



Health Matrix: The Journal of Law-Medicine

Volume 8 | Issue 1

1998

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PATIENT DUMPING AND EMTALA: PAST IMPERFECT/FUTURE SHOCK

David A. Hyman†

I. INTRODUCTION

THIS SYMPOSIUM ISSUE OF *HEALTH MATRIX* marks the tenth anniversary of the Emergency Medical Treatment and Active Labor Act (EMTALA).¹ Some groups mark similar anniversaries with marches, rallies, and demonstrations. Law school professors are less physical; we celebrate our anniversaries by holding symposia at which we consider legal means and ends. Ideally, such efforts will result in an assessment of whether “reform” has actually improved matters — which it often does not.

EMTALA is an unlikely candidate for such scrutiny. The statute is wildly popular across the entirety of the political spectrum, and among such disparate interest groups as physicians, advocates for the poor, professors of law and public health, and consumer groups. Unlike many reforms, EMTALA does not create a new administrative bureaucracy; it does not favor the interests of the well-connected against the less fortunate; its on-budget costs are modest; and it seems to be no more intrusive than is absolutely necessary to accomplish its objectives. The goal EMTALA was intended to accomplish —

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1. The Symposium was held on April 19, 1997 at Case Western Reserve University Law School. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), of which EMTALA is a single section, was signed by President Reagan on April 7, 1986. See Andrew Jay McClurg, *Your Money or Your Life: Interpreting the Federal Act Against Patient Dumping*, 24 WAKE FOREST L. REV. 173, 197-98 n.106 (1989) (chronicling the tortuous adoption of COBRA). EMTALA's provisions took effect on August 1, 1986. *Id.* at 198. Only lawyers, whose inadequacies in mathematics are well-documented, could conclude that the symposium marked EMTALA's tenth anniversary.

access to emergency care for those unable to pay — is similarly hard to take issue with. Not surprisingly, the conventional wisdom on EMTALA is overwhelmingly favorable.²

Despite this glowing picture, EMTALA's flaws far exceed its limited virtues. The statute is sloppily drafted, and the most important words are undefined or defined far too broadly. The premise of the statute is silly at best; one cannot impose open-ended obligations of this sort on private parties and expect them to meekly comply — and the inevitable adaptive responses make everyone worse off. The private right of action effectively creates a federalized medical malpractice regime with the distinct tendency to reward the wrong people. When the federal government enforces EMTALA, its aim and tactics leave much to be desired.

Some of these topics have been addressed by other authors, and I cover them at length in two other articles.³ Instead, this Article analyzes the original (anecdotal) case for EMTALA, and predicts the statute's future prospects in light of the changes in the health care marketplace. These may seem peculiar subjects for scrutiny at a Symposium marking the tenth anniversary of EMTALA. Academic symposia tend to be dominated by debate over intended and unintended statutory consequences, with future prospects a distant second — and statutory causes a non-starter.

2. To be sure, there has been quibbling about various peripheral issues — usually expressed in terms of “EMTALA could be improved by [fill in the blank].” See Lawrence E. Singer, *Look What They've Done to My Law, Ma: COBRA's Implosion*, 33 HOUS. L. REV. 113 (1996) (changing the definition of “appropriate” to eliminate overlap with malpractice law); William N. Wiechmann, *Language Barrier to Emergency Health Care: Definitional Imprecision Still Plagues the Consolidated Omnibus Budget Reconciliation Act*, 9 T.M. COOLEY L. REV. 161 (1992) (improving definitions of terms in statute); Demetrios G. Metropoulos, *Son of COBRA: The Evolution of a Federal Malpractice Law*, 45 STAN. L. REV. 263 (1992) (assessing the overlap with malpractice law). But see Maria O'Brien Hylton, *The Economics and Politics of Emergency Health Care for the Poor: The Patient Dumping Dilemma*, 1992 B.Y.U. L. REV. 971 (arguing that regulatory responses like EMTALA will not work, and Congress should focus on making insurance more affordable by, inter alia, eliminating community rating); Mark A. Hall, *The Unlikely Case in Favor of Patient Dumping*, 28 JURIMETRICS J. 389 (1988) (arguing that EMTALA is worse than no legislation).

3. See David A. Hyman, *Dumping EMTALA: When Bad Laws Happen to Good People* (Sept. 15, 1997) [hereinafter *Bad Laws*] (cataloguing problems with EMTALA) (unpublished manuscript, on file with author); David A. Hyman, *Should We Depend on the Kindness of Strangers?: Ethics, Economics, and Emergency Care* (Sept. 15, 1997) [hereinafter *Kindness of Strangers*] (arguing that public health is better served by focusing free and subsidized services in areas other than emergency care) (unpublished manuscript, on file with author).

Although statutory effects bear investigating, EMTALA's origins are worth considering, if only with the (faint) hope that Congress might not repeat the same mistakes the next time around.⁴ Similarly, EMTALA's prospects are worth considering, if only to avoid future shock.⁵ Accordingly, Part II provides a brief overview of EMTALA's provisions. Part III analyzes the anecdotal basis for EMTALA. Part IV assesses the empirical case for EMTALA. Part V discusses the prospects for EMTALA in light of the changes in the health care marketplace. Part VI offers a brief conclusion.

II. EMTALA

Although EMTALA has a series of interlocking provisions, its basic structure is fairly straightforward. Any individual who presents at a "qualifying hospital" and requests care is entitled to an "appropriate" medical screening examination to determine whether an "emergency medical condition" is present.⁶ If so, the patient cannot be "transferred" until the "emergency medical condition" is "stabilized."⁷ If the patient can

4. My hope is faint, because Congress routinely legislates on the basis of anecdote — and continues to use budget reconciliation acts to accomplish that objective. See Bradley J. Meier, *The New Patent Infringement Liability Exception for Medical Procedures*, 23 J. LEGIS. 265, 274-78 (1997) (noting use of Omnibus Consolidated Appropriations Act to enact anecdote-driven legislation prohibiting patenting of medical procedures).

5. See ALVIN TOFFLER, *FUTURE SHOCK* 4 (1970) ("In 1965, in an article in *Horizon*, I coined the term 'future shock' to describe the shattering stress and disorientation that we induce in individuals by subjecting them to too much change in too short a time.").

6. A "qualifying" hospital is a hospital that has a Medicare contract; this criterion includes almost all hospitals in the United States. EMTALA does not define "appropriate," and the regulations disclaim the possibility of doing so. 42 C.F.R. pts. 405, 489 (1997). EMTALA specifically defines "emergency medical condition" as:

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

(B) with respect to a pregnant woman who is having contractions (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

42 U.S.C.A. § 1395dd(e)(1) (West 1997).

7. A "transfer" is the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person. 42

not be "stabilized," definitive treatment must be provided, or an "appropriate transfer" may be performed.⁸

Physicians who are "on-call" to the emergency room are required to come to the hospital and provide all necessary services. Hospitals must also accept transfers if they have the capacity and capability to do so. Compliance is ensured by various enforcement provisions, including civil monetary penalties, civil suits, and exclusion from Medicare. Various house-keeping measures help to ensure compliance.⁹

III. THE ANECDOTAL CASE FOR EMTALA

The case for EMTALA was built on a foundation of heart-rending anecdotes in which hospital emergency departments (EDs) callously denied life-saving care to those in need.¹⁰

U.S.C.A. § 1395dd(e)(4) (West 1997).

"Stabilized" means that "no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility . . ." 42 U.S.C.A. § 1395dd(e)(3)(B) (West 1997). If the individual is a pregnant woman having contractions, "stabilized" effectively means that the woman has delivered both the child and the placenta, unless the hospital is prepared to accept a substantial EMTALA liability risk. *See* *Burditt v. United States*, 934 F.2d 1362 (5th Cir. 1991). The court stated:

We think that [EMTALA] allows hospitals to transfer at will women in uncomplicated labor who, within reasonable medical probability, will arrive at another hospital before they deliver their babies. A hospital that transfers a woman in labor when the timing call mandated by [EMTALA] is close risks a battle of experts regarding anticipated delivery time, distance, and safe transport speed.

...

We believe that Congress intended . . . to extend EMTALA's "treat or transfer" protection to women in labor who have any complication with their pregnancies regardless of delivery imminence.

Id. at 1369-70.

8. *Cf.* 42 U.S.C.A. § 1395dd(c)(1) (West 1997) (general prohibition on transfer unless stabilized), with 42 U.S.C.A. § 1395dd(c)(1)(A), (c)(2) (West 1997) (pre-stabilization transfer allowed if "appropriate" (*i.e.* transferring facility provides treatment it is able to; receiving facility has available space and personnel and has agreed to accept transfer; applicable medical records sent with patient; transfer effected with acceptable means) and the patient consents in writing after being informed of hospital's obligations under EMTALA and the risks of transfer or a physician or qualified medical person certifies in writing that benefits of transfer outweighs the risks).

9. These measures include preemption of conflicting state and federal laws; a requirement that hospitals maintain a log of all patients seen in the emergency room and report all violations of EMTALA to the federal government within 72 hours of their occurrence; post signs in the emergency department (ED) providing notice to all persons of the hospital's obligations under EMTALA; not delay care to inquire about the insurance status of a patient; and a prohibition on retaliation against "whistle-blowers" and physicians who refuse to approve the transfer of an unstable patient. *See* 42 U.S.C. §§ 1395dd(f), (i) (West 1997).

10. *See* 131 CONG. REC. S13892-01, 1985 ("Frankly, we do not know how pervasive this

Post-enactment monitoring of EMTALA also emphasized anecdotal evidence; at the only Congressional hearing on patient dumping, the first panel featured three witnesses who provided personal anecdotes about their experiences with dumping.¹¹ These trends are reflected in academic assessments of patient dumping; law review articles on the subject almost invariably include horrifying anecdotes about someone who suffered death, permanent disability, or the loss of a child as a result of the denial of necessary emergency care.¹²

Anecdotal evidence can help to put a human face on a particular problem.¹³ However, such evidence provides no basis for legislation until the truthfulness, typicality, and frequency of the anecdote is established — and disregarding these precepts is exceedingly unwise.¹⁴ Despite these difficulties,

practice of dumping the sick and the indigent from emergency rooms actually is. The evidence I have seen so far is primarily anecdotal.”) (statement of Sen. Durenberger). The Congressional Committee reports reflect a similar assessment. See H.R. Rep. No. 99-241, Pt.3 at 728 (1986), reprinted in 1986 U.S.C.C.A.N. 726, 728 (“There was little evidence available to the Committee during its consideration of H.R. 3128 as to the scope of the problem addressed by § 124, since there have been no hearings in either the House or the Senate on this issue or on the language recommended by the Ways and Means Committee.”). See also 132 CONG. REC. E24-02 (1986) (remarking that an article in the *Oakland Tribune* is “one of the reasons that we have been able to include in the reconciliation bill . . . antidumping language designed to stop hospitals from dumping poor patients on other public and charity hospitals.”) (statement of Rep. Stark).

11. The first panel featured two witnesses to alleged dumping incidents and a representative of an advocacy group who recounted anecdotes about various alleged episodes of dumping from around the nation. The second panel was composed of three long-time physician opponents of economically motivated patient transfers, two of whom had authored empirical studies of the issue (Drs. Ansell and Kellerman). The third panel was composed of representatives of the administration who were chided for their failure to enforce EMTALA.

12. See Karen H. Rothenberg, *Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care*, 26 HOUS. L. REV. 21, 21-22 (1989) (recounting anecdotes); McClurg, *supra* note 1, at 174-75 n.3 (recounting anecdotes).

13. Cf. Sidney Dean Watson, *In Search of the Story: Physicians and Charity Care*, 15 ST. LOUIS UNIV. PUB. L. REV. 353 (1996). He states:

The bioethical method, with its dependence on real cases and real stories, breathes life into the overwhelming, yet dry statistics about the face of poverty in this country. Generalities and statistics are necessary because they provide the big picture, but they mask the meanings, implications, and complexities for particular people and particular locations. Bioethics' stories show the experiences of real people.

Id. at 367-68.

14. See Michael J. Saks, *Do We Really Know Anything About the Behavior of the Tort Litigation System-And Why Not?*, 140 U. PA. L. REV. 1147, 1161 (1992):

The trouble with legislation by anecdote is not just that some of them are false or misleading. Even if true and accurate, anecdotes contribute little to developing a meaningful picture of the situation about which we are concerned. It makes a difference if for every ten anecdotes in which an undeserving plaintiff bankrupts an innocent defendant, one, ten, one hundred, or one thousand equal and opposite

anecdote-driven legislation is frequently embraced as the underlying subject matter becomes more complex and the trade-offs become tougher. Unfortunately, the higher the stakes, the greater the adverse consequences if the anecdote which is generalized is inaccurate or atypical.

EMTALA provides an object lesson on these points. Consider the legend of Mr. Terry Takewell. Mr. Takewell's legend has been infamous in health policy circles ever since his neighbor, Ms. Zettie Mae Hill, was the lead-off witness at the only Congressional hearing ever held on EMTALA.¹⁵ Mr. Takewell's story was prominently featured in the committee report which resulted from the hearing¹⁶ and became the principal example of patient dumping in academic commentaries on EMTALA.¹⁷

The standard version of the legend of Mr. Takewell is horrifying. Uninsured, unemployed, and afflicted with poorly controlled diabetes since his youth, he had run up a large bill at the local hospital. After his doctor ordered him admitted, he was taken to Methodist Hospital in Somerville, Tennessee by ambulance, gasping for breath, in a diabetic coma, and in dire need of emergency medical attention. He was met in his room

injustices are done to innocent plaintiffs. The proportion of cases that results in one or the other error, and the ratio of one kind of error to the other, ought to be of greater interest to serious policy-makers than a handful of anecdotes on either side of the issue. Reforms are intended to change that ratio and the tens of thousands of anecdotes the ratio summarizes.

15. Ms. Hill was presumably chosen for this honor because the story she related exemplified the points Representative Weiss, who was holding the hearing, wanted to make. Representative Weiss "considered the Administration to be lax in its enforcement" of EMTALA, and he believed that "hospitals and physicians needed to have the 'perception' that the law is being vigorously enforced and penalties applied." Michelle L. Robinson, *Patient 'Dumping' Regulations Offer Little Guidance*, 61 HOSP., Sept. 5, 1987, at 35, 36 (quoting Rep. Ted Weiss (D-NY)). The tenor of the hearing was captured by Rep. Fortney "Pete" Stark, one of the key figures in EMTALA's enactment, who urged Representative Weiss to "hammer on the table so that hospitals know we mean business." *Id.*

16. COMM. ON GOVERNMENT OPERATIONS, EQUAL ACCESS TO HEALTH CARE: PATIENT DUMPING, H.R. Rep. No. 100-531, at 11 (1988) (hereinafter EQUAL ACCESS).

17. See Erik J. Olson, *No Room at the Inn: A Snapshot of an American Emergency Room*, 46 STAN. L. REV. 449, 450-51 (1994) (using Takewell as an example); Sylvia A. Law, *A Right to Health Care That Cannot be Taken Away: The Lessons of Twenty-Five Years of Health Care Advocacy*, 61 TENN. L. REV. 771, 779 (1994) (citing the committee account of Takewell as "[o]ne of the most dramatic cases presented"); David M. Frankford, *Privatizing Health Care: Economic Magic to Cure Legal Medicine*, 66 S. CAL. L. REV. 1, 90 (1992) (describing Takewell's story as an "easy case"); Wiechmann, *supra* note 2, at 161-62; Rothenberg, *supra* note 12, at 21; McClurg, *supra* note 1, at 205 n.173 (using Takewell as an example).

by the hospital administrator, who picked him up out of his hospital bed and carried him out of the building and across the parking lot. Mr. Takewell was left under a tree — shirtless, barefoot, and helpless. His friends found him and took him home, where he died the next day. Following an investigation by a state board dominated by health care providers, Methodist Hospital was cleared of any responsibility for the incident.¹⁸

Although the legend of Mr. Takewell may appear compelling, there are a number of reasons to be skeptical. Ms. Hill did not personally witness most of the events in question.¹⁹ Her testimony at the hearing was not subjected to even friendly cross examination, nor was her testimony supplemented by that of any of the other witnesses to the events in question — of which there were many. Thus, the “official” version of Mr. Takewell’s story is based on a highly selective presentation of hearsay evidence.²⁰

Despite these warning signs, the legend of Mr. Takewell has become the paradigmatic case for the evils of patient dumping.²¹ Indeed, those who hear the legend take from it the understandable lesson that something must be done about patient dumping. After all, what kind of country is this where EDs can simply refuse to provide care to those in need? Bottom-line oriented administrators have no business making such decisions. Consistent with the Hippocratic oath, doctors and hospitals should take care of those in need — and anyone who interferes with that sacred mission should be incarcerated.²²

18. This narrative is drawn from EQUAL ACCESS, *supra* note 16, at 11.

19. Ms. Hill personally witnessed Mr. Takewell’s condition before he was taken to the doctor and, from a distance, while he was being examined by Dr. Bishop. She next saw Mr. Takewell under a tree in the hospital parking lot. Thus, she was not present during Mr. Takewell’s encounter with Methodist Hospital. See PATIENT DUMPING: HEARING BEFORE A SUBCOMM. OF THE COMM. ON GOVERNMENT OPERATIONS, HOUSE OF REPRESENTATIVES, 100th Cong. 17, 18 (1987) (statement of Zettie Mae Hill).

20. Hearsay is “a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted.” FED. R. EVID. 801(c). Hearsay is inadmissible, unless it falls within an exception to the rule or an exclusion from the definition. FED. R. EVID. 802-04. Hearsay is generally excluded because of the “risks that come with relying on the word or say-so of another person,” including misperception, failing of memory, shading of the truth, and misunderstanding of the declarant. CHRISTOPHER B. MUELLER & LAIRD C. KIRKPATRICK, EVIDENCE § 8.2 (1995).

21. See sources cited *supra* note 17.

22. As originally proposed, EMTALA provided for exactly that. The criminal provisions were deleted after the Senate Judiciary Committee observed that they might be counterproductive.

Some additional facts should be added in the interest of evaluating the legend of Mr. Takewell on the basis of a full record.²³ Mr. Takewell's diabetes was poorly controlled because he did not always take his insulin with the required regularity.²⁴ A psychologist testified that Mr. Takewell had a lengthy history of not taking his insulin so that he could be "rescued" by medical personnel.²⁵ When Mr. Takewell died, there was no insulin in his house — and the Medical Examiner noted on the death certificate that Mr. Takewell would use his money to purchase alcohol and drugs, including cocaine, instead of insulin.

During the two years prior to his death, Mr. Takewell had been treated at Methodist Hospital twelve times, including seven hospital admissions, for which he owed Methodist Hospital approximately \$9,500. Although Mr. Takewell would almost certainly have qualified for free care, he had repeatedly

H.R. Rep. No. 99-241, pt.3 at 6 (1985), *reprinted in* 1986 U.S.C.C.A.N. 726, 727 ("The Committee is concerned that if penalties are too severe, some hospitals, particularly those located in rural or poor areas, may decide to close their emergency room entirely rather than risk the civil fines, damage awards, and, as to physicians, criminal penalties that might ensue.")

23. The more complete version of Mr. Takewell's story contained in this Article is based on the case file of the Tennessee Board For Licensing Health Care Facilities (the "Board"). See Methodist Hospital of Somerville, Inc., Before the Tenn. Board for Licensing Health Care Facilities, Agency Case No. 86-0600 (excerpt from the transcript of proceedings, April 28-30, 1987) [hereinafter *Transcripts*]. The Board held two days of contentious hearings, at which testimony was taken under oath, and subjected to cross-examination. In the interest of style, a statement in the case file was treated as factual if two witnesses testified to it, and cross-examination did not shake the testimony, or if the statement was included in an official police report or autopsy record. If only one witness testified to a statement, it is attributed solely to that witness. All references are to specific pages in the hearing transcript. See *id.*

A more extensive analysis of the legend of Mr. Takewell and of several other patient dumping anecdotes is contained in David A. Hyman, *Lies, Damned Lies, and Narrative*, 73 IND. L. J. (forthcoming 1998) [hereinafter *Lies, Damned Lies*].

24. See *Transcripts, supra* note 23 at 145. "[A] lot of times he didn't follow his treatment right, and he'd get sick, you know, and get unable to work." *Id.* at 247. Other testimony reflected that Mr. Takewell was taking his insulin and eating properly "on and off for a couple of weeks." *Id.* at 367. However, a third witness testified that Mr. Takewell was taking his insulin and following his diet while living in Middle Coff Trailer Park. See *id.* at 32.

25. "Most of the literature indicates that the noncompliant diabetic — one of the motives, one of the perhaps unconscious motives is to quote create chaos or create a set of crises in which the authority figures in their lives are kind of kept off balance, kind of kept out of balance. The psychological and psychiatric literature interprets this as an effort to manipulate and to contrive crises such that the patient then has to be rescued . . ." *Id.* at 148-49. The psychologist also testified that Mr. Takewell had a history of coping with authority figures by "denial, avoidance, and more particularly by the mechanism of flight . . . if an authority figure frustrated him, rather than seeking to work out the problem or think through the problem, he would simply leave." *Id.* at 154. The psychologist had treated Mr. Takewell in 1979 and 1981, but had not seen him during the intervening years. See *id.* at 131.

refused to provide proof of income, which would have allowed Methodist Hospital to zero-out his bill. Methodist Hospital personnel had informed Mr. Takewell that they would provide care to him if he were in an emergency situation, but they needed him to provide proof of income for non-emergency care.

On September 16, 1986, an ambulance was summoned to pick up Mr. Takewell from his home because his neighbors believed he was sick. The emergency medical technician (EMT) who evaluated him at the scene did not believe he was ill.²⁶ The ambulance took him to the Morris Clinic, where he was evaluated by Dr. John Bishop.²⁷ After observing that Mr. Takewell was hyperventilating slightly, was somewhat lethargic, and had a modestly elevated blood glucose of 250, Dr. Bishop decided that he should be admitted to the hospital for testing.

When Mr. Takewell arrived at Methodist Hospital, he was taken directly to a patient room. The acting hospital administrator phoned Dr. Bishop to inform him the hospital would admit Mr. Takewell if it was an emergency, but they needed him to complete the forms for free care if it was not. Dr. Bishop told the administrator that Mr. Takewell "would probably be all right" if he was not admitted.²⁸

The acting hospital administrator went to Mr. Takewell's room and told him that he would be admitted only if he cooperated with Methodist Hospital's attempts to qualify him for free care, or if it was a true emergency. Mr. Takewell got up from his bed, walked into and used the bathroom, and then walked out of Methodist Hospital. The acting administrator walked with him, attempting to persuade him to stay and execute the forms.

26. The EMT testified that Mr. Takewell was not sweaty, did not have the fruity breath characteristic of diabetic ketoacidosis, was alert and oriented, with reactive pupils, and warm and dry skin. *See id.* at 342-46. The EMT testified that he did not believe that Mr. Takewell's condition constituted an emergency, and stated that "[T]here was no medical finding." *Id.* at 346, 357.

27. *See id.* at 17-18, 42. Dr. Bishop was board-certified in family practice and emergency medicine. *See id.* at 40. Mr. Takewell had previously received outpatient treatment at the Morris Clinic where Dr. Bishop was a partner. However, Dr. Bishop was not Mr. Takewell's doctor, and did not recall treating him previously. *See id.* at 42.

28. *Id.* at 80, 81, 87.

After he left Methodist Hospital, Mr. Takewell walked next door and waited under a tree in front of the local pharmacy. When Ms. Hill and one of her neighbors drove past Mr. Takewell on their way to the hospital, she testified that he recognized them at "some distance" and he made a "racket" or "holler[ed] out."²⁹ Although Ms. Hill testified that she spoke with Mr. Takewell about the reason he was "discharged," and also called Methodist Hospital to inquire about the same subject, the substance of her conversations was excluded as inadmissible. Mr. Takewell was found dead the next day. Shortly after Mr. Takewell's death, Methodist Hospital and Dr. Bishop issued the following joint media statement:

On Tuesday, September 16th Terry Takewell was brought to Morris Clinic of Somerville, Tennessee by ambulance, as a means of routine transfer and in a non-emergency mode from his home in Somerville. Dr. John Bishop examined Mr. Takewell, felt that he was not in a life-threatening condition at that time and Mr. Takewell was transported via routine transfer ambulance to the Methodist Hospital of Somerville for admission and further tests.

Upon arrival at the hospital, Terry Takewell was taken directly to a patient room, not to the intensive care unit. Due to his history of being an uncooperative patient during several previous admissions and due to the fact that he left the hospital against medical advice during his last admission in July of 1986, acting administrator Tom Staton telephoned Dr. Bishop to verify the need for admission. Dr. Bishop stated that in his opinion Mr. Takewell was not in a life-threatening condition at the time he saw him.

Following the telephone conversation with Dr. Bishop, Staton went to Mr. Takewell's room and explained to him that in order to be admitted, he would be required to sign certain hospital consent forms and provide some standard information. Mr. Takewell refused. Due to Mr. Takewell's refusal to sign such standard admission forms and the fact that he was not in a life-threatening condition requiring immediate hospitalization, he was not admitted to the hospital. Had his condition been assessed as a life-threatening emergency at that time by either Dr. Bishop or the medical personnel at Methodist Hospital of Somerville, he would have been admitted.

29. *Id.* at 22, 33.

Upon leaving the hospital, Takewell was repeatedly offered transportation to any destination, including Memphis, by acting administrator Tim Staton. He refused and left on foot.³⁰

Dr. Bishop made certain modifications to the joint media statement before he approved it, and he explicitly affirmed the accuracy and completeness of the statement at the hearing before the Board.

The credibility of the witnesses supporting the "conventional" version of the legend of Mr. Takewell is also problematic — which may explain why their stories were not credited by those who actually heard it delivered. Ms. Hill had a long-outstanding bill with Methodist Hospital, which routinely turned such bills over to collection agencies. After Mr. Takewell's death, she wrote a letter to the hospital telling them they should "forget about my bill or I'm going to split the hospital right open."³¹ Ms. Hill declined to classify her letter as an attempt to blackmail the hospital.³² Similarly, although the Congressional Report and law reviews suggested that multiple witnesses had seen Mr. Takewell carried from his hospital bed by the administrator, the sole source for that statement was the testimony of Mr. Takewell's temporary roommate in the hospital, John Murphy.³³ Mr. Murphy's testimony is shot through with internal contradictions,³⁴ is flatly inconsistent with the testimony of a number of other witnesses,³⁵ and had

30. *Id.* at 80-81.

31. *Id.* at 36.

32. *See id.* at 36. (stating "I don't know whether I'd call it blackmail, but I wrote them a letter."). "You told them that you were going to lay low, but they had better not push you too far." "Right." *Id.* at 37.

33. *See EQUAL ACCESS*, *supra* note 16; Weichmann, *supra* note 2, at 162 ("[a]ccording to eyewitnesses"); Law, *supra* note 17, at 779 ("[a]ccording to eyewitnesses"); Frankford, *supra* note 17, at 90 ("[a]ccording to eyewitnesses"). *But see McClurg*, *supra* note 1, at 205 n.173 (stating that Takewell also told a neighbor when she found him).

34. For example, Mr. Takewell's body was discovered on September 17, 1987. *See Transcripts*, *supra* note 23, at Exhibit A. Mr. Murphy testified that he had learned of the death of Mr. Takewell on September 16, 1987, from a nurse who was not on duty that night. *See id.* at 122. In like fashion, Mr. Murphy could not decide whether Mr. Takewell's body was two or three inches or two or three feet from his bed, so he testified to both. *See id.* at 110. Mr. Murphy had similar difficulty deciding whether the EMT who accompanied Mr. Takewell stayed in the room for a few seconds or several minutes, so he again testified it was both. *See id.* at 116.

35. For example, Mr. Murphy testified that the ambulance driver who accompanied Mr. Takewell was Mr. Luther Scruggs, an African-American, but there was testimony that the driver was Mr. Bubba Johnson, a European-American. *See id.* at 114-15. Similarly, Mr. Murphy denied that the nurse had ever left the room to obtain a bag into which Mr. Takewell could breathe. *See*

some indications of bias.³⁶

Finally, Methodist Hospital policy was to treat and admit indigent patients in need of emergency medical attention.³⁷ Dr. Bishop testified that Methodist Hospital had never refused to admit a patient, regardless of their ability to pay, in the fifteen years he had practiced there.³⁸

The Board held two days of hearings regarding the case, and made extensive factual findings.³⁹ The Board also determined that Methodist had done nothing "detrimental" to Mr. Takewell, and had not violated any significant statutory or regulatory obligations.⁴⁰ The Board did conclude that the incident should have been reported, and it imposed a corrective action plan on Methodist Hospital.⁴¹ The Health Care Financing Administration and the Department of Health and Human Services Office of the Inspector General also determined that the treatment received by Mr. Takewell was consistent with EMTALA.

The legend of Mr. Takewell is moving and exceedingly persuasive, but it bears at best a passing resemblance to the truth.⁴² If anything, the legend of Mr. Takewell belongs in a

id. at 118-19. The nurse testified that he had done so, and his testimony was at some personal risk, since the State Department of Health included an allegation to that effect in its list of charges against Methodist Hospital. In like fashion, Mr. Murphy testified that Mr. Takewell had not gone to the bathroom, although two other witnesses testified that he had. *See id.* at 119.

36. Mr. Murphy's sister had previously worked at Methodist Hospital as a nurse. *See id.* at 123. At the time of Mr. Takewell's death, Mr. Murphy erroneously believed his sister had been laid off by the hospital. *See id.*

37. *See id.* at 208, 248.

38. *See id.* at 70-71.

39. *See Hyman, Lies, Damned Lies, supra* note 23. The findings are consistent with the joint media statement released by Methodist Hospital and Dr. Bishop. *See supra* text accompanying note 30.

40. Methodist Hospital of Somerville, Inc., Before the Tennessee Board for Licensing Health Care Facilities, Agency Case No. 86-0600, 5th Conclusion of Law (Final Order, 1987) ("By a vote of 6 to 3, the Board finds that the conduct of Methodist Hospital of Somerville was *not* detrimental to the welfare of a patient in the institution."). Similarly, the 12th Conclusion of Law held by a vote of 8 to 4, that the hospital was not guilty "of conduct or practice detrimental to the welfare of a patient." *Id.*

41. *See id.*

42. Lest there be any doubt on this point (as well as on the inaccuracy of the legend of Mr. Takewell), the statements in the Committee Report which are wrong, unsubstantiated, or deceptively incomplete have been italicized:

On September 17, 1986, a young man, Mr. Takewell, died at his home in Somerville, TN, after having been *dumped in the parking lot at Methodist Hospital in Somerville*. Mr. Takewell had been a diabetic for years and on the day before he died, neighbors found him at his home, *suffering with acute ketoacidosis*. Mrs. Zettie Mae

collection of urban legends, rather than an official report of the U.S. Congress and a half-dozen law reviews on patient dumping.⁴³ What insights can be drawn from this object lesson in the use and abuse of anecdotal evidence? For starters, even the most horrific narrative of patient dumping should be approached with considerable skepticism. Complaints about dumping invariably feature the claims of the receiving hospital and patient advocates. Those who are alleged to have engaged in dumping rarely get an opportunity to tell their side of the story. The issue of the patient's conduct never even comes up. In this setting, the evidence that is available may be the truth, but it is rarely the whole truth. Indeed, some of the most extreme cases of "patient dumping" turn out to be nothing of the sort if one actually looks at the underlying facts.⁴⁴

Hill sent Mr. Takewell by ambulance to *his doctor, who was familiar with his medical history*. The doctor ordered Mr. Takewell to go immediately to the hospital for *emergency treatment*, so Mr. Takewell proceeded by ambulance to the hospital. According to *eyewitnesses*, the acting hospital administrator appeared at Mr. Takewell's bedside, *picked him up under the arms, lifted him out of bed, and still supporting him, walked him out of the hospital to the parking lot where he left him without shirt or shoes*. Mrs. Zettie Mae Hill testified at the subcommittee hearing that *Mr. Takewell told her that he was refused care because he had no insurance and still owed the hospital for previous treatment*. Mrs. Hill confirmed this in a call to the hospital. Mr. Takewell died at his home the next day.

EQUAL ACCESS, *supra* note 16, at 11.

43. See EQUAL ACCESS, *supra* note 16; McClurg, *supra* note 1, at 205 n.173; Weichmann, *supra* note 2, at 161-62; Rothenberg, *supra* note 12, at 21; Law, *supra* note 17, at 779; Frankford, *supra* note 17, at 90; (representing true believers in the legend of Mr. Takewell in Congress and the halls of academia).

A wide array of urban legends have circulated in recent years — often on the Internet. See, e.g., Roy Furchgott, *Surfing for Satisfaction: Consumer Complaints Go On Line*, N.Y. TIMES, June 8, 1997, at 8C (noting new urban legends circulating on the web, including Neiman Marcus and the \$250 cookie recipe); Lisa Hoffman, *Nonexistent Benefit May Swamp V.A. Workers: Rumors of Life Insurance Dividend May Be Reviving After Lying Relatively Dormant for Years*, THE DALLAS MORNING NEWS, Nov. 2 1997, at 39A (describing a thirty-two year-old urban legend stating certain military veterans are entitled to a special life insurance dividend); Richard Roper, *Truth of the Matter Is, Urban Legends Die Hard*, CHI. SUN-TIMES, Oct. 8, 1997, Late Sports Final Edition, NWS, at 11 (discussing the urban legend gaining momentum on the Internet regarding settlement of a non-existent class action suit against Gerber); JAN HAROLD BRUNVAND, THE BABY TRAIN AND OTHER LUSTY URBAN LEGENDS (1993).

Articles debunking these urban legends have appeared in a wide range of publications. See Katherine Ann Samon, *The 8 Most Incredible Stories You've Ever Heard*, MCCALL'S, Sept. 1993, at 120 (explaining common urban legends and how to identify them); Alison Brooks, *Frankenstein Stalks the Urban Jungle*, NEW SCIENTIST, Jan. 23, 1993, at 47; Richard Wolkomir, *If Those Cobras Don't Get You, the Alligators Will*, SMITHSONIAN, Nov. 1992, at 167; 'So There's This Guy, See . . .', U.S. NEWS & WORLD REP. Dec. 2, 1991, at 80; Joel Best, *The Myth of the Halloween Sadist*, PSYCHOL. TODAY, Nov. 1985, at 14 (noting various urban legends).

44. For example, in *Owens v. Nacogdoches County Hospital District*, 741 F.Supp. 1269

To be sure, Mr. Takewell is only one case — but it is an important and revealing case. Representative Weiss did not lead off the hearing on EMTALA with Mr. Takewell's story by accident. Many of the anecdotes which "spontaneously" emerge in the legislative arena are carefully packaged and presented by advocacy groups as part of a systematic and ongoing effort to influence public policy.⁴⁵ Advocacy groups expend considerable resources in finding and promoting such stories.⁴⁶ Every-

(E.D. Tex. 1990), the District Court concluded that EMTALA had been violated when a physician at Memorial Hospital sent Ms. Rebecca Owens, an indigent sixteen-year-old woman with labor pains, to John Sealy Hospital in Galveston, two hundred miles away. The woman left for John Sealy Hospital, in an eleven-year-old Pinto in bad condition, "in the middle of the night" of August 3rd. *Id.* at 1274. Upon arrival at John Sealy Hospital the next morning, she was examined and told that she would not be admitted because she was not sufficiently dilated. *See id.*

A temporary restraining order was issued by the District Court, and the woman ultimately delivered a healthy child at Memorial Hospital on August 7, 1987 — a full three days after she was discharged by John Sealy Hospital. *See id.* at 1275. Memorial Hospital sought to defend its conduct, in part, on the grounds the three-day delay meant that it could not have violated EMTALA. The District Court rejected this claim and came down hard on the hospital and physician, but did not even attempt to reconcile its determination that EMTALA had been violated with John Sealy Hospital's determination that Ms. Owens was not ready to deliver and it was safe for her to return the two hundred miles to Nacogdoches using the same eleven-year-old Pinto in bad condition in which she went to Galveston. *See id.* at 1279. Either both hospitals violated EMTALA (and John Sealy's conduct was worse, since it sent Ms. Owens on the same perilous trip twelve hours further into her labor), or neither of them did.

The overlap of EMTALA with medical malpractice also allows diagnostic mistakes to be condemned as dumping. *See Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 861 (4th Cir. 1994) (affirming lower court's dumping verdict for erroneous diagnosis and treatment of uninsured septic patient, but cutting damages from \$5 million to \$1 million under Virginia's malpractice cap). In a related suit, *Power v. Alexandria Physicians Group Ltd.*, 887 F. Supp 845, 846 (E.D. Va. 1995), *aff'd*, 91 F.3d 132 (4th Cir. 1996), the Judge who had heard the original case expressly acknowledged that the plaintiff had already "recovered \$1 million for her malpractice injuries in an EMTALA suit."

45. *See generally* Tamar Lewin, *Hybrid Organization Serves as a Conductor for the Health Care Orchestra*, N.Y. TIMES, July 28, 1994, at A20. Lewin states:

Using a careful mix of statistics, hard-luck stories and staged political events, Families USA [Foundation] has played an important behind-the-scenes role in shaping public perceptions of the nation's health care problems.

...

[W]hen NBC broadcast a two-hour special on the health care debate . . . several of the people who told their stories came from the Families USA 'misery bank,' a listing of people who have had problems with health insurance. In the four years since the list was compiled, it has been used by scores of reporters looking for examples to use in their reports on health policy.

Id. *See also* Jill Lawrence, *When Studies Don't Sway, Bring on the Victims*, L.A. TIMES, July 15, 1990, at A18 (noting that compelling stories "often surface in a newspaper story, a letter to a lawmaker or a list kept by an advocacy group").

46. Advocacy groups troll for such anecdotes through a variety of mechanisms. *See In Search of Health Care Hardship Stories* (visited Oct. 8, 1997) <<http://www.familiesusa.org/favict.html>> ("Families USA Foundation is searching for compelling stories of people who have had problems with their existing insurance coverage or with loss of coverage entirely.

one involved knows what they are looking for: “the perfect victim — someone who is genuine, articulate, and sympathetic.”⁴⁷ If the “spin” sometimes overtakes the facts, most advocacy groups can doubtless convince themselves that they have committed no great sin, since they *know* they are on the side of the angels.⁴⁸

Opponents of patient dumping had every incentive to find and present their best case to Congress — and they came up with Mr. Takewell. Even if the opponents of patient dumping had presented a truthful anecdote, it does not follow that such an anecdote is typical, nor that its frequency is sufficient for the problem to justify attention.⁴⁹

Bringing to the public’s attention the urgent human cost of Congressional inaction on these issues is crucial to our ability as advocates to be persuasive and thus effective For over 10 years, Families USA has maintained a database of health care hardship stories, now numbering over a thousand The database is an ongoing project of Families USA, and so we encourage anyone with a hardship story to tell, even one outside this search, to send your name and a brief description of your problem so that we can get in touch with you for more details Stories will also be checked for accuracy, to protect the integrity of all involved.”); *The Quality Watchline* (visited Oct. 1, 1997) <<http://www.consumers.org/wline.htm>> (announcing Consumer Coalition for Quality Health Care’s toll-free phone number and e-mail address to report complaints about managed care); *The HMO Page* (visited Oct. 1, 1997) <<http://www.hmopage.org>> (announcing “Atrocity of the Month,” “Managed Care Hall of Shame,” and soliciting additional stories).

47. Lawrence, *supra* note 45, at A18.

48. See Katherine Dunn, *Fibbers: The Lies Journalists Tell*, THE NEW REPUBLIC, June 21, 1993, at 18. She states:

Of all the lies that are swallowed and regurgitated by the media, the ones that hurt the most come from the Good Guys, the grass-roots do-gooders, the social work heroes, the non-profit advocacy groups battling for peace, justice and equality.

...

.. [A] lot of reporters don’t check facts provided by non-profit organizations because they assume non-profits don’t have anything to gain by lying.

...

.. The well-meaning grow desperate for results and stoop to the tactics of their enemies. It happens all the time.

Id. These creative efforts are not limited to anecdotal evidence, but include statistical gerrymandering as well. Indeed, the “Good Guys” have made inflated claims about a host of social ills, including the number of abducted children, suicides during the holiday season, and domestic violence during and after the Super Bowl. See *id.* See also Hyman, *Lies, Damned Lies*, *supra* note 23.

49. See Richard A. Posner, *Legal Narratology*, 64 U. CHI. L. REV. 737 (1997). Posner states:

The risk of narratology to which [Catherine] MacKinnon herself succumbs in her writings on pornography is that of atypicality. MacKinnon is a magnet for the unhappy stories of prostitutes, rape victims, and pornographic models and actresses. Even if all these stories are true (though how many are exaggerated? Does MacKinnon know?), their frequency is an essential issue in deciding what if anything the law should try to do about the suffering that the stories narrate.

Id. at 744. See also Andrew P. Morriss, *Bad Data, Bad Economics, and Bad Policy: Time to Fire*

IV. THE EMPIRICAL CASE FOR EMTALA

Ms. Dame's Article in this symposium issue of *Health Matrix* favorably mentions some of the empirical studies of patient dumping and economically motivated transfers, and suggests they provide a solid non-anecdotal basis for EMTALA.⁵⁰ In an earlier article, I analyzed the published empirical studies of this area and noted several methodological difficulties and unexamined assumptions.⁵¹ For the benefit of the reader, and to sharpen the debate, I have recapitulated my analysis of the three most significant articles mentioned by Ms. Dame.

A. Highland General Study⁵²

This pilot study, published in 1984, presented data from patients transferred from private hospitals to the emergency room of a public hospital in Alameda, California during the first six months of 1981.⁵³ A total of 458 patients were transferred, 272 of whom (60%) were admitted to the hospital, and 22 of whom (5%) required intensive care.⁵⁴ The reason for transfer was not usually recorded.⁵⁵ After in-depth review of the charts of patients thought to be at high risk, the authors concluded that 33 patients (7%) were "inappropriately" transferred and received "substandard" care — and some of the transfers appeared to be economically motivated.⁵⁶

Wrongful Discharge Law, 74 TEX. L. REV. 1901, 1914 (1996):

Courts created wrongful discharge law on a foundation of anecdotes drawn from the peculiar sample of cases that reach state courts. In general, anecdotes are a poor basis for public policy The grim picture of the workplace those anecdotes paint is contradicted by the evidence that does exist about the extent of the problems employees face in the workplace.

50. Lauren Dame, *The Emergency Medical Treatment and Active Labor Act: The Anomalous Right to Health Care*, 8 HEALTH MATRIX 3 (1998).

51. Hyman, *Lies, Damned Lies*, *supra* note 23.

52. David U. Himmelstein et al., *Patient Transfers: Medical Practice as Social Triage*, 74 AM. J. PUB. HEALTH 494 (1984) (analyzing transfers to public hospital in California). Highland General Hospital is the major public acute care facility in Alameda County. *See id.* at 494-95.

53. *See id.* Although the article appeared as a "public health brief" in the *American Journal of Public Health*, it clearly proceeded from a particular political slant: the first institutional affiliation of the authors is the "Research Group of the Committee to Defend the People's Health." *See id.*

54. *See* Himmelstein, *supra* note 52, at 495.

55. *See id.* at 496.

56. The authors identified 111 charts as high-risk patients requiring in-depth review. Charts

This study is limited by a variety of factors, only some of which were noted by the authors. The study was retrospective; it determined stability based on the application of subjective criteria to data drawn from medical records prepared for a different purpose;⁵⁷ it did not include an assessment of the numbers of patients treated by private hospitals (and the cost of such treatment) when the patients were uninsured but were not transferred; it did not include an assessment of the costs imposed on Highland General by the transfers; it failed to assess the results in light of the observation that private hospitals which transferred patients to Highland General also “often admit critically ill patients and do not have policies of routinely transferring such patients;”⁵⁸ it did not evaluate whether the transferring hospital was able to provide the required care;⁵⁹ and it did not evaluate whether there were any adverse consequences of transfer.⁶⁰

for 103 patients ultimately were available. All four clinician authors had to agree that the patient was “at risk of life-threatening complications in transit or that accepted practice would require immediate therapy that was delayed by transit” in order for the incident to be classified as one involving substandard care. *Id.* at 495 (emphasis added). Of the 103 charts which were reviewed in detail, 11 indicated that the patient was transferred because of inability to pay. *See id.*

57. *See id.* at 496 (noting that the medical records which were reviewed included those of the receiving hospital, which may have biased the determination that the patient was unstable at the time of transfer).

58. *Id.*

59. The authors do note the possibility that transferring physicians may have believed that “better care was available at the public hospital” because it has a residency training program. *Id.* at 496. However, the authors discount this as an explanation because (i) local hospitals opposed the designation of Highland General as a mandatory trauma referral center; (ii) few patients with private insurance were transferred; (iii) “32 of 33 jeopardized patients came from hospitals with full emergency capabilities, including inpatient critical care facilities and specialty surgical backup available within 30 minutes;” and some specialty services were available at private hospitals but not at Highland General. *Id.*

The ability of the private hospital to provide the care should not be dismissed so lightly. Indeed, the authors provide an illustration of the problems in this area in what they label a “particularly disturbing case” — a private hospital was forced to transfer an uninsured comatose victim of a beating to Highland General after two neurosurgeons refused to see the patient. *See id.* at 495. Even post-EMTALA, physicians who are not on-call to the emergency department retain the right to choose their patients.

60. Although the authors repeatedly use inflammatory language to describe the care which was received by the transferred patients (the transfers were “dangerous,” and “imperiled,” or “jeopardized” the patient), the study expressly disavowed making any determination on whether any harm had resulted from inappropriate transfer. Given the views of the authors on the subject they were studying — one does not create a “Committee to Defend the People’s Health” (*see* Himmelstein, *supra* note 52) unless one believes that economically motivated transfers and dumping are hazardous — it is hard to avoid the conclusion the authors would have been happy to include such data had they been able to identify anyone who had been injured as a result of transfer.

B. Cook County Study⁶¹

This study, published in 1986, presented data from the 500 patients who were admitted to the medical and surgical services after they were transferred to the Cook County Hospital ED from another ED during a forty-one day period in 1983.⁶² Cook County employed a telephone protocol for accepting such transfers.⁶³ Based on the responses to the telephone protocol, the authors concluded that eighty-seven percent of the transfers were made because the patients lacked insurance.⁶⁴

The authors determined that 106 patients (24%) were transferred in an unstable condition, although not all unstable patients required treatment in an intensive care unit.⁶⁵ In some of these patients, treatment had been initiated, but "definitive treatment was usually not begun."⁶⁶ Fatalities were much higher among those who were transferred in an unstable condition (7.5%) than in a stable condition (1.5%). Transfer was associated with an average delay in definitive treatment of approximately five hours, with delays ranging from one to

61. Robert L. Schiff et al., *Transfers to a Public Hospital: A Prospective Study of 467 Patients*, 314 NEW ENG. J. MED. 552 (1986) (studying medical and surgical patients who were transferred from EDs and admitted to Cook County Hospital). Cook County Hospital was Chicago's only public general hospital. *See id.* at 552.

62. During the study period, 602 medical and surgical patients were transferred to the Cook County ED, and 500 were admitted. Out of the 500 admissions, the authors identified a study population of 484 (patients were excluded if they had been transferred from an inpatient setting rather than an ED, or if they were not transfers to the medical and surgical services). *See id.* at 553. The authors were able to locate charts for 467 of the 484 patients. *See id.*

63. *See id.* at 552. The transfer protocol required the resident at Cook County to fill out a form with the name of the patient and transferring hospital, vital signs, a brief clinical summary, and the reason for the requested transfer. Ninety-three percent of requests for transfer were accepted. Transfer was refused when the resident concluded that hospitalization was not required, the patient was not sufficiently stable to be transferred, or there was noncompliance with Cook County's transfer protocol. *See id.*

64. *See id.* at 553. Responses were only available for 243 of the study patients (52%), but the authors believed that "this subgroup was representative of the entire study sample." *Id.* at 555.

65. Stability was determined "based on review of the clinical information available in the records of the transferring hospital," and the application of an extensive list of clinical criteria. *Id.* at 553. Only 435 charts (of the 467 patient population) contained sufficient records from the transferring hospital to perform this analysis. *See id.* at 554. Although 106 patients were admitted to the intensive care unit (ICU), only 41 were classified as unstable. However, compared to the transfer population as a whole, a much higher percentage of unstable patients were admitted to the ICU (39% v. 14.6%). *See id.*

66. *Id.* at 554. Definitive treatment includes "emergency surgical procedures (e.g., exploratory surgery, repair of vessels or vital organs or both, and craniotomies), antibiotic therapy, and emergency invasive diagnostic tests." *Id.*

eighteen hours. Few of the patients had consented to the transfer, and those that had been told of the transfer were not usually advised of the reasons.⁶⁷

Like the Highland General study, the Cook County Hospital study has certain limitations. Although the study was prospective, the analysis focused on patients who were admitted to Cook County.⁶⁸ As such, the study reported an artificially high rate of unstable transfers, compared to that which would have been determined with a more inclusive denominator.⁶⁹ As with the Highland General Study, the authors did not include an assessment of the numbers of patients treated by private hospitals (and the cost of such treatment) when the patients were uninsured but were not transferred, did not assess the extent to which the transferring hospital was able to provide treatment, and the analysis of the adverse consequences of transfer (which focused solely on mortality statistics) does not address certain significant issues.⁷⁰

67. A signed informed consent for transfer was present in 25 (6%) of the charts. Thirteen percent of patients reported they had not be told of their impending transfer. Of those who were informed, 36% indicated they were not told why they were being transferred. *See id.*

68. As noted previously, 602 medical and surgical patients were transferred to the Cook County ED, but only 500 were admitted. *See id.* at 553. In addition, Cook County Hospital routinely refuses to accept transfers if the patient does not require hospitalization. *See id.* at 552.

69. The denominator for determining the 24% rate of non-stable transfers was the number of located charts for patients admitted to the medical and surgical services of Cook County Hospital in which there was sufficient information to make a determination of stability. *See id.* at 554. If one uses the total number of patients transferred to Cook County Hospital (620), the rate of non-stable transfers could be as low as 17.6%. One should also consider the extent to which Cook County Hospital's general refusal to accept transfers of patients who did not require hospitalization has an impact on the pool of transfers — and might well result in an artificial overstatement of the incidence of non-stable transfers.

70. The study did not control for severity of illness and case mix in assessing the disparity in mortality rates between stable and unstable transfers. Similarly, the fatality rates were significantly higher among unstable patients transferred to the medical service (10.9%) compared to the surgical service (3.9%) — a result the authors did not attempt to explain. *See id.* at 555. This result is particularly interesting, since surgical service patients were significantly more likely to require the use of the ICU (60.8% v. 18.2% unstable; 16.5% v. 6.5% stable) than medical service patients. *See id.*

The authors suggest that lower mortality rates for surgical patients may be attributable to the preponderance of trauma in that population, since the most severely injured patients may have died before transfer — a plausible interpretation, but one that is unsupported by any data. The authors do observe that the higher mortality rates among transferred patients on the medical service may be due to differences in case mix or some aspect of the transfer process — but as with the surgical service, there is no basis in the data to assess the matter. *See id.* *See also* J. Douglas White, *Transfers to a Public Hospital*, 315 *NEW. ENG. J. MED.* 1421 (1986) (arguing that it is inappropriate to compare transferred and non-transferred patient populations); Jerrold B. Leiken & Kenneth S. Polin, *Transfers to a Public Hospital*, 315 *NEW. ENG. J. MED.* 1421 (1986) (same).

Finally, members of the Department of Surgery and the Section of Trauma at Cook County Hospital disagreed with the conclusions of the Cook County study.⁷¹ Since surgical patients accounted for a majority of those transferred to Cook County, their views should be accorded considerable weight. These commentators argued that the capabilities of the transferring hospital needed to be taken into account, and that transfer in an unstable condition was not necessarily indicative of inappropriate care, since "many patients with trauma or other emergency surgical conditions can never be stabilized in the primary hospital, and they therefore must be transferred to Cook County Hospital in an unstable condition."⁷² In addition, these authors correctly noted that transfer of stable patients requiring medical care was consistent with the "stated mission of Cook County Hospital . . . to render treatment to the medically indigent in our community."⁷³

C. Cook County II⁷⁴

In 1987, the first two authors of the Cook County Study published a "Special Communication" on dumping.⁷⁵ The article contained no empirical data but included the author's estimate that 250,000 patients a year are dumped — a figure that has attained the status of gospel through repetition in law reviews, Congressional hearings, newspaper articles, and medical literature.⁷⁶

71. John Barrett & Olga Jonasson, *Transfers to a Public Hospital*, 315 NEW ENG. J. MED. 1421 (1986).

72. *Id.*

73. *See id.*

74. David A. Ansell & Robert L. Schiff, *Patient Dumping: Status, Implications, and Policy Recommendations*, 257 JAMA 1500 (1987).

75. *See Schiff, supra* note 61.

76. *See Ansell & Schiff, supra* note 74, at 1500. For examples of the use of this figure, see U.S. *Termed Lax on 'Dumping' Patients*, N.Y. TIMES, Apr. 24, 1991, at A20 (stating that "[i]n 1987, a study published in *The Journal of the American Medical Association* estimated that 250,000 patients nationwide were "dumped" each year from hospital emergency rooms because they could not pay for their care or were on Medicaid"); Rochelle E. Moore, *Transfer Center Can Control, Manage Admissions*, HEALTHCARE FIN. MGMT., Sept. 1990, at 40 ("Despite the law, hospitals wrongly transfer an estimated 250,000 patients each year."). *Hospital's Handling of Uninsured Patients Faulted*, N.Y. TIMES, Mar. 30, 1988, at A25 (noting publication of a House Committee on Government Operations Report, which "said that more than 250,000 patients are dumped yearly"). Howard S. Berliner, *Patient Dumping: No One Wins and We All Lose*, 78 AM. J. PUB. HEALTH 1279, 1279 (1988) (repeating estimate elicited at Congressional hearing).

The claim that 250,000 patients a year are dumped is impressive, but is based on generalizing from a skewed sample while simultaneously using an overbroad definition. The authors arrived at this figure by extrapolating from studies conducted in Dallas, Oakland, and Chicago to “estimate” a total for nationwide patient dumping.⁷⁷ Each of these areas encompasses large urban populations with substantial numbers of indigent and uninsured individuals. Even taken in the aggregate, the sample is by no means representative of the country as a whole. Accordingly, a straightforward extrapolation based on population — which is what the authors did — is inappropriate.

The definition of “dumping” employed by the authors — “the denial of or limitation in the provision of medical services to a patient for economic reasons and the referral of that patient elsewhere” — is also overbroad.⁷⁸ This definition encompasses emergency, urgent, and non-urgent services for both stable and unstable patients. In essence, this definition would require all hospitals to provide all necessary services to all comers, regardless of whether the patient is stable or not, and regardless of the patient’s ability to pay (or to obtain cheaper services elsewhere, as in a managed care arrangement). EMTALA, for all its breadth, is facially limited to restrictions on the transfer of unstable patients.

D. Summary of Empirical Studies

Flawed as they are, these studies still make clear that the transfer of “unstable” patients is exceedingly uncommon. Two hundred and fifty thousand patient dumping episodes a year certainly sounds like a lot, but it is only 0.25% of the 100 million visits to EDs in 1995.⁷⁹ Correcting for the distortions in the studies (*i.e.*, overbroad definition of dumping, skewed

77. See Ansell & Schiff, *supra* note 74, at 1502.

78. *Id.* at 1500. It is unclear whether the authors, in fact, are limiting themselves to this broad definition, since they note that a patient may be dumped for exhibiting “undesirable” conditions, such as intoxication or overdose conditions. See *id.* Obviously, such patients may still be insured.

79. See AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS: EMERGING TRENDS IN HOSPITALS (1996-97) (data regarding total outpatient visits to emergency rooms compiled from the 1995 Annual Survey of Hospitals).

sample) can easily shrink the estimated frequency one-hundred-fold or more.

In these and other studies, the extent to which harm resulted from such transfers also turns out to be a hard thing to assess; although most transfers resulted in a delay in definitive treatment and increased costs for repeated tests, some patients received better care as a result of being transferred. The studies which examined the financial implications of such transfers invariably demonstrated significant financial impact on the hospitals which received such transfers, but the impact would be equally significant on the transferring hospitals, were they not allowed to transfer such patients. None of the studies attempted to measure the relative significance of charity care provided by private hospitals for patients they did not transfer. Thus, the empirical studies — including those cited by Ms. Dame — provide at best an uncontrolled snapshot of the numerator, but little insight into the denominator — and simply fail to support the claim that patient dumping is a generalized problem.

In the absence of useful empirical data, Congress acted on the basis of isolated and unrepresentative anecdotes. These anecdotes may have been sufficient to persuade Congress, but such an approach is asking for trouble — even without the difficulties highlighted by the legend of Mr. Takewell. Despite the tendency of Congress to believe otherwise, “[t]he plural of *anecdote* is not *data*.”⁸⁰

V. THE FUTURE OF EMTALA

When EMTALA was enacted, the hospital was the center of the health care universe. Indemnity insurance dominated the health insurance market. Medicare had implemented the prospective payment system, but cost-containment had not really had a major impact on hospitals. In the intervening eleven years, the hospital has been largely supplanted by outpatient treatment, and managed care has become the dominant form of health care insurance and delivery. Capitation and heavily

80. Edith Greene, *A Love Hate Relationship*, 18 JUST. SYS. J. 99, 100 (1995) (emphasis original).

discounted fee-for-service arrangements have become standard. Lengths of stay and rates of hospitalization have dropped precipitously. Hospitals have closed, merged, and downsized. Hospital finances have become increasingly tenuous, especially for "safety-net" hospitals.⁸¹

These pressures have had a disproportionate impact on care provided in the ED. Emergency Departments disproportionately serve patients covered by Medicaid and the uninsured. They often lose money, or make money on only a small percentage of well-insured individuals. These economic pressures have made it increasingly difficult for many hospitals to sustain ED services. In addition, managed care intentionally targeted care provided in the ED. Emergency Department charges are expensive. Those who present to the ED often do not require care in that setting, whether one judges prospectively or retrospectively. The philosophy of managed care is also based on continuity of care — an ideal which is routinely sacrificed when the ED is the locus of care. Finally, presentation at the ED can trigger a "clinical cascade," where the "better safe than sorry/cost is no object" default rule can result in substantial expenses when more cost-effective options are available.

Managed Care Organizations (MCOs) sought to limit ED utilization by using such mechanisms as mandatory preauthorization, restrictive coverage, selective contracting, high copayments and deductibles, and aggressive coverage denials.⁸² The results were pronounced; as managed care targeted ED utilization, patient visits to the ED declined in 1994 for the first time in twenty-two years, and again in 1995, de-

81. See Raymond J. Baxter & Robert E. Mechanic, *The Status of Local Health Care Safety Nets*, 16 HEALTH AFF. 7 (1997) (cataloguing deteriorating financial stability of safety-net institutions).

82. See David A. Hyman, *Consumer Protection (?), Managed Care, and the Emergency Department*, in ACHIEVING QUALITY IN MANAGED CARE: THE ROLE OF LAW 57 (John D. Blum ed., 1997) [hereinafter *Consumer Protection*] (analyzing how consumer protection laws interact with the cost-cutting efforts of MCOs); Diane E. Hoffman, *Emergency Care and Managed Care - A Dangerous Combination*, 72 WASH. L. REV. 315 (1997) (criticizing MCOs for being unduly restrictive regarding coverage of emergency medical treatment); Harry Davidson Kerr, *Access to Emergency Departments: A Survey of HMO Policies*, 18 ANNALS EMERGENCY MED. 274 (1989) (describing how HMOs control the costs of ED visits). Cf. Robert Pear, *H.M.O.'s Refusing Emergency Claims, Hospitals Assert*, N.Y. TIMES, July 9, 1995, at A1 (discussing how HMOs are allegedly shifting ED costs to hospitals, physicians, and patients through coverage decisions).

spite steady increases in the number of the uninsured. Nationwide, average ED utilization is approximately 360 visits/1000 people per year (with significant regional variation), but tightly controlled MCOs have decreased these figures significantly.

The growth of managed care created problems for hospitals in two directions — from the insured patients who no longer showed up, and (paradoxically enough) from the insured patients who did show up. The former problem was caused by the simple fact that EDs (and to a lesser extent hospitals) made most of their money from a small percentage of their customers — those with “good” insurance.⁸³ The “disappearance” of these patients placed a severe crimp in the revenue stream of many EDs.

The other difficulty arose from the opposite direction. MCOs had market power and used it to extract substantial discounts. Thus, even if a visit to the ED was “authorized,” the hospital received less revenue per paid ED encounter, further constraining the revenue stream. The final blow came from insured patients whose care was not “authorized.” As noted previously, MCOs used a variety of tools to restrict access to emergency care — and refused to pay for care that was not provided in accordance with its requirements. EMTALA may have obligated the hospital to screen and treat, but MCOs were under no compulsion to pay for such efforts. Worse still, EMTALA explicitly treated any attempt to secure pre-authorization as a violation, while MCOs were free to deny coverage if contractually required pre-authorization was not sought. Thus, EMTALA effectively left hospitals at the mercy of free-riding MCOs — and left both at the mercy of free-riding patients.

Hospitals now face the worst of all possible worlds in the ED: a declining relative and absolute volume of insured patients; those who are insured pay less; and those who are insured sometimes do not pay at all. The bad news is not limited

83. See, e.g., Olson, *supra* note 17, at 458:

Patient classes made highly unequal contributions to the profit picture. The hospital profited substantially by treating a few payor groups and lost nearly as much treating all other payor groups. Six payor categories generated positive revenues . . . [but two payor classes, totalling 33% of visits and 26% of expenses] contributed 90 percent of profits.

to the ED — the rest of the hospital faces similar difficulties.

Given these changes in the health care marketplace, the future prospects for EMTALA are exceedingly poor. Uncompensated care is financed by a complex web of cross-subsidies under the best of circumstances. The first rule of any system of cross-subsidies is that one needs a steady volume of cross-subsidizers, even if the rate of cross-subsidizees is flat. The growth of managed care and the increase in the number of uninsured has destabilized both sides of the equation. Even with the best of intentions, both ends of a see-saw can not be up at the same time.⁸⁴

EMTALA may make a federal case out of any failure to provide necessary care, but there are no free lunches — even in the ED. The predictable long-term consequence of EMTALA is a system-wide loss in ED capacity as hospitals close, downsize, or relocate, and physicians modify the nature of their relationships with EDs and hospitals. To be sure, there was excess capacity to begin with, and EMTALA is only one of a number of causes of the constriction in supply. However, the perversity of EMTALA is that, to a considerable extent, its costs are imposed on the hospitals and physicians who were already doing their part for those EMTALA was intended to help. Except in the (exceedingly) short-run, EMTALA can not increase ED capacity — and it has a distinct tendency to destroy it.

VI. CONCLUSION

The “‘dumping dilemma’ easily lends itself to anecdotal horror stories.”⁸⁵ However, “horror stories” are not necessarily reliable. Mr. Takewell’s case presents a particularly unflattering

84. In response to these difficulties, the American College of Emergency Physicians has sought legislation to force MCOs to pay for EMTALA-mandated screening and treatment. See Hyman, *Consumer Protection*, *supra* note 82; Hoffmann, *supra* note 82, at 368-93. Their efforts have met with some success, although most of the pending and enacted legislation has instead focused on whether a “prudent layperson” would have gone to the ED. Although this “solution” has some surface plausibility, at best it is an inadequate response to a problem created, to a first approximation, by EMTALA.

85. William Gary Reed et al., *The Effect of a Public Hospital’s Transfer Policy on Patient Care*, 315 NEW. ENG. J. MED. 1428, 1429 (1986) (footnote omitted) (quoting E. Friedman, *The Dumping Dilemma: The Poor are Always With Some of Us*, HOSP., Sept. 1, 1982, at 51).

example of “anecdotal advocacy,” and leaves little doubt why such evidence is shunned or “heavily discounted” in most fields.⁸⁶

To be sure, disproving an anecdote might seem no great accomplishment. Yet, if evidence of this caliber persuaded Congress to enact EMTALA, it is certainly fair to ask whether a fuller record should cause Congress to reconsider. Those who live by the anecdotal sword should be prepared to die by it. More importantly, reliance on anecdotes is intellectually sloppy. It is the mine run of cases we should care about — not the occasional anecdotal bad outcome.⁸⁷ It should take more than a few bad anecdotes to persuade Congress to take over an entire market — unless it is prepared to do so across the board, beginning with the legal profession.⁸⁸ Of course, one could just ignore these considerations and legislate — but in that direction lies EMTALA and other ineptly drafted, tunnel-visioned, short-sighted, and counterproductive laws. When it comes to EMTALA, the past is decidedly imperfect.

And what of the future? Although the United States is a land of optimists, EMTALA’s prospects are decidedly grim.⁸⁹

86. See Saks, *supra* note 14, at 1159. Of course, statistical evidence can be problematic as well — especially when it is “discovered” or promoted by those with an axe to grind. Cf. Dunn, *supra* note 48, and Hyman, *supra* note 23.

87. EMTALA’s enthusiasts understand this point perfectly well — and exploit it to considerable effect in opposing “reforms” they do not like. Compare Statement of Joan Claybrook, President, Public Citizen, Hearing on Product Liability Reform, House of Representatives Committee on the Judiciary, April 10, 1997 (visited Oct. 9, 1997) <<http://www.citizen.org/congress/civjus/jctest.html>> (opposing product liability reform on the ground that case in favor of such reform is based on “junk statistics . . . myths, and unrepresentative anecdotes”) with LAUREN DAME & SIDNEY M. WOLFE, PUBLIC CITIZEN’S HEALTH RESEARCH GROUP, UPDATE ON PATIENT DUMPING IN HOSPITAL EMERGENCY ROOMS (Mar. 1996); JOAN STIEBER & SIDNEY M. WOLFE, PUBLIC CITIZEN’S HEALTH RESEARCH GROUP, UPDATE ON PATIENT DUMPING VIOLATIONS (Oct. 1994).

88. See Hyman, *Kindness of Strangers*, *supra* note 3 (applying EMTALA’s model to other markets, including law); Tony Snow, *Clintoncare is Dead, But Don’t Tell NBC*, DENV. POST, June 24, 1994, at B7 (noting that town meeting on health care reform featured “tales of woe . . . Michael Thompson, who runs a small marketing company in Springfield, Va., complained about the technique of using tear-jerker anecdotes as a way to introduce stories. ‘If we’re going to set policy by horror stories,’ he said, ‘we ought to nationalize lawyers, since everybody has a horror story about lawyers.’”).

89. Certainly, one could not end up with a health care “system” like ours without being optimistic about human nature and the likely level of charity care. Those who need a more classical reference should consult ALEXIS DE TOCQUEVILLE, DEMOCRACY IN AMERICA 453 (George Lawrence trans., 1969) (noting American belief in “an ideal but always fugitive perfection”). For those who prefer literature, see F. SCOTT FITZGERALD, THE GREAT GATSBY 182 (1925):

Changes in the medical marketplace have virtually eliminated the cross-subsidies with which hospitals have historically financed uncompensated care. In addition, most managed care plans have imposed wide-ranging restrictions on access to the ED. If the touchstone for EMTALA was that everyone should have access to the ED because the insured do, these restrictions undercut the moral case for EMTALA.⁹⁰ Indeed, EMTALA effectively pegs the level of emergency care above the amount people are willing to pay for — and imposes it to a first approximation on the hospitals which are least capable of spreading the cost. This “solution” is a recipe for disaster. Only two things have kept the system from a complete meltdown: the increasingly strained efforts of the Courts to maintain a distinction between EMTALA and state malpractice law,⁹¹ and HCFA’s *sub silentio* acknowledgement that EMTALA is a symbolic law.⁹²

Gatsby believed in the green light, the orgastic future that year by year recedes before us. It eluded us then, but that’s no matter-tomorrow we will run faster, stretch out our arms farther And one fine morning -

So we beat on, boats against the current, borne back ceaselessly into the past.

90. See Hyman, *Consumer Protection*, *supra* note 82. But see Hoffmann, *supra* note 82, at 349-51 (arguing that various market imperfections and externalities prevent Americans from purchasing the level of emergency care coverage they want and/or need).

91. See *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996) (en banc reversal of panel decision breaching wall between EMTALA and state malpractice claims). See also *Power v. Alexandria Physicians Group Ltd.*, 887 F. Supp. 845, 852-53 (E.D. Va. 1995) (patient successfully used an EMTALA suit to recover for medical malpractice), *aff’d*, 91 F.3d 132 (4th Cir. 1996).

92. See John P. Dwyer, *The Pathology of Symbolic Legislation*, 17 *ECOLOGY L.Q.* 233 (1990). He states:

Most regulatory statutes instruct agencies to balance competing concerns in setting standards. Some regulatory statutes, however, impose short deadlines and stringent standard-setting criteria that are designed to address a single, overriding concern to the exclusion of other factors

The programs mandated by such legislation are more symbolic than functional. Frequently, the legislature has failed to address the administrative and political constraints that will block implementation of the statute. By enacting this type of statute, legislators reap the political benefit of voting . . . against ‘trading lives for dollars,’ and successfully sidestep the difficult policy choices

. . . .
Believing that it would be irresponsible and politically mad to interpret and implement symbolic statutory provisions literally, the agency’s usual response is to resist implementation.

Id. at 233-34. Professor Mark Hall characterized EMTALA as a symbolic act in Hall, *supra* note 2, at 397. For more on EMTALA as symbolic law, see Hyman, *Bad Laws*, *supra* note 3.

Symbolic laws are hard to change — let alone repeal.⁹³ However, even symbolic laws are subject to the laws of economics. EMTALA will be repealed — although whether the repeal will be *de jure* or *de facto* remains to be seen. It is appropriate that we celebrate EMTALA's tenth (actually eleventh) anniversary, since there will not be many more such occasions.

93. See Dwyer, *supra* note 92, at 287 (“Once Congress has taken the position that public health must be protected at any cost, it is difficult for the legislature to adopt a more moderate position. Position-taking by other legislators and charges of trading lives for dollars will deter many legislators from supporting such amendments.”).

The firefight between the Administration and the 104th Congress over amending the nation's environmental laws to explicitly incorporate consideration of costs and benefits demonstrates the likely difficulties. See John H. Cushman, Jr. & Timothy Egan, *Battles on Conservation are Reaping Dividends*, N.Y. TIMES, July 31, 1996, at A1:

When Republicans won control in 1994, they aggressively pressed forward with an antiregulatory agenda that environmentalists saw as threatening to dismantle a whole generation of rules that not only preserved open spaces and wilderness areas, but also put protection of the public's health and safety above other considerations, including economic ones.

An intense battle over how to reshape environmental regulations ensued, with the Administration presenting its own, moderate ideas but essentially playing a defensive game and labeling the Republicans as tools of industrial special interests. The fight made every issue, including cleaning up toxic wastes or chopping down ancient forests, a matter of pitched partisan politics.

However, the same Congress successfully enacted the Food Quality Protection Act, H.R. 1627, 104th Cong., 2d Sess. (1996), which repealed the Delaney Clause. See Richard Lugar, *The Food Quality Protection Act Balances Food Safety with Agricultural Productivity and Updates the Delaney Clause*, ROLL CALL, June 10, 1996 (reforming the Delaney Clause from “zero tolerance” to more reasonable standard through the Food Quality Protection Act); Rick Weiss, *Clinton Signs New Standards on Food Safety; President Also Ratifies Gambling Commission*, WASH. POST, Aug. 4, 1996, at A21 (describing the Food Quality Protection Act as replacing the Delaney Clause with the “reasonable certainty of no harm” standard); Margaret Kriz, *A Peace Treaty Over the Delaney Clause*, 28 NAT'L J. 31, 1642 (1996) (discussing the eventual capitulation of both political parties to changing the Delaney Clause); Gary Lee, *In Food Safety Changes, Victories for Many*, WASH. POST, July 28, 1996, at A4 (replacing the Delaney Clause with the “reasonable certainty of no harm” standard pleases many groups). The Delaney Clause, which prohibited pesticides posing a non-zero risk of cancer, was every bit as symbolic as EMTALA.