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The Fourth Circuit's Baby K Decision: Plain Language Does Not Make Good Law

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**THE FOURTH CIRCUIT'S *BABY K* DECISION:
"PLAIN LANGUAGE" DOES NOT MAKE GOOD
LAW**

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I. INTRODUCTION

The past history of entitlement programs suggests that once access is granted, an ethic of individual autonomy, which respects all wishes of its recipients, reigns supreme. A citizen ethic for both doctor and patient is necessary in order to distinguish between insatiate individual wishes and a responsible choice for needed care.¹

In 1992, Baby K was born in a Virginia hospital with anencephaly. Infants with this condition are missing most of their brain at birth and they have a brainstem which irregularly drives breathing along with ingestion and digestion of food. Baby K was "permanently unconscious," without hope of recovery from this condition. To survive,

1. Marion Danis & Larry R. Churchill, *Autonomy and the Common Weal*, 21 HASTINGS CENTER REP. 25, 30 (1991).

Baby K intermittently required the assistance of a mechanical ventilator. Baby K's mother, Ms. H, wanted ventilator care for the baby whenever necessary.² In contrast, the Hospital, a division of INOVA Health Systems (the Hospital), and Baby K's physicians wished to follow the accepted standard of care for anencephalic infants and to provide only comfort measures for Baby K.³

The Court of Appeals for the Fourth Circuit denied the Hospital a declaratory order that would have allowed the physicians to provide standard comfort measures for Baby K.⁴ Basing its opinion on the Emergency Medical Transport and Active Labor Act (EMTALA),⁵ the Fourth Circuit held that the Hospital was obliged to provide all necessary respiratory assistance to keep Baby K alive.⁶ The court explained: "[w]e recognize the dilemma facing physicians who are requested to provide treatment they consider morally and ethically inappropriate, but we cannot ignore the plain language of the statute."⁷

Until this ruling, physicians made decisions whether to use technological assistance for a terminally ill infant within the framework of

2. *Baby K*, 832 F. Supp. 1022, 1024-25 (E.D. Va. 1993), *aff'd*, 16 F.3d 590 (4th Cir. 1994), *cert. denied*, 115 S. Ct. 91 (1994).

3. See American Academy of Pediatrics, Committee on Bioethics, *Infants with Anencephaly as Organ Sources: Ethical Considerations*, 89 PEDIATRICS 1116 (1992) (explaining that customary medical care for anencephalic infants includes warmth and feeding but no major medical interventions); ROBERT F. WEIR, SELECTIVE NON-TREATMENT OF HANDICAPPED NEWBORNS: MORAL DILEMMAS IN NEONATAL MEDICINE 41 (1984) (explaining that no treatment is possible, so nursing care consists of holding the anencephalic infant); American Academy of Pediatrics, Committee on Bioethics, *Treatment of Critically Ill Newborns*, 72 PEDIATRICS 565 (1983) (explaining that anencephalic infants are "so impaired that treatment will serve only to maintain biologic functions").

4. *Baby K*, 16 F.3d at 596.

5. 42 U.S.C. § 1395dd(a) (Supp. II 1990) (Stating: In 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 and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.).

6. *Baby K*, 16 F.3d at 596.

7. *Id.*

federal and state law. Federal statutory law provides physicians guidelines for end-of-life decisions in severely disabled newborns.⁸ As well, the federal courts have allowed physicians to make decisions on these patients within the accepted standard of care, even when the patient is disabled.⁹ State law governs medical standards of care and allows physicians to refuse to provide care that violates their professional and ethical principles.¹⁰

After the *Baby K* ruling, physician decisions regarding terminally ill newborns may be controlled by the irrational beliefs of surrogates. Even if a patient is terminally ill, all care necessary to keep the patient alive may be demanded and must be provided, though it may be against the physician's best judgment. This Comment will propose that the Fourth Circuit's decision does not comport with federal nor state law. It will suggest that when dealing with irrational requests for life-sustaining measures, the federal courts must interpret EMTALA as it fits within existing law. This should provide appropriate latitude for physician judgment that is based upon established medical standards of care. The Comment will propose that specialty physician groups can provide clear guidelines for physicians to address requests for life-prolonging measures in such patients,¹¹ while the law can assure that practitioners maintain "openness, due process, and meticulous accountability."¹² It will emphasize the crucial role of medical and legal pro-

8. 42 U.S.C. §§ 5101 to 5107 (1988); *See also infra* Part III.C.2.

9. *United States v. University Hosp.*, 729 F.2d 144, 156-57 (2d Cir. 1984) (stating that Congress had no intention for the Rehabilitation Act to establish standards of care for terminally ill newborns).

10. VA. CODE ANN. § 54.1-2990 (Michie 1992).

11. Steven H. Miles, *Informed Demand for "Non-Beneficial" Medical Treatment*, 325 NEW ENG. J. MED. 512, 514 (1991) [hereinafter Miles]. The statements of the following professional organizations provide standards for end-of-life decisions: Council on Ethical and Judicial Affairs, AMA, *Guidelines for the Appropriate Use of Do Not Resuscitate Orders*, 265 JAMA 1868 (1991); Task Force on Ethics of the Society of Critical Care Medicine, *Consensus Report on the Ethics of Foregoing Life-sustaining Treatments in the Critically Ill*, 18 CRITICAL CARE MED. 1435 (1990); American Thoracic Society Position Paper, *Withholding and Withdrawing Life-sustaining Therapy*, 115 ANNALS INTERNAL MED. 478 (1991); The Multi-Society Task Force on PVS, *Medical Aspects of the Persistent Vegetative State (PVS)*, 330 NEW ENG. J. MED. 1499-1508, 1572-1597 (1994); Susanna E. Bedell et al., *Survival After Cardiopulmonary Resuscitation in the Hospital*, 309 NEW ENG. J. MED. 569 (1983).

12. Miles, *supra* note 11 at 514.

professionals in developing practice guidelines which help form the social consensus for necessary rationing of health care dollars in such cases.¹³ Finally, it will discuss the need for and likelihood of legislative reform of EMTALA.

II. STATEMENT OF THE CASE

A. Facts

Baby K was born to Ms. H on October 13, 1992 in an acute care hospital in Virginia.¹⁴ Baby K was born with anencephaly which results in extremely primitive movements and mentation throughout life because of the absence of most of the brain.¹⁵ According to Virginia law, Baby K was considered alive because she had a functioning brainstem.¹⁶ Most anencephalic infants die within days of birth.¹⁷ When Ms. H was informed that her fetus had anencephaly, she refused

13. See Marshall B. Kapp, *Futile Medical Treatment: A Review of the Ethical Arguments and Legal Holdings*, 9 J. GEN. INTERNAL MED. 170, 173 (1994) [hereinafter Kapp] (citing Peter A. Singer & Mark Siegler, *Advancing the Cause of Advance Directives*, 152 ARCHIVES INTERNAL MED. 22-24 (1992) (“[p]ractice parameters based on an intervention’s futility should be set at the institutional or societal . . . levels, not at the individual bedside, so that uniform criteria can be . . . applied to different patients”); Robert M. Veatch & Carol Mason Spicer, *Medically Futile Care: The Role of the Physician in Setting Limits*, 18 AM. J.L. & MED. 15, 15-36 (1992) (stating that the only acceptable grounds for overriding the wishes of a patient or surrogate is when society decides on withholding those resources)).

14. *Baby K*, 832 F. Supp. at 1024-25.

15. *Id.* at 1024 (Stating:

Anencephaly is a congenital defect in which the brain stem is present but the cerebral cortex is rudimentary or absent. There is no treatment that will cure, correct, or ameliorate anencephaly. Baby K is permanently unconscious and cannot hear or see. Lacking a cerebral function, Baby K does not feel pain. Baby K has brain stem functions primarily limited to reflexive actions such as feeding reflexes (rooting, sucking, swallowing), respiratory reflexes (breathing, coughing), and reflexive responses to sound or touch. Baby K has a normal heart rate, blood pressure, liver function, digestion, kidney function, and bladder function and has gained weight since her birth.).

16. VA. CODE ANN. § 54.1-2972 (Michie 1988).

17. American Academy of Pediatrics, Committee on Bioethics, *Infants with Anencephaly as Organ Sources: Ethical Considerations*, 89 PEDIATRICS 1116 (1992).

the option to abort the fetus.¹⁸ Because Baby K had respiratory difficulty at birth, Ms. H requested, and the baby received, resuscitation and was placed on a mechanical ventilator.¹⁹ Baby K's physicians, Baby K's biological father, Baby K's appointed guardian *ad litem*, and members of the hospital ethics committee all suggested ventilator care be withheld.²⁰ They all felt that because the baby had anencephaly, further mechanical ventilation would only prolong Baby K's inevitable death, and that, therefore, only comfort measures should be provided.²¹ However, Ms. H rejected this position in favor of providing Baby K all possible care.²² The Hospital provided that care.²³

After several weeks in intensive care, Baby K was able to breath without assistance and was discharged to a nursing home. Within a short time, Baby K was readmitted to the Hospital with respiratory difficulty, during which time her mother insisted that the infant be provided the support of a respirator.²⁴ During her second hospital stay, a tracheostomy²⁵ was inserted into her throat for greater ease of mechanical ventilation.²⁶ After Baby K's second admission, the Hospital filed for declaratory relief from being forced to treat the infant.²⁷ During her life, Baby K resided at a nursing home and was rushed to the Hospital six times for ventilator support, which the Hospital provided.²⁸ At age 30 months, after one such trip she had a cardiac arrest and died.²⁹

18. *Baby K*, 832 F. Supp. at 1025.

19. *Id.*

20. *Id.* at 1030.

21. *Id.* at 1025.

22. *Id.*

23. *Id.*

24. *Id.*

25. Tracheostomy is an opening into the trachea through the neck. STEADMAN'S MEDICAL DICTIONARY 1830 (26th ed. 1995). For Baby K, this avoided repeated oral- or nasal-tracheal intubations which can be damaging to the soft tissue of the mouth and prevent the infant from bottle feeding.

26. *Baby K*, 832 F. Supp. at 1025-26.

27. *Id.* at 1026.

28. *Baby K*, 832 F. Supp. at 1025.

29. Marylou Tousignant & Bill Miller, *Death of 'Baby K' Leaves a Legacy of Legal Precedents*, WASH. POST, Apr. 7, 1995, at B3.

B. Court Proceedings

The Hospital asserted that ventilation would not cure anencephaly, and thus it was not obligated to provide this care.³⁰ The Hospital's decision to seek relief was not related to the financing of Baby K's health care.³¹ Supportive of the Hospital's decision was the fact that no other hospital in the area was willing to provide the treatment that the mother demanded.³² The Hospital asserted that withholding ventilator treatment from Baby K over Ms. H's objections would not violate federal or state law.³³ The Hospital sought relief in United States District Court in the Eastern District of Virginia pursuant to the Declaratory Judgment Act.³⁴

The district court denied declaratory judgment, reasoning that withholding such life-sustaining treatment would violate EMTALA,³⁵ the Rehabilitation Act of 1973,³⁶ and the Americans with Disabilities Act (ADA).³⁷ The court held that, despite the Hospital's claim, there was no private right of action under the Child Abuse Amendments of 1984³⁸ and declined to assert jurisdiction to render a declaratory judgment under the Virginia Medical Malpractice Act.³⁹ The Hospital appealed to the Fourth Circuit Court of Appeals.⁴⁰ The Fourth Circuit affirmed the district court decision that under EMTALA the Hospital could not refuse to treat Baby K's respiratory distress when she was presented to the Hospital in need of stabilization.⁴¹

30. *Id.* at 1029.

31. *Id.* at 1026.

32. *Baby K*, 16 F.3d at 593.

33. *Id.* at 592.

34. *Baby K*, 832 F. Supp. at 1026; *See also* 28 U.S.C. § 2201 (1988).

35. *Baby K*, 832 F. Supp. at 1026.

36. *Id.* at 1027.

37. *Id.* at 1031.

38. *Id.* at 1029.

39. *Id.* at 1030.

40. *Baby K*, 16 F.3d at 593.

41. *Id.* at 592.

C. Issues

The Fourth Circuit's decision supports mandatory emergency care on demand. Any patient or his/her surrogate can demand, and must receive, the most sophisticated medical care in an emergency, even if physicians consider the treatment to be morally and ethically inappropriate.⁴² However, the court ignored federal legislation that specifically addresses care of disabled newborns.⁴³ This legislation permits physicians to withhold the same care that the Fourth Circuit's decision mandates they provide.⁴⁴

The court held that when a patient is denied emergency medical stabilization, state law is preempted by EMTALA even if the treating physicians consider the requested care to be medically or ethically inappropriate.⁴⁵ Prior to this decision, standards of emergency care were governed by state malpractice law. After this decision, claims of malpractice during emergency care may be heard under EMTALA in federal courts.⁴⁶

The court's expansion of patient rights through EMTALA creates conflicts which go to the heart of our legal and moral framework. It was reasonable for the Hospital to question delivery of the requested care to Baby K because anencephaly is so hopeless. The Hospital believed that it was more important to make the decision in such an extreme case according to the accepted medical standard of care than to preserve autonomous decisions of patient surrogates.⁴⁷ However, according to the district court, the Hospital's decision went against the mother's constitutionally protected right to "bring up children"⁴⁸ and her free exercise of religion.⁴⁹ This conflict juxtaposes the moral prin-

42. *Id.* at 596.

43. 42 U.S.C. §§ 5101 to 5107; *see also infra* Part III.C.2.

44. 42 U.S.C. 5106g(10) (1988) (stating exceptions to the definition of medical neglect for handicapped newborns); *see also infra* note 70.

45. *Baby K*, 16 F.3d at 597.

46. *See infra* Part V.D.

47. Candance Cummins Gauthier, *Philosophical Foundations of Respect for Autonomy*, 3 KENNEDY INST. ETHICS J. 21, 35 (1993) [hereinafter Gauthier]; *see also infra* Part V.F.1.

48. *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923); *see also Pierce v. Society of Sisters*, 268 U.S. 510, 534-35 (1925).

49. *Pierce*, 268 U.S. at 534-35; *see also Wisconsin v. Yoder*, 406 U.S. 205, 234

principle of beneficence and the professional standard of physician autonomy against basic constitutional freedoms.

The most important legal and ethical issues are: (1) whether the Fourth Circuit's *Baby K* decision is wrong when EMTALA is read *pari materia* with other federal statutes; (2) whether differential treatment of Baby K can be justified in an equal protection context;⁵⁰ and (3) whether such end-of-life decisions are susceptible to control by the courts,⁵¹ or alternatively, whether our society should ratify and enforce the standards of medical specialty groups that deal with such quality of life decisions.

III. BACKGROUND

A. Patient-Physician Decision-Making Generally

There is a strong constitutional basis for allowing parents to decide on the medical care provided to their children.⁵² However, in Virginia and Maryland, if a patient requests care, that in the physician's judgment is non-sensical or not in the patient's best interests, the physician is justified to refuse to provide that care and may refer the patient to another physician who will provide that care.⁵³

The courts have generally upheld the primacy of parental decision-making about medical care offered to their children.⁵⁴ Naturally, this includes the care offered to handicapped newborns. However, this view is not unanimous. In a Michigan case involving a severely impaired

(1972).

50. *Plyler v. Doe*, 457 U.S. 202 (1982) (stating that "[t]he Constitution does not require things which are different in fact . . . to be treated in law as though they were the same"); see also *F.S. Royster Guano Co. v. Virginia*, 253 U.S. 412, 415 (1920).

51. *Baby K*, 16 F.3d at 598 (Sprouse, J., dissenting).

52. See *infra* Part IV.A.2. for the Constitutional underpinnings that support Ms. H's decision.

53. VA. CODE ANN. § 54.1-2990 (Michie 1994); MD. CODE ANN., HEALTH-GEN. § 5-611 (1994).

54. See *Parham v. J.R.*, 442 U.S. 584 (1979); *In re Phillip B.*, 92 Cal. App. 3d 796, 801 n.51 (1979) ("[i]t is fundamental that parental autonomy is constitutionally protected").

infant, the court suspended parental rights after the mother refused to withdraw respirator care from the infant.⁵⁵ Subsequently, the guardian appointed by the court decided to withdraw life-sustaining treatment from the infant.⁵⁶

Some standards of medical care are initiated by groups of medical specialists. Though clear standards do not exist for every aspect of medical practice, medical specialty groups have developed guidelines for many end-of-life medical decisions.⁵⁷ The American Academy of Pediatrics, a national group dedicated to the health and welfare of children, has fostered interdisciplinary collaboration to determine the appropriate standard of care for anencephalias.⁵⁸

B. EMTALA

Congress enacted EMTALA in 1986 as Part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)⁵⁹ responding to its "concern that hospitals were 'dumping' patients [who were] unable to pay, by either refusing to provide emergency medical treatment or transferring patients before their emergency conditions were stabilized."⁶⁰ EMTALA was an attempt to provide an "adequate first re-

55. See James Bopp, Jr. & Richard E. Coleson, *Child Abuse by Whom?— Parental Rights and Judicial Competency Determinations: The Baby K and the Baby Terry Cases*, 20 OHIO N.U. L. REV. 821, 822 (1994) [hereinafter Bopp & Coleson] (citing *In re Achtabowski*, No. G93142173GD (Mich. Probate Ct. July 30, 1993)); see also John J. Paris et al., *Physician's Refusal of Requested Treatment: The Case of Baby L*, 322 NEW ENG. J. MED. 1012, 1012-15 (1990) (upholding the right of a hospital and physicians to refuse to provide care that violated their moral and ethical principles based on *Brophy v. New England Siani Hosp.*, 497 N.E.2d 626, 639 (Mass. 1986)).

56. Bopp & Coleson, *supra* note 55, at 822.

57. See *supra* note 11.

58. See *supra* note 3.

59. Pub. L. No. 99-272, 100 Stat. 82 (codified in scattered sections of 26 U.S.C.) (final regulations were not promulgated by the Health Care Financing Administration until recently). See 59 Fed. Reg. 32,087 (1994).

60. *Brooks v. Maryland Gen. Hosp., Inc.*, 996 F.2d 708, 710 (4th Cir. 1993) (defining dumping as the transfer of a patient from one hospital to another, generally because of the patient's indigence).

response to a medical crisis” for all patients.⁶¹ EMTALA has been succinctly described as follows:

The Act applies to all hospitals participating in Medicare that provide emergency services as well as the physicians on the hospitals’ medical staffs. The Act requires hospitals to provide an appropriate medical screening examination for any individual who presents at the hospital to determine whether the individual has an emergency medical condition. If the individual has an emergency medical condition as defined by the Act, the hospital must provide treatment to stabilize the condition or provide an appropriate transfer of the individual to another facility. Hospitals and physicians that violate the Act are subject to civil monetary penalties and termination from the Medicare program in addition to being subject to a private cause of action for damages suffered as a result of the violation.⁶²

An emergency medical condition is defined as a “medical condition manifesting itself by acute symptoms of sufficient severity . . . such that the absence of immediate medical attention could reasonably be expected to result in . . . serious impairment of bodily functions”⁶³ To stabilize means “to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result.”⁶⁴

C. Other Federal Law

1. Medicare

Emergency rooms that are governed by EMTALA are those in hospitals that have entered into a provider agreement with Medicare.⁶⁵ Because most hospitals have entered into such provider agreements,

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

62. Brenda Strama & Laura Gilchrist, *Patient Dumping: New Anti-Dumping Regulations Strengthen Patient Protections*, 11 No. 9 HEALTHSPAN 3 (1994) (providing a comprehensive review of all EMTALA provisions prior to the final *Baby K* decision).

63. 42 U.S.C. § 1395dd(e)(1)(A) (Supp. IV 1992).

64. 42 U.S.C. § 1395dd(e)(3)(A) (Supp. IV 1992).

65. 42 U.S.C. § 1395dd(e)(2) (Supp. IV 1992); *see also* 42 U.S.C. § 1395cc(a)(F)(1) (1988).

most emergency rooms in the U.S. are governed by EMTALA. EMTALA requires the government to utilize the Medicare peer review mechanisms when violations of the statute are suspected.⁶⁶ Under Medicare, physicians are governed by carefully constructed review organizations for all services related to Medicare recipients and hospitals with provider agreements throughout the health care system.⁶⁷ Under Medicare statutes, physicians must provide only such care as is medically necessary and consistent with prevailing standards.⁶⁸ EMTALA has no language that suspends Medicare law governing standards of care.

2. The Child Abuse Amendments of 1984

The Child Abuse Amendments of 1984 (the Amendments) set out specific criteria for appropriate end-of-life decisions in severely impaired newborns.⁶⁹ The Amendments sought to prevent medical ne-

66. 42 U.S.C. § 1395dd(d)(3) (Supp. IV 1992).

67. 42 U.S.C. § 1320c-5 (1988) (prescribing the standard of care hospitals and physicians are to follow in the Medicare program).

68. 42 U.S.C. § 1320c-3(a) (1988) (Providing for Physician Review Organization (PRO) review of Medicare hospitals and physicians. The secretary contracts pursuant to 42 U.S.C. § 1395cc to process data concerning health care services provided Medicare beneficiaries and to intervene when these data indicate that the services have been provided unnecessarily or with inadequate quality. The PRO is composed of practicing doctors, who because of their special expertise are able to perform reviews. There is also one consumer on the PRO. There can be no conflicts of interest between PRO members and hospitals reviewed. The functions set forth in 42 U.S.C. § 1320c-3(a) are to determine if services are reasonable, medically necessary, allowable, meet professional standards, and whether the patient needs admission to hospital).

69. 42 U.S.C. § 5106g(10) (1988) (Stating that medical neglect occurs only if "[the health care provider] fail[s] to respond to [an] infant's life-threatening conditions by providing treatment . . . which, in the treating physician's . . . reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions."). Explicitly excluded from the definition of neglect is the failure to provide treatment, other than appropriate nutrition, hydration and medication:

when, in the treating physician's . . . reasonable medical judgment[:] (A) the infant is chronically and irreversibly comatose; (B) the provision of such treatment would: (i) merely prolong dying; (ii) not be effective in ameliorating or correcting all the infant's life-threatening conditions; or (iii) otherwise be futile in terms of survival of the infant; or (C) the provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstanc-

glect of the infant by physicians and other health care providers. There is no evidence that EMTALA was meant to overrule the Child Abuse Amendments of 1984.

The Amendments provide that when a physician determines that further care of an infant is futile, the physician may reasonably withdraw care based on specific criteria.⁷⁰ When such care is withdrawn, the Amendments state that this action does not constitute medical neglect.⁷¹

The Amendments set criteria for end-of-life decisions that were a compromise between pediatricians, parents, and right-to-life groups.⁷² This extraordinary consensus came from medical and personal experiences and legislative know-how.⁷³ Although preservation of parental autonomy was a part of this consensus, another component was the need for reasonable decisions in the face of futility.⁷⁴ Under the Amendments:

If a handicapped newborn infant suffers from more than one life-threatening condition, for at least one of which (in the reasonable medical judgment of the attending physician) there is no corrective treatment, treatment need not be administered for any of the conditions, correctable or not.⁷⁵

Application of the clear language of the Amendments and the legislative intent permits physicians to withhold life-saving measures in anen-

es would be inhumane.

Id.

70. *Id.*

71. *Id.*

72. ALAN MEISEL, *THE RIGHT TO DIE* 444 nn.92-93 (1989) [hereinafter MEISEL] (citing 50 Fed. Reg. 14,878, 14,879 (1985))

73. *Id.*

74. See 45 C.F.R. § 1340.15(b)(2) (1987) (stating that physicians would not be held to treat a severely impaired newborn if treatment would "otherwise be futile in terms of the survival of the infant").

75. MEISEL, *supra* note 72, at 452 (citing *Joint Explanatory Statement by Principal Sponsors of Compromise Amendment Regarding Services and Treatments for Disabled Infants*, S. REP. No. 246, 98th Cong., 2d Sess. 41 (1984), reprinted in 1984 U.S.C.C.A.N. 2969, 2970).

cephalics because the severe brain anomaly in these infants cannot be corrected.⁷⁶

3. The Rehabilitation Act and the Americans with Disabilities Act (ADA)

The Rehabilitation Act (RA) and the Americans with Disabilities Act (ADA) are fashioned to prevent discrimination against handicapped individuals. The RA attempts to prevent discrimination in federally funded programs,⁷⁷ and the ADA in employment and in places of public accommodation, like the hospital.⁷⁸ Both acts are based on similar rationales and legislative histories.⁷⁹ The RA was not framed to apply to end-of-life medical decisions for handicapped newborns.⁸⁰ As well, there is no language in the ADA to this effect. Because the two acts are similar, the following information on the RA applies also to the ADA.

The RA provides that “[n]o otherwise qualified handicapped individual . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”⁸¹ A “handicapped individual” is defined in the RA as “any person who (i) has a physical or mental impairment which substantially limits one or more of such person’s major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment.”⁸² Under the RA, a handicapped individual “includes an infant who is born with a congenital defect.”⁸³

76. See *supra* notes 69 and 75.

77. 29 U.S.C. § 504 (1988).

78. 28 C.F.R. § 36.104 (1995).

79. *American Academy of Pediatrics v. Heckler*, 561 F. Supp. 395, 401 (D.D.C. 1983) (referring to the legislative history of the Rehabilitation Act); *United States EEOC v. AIC Sec. Investigation, Ltd.*, 820 F. Supp. 1060, 1064 (N.D. Ill. 1993) (stating that the legislative history of the ADA anticipates that the ADA will be guided by the precedent of the RA).

80. See *supra* note 9.

81. 29 U.S.C. § 794(a) (1995).

82. 29 U.S.C. § 706(8)(B) (1995).

83. *Bowen v. American Hosp. Ass’n*, 476 U.S. 610, 624 (1986).

In 1983, the Secretary of the Department of Health and Human Services attempted to promulgate regulations under section 504 of the RA to prevent medical neglect to handicapped newborns. This followed the death from starvation of Baby Doe, an infant with Down Syndrome whose parents refused life-sustaining esophageal surgery.⁸⁴ These regulations would have required notices to be placed in hospital nurseries stating that hospitals would violate Section 504 “by declining to treat an operable life-threatening condition in an infant . . . [and by aiding] a decision by the infant’s parents or guardian to withhold treatment or nourishment discriminatorily.”⁸⁵ The regulations also would have provided for emergency response teams to come to hospitals when summoned by anonymous “hot line” phone calls, to prevent medical neglect of handicapped newborns in hospitals.⁸⁶

The regulations were rejected by the Federal District Court for the Southern District of New York in *American Hospital Association v. Heckler*.⁸⁷ The court held that the RA did not authorize the regulations, and it enjoined their enforcement.⁸⁸ The lower court decision was summarily affirmed by the United States Court of Appeals for the Second Circuit, and was affirmed by a plurality of the United States

84. *Id.* at 617 (Stating:

[T]he hospital initiated judicial proceedings to override the parents’ decision, but an Indiana trial court, after holding a hearing the same evening, denied the requested relief [T]he court asked the local Child Protection Committee to review its decision. After conducting its own hearing, the Committee found no reason to disagree with the court’s ruling At the instance of the local prosecutor, the Indiana courts . . . held another hearing at which the court concluded that ‘Baby Doe’ had not been neglected under Indiana’s Child in Need of Services statute. Additional attempts to seek judicial intervention were rebuffed the same day. On the following day, the Indiana Court of Appeals denied a request for an immediate hearing. *In re* Infant Doe, No. GU 8204-004A (Monroe County Cir. Ct., Apr. 12, 1982). The Indiana Supreme Court, by a vote of 3 to 1, rejected a petition for a writ of mandamus. *State ex rel. Infant Doe v. Baker*, No. 482 S 140 (Ind. May 27, 1982). The infant died while a stay was being sought in this court, and [the U.S. Supreme Court] subsequently denied *certiorari*. *Infant Doe v. Bloomington Hosp.*, 464 U.S. 961 (1983).

85. 47 Fed. Reg. 26,027 (1982).

86. 48 Fed. Reg. 9631-32 (May 7, 1983).

87. 585 F. Supp. 541 (S.D.N.Y. 1984); *summarily aff’d* 794 F.2d 676 (2d Cir. 1984), *aff’d*, *Bowen v. American Hosp. Ass’n*, 476 U.S. 610 (1986).

88. *Heckler*, 585 F. Supp. at 542.

Supreme Court.⁸⁹ In enjoining enforcement of the regulations, the Court acknowledged that treatment of anencephalias was not required,⁹⁰ despite the fact that the enjoined regulations would have possibly unearthed other incidents of medical neglect under the RA.

The district court had held that *Heckler* is directly controlled by the Second Circuit decision in *United States v. University Hospital*.⁹¹ In *University Hospital*, the government challenged under section 504⁹² the parent's decision not to treat their severely handicapped newborn, Baby Jane Doe. When the Supreme Court affirmed *Heckler*, in *Bowen*,⁹³ it applied the rationale from *University Hospital* to explain why Section 504 did not apply to medical decisions in handicapped newborns:

[A]lthough Baby Jane Doe was a "handicapped individual," she was not "otherwise qualified" within the meaning of section 504 because "where medical treatment is at issue, it is typically the handicap itself that gives rise to, or at least contributes to the need for services"; as a result "the 'otherwise qualified' criterion of section 504 cannot be meaningfully applied to a medical treatment decision." For the same reason, the Court of Appeals rejected the Government's argument that Baby Jane Doe had been "subjected to discrimination" under section 504: "Where the handicapping condition is related to the condition(s) to be treated, it will rarely, if ever, be possible to say with certainty that a particular decision was 'discriminatory.'" . . . The difficulty of applying section 504 to individual medical treatment decisions confirmed the Court of Appeals in its view that "[C]ongress never contemplated that section 504 of the Rehabilitation Act would apply to treatment decisions involving defective newborn infants when the statute was enacted in 1973, when it was amended in 1974, or at any subsequent time."⁹⁴

89. *Bowen v. American Hosp. Ass'n*, 476 U.S. 610 (1986).

90. *Id.* at 476 U.S. at 615 n.4 (citing 45 C.F.R. pt. 84 app. C(a)(5)(iii) (1994) (stating that § 504 does not require treatment of anencephaly because it would "do no more than temporarily prolong the act of dying")).

91. *Heckler*, 585 F. Supp. at 542 (citing *United States v. University Hosp.*, 729 F.2d 144 (2d Cir. 1984)).

92. *University Hosp.*, 729 F.2d at 147.

93. *Bowen*, 476 U.S. at 623.

94. *Id.* at 622 (citing *University Hosp.*, 729 F.2d at 156-61).

Using the reasoning from *University Hospital*, the *Bowen* plurality stated that “[s]ection 504 does not authorize the Secretary to give unsolicited advice either to parents, to hospitals, or to state officials who are faced with difficult treatment decisions concerning handicapped children.”⁹⁵

Both *University Hospital* and *Bowen* held that the RA does not authorize government intervention when parents have refused the care offered.⁹⁶ The case where parents desire care but physicians wish to withhold that care is not considered in this line of cases.

D. State Law Governing Medical Decisions

In a majority of states, parents can decide whether to accept or refuse offered medical treatment or to seek other physicians for alternative treatments for their minor children.⁹⁷ Parental decisions can only be reviewed by the state under exceptional circumstances.⁹⁸

In 1983, the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (the Commission) discussed the issue of parental decision-making in handicapped newborns.⁹⁹ First, the Commission observed that under state law parents are strongly presumed to be the proper decision-makers for these infants based on the common law and the constitutional right to privacy.¹⁰⁰ Second, to protect helpless infants, the state, through *parens patriae* power, can punish child abuse and neglect and intervene when parental choices are harmful. However, as long as “parents

95. *Id.* at 647.

96. *University Hosp.*, 729 F.2d at 156-61; *Bowen*, 476 U.S. at 624.

97. *Bowen*, 476 U.S. at 628 (citing 50 Fed. Reg. 14,880 (1985) (final rule implementing Child Abuse Amendments of 1984) (“[t]he decision to provide or withhold medically indicated treatment is, except in highly unusual circumstances, made by the parents or legal guardian”)).

98. 50 Fed. Reg. 14,880 (1985).

99. PRESIDENT’S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL RESEARCH AND BEHAVIORAL, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, 212-14 (1983).

100. *Id.*

choose from professionally accepted treatment options, the choice is rarely reviewed in court and even less frequently supervised."¹⁰¹

According to Virginia law, "Nothing in [the Health Care Decisions Act] shall be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be medically or ethically inappropriate."¹⁰² If the physician's plan for treatment is contrary to the surrogate's decision, then the physician must transfer the patient to another physician who is willing to provide the care desired by the surrogate.¹⁰³ This physician's right is echoed in Maryland,¹⁰⁴ where a physician may "withhold or withdraw, as medically ineffective, a treatment that under generally accepted medical practices is life-sustaining in nature,"¹⁰⁵ as long as another physician agrees in writing.¹⁰⁶

IV. THE DECISION

A. Majority

The court noted:

[T]he hospital [sought] declaratory and injunctive relief from providing inappropriate care to Baby K under four federal statutes and one Virginia statute: the Emergency Medical Treatment and Active Labor Act . . . ; the Rehabilitation Act of 1973 . . . ; the Americans with Disabilities Act of 1990 . . . ; the Child Abuse Amendments of 1984 . . . ; and the Virginia Medical Malpractice Act¹⁰⁷

The Fourth Circuit affirmed the decision of the Federal District Court for the Eastern District of Virginia, Alexandria Division, that, under

101. *Id.*

102. VA. CODE ANN. § 54.1-2990 (Michie 1992)

103. *Id.*

104. MD. CODE ANN., HEALTH GEN. § 5-611(a) (1994) ("[n]othing in this subtitle may be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be ethically inappropriate").

105. MD. CODE ANN., HEALTH GEN. § 5-611(b)(2)(i) (1994).

106. *Id.*

107. *Baby K*, 832 F. Supp. at 1026.

EMTALA, the Hospital could not refuse to treat Baby K's respiratory distress when she presented to the Hospital for stabilization.¹⁰⁸

Both the circuit¹⁰⁹ and the district court¹¹⁰ used EMTALA as the cornerstone of their holdings. However, the district court explicated the constitutional and statutory bases for its decision,¹¹¹ whereas the circuit court chose not to address constitutional law, but instead dealt only with the clear language of EMTALA.¹¹²

The Fourth Circuit held that the Hospital must treat any patient, no matter what condition they are in, when they arrive at the emergency room and request treatment.¹¹³ The court interpreted EMTALA's definitions of "emergency medical condition"¹¹⁴ and "stabilization"¹¹⁵ of a patient literally, and as being without exception.¹¹⁶

The circuit court held that the Hospital would be liable under EMTALA if Baby K arrived at the emergency room in respiratory distress (or with some other emergency medical condition) and the Hospital failed to provide mechanical ventilation (or some other medical treatment) necessary to stabilize her acute condition.¹¹⁷ The court held:

The terms of EMTALA as written do not allow the Hospital to fulfill its duty to provide stabilizing treatment by simply dispensing uniform treatment. Rather, the Hospital must provide that treatment necessary to prevent the material deterioration of each patient's emergency medical condition. In the case of Baby K, the treatment necessary to prevent the material deterioration of her condition when she is in respiratory distress includes respiratory support.¹¹⁸

108. *Baby K*, 16 F.3d at 592.

109. *Id.*

110. *Baby K*, 832 F. Supp. at 1026.

111. *Id.* at 1030.

112. *Baby K*, 16 F.3d at 596.

113. *Id.*

114. 42 U.S.C. § 1395dd(e)(1)(A) (Supp. IV 1992); *see supra* note 63 and accompanying text.

115. 42 U.S.C. § 1395dd(e)(3)(A) (Supp. IV 1992); *see supra* note 64 and accompanying text.

116. *Baby K*, 16 F.3d at 597.

117. *Id.*, 16 F.3d at 596.

118. *Id.*

The court directly refuted any exceptions to EMTALA that would allow physicians to withhold treatment when the case is deemed hopeless.¹¹⁹ The court concluded its role would not permit it to go beyond the plain language of EMTALA.¹²⁰

Additionally, the court held that the statute does not accept a physician's judgment that care may be appropriate in one case and may be inappropriate in another, based on an acceptable standard of care in the profession.¹²¹ The court was unable to find any language in EMTALA or any legislative history that would exempt physicians from providing all care necessary to stabilize the patient.¹²² Even when EMTALA forces doctors to treat patients beyond acceptable standards of care, state and local laws that directly conflict with the requirements of EMTALA are preempted.¹²³

1. Other Statutes Addressed by the *Baby K* courts

The Fourth Circuit dealt perfunctorily with the Child Abuse Amendments of 1984, the Rehabilitation Act, the Americans with Disabilities Act, and the Virginia Medical Malpractice Act. The court noted:

In addressing these provisions, the district court concluded that a failure to provide respiratory support to Baby K because of her condition of anencephaly would constitute discrimination in violation of the ADA and the Rehabilitation Act but declined to rule on the application of the Child Abuse Act or Virginia law. Because we conclude that the Hospital has a duty to render stabilizing treatment under EMTALA, we need not address its obligations under the remaining federal statutes or the laws of Virginia.¹²⁴

119. *Id.*

120. *Id.* See also *Baber*, 977 F.2d at 878.

121. *Baby K*, 16 F.3d at 596.

122. *Id.* See also *Baber*, 977 F.2d at 880. (Holding that the hospital must stabilize all patients, not just indigents. This issue was not addressed in *Baby K*).

123. *Baby K*, 16 F.3d at 597; see also 42 U.S.C. § 1395dd(f) (Supp. IV 1992).

124. *Baby K*, 16 F.3d at 592 n.2.

Although the Fourth Circuit did not address federal and state laws, the district court discussed these laws in detail. Therefore, the district court's reasoning on these applicable laws will be discussed throughout this Comment.

The Fourth Circuit did not apply the Child Abuse Amendments of 1984.¹²⁵ These Amendments set specific standards to guide physicians in end-of-life decisions for severely impaired infants.¹²⁶ However, the Fourth Circuit did affirm the decision of the district court, which held that the Amendments were not applicable to this case because Virginia Child Protective Services was not a party to the case.¹²⁷ The district court held that the Amendments only apply to states which receive federal grants for child abuse and neglect programs. The Amendments authorize the states to bring legal action through their child protective service agencies to prevent the medical neglect of disabled infants.¹²⁸

Additionally, although the district court held that "the Hospital's desire to withhold ventilator treatment from Baby K over her mother's objections would violate the Rehabilitation Act,"¹²⁹ the circuit court only addressed EMTALA.¹³⁰ The district court had reasoned that the Hospital was governed by the Rehabilitation Act because it was a Medicare provider,¹³¹ and Baby K was a "handicapped individual" under the Rehabilitation Act.¹³² Therefore, the district court held that Baby K "has statutory rights not to be discriminated against on the basis of her handicap."¹³³ It further held that Baby K was qualified to receive ventilator treatment and ventilator treatment was being threat-

125. *Id.*

126. 42 U.S.C. §5106g(10) (1988); *see also supra* note 69.

127. *Baby K*, 832 F. Supp. at 1029.

128. 42 U.S.C. § 5106a(b)(10)(C) (1988).

129. *Baby K*, 832 F. Supp. at 1028.

130. *Baby K*, 16 F.3d at 592.

131. *See United States v. Baylor Univ. Medical Ctr.*, 736 F.2d 1039, 1049 (5th Cir. 1984), *cert. denied*, 469 U.S. 1189 (1985).

132. *See Bowen*, 476 U.S. at 624.

133. *Baby K*, 832 F. Supp. at 1028.

ened with denial because of an unjustified consideration of her anencephalic handicap.¹³⁴

Similarly, the circuit court did not address the district court's holding¹³⁵ that "the hospital would . . . violate the Americans with Disabilities Act if it were to withhold ventilator treatment from Baby K."¹³⁶ Baby K had a "disability"¹³⁷ and was cared for in a hospital, which is a place of "public accommodation."¹³⁸ The district court ruled that the Hospital would violate the ADA because the law states:

[I]t shall be discriminatory to subject an individual or class of individuals on the basis of a disability . . . to a denial of the opportunity of the individual or class to participate in or benefit from the goods, services, facilities, privileges, advantages, or accommodations of an entity.¹³⁹

Finally, the Fourth Circuit chose not to discuss Virginia laws because it held that the Hospital has the duty to render stabilizing treatment under EMTALA.¹⁴⁰ The district court held that Virginia statutes and case law played no role in its *Baby K* decision.¹⁴¹ The Hospital requested the district court to declare that refusing ventilatory care to Baby K was not malpractice¹⁴² within the Virginia Medical Malpractice Act.¹⁴³ The district court "refused to elbow its way into Virginia medical malpractice standards."¹⁴⁴ It claimed that neither the Virginia court nor the appointed Virginia Review Panel for Standards of Medi-

134. *Id.* at 1027.

135. *Baby K*, 16 F.3d at 592.

136. *Baby K*, 832 F. Supp. at 1028-29.

137. 42 U.S.C. § 12102(2)(A) (Supp. IV 1993) (explaining that a disability includes any "physical or mental impairment that substantially limits one or more of the major life activities of such individual"); 28 C.F.R. § 36.104 (defining "physical or mental impairment").

138. 42 U.S.C. § 12181(7)(F) (Supp. V 1993); *see also* 28 C.F.R. § 36.104 (1995).

139. 42 U.S.C. § 12182(b)(1)(A)(i) (Supp. V 1993).

140. *Baby K*, 16 F.3d at 592 n.2.

141. *Baby K*, 832 F. Supp. at 1029.

142. *Id.*

143. VA. CODE ANN. § 8.01-581.1 (Michie 1992).

144. *Baby K*, 832 F. Supp. at 1030.

cal Care had dealt with anencephaly, so Virginia laws should play no role in the decision.¹⁴⁵

2. Constitutional Underpinnings that Support Ms. H's Decision

The Fourth Circuit did not elaborate on the constitutional support for Ms. H's decision. Instead, it only addressed the letter of EMTALA.¹⁴⁶ However, the Fourth Circuit did affirm the district court's decision, which offered several constitutional bases for its ruling in favor of Ms. H. These bases include: (1) the standing that parents have to assert the constitutional rights of their minor children;¹⁴⁷ (2) the "right to 'bring up children' grounded in the Fourteenth Amendment's due process clause;"¹⁴⁸ (3) the "primary role" in the "nurture and upbringing of their children;"¹⁴⁹ (4) the "plenary authority parents have to seek medical care for their children, even when the decision might impinge on a liberty interest of the child;"¹⁵⁰ (5) the "free exercise of religion, protected by the First Amendment;"¹⁵¹ (6) the "need for a clear and compelling governmental interest [to] justify a statute that interferes with the person's religious convictions;"¹⁵² (7) the "presumption that the parents act in the best interests of their child" because the "natural bonds of affection lead parents to act in the best interests of their children;"¹⁵³ and (8) the explicit guarantees of a

145. *Id.* at 1029.

146. *Baby K*, 16 F.3d at 596.

147. *Baby K*, 832 F. Supp. at 1031 (citing *Eisenstadt v. Baird*, 405 U.S. 438, 446 n.6 (1972)).

148. *Baby K*, 832 F. Supp. at 1030 (citing *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923); *Pierce*, 268 U.S. at 534-35).

149. *Baby K*, 832 F. Supp. at 1030 (quoting *Wisconsin v. Yoder*, 406 U.S. 205, 232 (1972); *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944)).

150. *Baby K*, 832 F. Supp. at 1030 (citing *Parham v. J.R.*, 442 U.S. 584, 603-604 (1979)).

151. *Baby K*, 832 F. Supp. at 1030 (citing *Pierce*, 268 U.S. at 534-535; *Yoder*, 406 U.S. at 234).

152. *Baby K*, 832 F. Supp. at 1030 (citing *Employment Div., Dep't of Human Resources of Oregon v. Smith*, 494 U.S. 872, 881 n.1 (1990) (superseded by statute); *Yoder*, 406 U.S. at 233).

153. *Baby K*, 832 F. Supp. at 1030 (quoting *Parham*, 442 U.S. at 602).

right to life in the United States Constitution, Amendments V and XIV, and the Virginia Constitution, Article 1, Sections i and ii.

B. Dissent

Senior Circuit Judge Sprouse dissented to the majority opinion based on three issues.¹⁵⁴ First, EMTALA was designed as an anti-dumping statute. Nothing in the legislative history or in the act itself conceived of a case that judged physician end-of-life decisions.¹⁵⁵ Second, anencephaly was the relevant condition, not respiratory compromise.¹⁵⁶ Even though such an infant may suffer recurrent emergencies, EMTALA was not intended to deal with repeated emergencies in a terminal infant.¹⁵⁷ Baby K's anencephaly was her relevant condition, and the Hospital should not have to respond to her case as a series of discrete emergencies.¹⁵⁸ Finally, end-of-life decisions of this type do not lend themselves to legal oversight. According to Judge Sprouse, if the court required this oversight, it should be on a case-by-case basis under state malpractice law.¹⁵⁹

V. ANALYSIS

The *Baby K* decision is adverse to the long standing principle of physician autonomy in decision-making.¹⁶⁰ The following analysis will explain how the decision establishes the principle of "mandatory emergency medical care on demand"¹⁶¹ for all patients and how that principle replaces standards of care established by the medical profession.¹⁶² This Part of the Comment will describe how the Fourth Circuit superseded, circumvented¹⁶³ or preempted applicable federal and

154. *Baby K*, 16 F.3d at 598 (Sprouse, J., Dissenting).

155. *Id.*

156. *Id.*

157. *Id.*

158. *Id.*

159. *Id.*

160. *See supra* Part III.A.

161. *See infra* Part V.A.

162. *See infra* Part V.B.

163. *See infra* Part V.C.

state laws¹⁶⁴ in establishing this principle. Likewise, it will explain how the court ignored basic constitutional conflicts¹⁶⁵ and avoided ethical conflicts inherent in its decision.¹⁶⁶ Finally, this Part of the Comment will propose that medical specialty groups should provide Congress with consensus guidelines for these sensitive cases,¹⁶⁷ and that Congress should amend EMTALA to support stabilization with *medically appropriate* care in accordance with these guidelines.¹⁶⁸

A. *Mandatory Emergency Care on Demand*

The Fourth Circuit held unequivocally that the Hospital had a duty to stabilize a patient in an emergent situation under EMTALA.¹⁶⁹ The Hospital argued:

(1) [T]hat this court has previously interpreted EMTALA as only requiring uniform treatment of all patients exhibiting the same condition; (2) that in prohibiting disparate emergency medical treatment Congress did not intend to require physicians to provide treatment outside the prevailing standard of medical care; (3) that an interpretation of EMTALA that requires a hospital or physician to provide respiratory support to an anencephalic infant fails to recognize a physician's ability, under Virginia law, to refuse to provide medical treatment that the physician considers medically or ethically inappropriate; and (4) that EMTALA only applies to patients who are transferred from a hospital in an unstable condition.¹⁷⁰

The court repudiated each argument raised by the Hospital, holding that the issues of futility and prevailing standards of care were overridden by the need for stabilization of the patient's vital signs.¹⁷¹ In effect, any patient with any combination of life-threatening ailments can demand stabilization.¹⁷²

164. See *infra* Part V.D.

165. See *infra* Part V.E.

166. See *infra* Part V.F.

167. See *infra* Part V.G.1.

168. See *infra* Part V.G.2.

169. *Baby K*, 16 F.3d at 596.

170. *Id.* at 595.

171. *Id.* at 592.

172. See 42 C.F.R. § 489.24 (1995).

Under these holdings, the surrogate decision-maker for a victim of an imminently fatal, close-range, shotgun blast to the brain could demand that the patient receive ventilatory support for stabilization. After *Baby K*, even if all that remained of a patient's brain is a brainstem, the surrogate can rightfully demand mechanical ventilation.¹⁷³ The court held that the doctors must provide this treatment despite the fact that the appropriate standard of care is to give comfort measures only.¹⁷⁴

The court held that the Hospital cannot avoid EMTALA by claiming that it is providing the same care to all anencephalics¹⁷⁵ or other classes of patients. The Hospital can provide the same screening,¹⁷⁶ but not the same treatment if that treatment is to withhold mechanical ventilation. The Hospital can use the same procedures to determine the extent of respiratory compromise, but the duty to stabilize that respiratory condition is governed by EMTALA, not the "usual standard of care" for the class of patients having anencephaly.¹⁷⁷ Even if the court allowed uniform treatment of medical conditions, it held that *Baby K*'s emergent conditions were bradypnea and apnea,¹⁷⁸ not anencephaly.¹⁷⁹ In the case of the unfortunate shotgun victim, the physicians would have to base their treatment plan on the fact that the victim has breathing difficulty. Physicians are trained and encouraged to view the entire patient before embarking on a treatment decision.¹⁸⁰ In his dissent to the Fourth Circuit decision in *Baby K*, Judge Sprouse was in accord with this teaching: "I would consider anencephaly as the relevant condition and the respiratory difficulty as one of many subsid-

173. See *Baby K*, 16 F.3d at 596.

174. *Id.*

175. *Id.*

176. See *Baber*, 977 F.2d at 881; *Brooks*, 996 F.2d at 710-11.

177. *Baby K*, 16 F.3d at 596.

178. Bradypnea is an "abnormal slowness of breathing." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 230 (27th ed. 1988). In an infant who has established and sustained spontaneous breathing, apnea describes the cessation of respiration for more than 60 seconds. *Id.* at 112.

179. *Baby K*, 16 F.3d at 596 n.9.

180. John M. Freeman, *Ethical Aspects of Management of Infants with Severe Handicaps*, in PEDIATRICS 14-15 (Abraham M. Rudolph ed., 1977).

iary conditions found in a patient with the disease. EMTALA was not designed to reach such circumstances.”¹⁸¹

The court ruled that the “plain language” of EMTALA dictated that Baby K (and any other patient) receive all care requested for stabilization.¹⁸² However, EMTALA’s language is unrealistic because it separates the patient’s emergency event from the entire context of the patient’s illness. The statute’s language, as interpreted by the Fourth Circuit may sometimes force physicians to act against their moral, ethical and professional standards.

B. Beyond “Appropriateness” of Medical Care

Consensus standards of care in medicine are determined by medical groups representing large numbers of physicians with experience in the medical conditions in question. These standards exist for the care of anencephalic infants.¹⁸³ This kind of consensus on the care of specific types of terminally ill patients is rare,¹⁸⁴ and it is reached with difficulty. Sub-specialty medical groups continue to actively analyze outcomes of technical interventions in terminally ill patients¹⁸⁵ in order to clarify interventions that may be futile for these patients. Today, though consensus does exist with respect to the appropriate standards of care for anencephalics, the Fourth Circuit’s rigid interpretation of EMTALA ignores these standards altogether.

The Fourth Circuit construed EMTALA to require a level of care that was outside the prevailing standard of care. The district court based this same holding on the fear that if an exception were made for the class of patients with anencephaly, then physicians would feel free to withhold treatment from many other classes of patients.¹⁸⁶ The

181. *Baby K*, 16 F.3d at 599.

182. *Id.*

183. *Baby K*, 16 F.3d at 590; *see also supra* note 3.

184. *See supra* note 11.

185. Kathy Faber-Langendoen, *Resuscitation of Patients with Metastatic Cancer: Is Transient Benefit Still Futile?*, 151 ARCHIVES INTERNAL MED. 235 (1991) [hereinafter Faber-Langendoen].

186. *Baby K*, 832 F. Supp. at 1027.

Fourth Circuit justified its holding solely on the plain language of EMTALA.¹⁸⁷

The Sixth Circuit has interpreted EMTALA to not only protect indigents from emergency room “dumping,” but also to prevent selective non-treatment of handicapped individuals against whom some physicians may discriminate.¹⁸⁸ Dumping can occur when the hospital has a “distaste for a patient’s condition.”¹⁸⁹ To prevent such arbitrary discrimination, physicians must decide to withhold stabilization in an emergency only according to clear cut standards of care. These standards exist for anencephalias.¹⁹⁰

C. *Superseding or Circumventing other Federal Law*

The *Baby K* decision is not consistent with Medicare law that governs the standards of health care for Medicare patients.¹⁹¹ Furthermore, the decision does not take into account the clear intention of the Child Abuse Amendments of 1984, which explicitly address withholding care from terminally ill newborns.¹⁹² Finally, the decision ignores the RA and the ADA, both of which have specific provisions allowing physicians latitude in decision-making.¹⁹³

187. *Baby K*, 16 F.3d at 596.

188. *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 272 (6th Cir. 1990).

189. *Id.*

190. *See supra* note 3.

191. 42 U.S.C. § 1320c-5 (1988) (prescribing the standard of care that hospitals and physicians are to follow in the Medicare program).

192. 42 U.S.C. §§ 5101 to 5107 (1988).

193. SENATE COMM. ON LAB. AND HUMAN RESOURCES, THE AMERICANS WITH DISABILITIES ACT OF 1989, S. Rep. No. 101-116, 101st Cong., 1st Sess. 63 (1989), *reprinted in* 1 BERNARD D. REAMS, JR. ET AL., *DISABILITY LAW IN THE UNITED STATES: A LEGISLATIVE HISTORY OF THE AMERICANS WITH DISABILITIES ACT OF 1990* (1992) (stating that nothing in this legislation is intended to prohibit a physician from providing the most appropriate treatment in the physicians judgment); *see also* *AAP v. Heckler*, 561 F. Supp. 395, 401 (D.D.C. 1983); *United States v. University Hosp.* 729 F.2d 144, 158 (2nd Cir. 1984).

1. Medicare Law

EMTALA is intimately entwined in Medicare law,¹⁹⁴ yet the Fourth Circuit does not interpret EMTALA consistently with the Medicare statutes. EMTALA requires the government to utilize the standard peer review mechanisms¹⁹⁵ when violations of the statute are suspected:

In considering allegations of violations of the requirements of this section in imposing sanctions [civil penalties] under paragraph (1), the Secretary shall request the appropriate utilization and quality control peer review organization . . . to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings.¹⁹⁶

Medicare uses peer review standards to govern appropriateness of care throughout the health care system.¹⁹⁷ The circuit court does not discuss EMTALA's relation to Medicare law, but the district court discounts this mechanism of setting standards in an emergency situation.¹⁹⁸

The district court held that if hospitals and physicians follow established standards of care for certain end-of-life decisions, they would violate their statutory obligation under EMTALA.¹⁹⁹ However, there is no language in EMTALA which suspends Medicare law governing standards of care. Under 42 U.S.C. Section 1320c-5 and other Medicare statutes, physicians must provide only such care as is medically necessary and consistent with prevailing standards.²⁰⁰ Physicians are governed by Medicare's carefully constructed review organizations for all other services. Thus, the *Baby K* opinion forces physicians to be di-

194. See *supra* Part III.C.1.

195. 42 U.S.C. § 1395dd(d)(3) (Supp. II 1990).

196. *Id.*

197. 42 U.S.C. § 1320c-5 (1988) (prescribing the standard of care hospitals and physicians are to follow in the Medicare program).

198. *Baby K*, 832 F. Supp. at 1027.

199. *Baby K*, 16 F.3d at 596.

200. See *supra* note 68.

rected solely by patient or surrogate demands and the limits of technologic possibility, not by existing Medicare law.

The determinants of appropriate standards of health care codified in the Medicare statutes should govern the stabilization requirements in EMTALA. Appropriate standards, as determined by trained physicians, should control care given in emergency rooms. The use of the term "appropriate" in the statute should provide latitude for physicians to withhold life-saving stabilization when consensus standards agree. Those consensus standards are the standards of the profession, and, with respect to anencephaly, the standards exclude mechanical ventilation. By replacing these professional standards with EMTALA, the Fourth Circuit ignores the entire foundation of professional governance under Medicare.

2. Child Abuse Amendments of 1984

The Child Abuse Amendments of 1984 (the Amendments) set out specific criteria for appropriate end-of-life decisions in severely impaired newborns.²⁰¹ In *Baby K*, the Fourth Circuit avoids this statute entirely.²⁰² The district court discounts this important statute because Virginia Child Protective Services (CPS) were not a party to the case. Even though the Amendments are procedurally inapplicable to this case,²⁰³ failure to provide life-prolonging treatment to Baby K would not constitute medical neglect under the explicit provisions of the Amendments. In this case: (1) Baby K was chronically and irreversibly comatose; (2) treatment would merely prolong her death; (3) treatment did not and could not correct or ameliorate all of her life threatening

201. 42 U.S.C. § 5106g(10) (1988); *see also* note 69.

202. *See supra* Part IV.A.1.

203. *Baby K*, 832 F. Supp. at 1029 ("[t]his request for relief must be denied because the Hospital has failed to join a necessary party—the Virginia Child Protective Services"). *See* Child Abuse Prevention and Treatment Act, 42 U.S.C. § 5101 (1988). *See also* 42 U.S.C. § 5106a(b)(10)(C) (1988); 45 C.F.R. § 1340.15(c)(2)(iii) (1995) (authorizing states which receive federal grants for child abuse and neglect programs to bring legal action through their child protective services agencies to prevent the medical neglect of disabled infants).

conditions; and (4) treatment was otherwise futile in terms of her survival and, therefore, inhumane.

The district judge suggested that to apply this statute to Baby K, CPS needed to join with the Hospital in claiming that the baby was being abused by the mother's request for ventilatory support.²⁰⁴ A state child abuse agency has never charged a mother with neglect for insisting on life-saving treatment for her infant. In fact, the Amendments did not even consider this possibility. Instead, the Amendments sought to prevent medical neglect of the infant by physicians and parents.

The court ignored the consensus that was reached in the passage of the Amendments. The Amendments provide that when a physician determines that further care of an infant is futile, the physician may reasonably withdraw care.²⁰⁵ When such care is withdrawn, this action does not constitute medical neglect.²⁰⁶

The Fourth Circuit ignored the contribution that the Amendments can make to a reasonable interpretation of EMTALA. The Amendments came from a labor-intensive compromise between pediatricians, parents, and right-to-life groups.²⁰⁷ The Amendments were constructed to carefully deal with hopeless cases, trying to do the right thing for the unfortunate infant. It would be reasonable for other circuits to uphold the Amendments when interpreting EMTALA. There is no evidence that EMTALA was meant to overrule the Amendments. In *Baby K*, the Fourth Circuit did not address the Amendments because it could not square its holdings on EMTALA with the "plain language" of the Amendments. In failing to address the Amendments, the Fourth Circuit effectively stripped physicians of the flexibility to appropriately withhold life-saving measures from anencephalias based on established medical standards of care.

204. *Baby K*, 832 F. Supp. at 1029.

205. 42 U.S.C. § 5106g(10) (1988); *see also supra* note 69.

206. 42 U.S.C. § 5106g(10) (1988).

207. MEISEL, *supra* note 72, at 444.

3. The Rehabilitation Act and the ADA

Neither the Rehabilitation Act (RA) nor the Americans with Disabilities Act (ADA) comports with the Fourth Circuit's interpretation of EMTALA. The Fourth Circuit ignores the RA to avoid the standard of care issue.²⁰⁸ The court explained that:

[T]he district court concluded that a failure to provide respiratory support to Baby K because of her condition of anencephaly would constitute discrimination in violation of the ADA and the Rehabilitation Act.²⁰⁹

But the court failed to mention either the ADA or the RA again in its decision. The Fourth Circuit tacitly approved of the district court's holdings about both of these acts without squarely addressing the issue.

a. The Rehabilitation Act

Even though Baby K was handicapped and disabled under the RA,²¹⁰ using the Act to apply EMTALA's plain language to *Baby K* is not warranted. The district court believed that the Hospital wanted to avoid using a ventilator for Baby K because of an unjustified consideration of her anencephalic handicap.²¹¹ The court assumed that any withholding of ventilator treatment would be unjustified in the context of a handicapped and disabled baby. But the court did not consider the Amendments in this assumption.²¹² Furthermore, the court did not consider the legislative history of the RA. In contrast, another district court has recognized that "no congressional committee or member of the House or Senate ever even suggested that [the RA] would be used to monitor treatments of newborn infants or establish standards for preserving a particular quality of life."²¹³

208. *Baby K*, 16 F.3d at 592 n.2.

209. *Id.*

210. *See Bowen*, 476 U.S. at 624.

211. *Baby K*, 832 F. Supp. at 1027.

212. *See supra* note 69 and accompanying text.

213. *American Academy of Pediatrics v. Heckler*, 561 F. Supp. 395, 401 (D.D.C. 1983).

Further, in *United States v. University Hospital*, the Second Circuit noted that “at no point did any witness even remotely suggest that [the RA] could or would be applied to treatment decisions involving defective newborns.”²¹⁴ In *University Hospital*, the parents of Baby Jane Doe, a severely impaired newborn, wanted to withdraw treatment from the infant but they were thwarted by a petition invoking Section 504 from an outside party. The Second Circuit found no basis for impeding the parents’ wishes.²¹⁵ In *Baby K*, the district court tried to distinguish *University Hospital* by the arguing that the parents in *University Hospital* consented to the withholding of treatment from Baby Jane Doe, whereas Ms. H did not consent to the withholding of treatment from Baby K.²¹⁶ Although the cases are distinguishable on this issue, the root issue is whether anyone should withhold treatment based on the baby’s extremely poor prognosis. In *University Hospital*, the Second Circuit answered this affirmatively.²¹⁷

In *University Hospital*, the court also held that “[the RA] prohibits discrimination against a handicapped individual only where the individual’s handicap is unrelated to, and thus improper to consideration of, the services in question.”²¹⁸ Physicians who would withhold ventilator therapy from Baby K are not discriminating against the baby under the RA because her handicap was related to the services appropriately provided.²¹⁹

The RA does not serve as a basis for federal intervention in medical decision-making for impaired newborns.²²⁰ The physicians should be able to determine the appropriate end-of-life care for Baby K because she unfortunately meets the criteria for appropriate withdrawal of care under the Amendments.²²¹ The *Baby K* court was misguided in

214. *University Hosp.*, 729 F.2d at 159.

215. *United States v. University Hosp.*, 729 F.2d 144 (2d Cir. 1984).

216. *Baby K*, 832 F. Supp. at 1028.

217. *University Hosp.*, 729 F.2d at 156-57.

218. *Id.* at 156; see also *Johnson v. Johnson*, 971 F.2d 1487, 1493-94 (10th Cir. 1992), cert. denied, 113 S. Ct. 1255 (1993).

219. *University Hosp.*, 729 F.2d at 156-57; see also *supra* note 95 (quoting *Bowen*, 476 U.S. at 622).

220. See *supra* note 94 and accompanying text.

221. See *supra* note 69.

steadfastly clinging to the plain language of EMTALA, and, thereby, superseded the obvious intent of the RA.

b. The ADA

The ADA was also not meant to serve as a basis for federal intervention in medical decision-making. It prohibits discrimination against disabled individuals in employment and by public accommodations.²²² Baby K was disabled.²²³ The Fourth Circuit did not reach the question of disability discrimination under the ADA. Again, however, it did affirm the decision of the district court which held:

The Hospital's reasoning would lead to the denial of medical services to anencephalic babies as a class of disabled individuals. Such discrimination against a vulnerable population class is exactly what the American with Disabilities Act was enacted to prohibit. The Hospital would therefore violate the ADA if it were to withhold ventilator treatment from Baby K.²²⁴

The legislative history of the ADA makes it clear that the Act was not intended to prevent physicians from using their judgment and choosing the most appropriate care for patients.²²⁵ Also, decisions based on Section 504 of the RA guide interpretations of the ADA.²²⁶ The Supreme Court held in *Bowen*²²⁷ that the RA was not applicable to decisions that parents and doctors made together to withhold treatment from another severely handicapped infant. The Fourth Circuit should have looked to *Bowen* for guidance when it considered the practicality of EMTALA's plain language, but *Bowen* is not even mentioned by the court. The Fourth Circuit ignored the ADA to avoid the conflict between it and EMTALA with respect to appropriate standards of medical care.

222. 42 U.S.C. § 12181(7) (Supp. V 1993) (stating that the Hospital is a public accommodation under the ADA).

223. See 42 U.S.C. § 12102(2) (Supp. II 1990); see also 28 C.F.R. § 36.104 (1995) (defining "physical or mental impairment").

224. *Baby K*, 832 F. Supp. at 1029.

225. See *supra* note 193.

226. *AIC Sec. Investigation, Ltd.*, 820 F. Supp. at 1064.

227. *Bowen*, 476 U.S. at 624.

D. Preempting State Law on Appropriateness of Care

The Fourth Circuit held that EMTALA preempts state law that governs standards of medical care.²²⁸ The provisions of state law permitting a physician to act according to an appropriate standard of care conflict with EMTALA's mandate for stabilization in the emergency setting. EMTALA preempts any state law that conflicts with its requirements.²²⁹ This shift of medical practice from state to federal control is a drastic departure from the usual standard that governs medical tort claims. It may provide an alternative to state tort actions, while it confuses the state courts and lower federal courts about the appropriate tort law to apply in a given case.²³⁰

1. The Conflict Between State Law and the Fourth Circuit's Interpretation of EMTALA

Virginia law limits a patient's medical decision by establishing a physician's obligation to make reasonable medical decisions.²³¹ Under Virginia law, physicians are not required to provide treatment that they believe is medically or ethically inappropriate.²³² When physicians cannot agree with a patient or surrogate plan, the physician must then transfer the patient to another physician.²³³ Baby K, however, could not be transferred to another physician or facility, because in accord with the professional standard of care, no hospital or physician would provide the treatment that Ms. H wanted for Baby K.²³⁴

Under Virginia medical practice law, the Hospital could reasonably withhold ventilator therapy from Baby K.²³⁵ In fact, Ms. H had forced Baby K's doctor to practice medicine contrary to Virginia

228. *Baby K*, 16 F.3d at 597.

229. 42 U.S.C. § 1395dd(f) (Supp. II 1990) (stating that "[t]he provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section").

230. *See infra* Part V.D.3.

231. VA. CODE ANN. §§ 54.1-2990 (Michie 1994).

232. *Id.*

233. *Id.*

234. *Baby K*, 16 F.3d at 593.

235. *See* VA. CODE ANN. §§ 54.1-2990 (Michie 1994).

law²³⁶ by usurping his professional judgment. Nonetheless, the Fourth Circuit ignored this framework of state law and imposed EMTALA.

The effects of this preemption of state law by the Fourth Circuit are destructive to carefully defined medical practice law. EMTALA's duty to provide stabilizing treatment applies not only to participating hospitals but also to treating physicians in participating hospitals.²³⁷ The court does not provide an exception to EMTALA for stabilizing treatment that physicians may deem medically or ethically inappropriate.²³⁸ The circuit court noted that "[i]t is well settled that state action must give way to federal legislation where a valid act of Congress, fairly interpreted, is in actual conflict with the law of the state."²³⁹ Since Virginia Code Section 54.1-2990 exempts physicians from providing care they consider medically or ethically inappropriate, the Fourth Circuit's interpretation of EMTALA directly conflicts with the statute.

2. Determination of the Standard of Care

State malpractice law determines the duty of care required in a medical encounter, especially with respect to the terminally ill.²⁴⁰ In an earlier case, the Fourth Circuit acknowledged that questions as to proper treatment are questions best resolved under existing state negligence law.²⁴¹ Judge Sprouse echoed this belief in his dissent in *Baby K* by explaining that only state malpractice law should be used to test appropriateness of medical care.²⁴²

The Fourth Circuit failed to address the conflict between state medical practice standards and EMTALA. The standard of care for medical malpractice is established by the professionals who deal with

236. *Id.* (explaining that the practice of medicine is "prevention, diagnosis and treatment of physical or mental ailments, conditions, diseases, pain or infirmities by any means or method").

237. 42 U.S.C. § 1395dd(d)(1)(B) (Supp. II 1990).

238. 16 F.3d at 597.

239. *Id.* (citing *Savage v. Jones*, 225 U.S. 501, 533 (1912)).

240. VA. CODE ANN. § 54.1-2990 (Michie 1994).

241. *Baber*, 977 F.2d at 880.

242. *Baby K*, 16 F.3d at 599 (Sprouse, J., dissenting).

patients' problems daily. In anencephaly, the standard of care is to provide comfort only and not to engage in life-sustaining treatment such as mechanical ventilation.²⁴³ By remaining silent on such a crucial issue, the circuit court ignored an enormous conflict of laws that will shift numerous emergency room plaintiffs into federal court.²⁴⁴

The district court provided a curious spin to this conflict of laws. The district court claimed that the Virginia courts and legislature need to validate the national standard for anencephalic infants:

Virginia courts have not addressed the question of the appropriate standard of care for anencephalic infants and whether an exception to the general standard of care applies to them. Besides the Malpractice Act's general rule, Virginia's legislature has also been silent on the issue.²⁴⁵

This type of validation is not done with respect to most areas of medical practice that have profound implications. For example, physicians decide, rather than legislatures or the courts, which aged patients should receive hip replacements or coronary artery bypass procedures. Society should not expect the courts and the legislatures to make specific decisions in areas of medicine where clinicians routinely decide on the care that impacts longevity and quality of life.²⁴⁶ The district court held that Virginia courts had not addressed the exceptions to the general standard of care for anencephalics.²⁴⁷ But the court ignores the fact that such a standard or exception is rarely delineated by the courts. These standards are defined by medical specialty groups,²⁴⁸ and they are enacted daily by physicians with their patients.

After essentially invalidating state control of medical standards, the district court then boldly invoked *Erie*²⁴⁹ and the inherent power of

243. *Baby K*, 16 F.3d at 590; see also *supra* note 3.

244. See *infra* Part V.D.3.

245. *Baby K*, 832 F. Supp. at 1029.

246. Miles, *supra* note 11, at 514.

247. *Baby K*, 832 F. Supp. at 1029.

248. See *supra* notes 3 and 11.

249. *Baby K*, 832 F. Supp. at 1029 (citing *Erie R.R. v. Tompkins*, 304 U.S. 64 (1938) (espousing the interest in having states decide questions of state law)).

state law by implying that the state review panel²⁵⁰ should have evaluated and resolved this issue. The court stated:

Because of the significant state interests manifested by this review process as well as the Commonwealth's interest in resolving this contentious and unsettled social issue for itself, this court declines to "elbow its way" into Virginia medical malpractice standards.²⁵¹

Through its decision, the district court does "elbow in." Although the determination of the standard of medical care in Virginia involves a review panel, such a panel is not required for declaratory relief requests.²⁵² This task is naturally left to the courts.

By not discussing the conflict between EMTALA and state medical practice law, the Fourth Circuit left the district courts questioning how they should protect and administer existing medical standards, especially as these standards impact the treatment of patients in the emergency room.²⁵³ The overlap of state and federal standards for medical malpractice in emergency rooms is already confused.²⁵⁴ The Fourth Circuit's *Baby K* decision can only encourage plaintiffs' attorneys to seek a federal forum in such cases.

3. EMTALA as an Alternative to State Malpractice Actions

The clear intent of EMTALA, to prevent dumping, has been realized in cases like *Huckaby v. East Alabama Medical Center*.²⁵⁵ In

250. See generally VA. CODE ANN. § 8.01-581.1 (Michie 1992 & Supp. 1995).

251. *Baby K*, 832 F. Supp. at 1030.

252. See generally VA. CODE ANN. § 8.01-581.1 (Michie 1992 & Supp. 1995).

253. See *infra* Part V.D.3.

254. *Id.*

255. 830 F. Supp. 1399 (M.D. Ala. 1993); see also *Stevison v. Enid Health Systems, Inc.*, 920 F.2d 710, 713-14 (10th Cir. 1990) (holding that the hospital could be held liable under EMTALA when it did not provide adequate screening for stomach pains which signalled a ruptured appendix that occurred the next day); *Thompson v. St. Anne's Hosp.*, 716 F. Supp. 8, 10 (N.D. Ill. 1989) (holding a hospital liable under EMTALA for rejecting woman with 17 week pregnancy and bleeding); *Burditt v. U.S. Dep't H.H.S.*, 934 F.2d 1362 (5th Cir. 1991) (finding that under EMTALA, a physician had not adequately stabilized a patient with high blood pressure in labor when he sent her away from the emergency room 170 miles to another hospital).

Huckaby, the hospital transferred an unstable patient from the emergency room to another hospital after failing to obtain available neurosurgical help.²⁵⁶ However, in many other cases EMTALA has become an alternative emergency room medical malpractice action, creating a strange cross of federal law and state law.

In *Power v. Arlington Hospital Association*,²⁵⁷ a decision that mixed state and federal law, the Fourth Circuit held that: (1) proof of bad motive or nonmedical reason was *not* required to establish a disparate treatment claim under EMTALA;²⁵⁸ (2) a valid screening claim *was* a "malpractice claim" subject to Virginia's medical malpractice damages cap;²⁵⁹ (3) Virginia's liability limit for tax-exempt hospitals *applied*;²⁶⁰ and (4) Virginia's procedural requirements for malpractice claims *did not apply*.²⁶¹ Similarly, in *Delaney v. Cade*,²⁶² the Tenth Circuit held that a genuine issue of material fact existed for continuation of a malpractice action related to EMTALA's provisions.

Furthermore, some federal district courts have allowed malpractice actions typically handled in state court. This erroneously federalizes such state claims. In *Kaufman v. Cserry*,²⁶³ the court held that there were triable issues of fact as to whether the hospital violated the standard of care in its stabilization of the patient. In *Moore v. John F. Kennedy Memorial Hospital*²⁶⁴ and in *Helton v. Phelps County Regional Medical Center*,²⁶⁵ different federal district courts permitted standard malpractice actions under EMTALA, for physicians' acts during stabilization in an emergency room.

In other district court cases it has become clear that EMTALA preempts a variety of state laws governing medical malpractice. The district court in Kansas held that the state comparative fault law did

256. *Id.*

257. 42 F.3d 851 (4th Cir. 1993).

258. *Id.* at 858 (emphasis added).

259. *Id.* at 861 (emphasis added).

260. *Id.* at 864 (emphasis added).

261. *Id.* at 866 (emphasis added).

262. 986 F.2d 387, 392 (10th Cir. 1993).

263. 856 F. Supp. 1307 (S.D. Ill. 1994).

264. No. CIV.A.93-3428, 1994 WL 2531 (E.D. Pa. Jan. 5, 1994).

265. 817 F. Supp. 789 (E.D. Mo. 1993).

not apply, but damage limitations did apply,²⁶⁶ and in a separate case the same court found that the applicable statute of limitations is federal rather than state.²⁶⁷ A Florida district court held that a patient was not required to comply with Florida presuit procedural requirements for medical malpractice actions, to maintain a suit under EMTALA.²⁶⁸ A Missouri district court held that Missouri law purporting to provide sovereign immunity to a hospital was preempted.²⁶⁹ Finally, an Alabama district court held that the pleading necessary for a state medical malpractice action was totally different from, and irrelevant to, a cause of action based upon a violation of EMTALA.²⁷⁰

Even though a number of decisions prohibit private malpractice causes of action against physicians based on EMTALA,²⁷¹ the stage is set to shift emergency room malpractice actions against institutions to the federal courts through EMTALA. The *Baby K* decision tells plaintiffs with claims against physicians in the emergency room that the door to federal court is open, despite the fact that the physician acted according to accepted professional standards of medical care. As long

266. *Griffith v. Mount Carmel Medical Ctr.*, 842 F. Supp. 1359, 1365 (D. Kan. 1994).

267. *Brewer v. Miami County Hosp.*, 862 F. Supp. 305 (D. Kan. 1994).

268. *Cooper v. Gulf Breeze Hosp., Inc.*, 839 F. Supp. 1538, 1543 (N.D. Fla. 1993).

269. *Helton v. Phelps County Regional Medical Ctr.*, 817 F. Supp. 789 (E.D. Mo. 1993).

270. *Holcomb v. Monahan*, 807 F. Supp. 1526, 1530 (M.D. Ala. 1992) (comparing Alabama Code § 6-5-551 (1975), which applies to claims against health care providers based upon a breach of the standards of care, with 42 U.S.C. § 1395dd (EMTALA), which is based upon liability for violation of statutory requirements).

271. *Barber*, 977 F.2d at 877 (stating that Congress intentionally limited patients to suits against hospitals). Compare similar holdings in *Gateway v. Washington Healthcare Corp.*, 933 F.2d 1037, 1040 n.1 (D.C. Cir. 1991); *Helton*, 817 F. Supp. at 790; *Reynolds v. Mercy Hosp.*, 861 F. Supp. 214, 220 (W.D.N.Y. 1994); *Kaufman v. Cserny*, 856 F. Supp. 1307, 1311 (S.D. Ill. 1994); *Jones v. Wake County Hosp. Sys., Inc.*, 786 F. Supp. 538, 545 (E.D.N.C. 1991); and *Lavignette v. West Jefferson Medical Ctr.*, No. CIV.A.89-5495, 1990 WL 178708 (E.D. La. Nov. 7, 1990) with *Sorrells v. Babcock*, 733 F. Supp. 1189, 1194 (N.D. Ill. 1990) (holding that federal court has jurisdiction in COBRA suits against emergency room physicians who are alleged to have violated COBRA's provisions with civil monetary penalties against a physician for knowingly violating COBRA's provisions). See also 42 U.S.C. § 1395dd(d)(1)(B) (Supp. II 1990); *Moore v. John F. Kennedy Memorial Hosp.*, No. CIV.A.93-3428, 1994 WL 2531 (E.D. Pa. Jan. 5, 1994) (taking supplemental jurisdiction in medical malpractice claim against physician under EMTALA).

as a plaintiff can claim that he was inadequately screened or stabilized, then an action can commence in a federal court.

E. Constitutional Conflicts

The Fourth Circuit did not mention the United States Constitution in its decision. Although, the district court supported Ms. H's right to demand and receive life-sustaining care for Baby K based on constitutional grounds,²⁷² the circuit court chose not to address this important aspect of the case.

The constitutional arguments affirmed by the district court are the backbone of support for parental rights in American constitutional law.²⁷³ The Equal Protection Clause demands only that all persons who are similarly situated be treated alike, and that differential treatment be based upon legitimate criteria.²⁷⁴ The medical standard of care for anencephalics throughout the world is comfort care only,²⁷⁵ and such criteria is legitimate.

Moreover, the Supreme Court has sanctioned variations in autonomy-based rights of children and incompetents.²⁷⁶ In *Cruzan v. Director, Missouri Department of Health*, the Supreme Court embraced a modified right to life²⁷⁷ for permanently unconscious persons. The court based this modification on the patient's quality of life.²⁷⁸ In

272. See *supra* Part IV.A.2. (discussing constitutional underpinnings that support Ms. H's decision).

273. See *supra* Part IV.A.2.

274. *Plyler*, 457 U.S. at 216 (citing *Tigner v. Texas*, 310 U.S. 141, 147 (1940) (stating that the Constitution does not require things which are different in fact to be treated in law as though they were the same); Elizabeth G. Patterson, *Human Rights and Human Life: An Uneven Fit*, 68 TUL. L. REV. 1527, 1556 n.148 (1994) [hereinafter Patterson] (citing *F.S. Royster Guano Co. v. Virginia*, 253 U.S. 412, 415 (1920))).

275. See *supra* note 3.

276. *Bellotti v. Baird*, 443 U.S. 622, 633-37 (1979); *Ginsberg v. New York*, 390 U.S. 629, 637-39 (1968).

277. 497 U.S. 261 (1990); See also, e.g., *Furman v. Georgia*, 408 U.S. 238 (1972).

278. Patterson, *supra* note 274, at 1558 n.159 (Discussing *Cruzan*, 497 U.S. at 274, the court stated:

The opinion contains an extended discussion of state court cases holding that the state has a lessened interest in preservation of life when a patient's condition is

Cruzan, Justice Stevens argued that the sanctity of human life arises from human characteristics that transcend physiology and embrace the human spirit and the history and interests of each individual.²⁷⁹ When human existence is reduced to the mere biological persistence of bodily functions, with no consciousness and no possibility of recovery, “there is serious question as to whether the mere persistence of their bodies is ‘life’ as that word is commonly understood, or as it is used in both the Constitution and the Declaration of Independence.”²⁸⁰

Nonetheless, the district court in *Baby K* supported its holding with a standard right-to-life argument, and the Fourth Circuit implicitly adopted this view by affirming the lower court’s holding. The district court stated that choosing to continue care is not harmful or abusive and therefore cannot be wrong.²⁸¹ However, those in favor of withholding ventilator support from Baby K did not argue that ongoing treatment was harmful or abusive. They believed that keeping such an infant alive was “futile.”²⁸² It appears that the ongoing treatment for this infant had no purpose except to appease the infant’s mother and to avoid the imagined, diabolic, slippery slope of end-of-life decisions.

dire and that withdrawal of life-sustaining treatment could even be in the best interest of such a patient, without any suggestion that this analysis was constitutionally impermissible. *Cruzan*, 497 U.S. at 271-74. The *Cruzan* decision itself allows states to determine the conditions under which a third party may direct that life-sustaining treatment be withdrawn from a permanently unconscious patient. *Cruzan*, 497 U.S. at 281-83. This would seem to distinguish these persons from other incompetent patients, whose constitutional right to life would be violated by a state law allowing third parties to withdraw treatment necessary to continuation of life. Indeed, the treatment of permanently unconscious persons’ interest in life is quite similar to that of fetuses, although one is regarded as a person and the other is not).

279. *Cruzan*, 497 U.S. at 345-47.

280. Patterson, *supra* note 274, at 1561 n.164 (discussing *Cruzan*, 497 U.S. at 345 (1990)); accord *In re* Guardianship of L.W., 482 N.W.2d 60, 70-72 (Wis. 1992) (withdrawing life-sustaining medical treatment from patient in persistent vegetative state does not deprive patient of life for purposes of due process clause); see also *Delio v. Westchester County Medical Ctr.*, 516 N.Y.S.2d 677, 689-91 (N.Y. App. Div. 1987); *In re* Guardianship of Crum, 580 N.E.2d 876, 880 (Ohio 1991) (holding that the state has no interest in preservation of life of person in persistent vegetative state).

281. *Baby K*, 832 F. Supp. at 1031.

282. *Id.* at 1029.

Those who argue to keep the baby alive at all costs make the baby an object of the right-to-life philosophy.²⁸³ By objectifying the baby, this degrades the baby and those who make such an argument. The focus should be on the patient as a person, not on the patient as reduced to a group of separate organ systems.²⁸⁴ The baby should be viewed sympathetically in the reality that she presents: a hopeless accident of nature. She should not be objectified as a servant to “the cause.” To allow Baby K to die does not mean our country or physicians will give up on the thousands of handicapped and aged Americans who have a chance at some quality of life.

F. Ethical Conflicts Inherent in the Decision

The Fourth Circuit cursorily dismissed the ethical concerns of the physicians caring for Baby K.²⁸⁵ Profound ethical questions related to autonomy of patient and physician decision-making, allocation of scarce resources, and patient competence are raised by the *Baby K* decision. These issues have far-reaching consequences at a time when our country faces spiralling health care costs and rationing of health care. The Fourth Circuit has used the plain language of EMTALA to avoid these questions and create a simplistic legal solution. Nonetheless, we must address these ethical questions as we face health care needs of the next century. Unfortunately, the Fourth Circuit refused to address these questions.²⁸⁶

1. Non-Rational Autonomous Coercion²⁸⁷

The foundation of our free society is individual autonomy.²⁸⁸ Au-

283. George J. Annas, *Asking the Courts to Set the Standard of Emergency Care — The Case of Baby K*, 330 NEW ENG. J. MED. 1542, 1544 (1994).

284. *Id.*

285. *Baby K*, 16 F.3d at 597.

286. *Id.* at 598 (“[i]t is beyond the limits of our judicial function to address the moral or ethical propriety of providing emergency stabilizing medical treatment to anencephalic infants”).

287. Gauthier, *supra* note 47, at 35.

288. *Id.* at 33; see also JOHN LOCKE, TWO TREATISES OF GOVERNMENT 288-89 (Peter Laslett ed., 1967); *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dis-

tonomy is classically described as a negative-freedom from interference, not as a positive-freedom to receive or be given something.²⁸⁹ When a person demands that all possible medical care be given to sustain life, regardless of a predictable, devastating outcome, she or he is asking to be given something positive in the name of autonomy. This person takes from the limited resources of the society to appease his or her irrational beliefs.²⁹⁰ This is non-rational autonomous coercion, which is now codified in EMTALA and endorsed by the Fourth Circuit. Thus, any patient or surrogate must be given the stabilization that they demand or the hospital and physicians violate EMTALA.²⁹¹ The number of such cases where physicians must deal with these demands may be increasing.²⁹² However, there are occasional cases such as *Gilgunn v. Massachusetts General Hospital* where a jury has disallowed such coercion.²⁹³

Ms. H's demands for extraordinary care of Baby K were non-rational autonomous coercion. Requiring the hospital to provide ventilator and intensive care for Baby K is costly and sends the message that our country will support coercion when it relates to end-of-life health care decisions. No longer does the physician determine the reasonable options of treatment, now the patient decides. We must determine whether providing highly technical care is worth the expenditure at the end of life.²⁹⁴ When we are faced with a patient for whom this expense will be futile, we must determine what values our society will apply to justly distribute its resources.²⁹⁵ It is more important in some cases

senting) (stating that the right to be left alone is the most comprehensive of rights and the right most valued by civilized man).

289. Gauthier, *supra* note 47, at 33.

290. Kapp, *supra* note 13, at 175 (citing Edward R. Grant, *Medical Futility: Legal and Ethical Aspects*, 20 LAW MED. HEALTH CARE 330 (1992)).

291. *Baby K*, 16 F.3d at 597.

292. Brian McCormick, *Families, Physicians Increasingly in Conflict over Termination of Care*, 34 AM. MED. NEWS 1 (1991).

293. See Gina Kolata, *Court Ruling Limits Rights of Patients: Care Deemed Futile May be Withheld*, N.Y. TIMES, Apr. 22, 1995, at 6. (Discussing the case of Katherine Gilgunn, who died on August 10, 1989, after her doctors issued a do-not-resuscitate order over her family's objections. The jury in the case returned a verdict in favor of the defendant health care providers.)

294. Gauthier, *supra* note 47.

295. *Id.* at 35.

for a society as a whole to decide equitably than to bow to autonomy in every instance.

2. The Issues of Competence and Reasonableness

In *Baby K*, the Hospital did not challenge Ms. H's competence for medical decision-making, so the court did not address this issue. However, patient competence, or alternatively surrogate competence, must be assured before physicians are required to comply with specific demands for medical care.²⁹⁶

Ms. H was intelligent, well-informed, and understood the baby's prognosis. Therefore, she was generally competent to make the treatment decision about Baby K.²⁹⁷ However, we must ask whether her decision was reasonable. It was only reasonable in the context of her fundamentalist faith and was contrarily far afield from the norms of the medical profession. Society should not be responsible for providing treatment at this extreme, and such treatment should not be validated by our courts. Unfortunately, such extreme beliefs have been allowed by other courts when dealing with similar situations,²⁹⁸ and reasonableness of the decisions has not been considered. One court did address reasonableness in a similar case involving a severely impaired infant.²⁹⁹ A Michigan court in *In re Achtabowski* suspended the mother's parental rights and appointed a guardian. The guardian then decided to withdraw life-sustaining treatment from the infant.³⁰⁰ How-

296. MEISEL, *supra* note 72, at 172.

297. *See id.* at 188.

298. *Lane v. Candura*, 376 N.E.2d 1232, 1236 (Mass. 1978) (holding that a court's belief that a person's decision is "irrational" does not make the person incompetent); *In re Wanglie*, No. PX-91-283 (Minn. P. Ct. July 1, 1991), *reprinted in* 7 ISSUES L. & MED. 369, 371 (1991) (A hospital sought to have the husband of a brain-damaged woman declared incompetent to make treatment decisions for her. The court found that "other than proving that [Mr.] Wanglie does not accept the advice and counsel of the physicians . . . [there has been] no evidence that [Mr.] Wanglie is incompetent" to make treatment decisions for his wife.).

299. *Bopp & Coleson*, *supra* note 55, at 822 (citing *In re Achtabowski*, No. G93-142173-GD (Mich. P. Ct. July 30, 1993) (mother found incompetent when she refused to discontinue respirator care on a severely impaired premature infant)).

300. *Id.*

ever, this case is the exception to the rule that if the patient's surrogate is competent, then their decisions are assumed reasonable by the court. The *Baby K* case clearly shows that this rule is flawed. Ms. H was competent, but her decision was not reasonable.

G. Restoring Physician Autonomy and Existing Law without Destroying EMTALA

The Fourth Circuit's interpretation of EMTALA in *Baby K* has propelled an ethical question from the privacy of the doctor-patient relationship into the legal battlefield. Ethical and medical standards of care for terminally ill patients are uncertain because of EMTALA.³⁰¹ In response to this uncertainty, specialty physician groups must exert their influence on Congress to amend EMTALA to permit decisions that are medically appropriate in accordance with current medical standards.

1. Consensus Guideline Development by Medical Specialty Groups

Medical specialty groups have developed consensus guidelines for withdrawing and withholding life-sustaining treatment in certain limited cases.³⁰² However, the Fourth Circuit held that such guidelines are inconsequential to the plain language of EMTALA.³⁰³ Medicine must strive to clarify these guidelines in order to more effectively deal with requests for life prolonging measures.³⁰⁴ Physicians and sub-specialty groups must create a spirit of "openness, due process, and meticulous accountability."³⁰⁵ By creating this environment, it is more likely that patients and surrogates will (1) understand the slim odds for recovery in specific instances, (2) trust that the physician believes withdrawing or withholding care is in the best interests of the patient, and (3) make

301. See *supra* Part V.D.2.

302. Miles, *supra* note 11.

303. *Baby K*, 16 F.3d at 597.

304. Norman Daniels, *The Ideal Advocate and Limited Resources* 8 THEOR. MED. 69-80 (1987).

305. Miles, *supra* note 11.

a rational decision. In turn, the individuals in these families will feel more confidence in their physicians and will be more likely to support physician groups in the legislative process of ratifying these standards.

If specialty groups succeed, they will provide physicians with meticulous data on a patient's chance of survival. Armed with this information, physicians will be less troubled when explaining the limited treatment alternatives that are reasonable. Given the fact that clear guidelines exist for anencephalias, it would have been reasonable for the physicians at the Hospital to refuse to use a ventilator on Baby K from birth. Whatever the outcome, the physicians would have been clearly within the medically accepted standard of care.³⁰⁶

Congress passed EMTALA without foreseeing the problem presented by *Baby K*. However, medical specialty groups are in part to blame. Medical specialty groups should actively continue to develop standards, and energetically help to form the social consensus necessary to guide legislation.³⁰⁷

Along with practice guidelines, specialty groups should develop guidelines for palliative treatments for debilitation and pain. All guidelines should be presented to patients in standard informed consent procedures.³⁰⁸ This would allow the patient to be transferred if indicated, to achieve an understanding about why a particular therapy will or will not be used, and to avoid any suggestion of covert or deceptive decision-making.³⁰⁹

Reasonable withdrawal of care should be as important to medical specialty groups as are other therapeutic decisions. Guidelines cannot be based solely on medicine's ability to keep patients alive, because medicine can keep patients alive through nearly total devastation. Con-

306. *See supra* note 3.

307. *See supra* note 11.

308. 1 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL RESEARCH AND BEHAVIORAL, MAKING HEALTH CARE DECISIONS 43 (1982) ("[I]nformed consent does not mean that patients can insist upon anything they might want. Rather, it is a choice among medically accepted and available options . . .").

309. Miles, *supra* note 11, at 514 (citing American Thoracic Society Position Paper, *Withholding and Withdrawing Life-sustaining Therapy*, 115 ANNALS INTERNAL MED. 478 (1991)).

trary to the adage that physicians should only deal with physiology of the living, specialty groups must grapple with the ultimate goal for a given treatment³¹⁰ and the economic realities of that treatment.³¹¹ There are many voices pleading with Congress to legislate end-of-life decisions. Perhaps, if medical specialty groups speak with strong and clear voices on these issues, Congress will formulate policy that reflects a clinician's view.

2. An Amendment to EMTALA

Unless other circuit courts and the Supreme Court are quick to contradict the Fourth Circuit, Congress should amend EMTALA to support stabilization with medically appropriate care in accordance with current *medical* standards. Such an amendment is needed to prevent patients from demanding and receiving care that is not indicated according to these standards. Moreover, it would limit costs and secure "fairness to [citizens] who have pooled their resources (by purchasing health insurance) to assure their collective access to appropriate health care."³¹²

The ideal amendment should conform with Medicare law,³¹³ protecting the Medicare system from expenditures on services that are the whim of unreasonable patients, and conform with the intent of the Child Abuse Amendments of 1984.³¹⁴ It would bring EMTALA into reasonable accord with the Rehabilitation Act³¹⁵ and with the Americans with Disabilities Act.³¹⁶ Finally, such an amendment would shift malpractice controversies back into state court where they belong.³¹⁷

310. Daniel Callahan, *Medical Futility, Medical Necessity: The Problem Without a Name*, HASTINGS CENTER REP., July-Aug. 1991, at 30.

311. Conny Davinroy Beatty, *Case of No Consent: The DNR Order as a Medical Decision*, 31 ST. LOUIS U. L.J. 699, 715 (1987); Michael Rie, *The Limits of a Wish*, HASTINGS CENTER REP., July-Aug. 1991, at 27 (suggesting the costs and tangential benefits of unrestrained patient or surrogate choice must be taken into account by the community).

312. Miles, *supra* note 11.

313. *See supra* Part V.C.1.

314. *See supra* Part V.C.2.

315. *See supra* Part V.C.3.a.

316. *See supra* Part V.C.3.b.

317. *See generally* VA. CODE ANN. § 8.01-581.1 (Michie 1992).

The Fourth Circuit itself has acknowledged that the area of medical decision-making is best left to physicians. In commenting on EMTALA, the Fourth Circuit stated that even in its weakest moments, Congress would not have attempted to impose federal control of such personal health care decisions. Rather, the statute was designed narrowly to correct a specific abuse: hospital dumping of indigent or uninsured emergency patients.³¹⁸

After such an amendment is passed, in similar cases (like *Baby K*), physicians would feel free to tell the baby's surrogate that such life-sustaining treatment is not offered to a baby with anencephaly. Without using a mechanical ventilator, physicians would provide the comfort measures uniformly given in the past. Such measures would avoid spending nearly half a million dollars on the intensive care of a baby without a brain.

3. Political Realities: Will Resolution be Possible?

An amendment to EMTALA would provide a reasonable resolution to the conflicts enumerated in this Comment. EMTALA would remain intact, functioning to prevent patient "dumping." The constitutional framework used by the district court in *Baby K* would be altered only for the few cases where parents object to clearly articulated medical standards as in the case of anencephaly and Baby K.

However, there are substantial forces that will likely work against such an amendment. First, such an amendment would amount to a form of rationing of medical care, and Congress seems unwilling to ration. A prime example of this is the failure to ration dialysis for end stage renal disease. Congress's response to rationing dialysis in the 1960s and 1970s was to provide dialysis for all who qualified through Medicare.³¹⁹

Second, the present American welfare system encourages the misinterpretation of autonomy to mean that individuals are entitled to

318. *Brooks*, 996 F.2d at 710.

319. Arnold S. Relman & Drummond Rennie, *Treatment of End Stage Renal Disease, Free but Not Equal*, 303 NEW ENG. J. MED. 996 (1980).

goods and services from the society. This contrasts with the classical meaning of autonomy — freedom from interference. Entitlements have extended into health care through Medicare and Medicaid, and EMTALA embodies such an entitlement. The Fourth Circuit's extension of EMTALA to mandate "emergency treatment on demand" is in accord with these other entitlements.

Third, the "right-to-life" forces that were organized around the opposition to abortion have forged an alliance with those advocating "disability rights" and those opposed to the "right-to-die."³²⁰ Each of these groups has reason to oppose a standard of care amendment to EMTALA and would likely do so with vigor. To anti-abortion groups, supporting *Baby K* avoids the slippery slope of infanticide. To disability rights advocates, supporting *Baby K* furthers their goal of preventing the wholesale elimination of the elderly and disabled. To those opposed to the "right to die," supporting *Baby K* furthers their goal of preventing the premature "extermination" of the terminally ill. Those favoring a standard of care amendment to EMTALA must be highly organized and persistent to overcome this principled opposition.

Fourth, medical specialty groups have ample data on the futility of certain medical interventions,³²¹ but none of these has evolved into guidelines which Congress has used as a model of end-of-life decision-making. Although inundated with data, there is no attempt to prune the ever expanding tree of end-of-life medical efforts.

Finally, the fact that *Baby K* was an infant may prevent many politicians from entering the battle for an amendment. Thus, a different type of case may need to surface before such an amendment is possible.

These obstacles can be overcome. Congress is on the verge of major Medicare and Medicaid cutbacks which will require rationing of

320. See *University Hosp.*, 729 F.2d at 145-46 (A. Lawrence Washburn, Jr., a right-to-life attorney, commenced this litigation where parents withheld care from a handicapped newborn. The U.S. Attorney appealed the matter, and the Western Law Center for the Handicapped, The American Coalition of Citizens With Disabilities, The Association For Retarded Citizens, The Association For The Severely Handicapped, Disabled In Action of Metropolitan New York, and The Disabled Rights Union filed briefs for the appellant.).

321. Miles, *supra* note 11.

care. Amending EMTALA in accord with consensus *medical* standards is one way Congress could cut costs.

The proposed amendment does not advocate infanticide, termination of the elderly, or extermination of the disabled. Clear cut guidelines for end-of-life decisions are rare, and when they do exist, they are addressed at those very close to death. Additionally, anti-abortion advocates, disability rights advocates and those opposed to the "right to die" must play a pivotal role in the consensus guidelines that are reached. Balance can be achieved as it was in the Child Abuse Amendments of 1984.

There is accurate data on the efficacy of certain emergency interventions. For example, the use of cardiopulmonary resuscitation for the elderly³²² and for patients with metastatic cancer³²³ reveal extremely poor outcomes. As well, neurologically intact survival in very low birth weight infants is extremely rare.³²⁴ Not all of the potential guidelines relate to handicapped newborns. Congress and specialty groups can join forces to determine what is reasonable care in a limited number of emergency circumstances.

VI. CONCLUSION

The Fourth Circuit has construed the clear language of EMTALA literally, holding that hospitals must provide stabilization on demand of any patient. However, the court's reasoning in support of this construction is faulty when applied to *Baby K*. Existing federal law is ignored or glossed over, state law on medical standards is brushed aside, and fine points of constitutional law are left out. Unfortunately, hospitals now have a mandate for emergency stabilization that does not comport with the principles that govern all other medical care. Although Congress should amend EMTALA so that stabilization will be in accord

322. Donald J. Murphy et al., *Outcomes of CPR in the Elderly*, 111 ANNALS INTERNAL MED. 199 (1989).

323. Faber-Langendoen, *supra* note 185.

324. John D. Lantos et al., *Survival After Cardio-Pulmonary Resuscitation in Babies of Very Low Birth Weight: Is CPR Futile Therapy*, 318 NEW ENG. J. MED. 91 (1988).

with accepted standards of medical care, the passage of such an amendment will be a difficult battle.

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