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Emergency Medical Care for Indigents: All Hospitals Must Provide Stabilizing Treatment or Pay the Price

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EMERGENCY MEDICAL CARE FOR INDIGENTS: ALL HOSPITALS MUST PROVIDE STABILIZING TREATMENT OR PAY THE PRICE

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I. INTRODUCTION

The thought of allowing a critically ill or injured person perish, while the people and equipment capable of saving his or her life stand idle a few yards away, is unconscionable.¹ And yet, similar scenes take place in our hospitals daily.

1. S 1730, 99th Cong., 1st Sess., 131 CONG. REC. 13,903 (daily ed. Oct. 23, 1985) (Sen. Durenberger stated that "the practice of rejecting indigent patients in life threatening situations for economic reasons alone is unconscionable").

It has been estimated that 250,000 deserving people are denied basic emergency medical care in the United States yearly.² One has to ask how such a tragedy can happen in a country that has one of the most advanced health care systems in the world. The simple answer to the question is money. People are denied emergency care because they can't pay for it or have no insurance.

Often, denial of emergency care does not come in the form of an outright refusal. The more common and subtle methods of denial include delay and inappropriate transfer. A transfer is inappropriate when a hospital that is capable of providing the necessary care declines to because of a patient's inability to pay.³ The horror stories of "patient dumping" abound.⁴ When the human factors of these stories are exposed it is difficult to comprehend how such an uncivilized practice has been allowed to take place.

Historically, denial of care by inappropriate transfer has not been sanctioned by the medical profession.⁵ Private hospitals, as well as public hospitals, have a long tradition of charity and indigent care.⁶ It is only the recent soaring costs that have caused some hospitals to reexamine their priorities.⁷ These increased costs were coincidentally encountered with a reduction of state and federal funding. This has only exacerbated the problem.⁸ Another contributing factor is that many private hospitals now view their role as that of a competitive business.⁹ As with any competitive business, bad debts must be minimized. One easy way to minimize debt is to transfer indigent

2. Berliner, *Patient Dumping No One Wins and We All Lose*, 78 AM. J. PUB. HEALTH 1279, 1279 (1988).

3. Zumpft, *The Correction of Interhospital "Dumping" By Legislation*, 6 J. EMERGENCY MED. 443, 444 (1988).

4. Usually, such dumping does not result in death, but occasions where it has are well documented in articles on the subject. For a graphic description of the problem, see Wrenn, *No Insurance, No Admission*, 312 N. ENG. J. MED. 373 (1985). See also Schiff, Ansell, Schlosser, *Transfers to a Public Hospital: A Prospective Study of 467 Patients*, 314 N. ENG. J. MED. 552 (1986).

5. Beitsch, *Economic Patient Dumping: Whose Life is it Anyway?*, 10 J. LEGAL MED. 433, 440 (1989).

6. Uzych, *Patient Dumping*, 77 J. FLA. MED. A. 97, 98 (1990).

7. See McClurg, *Your Money or Your Life: Interpreting the Federal Act Against Patient Dumping*, 24 WAKE FOREST L. REV. 173, 180 (1989).

8. Lebow, *Patient Transfers to a Public Hospital*, 6 J. EMERGENCY MED. 447, 447 (1988).

9. McClurg, *supra* note 7, at 179/5

patients to public facilities. One public hospital that was the recipient of a number of dumped patients incurred a ninety-two day deficit of \$320,000.00 in bad debts shifted to it by local private hospitals.¹⁰ The experiences of that hospital are mirrored by other public hospitals throughout the country.¹¹

It is tempting to rationalize that it is the job of public hospitals to absorb this debt because public hospitals receive public funds. This, however, should not be the critical issue of the problem. The true losers in this fight are not the public hospitals but the indigents who die or are permanently injured as a result of the process.

An economic transfer may save a private hospital some money, but these transfers take time. It is this delay in treatment that may cause irreversible harm.¹² Often, the initial actions of a receiving physician in stabilizing a true emergency patient are the most critical. Because of their inability to pay, indigents have been forced to accept unequal treatment that is not only unfair but disproportionately unsafe.

The Americans that are most likely to have to deal with this problem are the uninsured. Often, the first question asked of an emergency room patient is whether or not he or she has health insurance. It is estimated that there are 37 million people in this country who are uninsured¹³ and possibly up to 15 million who are underinsured.¹⁴ Potentially, 20% of the United States population is affected. These people must live their lives with the knowledge that when they are the most vulnerable, they may face the problem known as "patient dumping."

The purpose of this article is to examine the current law concerning the duty of all hospitals, private and public, to provide basic

10. Kellerman, *Emergency Department Patient 'Dumping': An Analysis of Interhospital Transfers to the Regional Medical Center at Memphis, Tennessee*, 78 AM. J. PUB. HEALTH 1287, 1289 (1988).

11. See Lebow, *supra* note 8, at 447.

12. Uzych, *supra* note 6, at 98.

13. Berliner, *supra* note 2, at 1279. See also Medically Indigent Health Care Service Project: A Report from the Legislative Task Force on Uncompensated Health Care and Medicaid Expenditures (1988). This report by the West Virginia Legislature includes a discussion and illustration of the demographics of the uninsured in West Virginia and the United States.

14. Berliner, *supra* note 2, at 1279.

emergency treatment for all people regardless of economic resources. There have been many recent changes that guarantee that this legal duty does exist. This legal duty is a ripe basis for lawsuits if it is breached. Physicians, hospitals, attorneys and, most of all, patients can gain from a compilation of the current law on the subject.

This note will begin with a brief overview of the common law history of the duty of hospitals to provide emergency care for indigents. The next section examines a recent federal law that imposes a statutory duty on all hospitals which receive federal funds to provide stabilizing treatment for indigent emergency patients.¹⁵ This section includes an analysis of all federal case law which has interpreted the statute. The final section focuses on the role of state law. An attempt will be made to suggest how West Virginia should react to the duty of all hospitals to provide basic emergency care for indigents. The laws of other states will be examined in an attempt to discern some possible solutions to the problem of providing guaranteed emergency medical care for indigents. The more effective alternatives may suggest potential approaches for future legislation in West Virginia.

II. THE COMMON LAW

Until recently, the common law imposed no duty on private hospitals to provide emergency care for people who were unable to pay.¹⁶ A primary example of this no-duty rule was *Birmingham Baptist Hospital v. Crews*.¹⁷ That case involved a two-year-old child who was refused treatment because she had diphtheria.¹⁸ The court in that case held that the hospital was a "private corporation, and not a public institution, and owes no duty to accept any patient not desired by it."¹⁹ There are many examples of courts following this basic no-duty rule.²⁰

15. Social Security Act, 42 U.S.C.S. § 1395dd (Law. Co-op. 1990).

16. Annotation, *Liability of Hospital for Refusal to Admit or Treat Patient*, 35 A.L.R.3d 841, 845 (1971).

17. 229 Ala. 398, 157 So. 224 (1934).

18. *Id.* at 399, 157 So. at 225.

19. *Id.*

20. See *Costa v. Regents of University of California*, 116 Cal. App. 2d 445, 460, 254 P.2d

A sizeable minority of courts, however, managed to find reasons to justify the recognition of a "common law duty to render emergency treatment."²¹ These courts have followed at least three different methods of arriving at the same conclusion.

The first theory set forth to support the minority rule was carved out by a Delaware court using the concept of detrimental reliance. *Wilmington General Hospital v. Manlove*²² was quickly recognized as breaking from the previous rule concerning private hospitals' liability. At the time it was decided, the case was seen as setting the "modern trend of tort liability"²³ in the area. In *Wilmington*, an infant was refused emergency care because she had previously been under the care of another doctor who was not present. The court held that if a patient relies to his detriment upon a "well-established custom of the hospital to render aid in such a case," a duty to render emergency care takes effect.²⁴

The theory of detrimental reliance differed from the no-duty rule only in the emergency room. *Wilmington* and courts that followed it continued to recognize a no-duty rule in non-emergency situations.²⁵ Nevertheless, *Wilmington* was an important step because it was the first case to recognize that a hospital may be liable if it refuses to treat patients with emergency medical conditions.

Another theory in support of the minority rule arose when an Alabama court created liability in the case of a hospital that acted affirmatively to assume an obligation of care for a patient.²⁶ In *Schoulin*, the emergency room orderlies placed the patient on a stretcher and rolled him into the emergency room where he was

85, 95 (1953); *Natale v. Sisters of Mercy*, 243 Iowa 582, 52 N.W.2d 701 (1952); *Hill v. Ohio County*, 468 S.W.2d 306, 309 (Ky. 1970), *cert. denied*, 404 U.S. 1041 (1972); *Levin v. Sinai Hospital of Baltimore*, 186 Md. 174, 180, 46 A.2d 298, 301 (1946); *Van Campen v. Olean General Hospital*, 210 App. Div. 204, 209, 205 N.Y.S. 554, 558, *aff'd*, 239 N.Y. 615, 147 N.E. 219 (1924).

21. McClurg, *supra* note 7, at 183 (to support his conclusion, the author cites cases from the 14 states that have recognized this common law duty).

22. 54 Del. 15, 174 A.2d 135 (1961).

23. Comment, *Torts-Private Hospitals-Liability for Refusal to Provide Emergency Treatment*, 64 W. VA. L. REV. 234, 236 (1961-62).

24. *Wilmington*, 54 Del. at 25, 174 A.2d at 140.

25. *E.g.*, *Stanturf v. Sipes*, 206 N.W.2d 198 (Wis. 1973).

26. *Citizens Hospital Association v. Schoulin*, 48 Ala. App. 101, 262 So. 2d 303 (1972).

examined by a nurse. After examining him and finding out that he lacked insurance, the nurse refused to admit him. Later, the patient was admitted to another hospital where he was diagnosed as having a broken back. The court held that the affirmative action of the nurse created liability.²⁷ This case may be distinguished from *Wilmington* and its progeny because in this case, the hospital was held liable because its employees took affirmative action to care for the patient by placing him on the stretcher. In *Wilmington*, no such affirmative action was present. In both cases, though, the result was the same. The courts recognized a duty by hospitals with emergency rooms to supply the services to those who were in need. The *Wilmington* court relied on the theory of detrimental reliance, while the *Schoulin* court relied on a theory of affirmative action by the employees.

A third theory which has been raised to justify a duty to treat emergency room patients was taken by two state courts in the early 1970's.²⁸ A Wisconsin court affirmed a common law duty for private hospitals to provide such care in *Mercy Medical Center of Oshkosh v. Winnebago County*.²⁹ The court based its opinion squarely on public policy. In that case, a private hospital was seeking to recover funds for emergency services it had rendered to an indigent woman. The court granted the request and noted that "[I]t would shock the public conscience if a person in need of medical emergency aid would be turned down at the door of a hospital having emergency service because that person could not at that moment assure payment for the service."³⁰ Other courts were reluctant to follow a public policy argument.³¹ One other court, however, followed this precedent in 1975. An Arizona court recognized the argument of public policy in *Guerrero v. Copper Queen Hospital*.³² In that case, two Mexican children who had been badly burned were denied care by a private

27. *Id.* at 107, 262 So. 2d at 300.

28. Beitsch, *supra* note 5, at 460.

29. 206 N.W.2d 198 (Wis. 1973).

30. *Id.* at 201.

31. *E.g.*, *Campbell v. Mincey*, 413 F. Supp. 16 (N.D. Miss. 1975), *aff'd mem.*, 542 F.2d 573 (5th Cir. 1976).

32. 112 Ariz. 104, 537 P.2d 1329 (1975).

hospital. Citing state statutes which required all hospitals to maintain emergency rooms, the court held that public policy required hospitals to treat all individuals that present themselves.³³

One recognizable problem with the common law is that there was no consistency from jurisdiction to jurisdiction. The duty to treat was the exception rather than the rule. Relief was only granted in the case of misfeasance, and misfeasance can only be shown where there is a recognized duty that is breached. Since most courts were unwilling to recognize a duty to treat, there was normally no actionable tort for a hospital's failure to provide its gratuitous services. Misfeasance could only exist, therefore, when there was a contractual agreement between hospital and patient, or when the court chose to follow the exceptions mentioned above.

There was also no common definition of what constituted emergency or how much treatment a hospital was required to render before it released a patient. There was no way to determine at what point in the treatment of a patient a hospital had fulfilled its duty to provide emergency care.³⁴ Many states recognized these problems and attempted to remedy them.³⁵ Such attempts met with varying success.

In response to the confusion created by the growing problem of patient dumping and the lack of a consensus on how to deal with the problem, a number of United States senators drafted a law to deal with the problem.³⁶ This law was studied by Congress,³⁷ and was overwhelmingly accepted and passed as an obscure amendment which was attached to the huge Comprehensive Omnibus Budget Reconciliation Act (COBRA) of 1985.³⁸ This legislation has brought much needed attention to patient dumping at a time when the prac-

33. *Id.* at 106, 537 P.2d at 1330.

34. Beitsch, *supra* note 5, at 461.

35. *See infra* note 139 and accompanying text. To date, 21 states have passed laws which recognize and attempt to regulate the problem. The content of these laws varies widely.

36. *See supra* note 1.

37. *See, e.g.*, H.R. REP. NO. 241(1), 99th Cong., 1st Sess. 28 (1985), *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 606.

38. Comprehensive Omnibus Budget Reconciliation Act, Pub. L. No. 99-272, Title IX, § 9121(b), 100 Stat. 164 (1985) [hereinafter COBRA] (codified as amended at 42 U.S.C.S. § 1395dd (Law. Co-op. 1990)).

tice has been growing at an alarming rate. The legislation also created a statutory duty of care which abandons the common law rules.³⁹ The abolishment of the common law rules by the federal statute has greatly contributed to the possibility of controlling patient dumping.

III. A FEDERAL STATUTORY DUTY TO PROVIDE EMERGENCY CARE: COBRA

A. Overview of the Act

The anti-dumping amendment to COBRA is entitled "Examination and Treatment for Emergency Medical Conditions and Women in Active Labor."⁴⁰ The commonly accepted name for the statute is COBRA, obviously named after the huge Act to which it was attached. The official title of COBRA does not do justice to its true purpose or impact. The purpose of the Act is to prevent "patient dumping."⁴¹ The Act is intended to accomplish this goal by providing a set of guidelines which hospitals must follow with respect to emergency patients. The Act also sets standards that must be met before an individual can be transferred.

COBRA applies to all hospitals with emergency room facilities.⁴² The law has subsequently been amended on four occasions. As a result of an amendment to the law in 1989, when an emergency patient presents himself, the hospital must utilize all "ancillary services routinely available to the emergency department" in treating that patient.⁴³ The requirements of the Act are complex, but what the Act basically mandates is that all individuals who present themselves to the emergency room are required to be given an appropriate medical screening examination to determine if an emergency medical condition exists.⁴⁴ If it is determined that an emergency medical condition does exist, the hospital must provide stabilizing treatment.⁴⁵

39. Fine, *Opening the Closed Doors: The Duty of Hospitals to Treat Emergency Patients*, 24 WASH. U.J. URB. & CONTEMP. L. 123, 125 (1983).

40. 42 U.S.C.S. § 1395dd (Law. Co-op. 1990).

41. See *supra* note 1.

42. 42 U.S.C.S. § 1395dd(a) (Law. Co-op. 1990).

43. *Id.*

44. *Id.*

45. *Id.* § 1395dd(b)(1)(A).

In order to properly stabilize a patient, the physician must provide treatment necessary to assure that the patient will not deteriorate in transit to a receiving hospital.⁴⁶ It is only after this initial treatment that a hospital may consider transferring a patient to a public hospital.

Of course, the hospital will not be held liable if the patient refuses treatment or if the patient consents to a transfer prior to stabilization. As a result of the most recent amendment, the hospital is required to inform the individual of all the risks of a transfer and obtain written consent of this refusal of treatment.⁴⁷

The only exceptions that allow a hospital to transfer an unstabilized patient include: a written, informed request for transfer by the individual (or a legally responsible person); and certification signed by a physician that the medical benefits of the transfer outweigh the risks to the individual or unborn child.⁴⁸ An amendment of 1989 also made it mandatory that an individual authorizing the transfer must be a physician, even if a physician is not present in the emergency room.⁴⁹

In order to effect an appropriate transfer, the transferring hospital must first provide stabilizing treatment "within its capacity which minimizes the risks to the individual's health and . . . the health of the unborn child."⁵⁰ The transferring hospital must also obtain an agreement by the receiving facility to accept the transfer, and the receiving facility must be qualified to accept the individual.⁵¹

The transferring hospital must send with the patient all records of the individual, including the diagnosis, observations and treatment provided by the transferring hospital.⁵² The records package must also contain any copies of written informed consent documents

46. *Id.* § 1395dd(e)(3).

47. Pub. L. 101-239, Title VI §§ 6211(b)(1)(A)-(C), Dec. 19, 1989, 103 Stat. 2245, (codified at 42 U.S.C.S. § 1395dd(b)(2) (Law. Co- op. 1990)).

48. 42 U.S.C.S. §§ 1395dd(c)(1)(A)(i), (ii).

49. *Id.* § 1395dd(c)(1)(A)(iii).

50. *Id.* § 1395dd(c)(2)(A).

51. *Id.* § 1395dd(c)(2)(B).

52. *Id.* § 1395dd(c)(2)(C).

and the names of any on-call physicians who refused to respond to the emergency while the patient was at the transferring hospital.⁵³

The Act has stiff enforcement mechanisms. If the Act is violated, there are two options of enforcement: government enforcement and individual civil suits. The government enforcement is handled by the Health Care Financing Administration (HCFA). If the HCFA decides to pursue a claim against a hospital, it may either terminate or suspend the hospital's Medicare provider agreement, making the hospital ineligible to receive Medicare or Medicaid payments, or impose a civil monetary penalty of up to \$50,000 on the hospital, or both. With regard to a physician, the HCFA may either deny that physician participation in any Medicare provider agreements and state health care programs or impose a fine of up to \$50,000, or both.⁵⁴

Medicare provider agreements may be terminated if a hospital or physician violates the provisions of the law either knowingly or negligently.⁵⁵ Monetary penalties, on the other hand, may only be imposed if a hospital or physician violates the provisions knowingly.⁵⁶

The examining physician or an on-call physician may be held liable. The examining physician is responsible if he authorizes a transfer when he knew or should have known that the benefits of such transfer did not outweigh the risks, or if he knowingly misrepresents an individual's condition.⁵⁷ The on-call physician is liable if, after being notified by the examining physician, he refuses to appear or refuses to appear within a reasonable period of time.⁵⁸

The second enforcement provision is the right of any individual "who suffers personal harm as a direct result of a participating hospital's violation . . . [to] obtain those damages available for personal injury under the law of the State in which the hospital is

53. *Id.*

54. *Id.* § 1395dd(d).

55. *Id.* § 1395dd(d)(1).

56. *Id.* §§ 1395dd(d)(2)(A), (B).

57. *Id.* § 1395dd(d)(2)(B).

58. *Id.* § 1395dd(d)(2)(C).

located.”⁵⁹ A hospital that receives a patient in violation of the Act may also sue for its financial loss in treating the individual wrongfully transferred.⁶⁰

The statute of limitations for any suit under the Act is set at two years from the time of the violation.⁶¹ This statute of limitations likely applies in state as well as federal courts that entertain suits under the Act.⁶²

The Act defines the terms which are critical to its enforcement. “Emergency medical condition” is defined as:

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or

(ii) serious impairment to bodily functions, or

(iii) serious disfunction of any bodily organs or part; or

(B) with respect to a pregnant woman who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.⁶³

The language and definitions of COBRA seemed clear when it was passed. In reality, though, COBRA had little effect until the judiciary began interpreting its provisions, thereby giving them concrete meaning. The next section will look at how various courts have interpreted the language of COBRA.

B. Federal Courts Interpret COBRA

Hospitals, physicians and patients initially had many questions about the impact of COBRA. Some questions have been answered,

59. *Id.* § 1395dd(d)(3)(A).

60. *Id.* § 1395dd(d)(3)(B).

61. *Id.* § 1395dd(d)(3)(C).

62. See *infra* notes 78-88 and accompanying text (note particularly the decision affecting state procedural limitations).

63. 42 U.S.C.S. § 1395dd(e)(1).

but many still have not. This section analyzes portions of the thirteen cases wherein federal courts have written opinions clarifying certain issues under the Act.⁶⁴ These cases form a cumulative compilation of all opinions which have been rendered on COBRA. To date, no complaints have been made in any state courts alleging a violation of COBRA. Obviously, the federal cases have only persuasive authority to courts outside their jurisdiction; nevertheless, they are informative, and in the relatively new COBRA cases the federal courts frequently cite persuasive authority from other jurisdictions.

1. Jurisdiction

The first and most pressing issue to be decided was what courts had subject matter jurisdiction over suits brought under the Act. It was decided early that any appeal by a hospital or physician concerned with penalties imposed by the HCFA would be resolved by an Administrative Law Judge of the Federal Department of Health and Human Services.⁶⁵ Generally, therefore, the problem of jurisdiction only applies to suits by individuals under the civil enforcement section of the Act.

The first federal case to clarify any of the issues of the Act was *Bryant v. Riddle Memorial Hospital*.⁶⁶ In that case, the Pennsylvania

64. The cumulative list of federal cases interpreting section 1395dd includes: *Thornton v. South-west Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990); *Wilson v. Atlanticare Medical Center*, 868 F.2d 34 (1st Cir. 1989); *Owens v. Nacogdoches County Hosp.*, No. L-87-97-CA (E.D. Tex. June 26, 1990) (LEXIS, Genfed Library, Dist file); *DeBerry v. Sherman Hosp. Ass'n*, No. 90-C-1173 (N.D. Ill. E.D. June 15, 1990) (LEXIS, Genfed Library, Dist. file); *Sorrells v. Babcock*, 733 F. Supp. 1189 (N.D. Ill. 1990); *Stewart v. Myrick*, 731 F. Supp. 433 (D. Kan. 1990); *Evitt v. University Heights Hosp.*, 727 F. Supp. 495 (S.D. Ind. 1989); *Verhagen v. Olarte*, No. 89 Civ. 300 (S.D.N.Y. Nov. 17, 1989) (LEXIS, Genfed Library, Dist file); *Thompson v. St. Anne's Hosp.*, 716 F. Supp. 8 (N.D. Ill. 1989); *Nichols v. Estabrook*, No. 87-430-D (D.N.H. June 21, 1989) (WESTLAW, DCT database); *Reid v. Indianapolis Osteopathic Medical Hosp.*, 709 F. Supp. 853 (S.D. Ind. 1989); *Maziarka v. St. Elizabeth Hosp.*, No. 88-C-6658 (N.D. Ill. Feb. 15, 1989) (LEXIS, Genfed Library, Dist. file); *Bryant v. Riddle*, 689 F. Supp. 490 (E.D. Pa. 1988).

65. The first case addressing this issue is *Inspector General v. Burdett*, No. C-42, Department of Health and Human Services, Department Appeals Board (July 28, 1989). At present, the HHS has a "punish now, appeal later" approach to fines and suspensions. This has raised a due process question that has not been answered. For a detailed analysis of the frustrations experienced by Dr. Burdett in his fight against the HHS, see Jones, *The Devil or the Sea? Transfer Regulations Create a Dilemma*, 85 TEX. MED. 70 (1989). For a discussion of HHS enforcement, see *infra* notes 129-138 and accompanying text.

66. 699 F. Supp. 490 (E.D. Pa. 1988).

district court confronted the issue of jurisdiction head-on. The plaintiff in that case was a nursing home patient who was taken to a hospital for a separated shoulder.⁶⁷ She was released within 24 hours. The plaintiff filed a suit under 42 U.S.C. 1395dd in federal court alleging that she was released before her condition had stabilized.⁶⁸ The hospital moved to dismiss on the ground that the Act does not provide a basis for federal jurisdiction.⁶⁹ The court rejected that theory and held that the Act does provide a basis for federal jurisdiction because disputes under it are founded on a federal question.⁷⁰ In order to reach this conclusion, the court examined the legislative history of COBRA. In doing so, the court determined that the language of the Judiciary Committee hearing was clear. A member of the committee stated that an aggrieved party may "bring an action in federal or state court."⁷¹ The court concluded its analysis by holding that the clear intent of Congress was to "provide a federal cause of action and to instruct State and federal courts to apply state law when determining damages."⁷² It is obvious from this holding that the *Bryant* court has adopted concurrent subject matter jurisdiction; thus, a suit brought in state or federal court is likely to be within the jurisdiction of that court.

2. Who May Be Sued?

Section 1395dd(a)(d)(A) allows an individual harmed as a result of a violation of COBRA to maintain a private cause of action.⁷³ There is disagreement as to whether this provision is applicable only to hospitals, or both hospitals and physicians. The text of the statute only mentions hospitals,⁷⁴ but an Illinois district court has ruled that physicians may be sued under this provision.⁷⁵ Of the thirteen federal cases pursued under 1395dd(a)(d)(A), three have included physicians

67. *Id.* at 491.

68. *Id.*

69. *Id.*

70. *Id.*

71. *Id.* at 493.

72. *Id.*

73. 42 U.S.C. § 1395dd(d)(3)(A).

74. *Id.*

75. *Sorrels v. Babcock*, 773 F. Supp. 1189, 1194 (N.D. Ill. 1990).

as defendants.⁷⁶ Only one of the three was dismissed, and it was dismissed on other grounds.

A New York district court, on the other hand, stated that physicians may not be sued under the statute⁷⁷ because the plain language of the statute says that only hospitals may be sued. A majority of suits under this provision have supported this conclusion and have only included the hospital as a defendant. It is likely that when the circuit courts are asked to resolve this discrepancy, they will follow the plain meaning of the statute and the majority of the district courts.

3. Conflict of Laws

One problem encountered by the federal courts has been the question of how state law should be applied to the federal cause of action. This question was addressed superficially in *Reid v. Indianapolis Osteopathic Hospital*.⁷⁸ In that case, a patient who had been involved in a serious accident was examined and treated, but soon thereafter transferred to another hospital. After being admitted to the other hospital, she died.⁷⁹ The decedent's administrator brought an action under COBRA alleging that his wife had not received the proper stabilizing treatment by the first hospital prior to transfer. The defendant moved to dismiss because the plaintiff failed to comply with the procedures required by state law before bringing an action for medical malpractice.⁸⁰

Medical malpractice regulation has traditionally been left to the states to implement. The procedural methods of bringing a medical malpractice suit differ between states. Some states require a peer review prior to a suit,⁸¹ while others do not. The crucial question

76. See *id.*; *Stewart v. Myrick*, 731 F. Supp. 433 (D. Kan. 1990); *Nichols v. Estabrook*, No. 87-430-D (D. N.H. June 21, 1989) (WESTLAW, DCT database).

77. *Verhagen v. Olarte*, No. 89 Civ. 300 (S.D.N.Y. Nov. 17, 1989) (LEXIS, Genfed Library, Dist file).

78. 709 F. Supp. 853 (S.D. Ind. 1989).

79. *Id.*

80. *Id.* at 854.

81. *E.g.*, IND. CODE § 16-9.5-9-2 (1990); MASS. GEN. L. ch. 231, § 60B (Mass. Law. Co-op. 1985 & Supp. 1990).

to be decided was whether these limitations applied to federal law.

The court in *Reid* looked to the legislative history of COBRA to determine how to properly apply the state medical malpractice law.⁸² In that case, the applicable law was the law of the state of Indiana. As the court noted:

[I]n Indiana, medical malpractice actions are statutorily limited in two different ways: they are limited procedurally, see IND. CODE 16-9.5-9-2 (stating that '[n]o action against a health care provider may be commenced in any court of this state before the claimant's proposed complaint has been presented to a medical review panel established pursuant to this chapter and an opinion rendered by the panel'), and they are limited [substantively] in the amount of damages they may seek.⁸³

Based on the legislative history, the court decided that Congress did not intend for the procedural limitations of the state medical malpractice laws to apply to the federal cause of action.⁸⁴ The court also reasoned that the preemption clause of the Act directly disallows the application of state procedural limitations.⁸⁵ In contrast to state procedural limitations which do not apply, the court ruled that substantive state laws on limits of recovery do apply.⁸⁶ The court also opined that Congress was "aware of the growing concern in some states that excessive damage awards were fueling a medical malpractice 'crisis.'"⁸⁷ Based on this awareness, the court decided that Congress intended that the substantive limitations will apply.⁸⁸

In *Wilson v. Atlanticare Med. Center*, the First Circuit also briefly discussed the issue of state procedural limitations.⁸⁹ In that case, the administratrix of a nursing home patient brought suit under the Act against a hospital for returning the decedent to her nursing home prematurely, resulting in her death.⁹⁰ While the court never held explicitly that state procedural limitations should apply, it did note

82. *Reid*, 709 F. Supp. at 855.

83. *Id.* at 854.

84. *Id.* at 855.

85. *Id.* (citing to 42 U.S.C. § 1395dd(f)).

86. *Reid*, 709 F. Supp. at 855.

87. *Id.*

88. *Id.*

89. 868 F.2d 34, 35 (1st Cir. 1989).

90. *Id.*

that “[d]octors and hospitals . . . need screening protection against frivolous claims as much under the federal statute [COBRA] as they do for other malpractice charges.”⁹¹ This language is strongly suggestive that the court would apply state procedural limits in COBRA cases.

Arguably, the issue is unresolved because of this apparent conflict. It is likely, however, that the position of the court in *Reid* will be more persuasive because it was a holding by the court, while the statements of the *Wilson* court were dicta. The final resolution of the issue will require the deciding court to look at the preemption clause of the statute. If the court is persuaded, as the *Reid* court was, that the preemption clause prohibits an application of state procedural law, then a federal cause of action under COBRA will not necessitate any compliance with state medical malpractice law.

A final important issue addressed by the court in *Reid* dealt with whether medical malpractice damage caps were the appropriate limitation of recovery or simply damages under state law for personal injury. The statute specifically states that any individual “may . . . obtain those damages available for *personal injury* under the law of the state in which the hospital is located.”⁹² The plaintiff in *Reid* argued that medical malpractice limits do not apply because the statute specifically says “personal injury.”⁹³ The court rejected this notion on the grounds that such an argument would “render the statute’s incorporation clause effectively meaningless.”⁹⁴ In addition, the court reasoned that most medical malpractice damage caps are simply personal injury claims against a health care provider, as is a claim under the federal antidumping act.⁹⁵

4. Strict Liability or Negligence

A collateral issue of *Reid* that was only mentioned briefly, but is likely to cause many questions, is whether an action under the

91. *Id.* at 35.

92. 42 U.S.C.S. § 1395dd(d)(3)(A) (Law. Co-op. 1990).

93. *Reid*, 709 F. Supp. at 855.

94. *Id.*

95. *Id.* at 856.

Act is based on traditional negligence or strict liability. This question is significant because if strict liability is applicable, fault need not be proven. At one point in *Reid*, in relation to the state procedural requirement for a medical malpractice review panel, the court noted that “the panel’s opinion [on negligence] . . . could ‘directly conflict’ with the *strict liability* standards of the federal statute — further justifying preemption.”⁹⁶ Although this comment was dicta, it offers an argument that courts may apply strict liability. Further evidence of this is the language of the statute itself, which requires only proof of violation, causation and damages.⁹⁷

The problem with applying the strict liability standard is that hospitals and physicians may be penalized even if they are able to satisfy the objective negligence test. Later cases have avoided using any references to strict liability and have taken the more reasonable approach that a “violation of a statutory standard of conduct can constitute negligence and may give rise to liability in tort.”⁹⁸ Such an approach will allow a detailed inquiry into whether a patient was properly stabilized in accordance with the requirements of COBRA.

5. Punitive Damages

The question of punitive damages was addressed in the case of *Maziarka v. St. Elizabeth Hospital*.⁹⁹ In that case, an uninsured, elderly man was given emergency treatment by the defendant, but this treatment was discontinued when it was found out that the plaintiff had no insurance. In addition to actual damages and an injunction, the plaintiff sought punitive damages. The court held that actual damages and an injunction were recoverable, but punitive damages were not because the state where the case was heard did not allow punitive damages in medical malpractice cases.¹⁰⁰ This ruling is important because it provides a strong tool to limit damages

96. *Id.* at 855.

97. McClurg, *supra* note 7, at 207. The article by McClurg examines the relationship of strict liability to section 1395dd. The author provides some convincing arguments that the traditional negligence standard should be retained for actions under section 1395dd.

98. *Nichols v. Estabrook*, No. 87-430-D (D. N.H. 1989) (WESTLAW, DCT database).

99. No. 88-C-6658 (N.D. Ill. Feb. 15, 1989) (LEXIS, Genfed Library, Dist file).

100. *Id.*

for a hospital operating in a state which disallows punitive damages for medical malpractice. On the other hand, a patient in a state allowing punitive damages will have a strong argument that those type of damages may be recovered.

6. Determining When a Violation Has Occurred

A recurring basis for dispute over the Act involves the problem of determining when a violation occurs. The language of COBRA states that a violation takes place when an unstabilized patient is transferred inappropriately. For this violation to occur, the hospital or attending physician must take some action. What about the hospital or physician that fails to act or to even examine a patient? Can this hospital or physician be liable under COBRA? An Illinois district court ruled that denial in treating an indigent may equal a violation of the Act.¹⁰¹ The decision is based on the legislative history of COBRA and statutory requirement under the Act to provide stabilizing treatment.¹⁰² It has not been determined in any court what happens when a hospital delays treatment for a patient. All that is clear is that any delay that an indigent may be exposed to should be minimized by treating and processing an indigent patient in the same manner as an insured patient. This seems to be the only sure way for a hospital to avoid liability for delaying treatment.

7. Possible Limitations of COBRA

Many recent cases have made it clear that COBRA may not be the panacea to all emergency room patients who encounter problems. Some courts have demonstrated a willingness to limit the reach of the Act in providing the federal cause of action. The first case to rule against an emergency room patient who had brought an action under COBRA was *Evitt v. University Heights Hosp.*¹⁰³ In that case, a patient was treated and released from the emergency room after

101. *Thompson v. St. Anne's Hosp.*, 716 F. Supp. 8, 9 (N.D. Ill. 1989).

102. 42 U.S.C.S. § 1395dd(b)(1) (Law. Co-op. 1990).

103. 727 F. Supp. 495 (S.D. Ind. 1989).

experiencing chest pains. She was directed to see her own doctor in the morning. The plaintiff later suffered a heart attack.¹⁰⁴

The plaintiff claimed that the hospital failed to provide her with an appropriate screening exam in violation of the provisions of COBRA. The court never resolved the issue because the plaintiff could not show that she was dismissed for economic reasons.¹⁰⁵ The court held that “[c]laims regarding diagnosis and treatment lie in the area of medical malpractice, an area traditionally regulated by state law.”¹⁰⁶ The obvious lesson of this case is that COBRA only applies if an individual is denied treatment for economic reasons. Congress enacted the law to guarantee indigent access to emergency care.

The opinion of the court in *Evitt* was reaffirmed with additional clarity in *Stewart v. Myrick*.¹⁰⁷ That case also involved a patient who came to the emergency room for chest pains. Tragically, the patient died before he could return to the hospital after his release. The patient’s widow sued the hospital and the attending physician.¹⁰⁸ The defendant hospital moved for summary judgment on the ground that the plaintiff’s expert witness agreed that the hospital was not negligent. The court, however, ignored this argument and granted the motion because both parties agreed that the plaintiff had not been turned away for economic reasons.¹⁰⁹

In an effort to avoid summary judgment from the agreed fact that he was not refused treatment due to an inability to pay, the plaintiff argued that the defendants only violated one portion of the Act, namely, the section that requires a screening examination and treatment of emergency medical conditions.¹¹⁰ The court flatly rejected this notion and held that the Act was designed to protect indigents. The court further stated that the case at hand “represents

104. *Id.* at 496.

105. *Id.* at 498.

106. *Id.* at 497. See also *Nichols v. Estabrook*, No. 87-430-D (D.N.H. 1989) (WESTLAW, DCT database) (dismissing the plaintiff’s claim because it was not based on a denial of services for economic reasons).

107. 731 F. Supp. 433 (D. Kan. 1990).

108. *Id.*

109. *Id.* at 434.

110. See *id.* (the plaintiff was alleging violation of § 1395dd(a) and § 1395dd(b)(1)).

a traditional claim for medical malpractice."¹¹¹ It is clear from these cases that a transfer based on economic reasons is a necessary prerequisite to any claim under the Act. For those who feel that they received a misdiagnosis or were turned away for different reasons, their remedy is a suit for medical malpractice under the laws of the appropriate state.

One very recent decision disagrees with the limitations placed on COBRA by *Evitt* and *Stewart*. In *DeBerry v. Sherman Hosp. Ass'n*,¹¹² the court rejected the notion that COBRA is designed only to protect indigents.¹¹³ In that case, the plaintiff's daughter was treated and released for noneconomic reasons. Later, the patient was readmitted and diagnosed as suffering from spinal meningitis. The plaintiff did not allege that she was turned away for economic reasons. The court specifically mentioned the holdings of *Evitt* and *Stewart* when it held that the language of COBRA does not include the limitation that the patient must be dumped for economic reasons in order to be protected by the statute.¹¹⁴ The court accused the courts in *Evitt* and *Stewart* of attempting "to undercut the plain meaning of [a statutory provision] by looking to its legislative history."¹¹⁵

There is no doubt that the legislative history of COBRA mentions many times that the purpose of COBRA is to prevent economic patient dumping.¹¹⁶ The *DeBerry* court, however, is equally correct in its assertion that the plain language of the Act never mentions the economic condition of the patient. Obviously, the opinion of the *DeBerry* court has the potential of greatly increasing the number of patients who can seek the protection of COBRA. The complaint in *DeBerry* alleged that the patient was dumped simply due to an improper diagnosis. Such a claim sounds strikingly similar to a traditional state medical malpractice claim. It is unlikely that any of the sponsors of the Act envisioned that COBRA would be interpreted as broadly as the court in *DeBerry* has interpreted it. This

111. *Stewart v. Myrick*, 731 F. Supp. 433, 436 (D. Kan. 1990).

112. No. 90-C-1173 (N.D. Ill. 1990) (LEXIS, Genfed Library, Dist file).

113. *Id.*

114. *Id.*

115. *Id.* (quoting *Stewart v. Abend*, 110 S. Ct. 1750 (1990)).

116. See *supra* note 1.

is a glaring conflict among the district courts. Until the conflict is resolved, other courts will have to choose whether they accept the reasoning of *Evitt* and *Stewart* or choose to follow the *DeBerry* court.

8. When Hospitals May Cease Treatment Under COBRA

One recent case which highlights another problem of interpreting COBRA is *Thornton v. Southwest Detroit Hosp.*¹¹⁷ This case sets the upper limit on how far treatment of indigents must be taken by a hospital that receives them. Can a hospital discharge patients after no major danger to the patient exists, or must they nurture them to recovery? These issues were examined carefully in *Thornton*. The facts of the case involve an elderly woman who was transferred because of a stroke from her nursing home to the emergency room of the defendant. The hospital provided intensive care treatment and eleven full days of inpatient care. Following this care, the hospital attempted to transfer her to the Detroit Rehabilitation Institute, but the Institute refused to accept her because she was not able to pay for services. Subsequently, the defendant hospital released her for in-home care.¹¹⁸

Initially, the court, *sua sponte*, reaffirmed federal subject matter jurisdiction. It was decided that jurisdiction did exist and that this jurisdiction was founded on the resolution of a federal question.¹¹⁹ The court also made it clear that any claim under the Act must show that the plaintiff had an emergency medical condition and that the plaintiff was transferred before being stabilized.¹²⁰

The court then decided that there was no doubt that the plaintiff had an emergency medical condition prior to being admitted to the hospital. "The key question is whether the Hospital violated the Act by releasing Elease Thornton before her condition 'stabilized.'"¹²¹ The court held that ample evidence showed that the hospital fulfilled

117. 895 F.2d 1131 (6th Cir. 1990).

118. *Id.*

119. *Id.* at 1133.

120. *Id.*

121. *Id.* at 1134.

its requirements under the Act.¹²² The court based its reasoning on the fact that Congress intended the Act to guarantee only emergency treatment to indigents. It was not intended to “bring patients to a complete recovery.”¹²³ Thus, it is apparent from *Thornton* that it is not necessary for a hospital to provide long-term care for indigents.

A collateral issue which was discussed briefly in the opinion was whether COBRA applies to patients who have been previously admitted by the hospital. The defendant in *Thornton* had argued that once admitted, a patient is no longer protected by the Act.¹²⁴ The court rapidly dismissed this argument by stating that “[h]ospitals may not circumvent the requirements of the Act merely by admitting an emergency room patient to the hospital, then immediately discharging that patient.”¹²⁵

The *Thornton* case highlights the problem of drawing a line between emergency care and continuing medical treatment after the patient is stabilized. Many within the medical community are unsure about where to draw the line. On the surface, the answer seems clear enough. COBRA defines the term “stabilize.”¹²⁶ It would seem that hospitals would only need to follow the provisions of the law in order to avoid liability. In practice, though, the process requires some line drawing. In any transfer of an emergency patient there is risk. The problem is how much risk is acceptable. Even a stabilized

122. *Id.* at 1135.

123. *Id.* at 1134.

124. *Id.* at 1135.

125. *Id.*

126. 42 U.S.C.S. § 1395dd(e)(4)(A) (Law. Co-op. 1990). This section provides:

(3)(A) The term “to stabilize” means, with respect to an emergency medical condition described in paragraph (1)(A), 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 from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term “stabilized” means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

patient is at some risk. COBRA provides that an emergency patient may be transferred only when an informed request for transfer is made by the patient, when the medical benefits of the transfer outweigh the risks, or when the patient is stabilized. A patient is stable when there is a “reasonable medical probability, that no significant deterioration is likely to result from the transfer.”¹²⁷ A resolution of the question of what is reasonable will require the use of expert witnesses and will closely resemble a common law suit in negligence.

Some courts, however, have already indicated a willingness to interpret COBRA as imposing strict liability.¹²⁸ Under those rulings, any economic transfer resulting in damages may lead to liability. A majority of the courts which have decided cases under the Act have not followed such a strict liability approach. The trend seems to be that the statute provides the duty, and the violation of this duty must be proven by the complainant. Overall, though, the issue of just when a violation occurs will depend on the facts of each case. In the meantime, physicians and hospitals are warned to take notice of this ambiguity and should attempt to err on the side of certainty. Risky economic transfers are likely to lead to liability.

C. Government Enforcement of COBRA

As the previous section of this note demonstrates, individuals are gradually becoming aware of their rights under COBRA and are exercising these rights in ever-increasing numbers. A concurrent question is whether the federal government is doing its part to see that indigent patients are not being dumped.

The evidence shows that the government is making substantial progress in enforcing the Act. The Health Care Financing Administration (HCFA) of the Department of Health and Human Services has the “primary responsibility for enforcing the . . . provisions.”¹²⁹ No specific regulations regarding enforcement of the Act were pro-

127. Schneider, *Federal Anti-Dumping Law Hospital and Physician Responsibility*, 85 TEX. MED. 58, 59 (1989).

128. Reid v. Indianapolis Osteopathic Hospital, 709 F. Supp. at 855.

129. Uzych, *supra* note 6, at 99.

posed by HCFA until June of 1988.¹³⁰ There was an initial hesitation on the part of the HCFA to enforce the law. This, however, changed after Congress demanded appropriate action.¹³¹ Prior to regulations being enacted, the HCFA had investigated 177 complaints and found 53 hospitals in violation.¹³² As a result of the violations, the HCFA "suspended two Texas hospitals from the Medicare Program and levied more than \$115,000 in fines for patient dumping."¹³³ By the fourth quarter of 1989, the amount of fines levied had reached \$272,999.¹³⁴

These statistics make it clear that the HCFA has begun to have an impact on patient dumping. Obviously, the HCFA has powerful tools to work with, including the ability to strip a hospital of its Medicare provider agreement.¹³⁵ This would spell almost certain death for many hospitals that rely on Medicare funds for a substantial portion of their resources. This penalty is used very sparingly. Most cases of violation generally result in a fine. More often than not, this fine is less than the full amount possible under the provisions.¹³⁶

Ironically, one regional HCFA office has reported that a majority of the complaints which lead to investigations do not come from the patient or family members. A number of the violations are reported by "ambulance crews, law enforcement officers, and other medical personnel."¹³⁷ The fact that other medical personnel reported many of the cases probably stems from their awareness of the law against dumping. In order to protect such whistle-blowers

130. 53 FED. REG. 116,22517 (1988) (to be codified at 42 C.F.R. part 489, pt. 1001 and pt. 1003) (proposed June 16, 1988).

131. Berliner, *supra* note 2, at 1279 (wherein the author makes his conclusion based on the transcript of House Comm. on Government Operations, Equal Access to Health Care: Patient Dumping, 100th Cong., 1st Sess., 149 (1988)).

132. Javurek, *COBRA and Interhospital Transfers*, 41 S.D.J. MED. 21, 22 (1988).

133. Holthaus, *HCFA Eager to Crack Down on Patient Dumping*, 62 HOSP. 82 (1988).

134. Telephone interview with Judy Holtz, Office of Public Affairs of the Office of Inspector General of Health and Human Services (August 9, 1990).

135. Office of Inspector General, *Patient Dumping After COBRA: U.S. Dept. of Health and Human Services Response to Complaints*, OAI 12-88-00831 (Nov. 1988).

136. See Jones, *The Devil or the Sea? Transfer Regulations Create a Dilemma*, 85 TEX. MED. 70, 74 (1989). In the case of *Office of Inspector General v. Burditt*, the government offered to settle for \$2,000. Dr. Burditt refused and was later fined \$20,000. No. C-42, Dept. HHS, Dept. App. Bd. (July 28, 1989).

137. Schneider, *supra* note 126, at 60.

from retaliation by their employers, Congress recently amended COBRA to include what it calls whistle-blower protection:

A participating hospital may not penalize or take adverse action against a physician because the physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized.¹³⁸

Unfortunately, this protection, if interpreted literally, does not really protect whistle-blowers. It only protects physicians who refuse to violate the Act. In addition, it excludes protection for nurses or other nonphysician health care officials. Since a large percentage of complaints come from such people, the law probably ought to be amended again to provide them with protection.

Hospitals should adopt internal regulations to ensure that they comply with COBRA. In doing so, they can avoid the fate of other hospitals that have lost their Medicare provider agreements or physicians that suddenly find themselves penalized by the federal government.

IV. STATE LAWS ON PATIENT DUMPING

In addition to the protection offered by the federal law, twenty-one states have passed laws which attempt to regulate the problem of patient dumping.¹³⁹ The subject matter and scope of these state laws differ as widely as the protection afforded by them. It will be the purpose of this section to briefly review the benefits of such laws. Such a review may provide a guideline for states that are considering implementing or amending similar laws. One example of a state that is presently attempting to deal with the difficult prob-

138. 42 U.S.C.S. § 1395dd(i).

139. ALASKA STAT. § 18.08.086(b) (1986); CAL. HEALTH & SAFETY CODE § 1317.2 (West Supp. 1990); FLA. STAT. ANN. § 395.0144 (West Supp. 1990); GA. CODE ANN. § 31-8-40 (1984); HAW. REV. STAT. § 321-232(b) (1985); IDAHO CODE § 39-1391b (1973); ILL. REV. STAT. ch. 111^{1/2}, para. 86 (1969); KY. REV. STAT. ANN. § 2163.400 (Michie/Bobbs-Merrill Cum. Supp. 1988); LA. REV. STAT. ANN. § 40:2113.6 (West Supp. 1990); MASS. ANN. LAWS ch. 111, § 70E(k) (Law Co-op. 1985); 1987 NEV. STAT. 867; N.Y. PUB. HEALTH LAW § 2805-b (West Supp. 1989); OR. REV. STAT. 441.094 (1987); PA. STAT. ANN. tit. 35, § 449.8 (West Supp. 1990); R.I. GEN. LAWS § 23-17-26 (Michie 1989); S.C. CODE ANN. § 44-7-260(E) (Law. Co-op. 1988); TENN. CODE ANN. § 68-39-301 (1986), 68-11-701 (1972); TEX. HEALTH & SAFETY CODE § 311.022 (Vetron 1989); UTAH CODE ANN. § 26-8-8 (1989); WIS. STAT. ANN. § 146.301 (West 1989); WYO. STAT. § 35-2-115 (1988).

lem of providing health care to indigents is West Virginia.¹⁴⁰

A. *Why State Laws Are Necessary*

COBRA provides an excellent foundation for a solution to the problem. Some states have passed legislation to supplement the federal law or to fill the gaps in it.

Eight of the twenty-one states mandating a duty to provide emergency care have passed their laws since COBRA was enacted in 1985.¹⁴¹ Most states have simply passed prohibitions which really have no substance or enforcement provisions.¹⁴² The sole purpose of such a law is to let those affected by it see that the state is concerned with the problem. Such symbolic action by a state legislature is an important function.¹⁴³ This action shows a resolve by the duly elected representatives of the people to take action with regard to a particular issue.

Other states have taken the opportunity to enact useful laws that fill the gaps of the federal law.¹⁴⁴ This approach is the most effective and desirable way to deal with the problem of patient dumping, because it combines the importance of symbolic action with the effectiveness of purposeful action.

When the Legislature of the State of West Virginia meets in 1993 to decide how to deal with the problem of providing health care to its indigent population, in accordance with W. VA. CODE 16-29C-4,¹⁴⁵ it should seize the opportunity to include in its legislation certain provisions to supplement and support COBRA.

140. W. VA. CODE § 16-29C-4 (1990). This statute appointed a board to study the problem of uncompensated health care. One specified responsibility of the task force is to study the role of "public, private and private non-profit sectors in providing health care services to the citizens of this state." *Id.* Thus, the impact of section 1395dd should be considered when concluding the responsibilities of the above-mentioned health care sectors.

141. Office of the Inspector General, Patient Dumping After COBRA: Assessing the Incidence and the Perspectives of Health Care Professionals, OAI 12-88-00830 (1988).

142. *See, e.g.*, KY. REV. STAT. ANN. § 2163.400 (Michie/Bobbs- Merrill Cum. Supp. 1988).

143. Jacob, Dimensions of State Politics 6 (A. Heard, State Legislatures in American Politics, 1966).

144. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1317.2, 1317.3(d), 1797.98 (West 1990).

145. The statute requires the members of the task force to submit a final report on uncompensated care to the legislature and the joint committee on government and finance, W. VA. CODE § 16-29C-4 (1990).

B. Gaps in COBRA That Have Led to State Solutions

One immediate problem not addressed by COBRA is funding. The Act requires all hospitals (public and private) that receive federal funds to provide emergency care for indigents. No mention of reimbursement is made anywhere in COBRA. Without reimbursement, hospitals may be tempted to sidestep the requirements of the Act in close cases. When provided with assurances that the funding of indigent care will be reimbursed, there is a greater tendency to comply. Very few states have enacted laws which provide for funding of emergency room service for indigents.¹⁴⁶ Obviously, all states have some sort of funding for indigent care at public facilities. The New Jersey and California statutes go beyond this by providing private hospitals a chance to collect for uncompensated care.¹⁴⁷ The California statute is the most practical of the two. It provides for an "Emergency Medical Services Fund."¹⁴⁸ This fund "shall be utilized to reimburse physicians and hospitals for patients who do not make payment for emergency medical services."¹⁴⁹ The fund is to be administered by each county, and the source of the funds is provided from a fractional assessment of \$2.00 for every \$10.00 collected for "every fine, penalty, or forfeiture imposed . . . by the county for criminal offenses."¹⁵⁰ This includes offenses of the Vehicle Code.¹⁵¹ The California statute also provides for the specific procedure that physicians and hospitals may use to apply for reimbursement.¹⁵² The State of West Virginia should adopt a funding program based on either the New Jersey or California statutes or, in the alternative, the West Virginia Legislature should make funds available from its Indigent Care Fund.¹⁵³ The latter could be accomplished by amending the provisions of the Indigent Care Fund. The decision of where the money will come from will have to be left to the Legislature.

146. See, e.g., CAL. HEALTH & SAFETY CODE § 1797.98a (West Supp. 1990); N.J. STAT. ANN. § 26:2H-18.1 (Supp. 1990).

147. *Id.*

148. CAL. HEALTH & SAFETY CODE § 1797.98 (West Supp. 1990).

149. *Id.* 1797.98a.

150. CAL. PENAL CODE § 1465.

151. *Id.*

152. CAL. HEALTH & SAFETY CODE § 1797.98c (West Supp. 1990)

153. See W. VA. CODE § 16-29C-3 (Supp. 1990).

Even the California Legislature acknowledges that it is likely that physicians and hospitals will only recover a portion of their actual expenses,¹⁵⁴ but a portion is better than no recovery at all.

Another potential gap in the federal law is a lack of criminal penalties for violation. Five states have decided that the problem is severe enough to warrant criminal sanctions.¹⁵⁵ The consensus among the states imposing criminal sanctions is that a knowing denial of emergency services to a patient should be classified as a misdemeanor. To a physician who has an unblemished record, the stigma of any criminal conviction, even for a misdemeanor, could provide a strong deterrent. Considering that people have died or been permanently injured as a result of patient dumping, a criminal sanction is appropriate.

The federal law could also use some bolstering in the area of whistle-blower protection. Such protection prevents employer re-primation against conscientious health care providers that inform the appropriate agency when their employers violate the law. COBRA was recently amended to provide such protection, but the protection, when read literally, does not solve the problem.¹⁵⁶ In addition, the protection was not afforded to any employees other than physicians.¹⁵⁷ This protection should be afforded to nurses and emergency medical technicians. In fact, two states have done this by making the protection available to physicians and other personnel.¹⁵⁸ This would be an adequate response.

Inadequate record keeping by hospitals of patient transfers has also hampered federal enforcement of COBRA. COBRA does not require hospitals to keep records of their transfers or the reasons for their transfers. The decision concerning records is left up to the individual hospital administrators. In addition, only a few states require such records to be kept. An appropriate response to the

154. CAL. HEALTH & SAFETY CODE § 1797.98c (West Supp. 1990).

155. See, e.g., TENN. CODE ANN. § 68-39-303 (Supp. 1989).

156. See *supra* note 137 and accompanying text.

157. Social Security Act, 42 U.S.C.S. § 1395dd(f) (Law. Co-op. 1990).

158. See CAL. HEALTH & SAFETY CODE § 1317.4(e) (West Supp. 1990); FLA. STAT. ANN. §

395.0142(4)(c) (West Supp. 1990).

problem is offered by the state of Florida.¹⁵⁹ The Florida statute requires all hospitals to maintain records of transfers. Such a system will allow both federal and state enforcement agencies to properly monitor compliance with the law.

The question of attorney's fees was largely ignored by COBRA. A number of states recently enacted provisions to include the right to recover attorney's fees.¹⁶⁰ Such provisions add some incentive to lawyers to take the cases of indigents who are the most likely to be unable to afford legal assistance to recover for their damages. In a recent federal case, a Texas district court recognized the importance of reimbursing attorneys for assisting indigents.¹⁶¹ In that case, a woman was refused treatment during the final stages of her pregnancy.¹⁶² After the issuance of a restraining order, enjoining the hospital from refusing to deliver the baby, the hospital provided treatment to the plaintiff.¹⁶³ She and her baby were unharmed, but the district court granted damages in the amount of \$25,000 based on the negligent infliction of mental anguish.¹⁶⁴ The court also awarded an additional \$25,000 for attorney's fees.¹⁶⁵

The final noteworthy state law supplement to COBRA is perhaps the most important. It is a clause prohibiting discrimination in providing emergency room care. Such a clause should state in clear, unambiguous language that all hospitals are required to provide emergency medical care to all persons, with emergency conditions, who present themselves, "regardless of race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services."¹⁶⁶ There is no such discrimination clause in COBRA. Such statements comprise the entire leg-

159. FLA. STAT. ANN. § 395.0142(4).

160. *E.g.*, 1987 NEV. STAT. 867.

161. *Owens v. Nacogdoches County Hosp.*, No. L-87-97-CA (E.D. Tx. June 26, 1990) (LEXIS, Genfed Library, Dist file).

162. *Id.*

163. *Id.*

164. *Id.*

165. *Id.*

166. CAL. HEALTH & SAFETY CODE § 1317(b) (West Supp. 1990).

isolation of some of the state laws examined.¹⁶⁷ If a state is truly concerned with solving the problem, though, such a statement should only be an introductory provision.

C. *A Proposal for West Virginia*

Since the Legislature of the State of West Virginia is currently studying its options on how to deal with the problem of providing health care for indigents, it is appropriate to recommend at this point a model for possible legislation. Certainly, this model will only deal with one small portion of the overall problem, namely the provision of emergency medical care. The previous sections outlined some of the shortcomings of COBRA that may be solved at the state level. By including provisions to fill these gaps, West Virginia will come a long way toward further ensuring that indigents are provided emergency care.

It seems logical that any attempt to solve a difficult problem such as this is best handled by using methods that have been tested and determined to be effective. It would be easy to opt for the passage of a simple "statement of findings." In order to be truly effective, legislation must go further to include enforcement provisions.

Based on an analysis of all state laws on the subject, the laws of one state clearly have set the stage for recent legislation in the area of "patient dumping." That state is California. This is not surprising when one considers the fact that of the fifty state legislatures, California was ranked first in effectiveness by the Citizens Conference on State Legislatures.¹⁶⁸ This effectiveness is obviously reflected in California's approach to patient dumping. In fact, a substantial portion of the recent amendments to COBRA were a direct result of the influence of California's legislation.¹⁶⁹

167. *E.g.*, ILL. REV. STAT. ch. 111 $\frac{1}{2}$, para. 86 (1969).

168. Citizens Conference on State Legislatures, *State Legislatures: An Evaluation of Their Effectiveness* 40 (1971).

169. See Office of Inspector General, *Patient Dumping After COBRA: Assessing the Incidence and the Perspectives of Health Care Professionals*, OAI 12-88-0830, at 3 (1988) The California patient dumping legislation was included as an appendix to this report. Some of its provisions were enacted as amendments to COBRA in 1989.

California's legislation covers each of the demonstrated gaps in COBRA. One author summed up the potential impact of California's law as follows:

In many ways, COBRA and California anti-dumping legislation complement one another to maximize the level of protection afforded potential dumping victims. COBRA provides a baseline point of departure for the safeguards California offers. COBRA provides stabilization, California pays for it COBRA grants patients certain rights, California makes certain the patients know about them.¹⁷⁰

Assuming that the Legislature of the State of West Virginia will agree that the problem of patient dumping needs to be addressed, and assuming that this is best accomplished by supplementing pre-existing federal law, it is recommended that the state adopt provisions similar to the California anti-dumping provisions.¹⁷¹

V. CONCLUSION

If an individual is turned away from any hospital emergency room, for economic reasons, that individual will have a cause of action against the hospital and, arguably, the physician for damages. Both hospitals and physicians are subject to fines and penalties that may be imposed by the federal government.

The common law no-duty rule concerning emergency room treatment has been abandoned in its entirety. Where the common law used to provide refuge for private hospitals, there is no longer protection. Congress decided that it was intolerable that institutions set up to help the sick and injured would be able to callously refuse to treat those who could not pay. As a result, COBRA was passed. COBRA applies to as many hospitals as Congress had the power to affect. Any hospital that receives federal funds must comply with its provisions. That includes virtually all hospitals with emergency rooms.

COBRA set the standards for emergency room care by requiring a competent medical screening examination and by setting the re-

170. Beitsch, *supra* note 5, at 474-75.

171. The following California statutes should be examined: CAL. HEALTH & SAFETY CODE §§ 1317-1317.8 & 1797.98a-c (West Supp. 1990).

quirements which must be adhered to prior to transferring a patient. COBRA also provides for enforcement by the government and by an injured individual. The statute's vague language has, however, left many legal questions for the courts in enforcing the Act. Some of the most important legal questions have been answered. It is likely that any court confronted with the subject of patient dumping will refer to the cases mentioned for guidance and information.

The Health Care Financing Administration has also been doing its part to ensure that COBRA is followed. As this enforcement continues, it should place an increasing number of hospitals on notice as to their duty to provide emergency care to all. Eventually, the enforcement procedures will become set, thus allowing all parties to understand what their exact duties are.

COBRA is a good law with an admirable purpose. It has provided a solution for one of the most obvious problems of indigent care, namely, emergency room treatment. Many have lamented COBRA because it has not gone far enough. The problem of indigent health care must, however, be solved politically. At this time in history, COBRA is politically acceptable. COBRA is one step in the right direction. Once taken, that step cannot be retracted. Acceptance of this step is a foundation for another step that can be taken later. In the meantime, all people now have access to emergency room treatment.

Some states have recognized shortcomings in COBRA and have attempted to remedy the problem by enacting statutes to supplement COBRA. The statutes from the State of California are particularly noteworthy. The West Virginia Legislature has already evidenced its concern over the problem of indigent medical care by appointing a task force to study the problem. It is now time for this task force to recommend appropriate solutions. One part of this recommendation should include a statute to supplement COBRA.

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