. In some cases, patients may be ineffectively screened and face longer waiting times for specialists on-call at more than one hospital, and hospitals will find it easier to avoid treating the uninsured.<sup>175</sup> As one commentator noted, “[i]t is clearly giving hospitals some fudge room to cut back on taking people in, keeping them there and having an ample network of specialists ready to meet people’s needs.”<sup>176</sup>

#### IV. RESOLUTION

##### A. *How the Courts Should Respond*

The amended regulations to EMTALA weaken an already faltering federal statute. After years of judicial inconsistency, the final rule set forth by CMS clarifies the scope of the Act and the obligations of the hospital and physicians. While administrative efficiency is essential, it is also vital to recall that Congress intended the statute to provide a remedy to injured patients.<sup>177</sup> As a result, courts must take the opportunity to sharpen EMTALA’s teeth.

Courts could make the Act more effective by requiring the hospital to overcome a burden of presumption. Once a patient has made a *prima facie* showing that the hospital breached its duty to appropriately screen and stabilize, the courts should presume an EMTALA violation and require the hospital to overcome this burden. An Oklahoma court properly held, in an action against a hospital by a person denied treatment in the hospital’s emergency department, that once the plaintiff satisfies the initial burden of showing that she made a request for treatment and that an appropriate medical screening examination did not occur, the hospital has the burden of showing, by a preponderance of the evidence, that the plaintiff either refused to consent to treatment or withdrew a request for treatment.<sup>178</sup> Shifting the burden to the hospital recognizes the original intent of the Act by requiring the hospital, which could avoid the harm to the patient, to more strictly follow EMTALA’s obligations.

Courts should adhere to the lead of the Supreme Court in *Roberts v. Galen of Virginia*<sup>179</sup> by construing the language of the Act strictly and

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174. See *id.* (quoting the acting deputy administrator of CMS, Leslie Norwalk, who asserted that the new regulations could have a tangible financial impact for hospitals that can spend less on administrative costs).

175. See Austin, *supra* note 165, at A-01.

176. Berenstein, *supra* note 165, at C1.

177. Bryan v. Rectors & Visitors, 95 F.3d 349, 351 (4th Cir. 1996) (EMTALA’s “core purpose is to get patients into the system who might otherwise go untreated and be left without a remedy because traditional medical malpractice law affords no claim for failure to treat”).

178. Stevison v. Enid Health Sys., Inc. 920 F.2d 710, 713–14 (10th Cir. 1990).

179. 525 U.S. 249, 250 (1999).

steering clear of giving hospitals more incentive to avoid complying with EMTALA's requirements. In *Galen*, the plaintiff claimed she was inappropriately transferred from a hospital in violation of EMTALA.<sup>180</sup> The Court declined to impose a burden on the plaintiff to prove that the hospital had an improper motive in transferring her to another hospital.<sup>181</sup> Instead, the plaintiff was required to show only that she was not provided treatment required to stabilize her medical condition.<sup>182</sup> Thus, the Court refused to make it more difficult for a plaintiff to prevail on an EMTALA claim. While improper motive may have been involved in the hospital's decision to transfer the plaintiff, it would have been nearly impossible for her to prove it. By not requiring such a burden of proof, plaintiffs may be more likely to bring private causes of action against hospitals and physicians. The more EMTALA claims filed against hospitals, the more likely hospitals will be to comply diligently with the Act's requirements in the future.

*B. How Congress Should Respond*

EMTALA's current regulations to EMTALA provide even less protection to uninsured and underinsured patients than previous regulations, while providing no greater incentive for hospitals to curb the practice of patient dumping. To make EMTALA more effective, Congress should amend the Act and increase the hospital's obligation to appropriately screen and stabilize all patients who come into the hospital in a state of emergency, regardless of which department within the hospital they first arrive at. It makes little sense to exclude emergency patients based on the patient's misfortune of developing a medical emergency while located in a part of the hospital not designated as an emergency room. Additionally, it is far too dangerous to allow specialists to be on-call at more than one hospital at a time because it does not account for the reality that there may often be an emergency at both hospitals simultaneously. While this places a burden on hospitals in smaller communities, it is necessary to ensure that no hospital is left without a physician trained to treat an emergency case.<sup>183</sup>

Moreover, Congress needs to encourage stricter enforcement of EMTALA and increased punishment for EMTALA violators to improve compliance with the statute. The current fines are rarely enforced and are arguably not large enough to affect conformity with the obligations

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180. *Id.* at 252.

181. *Id.* at 253.

182. *Id.*

183. *But see* Roger Mezger, *Clinic, UH Doctor Says Revised Rules Won't Limit Emergency Care for Poor*, PLAIN DEALER (Cleveland, OH), Sept. 4, 2003, at B4 (quoting a doctor who claims the new rule is reasonable because smaller communities often have only one doctor in a certain specialty area available to cover two hospitals).

of the Act.<sup>184</sup> Moreover, because EMTALA only applies to Medicare-provider hospitals, Congress should not only threaten a hospital's Medicare-provider status for EMTALA violations, but should actually follow through with such action.<sup>185</sup> A hospital that loses its Medicare-provider status would lose a large part of its revenue.<sup>186</sup> Thus, substantially larger fines and revocation of participation in Medicare would undoubtedly encourage greater hospital compliance with the Act.

## V. CONCLUSION

The recent amendments to the regulations of EMTALA will ultimately decrease access to health care for uninsured and underinsured patients seeking emergency treatment. By narrowing the hospital's duty under the Act, CMS gave hospitals more ways to avoid providing emergency medical care to those who are unable to pay for it. Additionally, while the new regulations clear up some of the prior ambiguities courts have struggled with, they also create new loopholes for hospitals to evade EMTALA's obligations and generate the potential for inconsistent application of the Act.

Congress should amend and enforce EMTALA to better achieve its original purpose of ensuring emergency medical treatment to those who cannot afford it. Hospitals must have an increased, yet well-defined, obligation to provide appropriate screening and stabilization to all emergent patients. Furthermore, for EMTALA to have a substantial effect, courts must strictly construe the language of the statute and place the burden of proof for violations on the hospitals. As long as uninsured people continue to depend on receiving medical care in emergency departments, Congress and the courts must provide them with adequate protection through EMTALA.

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184. Gionis, *supra* note 12, at 199. EMTALA calls for a civil monetary penalty of not more than \$50,000 dollars per violation, or not more than \$25,000 dollars per violation for hospitals with less than 100 beds.

185. *St. Anthony Hosp. v. United States Dep't of Health and Human Servs.*, 309 F.3d 680, 693 (10th Cir. 2002) (citing OFFICE OF INSPECTOR GEN., DEP'T OF HEALTH & HUMAN SERVS., THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT: THE ENFORCEMENT PROCESS 8 (2001)).

186. Berenstein, *supra* note 165, at C1.