



1997

The Emergency Medical Treatment and Active Labor Act: An Act Undergoing Judicial Development

Diane S. Mackey

Follow this and additional works at: <https://lawrepository.ualr.edu/lawreview>



Part of the [Health Law and Policy Commons](#)

Recommended Citation

Diane S. Mackey, *The Emergency Medical Treatment and Active Labor Act: An Act Undergoing Judicial Development*, 19 U. ARK. LITTLE ROCK L. REV. 465 (1997).

Available at: <https://lawrepository.ualr.edu/lawreview/vol19/iss3/3>

This Article is brought to you for free and open access by Bowen Law Repository: Scholarship & Archives. It has been accepted for inclusion in University of Arkansas at Little Rock Law Review by an authorized editor of Bowen Law Repository: Scholarship & Archives. For more information, please contact mmserfass@ualr.edu.

THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT: AN ACT UNDERGOING JUDICIAL DEVELOPMENT

*Diane S. Mackey**

I. INTRODUCTION

A. History of the Act

On April 7, 1986, President Reagan signed the Comprehensive Omnibus Budget Reconciliation Act of 1986 ("COBRA").¹ The Emergency Medical Treatment and Active Labor Act ("EMTALA") was enacted as part of COBRA.² The Act is commonly known as the "Patient Anti-Dumping Act." Given the complexity of the Act, it is not surprising that ten years later, unresolved issues and unsuspecting violators exist.³

Congress enacted EMTALA after a series of congressional hearings in response to a growing concern about "the provision of adequate emergency-room medical services to individuals who seek care, particularly the indigent and uninsured."⁴ Congress was concerned that emergency departments were denying uninsured patients the same treatment given to insured patients. In response, Congress wanted to attack the refusal to provide care and the transfer of uninsured patients to other facilities, especially when the receiving facility had not agreed to the patient's transfer. The testimony about patient dumping was stark and persuasive and included the fact that some hospitals were abandoning the tradition that any facility with an emergency department would care for any patient.⁵

The legislative history makes it clear that the dumping of indigent patients and those without health insurance was the focus of EMTALA.⁶ At

* Adjunct Professor of Law, University of Arkansas at Little Rock; J.D., University of Arkansas at Little Rock (1978); B.S., Northwestern University (1958). The author is a partner in the commercial litigation section, with an emphasis on health and environmental law, at the law firm of Friday, Eldredge & Clark in Little Rock.

1. Comprehensive Omnibus Budget Reconciliation Act of 1986 § 9121, 42 U.S.C. § 1395dd (1994).

2. *Id.*

3. "ER Errors Prompt Warnings St. Vincent, Baptist Faced Medicare Pull Out," *Arkansas Democrat-Gazette*, Sept. 8, 1996.

4. H.R. REP. No. 241, 99th Cong., 1st Sess. (1986), reprinted in 1986 U.S.C.C.A.N. 726-27.

5. See generally Note, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. Rev. 1186 (1986); *Equal Access to Health Care: Patient Dumping: Subcomm. on Human Resources and Intergovernmental Relations to the House Committee on Government Operations*, H.R. REP. No. 531, 100th Cong., 2d Sess., 6-7 (1988).

6. COBRA § 9121, 42 U.S.C. § 1395dd (1994). For purposes of scholarship and pleadings, EMTALA is the most useful designation.

enacted statutes requiring hospitals to provide emergency services to some extent. But the House of Representatives found the statutes and common law inadequate protection for patients. Although Congress was primarily concerned about the failure to provide emergency room care because of economic motives, nowhere in the Act did Congress limit its concern to persons without economic resources for emergency care.

B. Ambiguities of the Act

Congress left many undefined terms in EMTALA. In response to the ambiguities, soon after the Act became effective many complaints were filed alleging a variety of EMTALA violations. By 1990, in the Court of Appeals for the Sixth Circuit, EMTALA issues were already being decided.⁷ Courts have been considering a broad range of EMTALA issues ever since.

The plethora of cases is not surprising, given Congress's enactment of a statute with ambiguous or easily misunderstood terminology.⁸ The courts have relied on the legislative history and statutory language in defining some of the Act's requirements and in many cases have genuinely and practically met Congress's intention. The interpretation of other parts of the Act, however, have expanded the Act beyond its scope defined in hearings and in Congress and must be surprising to its sponsors. This expansion has occurred while courts were citing *Chevron U.S.A. v. Natural Resources Defense Council, Inc.*⁹ for the proposition that in any dispute over the meaning of a statute, the language of the statute itself becomes of overriding importance.¹⁰ The Court of Appeals for the Eighth Circuit formulated its interpretative task by requiring that first the plain meaning of the statute be consulted and that the court must give effect to any unambiguously expressed intent of Congress when interpreting the act.¹¹ Despite the occasional expansion, as courts have construed EMTALA, the plain words of the statute have prevailed in most issues relating to interpretation. Thus, because Congress neglected explicitly to include limitation of the Act's purview to the economically disadvantaged and uninsured, the courts have

7. *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990); *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990).

8. EMTALA can stand as an example of many statutes in which Congress sketches in the outline and leaves it to the regulators and courts to fill in the effective meaning of the statute.

9. 467 U.S. 837 (1984).

10. *Id.* at 842-43.

11. *United States v. Manthei*, 979 F.2d 124, 126 (8th Cir. 1992); *see United States v. Talley*, 16 F.3d 972, 976 (8th Cir. 1994).

declined to limit the Act's coverage to that group and instead have looked to the statutory language.

II. APPLICABILITY OF THE STATUTE

The Act protects a wide class of patients from being summarily sent away from an emergency department. According to 42 U.S.C. § 1395dd(a), patients include "any individual" who visits an emergency department. This designation covers a wide range of people, making no distinctions as to whether the patients are insured, employed, decent, dirty, psychotic, in the midst of a drug reaction, illegally in the country, politically unacceptable, or members of any particular social stratus.

Initially the courts struggled with the issue of whether an EMTALA plaintiff would be required to plead and prove an improper motive for denial of emergency services. This was a way of asking whom EMTALA protected. Several courts required plaintiffs to prove some sort of economic motive for their dumping.¹² These decisions were influenced by the legislative history. In the end, they did not prevail.

In *Gatewood v. Washington Healthcare Corp.*,¹³ the court held that EMTALA applied to all patients, regardless of the motive for turning them away. The court noted the Act's legislative history, but felt bound by the Act's unambiguous language to extend its protection to any person presented to the emergency department,¹⁴ especially since to hold that no showing of motive is required is consistent with the legislative intent.¹⁵

The Eighth Circuit did not directly resolve the issue in its earliest EMTALA ruling, *Williams v. Birkeness*,¹⁶ leaving it to the lower courts to struggle with the issue.¹⁷ However, subsequently, the Eighth Circuit was squarely presented with the issue in *Summers v. Baptist Medical Center*

12. See *Cleland*, 917 F.2d at 272; *Coleman v. McCurtain Memorial Medical Management*, 771 F. Supp. 343 (E.D. Okla. 1991); *Stewart v. Myrick*, 731 F. Supp. 433 (D. Kan. 1990); *Nichols v. Estabrook*, 741 F. Supp. 325 (D.N.H. 1989); *Evitt v. University Heights Hosp.*, 727 F. Supp. 495 (S.D. Ind. 1989).

13. 933 F.2d 1037 (D.C. Cir. 1991).

14. *Id.* at 1039-40.

15. See *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 857-58 (4th Cir. 1994); *Baber v. Hospital Corp. of America*, 977 F.2d 872, 880 (4th Cir. 1992) (quoting 131 Cong. Rec. S13, 904 (daily ed. Oct. 23, 1985) (statement of Sen. Durenberger)); *Brooker v. Desert Hosp. Corp.*, 947 F.2d 412, 415 (9th Cir. 1991); *Jones v. Wake County Hosp. Sys.*, 786 F. Supp. 538, 544 (E.D.N.C. 1991); *Deberry v. Sherman Hosp. Ass'n*, 769 F. Supp. 1030, 1034 (N.D. Ill. 1991).

16. 34 F.3d 695 (8th Cir. 1994).

17. See, e.g., *Brodersen v. Sioux Valley Memorial Hosp.*, 902 F. Supp. 931 (N.D. Iowa 1995).

Arkadelphia.¹⁸ In *Summers*, the plaintiff informed the hospital that he had money and insurance. The court stated that the plain language of the statute required that the Act be applicable to "any individual," despite Congress's original intention to prevent hospitals from refusing treatment based on an individual's inability to pay. The court added, "[i]f Congress wishes to narrow the statute's application, it may amend the statutory language."¹⁹ Therefore, in the Eighth Circuit's jurisdiction, any individual is protected by EMTALA. To the extent a split in authority exists, further decisions will perhaps clarify the situation, if Congress or the Supreme Court do not resolve it first.

EMTALA particularly applies to women in active labor. The term "active labor" is defined as labor at a time at which delivery is imminent, or there is inadequate time for a safe transfer, or a transfer poses a threat to mother or baby.²⁰ That term is being further defined by the courts on a case-by-case basis and has been broadened by court interpretation. In *McIntyre v. Schick*,²¹ a period of seventeen hours between discharge and delivery did not protect the hospital from EMTALA liability.²²

Another issue concerns whether the patient must actually come to the emergency department before EMTALA obligations are triggered. The statutory language addressing this issue states, "In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under [Medicare]) comes to the *emergency department*"²³ Another section provides, however, that, "If any individual (whether or not eligible for benefits under [Medicare]) comes *to the hospital* and the hospital determines that the individual has an emergency medical condition"²⁴

Courts have held that the latter language provides that EMTALA is not limited to an admission to the emergency department followed by transfer or discharge of the patient from the hospital.²⁵ In *Thornton v. Southwest Detroit Hospital*,²⁶ the court was concerned that a hospital could admit an

18. 69 F.3d 902, 904 n.3 (8th Cir. 1995), *reh'g en banc*, 91 F.3d 1132 (8th Cir. 1996).

19. *Id.* (citing and relying upon 42 U.S.C. § 1395dd(a) (1994); H.R. REP. No. 241(I), 99th Cong., 2d Sess., at 27 (1976), *reprinted in* 1986 U.S.C.C.A.N. 42, 605); *Gatewood*, 933 F.2d at 1037.

20. 42 U.S.C. § 1395dd (1994).

21. 795 F. Supp 777 (E.D. Va. 1992).

22. *Id.* at 781.

23. 42 U.S.C. § 1395dd(a) (1994) (emphasis added).

24. 42 U.S.C. § 1395dd(b)(1) (1994) (emphasis added).

25. *Helton v. Phelps County Regional Medical Ctr.*, 794 F. Supp. 332 (E.D. Mo. 1992); *Smith v. Richmond Memorial Hosp.*, 416 S.E.2d 689 (Va. 1992), *cert. denied*, 506 U.S. 967 (1992).

26. 895 F.2d 1131 (6th Cir. 1990).

emergency department patient and then immediately discharge him from the service to which the patient was admitted in order to evade EMTALA.²⁷

Given these decisions, a question exists as to whether EMTALA procedures apply to the discharge of any patient who was in an emergency medical condition at any time before routine discharge. Whether an affirmative answer will be universally adopted remains to be seen.

The Health Care Financing Administration's ("HCFA") current position appears to be that if a patient is admitted through the emergency department to an inpatient unit and is found to have been transferred from the inpatient unit to another facility prior to stabilization of the original admitting diagnosis which led to presentation in the emergency department, the hospital must comply with EMTALA transfer requirements. On the other hand, a patient who is admitted through the emergency department to an inpatient unit, but later transferred for an emergency unrelated to the original admitting emergency diagnosis, may be transferred without regard to the EMTALA transfer requirements. This position has been enforced not only by HCFA but by reviewing courts.²⁸

Because EMTALA compliance will be required of their member hospitals, managed-care plans with rigid parameters for discharge should consider the Act before insisting on the discharge of a patient who arguably has not been sufficiently stabilized for appropriate transfer.²⁹ Were a plaintiff to be able to support an allegation of failure to stabilize, the consent, certification, documentation, and appropriate transfer requirements would apply but would not have been met, and an EMTALA claim could be made without any proof of negligence.

If the interpretation that any presentation to the hospital creates EMTALA obligations prevails, those hospitals without emergency departments would also be under the initial screening requirements. The court in *Helton*³⁰ stated that it is the condition of the patient when admitted that is controlling, not the type of facility in the hospital.³¹

It should also be noted that the screening examination that is required is that which is "within the capability of the hospital's emergency depart-

27. *Id.* at 1132.

28. See *Hussain v. Kaiser*, 914 F. Supp 1331 (E.D. Va. 1996); *Smith v. Richmond Memorial Hosp.*, 416 S.E.2d 689 (Va.), *cert. denied*, 506 U.S. 967 (1992).

29. 42 U.S.C. § 1395dd(b)(1) (1994).

30. *Helton*, 794 F. Supp. at 333.

31. *Id.* Subsection (e)(5) of EMTALA specifically includes a rural primary care hospital if it is a Medicare provider. It is commonly accepted that a woman in active labor is a very difficult patient to transfer, even for some rural primary care hospitals or psychiatric facilities, which may be ill equipped for a delivery that it may be required to provide. 42 U.S.C. § 1395dd(e)(5) (1994).

ment, including ancillary services routinely available to the emergency department."³² That standard applies whenever an emergency exists. Not all hospitals have ancillary services. But section 1395dd(b) requires that all hospitals, no matter which facilities are available at that hospital, must either do a further medical examination and treatment to stabilize the condition or provide appropriate transfer to another facility.³³ Therefore, although its facilities may warrant transfer more often, even a psychiatric hospital without an emergency department should be aware of and comply with EMTALA in order to avoid liability.

The Ninth Circuit has considered the applicability of an EMTALA claim under section 1395dd(c)³⁴ alone. That section states:

(c) Restricting transfers until individual stabilized. (1) Rule. If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless—

(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 186(r)(1) [42 USCS § 1395x(r)(1)] has signed a certificate that[,] based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 186(r)(1) [42 USCS § 1395x(r)(1)], in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification³⁵

A subsection (c) claim requires a showing that an individual was at a hospital and has an emergency condition. Hospitals retort that until a hospital determines that a patient has an emergency medical condition under subsection (b), the transfer restrictions of subsection (c) do not operate and EMTALA does not provide the basis for a claim. In other words, the procedural requirements do not come into play until after an "appropriate

32. 42 U.S.C. § 1395dd(a) (1994).

33. *Id.* § 1395dd(b) (1994).

34. *James v. Sunrise Hosp.*, 86 F.3d 885 (9th Cir. 1996).

35. 42 U.S.C. 1395dd(c) (1994).

medical screening examination," and it is determined that the patient has an emergency medical condition. The Ninth Circuit joined four other circuits in holding that there is no liability under subsection (c) unless there has been a determination that the patient has an emergency medical condition.³⁶

In *Gossling v. Hays Medical Center*,³⁷ the court ruled that psychiatric patients are no exception, so long as they are treated in a participating hospital. A community mental health center does not qualify as a participating hospital, so it is not subject to EMTALA.³⁸ The *Gossling* court did not rule on the question of whether a community mental health center that entered into a joint venture with a participating hospital would come within EMTALA's ambit.³⁹ For psychiatric patients who come to the hospital, however, because the duty would be the same to every patient regardless of diagnosis, the answer is so apparent that it does not seem to have been litigated. The psychiatric patient who comes to an acute care hospital must be screened. According to HCFA regulations, even a psychiatric hospital that has never provided emergency services is required by special directive to comply.⁴⁰ A challenge to HCFA's regulation is likely to be forthcoming. In any case, a psychiatric hospital has no duty under EMTALA to provide long-term, non-emergency care.⁴¹

A term that has not served as the basis of dispute is "participating hospital." A hospital is considered to be a participating hospital and must comply with EMTALA if it has a Medicare contract. The patient need not be a Medicare recipient; it is the hospital's provider status that matters.⁴²

The EMTALA status of a patient picked up by ambulance presents questions to which there is currently no one answer. In *Madison v. Jefferson Parish Hospital Service*,⁴³ it was undisputed that the plaintiff never actually entered the hospital. The court focused on two requirements before EMTALA applied: that the individual come to the emergency department,⁴⁴

36. *James v. Sunrise Hosp.*, 86 F.3d 885 (9th Cir. 1996). See also *Urban v. King*, 43 F.3d 523, 525-27 (10th Cir. 1994); *Baber v. Hospital Corp. of Am.*, 977 F.2d 872, 883 (4th Cir. 1992); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991); and *Cleland*, 917 F.2d at 271.

37. Nos. 92-1488-PFK, 93-1302-PFK, 93-1492-PFK, 1995 WL 254269 (D. Kan. 1995).

38. *Id.*

39. *Id.* at *7-8.

40. 59 Fed. Reg. 32,086, 32,101 (1994) (adopted after HCFA lost cases in Texas and the District of Columbia, which ruled that EMTALA did not apply to psychiatric hospitals without emergency departments).

41. *Gossling*, 1995 WL 254269, *9.

42. *Summers*, 91 F.3d 1136-37.

43. *Dt. No. 1*, No. 93-2938, 1995 WL 396316 (E.D. La. 1995).

44. The court stated that "comes to the emergency department" means that "the individual is on hospital property." *Id.* at *1 ("[p]roperty includes ambulances owned and

and that a request be made for examination or treatment.⁴⁵ Thus, as soon as the patient enters the hospital's owned and operated ambulance, EMTALA applied, assuming that the patient or someone on his or her behalf has requested examination or treatment. If the patient is en route in an ambulance that is not owned and operated by the hospital, and the ambulance has not yet arrived on the hospital's property, including the parking lot, the hospital may refuse to accept the patient if the paramedic calls the hospital. If the ambulance comes to the hospital anyway, the hospital must accept the patient. Obviously questions exist about joint-venture and independent contractor relationships between hospitals and ambulance services. These questions have yet to be resolved either by regulation or court decision. The practical implication is that because ambulances may be considered to be part of the hospital, administrators must not neglect training their ambulance or emergency department staffs about EMTALA applicability.

As the court in *Madison* noted, before the Act applies to a patient, the patient or someone on behalf of the patient must make a request for examination or treatment.⁴⁶ That request can be withdrawn by the requesting person or patient.⁴⁷ Special care must be taken in such situations, because the patient's competency to make such a decision will likely be questioned as to whether in fact there was a withdrawal. A request should be presumed for a comatose or incompetent, unaccompanied patient as a matter of hospital risk-reduction policy. That presumption is not specifically required by the statute, but it is likely that courts will infer the request from the patient's presence at the hospital.

To summarize, EMTALA applies to every individual in an emergency medical condition who comes to a hospital, whether the patient is rich or poor or whether he is an acceptable kind of patient.

operated by the hospital, even if the ambulance is not on hospital grounds") (citing 42 C.F.R. § 489.24 (1994)). The language in subsection (b) is simply not discussed.

45. *Id.* at *2. There is no statutory basis for HCFA's interpretation. Therefore, should a hospital be faced with this issue, it has good grounds to challenge the conclusion. Because only hospital owned and operated, not leased ambulances, are subject to this regulation, counsel may wish to arrange the organization of the hospital's ambulance (and clinic) services in light of HCFA's position. *See also*, Letter from Anthony J. Tirone, Director, Office of Survey & Certification, HCFA, to Robert E. Doble, undated.

46. *Madison*, No. 93-2938, 1995 WL 39316 (E.D. La. 1995).

47. When this occurs, clear documentation is required; because in case of an EMTALA challenge, the hospital will presumably have the burden of proving withdrawal.

III. LIABILITY UNDER EMTALA

Hospitals are liable to patients and their families for EMTALA violations.⁴⁸ This liability may extend even to emotional distress, although this determination will vary with the jurisdiction where the case is brought.⁴⁹

Hospitals are liable to patients for violations of EMTALA for all the harm that proximately results from the violations, but hospitals are not liable for bad medical decisions and treatment.⁵⁰ If a patient wants to claim medical malpractice, the patient must allege a pendant claim based on state law. To some extent this permits plaintiffs in non-diversity medical cases to get to federal court if the EMTALA claim is not denied on motion to dismiss or summary judgment. If the EMTALA claim fails, the pendant malpractice claim is subject to dismissal on jurisdictional grounds.⁵¹ The plaintiff must to plead an EMTALA claim, not a medical malpractice claim, to stay in federal court.

The amount of damages awarded is subject to state law, thereby raising questions about the application of comparative fault, damage caps, and procedures.⁵² The private litigant simply files a civil action in federal court to initiate an action against a hospital.

Hospitals are liable to the government for civil penalties as well.⁵³ These penalties are up to \$25,000 for a less than 100-bed hospital and \$50,000 for larger hospitals for each violation. Penalties also include the possibility of the hospital's revocation of Medicare participation.⁵⁴ If the hospital violates EMTALA procedures in dealing with a number of patients due to a faulty emergency protocol, it can be fined for each patient affected.⁵⁵ It is conceivable that a claim under the False Claims Act could

48. 42 U.S.C. § 1395dd(d)(2)(A) (1994).

49. See *McIntyre v. Schick*, 795 F. Supp. 777, 781-82 (E.D. Va. 1992) (patient stating a claim under Virginia law).

50. *Summers v. Baptist Medical Ctr. Arkadelphia*, 91 F.3d 1132, 1136-39 (8th Cir. 1996).

51. See *Palmer v. Hospital Auth. of Randolph County*, 22 F.3d 1559 (11th Cir. 1994). The court had authority, but could dismiss based on its discretion. EMTALA must only be non-frivolous when filed.

52. See, e.g., *Tolton v. American Bisdyne, Inc.*, 48 F.3d 937, 943-44 (6th Cir. 1995); *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 860-66 (4th Cir. 1994); *Tank v. Chronister*, (D. Kan. 1996); *Lane v. Calhoun-Liberty County Hosp. Ass'n, Inc.*, 846 F. Supp. 1543 (N.D. Fla. 1994); *Cooper v. Gulf Breeze Hosp., Inc.*, 839 F. Supp. 1538, 1541-43 (N.D. Fla. 1993); *Helton v. Phelps County Regional Med. Ctr.*, 817 F. Supp. 789, 791-92 (E.D. Mo. 1993); *Griffith v. Mt. Carmel Med. Ctr.*, 826 F. Supp. 382, 383-85 (D. Kan. 1993).

53. 42 U.S.C. § 1395dd(d)(1)(a) (1994).

54. *Id.*

55. 42 U.S.C. §§ 1320a-7a (1996). The procedure by which the government conducts its enforcement and provisions for appeal are located in 42 U.S.C. §§ 1320a-7a(c), (d), and (e).

be filed alleging that the service for which reimbursement is claimed was not delivered if an appropriate screening is not given but the claim for examination is filed anyway.

If a medical facility violates EMTALA when it transfers a patient and the receiving hospital suffers a financial loss as a result, the receiving hospital may institute a civil action to recoup any losses.⁵⁶ The original legislative intent to deal with indigent dumping is evident here.⁵⁷ It would be the indigent patient without insurance who would create a loss for the receiving hospital. Additionally, because Medicaid reimbursement does not reimburse in full, one can imagine that a case could be brought to recover the hospital's difference in cost and Medicaid reimbursement. In fact, this provision⁵⁸ has not been invoked by a great number of hospitals, although anecdotal information indicates a recent increase.⁵⁹

County and municipal hospitals may not avail themselves of sovereign immunity because the suits against them are not suits directly against the state.⁶⁰ The defense of charitable immunity has not been raised in a published EMTALA case, and would be of unpredictable usefulness.

What about physicians? After all, it is they who adopt emergency department protocols and make the medical decisions in those cases where damages are claimed. Nevertheless, a patient cannot file an EMTALA action against a hospital physician.⁶¹

The physician who is responsible for the examination, treatment, or transfer (including the on-call doctor) is, however, liable to the government for civil monetary penalties in the amount of not more than \$50,000 for each violation.⁶² The doctor may even be excluded from Medicare participation if his violation is gross, flagrant, or repeated.⁶³

Imbedded in the language of the statutes are several defenses that a physician may claim to defeat an enforcement action.⁶⁴ He may deny responsibility for the patient, deny that he negligently violated EMTALA,

56. 42 U.S.C. § 1395dd(d)(2)(B) (1994).

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

58. 42 U.S.C. § 1395dd(d)(2)(B) (1994).

59. Presentation by Maureen Mudren, American Hospital Association, Address at the New York Greater Hospital Association (Oct. 11, 1996).

60. *See, e.g., Streight v. Ragland*, 280 Ark. 206, 655 S.W.2d 459 (1983).

61. *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1256 (9th Cir. 1995); *King v. Ahrens*, 16 F.3d 265, 271 (8th Cir. 1994); *Deloney v. Cade*, 986 F.2d 387, 393 (10th Cir. 1993); *Baber v. Hospital Corp. of Am.*, 977 F.2d 872, 878 (4th Cir. 1992). There appears to be no disagreement.

62. 42 U.S.C. § 1395dd(d)(1)(B) (1994).

63. *Id.*

64. The procedure against the physician is governed by 42 U.S.C. § 1320a-7(a) and (b) (1994).

and deny certification or knowledge that the medical risks of transfer would outweigh the benefits. Also, he can maintain that he misrepresented nothing but instead followed the Act.⁶⁵

A word of caution is necessary. When the statute speaks of negligence in connection with a claim against the doctor, it states clearly, "negligently violated EMTALA."⁶⁶ Once again, the plain language shows that the legislative intent is not to federalize general medical negligence. Instead, the statute deals only with violations of EMTALA and its requirements. Those requirements have nothing to do with medical negligence and failure to meet the applicable standard of medical care.

A partial "safe harbor" is provided by the statute for use by a physician in a specific situation.⁶⁷ If the physician conducts a medical examination, presumably "appropriate," and decides that the patient requires services by another doctor who is on-call, notifies the on-call physician, and the on-call physician refuses or fails to appear in a reasonable time, the original doctor can order that the patient be transferred without being subject to a civil monetary penalty by the government because without the services of the on-call physician the benefits of transfer outweigh the risks.⁶⁸ This section does, however, reserve the right for the government to seek penalties from the hospital due to the absent on-call physician.⁶⁹ Presumably, the hospital will be allowed to defend itself on the basis that it and its staff, save for the recalcitrant, physician, performed properly under the Act so that it should not be fined. The Act does not say that; it does say that one person who refuses to do his duty could cost the hospital a huge fine, which would seem highly inequitable. The statute does speak of "such equitable relief as is appropriate" for the patient.⁷⁰ Appropriate equitable relief should also be considered for hospitals in this particular situation no matter who the claimant.

The statute of limitations for actions pursuant to EMTALA is two years after the violation.⁷¹ In a state similar to Arkansas, with a two-year tort statute of limitations,⁷² EMTALA realistically will not be used to "backdoor" an extension of the statute for medical malpractice actions. In states such as Tennessee, however, the applicable statute of limitations is one year, and it would not be surprising to see plaintiffs trying to evade the statute by

65. *Id.*

66. 42 U.S.C. § 1395dd(d)(1)(B) (1994).

67. 42 U.S.C. § 1395dd(d)(1)(C) (1994).

68. *Id.*

69. *Id.*

70. 42 U.S.C. § 1395dd(d)(2)(A) (1994).

71. 42 U.S.C. § 1395dd(d)(2)(C) (1994).

72. ARK. CODE ANN. § 16-14-203 (Michie 1987).

claiming an EMTALA violation, which is really a medical malpractice claim.

Besides damages and fines, injunctive relief to bar future violation is available.⁷³ This sort of relief is more likely, one would expect, in conjunction with a claim for damages rather than standing alone.⁷⁴

IV. PROCEDURAL REQUIREMENTS OF THE ACT

A. The Appropriate Medical Screening Examination

Once a patient has come to the emergency department and a request has been made on his behalf for examination or treatment for a medical condition, the Act states: "[T]he 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 . . ." ⁷⁵ Subsection (b)(1) of the Act does not use the words "appropriate medical screening examination," but the requirement seems implicit, since the subsection states that, "if any individual . . . comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either (a) within the staff and facilities available . . . for such further medical examination and such treatment as may be required to stabilize the medical condition or (B) for transfer of the individual . . ." ⁷⁶

Unfortunately the term "appropriate medical screening examination" is not defined, probably because of the difficulty of getting a consensus on a definition that would apply to each particular medical circumstance. Therefore, it has been left to the courts to define that term. Much of the litigation to date has focused on just what constitutes an "appropriate" examination. The litigation has been particularly important, far beyond the EMTALA need to define the term so that hospitals can act accordingly, because at the heart of the dispute over the definition is the issue of whether EMTALA really is a federal medical malpractice statute in anti-dumping clothing or is instead a statute setting procedural obligations without duties relating to the standard of care. As one court put it, EMTALA is not to decide whether the diagnosis resulting from the examination was right or

73. *Jones v. Wake County Hosp. Sys., Inc.*, 786 F. Supp. 538, 545 (E.D.N.C. 1991).

74. *Cf. Hart v. Riverside Hosp., Inc.*, 899 F. Supp. 264 (E.D. Va. 1995). The *Hart* court also discussed standing in a private action, limiting it to one who has suffered personal harm. *Id.* at 266.

75. 42 U.S.C. § 1395dd(a) (1994).

76. 42 U.S.C. § 1395dd(b)(1)(A)-(B) (1994).

wrong or whether the techniques to stabilize were acceptable within the standards of practice applicable to a given situation.⁷⁷ As each circuit has spoken to the general obligations of a hospital, as to screening and as to stabilization when required, they have spoken clearly to differentiate medical malpractice claims from EMTALA claims.⁷⁸

Therefore, it is clear that when the statute requires an "appropriate" medical screening, it is not speaking of a screening up to the applicable standard of care nor is it speaking of a screening that results in a correct diagnosis.⁷⁹ Instead, the statutory requirement, which makes it "appropriate," is a uniform screening. Each court has formulated the requirement in slightly different language, but that is the heart of their definitions. Often "disparate" or "standard" is added to or substituted for "uniform," but the meaning remains the same: that the screening must be provided that is the same for every patient presented in the same condition.⁸⁰

77. Because of the importance of the answer to this question, many of the cases, when they reached the appellate level, have been argued by amicus curiae. See, e.g., *Summers v. Baptist Medical Ctr.-Arkadelphia*, 69 F.3d 902 (8th Cir. 1995), *reh'g en banc*, 91 F.3d 1132 (8th Cir. 1996) (Arkansas Hosp. Ass'n); *Vogel v. Linde*, 23 F.3d 78 (4th Cir. 1994) (American Hosp. Ass'n); *Bunditt v. U.S. Dep't of Health & Human Servs.*, 934 F.2d 1362 (5th Cir. 1991) (Calif. Med. Ass'n); *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851 (4th Cir. 1994) (American Hosp. Ass'n); *Richmond Memorial Hosp. v. Smith*, 416 S.E.2d 689 (Va.), *cert. denied*, 506 U.S. 967 (1992) (American Hosp. Ass'n).

78. *Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139, 145 (4th Cir. 1996) ("[A]nalysis by hindsight' is not sufficient to impose a liability under EMTALA"); *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995); *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 856 (4th Cir. 1994), *cert. denied*, 117 S. Ct. 514 (1996) ("EMTALA is not a substitute for state law malpractice actions"); *Repp v. Anadorko Mun. Hosp.*, 43 F.3d 519, 522 (10th Cir. 1994) (EMTALA "is 'neither a malpractice nor a negligence statute'"); *Holcomb v. Monahan*, 30 F.3d 116, 117 (11th Cir. 1994) (EMTALA is "not designed to redress a negligent diagnosis"); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991) (EMTALA "is not intended to duplicate pre-existing legal protections").

79. De minimis variations may be tolerated. See, e.g., *Repp v. Anadorko Mun. Hosp.*, 43 F.3d 519, 523 (10th Cir. 1994). But de minimis is in the eye of the beholder, not the hospital.

80. See, e.g., *Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139, 144 (4th Cir. 1996); *Repp v. Anadorko Mun. Hosp.*, 43 F.3d 519, 522 (10th Cir. 1994); *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 856 (4th Cir. 1994); *Matter of Baby K*, 16 F.3d 590, 595 (4th Cir.), *cert. denied*, 115 S. Ct. 91 (1994); *Brooks v. Maryland Gen. Hosp., Inc.* 996 F.2d 708, 713 (4th Cir. 1993); *Baber v. Hospital Corp. of Am.*, 977 F.2d 872, 879 (4th Cir. 1992). Introduction of the term "triage" creates difficulties. If used in the traditional sense that it involves a "sorting" of patients, it is a dangerous concept to introduce into EMTALA compliance procedures, although the Act seems to recognize that uniform treatment is required for patients in the same, not different conditions. Triage is not an appropriate medical screening examination in the EMTALA context. It may begin the examination, but it is not the examination. When state regulations, particularly relating to Medicaid managed care, use the term, it creates confusion among providers.

Power makes it clear that it is up to the hospital to choose whether to have one general or several tailored protocols for screening, depending on the exhibited symptoms.⁸¹ *Summers* adds that the standard screening procedure does not have to be in writing.⁸² In that case, it would seem imperative that all physicians and registered nurses know it. The discussion in *Power*, however, makes it clear that it is not enough to have a standard screening procedure and that everyone know it; it must also be applied every time, twenty-four hours a day. If the hospital departs from this procedure, a violation of EMTALA has occurred.⁸³

EMTALA contains other qualifiers relative to the "appropriate" medical screening. The examination requirement is limited to the capability of the hospital's emergency department, including ancillary services available to the emergency department.⁸⁴ The plain language creates a multilevel definition. A hospital need only screen to the level of its resources; and, of course, these resources will vary. This provision is especially useful for small community and rural hospitals that cannot duplicate the resources of an urban teaching hospital.

The uniformity of screening must apply to the use of available ancillary services.⁸⁵ If an MRI is available, and it would be used should the Governor come to the hospital, then the MRI must be used for all in order to meet the uniformity requirement of an appropriate screening. One assumes that the variety of such resources is one factor that prevented Congress from further defining "appropriate medical screening." The medical screenings must be conducted by a qualified member of the medical staff, a person whose scope of practice includes assessments,⁸⁶ and a sufficient number of medical and nursing personnel must be available to meet anticipated needs.

81. *Power*, 42 F.3d at 859-60.

82. *Summers*, 69 F.3d at 904.

83. See also *Richmond v. Community Hosp. of Roanoke*, 885 F. Supp. 875 (W.D. Va. 1995). *Power* suggests that there could be a uniform screening which is of so little content as to violate EMTALA. *Power v. Arlington Hosp. Ass'n.*, 42 F.3d 851 (4th Cir. 1994).

84. 42 U.S.C. § 1395dd(a) (1994).

85. *Id.*

86. Condition of Participation: Emergency Services, 42 C.F.R. § 482.55 (1997).

B. The "Emergency Medical Condition"

The purpose of required screening is to discover "whether or not an emergency medical condition exists."⁸⁷ The term is quite broad, but has not bred as much specific litigation as the phrase "appropriate medical screening." This may be because Congress used language that practitioners could interpret in the reality of the emergency department. Had EMTALA been ruled to be a federal malpractice statute, however, one would expect that whether a correct determination relating to the patient's medical condition had been made would become the battlefield. Indeed, many EMTALA complaints alleging an inappropriate screening have been dismissed when the complainant was really attacking the diagnosis that no emergency medical condition existed. In the future, attacks on misdiagnoses are vulnerable to dismissal, given the widespread opinions that EMTALA is not concerned with the standard of care, but rather with compliance with procedures. Therefore, it is unlikely that this term, standing alone, will be the focus of court development.⁸⁸

HCFA regulations require that the hospital governing board designate the medical personnel that can serve as qualified medical personnel ("QMP"). Emergency medical technicians or registered nurses have been designated, although physicians are the usual QMPs. Unfortunately, many hospital boards do not know of the requirement, which is not difficult to meet. Designation should provide an opportunity for discussion about all EMTALA requirements at the board level.

87. 42 U.S.C. §1395dd(a) (1994). "Emergency medical condition" is defined in subsection (e)(1) as:

(1) The term 'emergency medical condition' means—

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

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

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

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

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

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

42 U.S.C. § 1395dd(e)(1) (1994).

88. See Condition of Participation: Emergency Services, 42 C.F.R. § 482.55 (1997). The policies and procedures in an emergency department must be established by the medical staff, and are a continuing responsibility of that staff. *Id.*

If after the uniform screening, the determination is made that no emergency medical condition exists, EMTALA obligations end. The Act simply does not apply to a non-emergency situation. No requirement exists to stabilize or transfer, absent the emergency condition.⁸⁹ Adequate documentation of the conclusion and the basis for the conclusion must be entered into the chart and signed by the QMP. Standard emergency department discharge procedures would then take place. State regulations and Medicare standards may require more, most notably a physician's determination.

C. Procedure if the "Condition" Exists

If after the uniform screening, it is determined that an emergency medical condition exists, it is said that the hospital must treat or transfer. The statutory terms are "stabilize" or "transfer." The statute speaks in the alternative.⁹⁰ The hospital's duty is not to alleviate completely an emergency medical condition, but rather to stabilize it.⁹¹

The necessity of transfer is definitional of EMTALA coverage and EMTALA may not be applicable if the patient is immediately admitted to the hospital. In that situation HCFA maintains that when a patient comes in with an emergency medical condition and is admitted, that patient remains an EMTALA case that will require the hospital to follow EMTALA discharge procedures even days later.⁹² The statutory requirement states that the emergency department must attempt to stabilize or to transfer.⁹³ In most

89. *Green v. Reddy*, 918 F. Supp. 329, 334-35 (D. Kan. 1996).

90. *Gatewood*, 933 F.2d at 1041.

91. *Brooker v. Desert Hosp. Corp.*, 947 F.2d 412, 415 (9th Cir. 1991). EMTALA does define "stabilize," in 42 U.S.C. § 1395dd(e)(3)(A) as:

[W]ith 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).

42 U.S.C. § 1395dd(e)(3) (1994).

92. Letter from Teresa L. Trimble, Chief Survey & Certification Branch, Division of Health Standards & Quality to R. C. Sinnott, M.D. (Sept. 26, 1995). *Contra*, *Hussain v. Kaiser Found.*, 914 F. Supp. 1331, 1334-35 (E.D. Va. 1996).

93. 42 U.S.C. § 1395dd(b)(1) states:

If any individual (whether or not eligible for benefits under this subchapter [42

cases the sequence is that if stabilization fails, transfer is undertaken if possible. In those cases in which the facility, immediately after screening, determines that it cannot handle the emergency, transfer is the acceptable alternative. The difference, but not necessarily the sequence, is important, however, in analyzing whether the patient was properly "stabilized," and whether he was properly "transferred." There is no legal support in EMTALA for the proposition that the patient must be stabilized before transfer.

This should not be understood as allowing a hospital to find an emergency medical condition, decide to transfer properly, and do nothing in between. The court noted in *Eberhart* that a hospital should provide individualized treatment to assure that no material deterioration of the patient's condition is likely to result, and hospitals should not merely provide uniform stabilizing procedures.⁹⁴

Keep in mind that the duty to stabilize does not arise until the emergency nature of the condition is known to the QMP. The hospital is required to stabilize only that condition known to it.⁹⁵ One court held that its duty does extend to conditions that the facility should have known.⁹⁶ If, based on what the QMP knows after screening, an emergency condition exists, stabilization efforts or transfer should ensue. The duty to provide stabilizing treatment arises even if the required treatment would exceed the prevailing standard of care.⁹⁷ This does not create a standard of care for

USCS §§ 1395 *et seq.*] comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or (B) for transfer of the individual to another medical facility in accordance with subsection (c).

42 U.S.C. § 1395dd(b)(1) (1994).

94. *Eberhart*, 62 F.3d at 1259. The court wrote, "[We] do note that the stabilization requirement is not met by simply dispensing uniform stabilizing treatment, but rather, by providing the treatment necessary' to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result" 42 U.S.C. 1395dd (e)(3)(A) (1994). *See also*, In the Matter of Baby K, 16 F.3d 590, 596 (4th Cir.) ("The Hospital must provide that treatment necessary to prevent the material deterioration of each patient's emergency medical condition."), *cert. denied*, 115 S. Ct. 91 (1994).

95. *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1259 (9th Cir. 1995); *Baber v. Hospital Corp. of America*, 977 F.2d 872, 883 (4th Cir. 1992); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991); *Cleland v. Bronson Health Care Corp., Inc.*, 917 F.2d 266, 271 (6th Cir. 1990); *Gossling v. Hays Medical Ctr., Nos. 92-1488-PFK, 93-1302-PFK, 93-1492-PFK*, 1995 WL 254269 (D. Kan. Apr. 21, 1995).

96. *Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139 (4th Cir. 1996).

97. In the Matter of Baby K, 16 F.3d 590, 596 (4th Cir.), *cert. denied*, 115 S. Ct. 91 (1994).

stabilization. Instead it means that the facility cannot justify lack of stabilizing treatment on this basis.⁹⁸

The statute provides no explicit guidance for the situation when an emergency medical condition exists but is treated so that an emergency no longer exists. This omission requires the conclusion that EMTALA obligations have ended with the treatment. Stabilized would be an inappropriate term to describe this situation. "Stabilize" implies a continued emergency. Yet stabilization or transfer are the only options provided for in the Act. When there is no continuing emergency, because the emergency has been treated, one would argue that the EMTALA obligations have been met, unless one considers this situation to constitute a transfer. If so, what procedures apply? None are spelled out. A prudent hospital will require careful documentation by a QMP of the basis for a discharge with complete treatment and certification that an emergency medical condition no longer exists. The Department of Health and Human Services has affirmed this principle.⁹⁹ Any conclusion other than that a hospital may discharge a screened and treated patient without EMTALA liability would throw emergency care into total disarray.

On the other hand, an argument that the Act's provisions apply can be made based on statutory language:

The term 'transfer' means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.¹⁰⁰

A strict reading of that language compels the conclusion that every discharge of a patient who had an emergency medical condition is a transfer pursuant to EMTALA. If that is the case, all the requirements of 42 U.S.C. § 1395dd(c) apply to every emergency department discharge, including the certification. Yet the requirements in 42 U.S.C. § 1395dd(c) apply only to unstabilized patients. The patient treated beyond stabilization is not addressed. One can predict, however, that if the decision to release as fully

98. *Id.*

99. Hospital Responsibility for Emergency Care, 53 Fed. Reg. 22,513, 22,517 (1988) (to be codified at 42 C.F.R. § 405). The department's comments relating to the Proposed Rule on Hospital Responsibility for Emergency Care for the Civilian Health and Medical Program of the Uniformed Services included the following: "[T]he hospital is responsible for treating and stabilizing any individual . . . and for providing such care until the condition ceases to be an emergency or until the patient is properly transferred to another facility." *Id.*

100. 42 U.S.C. § 1395dd(e)(4) (1994).

treated is challenged, a battle of experts will ensue as to whether the patient was fully treated, or whether the patient was stabilized.¹⁰¹

Assuming that the patient has been screened and cannot be stabilized, specific procedures for the emergency department personnel are laid out in the Act. If the patient is not stabilized, then the emergency department personnel must follow the special transfer rules.¹⁰² Perhaps because of this specificity, there is less reported litigation on transfer issues, although there may be more enforcement. Nevertheless, there has been recent case law analyzing when transfer requirements apply.¹⁰³

The Act mentions, but has no specific direction for, the patient who is screened and stabilized, but still in need of treatment. It does not state whether the patient may be discharged, admitted, or transferred. Presumably, so long as a hospital can verify that it did stabilize the patient, as defined in EMTALA, it is free to do as it chooses.¹⁰⁴ The decision will be restricted, not by EMTALA, but by the requisite standard of care. At any rate, an attempt to achieve stabilization cannot be avoided by choosing to transfer instead, even though the Act's language seems to offer that alternative. Conservative practice would mandate that, even in the case of a stabilized patient, when a transfer to another medical facility is contemplated, the transfer provisions of 42 U.S.C. § 1395dd(c) must be complied with, even though the Act has no such explicit requirement.¹⁰⁵

101. See, e.g., *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 856 (4th Cir. 1994).

102. *Tank v. Chronister*, 941 F. Supp. 969 (D. Kan. 1996).

103. See, e.g., *James v. Sunrise Hosp.*, 86 F.3d 885 (9th Cir. 1996). In that case the patient was at the hospital before the emergency medical condition occurred. *Id.*

104. See *Green v. Tuoro Infirmary*, 992 F.2d 537, 539 (6th Cir. 1993).

105. EMTALA defines appropriate transfer as follows:

An appropriate transfer to a medical facility is a transfer—

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health, and in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility—

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and

The initial transfer requirements can be summarized as requiring that: (1) the patient or his legal representative consents in writing; (2) the physician signs a certification that the medical benefits of transfer outweigh the risks to the individual; or (3) if the physician is not physically present, a qualified medical person signs the certification after a physician in consultation with the person has made the appropriate risk/benefit determination, and the physician subsequently countersigns the certification.¹⁰⁶ The Act also requires that a summary of the risks and benefits be included in the certification.¹⁰⁷

The plaintiff in an EMTALA action will have the burden of proving, presumably with the help of a medical expert, that any deterioration of condition was likely during, or was the result of, a transfer.¹⁰⁸ The hospital, however, must prove its compliance with the "technical" requirements as set out in subsection (c)(1).¹⁰⁹ Hospitals ought to protect themselves by educating the emergency department staff and adopting a protocol that covers all transfers. Creation of easy to use forms will encourage compliance.

A hospital's compliance will extend to the type of transportation used for a transfer.¹¹⁰ The staffs of the emergency department and ambulances are presumed and required to be adequate. Sending an unstabilized patient in an ordinary automobile would likely be a violation.¹¹¹ Were that the only transportation available, then travel with a qualified person with life support systems in the car might be sufficient. Given the choice between helicopter or ambulance transfer, the helicopter may be required despite its greater cost if time is important.

No transfer may be made of an unstabilized patient without physician approval. In a rural area, where transfer is most likely to be needed, and where physician approval cannot be obtained speedily, this could create a hardship. The Act, however, makes no provision and gives no leeway for such situations.¹¹²

transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

42 U.S.C. § 1395dd(c)(2) (1994).

106. See 42 U.S.C. § 1395dd(c)(1) (1994).

107. *Id.*

108. See *Green*, 992 F.2d at 539; *Deron v. Wilkins*, 879 F. Supp. 603 (S.D. Miss. 1995).

109. 42 U.S.C. § 1395dd(c)(1) (1994).

110. 42 U.S.C. § 1395dd(c)(2)(D) (1994).

111. See *id.*

112. An on-call physician who has an agreement for emergency department coverage with the hospital has a duty to respond, but, according to a Texas court, the physician may

The consent requirement, however, does have provisions to complete transfer despite the absence of consent. This exception should be relied upon only when necessary because a violation could be found if the hospital negligently failed to obtain or pursue consent, or made only halfhearted attempts to get it. Information relating to risks and benefits must be given carefully and will influence consent in most cases. Failure to obtain consent, or even worse, a pattern of failure, would reflect on the informed consent process, as well as EMTALA compliance.

IV. CONCLUSION

EMTALA was enacted to address a specific social problem—the refusal by some hospital emergency departments to care for the medically indigent or uninsured. Courts, however, have interpreted the law to be much broader. What seemed to be a fairly straightforward set of rules has proven difficult to comply with because the Act does not explicitly cover many cases that are presented to an emergency department, and because HCFA regulations have sometimes gone beyond the statutory basis for those regulations.

Nevertheless, every hospital must conform its emergency department practices to the Act's requirements. The Act has been in effect long enough that the claim of innocence due to ignorance will not shield the hospitals and its physicians from liability, unless they can demonstrate earnest efforts to comply with EMTALA.

decline to provide treatment and thereby avoid creating a doctor-patient relationship. The mere fact that the doctor is "on-call" is not enough to create that relationship. *St. John v. Pope*, 901 S.W.2d 420 (Tex. 1995). In reality most on-call doctors will be in a contractual relationship with the hospital and therefore must respond.

