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*Power v. Arlington Hospital*¹: A Federal Court End Run Around State Malpractice Limitations

I. INTRODUCTION

When asked about escalating health care costs, President George Bush responded:

She asked the question, I think, is whether - if [the] health care profession was to blame, no. One thing to blame is these malpractice lawsuits, they're breaking the system. It costs twenty to twenty-five billion dollars a year and I want to see those outrageous claims capped.²

The increasing costs of medical treatment and the lack of access of some of the population to adequate medical care have captured the mind of the public. Despite the current rhetoric, steps have been taken on both the federal and state level to help improve the medical system.

Many states have enacted medical malpractice award limitations or personal injury damages award limitations.³ These

1. 800 F. Supp. 1384 (E.D. Va. 1992).

2. President George Bush, Presidential Debate, October 15, 1992, CNN Transcripts.

3. The following twenty-two states have enacted statutory caps on awards: ALASKA STAT. § 09.17.010 (1992) (\$500,000 limit for noneconomic damages in personal injury actions, not including disfigurement or severe physical impairment); CAL. CIV. CODE § 3333.2 (West 1993) (\$250,000 limit for noneconomic damages in medical malpractice cases); COLO. REV. STAT. § 13-21-102.5 (1992) (\$250,000 limit for noneconomic damages generally, \$500,000 limit for noneconomic damages where there is clear and convincing evidence which justifies such a finding by the court); IDAHO CODE § 6-1603 (1992) (\$400,000 limit for noneconomic damages in personal injury action); 735 ILL. COMP. STAT. ANN. 5/2-1115 (Smith-Hurd 1992) (no punitive damages allowed in medical malpractice cases); IND. CODE ANN. § 16-9.5-2-2 (Burns 1992) (\$750,000 limit on all damages recoverable for injuries in a medical malpractice action); KAN. STAT. ANN. § 60-340 (1986) (\$250,000 limit on noneconomic damages in medical malpractice cases); LA. REV. STAT. ANN. § 40:1299.39.F (West 1992) (\$500,000 limit on all damages except medical expenses); MD. CTS. & JUD. PROC. CODE ANN. § 11-108 (1992) (\$350,000 limit on noneconomic damages in any action for personal injury); MASS. GEN. LAWS ANN. ch. 231, § 60H (West 1992) (\$500,000 limit for noneconomic damages in medical malpractice actions, not including wrongful death actions); MICH. COMP. LAWS § 600.1583 (1986) (\$225,000 limit for noneconomic damages in medical malpractice cases); MO. ANN. STAT. § 538.210 (Vernon 1992) (\$350,000 limit for noneconomic damages in medical malpractice cases); NEB. REV. STAT. § 44-2825 (1992) (\$1,250,000 limit on all damages in medical malpractice cases); N.H. REV. STAT.

statutes are designed in part to reduce the cost and increase the availability of malpractice insurance for doctors.⁴ The lower costs for doctors are to be passed on to the consumer in the form of lower medical bills and lower costs for health insurance.

While states were attacking the medical crisis by limiting damages, Congress was approaching the crisis from another direction. Congress was taking action to force hospitals to provide care for those who could not afford it. Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA) to force Medicare-participating hospitals to treat indigent patients, thereby producing better care for those who cannot afford to pay for treatment.⁵

In theory, these two separate approaches should act together to improve the health care system in the United States. However, EMTALA and the state statutes have come into conflict with each other. The United States District Court for Vir-

ANN. § 508:4-d (1986) (\$875,000 limit on noneconomic damages for personal injury cases); N.M. STAT. ANN. § 41-5-6 (Michie 1992) (\$500,000 limit on punitive damages in medical malpractice action); OR. REV. STAT. § 18.560(1) (1992) (\$500,000 limit on damages arising from bodily injury); S.D. CODIFIED LAWS ANN. § 21-3-11 (1992) (\$1,000,000 limit for all damages in medical malpractice cases); UTAH CODE ANN. § 78-14-7.1 (1987) (\$250,000 limit on noneconomic damages in medical malpractice cases); VA. CODE ANN. § 8.01-581.15 (Michie 1992) (\$1,000,000 limit for all damages in medical malpractice cases); W. VA. CODE § 55-7B-8 (1992) (\$1,000,000 for noneconomic loss in medical malpractice cases); WIS. STAT. ANN. § 893.55(4)(d) (West 1992) (\$1,000,000 limit for noneconomic damages in medical malpractice cases); WYO. STAT. § 1-4-101 (1992) (damages for personal injury limited to that recoverable under the wrongful death act).

In addition to those states above, the following three states previously had caps: HAW. REV. STAT. §§ 663-8.5, -8.7 (1991) (\$375,000 limit for pain and suffering, distinguished from other noneconomic damages of mental anguish, disfigurement, loss of enjoyment of life, loss of consortium, and other pecuniary losses or claims) (legislation repealed effective Oct. 1, 1993); MINN. STAT. § 549.23 (1993) (\$400,000 limit on embarrassment, emotional distress, and loss of consortium) (legislation repealed effective May, 4 1990); WASH. REV. CODE ANN. § 4.56.250 (West 1992) (\$1,000,000 variable cap on noneconomic damages for personal injury cases) (legislation declared unconstitutional in *Sofie v. Fibreboard Corp.*, 771 P.2d 711 (Wash. 1989)). *Cf.* Thomas R. Ruge, *Medical Malpractice*, 22 IND. L. REV. 535, 549 n.75 (1989) (listing nineteen states as having enacted statutory caps on awards).

4. See, e.g., REPORT OF THE JOINT SUBCOMMITTEE STUDYING THE LIABILITY INSURANCE CRISIS AND THE NEED FOR TORT REFORM TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA OF 1987, S. Doc. No. 11 at 12-13 (1987), discussed in Sandra J. Morris, Comment, *Will Tort Reform Combat the Medical Malpractice Insurance Availability and Affordability Problems That Virginia's Physicians Are Facing?*, 44 WASH. & LEE L. REV. 1463, 1463 nn.1-3 (1987).

5. EMTALA was passed as part of the Consolidated Omnibus Reconciliation Act (COBRA) of 1986, Pub. L. No. 99-272, § 9121 (codified as amended at 42 U.S.C. § 1395dd (1988) (effective August 1, 1986)).

ginia recently ruled on a motion to apply a state medical malpractice damages award cap to an EMTALA claim in *Power v. Arlington Hospital*.⁶ The defendants wanted the limits to apply to the action, thereby limiting the potential damages they would have to pay. The court held that the state malpractice cap did not apply to the EMTALA action, effectively circumventing the state malpractice damage limitations.⁷ The *Power* court is apparently the first court in an EMTALA action to allow a plaintiff to recover more than the state malpractice damage caps.

This note will explore the conflicts between EMTALA and the state statute involved in *Power* and the issues involved in applying EMTALA in jurisdictions with medical malpractice award damages caps. Section II will give background information about medical malpractice limitations and EMTALA. Section III will provide a factual summary of the case. Section IV will cover the court's reasoning. Section V will analyze the decision in light of other developments in the judiciary's interpretation of EMTALA.

II. BACKGROUND

A. Medical Malpractice Legislation

In 1992, the estimated \$800 billion in health care spent in the United States accounted for 14% of the Gross National Product; in contrast, only 5.9% of the GNP was spent on health care in 1965.⁸ High medical malpractice awards are blamed by some for the current medical cost boom.⁹

One of every five physicians is subject to a medical malpractice suit each year.¹⁰ A recent Harvard study found that although 80% of all medical malpractice suits filed show no evidence of malpractice, fifteen of every sixteen persons actual-

6. 800 F. Supp. 1384 (E.D. Va. 1992).

7. *Id.* at 1397-98.

8. Pete V. Domenici, *Yes: A Prime Factor. (Health Care Reform: Should Curbing Medical Malpractice Litigation Be Part of the Solution?)*, A.B.A. J., Aug. 1992, at 42 [hereinafter Domenici].

9. *Id.*

10. *Malpractice Suits: Doctors Under Siege*, NEWSWEEK, Jan. 26, 1987, at 62.

ly injured due to a doctor's negligence are never compensated.¹¹

In 1985, physicians' malpractice premiums were 2% of all property and casualty premiums written, but accounted for 5% of all underwriting losses.¹² Because of the losses, insurance companies suffered. They began restricting insurance availability, thereby making it difficult for health care providers to get insurance.¹³

Some states reacted to this problem by enacting statutes designed to reform the malpractice tort system. Many states enacted statutes that limit medical malpractice damages.¹⁴ The effectiveness of these statutes is currently an issue of debate.¹⁵ Virginia enacted a statute that both established a review board to screen malpractice claims before they were brought before the court¹⁶ and limited the amount of punitive damages that could be awarded in a malpractice case.¹⁷

11. Domenici, *supra* note 7, at 42.

12. *Malpractice Suits: Doctors Under Siege*, *supra* note 10, at 62.

13. See, e.g., Sandra J. Morris, Comment, *Will Tort Reform Combat the Medical Malpractice Insurance Availability and Affordability Problems That Virginia's Physicians are Facing?*, 44 WASH. & LEE L. REV. 1463, 1463 nn.2-3 (1987) (discussing problems of Virginia physicians trying to obtaining insurance).

14. See *supra* note 2. Eleven states which have enacted statutes specifically designed to limit malpractice awards: California, Indiana, Kansas, Massachusetts, Michigan, Missouri, Nebraska, South Dakota, Utah, West Virginia and Wisconsin. The statutes and section numbers are listed in note 2.

15. Full discussion of the effectiveness of tort reform legislation, and the debate that rages concerning tort reform, is beyond the scope of this article. See Margaret Cronin Fisk, *Reform Measures Made Little Impact*, NAT'L L.J., Nov. 16, 1992, at 33 (discussing Indiana malpractice caps which reduced the insurance premium for doctors but increased malpractice award amounts); Pete V. Domenici & William W. Falsgraf, *Health Care Reform: Should Curbing Medical Malpractice Litigation be Part of the Solution?*, A.B.A. J., Aug. 1992 at 42-43 (Mr. Domenici writing in favor of curbing medical malpractice litigation and Mr. Falsgraf writing against limitations).

16. "The claimant or health care provider may within sixty days of [notification of a malpractice action] file a written request for a review by a medical malpractice review panel established as provided in § 8.01-581.3." VA. CODE ANN. § 8.01-581.2 (1992).

17. The Virginia malpractice limitation statutes states:

In any verdict returned against a health care provider in an action for malpractice where the act or acts of malpractice occurred on or after October 1, 1983, which is tried by a jury or in any judgment entered against a health care provider in such an action which is tried without a jury, the total amount recoverable for any injury to, or death of, a patient shall not exceed one million dollars.

VA. CODE ANN. § 8.01-581.15 (Michie 1992).

B. EMTALA

1. History

In 1987, it was estimated that annually 250,000 emergency patients were transferred or discharged from health care facilities because of inability to pay for medical services.¹⁸ The practice came to be known as "patient dumping" and caused significant increases in complications and mortality among the transferred patients.¹⁹ In 1986, as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA), Congress enacted EMTALA.²⁰

EMTALA requires hospitals participating in Medicare to fulfill two obligations to patients entering the emergency room. First, the hospital must provide "an appropriate medical screening examination"²¹ to determine whether or not an "emergency medical condition"²² exists. Second, the hospital may not transfer an individual with an emergency medical condition until that condition has been stabilized.²³

18. Christine A. Fedas, *Emergency Treatment Act: A Federal Response to Patient Dumping*, 76 MASS. L. REV. 110 (1991) (citing Ansell & Schiff, *Patient Dumping: Status, Implications, and Policy Recommendations*, 257 JAMA 1500 (March 20, 1987)).

19. Ansell & Schiff, *supra* note 18, at 1500-01.

20. See *supra* note 4. The act was amended in 1989, to make the act applicable to more transfers, as part of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6211 (codified as amended at 42 U.S.C.A. § 1395dd (Supp. 1990) (effective July 1, 1990)).

21. 42 U.S.C. § 1395dd(a) (1988).

22. Section 1395dd states:

The term "emergency medical condition" means — (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could result in — (i) placing the health of the individual in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part

42 U.S.C. § 1395dd(e)(1) (1988).

23. 42 U.S.C. § 1395dd(c) (1988). "The term 'stabilized' means, with respect to an emergency medical condition described in paragraph (1)(A), 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. § 1395dd(e)(3)(B).

The legislative history of the Act indicates that the intent of the legislation was to respond to the "dumping" of indigent patients who had no insurance.²⁴ The Act applies to any Medicare-participating institution²⁵ that has a "hospital emergency department."²⁶ The Act explicitly refuses to "preempt any state or local law requirement, except to the extent that the requirement directly conflicts with a requirement of [EMTALA]."²⁷

2. *Enforcement provisions*

The statute creates a federal private cause of action to enforce the hospital obligations outlined above. The relevant section reads as follows:

(2) Civil Enforcement. (A) Personal Harm. Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.²⁸

3. *Court interpretations*

Consensus regarding the meaning of the terms of EMTALA has not been reached. Some courts have construed EMTALA to include the substantive provisions of state law, but not the procedural or jurisdictional limitations.²⁹ Some courts have interpreted EMTALA to extend not just to indigent patients, but to anyone who seeks care in a Medicare-participating emergency room.³⁰

24. See generally H.R. Rep. No. 241, 99th Cong., 2d Sess. 27, reprinted in 1986 U.S.C.C.A.N. 42, 605-06; *Owens v. Nacogdoches County Hosp. Dist.*, 741 F. Supp. 1269, 1271-72 (E.D. Tex. 1990) (outlining reasons for enactment and providing further documentation).

25. 42 U.S.C. § 1395dd(e)(2).

26. 42 U.S.C. § 1395dd(a).

27. 42 U.S.C. § 1395dd(f).

28. 42 U.S.C. § 1395dd(2)(A).

29. *Reid v. Indianapolis Osteopathic Medical Hosp.*, 709 F. Supp. 853, 855-56 (S.D. Ind. 1989).

30. See *Brooker v. Desert Hosp. Corp.*, 947 F.2d 412, 415 (9th Cir. 1991); *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990); *Deberry v. Sherman Hosp. Ass'n*, 741 F. Supp. 1302 (N.D. Ill. 1990). But see *Evit v. University Heights Hosp.*, 727 F. Supp. 495 (S.D. Ind. 1989); *Stewart v. Myrick*, 731

The legislative history of the Act indicates a concern for indigent patients. Since the Act does not explicitly require indigency, however, some courts apply the Act to all persons entering the emergency room.³¹ The statute itself states, "[i]n the case of a hospital that has a hospital emergency department, if any individual (*whether or not eligible for benefits under this subchapter*) comes to the emergency department . . . the hospital must provide for an appropriate screening examination."³² The lack of explicit congressional guidance allows the judiciary to establish its own, often conflicting, standards.

III. FACTUAL SUMMARY AND PROCEDURAL HISTORY

A. *Factual Summary*

Susan Power, a British citizen living in the United States, arrived at Arlington Hospital's emergency room at approximately 5:45 a.m. on February 24, 1990.³³ She was unable to walk, and complained of hip pain.³⁴ Upon admittance her vital signs were taken, an x-ray of her hip was taken, a preliminary urinalysis was done, and a more thorough urinalysis was ordered.³⁵ Shortly after her arrival, the hospital learned that Ms. Powers was uninsured and unemployed.³⁶

When she arrived, Ms. Power was examined by the doctor on duty and the doctor from the ensuing shift. Neither doctor reached any definite diagnosis.³⁷ Before the urinalysis results became available, the doctor gave her a pain prescription, told her to return if her condition worsened, and discharged her from the hospital.³⁸

F. Supp. 433 (D. Kan. 1990).

31. "Obviously we will not allow a few references to the statute's purpose [i.e., protecting indigent patients] in the legislative history to override the plain meaning of its terms as enacted." *Deberry v. Sherman Hosp. Ass'n*, 741 F. Supp. 1302 (N.D. Ill. 1990).

32. 42 U.S.C. § 1395dd(a) (emphasis added). Chapter 7 is Social Security.

33. *Power v. Arlington Hosp.*, 800 F. Supp. 1384, 1386 (E.D. Va. 1992).

34. *Id.*

35. *Id.*

36. *Id.*

37. *Id.*

38. *Id.*

Ms. Power returned to the emergency room the following day and was immediately admitted.³⁹ She was diagnosed as having septic shock.⁴⁰ She remained hospitalized for four months. Because of her condition she lost sight in one of her eyes and had both legs amputated below the knee.⁴¹ At the end of the four months, Ms. Power was transferred to Central Middlesex Hospital in Britain.⁴²

B. Procedural History

Ms. Power filed a four-count, \$180 million action in federal court against the hospital, a physician, and a physicians' group. Two of the counts were EMTALA claims. The first EMTALA claim alleged patient dumping based on the failure to provide an appropriate screening examination during her first visit to the emergency room.⁴³ The second claim was based on Ms. Power's transfer to the British hospital.⁴⁴

The court dismissed claims against the physicians and the physicians' group because the Act authorizes action only against "participating hospitals."⁴⁵ The hospital sought and was denied summary judgment. Prior to the trial, the parties filed cross motions in limine to resolve the question of whether damages were limited by the Virginia medical malpractice damages cap.⁴⁶

Ms. Power's third claim, a state tort law cause of action based on the amputations, was dismissed by the court without prejudice. Dismissal was on the grounds that the tort claim would have to be subjected to the Virginia Malpractice Act, requiring a medical malpractice review process, before it could be

39. *Id.*

40. Septic shock is a condition in which there is tissue damage and a dramatic drop in blood pressure as a result of the multiplication of bacteria and the presence of their toxins in the blood. Septic shock may cause tissue damage and prohibit the circulation of blood. It requires immediate treatment, including use of antibiotics and sometimes surgery. "Despite treatment, septic shock remains a grave condition; survival rates are no better than 50 percent." THE AMERICAN MEDICAL ASSOCIATION, *ENCYCLOPEDIA OF MEDICINE* 895 (Charles B. Clayman ed., 1989).

41. 800 F. Supp. at 1386.

42. *Id.*

43. 42 U.S.C. § 1395dd(a) (1988).

44. 42 U.S.C. § 1395dd(c). This is a dispute over whether the transfer was properly performed according to the requirements outlined in section (c) of the statute.

45. 42 U.S.C. § 1395dd.

46. 800 F. Supp. at 1387.

heard by the court.⁴⁷

IV. REASONING

The court framed the main issue as “whether the phrase ‘those damages available for personal injury under the law of the state’ encompasses or excludes Virginia’s medical malpractice damages cap.”⁴⁸ The court began with the language of the statute itself.

The court interpreted the language of the statute, “personal injury,” as meaning state personal injury damages, not damages under medical malpractice.⁴⁹ The Virginia personal injury laws contain no dollar limit on damages that can be awarded.⁵⁰ The court also found no language in EMTALA limiting “personal injury” damages to malpractice damages.⁵¹ It therefore concluded that EMTALA damages in Virginia were not limited by a dollar amount.⁵²

The court found support for its conclusion by reviewing the differing statutory purposes underlying the EMTALA provisions and the Virginia malpractice cap. According to the court, EMTALA was enacted to deter hospitals from, and compensate victims of, “patient dumping.” The Virginia malpractice cap was enacted not to deter nor to compensate, but rather “to combat medical malpractice insurance availability and affordability problems plaguing Virginia’s health care providers.”⁵³ “Th[e] sharp difference in statutory purposes militates firmly against engrafting Virginia’s malpractice damages cap onto EMTALA, particularly where, as here, EMTALA’s plain language does not invite it.”⁵⁴

The court then addressed and declined to follow two cases

47. *Id.*; VA. CODE ANN. § 8.01-581.2. (1992).

48. 800 F. Supp. at 1388.

49. *Id.*

50. *Id.*

51. “The provision merely refers to ‘damages available for personal injury;’ it does not say ‘damages available for personal injury except as may be limited in certain states by medical malpractice statutes.’” *Id.* at 1389.

52. *Id.*

53. *Id.*

54. *Id.*

which had reached the opposite result, holding that medical malpractice damage caps did apply to EMTALA.⁵⁵

A. Reid

In the first case, *Reid v. Indianapolis Osteopathic Medical Hospital*,⁵⁶ the court held that Congress intended to incorporate the states' malpractice damages cap on EMTALA claims. The *Reid* court based its findings on both legislative history and the incorporation clause in EMTALA.

In *Reid*, the court found the history of EMTALA silent on the issue of whether or not state malpractice caps were to be included or excluded.⁵⁷ Because Congress knew of the growing concern about the large monetary amounts of malpractice damages awards and that states were enacting malpractice caps, the court concluded that Congress wanted to incorporate the state limits into the EMTALA.⁵⁸ The *Reid* court found no evidence of states limiting personal injury damages outside of medical malpractice limitations and concluded that reading EMTALA to exclude malpractice caps would make the incorporation clause "effectively meaningless."⁵⁹

The *Power* court found the assumptions of the *Reid* court to be inconsistent with the legislative history and plain language of the statute. The court held that a malpractice cap was at odds with EMTALA's deterrence purpose, reasoning that if the caps were placed too low the deterrence goals of EMTALA would be defeated.⁶⁰ The *Power* court concluded by stating that the findings of the *Reid* court were flawed because they ignored:

- (i) that the statutory phrase "damages available for personal injury" has a well-understood generic meaning that is different from "damages available for malpractice claims;"
- (ii) that state malpractice actions are separate and distinct from EMTALA actions, each focusing on different conduct and each seeking to achieve different goals; and
- (iii) that in light of (i) and (ii), there is no good reason to engraft state malpractice

55. *Lee by Wetzel v. Allegheny Regional Hosp. Corp.*, 778 F. Supp. 900 (W.D. Va. 1991); *Reid v. Indianapolis Osteopathic Medical Hosp.*, 709 F. Supp. 853 (S.D. Ind. 1989).

56. 709 F. Supp. 853 (S.D. Ind. 1989).

57. *Id.* at 855.

58. *Id.*

59. *Id.*

60. *Power*, 800 F. Supp. at 1390.

damages caps onto EMTALA private actions.⁶¹

B. Lee

The second case, *Lee by Wetzel v. Allegheny Regional Hospital Corp.*,⁶² followed *Reid* in applying the malpractice damages cap to an EMTALA cause of action. The *Lee* court found no states that limited all personal injury damages.⁶³ In accordance with *Reid*, the court found that interpreting EMTALA to exclude medical malpractice damages caps would render the incorporation clause meaningless.⁶⁴ It also found that "it is a fundamental rule of statutory construction that a statute should not be constructed in a manner which renders certain provisions meaningless or insignificant."⁶⁵

The *Power* court cited *Lee* as "unpersuasive" because it followed *Reid* without any additional reasoning. The *Power* court also listed eight states that had enacted personal injury damage caps outside of the medical malpractice realm.⁶⁶

The court concluded its analysis with a number of cases holding that EMTALA cases do not need to be brought before a state medical malpractice board.⁶⁷ The "procedural obstacle" of

61. *Id.*

62. 778 F. Supp. 900 (W.D. Va. 1991).

63. *Id.* at 904.

64. *Id.*

65. *Id.*, citing *Woodfork v. Marine Cooks & Stewards Union*, 642 F.2d 966, 970-71 (5th Cir. 1981).

66. *Power*, 800 F. Supp. at 1390 n.16. The states and limits listed by the court are as follows: ALASKA STAT. § 09.17.010 (1986) (noneconomic damages for personal injury may not exceed \$500,000); COLO. REV. STAT. § 13-21-102.5 (1991) (noneconomic damages for "any civil action" shall not exceed \$500,000); IDAHO CODE § 6-1603 (1991) (noneconomic damages for personal injury shall not exceed \$400,000); KAN. STAT. ANN. § 60-19a01.(b) (1990) (total amount of damages in any personal injury action shall not exceed the sum total of \$250,000); MD. CTS. & JUD. PROC. CODE ANN.

§ 11-108 (1989 Repl. Vol.) (noneconomic damages in personal injury action limited to \$350,000); N.M. STAT. ANN. § 41-5-6 (Michie 1978) (limitation of \$500,000 per occurrence in any action); OR. REV. STAT. § 18.560(1) (1989) (damages arising out of bodily injury may not exceed \$500,000); WYO. STAT. § 1-4-101 (1977) (damages for personal injury limited to that recoverable under the wrongful death act).

67. *Smith v. Richmond Memorial Hosp.*, 416 S.E.2d 689 (Va. 1992), *cert. denied*, 113 S. Ct. 442 (1992); *Toliver v. Culpeper Memorial Hosp.*, C.A. No. 90-0501-A, slip

the board review was seen as being "directly at odds with the purpose and structure of the EMTALA."⁶⁸ The cases were applied by analogy to the case at bar, reasoning that unless removed, the malpractice caps might frustrate EMTALA goals to deter patient dumping. Therefore, the caps must be removed just as the other "obstacles" to EMTALA had been removed because they frustrated the purpose of the act.⁶⁹

V. ANALYSIS

A. *Issues Power Ignored*

In its criticism of the *Reid* case, the *Power* court argued that the medical malpractice award damage caps were inconsistent with EMTALA's purpose. The court stated that low limits on damages would reduce the statute's deterrent effect. However, the court failed to consider several relevant issues.

The court listed typical damage cap amounts that it considered to be at odds with EMTALA's goals, "\$1,000 or even \$10,000."⁷⁰ These amounts are significantly lower than the \$1 million limit in the state. Yet the court never addresses the issue of whether a \$1 million award limit is at odds with EMTALA's goal.

The court presented evidence which implied that the Virginia standard did not obstruct EMTALA goals when it listed personal injury limitations enacted by other states. The court listed the limitations to refute the *Reid* court's assertion that states do not have limitations on personal injury outside of malpractice limits.⁷¹ These state personal injury limitations, however, were all below the \$1 million Virginia limit.⁷² The lowest state personal injury limit was only \$250,000, far below the Virginia malpractice limits.⁷³ Given the fact that the court found the state personal injury limitations consistent with the goals of EMTALA, the court should not have been concerned that Virginia malpractice limits were too low and would there-

op. (E.D. Va. Aug 30, 1991).

68. 800 F. Supp. at 1391.

69. *Id.*; 42 U.S.C. § 1395dd(f) (allowing for the removal of conflicting state and local requirements).

70. 800 F. Supp. at 1390.

71. *Id.*

72. See *supra* note 64 for statute malpractice cap amounts.

73. *Id.* The state mentioned by the court with the lowest limit is Kansas. The Kansas limit is \$250,000 on noneconomic damages in medical malpractice cases. KAN. STAT. ANN. § 60-19a01(b) (1990).

fore obstruct the purpose of EMTALA.

The court further stated that if a court found dollar amounts of personal injury limitations so low that they frustrated EMTALA's purposes, such as the \$1,000 or \$10,000 limits mentioned earlier, the caps would probably be struck down because they blocked attainment of EMTALA's goals.⁷⁴ The court did not address why courts could not apply the same remedy if malpractice caps were excessively low. If the court could strike down any excessively low malpractice limit that hindered EMTALA, the court would also need to rule on whether the \$1 million limit was in direct conflict with EMTALA. The *Power* court failed to make such finding. Blanket invalidation of all malpractice damage limitations was unjustified, given the court's ability to invalidate offending statutes.

While the court couched its arguments in terms of objections to the application of the medical malpractice caps to EMTALA, it actually presents problems that may arise if any limit on damages is so low that it prevents proper enforcement of the EMTALA. The court never addresses exactly where the threshold amount lies. Nevertheless, the court does make it clear that if a limit is too low, courts have tools to effectively deal with the problem.

B. Purposes for Enactment

After addressing the effect of malpractice limitations on EMTALA's goals, the court discussed the reasons for enactment of the statutes as another grounds for not applying the malpractice limits to EMTALA claims. The court pointed to the difference between the purposes for which the two statutes were created. Although the purposes were different, they seem to overlap in more areas than the court would have us believe.

1. EMTALA actions are usually malpractice cases

EMTALA causes of action arise out of what is normally a medical malpractice situation. If a doctor transfers a patient who should not have been transferred and the patient is in-

74. 800 F. Supp. at 1390.

jured, she can probably file a malpractice action and an EMTALA action.⁷⁵ The overlap in the cause of action gives some indication that the two statutes are related. Moreover, an analysis of personal injury and medical malpractice causes of action provides further evidence of how EMTALA and the malpractice damages are related.

2. *Every malpractice claim is a personal injury*

In *Maziarka v. St. Elizabeth Hospital*,⁷⁶ the plaintiff sued for punitive damages under an EMTALA cause of action. Under Illinois law punitive damages were not available in malpractice actions.⁷⁷ The plaintiff asked the court to award punitive damages under EMTALA. The court refused to grant punitive damages on the grounds that "the only claim plaintiff could have against defendants under the law of Illinois is for medical malpractice which is barred by Illinois statute."⁷⁸

The *Maziarka* court viewed medical malpractice as a subdivision of personal injury law.⁷⁹ Under this view, every medical malpractice claim is a personal injury claim (although the opposite is not true: every personal injury claim is not a medical malpractice claim). If medical malpractice is viewed as a specific type of personal injury claim, it would appear that Congress must have intended the medical malpractice limits to apply to EMTALA causes of action.

3. *Does EMTALA limit malpractice cap effectiveness*

The *Power* court was obligated to overrule the state limits if they directly conflicted with EMTALA, so the court only considered the problem from the view point of why EMTALA was drafted and whether or not the malpractice cap hindered the goal of EMTALA. However, in gaining a full understanding of the effect of the decision it is important to also consider why the malpractice statute was enacted, and whether excluding EMTALA actions from the cap limits its effectiveness.

75. *Id.* at 1389 n.15.

76. No. 88 C 665, 1989 WL 13195 (N.D. Ill. Feb. 16, 1989).

77. *Id.* at 2, citing ILL. REV. STAT., ch. 110, § 2-1115 (1988).

78. *Id.* This is a case where the *Power* court might find the state law to prevent the goals of the EMTALA from being achieved and would consider the use of judicial tools to provide remedy. However, this statute only bars recovery of punitive damages, not personal injury damages, which is what EMTALA provides.

79. *Maziarka*, No. 88 C 6658, 1989 WL 13195 at 2.

It is important to note that many courts, including the *Power* court, have interpreted EMTALA to apply to any patient in a Medicare-participating emergency department.⁸⁰ Commentators have suggested that EMTALA be re-written to specifically include only indigent patients to comply with the statute's original rationale.⁸¹ Nevertheless, until a resolution of the problem is found, many courts will continue to construe EMTALA to cover all individuals.

The broad application of EMTALA to all individuals creates a large potential source of litigation.⁸² Each of these causes of action could result in damage amounts far in excess of the malpractice caps. Because EMTALA cases are also malpractice cases, allowing this large group to circumvent the malpractice damage caps could frustrate the cost-controlling purpose of award caps. Hospitals may again face great difficulties in obtaining insurance. While courts are able to remedy potential problems that arise if caps are allowed under EMTALA, the courts lack the tools available to correct problems created by EMTALA claims not limited by malpractice caps.

C. *Suggested Solution*

The best solution is to allow the medical malpractice limitations to apply to EMTALA claims. This allows the purposes of both statutes to be carried out. Malpractice awards will be limited, allowing better availability of insurance and therefore better health care, and patient dumping will be deterred by the threat of EMTALA actions.

It appears likely that if the courts do not fix this problem

80. *Power*, 800 F. Supp. at 1388 n.8; *Brooker v. Desert Hosp. Corp.* 947 F.2d 412, 415 (9th Cir. 1991); *Deberry v. Sherman Hosp. Ass'n*, 741 F. Supp. 1302 (N.D. Ill. 1990).

81. Thomas L. Stricker, Jr., Note, *The Emergency Treatment & Active Labor Act: Denial of Emergency Medical Care Because of Improper Economic Motives*, 67 NOTRE DAME L. REV. 1121 (1992) (citing cases which have limited EMTALA to indigent patients only and cases that have allowed all claimants and arguing that the plain language of the statute be amended to reflect the legislative history and limit EMTALA causes of action to indigent patients).

82. See *supra* note 18 and accompanying text. The estimated cases were only from indigent patients; no statistics were available on patient dumping for reasons other than indigency.

the state legislatures or Congress may be forced to act. The state legislatures may limit personal injury award amounts; but states may not want to limit those damages. Congress could explicitly state that EMTALA only applies to indigent patients, which may limit the impact on the availability of insurance for hospitals; or Congress could expressly include the malpractice limitations imposed by states.

Unfortunately, the states are left with the fewest alternatives and the most potential problems. It is a logical judicial decision, within congressional intent, to apply state malpractice limitations so that the reduced damages do not hamper EMTALA's deterrent effect.

VI. CONCLUSION

The *Power* court's decision to allow EMTALA cases to fall outside the medical malpractice damages awards cap could have serious negative effects on state legislative efforts to deal with the current nationwide medical crisis. Permitting EMTALA cases to circumvent state medical malpractice damages caps significantly limits the effectiveness of the damages caps, especially in light of the court's broad application EMTALA to all patients, regardless of economic stature.

EMTALA allows for preemption of state law only where the law directly conflicts with EMTALA. The *Power* court could not demonstrate that the state malpractice damages cap directly conflicted with EMTALA. The court referred to damages amount caps so low that they would conflict. However, those amounts were significantly lower than those of the state. The court also failed to show that application of the state limits would prevent the accomplishment of the goals of EMTALA.

Conversely, allowing the cap to apply to EMTALA cases would not limit the effectiveness of EMTALA's goal of preventing "patient dumping" and would further the state goals in enacting the malpractice damages cap. The decision of the court unnecessarily allows emergency patients to do an end-run around the state limits and defeats the state legislatures' purpose for enacting the statute.

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