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EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT—ONE OF THESE THINGS IS NOT LIKE THE OTHER: THE ERROR OF APPLYING STATE MEDICAL MALPRACTICE LIMITS TO DAMAGES AWARDED UNDER THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT

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NOTES

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT—ONE OF THESE THINGS IS NOT LIKE THE OTHER: THE ERROR OF APPLYING STATE MEDICAL MALPRACTICE LIMITS TO DAMAGES AWARDED UNDER THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT

INTRODUCTION

In 1986 Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA) in an attempt to bring a stop to the growing practice of patient dumping.[1] Patient dumping occurs when a hospital denies treatment to an emergency patient that is uninsured or impoverished, or when a hospital transfers an uninsured or impoverished patient without properly stabilizing that patient.[2] EMTALA, included as a part of the Comprehensive Omnibus Budget Reconciliation Act of 1986 (COBRA), was intended to stop the practice of patient dumping by requiring participating hospitals[3] to comply with statutory provisions regarding the treatment of patients seeking care for emergency conditions.[4]

Unfortunately, in drafting EMTALA, Congress used language that is both vague and broad,[5] leaving the courts to muddle their way through the interpretation of this statute.[6] One of the issues that the courts of appeals have had to resolve is whether state medical malpractice limits on noneconomic or punitive damages should

1. Amy J. McKitrick, Note, *The Effect of State Medical Malpractice Caps on Damages Awarded Under the Emergency Medical Treatment and Active Labor Act*, 42 CLEV. ST. L. REV. 171, 171 (1994).

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

3. EMTALA defines a "participating hospital" as a "hospital that has entered into a [Medicare] provider agreement under section 1395cc of this title." 42 U.S.C. § 1395dd(e)(2) (2000); *see* McKitrick, *supra* note 1, at 174.

4. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd(a).

5. Michael J. Frank, *Tailoring EMTALA to Better Protect the Indigent: The Supreme Court Precludes One Method of Salvaging a Statute Gone Awry*, 3 DEPAUL J. HEALTH CARE L. 195, 195 (2000).

6. *Id.*

be applied to actions arising under EMTALA.[7] Although some circuits have held that EMTALA is not a federal action for malpractice,[8] others have held that state statutory limits on noneconomic damages for malpractice actions *should* be applied to actions arising under EMTALA.[9] These decisions have allowed a federal statute to move into a terrain reserved for state statutory law.[10] State law damage caps have been applied to some awards for noneconomic damages despite different standards of proof for EMTALA violations and medical malpractice claims.[11]

The courts that have held that state statutory caps on noneconomic or punitive damages should be applied to actions arising under EMTALA have added a meaning to this statute that Congress did not intend. These courts have gone beyond the plain language of the statute in attempting to determine the legislative intent of Congress.[12] This analysis is unnecessary, given the plain language of the statute.[13] Moreover, these decisions have made a violation of EMTALA's standards nothing more or less than a federal cause of action for medical malpractice. This was not Congress's purpose in enacting this statute.[14]

Part I of this Note will provide a background of EMTALA, and will discuss the statutory language, as well as policy reasons for enacting the statute. Part II of this Note will discuss some of the case law that has interpreted EMTALA and will explore the legal context in which an EMTALA action can arise. Specifically, it will explore how the requirements to bring an action under EMTALA differs from those to bring an action under a state medical malpractice law. Part III of this Note will identify and discuss the cases that

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7. *See, e.g.*, Smith v. Botsford Gen. Hosp., 419 F.3d 513, 517 (6th Cir. 2005); *Power*, 42 F.3d 851; Cooper v. Gulf Breeze Hosp., Inc., 839 F. Supp. 1538, 1542 (D. Fla. 1993), *aff'd*, 82 F.3d 429 (11th Cir. 1996).

8. Brooks v. Md. Gen. Hosp., Inc., 996 F.2d 708, 710 (4th Cir. 1993); Baber v. Hosp. Corp. of Am., 977 F.2d 872, 876-77 (4th Cir. 1992). Moreover, it was the Court of Appeals for the Fourth Circuit that later held in *Power* that state malpractice limits should be applied to actions arising under EMTALA despite the fact that it had already held that an action arising under EMTALA was legally different than a state law action for medical malpractice. *Compare Power*, 42 F.3d at 869, *with Brooks*, 996 F.2d at 710, *and Baber*, 977 F.2d at 876-77.

9. *Smith*, 419 F.3d 513; *see also Power*, 42 F.3d at 869.

10. Frank, *supra* note 5, at 195-96.

11. *Cooper*, 839 F. Supp. 1538.

12. *Smith*, 419 F.3d 513; *see also Power*, 42 F.3d 851.

13. *See* Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2000).

14. Baber v. Hosp. Corp. of Am., 977 F.2d 872, 876-77 (4th Cir. 1992).

have dealt with the question of whether state malpractice limits on noneconomic damages should be applied to an action arising under EMTALA. Part IV of this Note will argue that because EMTALA is not merely a malpractice action in a federal venue, there is no legitimate reason that malpractice damage limits should apply to damage awards in actions arising under EMTALA.

I. EMTALA

A. *Policy Reasons for Enacting EMTALA*

In 1986, Congress became acutely aware of a practice among American hospitals known as "patient dumping."[15] The most malicious and obvious type of patient dumping occurs when a hospital denies treatment to any person believed to be uninsured or indigent.[16] In these cases, the patient is "dumped"[17] on another hospital, usually a public facility, despite the fact that the patient may require immediate medical attention.[18] These situations are often so extreme as to inspire disbelief. For example, one such case involved an uninsured man who had severe burns on over ninety-five percent of his body.[19] When his doctor requested that he be admitted immediately, over forty hospitals with separate burn centers refused to treat him, and at least half of the hospitals indicated that their refusal was due to the man's lack of medical insurance.[20]

Patient dumping can also occur before the patient ever reaches the emergency room.[21] Emergency transport crews in ambulances and air transport vehicles can be instructed by hospital officials to divert patients perceived to be uninsured or indigent to public facilities, even though the delay may cause those patients serious medical harm.[22] Additionally, patient dumping can even occur when a receiving hospital refuses to admit a transferred patient due to the

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15. Frank, *supra* note 5, at 197.

16. Andrew Jay McClurg, *Your Money or Your Life: Interpreting the Federal Act Against Patient Dumping*, 24 WAKE FOREST L. REV. 173, 174 (1989).

17. Lawrence E. Singer, *Look What They've Done to My Law, Ma: COBRA's Implosion*, 33 HOUS. L. REV. 113, 126 (1996).

18. *Id.* at 127.

19. Karen I. Treiger, Note, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. REV. 1186, 1186 (1986) (citing *Burn Victim Refused by 40 Hospitals*, WASH. POST, May 12, 1982, at A1). For more examples of malicious patient dumping, see generally H.R. REP. NO. 100-531, at 3-5 (1988).

20. Treiger, *supra* note 19, at 1186.

21. Singer, *supra* note 17, at 127.

22. *Id.* at 128.

individual's lack of insurance.[23] However, patient dumping can be difficult to ascertain given the many forms it can take and the many valid reasons a hospital can offer for its actions.[24] In *Roberts ex rel. Johnson v. Galen of Virginia* the Court of Appeals for the Sixth Circuit attempted to make defining patient dumping easier by requiring the EMTALA plaintiff to prove that the hospital had an improper motive in refusing to treat the patient.[25] The Supreme Court later overturned the Sixth Circuit's decision, holding that the motive of the healthcare provider was irrelevant in an action arising under EMTALA.[26]

EMTALA, commonly known as the "anti-dumping statute,"[27] was enacted to put an end to patient dumping by creating administrative and civil enforcement measures for hospitals that violate the provisions of the statute.[28] By making patient dumping illegal and creating consequences for the hospitals that continue to engage in the practice, EMTALA managed to fill a hole usually left by state law.[29]

Several courts, including the Courts of Appeals for the Sixth, Eighth, and D.C. Circuits have construed EMTALA according to the plain language of the statute and its purpose of preventing patient dumping.[30] "Hoping to prevent EMTALA from becoming a malpractice statute, these Circuits have held that . . . courts should only address the question of whether the hospital's procedures are

23. *Id.* at 127.

24. *Id.* at 128 ("Delays in treatment, referrals, or patient transfers all can be appropriate responses of a taxed institution seeking to provide quality medical care responsive to a patient's needs.").

25. Roberts *ex rel.* Johnson v. Galen of Va., Inc., 111 F.3d 405, 409 (6th Cir. 1997) ("The District Court in the instant case properly interpreted the *Cleland* holding as requiring that a plaintiff prove a hospital acted with an improper motive in order to recover under the EMTALA."), *rev'd*, 525 U.S. 249 (1999).

26. Roberts *ex rel* Johnson v. Galen of Va., Inc., 525 U.S. 249, 253 (1999) (holding that EMTALA "contains no express or implied 'improper motive' requirement"). For an explanation of how the decision of the Supreme Court in *Roberts* increased the field of confusion surrounding the scope of EMTALA, see Frank, *supra* note 5, at 230-31, 236.

27. Arrington v. Wong, 237 F.3d 1066, 1069 (9th Cir. 2001).

28. 42 U.S.C § 1395dd(d) (2000).

29. EMTALA was largely designed to punish hospitals' conduct that is not covered by state medical malpractice statutes. While EMTALA proscribes patient dumping, or a refusal to treat, state common law and state medical malpractice statutes proscribe incompetent or negligent care. Therefore, the proof in a malpractice claim tends to show that the defendant acted in a manner below the professional standard of care, and that this substandard care was the cause of the plaintiff's injuries. *See infra* Part II.A.

30. Frank, *supra* note 5, at 206-07.

uniformly followed, regardless of a patient's insurance status or other nonmedical factors."[31]

B. *The Statutory Landscape of EMTALA*

In general, EMTALA requires participating hospitals[32] to (1) provide a medical screening for "any individual" for whom "a request is made,"[33] and (2) refrain from transferring any patient, for any reason, unless certain provisions regarding stabilization are met.[34] In order to properly understand the obligation of participating hospitals, each requirement must be looked at individually.

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31. *Id.* at 207.

32. The American Hospital Association's statistics indicate that ninety-eight percent of all the hospitals in the United States and its territories are participating hospitals as defined by the provisions of EMTALA. Treiger, *supra* note 19, at 1186, 1188 n.19.

33. 42 U.S.C. § 1395dd(a). "[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, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists." *Id.* However, the Act fails to define the meaning of the word "appropriate." *See id.*

34. *Id.* § 1395dd(c)(2).

> An appropriate transfer . . . 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 with 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)) 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 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.

Id.

1. The Medical Screening Requirement

The "appropriate medical screening examination"[35] requirement is the crucial part of the statute[36] because the examination determines if the patient has an emergency medical condition, which triggers EMTALA's stabilization or transfer requirement.[37] If an individual arrives at a hospital and is determined *not* to have an emergency medical condition, the stabilization or transfer requirement of EMTALA will never arise, and the individual will not have a claim for civil enforcement of the statute.[38] Consequently, the question of whether administrative or civil enforcement measures can be brought against a participating hospital depends almost entirely on whether the hospital provided an "appropriate medical screening examination."[39] Because Congress did not define the meaning of the word "appropriate" in the statute,[40] the courts have been left to find their own method of determining its meaning.[41] Most courts have held an "appropriate medical screening examination" is one that would be given to all patients, regardless of economic motivations.[42] Therefore, a hospital can comply with this provision of the statute by creating and maintaining a standard screening process, and by applying that same screening process to any patient that comes into the emergency room seeking medical attention.[43] Moreover, a "minimal variation" from that

35. *Id.* § 1395dd(a).

36. *See id.* (requiring an "appropriate medical screening examination").

37. *See id.* § 1395dd(b)(1).

> 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 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) of this section.

Id. (emphasis added).

38. *Id.* § 1395dd(b).

39. 42 U.S.C. § 1395dd(a); *see also* Singer, *supra* note 17, at 138.

40. *See* 42 U.S.C. § 1395dd(a).

41. *See* McKitrick, *supra* note 1, at 174 & n.15 (citing Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 272 (6th Cir. 1990), which held that "appropriate" would be defined using a subjective standard, rather than the objective standard used in determining medical malpractice).

42. Frank, *supra* note 5, at 207.

43. Alicia K. Dowdy, Gail N. Friend & Jennifer L. Rangel, *The Anatomy of EMTALA: A Litigator's Guide*, 27 ST. MARY'S L.J. 463, 476 (1996).

screening process will not be sufficient to give rise to a violation of EMTALA.[44]

Once the medical screening has been completed, the remaining issue is whether the patient has an "emergency medical condition" as defined by the statute.[45] If the emergency room staff determines that an "emergency medical condition"[46] exists, the stabilization and transfer requirements are triggered, and if not properly complied with, can give rise to a cause of action under EMTALA.[47]

2. The Stabilization and Transfer Requirements

"Once a hospital has actual knowledge of a patient's emergency medical condition,"[48] EMTALA allows it to take one of two actions. The hospital can choose to provide the necessary medical treatment to the patient "within the staff and facilities available at the hospital,"[49] or, in the alternative, the hospital officials can opt to transfer the patient to another hospital.[50] If the hospital authorities decide to transfer the patient they must first ensure that the conditions imposed by EMTALA have been met.[51]

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44. *Id.* However, "[a] participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) of this section in order to inquire about the individual's method of payment or insurance status." 42 U.S.C. § 1395dd(h).

45. 42 U.S.C. § 1395dd(e)(1). EMTALA defines an "emergency medical condition" as:

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

Id. (citation omitted).

46. *Id.*

47. *Id.* § 1395dd(a)-(b).

48. Dowdy, Friend & Rangel, *supra* note 43, at 482.

49. 42 U.S.C. § 1395dd(b)(1)(A).

50. *Id.* § 1395dd(b)(1) (allowing hospitals to transfer patients with emergency conditions once certain conditions are met).

51. *Id.* § 1395dd(b)(1)(B), (c)(1).

First among these conditions is the requirement that the patient be stabilized before any transfer occurs.[52] However, the Act also carves out exceptions to the stabilization requirement.[53] If "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," then transferring that individual without first ensuring stabilization will not be a violation of the statute.[54] Additionally, if the transfer of the individual is an "appropriate transfer," then a transfer of that individual without first ensuring stabilization will not be a violation of the statute.[55] Unless a patient is properly stabilized, or the individual case falls within one of the statutory exceptions described above, the transfer of the patient will give rise to a cause of action under EMTALA.[56]

C. *Administrative and Civil Enforcement of EMTALA*

A statutory violation of EMTALA can occur at two different points between an individual's arrival at the emergency room, and the subsequent injury to, or death of, the individual.[57] The first point is at the time of the patient's arrival in the emergency room.

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52. *Id.* § 1395dd(c)(1). EMTALA defines stabilization as follows:

> (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).

Id. § 1395dd(e)(3). The Act's primary definition of both "to stabilize" and "stabilized" is the same. *See id.*

53. *Id.* § 1395dd(c)(1)(A)-(B).

54. *Id.* § 1395dd(c)(1)(A).

55. *Id.* § 1395dd(c)(1)(B). For the statutory definition of an appropriate medical transfer, see *supra* note 34.

56. *Id.* § 1395dd(c); *see also id.* § 1395dd(g) ("A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.").

57. *See id.* § 1395dd(a).

Recall that the hospital is required to provide an "appropriate medical screening examination" to the individual.[58] If the hospital fails to provide an examination, or fails to provide an examination that is "appropriate"[59] as defined by case law,[60] the hospital will have violated the statute at that point.[61]

The second point at which a statutory violation can occur is when the hospital has determined that the individual has an "emergency medical condition" as defined by the statute.[62] A violation at this point can take place in one of two ways: (1) the hospital fails to provide the necessary medical treatment to the individual, or (2) the hospital fails to transfer the patient to another medical facility properly.[63] If a violation is committed at either one of these two stages, the offending medical facility is subject to both administrative and civil enforcement of the statute.

EMTALA is enforced by the federal government through both the Health Care Financing Administration and the Office of the Inspector General.[64] Any hospital that is found to have violated one or more of the requirements of EMTALA, whether intentionally or negligently,[65] "is subject to a civil money penalty of *not more than* $50,000 . . . for each such violation."[66] These civil penalties are separate and distinct from any damages awarded in a lawsuit claiming a cause of action arising under EMTALA.[67]

In addition to administrative penalties, a hospital violating one or more of the provisions of EMTALA may be subject to civil action[68] in which an individual can seek monetary "damages available for *personal injury* under the law of the State in which the hospital

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58. *Id.*; *supra* Part I.B.1.

59. 42 U.S.C. § 1395dd(a). However, the Act fails to define the meaning of the word "appropriate." *See id.*

60. *See* McKitrick, *supra* note 1, at 174 & n.15 (citing Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 272 (6th Cir. 1990), which held that "appropriate" would be defined using a subjective standard, rather than the objective standard used in determining medical malpractice).

61. 42 U.S.C. § 1395dd(a).

62. *Id.* § 1395dd(e)(1).

63. *See id.* § 1395dd(c).

64. Frank, *supra* note 5, at 217.

65. *Id.*

66. 42 U.S.C. § 1395dd(d)(1)(A) (emphasis added). However, this penalty is modified to be a fine of "*not more than* $25,000 in the case of a hospital with less than 100 beds." *Id.* (emphasis added).

67. *See id.* § 1395dd(d)(2) (indicating a separate provision for "civil enforcement" of the statute).

68. *Id.* § 1395dd(d)(2)(A).

is located, *and such equitable relief as is appropriate*."[69] A hospital that violates one or more of the requirements of EMTALA will also be subject to suit from "[a]ny medical facility that suffer[ed] a financial loss as a direct result" of the statutory violation.[70] Both of these civil remedies carry a statute of limitations of two years.[71]

Commonly, it is the doctors who are largely responsible for drafting emergency medical procedures and are almost solely responsible for ensuring that these procedures are uniformly applied to all patients.[72] Nonetheless, an individual *may not* bring an action against a specific doctor under EMTALA.[73] However, "[t]he physician who is responsible for the examination, treatment, or transfer (including the on-call doctor) is . . . liable to the government for civil monetary penalties in the amount of not more than $50,000 for each violation."[74] Additionally, an individual physician can be excluded from any Medicare participation if his violation is defined as gross, flagrant, or repeated.[75]

Although the statutory language indicates that the penalties for violating EMTALA will be severe,[76] in practice there is doubt as to the effectiveness of enforcing EMTALA's provisions.[77] Many in-

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69. *Id.* (emphasis added).

70. *Id.* § 1395dd(d)(2)(B).

71. *Id.* § 1395dd(d)(2)(C).

72. Diane S. Mackey, *The Emergency Medical Treatment and Active Labor Act: An Act Undergoing Judicial Development*, 19 U. ARK. LITTLE ROCK L.J. 465, 474 (1997).

73. *Id.*

74. *Id.* (citing Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd(d)(1)(B) (1994)).

75. *Id.* (citing 42 U.S.C. § 1395dd(d)(1)(B)); *see also* Frank, *supra* note 5, at 218 (quoting MIKEL A. ROTHENBERG, EMERGENCY MEDICINE MALPRACTICE § 1.11 (1994)) (stating that the "real economic weapon" of EMTALA "is not the $50,000 fine but, rather, the 'fast track termination' from Medicare"). *But see* Thomas A. Gionis et al., *The Intentional Tort of Patient Dumping: A New State Cause of Action to Address the Shortcomings of the Federal Emergency Medical Treatment and Active Labor Act (EMTALA)*, 52 AM. U. L. REV. 173, 200-01 (2002) (stating that most hospitals are never even charged the financial penalty, much less prohibited from participating in the Medicare program).

76. 42 U.S.C. § 1395dd(d)(2)(B); *see also* MARK M. MOY, THE EMTALA ANSWER BOOK xxxviii (2007 ed. 2007) ("In order to put teeth into the law, Congress interjected stiff penalties for violating the demands of EMTALA . . . ."); Dowdy, Friend & Rangel, *supra* note 43, at 497-98. Again, an EMTALA violation can carry a fine of not more than $50,000 per violation against a participating hospital or, in more extreme cases, can result in a physician being barred from participation in the Medicare program. *See* 42 U.S.C. § 1395dd(d)(1)(a).

77. Mackey, *supra* note 72, at 485. Statistics show that patient dumping practices continue to rise among American hospitals. Gionis et al., *supra* note 75, at 200. These studies also show that enforcement of EMTALA has not been vigilant, and that many

vestigations into alleged violations never result in enforcement of the penalties.[78] The question of how effective EMTALA can be as a deterrent to patient dumping is left unanswered due to the sporadic enforcement of the statute leaves.

D. *Preemption of State Law by EMTALA*

EMTALA contains a provision that expressly asserts that the Act does not preempt state law.[79] This provision states, "The provisions of this section do not preempt any State or local law requirement, *except to the extent that the requirement directly conflicts with a requirement of this section.*"[80] Congress did not mean to supplant state common law by enacting EMTALA; rather, the federal legislature intended to fill a hole left by state common law in the area of a refusal to treat or, in plainer terms, "patient dumping."

This preemption provision of EMTALA has been the source of much of the confusion surrounding the applicability of malpractice limits to EMTALA damages. Because the statute clearly preempts only those state laws that are in direct conflict with the provisions of the federal statute, much of the debate over this provision has involved the question of whether malpractice limits are in direct conflict with the provisions of EMTALA.[81]

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hospitals have never been penalized for failing to meet the requirements of the statute. *Id.* at 200-01.

78. Gionis et al., *supra* note 75, at 200-01.

79. 42 U.S.C. § 1395dd(f).

80. *Id.* (emphasis added). This provision of the statute is what inspires at least some of the debate regarding whether to apply state malpractice caps to damages awarded in EMTALA actions. *See id.* Some courts believe this provision requires the application of state damage caps on EMTALA actions, while other courts have held both that the clear language of the statute prohibits this application of state caps, and that a state cap is necessarily in "direct conflict" with EMTALA since EMTALA makes no mention of limiting noneconomic damages. *See* Frank, *supra* note 5, at 224-25 (citing Power v. Arlington Hosp. Ass'n, 42 F.3d 851, 861 (4th Cir. 1994); Cooper v. Gulf Breeze Hosp. Inc., 839 F. Supp. 1538, 1543 (N.D. Fla. 1993), *aff'd*, 82 F.3d 429 (11th Cir. 1996); Reid v. Indianapolis Osteopathic Med. Hosp. Inc., 709 F. Supp. 853, 855 (S.D. Ind. 1989); Spradlin v. Acadia St. Landry's Med. Found., 711 So. 2d 699, 702-03 (La. Ct. App. 1998), *aff'd*, 758 So. 2d 116 (La. 2000)).

81. *See generally* Mackey, *supra* note 72 (stating that the number of reported patient dumping cases has not decreased). Statistics show that patient dumping practices continue to rise among American hospitals. Gionis et al., *supra* note 75, at 176-77.

II. EMTALA AND THE LAW

A. *EMTALA Versus State Malpractice Laws*

There is much confusion between common law malpractice and an action arising under EMTALA.[82] However, the difference between the two causes of action is relatively simple. At the most basic definition, the standard for proving medical malpractice is a negligence standard.[83] *Black's Law Dictionary* defines "malpractice" as "[a]n instance of negligence or incompetence on the part of a professional."[84] Generally, a malpractice claim alleges that the care received from a medical professional was below the standard of care that would have been provided by professionals in the same field in that situation.[85] Put another way, "[m]edical malpractice is a species of negligence. As with any cause of action for negligence, the plaintiff must prove that the defendant failed to exercise reasonable care and that this *substandard conduct* was a factual and legal cause of the plaintiff's injuries."[86]

Conversely, a plaintiff alleging a violation of EMTALA does not have to show that the care she received was "substandard."[87] Rather, she must show that any care she received was different from the care that an individual perceived to have health insurance would have received.[88] The enforcement provisions of EMTALA deal only with the requirements of the statute and have nothing to do with negligence or a professional standard of care.[89] The standard required to show a violation of EMTALA is markedly differ-

82. Gionis et al., *supra* note 75, at 209-10.

83. *Id.* at 211.

84. BLACK'S LAW DICTIONARY 978 (8th ed. 2004).

85. *See generally* LAWRENCE S. CHARFOOS, THE MEDICAL MALPRACTICE CASE: A COMPLETE HANDBOOK 19-44 (1977); JOSEPH H. KING, JR., THE LAW OF MEDICAL MALPRACTICE IN A NUTSHELL 39-54 (2d ed. 1986); RICHARD E. SHANDELL, THE PREPARATION AND TRIAL OF MEDICAL MALPRACTICE CASES (1981).

86. DAVID W. ROBERTSON ET AL., CASES AND MATERIALS ON TORTS 581 (3d ed. 2000) (emphasis added). *See generally* DAVID M. HARNEY, MEDICAL MALPRACTICE § 21.1, at 505 (Miche Co. 3d ed. 1993) (1973) ("Basically, medical malpractice is the infliction of injury or death under circumstances where it may be said that the cause thereof is a failure on the part of the medical practitioner to have complied with applicable standards of medical practice."); H. BARRY JACOBS, THE SPECTRE OF MALPRACTICE 3-13 (Clifford A. Bennett et al. eds., 1978).

87. ROBERTSON ET AL., *supra* note 86, at 581.

88. Mackey, *supra* note 72, at 475.

89. *Id.* Indeed, it is possible for a patient to receive substandard or negligent care and still not have a claim for an EMTALA violation. The crucial inquiry is whether the patient received the same care as any other patient, not whether the uniform care was below the professional standard. *Id.*

ent from that required to show malpractice. The fact that the "ultimate diagnosis might have been incorrect or even inconsistent with the diagnosis that a reasonable physician under similar circumstances would have made is irrelevant under the civil penalty provision of the anti-dumping act."[90] A plaintiff alleging a violation of EMTALA does not need to prove that the care given was substandard. Rather, this plaintiff must show only that the "medical screening examination"[91] was not "appropriate"[92] as defined by case law, or that she was not properly stabilized, as defined by the provisions of EMTALA.[93]

The standards to prove both EMTALA and medical malpractice make it clear that the two causes of action do not require, nor tolerate, the same standard of proof.[94] Nevertheless, the legal community continues to struggle with the distinction between the standards of EMTALA and those of medical malpractice.[95] The distinction is not easily ascertained due, at least in part, to the fact that the language of the statute offers no guidance as to the standard of proof required to make a case for civil enforcement.[96]

B. *The Courts' Interpretation of EMTALA Versus State Malpractice Laws*

Most courts have recognized that Congress did not mean for EMTALA to act simply as a federal action for malpractice.[97] The

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90. DeBerry v. Sherman Hosp. Ass'n, 769 F. Supp. 1030, 1034-35 (N.D. Ill. 1991).

91. 42 U.S.C. § 1395dd(a) (2000).

92. *See* McKitrick, *supra* note 1, at 174 & n.15 (citing Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 272 (6th Cir. 1990) (holding that "appropriate" would be defined using a subjective standard, rather than the objective standard used for determining medical malpractice)); *see also* Dowdy, Friend & Rangel, *supra* note 43, at 476.

93. For EMTALA's definition of stabilization, see *supra* text accompanying note 55. The Act defines both "to stabilize" and "stabilized" although the primary definition is the same. *See* 42 U.S.C. § 1395dd(e)(3).

94. *DeBerry*, 769 F. Supp. at 1034-35; ROBERTSON ET AL., *supra* note 86, at 581.

95. Heather K. Bardot, Note, *COBRA Strikes at Virginia's Cap on Malpractice Actions: An Analysis of* Power v. Arlington Hospital, 2 GEO. MASON INDEP. L. REV. 249, 255-56 (1993).

96. *Id.* at 256.

97. *See* Power v. Arlington Hosp. Ass'n, 42 F.3d 851, 856 (4th Cir. 1994) (holding that although EMTALA was a different cause of action than malpractice, state malpractice limits were nonetheless applicable under EMTALA); Brooks v. Md. Gen. Hosp., Inc., 996 F.2d 708, 710 (4th Cir. 1993); Baber v. Hosp. Corp. of Am., 977 F.2d 872, 880 (4th Cir. 1992); *Cleland*, 917 F.2d at 268; *see also* Cooper v. Gulf Breeze Hosp., Inc., 839 F. Supp. 1538, 1542 (N.D. Fla. 1993), *aff'd*, 82 F.3d 429 (11th Cir. 1996); Power v. Arlington Hosp. Ass'n, 800 F. Supp. 1384 (E.D. Va. 1992), *aff'd in part*, 42 F.3d 851, 856 (4th Cir. 1994).

intention of Congress not to supplant state medical malpractice law by creating a federal malpractice statute is clear from the legislative history of the statute.[98] By exploring this legislative history, courts have been clear that the causes of action under state malpractice statutes and the federal anti-dumping statute are separate and distinct.[99] However, the distinction has become much less clear when the issue of whether to apply state medical malpractice limits on noneconomic damages to actions arising under EMTALA appears. Here, the courts of appeals have held differently.

For example, the Court of Appeals for the Fourth Circuit has held that, although EMTALA is clearly not an action for malpractice, Congress intended for state malpractice limits to be applied to noneconomic damages awarded in an action arising under EMTALA.[100] Conversely, the Court of Appeals for the Eleventh Circuit has expressly declined to apply these malpractice limits to actions arising under EMTALA, citing the different causes of action to be the persuasive factor.[101]

This split among the courts of appeals creates grossly unequal remedies under EMTALA.[102] A plaintiff fortunate enough to be able to bring a suit for EMTALA violations in the Eleventh Circuit will, by virtue of sheer luck of location, be allowed the opportunity to collect noneconomic damages beyond the statutory limit of the state in which the defendant hospital is located.[103] However, should the same plaintiff be unfortunate enough to be required to bring suit in the Fourth Circuit, she will have those same non-

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98. *See generally* Moy, *supra* note 76, at xxix-xxxvii ("The legislative history shows that Congress intended EMTALA to address the problem of emergency medical care for the uninsured and indigent who come to a hospital's emergency department for care.").

99. *See Power*, 42 F.3d at 856; *Brooks*, 996 F.2d at 710; *Baber*, 977 F.2d at 880; *Cleland*, 917 F.2d at 268.

100. *See Brooks*, 996 F.2d at 715; *Baber*, 977 F.2d at 880 (holding that a cause of action for EMTALA was different than a cause of action for malpractice). *But see Power*, 42 F.3d at 860-61 (holding that state malpractice limits on noneconomic damages were applicable to actions arising under EMTALA).

101. *Cooper*, 839 F. Supp. at 1543.

102. Consider the remedy that Susan Power received in *Power*. *Power*, 42 F.3d at 854. Ms. Power was awarded damages in the amount of several million dollars and had that damage award reduced to $359,000 by the Court of Appeals for the Fourth Circuit according to Virginia's statutory limits on medical malpractice awards. *Id.* at 856. Conversely, had the *Power* case been heard in the Eleventh Circuit she would have retained the entire award mandated by the jury. *See Cooper*, 839 F. Supp. at 1543.

103. *See Cleland*, 917 F.2d at 272; *Cooper*, 839 F. Supp. 1538.

economic damages limited, or reduced to the limit imposed by the state law for the state in which the hospital is located.[104]

C. *The Case Law on EMTALA*

Few cases have been brought under EMTALA in the years since its enactment.[105] Moreover, there is even less case law available regarding the issue of the application of state malpractice limits on damages awarded under EMTALA. However, while the cases are not numerous, they differ vastly in result and analysis. The distinction arising from these differing analyses has only added to the confusion surrounding this statute.

The relevant cases can be divided into two groups: those that have held that state malpractice limits should be applied to damages in actions arising under EMTALA, and those that have held that state malpractice limits should *not* be applied to damages in actions arising under EMTALA. The cases that have held that these limits should be applied have used a more liberal interpretation of the statute,[106] looking to the legislative history of EMTALA to determine the issue of state malpractice limits.[107] In contrast, the courts that have held that state malpractice limits should not be applied to actions arising under EMTALA have favored a strict interpretation of the statute, and have refused to look into the legislative history of EMTALA to determine congressional intent.[108] This Part will explore the reasoning of the courts that have made these respective decisions in order to explain the error of applying state malpractice limits to EMTALA actions.

1. Liberal Interpretation of the Act—*Smith v. Botsford General Hospital*[109] and *Power v. Arlington Hospital Ass'n (Power II)*[110]

Surprisingly, the courts that have favored taking a broader view of the statute to determine its meaning have actually limited

104. *Power*, 42 F.3d at 860.

105. McKitrick, *supra* note 1, at 178.

106. *Id.* at 179.

107. *Id.*; *see also* Smith v. Botsford Gen. Hosp., 419 F.3d 513 (6th Cir. 2005); *Power*, 42 F.3d 851.

108. *See Cooper*, 839 F. Supp. 1538.

109. *Smith*, 419 F.3d 513.

110. *Power*, 42 F.3d 851. Although the decision and reasoning of the district court in *Power* were expressly overruled by the Court of Appeals for the Fourth Circuit, the same reasoning was subsequently relied on by the other courts in holding that malpractice limits were not applicable in actions for EMTALA. For this reason, both

the scope of EMTALA.[111] Both the Fourth and Sixth Circuits have limited the scope of EMTALA by holding that noneconomic damages in EMTALA actions cannot exceed the damages available for malpractice in the state in which the offending hospital is located.[112]

In *Smith v. Botsford General Hospital*, Kelly Smith's estate sued for damages when he died after fracturing his left femur.[113] The Plaintiff's estate sued the hospital under EMTALA and was awarded noneconomic damages in the amount of five million dollars. The defendant hospital sought a reduction of damages based on the Michigan state cap on noneconomic damages.[114] The appeals court granted the defendant's request and remanded the case for a damages reduction.[115]

In holding that Smith's damages should be reduced to those allowed for malpractice claims, the Sixth Circuit Court of Appeals relied heavily on the Court of Appeals for the Fourth Circuit's reasoning in *Power v. Arlington Hospital Ass'n* (*Power II*).[116] Susan Power, who at the time was unemployed and uninsured, was given an examination that included a urinalysis, a physical examination by a doctor, and several x-rays.[117] Neither the results of Power's urinalysis nor her x-ray results were recorded on her chart, although it was noted clearly that she was unemployed and uninsured.[118] Power was discharged with the instructions not to put

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the Fourth Circuit Court of Appeals and the district court opinion will be cited frequently. Where it is necessary to avoid confusion the district court opinion will be noted as *Power I*, and the Fourth Circuit Court of Appeals opinion will be noted as *Power II*.

111. McKitrick, *supra* note 1, at 178-86.

112. *See Smith*, 419 F.3d 513; *see also Power II*, 42 F.3d 851.

113. The plaintiff in this case was a grossly obese, thirty-three-year-old male, suffering from a broken leg sustained in a motor vehicle accident. Smith was brought to the defendant hospital for treatment and, "[c]onsidering its limited capacity to care for someone Smith's size," the hospital made the decision to move Smith to another facility. While on the way, Smith's condition worsened and he died shortly after "from extensive blood loss." *Smith*, 419 F.3d at 515.

114. *See id.*

115. *Id.* at 521.

116. *See id.* at 517-18. In *Power*, Ms. Power, a thirty-three-year-old woman, presented at the defendant hospital with pain in her back, leg, left abdomen, and hip. Ms. Power also suffered from a large boil on her cheek, "although her medical records did not reflect this condition, and the examining physicians and nurses testified that they did not see it." C. Celeste Creswell, Comment, Power v. Arlington Hospital Association: *Extending COBRA's Striking Distance While Weakening the Power of Its Venom*, 29 GA. L. REV. 1171, 1175 (1995).

117. Creswell, *supra* note 116, at 1175.

118. *Id.*

weight on her left leg.[119] However, she returned the next day with an infection, caused by her lancing the boil on her face that eventually resulted in both of her legs being amputated below the knee, blindness in one eye, and permanent lung damage.[120]

The district court held in a motion in limine that the Virginia cap on malpractice damages was not applicable to actions arising under EMTALA,[121] and the jury awarded Power damages in the amount of five million dollars.[122] The Court of Appeals for the Fourth Circuit reversed, holding that Virginia's cap on damages was applicable to EMTALA actions.[123]

In holding the state cap applicable, the Fourth Circuit Court of Appeals looked to the legislative history of EMTALA and stated that Congress had "explicitly directed federal courts to look to state law in the state where the hospital is located to determine both the type and amount of damages available in EMTALA actions."[124] The court determined that the appropriate issue was whether the action, if filed in a state court, would be an action for malpractice.[125] In determining that this action would be classified as malpractice, the court held that the state limits on malpractice damages should be applied to the damages awarded to Susan Power.[126] In making this decision, the *Power* court looked to the Virginia statute to determine how the state of Virginia defined malpractice.[127] The court found that Virginia law defined malpractice as "'any tort based on health care or professional services rendered . . . by a health care provider, to a patient.'"[128] Based upon this broad definition of malpractice, the court determined that Susan Power's action, if filed in a state court, would have been deemed an action for

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119. Power v. Arlington Hosp. Ass'n (*Power II*), 42 F.3d 851, 855 (4th Cir. 1994).

120. *Id.*

121. *Id.* at 854.

122. *Id.*

123. *Id.* at 869.

124. *Id.* at 860. The court based this conclusion on the phrase in the statute that reads,

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

Id. (citing 42 U.S.C. § 1395dd(d)(2)(A) (1986)).

125. *Id.*

126. *Id.*

127. *Id.* at 861.

128. *Id.* (quoting VA. CODE ANN. § 8.01-581.1 (Supp. 1993)).

malpractice and, therefore, should be subject to the state cap on damages.[129]

Unfortunately, in applying the state cap to the damages awarded to Susan Power, the Court of Appeals for the Fourth Circuit seemed to ignore its earlier decision in *Brooks v. Maryland General Hospital, Inc.*,[130] which held that EMTALA and medical malpractice were two different and separate causes of action.[131] Although the *Power* court acknowledged its decision in *Brooks*,[132] it maintained that its decision to apply malpractice limits to actions arising under EMTALA did "not undermine" the "clear holding[ ]" in *Brooks*.[133] However, the court did not offer an explanation as to how its decision to apply the limits of one cause of action to an admittedly completely different cause of action would not undermine its decision that an action under EMTALA was not an action for malpractice.

Furthermore, the court determined that Ms. Power's claim, if filed in a state court, would have been an action for medical malpractice.[134] However, rather than dismissing Ms. Power's claim with leave for her to refile her action as a malpractice claim in a state court, the *Power* court chose to allow Ms. Power's claim to stand as an action under EMTALA, but subject to medical malpractice limits. This decision creates a dangerous precedent that could result in a limitation of damages in a pure EMTALA action.[135]

Moreover, neither the *Power II* court nor the *Smith* court gave any weight to EMTALA's preemption clause.[136] Although a discussion of the preemption clause was seemingly unnecessary given the court's reasoning for holding malpractice limits applicable to EMTALA damages,[137] there are arguments that indicate that this

129. *Id.*

130. Brooks v. Md. Gen. Hosp., Inc., 996 F.2d 708, 710 (4th Cir. 1993).

131. *Id.*

132. *Power II*, 42 F.3d at 863.

133. *Id.* at 864.

134. *Id.* at 862.

135. By "pure EMTALA action," the author means to indicate an action arising under EMTALA that does not also indicate a claim arising under a negligence theory of medical malpractice.

136. 42 U.S.C. § 1395dd(f) (2000). "The provisions of this section do not preempt any State or local law requirement, *except to the extent that the requirement directly conflicts with a requirement of this section.*" *Id.* (emphasis added).

137. *See Power II*, 42 F.3d 851; *see also* Smith v. Botsford Gen. Hosp., 419 F.3d 513 (6th Cir. 2005).

preemption clause prohibits the application of state malpractice damage limits to actions arising under EMTALA.[138]

EMTALA was enacted in an effort to stop the practice of patient dumping among American hospitals.[139] State malpractice limits, if applied to EMTALA actions, will have the effect of limiting the compensation available to the victims of patient dumping and, additionally, will inhibit the deterrent effect of the statute.[140] The administrative enforcement discussed in Part I of this Note is statutorily limited to a maximum fine of $50,000.[141] Still, there is doubt as to the effectiveness of the administrative penalties since they are not enforced with much regularity.[142]

The ineffectiveness of the administrative enforcement provision of the Act makes the civil enforcement of the statute more important in deterring patient dumping. However, by limiting the compensation available to the victims of patient dumping, the statute is less effective at preventing the proscribed conduct. This interference with the statute's intended, stated purpose should be sufficient to prevent the application of state malpractice limits based solely on the preemption clause of the statute.[143]

2. The Strict Interpretation of the Act—*Cooper v. Gulf Breeze Hospital, Inc.*[144] and *Power v. Arlington Hospital Ass'n (Power I)*[145]

In holding that state limits on malpractice damages were not applicable to actions arising under EMTALA, the Eleventh Circuit

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138. *See generally* McKitrick, *supra* note 1.

139. H.R. Rep. No. 99-241, pt. 1, at 27 (1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 605. "The Committee is greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance. The Committee is most concerned that medically unstable patients are not being treated appropriately." *Id.*

140. McKitrick, *supra* note 1, at 193.

141. 42 U.S.C. § 1395dd(d)(1)(A). However, this penalty is modified to be a fine of "*not more than* $25,000 in the case of a hospital with less than 100 beds." *Id.* (emphasis added).

142. Gionis et al., *supra* note 75, at 200-01 (stating that most hospitals are never even charged the financial penalty).

143. McKitrick, *supra* note 1, at 193. As noted earlier, this provision states, "The provisions of this section do not preempt any State or local law requirement, *except to the extent that the requirement directly conflicts with a requirement of this section.*" 42 U.S.C. § 1395dd(f) (emphasis added).

144. Cooper v. Gulf Breeze Hosp., Inc., 839 F. Supp. 1538 (N.D. Fla. 1993), *aff'd*, 82 F.3d 429 (11th Cir. 1996).

145. Power v. Arlington Hosp. Ass'n (*Power I*), 800 F. Supp. 1384, 1390 (E.D. Va. 1992), *aff'd in part*, 42 F.3d 851 (4th Cir. 1994).

relied heavily on the reasoning of the district court in *Power v. Arlington Hospital Ass'n*, which was later overturned by the Court of Appeals for the Fourth Circuit.[146]

Both the district court in *Cooper* and the district court in *Power* based their decisions on two facts when holding that state limits were not applicable to EMTALA actions. First, these courts recognized that the plain language of the statute was clear in indicating that Congress did not intend for malpractice limits to be applied to EMTALA actions.[147] Second, both courts indicated that while it was "probably true that Congress knew of the existence of medical malpractice caps,"[148] it did not automatically follow that "Congress intended to incorporate those caps in EMTALA. Indeed, the opposite inference is more plausible because it is more consistent with the statute's plain language and its purpose."[149] Since Congress expressly indicated that personal injury limits "for the state in which the hospital is located" should be applied to EMTALA actions, but failed to indicate that *malpractice* limits for the state in which the hospital is located should also be applied, these courts held that the plain language of the statute clearly indicated that malpractice limits should *not* applied to EMTALA actions.[150]

The argument is a simple one: if Congress had intended for EMTALA damages to be limited or reduced by state malpractice damage caps, then it would have indicated that intention in the language of the statute, the way that personal injury limits were indicated.[151]

III. ANALYSIS

A. *The "Plain Language" Argument*

It is clear that the plain language of this statute does not specifically dictate that medical malpractice caps should be applied to

146. *Cooper*, 839 F. Supp. at 1538.

147. *Id.* at 1542; *Power I*, 800 F. Supp. at 1390.

148. *Power I*, 800 F. Supp. at 1390; *see Cooper*, 839 F. Supp. at 1542 (quoting *Power I*, 800 F. Supp. at 1390).

149. *Power I*, 800 F. Supp. at 1390; *see Cooper*, 839 F. Supp. at 1542 (quoting *Power I*, 800 F. Supp. at 1390).

150. *Cooper*, 839 F. Supp. at 1542 (citing *Power I*, 800 F. Supp. at 1390); *Power I*, 800 F. Supp. at 1390.

151. There are many criticisms of using plain language to interpret statutory intent that this Note will not address. For a general discussion of the negative aspects of the plain language rule when used to determine statutory intent, see David Zell Myerberg, *The Fourth Circuit's Baby K Decision: "Plain Language" Does Not Make Good Law*, 98 W. VA. L. REV. 397 (1995).

EMTALA damages.[152] Therefore, the plain and unambiguous language of the statute seems to indicate that Congress did not intend malpractice caps to be applied to EMTALA damage awards. However, there are flaws in this argument that made it an unpopular one with the Fourth and Eleventh Circuits.[153] Primary among these flaws is the notion that the phrase "personal injury" does not encompass limits on damages in a medical malpractice action. As the *Power II* court noted,

> [I]t is equally sensible to read § 1395dd(d)(2)(A) as reflecting Congress' deliberate choice of the more inclusive phrase "personal injury" so that it would not be necessary to delineate each and every type of limitation on damages, e.g. limitations on punitive damages, noneconomic losses, and malpractice damages caps, that the states might have enacted.[154]

The basis of this argument is that it would have been prohibitive for Congress to include every type of damage limitation available in the language of the statute. Instead, it is more logical that Congress would indicate the limits on "personal injury" and intend for that to encompass the greater field of negligence actions. Regardless, the argument that personal injury is not a clear and unambiguous term and requires further inspection of the legislative history to determine its meaning, has some merit. Although the courts that have followed the plain language rule have achieved the result that makes the most logical sense, the argument they relied upon is weak, and is not the best argument out there.[155]

B. *The Legislative History Argument*

In holding that malpractice caps should be applied to EMTALA damages, the *Power II* court relied on Congress's concern over the medical malpractice crisis.[156] The Eleventh Circuit interpreted this concern to mean that Congress intended for EMTALA damages to be limited by state malpractice caps.[157] However, this

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152. *Cooper*, 839 F. Supp. at 1542 (citing *Power I*, 800 F. Supp. at 1390); *Power I*, 800 F. Supp. at 1390.

153. *See* Power v. Arlington Hosp. Ass'n. (*Power II*), 42 F.3d 851, 862 (4th Cir. 1994); *see also* Smith v. Botsford Gen. Hosp., 419 F.3d 513 (6th Cir. 2005).

154. *Power II*, 42 F.3d at 862.

155. *See Cooper*, 839 F. Supp. at 1542 (citing *Power I*, 800 F. Supp. at 1390); *Power I*, 800 F. Supp. at 1390; *see also* McKitrick, *supra* note 1, at 179.

156. H.R. REP. No. 99-241, pt. 3, at 6 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 728.

157. *Power II*, 82 F.3d 429.

reasoning ignores the fact that EMTALA and medical malpractice have conflicting statutory purposes.[158] Malpractice laws are designed to deter and prevent negligent or substandard care, while EMTALA was designed to put an end to patient dumping, or, put another way, a refusal to treat.[159] Moreover, the purpose of the Virginia damages cap is to ensure that malpractice insurance does not become prohibitively expensive for physicians.[160] Since an individual physician cannot be held responsible under the statutory construct of EMTALA,[161] this concern is irrelevant in considering the damages available to an EMTALA plaintiff. The consequences of applying these limits to EMTALA actions are twofold: first, the deterrent effect of the statute is frustrated, and second, the compensation available to victims of patient dumping is artificially limited.[162] Simply put, EMTALA was enacted to *punish* a hospital for its refusal to treat, while malpractice laws are designed to deter substandard care and the negligence of physicians. Therefore, since the application of malpractice caps frustrates the very reason that EMTALA was enacted, the preemption provision of the statute bars their application.[163]

C. *EMTALA Is* Not *a Federal Cause of Action for Malpractice*

Despite the different holdings of the Fourth, Sixth, and Eleventh Circuit Courts of Appeals regarding the application of state medical malpractice limits to actions arising under EMTALA, one

158. McKitrick, *supra* note 1, at 192.

159. *Id.* at 193.

160. *Id.*

161. 42 U.S.C. § 1395dd(d)(2)(A).

162. *Id.*

163. *Id.* § 1395dd(f); *see* McKitrick, *supra* note 1. It is interesting to note that the *Power II* court did not consider bifurcating the claim to distinguish between Ms. Power's medical malpractice claims, and her claims under EMTALA. In Ms. Power's case, the defendant hospital initially refused to treat her, which gave rise to an EMTALA violation. Power v. Arlington Hosp. Ass'n. (*Power II*), 42 F.3d 851, 864 (4th Cir. 1994). However, when Ms. Power returned to the defendant hospital the next day she received care that was determined to be substandard. It was this substandard care that gave rise to an action for medical malpractice. In addition, it was this care that led the Court of Appeals for the Fourth Circuit to determine that malpractice caps should be applied to Ms. Power's EMTALA damages. *Id.* However, there was a simpler solution to this confusion. Had the court bifurcated Ms. Power's claim the malpractice cap could have been applied to the damages awarded for the medical malpractice, and the EMTALA damages could have been allowed to stand. This would have required an additional jury instruction by the district court, and in this case, would have required a new trial on the issue of damages. However, taking this action would have avoided creating a dangerous precedent limiting EMTALA damages according to a standard for medical malpractice.

holding remains constant: EMTALA is not a federal cause of action for malpractice.[164] While the purpose of state malpractice laws is to ensure that each patient receives adequate care and has the best possible opportunity for an accurate diagnosis, EMTALA was never intended to accomplish either of these aims.[165]

Indeed, "a medical malpractice action and an EMTALA action . . . are separate and distinct causes of action focused on different conduct and aimed at different goals."[166] Additionally, the standard to prove medical malpractice is different than that required to prove a violation of EMTALA. As indicated in Part II.A of this Note, the standard to prove medical malpractice is a negligence standard. Simply put, the malpractice plaintiff must prove that she was given substandard care, and that this substandard care was the factual and legal cause of his or her injuries.[167] On the other hand, the EMTALA plaintiff does not have to allege or prove substandard care. Instead, the EMTALA plaintiff must prove only that the "medical screening examination"[168] was not "appropriate"[169] as defined by case law, or that she was not properly stabilized, as defined by the provisions of EMTALA.[170]

Again, as previously noted in Part II.A of this Note, these two causes of action do not require, nor do they tolerate, the same standard of proof.[171] It is clear from the prevailing case law that EMTALA and medical malpractice are viewed as two separate and

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164. *See* Brooks v. Md. Gen. Hosp., Inc., 996 F.2d 708, 710 (4th Cir. 1993); Baber v. Hosp. Corp. of Am., 977 F.2d 872, 880 (4th Cir. 1992); Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 268 (6th Cir. 1990); Cooper v. Gulf Breeze Hosp., Inc., 839 F. Supp. 1538, 1542 (N.D. Fla. 1993), *aff'd*, 82 F.3d 429 (11th Cir. 1996); *see also* Gatewood v. Wash. Healthcare Corp., 933 F.2d 1037, 1041 (D.C. Cir. 1991).

165. *Power II*, 42 F.3d at 864 (citing *Brooks*, 996 F.2d at 711; *Baber*, 977 F.2d at 880).

166. *Id.* (quoting Power v. Arlington Hosp. Ass'n (*Power I*), 800 F. Supp. 1384, 1390 (E.D. Va. 1992), *aff'd in part*, 42 F.3d 851, 856 (4th Cir. 1994)).

167. ROBERTSON ET AL., *supra* note 86, at 512. *See generally* HARNEY, *supra* note 86, § 21.1, at 505 ("Basically, medical malpractice is the infliction of injury or death under circumstances where it may be said that the cause thereof is a failure on the part of the medical practitioner to have complied with applicable standards of medical practice."); JACOBS, *supra* note 86, at 3-13 (describing conflicts between lawyers, physicians, and patients during a malpractice suit).

168. 42 U.S.C. § 1395dd(a).

169. *See* McKitrick, *supra* note 1, at 174 n.15 (citing *Cleland*, 917 F.2d at 272, which held that "appropriate" would be defined using a subjective standard, rather than the objective standard used in determining medical malpractice); *see also* Dowdy, Friend & Rangel, *supra* note 43, at 476.

170. 42 U.S.C. § 1395dd(e)(3).

171. DeBerry v. Sherman Hosp. Ass'n, 769 F. Supp. 1030, 1034-35 (N.D. Ill. 1991); ROBERTSON ET AL., *supra* note 86, at 512.

distinct causes of action for damages. Moreover, applying the statutory limits of one cause of action to an entirely different cause of action is illogical.

Additionally, it is clear from both case law and the legislative history of the statute that the purpose behind EMTALA is to prevent patient dumping, or a failure to treat.[172] Applying malpractice limits to this statute subverts the penalty that hospitals will suffer for violating the provisions of EMTALA. Thus, applying malpractice limits to EMTALA damages not only implies that the two causes of action are the same, but also frustrates the very purpose of EMTALA. This application creates a paradox in which the behavior that this statute was meant to stop is not deterred by the enforcement of the statute.

D. *Analyzing the Applicability of Malpractice Limits on EMTALA Actions*

Neither of the two prevailing arguments regarding the applicability of malpractice limits on EMTALA actions is based on the fact that malpractice and EMTALA are two separate and distinct causes of action.[173] However, if EMTALA and malpractice really are two different causes of action, with two different standards of proof, then an analysis of the plain language of the statute or the legislative intent of Congress is unnecessary to determine if malpractice limits are applicable to EMTALA actions.[174]

Statutory caps on damages available in malpractice actions were, and are, designed to limit the amount of noneconomic damages available when a plaintiff prevails on the theory that she received substandard care, and that said substandard care caused her injury.[175] However, when a plaintiff alleges that no malpractice was committed, but rather argues that she was not treated according to the procedure of the defendant hospital, applying a malpractice limit is illogical and unnecessary. Applying malpractice limits to EMTALA actions when each has been recognized as a separate cause of action from the other is equal to applying the damage lim-

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172. 42 U.S.C. § 1395dd(d).

173. *See* Cooper v. Gulf Breeze Hosp., Inc., 839 F. Supp. 1538, 1542 (D. Fla. 1993), *aff'd*, 82 F.3d 429 (11th Cir. 1996); Power v. Arlington Hosp. Ass'n (*Power I*), 800 F. Supp. 1384, 1390 (E.D. Va. 1992), *aff'd in part*, 42 F.3d 851 (4th Cir. 1994).

174. McKitrick, *supra* note 1, at 195.

175. ROBERTSON ET AL., *supra* note 86, at 512.

its for an action for breach of contract to the damages awarded under an action for battery.[176]

The doctrine of stare decisis is an important one in our judicial system, and one of the unique attributes of American law that is a growing and evolving understanding of what our laws mean. It is clear and undisputed that EMTALA and medical malpractice are different causes of action with different standards of proof.[177] However, some circuits have blurred this distinction by applying the limits of one cause of action to the other.[178] To avoid overturning the precedent that made these statutes separate causes of action, the courts of appeals must ensure that malpractice limits do not lower the compensation available to EMTALA plaintiffs.

Most compelling, however, is the element of intent inherent in the EMTALA cause of action. As previously discussed, a hospital can transfer a patient without treating the patient under statutorily defined appropriate circumstances.[179] Specifically, EMTALA requires that a patient be stabilized before being transferred.[180] If the hospital chooses not to transfer the patient, then the statute requires that an "appropriate medical screening examination" be provided to the patient.[181] Consequently, if the patient is transferred without being stabilized or if the hospital refuses to provide an "appropriate medical screening examination," the resulting harm is not the product of negligence on the part of the physician. Rather, it is an intentional refusal to treat and it is markedly different from a negligent failure to provide the reasonable standard of medical care.

Punitive damages are appropriate in instances where the defendant has acted with animus.[182] Where the cause of action is de-

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176. McKitrick, *supra* note 1, at 195.

177. DeBerry v. Sherman Hosp. Ass'n, 769 F. Supp. 1030, 1034-35 (N.D. Ill. 1991); ROBERTSON ET AL., *supra* note 86, at 512.

178. Smith v. Botsford Gen. Hosp., 419 F.3d 513 (6th Cir. 2005); *see also* Power v. Arlington Hosp. Ass'n (*Power II*), 42 F.3d 851 (4th Cir. 1994); *Cooper*, 839 F. Supp. 1538.

179. *See* 42 U.S.C. § 1395dd(c) (2000).

180. *Id.* § 1395dd(b)(1).

181. *Id.* § 1395dd(a).

182. Melissa Ballengee, Bajakajian*: New Hope for Escaping Excessive Fines Under the Civil False Claims Act*, 27 J.L. MED. & ETHICS 366, 373 (1999) ("[P]unitive damages also have an expressive and retributive purpose. They reflect the community's consensus that certain behavior merits punishment. The more egregious the conduct, the larger the punishment should be."); *see also* BMW of N. Am. v. Gore, 517 U.S. 559, 575 (1996) ("Perhaps the most important indicium of the reasonableness of a punitive damages award is the degree of reprehensibility of the defendant's conduct."); Kevin J.

signed to prevent behavior, punitive damages are not always necessary since the wrong was not intentional but inadvertent. However, in this case the harm caused by an EMTALA violation is not negligent but intentional. As previously discussed, an EMTALA violation can occur at two different points: (1) the patient can be refused any treatment at all, whereby the hospital violates the "appropriate medical screening examination" requirement; or (2) the hospital can transfer the patient without properly stabilizing the patient's condition, thereby violating the stabilization requirement of the statute.[183] In neither case is the negligence of the physician the cause of the harm to the patient; in either scenario it is the intent of the hospital *not* to treat the patient. It is the intent of the hospital to avoid treating the patient that makes punitive damages appropriate. Therefore, the limits that are imposed on medical malpractice damages are inappropriate when applied to an EMTALA action.

Moreover, if this alone is not persuasive, it is also clear that the purposes of EMTALA and state malpractice caps are in conflict with one another. EMTALA explicitly provides that when state law is in conflict with EMTALA provisions that state law is to be ignored.[184] Thus, malpractice limits should also be barred due to the preemption provision created by Congress when enacting EMTALA.

Conclusion

While the courts of appeals disagree about whether to apply state medical malpractice limits to actions arising under EMTALA, they are at least unified on one crucial point: EMTALA is not a federal cause of action for medical malpractice. In fact, the courts of appeals are clear in their assertion that the stated purpose of EMTALA leaves no room for doubt that it is a separate and distinct cause of action from medical malpractice.[185] This belief is

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Kelly, Comment, *Placing the Burden Back Where It Belongs: A Proposal to Eliminate the Affirmative Duty from Willful Infringement Analyses*, 4 J. MARSHALL REV. INTELL. PROP. L. 509, 516 (2005) ("The purpose of an award in punitive damages is to punish unlawful conduct and to deter its repetition. Numerous Supreme Court decisions have held that punitive damages should only be awarded in situations where conduct is egregious or reprehensible.").

183. *See supra* notes 32-34 and accompanying text.

184. 42 U.S.C. § 1395dd(f).

185. *See* Gatewood v. Wash. Healthcare Corp., 933 F.2d 1037 (D.C. Cir. 1991). *See generally* Brooks v. Md. Gen. Hosp., Inc., 996 F.2d 708, 710-11 (4th Cir. 1993); Baber v. Hosp. Corp. of Am., 977 F.2d 872 (4th Cir. 1992); Cleland v. Bronson Health

most clearly articulated by the court in *Cooper v. Gulf Breeze Hospital, Inc.*:

> [M]edical malpractice actions are separate and distinct from EMTALA actions. Malpractice actions are based on negligence and seek to compensate victims for injuries suffered when health care providers breach the applicable standard of care. As noted earlier, the EMTALA targets the evil of "patient dumping" and is not based on fault. The EMTALA narrowly defines the sanctionable conduct and holds hospitals alone liable. Thus, EMTALA and malpractice actions focus on different conduct and seek different goals. Given these distinctions, it is improper to assume, as the *Reid* court did, that § 1395dd(d)(2)(A) incorporates state law damage limits on medical malpractice actions.[186]

Although the *Power II* court attempted to distinguish that decision from its earlier decision in *Brooks v. Maryland General Hospital, Inc.*, which held EMTALA actions as separate and distinct from medical malpractice actions, its reasoning was unpersuasive.[187]

Logic dictates that the Fourth and the Sixth Circuits must make a firm decision. Either EMTALA and medical malpractice are two separate causes of action with two different standards of proof or they are the same cause of action in two different judicial venues. However, unless the Fourth and the Sixth Circuits are willing to expressly overrule their decisions holding EMTALA separate from malpractice, their decisions to apply malpractice limits to EMTALA actions seem forced and illogical.

The legislative history of EMTALA is clear on this point.[188] Moreover, the circuit courts have looked to the legislative history of this statute to show that Congress did not mean to create a federal action of malpractice and then have looked at the same legislative

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Care Group, Inc., 917 F.2d 266 (6th Cir. 1990); Cooper v. Gulf Breeze Hosp., Inc., 839 F. Supp. 1538 (N.D. Fla. 1993), *aff'd*, 82 F.3d 429 (11th Cir. 1996).

186. *Cooper*, 839 F. Supp. at 1542-43 (citing Power v. Arlington Hosp. Ass'n (*Power I*), 800 F. Supp. 1384, 1390 (E.D. Va. 1992), *aff'd in part*, 42 F.3d 851 (4th Cir. 1994) and discussing Reid v. Indianapolis Osteopathic Med. Hosp., Inc., 709 F. Supp. 853 (S.D. Ind. 1989)).

187. *Brooks*, 996 F.2d at 710; *Power II*, 42 F.3d at 860-61.

188. H.R. REP. NO. 99-241, pt. 1, at 27 (1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 605. "The Committee is greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance. The Committee is most concerned that medically unstable patients are not being treated appropriately." *Id.*; *see* Frank, *supra* note 5, at 197 n.14.

history to conclude that Congress intended for courts to hold state malpractice limits to actions arising under EMTALA.[189]

Until the Supreme Court offers some guidance on the standard of proof for EMTALA actions or until Congress modifies the statutory language to offer some guidance on the issue, this confusion is unlikely to be settled conclusively.[190]

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189. *Power II*, 42 F.3d at 864 (citing *Brooks*, 996 F.2d at 711); *Baber*, 977 F.2d at 880).

190. *See* Bardot, *supra* note 95, at 255-56 (stating that the statutory ambiguities of EMTALA need to be interpreted by either the Supreme Court or Congress).

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