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Emergency Medical Treatment & Active Labor Act: Denial of Emergency Medical Care Because of Improper Economic Motives

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The Emergency Medical Treatment & Active Labor Act: Denial Of Emergency Medical Care Because of Improper Economic Motives

I. INTRODUCTION

"Speak up for those who cannot speak for themselves, for the rights of all who are destitute.
Speak up and judge fairly; defend the rights of the poor and needy."[1]

In 1986, Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA).[2] Congress hoped that EMTALA would prohibit hospitals from refusing to administer emergency medical care because of what I would term "improper economic motives."[3] In spite of this attempt to prohibit improper economic

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1 *Proverbs* 31:8, 9.

2 42 U.S.C.A. § 1395dd (1992).

3 I define "improper economic motives" as a refusal to screen, stabilize, or properly transfer because a person is "indigent and uninsured" (Congress' own language, *infra*) or believed to be unable to pay for emergency medical care. *See infra* notes 184-87 and accompanying text.

The legislative history shows Congress's intent in enacting EMTALA:

> 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. There have been reports of situations where treatment was simply not provided. In numerous other instances, patients in an unstable condition have been transferred improperly, sometimes without the consent of the receiving hospital. The committee wants to provide a strong assurance that pressures for greater hospital efficiency are not to be construed as license to ignore traditional community responsibilities and loosen historic standards.

H.R. REP. No. 241, 99th Cong., 2d Sess. 27 (1986), *reprinted in* 1986 U.S.C.C.A.N. 42, 605; *see* H.R. REP. No. 241, 99th Cong., 2d Sess. 5 (1986), *reprinted in* U.S.C.C.A.N. 42, 726 ("In recent years there has been a growing concern about the provision of adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured . . . . [S]ome are convinced that the problem needs to be addressed by federal sanctions."); *see also* Andrew Jay McClurg, *Your Money or Your Life: Interpreting the Federal Act Against Patient Dumping*, 24 WAKE FOREST L. REV. 173 (1989); Phillip Green, Note, *COBRA: Another Patch on an Old Garment*, 33 ST. LOUIS U. L.J. 743 (1989); Karen I. Treiger, Note, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. REV. 1186 (1986).

motive, the language of the statute requires an initial medical screening for "any" person who comes to an emergency room.[4] Because of this broad language, plaintiffs alleging improper medical treatment have attempted to use EMTALA for purposes beyond Congress's intent.[5] This inconsistency has led to a division among the federal courts as to the appropriate scope of EMTALA. Some courts maintain that a cause of action under EMTALA will lie only when a hospital or doctor denies emergency care because of economic motive.[6] Other courts rule that EMTALA should apply to anyone denied emergency medical treatment.[7]

Part II of this Note introduces the problem of "patient dumping"[8] and the attempts to remedy that problem. Part III introduces EMTALA. Examination of the statute illustrates the contradiction between EMTALA's legislative history and its present language.

Part IV presents the court confusion the current language engenders. Examination of cases that have attempted to define the present scope of EMTALA illustrate this confusion. Cases holding that EMTALA applies only to persons denied emergency medical care because of economic motives are analyzed and compared with cases that have ruled EMTALA should apply to anyone. Part IV concludes with other problems resulting from the statute's present language. These problems include: (1) Uncertainty of potential parties about whether EMTALA regulates their activity; (2) waste of judicial resources for adjudication of claims beyond the scope of EMTALA; and (3) inefficient "double regulation" by EMTALA of conduct already governed by other laws. All of these problems weaken EMTALA's effectiveness.

Following the examination of EMTALA's problems, Part V proposes that Congress amend EMTALA to create a stronger, more effective statute. This amendment should expressly narrow

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4 42 U.S.C.A. § 1395dd(a) (West Supp. 1991).

5 In addition to the legislative history, *supra* note 3, courts do not dispute that the legislative intent behind EMTALA was to protect against the denial of care because of economic motives. *See e.g.*, Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1040 (D.C. Cir. 1991); Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 269 (6th Cir. 1990).

6 *See infra* note 40.

7 *See infra* note 42.

8 Patient dumping is "the refusal to admit a person as a patient to a hospital, transferring a patient to a different facility or prematurely discharging a patient based upon purely economic criteria." Susan F. Kriesser Bieniek, Note, *COBRA: Straightening Out the Serpentine Law Regarding "Patient Dumping"*, 14 MINN. TRIAL LAW. 10, 10 (1989).

EMTALA to apply only when insufficient emergency medical care is given because of improper economic motive. Additionally, Congress should construct a standard requiring a plaintiff to build a prima facie case under EMTALA. This prima facie case would raise a presumption of an improper economic motive by the defendant. The presumption would better equip a plaintiff to prove an EMTALA violation which, in turn, would help to make EMTALA a stronger, more effective statute.

Finally, Part VI examines a recent EMTALA case.[9] This case illustrates a potential counterargument to the proposed amendments to EMTALA. However, analysis of the case and its implications reveals the rationale for amending EMTALA in spite of this counterargument. By amending EMTALA, the statute will better serve its stated end—prohibiting the denial of emergency medical care because of improper economic motive.

II. THE PROBLEM: PATIENT DUMPING AND EARLY ATTEMPTS TO PREVENT IT

Most estimates indicate that between thirty-one and thirty-six million Americans lack health insurance.[10] According to the 1990 reports of the United States Department of Health and Human Services, national spending on health care rose 128 percent from 1980 to 1989.[11] These inflating medical costs, coupled with the rising number of medically uninsured persons, increase the likelihood of hospitals engaging in patient dumping.[12]

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9 Burditt v. United States Dep't of Health and Human Servs., 934 F.2d 1362 (5th Cir. 1991).

10 *See Access to Health Insurance: Hearings Before the Subcommittee on Health of the House Comm. on Ways and Means*, 102d Cong., 1st Sess. 2 (1990) (estimating thirty-three million Americans without insurance); U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, A PROFILE OF UNINSURED AMERICANS: RESEARCH FINDINGS 5 (1989) (estimating the numbered of uninsured Americans in the 1987 National Medical Expenditure Survey to be 36.9 million); *see also* Emily Friedman, *The Uninsured: From Dilemma to Crisis*, 265 JAMA 2491 (1991). Friedman cites the following factors for the large number of uninsured:

1) the erosion of Medicaid coverage for the poor;
2) a decline in employer-subsidized health insurance;
3) exceedingly high costs of health care.

Id. at 2492-93.

11 *See* MARSHALL W. RAFFELL & NORMA K. RAFFELL, THE U.S. HEALTH SYSTEM: ORIGINS AND FUNCTIONS 222 (3d ed. 1989) (citing estimates that health care accounted for 12% of the GNP in 1990); *see also* Peter Temin, *An Economic History of American Hospitals*, *in* HEALTH CARE IN AMERICA 75-102 (H.E. Frech, III ed. 1988) (analyzing the changing historical role of hospitals and the impact of increasing health care costs); Friedman, *supra* note 10, at 2493.

12 For a detailed account of the emphasis upon economics and profit and its effect

Before 1986, attempts had been made to alleviate patient dumping. State courts, for example, attempted to impose a duty of care upon hospitals to treat those who came to the hospitals seeking emergency treatment.[13] In 1946, Congress passed the Hospital Survey & Construction Act (Hill-Burton), a federal attempt to address patient dumping.[14] That Act required hospitals financed with federal funds to make a certain percentage of their services available to those in the community who could not pay.[15] Numerous state legislatures have also attempted to eliminate patient dumping through the enactment of state statutes.[16] For a variety

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upon the healthcare profession, see BRADFORD H. GRAY, THE PROFIT MOTIVE AND PATIENT CARE: THE CHANGING ACCOUNTABILITY OF DOCTORS & HOSPITALS (1991); *see also* Treiger, *supra* note 3, at 1193-95.

13 *See, e.g.*, Gonzalez v. United States, 600 F. Supp. 1390 (W.D. Tex. 1985) (liability for refusal to treat unmistakable emergency condition if the patient relied upon hospital's custom to give emergency care); Carr v. St. Paul Fire & Marine Ins. Co., 384 F. Supp. 821 (W.D. Ark. 1974); Wilmington Gen. Hosp. v. Manlove, 174 A.2d 135 (Del. 1961); Brownsville Medical Ctr. v. Garcia, 704 S.W.2d 68 (Tex. Ct. App. 1985); Valdez v. Lyman-Roberts Hosp., 638 S.W.2d 111 (Tex. Ct. App. 1982); Mercy Medical Ctr. v. Winnebago County, 206 N.W.2d 198 (Wis. 1973); *cf.* St. Joseph's Hosp. & Medical Ctr. v. Maricopa County, 688 P.2d 986 (Ariz. 1984) (hospital cannot release indigent and seriously ill patient merely because receiving hospital will not take the patient); Guerro v. Copper Queen Hosp., 537 P.2d 1329 (Ariz. 1975); Hiser v. Randolph, 617 P.2d 774 (Ariz. Ct. App. 1980) (state's public policy placed duty on hospital to render emergency care to any patient).

14 42 U.S.C. § 291 (1988).

15 42 U.S.C. § 291c(e) provides:

> [T]he State plan shall provide for adequate hospitals, and other facilities . . . for all persons residing in the State, and adequate . . . to furnish needed services for persons unable to pay therefor. Such regulations may also require that before approval of an application for a project is recommended by a State agency to the Surgeon General for approval under this part, assurance shall be received by the State from the applicant that . . . there will be made available in the facility or portion thereof to be constructed or modernized a reasonable volume of services to persons unable to pay therefor . . . .

16 A brief summary of these statutes illustrates the varied approaches that states have taken with regard to patient dumping:

Arizona: ARIZ. REV. STAT. ANN. § 41-1831 to -1837 (1992) establishes the rules governing emergency medical services in the state of Arizona. The Arizona Supreme Court has held that this statute creates a public policy requiring all licensed hospitals to render emergency care to all patients who present themselves for care. Additionally, the patient may not be transferred until the emergency medical care is complete. *See* Thompson v. Sun City Community Hosp., Inc., 688 P.2d 605 (Ariz. 1984).

California: CAL. HEALTH & SAFETY CODE § 1317 (West 1990) provides that emergency care may not be denied because of insurance or economic status. The hospital must render emergency care before inquiring into the patient's ability to pay. Section 1317.2 states that the hospital may not transfer of an emergency care patient because of inability to pay. According to § 1317.3, the receiving facility is under an obligation to receive the transfer patient. Section 1317.6 provides civil penalties and civil damages for patients and

hospitals injured by the violation.

Florida: FLA. STAT. ANN. § 395.0144 (West Supp. 1992) prohibits refusal to admit a patient diagnosed as needing emergency medical care because of economic criteria or indigency. If the hospital is unable to render the emergency care the patient requires, the hospital may transfer the patient. No transfer may be made until the patient is stabilized.

Georgia: GA. CODE ANN. § 31-8-42 (Michie 1991) prohibits a hospital with an emergency room from denying treatment to any pregnant woman in active labor who is a resident of the state. If the hospital cannot render appropriate care, the hospital may transfer the patient.

Hawaii: HAW. REV. STAT. § 321-232(b) (1985) states that emergency services or ambulance services may not be denied to a patient because the patient cannot pay or lacks health insurance.

Idaho: IDAHO CODE § 39-1391b (1985) expressly denies an obligation to provide emergency care. However, the statute prohibits refusal of emergency care for a variety of factors, one of them being the inability to pay. This seems to indicate that if a facility provides emergency treatment services, it may not discriminate in rendering those services.

Illinois: ILL. ANN. STAT. ch. 111 1/2 para. 86, § 1 (Smith-Hurd Supp. 1991) establishes a general duty for an emergency care facility to render emergency care to all who apply to the facility with an emergency medical condition.

Kentucky: KY. REV. STAT. ANN. § 216B.400(1) (Baldwin 1990) forbids a hospital from denying admission to anyone needing emergency medical care because of inability to pay for that care.

Louisiana: LA. REV. STAT. ANN. § 40:2113.4 (West Supp. 1992) provides that state funded hospitals may not discriminate against persons residing within the territorial area because of economic status. Section 2113.6 provides that an employee, officer or member of the medical staff licensed by the Department of Health & Human Services shall not deny emergency care or discriminate because of a patient's economic status.

Maryland: MD. HEALTH-GEN. CODE ANN. § 19-308.2 (1990) requires the Department of Health and Mental Hygiene to establish guidelines for transferring patients. Although these guidelines do not refer to economic motive, they are designed to insure that medical considerations, and not economic considerations, are the basis for transfer.

Massachusetts: MASS. ANN. LAWS ch. 111, § 70E(n) (Law. Co-op. 1991) enumerates part of the patient's bill of rights. It provides that if the patient is refused treatment because of economic status, the patient has the right to require the refusing facility to effect a safe transfer to another, accepting facility.

Michigan: MICH. COMP. LAWS ANN. § 333.20921(e) (West 1991) mandates that any mobile emergency care service or ambulance service must administer emergency aid before inquiring into ability to pay for care.

Missouri: MO. ANN. STAT. § 205.989 (Vernon 1983) establishes that a public health facility or a not-for-profit corporation in which a county provides services shall render emergency care to patients who cannot pay for that care.

Nevada: NEV. REV. STAT. ANN. § 439B.410 (Michie 1991) provides that all hospitals must provide emergency care regardless of the patients financial status. A hospital may transfer a patient to another facility if the patient's insurance will pay for care at that other facility. Additionally, a hospital may transfer a patient if the county has spent all money available for paying for indigent patients.

New Hampshire: N.H. REV. STAT. ANN. § 151.21(XVI) (Supp. 1991) establishes that a patient may not be denied appropriate care because of source of payment. Section 151.21 (IV) allows a facility to transfer a patient for medical reasons or for nonpayment, except as prohibited by titles XVIII and XIX of the Social Security Act.

of reasons, the common law doctrine, Hill-Burton, and the state statutes have experienced limited success in prohibiting hospitals from denying care because improper economic motives.[17] In re-

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New York: N.Y. PUB. HEALTH LAW § 2805-b(1) (McKinney Supp. 1992) prohibits a hospital from denying emergency care to a patient diagnosed as in need of emergency care because of inability to pay.

Oregon: OR. REV. STAT. § 441.094 (Supp. 1990) prohibits any employee or officer of a hospital from denying emergency care to a patient diagnosed as in need of emergency care because of inability to pay.

Pennsylvania: PA. STAT. ANN. tit. 35, § 449.8 (Supp. 1991) establishes state policy requiring facilities to provide emergency medical services to all persons regardless of ability to pay. A transfer is only appropriate if the facility is unable to render proper treatment.

Rhode Island: R.I. GEN. LAWS § 23-17-26 (1989) provides that all emergency care units render emergency treatment regardless of the patient's economic status or source of payment. The facility may not deny treatment to inquire into source of payment if such a delay would pose material risk to the patient's health.

South Carolina: S.C. CODE ANN. § 44-7-260(E) (Law. Co-op. Supp. 1991) prohibits a hospital from denying emergency medical care to any person diagnosed as requiring emergency care. The statute defines emergency care as that necessary to sustain life, prevent serious, permanent disfigurement, loss or impairment of a bodily member or organ, and a woman in labor.

Tennessee: TENN. CODE ANN. § 68-39-301 (1987) requires every facility with general medical and emergency services to provide emergency treatment to any person needing emergency medical care. Section 68-39-302 states the purpose of the statute is to insure that medical need and not the financial resources of the patient determines the scope of medical care provided. Additionally, § 68-39-511(12) provides that a facility may not discriminate on the basis of race, sex, creed, religion, national origin, or ability to pay.

Texas: TEX. HEALTH & SAFETY CODE ANN. § 311.022 (West 1992) provides in subpart (a) that a hospital may not deny emergency medical services because of inability to pay if those services are available and the person is diagnosed as needing emergency services. Subpart (b) provides that a person may not be denied access to diagnosis because of inability to pay.

Utah: UTAH CODE ANN. § 26-8-8 (1989) establishes that emergency medical care shall be given to all persons needing such care to prevent loss of life, regardless to the patient's race, sex, color, creed, or ability to pay.

Vermont: VT. STAT. ANN. tit. 18, § 1852 (Supp. 1991) establishes a bill of rights for patients. Subpart (8) states that a patient may not be transferred to another facility without receiving complete information on the need for and the alternatives to transfer.

Wisconsin: WIS. STAT. ANN. § 146.301 (West 1989) provides that hospitals must offer emergency treatment to any sick or injured person. Treatment may not be delayed for purposes of collecting payment information if such a delay is likely to cause increased medical complications, permanent disability, or death. Each hospital must have a referral plan for when it is unable to provide emergency care to a patient.

Wyoming: WYO. STAT. § 35-2-115(a) (1991) requires emergency care for any person requesting such care for a condition posing a danger of loss of life, serious injury, or illness. Subpart (b) allows a hospital to refuse emergency treatment for a patient if (1) permanent injury of illness will not result from lack of treatment; (2) the facility does not have sufficiently qualified personnel for rendering treatment; or (3) facilities or equipment are unavailable for treatment.

17 For analysis of the limited effectiveness of the common law, see Karen H. Rothenberg, *Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care*, 26 HOUS. L. REV. 21 (1989); *see also* Green, *supra* note 3, at 761-65.

sponse to the growing crisis, Congress decided to directly confront the patient dumping problem by enacting EMTALA.[18]

III. THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT

EMTALA, as it is presently structured, imposes several obligations upon federally funded hospitals.[19] First, the hospital must provide an appropriate medical screening of any person who comes to the emergency room for treatment.[20] Section 1395dd(a) states:

> In the case of a hospital emergency department . . . if *any* individual . . . comes to the emergency department and a request is made on the individual's behalf for an examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition . . . exists.[21]

Section 1395dd(e)(1) defines an *emergency medical condition* as:

> (A) a medical condition manifesting itself by 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.[22]

A hospital that fails to provide this initial emergency medical screening violates EMTALA. The statute provides no definition of

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18 42 U.S.C.A. § 1395dd (West Supp. 1991).

19 "The term 'participating hospital' means a hospital that has entered into a provider agreement under section 1395cc of this title." § 1395dd(e)(2).

20 § 1395dd(a).

21 *Id.* (emphasis added).

22 § 1395dd(e)(1).

what constitutes an appropriate screening other than "within the capability of the hospital's emergency department."[23]

If a hospital determines that an emergency medical condition exists, two options are available.[24] First, the hospital may act to stabilize the patient. According to section 1395dd(e)(3), *stabilized* means "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 . . . ."[25]

The second option available to a hospital is to properly transfer a patient with an emergency medical condition to another facility.[26] Under EMTALA, a hospital may transfer a patient only if a physician initially determines that the benefits of the transfer are "reasonably expected to outweigh the risks."[27] Additionally, section 1395dd(c) provides that a transfer is only *appropriate* if:

(1) the patient or a legal representative requests in writing to be transferred after being informed of the risks of transfer,

(2) the transferring hospital provides treatment to minimize the risks of the transfer,

(3) the receiving facility has available space and qualified personnel and has agreed to accept transfer,

(4) the transferring hospital sends all medical records to the receiving facility and,

(5) qualified personnel and transportation equipment effect the transfer.[28]

Any transfer not meeting these requirements is a violation of EMTALA.

Section 1395dd(d) of EMTALA provides that both a hospital and a physician may be subject to civil penalties for negligently violating the provisions of the statute.[29] These penalties may not

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23 § 1395dd(a).

24 Section 1395dd(b)(1)(A) states:

> If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide . . .
> (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 . . . .

25 § 1395dd(e)(3).

26 § 1395dd(c)(1).

27 *Id.*

28 § 1395dd(c)(1)-(2).

29 § 1395dd(d)(1)(A)-(C).

exceed $50,000.[30] If the violation is flagrant or repeated, the physician may be excluded from state and federal funding.[31] In addition to civil penalties, this section provides for civil damages against the violating hospital to any patient or receiving facility that is injured by the EMTALA violation.[32] The Act imposes a two year statute of limitations on any cause of action.[33]

Despite these seemingly stringent standards and a comprehensive enforcement scheme, EMTALA has experienced limited success. According to a recent report by Public Citizen's Health Research Group, in five years of enforcement only 140 hospitals and three physicians have been identified as violators of EMTALA.[34] Of those identified, only nineteen have been penalized.[35] These low numbers exist despite estimates that 250,000 incidents of patient dumping occur in America yearly.[36] These numbers indicate that patient dumping remains a serious problem.

IV. THE DIAGNOSIS: WHAT AILS EMTALA?

The legislative history clearly indicates that Congress enacted EMTALA to remedy incidents where emergency care was denied because of economic motive.[37] Yet, economic motive is conspicuously absent from the statute's provisions.[38] The inconsistency between the legislative history and the language of the statute weakens the effectiveness of EMTALA. This weakness manifests itself in many ways.

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30 § 1395dd(d)(1)(A)-(B).

31 *Id.*

32 § 1395dd(d)(2)(A)-(B).

33 § 1395dd(d)(2)(C).

34 *Public Citizen Calls HHS' Enforcement of Patient Dumping Act 'Tragic Failure,'* DAILY REPORT FOR EXECUTIVES, April 24, 1991, at A-14. According to the report, 36.9% of the violations involved a hospital's failure to provide an appropriate screening; 45.6% involved a failure to stabilize; and 63.1% involved an illegal transfer. *Id.*

35 Of the nineteen that were penalized, six were terminated from Medicare funding. Three of the six were later recertified for Medicare participation. *Id.*

36 *Id.*

37 *See* Gatewood v. Washington Healthcare Corp., 933 F.2d 1037 (D.C. Cir. 1991) ("[T]he Emergency Act's [EMTALA] legislative history reflects an unmistakable concern with the treatment of uninsured patients . . . ."); Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266 (6th Cir. 1990) ("[T]here is nothing in the legislative history showing that Congress had any concern about the treatment accorded any patients other than the indigent and uninsured."); *see also supra* note 3.

38 *See* § 1395dd(a).

A. Confusion in the Courts Over EMTALA's Application

First, and most apparent, is the court confusion about the proper application of EMTALA. Courts currently disagree about whether economic motive is relevant to finding an EMTALA violation. Some courts follow a statutory construction standard that permits examining legislative history whenever interpreting a statute.[39] Because EMTALA's legislative history evidences a concern for the denial of care because of improper economic motives, these courts maintain that a cause of action will lie only when improper economic motive is present.[40]

Conversely, other courts adhere to the tenet of statutory construction that legislative history will only be examined if the statute's language is ambiguous.[41] Finding no ambiguity in the language of section 1395dd(a), which states "any individual," these courts apply EMTALA to any person, regardless of economic mo-

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39 *See* Association of Westinghouse Salaried Employees v. Westinghouse Elec. Corp., 348 U.S. 437 (1955); *see also* NORMAN J. SINGER, STATUTES AND STATUTORY CONSTRUCTION § 48.03, at 315(5th ed. 1992) ("It is established practice in American legal process to consider relevant information concerning the historical background of enactment in making decisions about how a statute is to be construed and applied.").

40 Coleman v. McCurtain Memorial Medical Management, 771 F. Supp. 343 (E.D. Okla. 1991) (a claim of misdiagnosis rather than a claim of insufficient care because of improper economic motive is beyond the regulation of EMTALA); Stewart v. Myrick, 731 F. Supp. 433 (D. Kan. 1990) (EMTALA was designed to protect those who are denied medical care for economic reasons); Nichols v. Estabrook, 741 F. Supp. 325 (D.N.H. 1989) (failure to allege that financial condition of the plaintiff affected treatment placed the claim beyond the regulation of EMTALA); Evitt v. University Heights Hosp., 727 F. Supp. 495 (S.D. Ind. 1989) (requiring an indigent or uninsured plaintiff for a cause of action under EMTALA).

41 United States v. Donruss Co., 393 U.S. 297, 303 (1969)(proposing that the Court may consider the legislative history because the language of the statute does not provide a clear answer); *Ex parte* Collett, 337 U.S. 55 (1949)("[T]here is no need to refer to the legislative history where the statutory language is clear."); SINGER, *supra* note 39, § 48.01, at 302 ("It is said that extrinsic aids may be considered only when a statute is ambiguous and unclear.").

tive.[42] This inconsistency and confusion among the courts are needless byproducts of EMTALA's present language.

1. Applying EMTALA only when improper economic motive exists

(*a*) *Nichols v. Estabrook*.[43]—The first case in which a court ruled that EMTALA provides a cause of action only when improper economic motive is present is *Nichols v. Estabrook*.[44] In *Nichols*, the plaintiffs were the parents of a sixteen week old baby that had been suffering from vomiting and diarrhea. They took their son to the hospital emergency room for treatment. After examining the baby and taking a blood sample, the doctor ordered the baby taken to another hospital. The doctor did not provide an ambulance to transport the baby because he did not feel an emergency condition existed. Contrary to the doctor's diagnosis, however, the baby was seriously ill, and died approximately forty-five minutes after arriving at the second hospital.[45]

In their medical malpractice lawsuit, the plaintiffs alleged that EMTALA established a statutory duty of care.[46] The plaintiffs argued that the doctor, in misdiagnosing their child's condition, had breached that duty and was negligent per se.[47] Rejecting this ar-

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42 Brooker v. Desert Hosp. Corp., 947 F.2d 412 (9th Cir. 1991) (EMTALA applies to all patients denied emergency medical care); Burditt v. United States Dep't of Health & Human Servs., 934 F.2d 1362 (5th Cir. 1991) (rejecting a motive requirement for an EMTALA violation); Gatewood v. Washington Healthcare Corp., 933 F.2d 1037 (D.C. Cir. 1991) (holding motive inconsequential to showing an EMTALA violation); Cleland v. Bronson Health Care Group, 917 F.2d 266 (6th Cir. 1990) (requiring any improper motive, but not necessarily an economic motive); Foster v. Lawrence Memorial Hosp., No. 91-1151-C, 1992 WL 24099 (D. Kan. Jan. 8, 1992) (EMTALA is not limited to instances of denial of care because of a patient's inability to pay for treatment); Urban v. King, No. 91-2317-V, 1992 WL 25664 (D. Kan. Jan. 7, 1992) (rejecting a limitation of EMTALA to those denied emergency medical care because of inability to pay); Jones v. Wake County Hosp. Sys., Inc., No. 90-523-CIV-5, 1991 WL 32527 (E.D.N.C. Nov. 4, 1991) (rejecting an economic motive requirement for an EMTALA violation); Deberry v. Sherman Hosp. Ass'n, 741 F. Supp. 1302 (N.D. Ill. 1991) (recognizing no indigency or lack of insurance requirement for an EMTALA violation); Burrows v. Turner Memorial Hosp., 762 F. Supp. 840 (W.D. Ark. 1991) (rejecting a requirement that the plaintiff be indigent or uninsured to have a cause of action under EMTALA).

43 741 F. Supp. 325 (D.N.H. 1989).

44 *Id.*

45 *Id.* at 326.

46 *Id.*

47 For a description of the effect of a negligence per se claim, see RESTATEMENT (SECOND) TORTS § 286 (1965) providing, "The unexcused violation of a legislative enactment or an administrative regulation which is adopted by the court as defining the stan-

gument, the court ruled that EMTALA's duty of care had not been crafted to protect against such a consequence as the death of the plaintiff's baby.[48] To reach this conclusion, the court examined EMTALA's legislative history, determining that Congress' intent in passing EMTALA was "to provide some assurance that patients with emergency medical conditions will be examined and treated regardless of their financial resources."[49] The court therefore ruled that EMTALA only applies to those who suffer injury because they are denied adequate care due to economic motives. Because the plaintiffs had not alleged an impermissible economic motive in the doctor's failure to properly treat their child, the court found no cause of action under EMTALA.[50]

(*b*) *Evitt v. University Heights Hospital.*[51]—A second case ruling that EMTALA applies only to the indigent and uninsured is *Evitt v. University Heights Hospital.*[52] In *Evitt,* the plaintiff had arrived at the hospital emergency room complaining of severe chest pain. A doctor and a nurse examined the plaintiff. They instructed the patient to stop taking a prescribed medicine, to take a different medicine, and to call her personal physician. The plaintiff was then sent home. Later that day, the plaintiff returned to the hospital and was diagnosed as suffering a heart attack.[53] In her lawsuit against the hospital, the plaintiff alleged that the hospital had violated section 1395dd(a) by not providing an appropriate medical screening. Alternatively, she alleged the hospital had violated section 1395dd(b) by not stabilizing her condition, or it had vio-

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dard of conduct of a reasonable man, is negligence in itself."

48 "A review of COBRA [EMTALA] reveals that the consequences which it contemplated have not resulted from negligent conduct as alleged by plaintiffs." *Nichols,* 741 F. Supp. at 329.

49 *Id.* at 330.

50 In rejecting a negligence per se theory under EMTALA, the court stated:

> Plaintiffs here do not allege that their financial condition or lack of health insurance contributed to Dr. Estabrook's decision not to treat their son. The interest which Congress sought to protect by enacting 42 U.S.C. § 1395dd was not invaded by the defendant's conduct as here alleged and, accordingly, plaintiffs' negligence per se theory cannot be sustained.

Id. Cf. Abercrombie v. Osteopathic Hosp. Founders Ass'n, 950 F.2d 676, 680-81 (10th Cir. 1991) (holding that a hospital that fails to meet the guidelines of EMTALA is strictly liable).

51 727 F. Supp. 495 (S.D. Ind. 1989).

52 *Id.*

53 *Id.* at 496.

lated section 1395dd(c) by not properly transferring her to another facility.[54]

In ruling for the defendant hospital, the court based its decision upon a construction of EMTALA that provides a cause of action only when care is denied because of economic factors.[55] The court rested such a narrow construction upon two grounds. First, the court examined EMTALA's legislative history and noted that Congress had enacted EMTALA to "combat the growing problem of 'patient dumping.'"[56] Therefore, the court interpreted the act to be "specifically directed toward preventing prospective patients from being turned away for economic reasons."[57]

Second, the court concluded that to allow this plaintiff to recover under EMTALA would lead to federal preemption of state malpractice law.[58] The court characterized the plaintiff's complaint as one that "rather than focusing on the 'patient dumping' problem, begins by attacking the doctor's provisional diagnosis."[59] In characterizing the plaintiff's case as a misdiagnosis claim, the court ruled that it should be resolved under state malpractice law.[60] The court noted that to rule a misdiagnosis as inappropriate under section 1395dd(a) would be to allow a misdiagnosed plaintiff a cause of action under EMTALA regardless of the reasonableness of the defendant's diagnosis at the time of examination.[61] Applying such a standard, the court reasoned, would preempt state malpractice law.[62]

The court then looked to section 1395dd(f) of EMTALA and stated that Congress had intended the Act not to preempt state medical malpractice law.[63] In order to avoid federal preemption,

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54 *Id.*

55 "She [the plaintiff] has been unable to present evidence which could prove that she was turned away from the Hospital for economic reasons, in violation of 42 U.S.C. § 1395dd." *Id.* at 498.

56 *Id.* at 497.

57 *Id.*

58 "To adjudicate these issues under the anti-dumping provision would lead to federal preemption not contemplated under the Act [EMTALA]." *Id.*

59 *Id.*

60 *Id.*

61 *Id.* at 498.

62 *Id.*

63 "The statute in question contains no explicit language aimed toward federal preemption of general medical malpractice law. On the contrary, the statute directs that there will be no preemption, except where state law directly conflicts with the statute." *Id.*

the court ruled that "appropriate" under EMTALA requires establishing a denial of care because of economics factors.[64] In other words, medical treatment will be inappropriate only if, because of improper economic motive, the treatment varies from that which the hospital normally administers. If the plaintiff could not show that economic considerations played a part in the defendant's conduct, the *Evitt* court would rule that state law should govern that conduct. To avoid federal preemption of state law, the *Evitt* court would hold the conduct to lie beyond the reach of EMTALA.

(*c*) *Stewart v. Myrick.*[65]—A third case requiring an economic motive in order to state a cause of action under EMTALA is *Stewart v. Myrick.*[66] The plaintiff's husband in *Stewart* went to the hospital emergency room for treatment. Dr. Myrick, the examining physician, instructed the patient to go home and return the next day for tests. Two days later, the patient returned to the hospital. Although Dr. Myrick reexamined the patient, and conducted the tests, the results were inconclusive. As a result, the doctor sent the patient home.[67] Eight days later, the patient, suffering from severe pain and vomiting, collapsed. He died shortly after arriving at the hospital.[68] The plaintiff alleged that the hospital and Dr. Myrick had violated section 1395dd(a) and (b)(1) of EMTALA by failing to provide an appropriate medical screening or transfer.[69]

Following the reasoning of *Evitt,* the court characterized the plaintiff's claim as "a traditional claim for medical malpractice."[70] Similarly, the court noted that EMTALA is specifically directed toward patient dumping and explicitly prohibiting preemption of

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The relevant section of EMTALA provides, "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." § 1395dd(f).

64 *Evitt,* 727 F. Supp. at 498.

65 731 F. Supp. 433 (D. Kan. 1990).

66 *Id.*

67 *Id.* at 434.

68 *Id.*

69 *Id.*

70 *Id.* at 436.

state malpractice law.[71] The court, therefore, ruled that EMTALA did not apply to the plaintiff's claim.[72]

(*d*) *Coleman v. McCurtain Memorial Medical Management Inc.*[73]—The fourth and most recent case following the reasoning set forth in *Evitt* is *Coleman v. McCurtain Memorial Medical Management, Inc.*[74] In *Coleman,* the plaintiff's wife went to the emergency room complaining of chest and abdominal pain. An emergency room physician examined the patient and diagnosed her as suffering from a virus. He ordered treatment and sent the patient home.[75] Two days later, the patient returned to the hospital in a deteriorated condition. The patient died two days after returning to the hospital.[76] The plaintiff sued the hospital, alleging medical malpractice and a violation of EMTALA by refusing to stabilize or treat his wife's serious heart condition.[77]

Refusing to recognize a violation of EMTALA by the hospital, the court characterized the plaintiff's claim as a "misdiagnosis" case.[78] Because misdiagnosis properly falls within medical malpractice adjudication, the court relied upon the reasoning of *Evitt,*[79] arguing that EMTALA does not preempt state medical malpractice law.[80] The court, therefore, denied the plaintiff's claim of an EMTALA violation.[81]

(*e*) *Difficulty with a narrow construction.*—As these four cases indicate, some courts have applied EMTALA only when impermissible economic motive is present. The courts are able to so con-

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71 The court said:

> It does not represent a case of patient dumping, in which the plaintiff was turned away from medical care for economic reasons. As result, the case does not present the type of evil that Congress sought to eliminate in the Act [EMTALA], and the federal claim will be dismissed.

Id.

72 *Id.*

73 771 F. Supp. 343 (E.D. Okla. 1991).

74 *Id.*

75 *Id.* at 344-45.

76 *Id.*

77 *Id.* at 344.

78 "Notwithstanding plaintiff's characterization of his claim, the court finds that the undisputed facts establish this case as one seeking redress under the Act [EMTALA] based on a 'misdiagnosis' and failure to treat." *Id.* at 347.

79 *See supra* notes 58-64 and accompanying text.

80 *Coleman,* 771 F. Supp. at 347.

81 *Id.*

strue EMTALA by citing specific language from the congressional record.[82] In addition, the courts cite the language of section 1395dd(f), arguing that EMTALA is expressly crafted not to preempt state law.[83] By characterizing a medical claim not based upon improper economic motive to lie within the regulation of state law, the courts hold that applying EMTALA would constitute federal preemption. Such preemption, the courts conclude, is expressly prohibited by EMTALA.

The difficulty with narrowly applying EMTALA is the weakness of the federal preemption argument introduced in *Evitt*.[84] As evidenced in the next Part, at least one court has established a contradictory argument to this preemption view.[85] The shortcoming of the *Evitt* court's argument lies in the court's definition of federal preemption.[86]

In its analysis, the *Evitt* court urged that to allow a misdiagnosed patient a cause of action under EMTALA would amount to a cause of action for any misdiagnosed patient regardless of the reasonableness of that diagnosis.[87] Correctly, the court recognized this to be an implausible result.[88] The court stated further that to allow a misdiagnosis claim under EMTALA would impermissibly preempt state malpractice law.[89] According to the court, Congress had proscribed such preemption in section 1395dd(f).[90]

Allowing misdiagnosis as a claim under EMTALA, however, does not constitute the federal preemption alleged by the *Evitt* court.[91] Although subject to varying interpretations, preemption

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82 *See, e.g., supra* text accompanying note 49.

83 *See supra* note 63 and accompanying text.

84 *See supra* note 63.

85 Deberry v. Sherman Hosp. Ass'n, 741 F. Supp. 1302 (N.D. Ill. 1990); *see infra* notes 109-14 and accompanying text.

86 *See* Evitt v. University Heights Hosp., 727 F. Supp. 495, 497 (S.D. Ind. 1989).

87 "This construction would in effect make the Hospital the guarantor of the physicians' diagnosis and treatment irrespective of how reasonable such diagnosis may have appeared at the time of the patient's release . . . ." *Id.* at 498.

88 *Id.*

89 *Id.* at 497.

90 "[T]he statute directs that there will he [sic] no preemption, except where the law directly conflicts with the statute." § 1395dd(f).

91 *See* California Fed. Sav. & Loan Ass'n v. Guerra, 479 U.S. 272 (1986). The Court cites three different ways federal law may preempt state law:

(1) Congress expressly states it will preempt state law, *id.* at 280;

(2) the federal regulation is so comprehensive as to leave no room for state regulation, *id.* at 280-81;

(3) compliance with both federal and state law is physically impossible, or the state law prevents complete execution of the federal law. *Id* at 281. Because § 1395dd(e) ex-

has been defined to arise "where there is an actual conflict between 'the two sets of legislation such that both cannot stand . . . ."[92] If EMTALA were applied to misdiagnosis claims by any patient, this would not prohibit state's from continuing to regulate such conduct. The result would merely be a "double regulation"[93] of the same activity. This is not preemption as alleged by the court.

The *Evitt* court used the preemption argument to strengthen its interpretation of EMTALA's scope. Because the court believed Congress had enacted EMTALA only to prohibit patient dumping,[94] the court sought to substantiate that view. The only basis for that view, however, lay in the legislative history. The court sought another ground upon which to rest its narrow construction of EMTALA. Ironically, the court did not need to go as far as the preemption argument in order to deny the plaintiff, who had not alleged an impermissible motive, a cause of action.

As noted, the plaintiff alleged that the defendant had violated EMTALA because of an incorrect diagnosis in the emergency room.[95] The court could have merely held that misdiagnosis is not proof of an inappropriate screening.[96] Section 1395dd(a) requires an emergency medical screening that is within the hospital's capabilities.[97] So long as the defendant had performed a screening "within its capabilities,"[98] the court could have argued no EMTALA violation would exist.[99] Because the plaintiff could not show that the defendant had failed to meet the statutory screening requirement, the court could have properly held for the defen-

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pressly forbids preemption except where there is a direct conflict, preemption can only occur under EMTALA where compliance with state law and EMTALA would be impossible; *see also* Deberry v. Sherman Hosp. Ass'n, 741 F. Supp. 1302, 1307 (N.D. Ill. 1990).

92 JOHN E. NORVAK ET AL., CONSTITUTIONAL LAW 295 (3d ed. 1986). For analysis of the changing role of federal preemption, see JOSEPH F. ZIMMERMAN, FEDERAL PREEMPTION: THE SILENT REVOLUTION (1991).

93 *See Deberry*, 741 F. Supp. at 1307.

94 Evitt v. University Heights Hosp., 727 F. Supp. 495, 497 (S.D. Ind. 1989).

95 *Id.*

96 *See* § 1395dd(a).

97 *Id.*

98 *Id.*

99 Under such an analysis, a hospital or physician could misdiagnosis a patient without violating EMTALA. By conducting a screening within the hospital's capabilities, the physician or hospital would have met its duty under § 1395dd(a). If that appropriate screening resulted in a misdiagnosis, this would not violate EMTALA. Of course, the hospital or physician may be liable under state malpractice law for the misdiagnosis. *See id.*

dant. This would have insured the same result as that which the court ultimately reached without the necessity of the preemption argument.

The *Evitt* court's preemption argument illustrates why Congress should amend EMTALA. Courts sensitive to the intent behind the statute must rest their analysis solely upon the legislative history. To substantiate that reliance, the courts utilize the preemption doctrine. The fallacy of such a preemption argument, however, illustrates how courts are utilizing incorrect arguments to attempt to substantiate limiting EMTALA to only improper economic motive. By amending EMTALA, Congress will eliminate this weakness. Controversy over construction will disappear, and courts will apply the statute only when improper economic motive dictates insufficient medical care.

2. Applying EMTALA to Any Person Denied Emergency Care

In contrast to those courts that have held EMTALA to apply only when improper economic motive is present, other cases have expressly rejected the economic motive requirement. Rather than first considering the legislative history to determine the proper scope of EMTALA, these courts rely upon the language of the statute. Accordingly, the courts hold that EMTALA should apply to any person denied sufficient emergency medical care. These decisions not only conflict directly with those courts that hold EMTALA to apply only when economic motive is present, but additionally, this group of courts disagree among themselves about the proper standard for showing a violation. This inconsistency and needless complexity further strengthen the argument for amending EMTALA.

(*a*) *Deberry v. Sherman Hospital Association.*[100]—One case to decide that a plaintiff need not allege improper economic motive to state a cause of action under EMTALA is *Deberry v. Sherman Hospital Association.*[101] The plaintiff's daughter in *Deberry* was brought to the emergency room of the defendant hospital suffering from a fever, rash, stiff neck, irritability and lethargy. According to the plaintiff, her daughter was treated but not stabilized before the hospital sent her home. Two days later, the child's condition had worsened, and the plaintiff returned to the hospital with her

100 741 F. Supp. 1302 (N.D. Ill. 1990).
101 *Id.*

daughter. The doctor ultimately diagnosed the child to be suffering from spinal meningitis.[102] In her lawsuit against the hospital, the plaintiff alleged a violation of EMTALA and a state medical malpractice claim.[103]

Although the court noted that the legislative history of EMTALA indicates an intent to prohibit patient dumping, it refused to interpret the statute contrary to its express language.[104] As such, the court would not limit an EMTALA cause of action to claims of refusal of medical care based on an inability to pay.[105] Rather, the court set forth the necessary elements of an EMTALA violation. According to the court,

> the plaintiff must allege that he (1) went to the defendant's emergency room (2) with an emergency medical condition, and that the hospital either (3) did not adequately screen him to determine whether he had such a condition, or (4) discharged or transferred him before the emergency condition had been stabilized.[106]

If these elements are met, the court ruled that a cause of action under EMTALA exists regardless of the plaintiff's ability to pay for medical care.[107]

In ruling that an EMTALA violation existed irrespective of any claim of indigency or lack of insurance, the court relied upon two factors. The first involved the court's view of statutory construction. According to the court, legislative history would not be considered in interpretation unless ambiguity arose from the statute's language.[108] Because the statute expressly provides a cause of action for *any* patient, the court refused to limit its scope.

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102 *Id.* at 1303.

103 *Id.*

104 The court stated:

> [W]hile the legislative history of § 1395dd indicates that perhaps the principle reason for its enactment was the refusal to treat indigents by certain hospitals . . . the language of the statute quite plainly goes further . . . . Obviously we will not allow a few references to the statute's purpose in the legislative history to override the plain meaning of its terms as enacted.

Id. at 1306.

105 *Id.*

106 *Id.* at 1305.

107 *Id.*

108 *Id.* at 1306 ("Inquiries into such peripheral matters as policy and legislative intent are relevant only 'when . . . a statute has an hiatus that must be filled or there are ambiguities in the legislative language that must be resolved.'" (quoting Unexcelled Chemical Corp. v. United States, 345 U.S. 59 (1953))).

Second, the court disagreed with *Evitt*'s analysis of federal preemption.[109] According to the court, the *Evitt* court had erred because it "had assumed that double coverage was prohibited."[110] The *Deberry* court, however, read section 1395dd(f) to mean that EMTALA should not regulate to the *exclusion* of state malpractice law.[111] This did not mean, the court reasoned, that EMTALA could not regulate the same conduct that state malpractice law regulated.[112] Only when it was impossible to comply with both EMTALA and state law, the court concluded, would EMTALA preempt state medical malpractice law.[113]

The court therefore contradicted the *Evitt* court's conclusion, and argued that applying EMTALA to any person would not exclude state malpractice law. The court noted that such a broad scope "simply means that more conduct will be proscribed by both federal and state law."[114] Because the court found that allowing any person to sue under EMTALA would not cause federal preemption of state law, the court was able to rely upon the statute's language. Accordingly, the court held EMTALA to apply to any person regardless of economic motive.[115]

(*b*) *Cleland v. Bronson Health Care Group, Inc.*[116]—Although construing EMTALA to apply to any person, a second case deciding the issue sought to pay more heed to the legislative history.

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109 *See* Evitt v. University Heights Hosp., 727 F. Supp. 495, 497 (S.D. Ind. 1989).

110 Deberry v. Sherman Hosp. Ass'n, 741 F. Supp. 1302, 1307 (N.D. Ill. 1990).

111 The court distinguished between *field preemption* and *conflict preemption*. In defining field preemption, the court stated:

> *Field preemption* simply means that Congress intended not only to regulate whatever is covered by the federal law at issue but to regulate it to the *exclusion* of the states. Field preemption, however, is never presumed; in fact, it is disfavored and must be clearly manifested by the statute in question, either through express language or its scheme, in order to exist.

Id. (first emphasis added). The court characterized *conflict preemption* to "not forbid double regulation; it only preempts those state laws where 'compliance with both federal and state regulations is a physical impossibility,' or which pose 'an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'" *Id.* (quoting California Fed. Sav. & Loan Ass'n v. Guerra, 479 U.S. 272 (1987)).

112 "[A] broad interpretation of § 1395dd—an interpretation which we have already concluded is mandated by the express language of the statute—will not result in the wholesale preemption of state malpractice law as predicted by the *Evitt* court." *Id.*

113 *Id.*

114 *Id.*

115 *Id.*

116 917 F.2d 266 (6th Cir. 1990).

The plaintiffs in *Cleland v. Bronson Health Care Group, Inc.*[117] took their son to the emergency room of the defendant hospital. The boy was diagnosed as having the flu and was sent home. Less than twenty-four hours later, the child died.[118] In their lawsuit, the plaintiffs alleged that the hospital had violated EMTALA by failing to adequately screen, failing to adequately treat, and discharging without stabilizing an emergency condition.[119]

The court ruled for the defendant hospital, stating that the hospital had provided the appropriate emergency care as dictated by EMTALA.[120] In its analysis, the court recognized that a major force behind the creation of EMTALA had been the intent to eliminate patient dumping.[121] The court noted, however, that to apply EMTALA to any person necessarily encompasses Congress' concern for those unable to pay for care. Although such a statutory construction appeared broader than Congress' intent, the court stated that such a construction complied fully with the language of EMTALA.[122]

In ruling for the defendant hospital, the court also considered the standard required by "appropriate" in section 1395dd(a).[123] Rejecting a malpractice standard, the court noted that "appropriate" as used in section 1395dd(a) "must more correctly be interpreted to refer to the *motives* with which the hospital acts. If it acts in the same manner as it would have for the usual paying patient, then the screening provided is 'appropriate' within the meaning of the statute."[124] In other words, medical treatment will be inappropriate, thus violating EMTALA, only if, because of improper motive, the treatment varies from that which the hospital normally administers. With this language, the court seemingly created an improper motive requirement for an EMTALA violation. The court was careful to point out than an improper motive requirement

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117 *Id.*

118 *Id.* at 268.

119 *Id.* at 269.

120 *Id.* at 271.

121 "[T]here is nothing in the legislative history showing that Congress had any concern about the treatment accorded any patients other than the indigent and uninsured." *Id.*

122 "Here, the result we reach in no way vitiates or is contrary to Congress's indicated concern in passing the legislation. It may go further than what Congress contemplated, but that is not a reason to distort or excise the words that Congress wrote." *Id.* at 270.

123 *Id.* at 272.

124 *Id.* (emphasis added).

does not limit the statute to the indigent or uninsured, stating, "This result does not constitute a backdoor means of limiting coverage to the indigent or uninsured. A hospital that provides a substandard (by its standards) or nonexistent medical screening for any reason . . . may be liable under this section."[125]

(c) *Gatewood v. Washington Healthcare Corp.*—The court in *Gatewood v. Washington Healthcare Corp.*,[126] in ruling that EMTALA should apply regardless of economic motive, flatly rejected a motive requirement for an EMTALA violation. The plaintiff's husband in *Gatewood* was taken to the hospital emergency room with pain in his left arm and chest. A doctor examined and diagnosed him, and then sent the patient home. The next day, the patient died of a heart attack.[127] In her lawsuit, the plaintiff alleged violations of EMTALA and a state malpractice claim.[128]

In its analysis, the court recognized the legislative history's express intent to remedy the lack of treatment for the uninsured.[129] Like *Deberry*[130]and *Cleland*,[131] however, the court felt bound to follow the express language of the statute. As a result, the court ruled that any person may bring a cause of action under EMTALA.[132]

In ruling for the defendant, the court held that the hospital had indeed met the requirements set forth by section 1395dd(a) of EMTALA.[133] According to the court, motive is irrelevant in determining whether the emergency care has been "appropriate."[134] Rather, "'appropriate' screening is properly deter-

125 *Id.*

126 933 F.2d 1037 (D.C. Cir. 1991).

127 *Id.* at 1039.

128 *Id.*

129 "Though the Emergency Act's legislative history reflects an unmistakable concern with the treatment of uninsured patients, the Act itself draws no distinction between persons with and without insurance." *Id.* at 1040.

130 741 F. Supp. 1302 (N.D. Ill. 1990).

131 617 F.2d 266 (6th Cir. 1990).

132 "[T]he Act's plain language unambiguously extends its protections to '*any* individual' who seeks emergency room assistance . . . . We conclude that we are bound by statutory language this clear, at least, where as here, it is not manifestly inconsistent with legislative intent." *Gatewood*, 933 F.2d at 1040.

133 *Id.* at 1040.

134 Defining appropriate emergency care, the court stated:

> [A]ny departure from standard screening procedures constitutes inappropriate screening in violation of the Emergency Act. The motive for such departure is not important to this analysis, which applies whenever and for whatever reason a patient is denied the same level of care provided others and guaranteed him or

mined . . . by reference to a hospital's screening procedures."[135] Under this analysis, any deviation from normal procedure may be construed as inappropriate under EMTALA. The motive underlying that deviation, according to the court, is of no consequence. In this regard, the court differed substantially from the *Cleland* court which had ruled that impermissible motive is the determining factor in proving an EMTALA violation.[136]

In further analyzing the standard necessary to comply with the "appropriate" requirement of section 1395dd(a), the court rejected any type of negligence or malpractice standard.[137] Instead, the court stated, "The federal Emergency Act is not intended to duplicate preexisting legal protections, but rather to create a new cause of action, generally unavailable under state tort law, for what amounts to failure to treat."[138] Accordingly, the court noted that a claim challenging the adequacy of a hospital's screening procedures "must remain the exclusive province of local negligence law."[139] In other words, an EMTALA violation may be shown only by proving a deviation from normal hospital procedures. If, however, a plaintiff wishes to challenge the adequacy of the medical procedures themselves, the *Gatewood* court would rule such a claim to fall beyond the scope of EMTALA.

(*d*) *Summary of cases applying EMTALA to any patient.*—As these cases indicate, several courts, in spite of the legislative history, have felt constrained to follow EMTALA's express statutory language, providing a cause of action for any patient denied emergency medical care. Such a construction, however, has been the source of unnecessary court confusion. The *Cleland* court's construction of the *any* improper motive requirement illustrates this needless confusion. In analyzing EMTALA's scope, the *Cleland* court ruled "any individual" in section 1395dd(a) to be an unambiguous term.[140] As such, the court would not look to the

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her by subsection 1395dd(a).

Id. *See also* Jones v. Wake County Hosp. Sys., Inc., No. 90-523-CIV-5, 1991 WL 325271, at *5 (E.D.N.C. Nov. 4, 1991) (adopting the *Gatewood* analysis of requiring no motive to show an EMTALA violation).

135 *Gatewood*, 933 F.2d at 1040.

136 *See supra* text accompanying note 124.

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

138 *Id.*

139 *Id.*

140 Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 270 (6th Cir. 1990).

statute's legislative history. Rather, the court, in deference to the legislature,[141] broadly construed EMTALA to apply to any person.[142] Within the same section of EMTALA, however, the court confronted the term "appropriate" medical screening.[143] By the court's own admission, "appropriate" is an ambiguous term.[144] Accordingly, the court could have examined the legislative history to interpret that term. The legislative history, however, revealed a congressional concern for insufficient care because of economic motive.[145] To have defined inappropriate as insufficient because of economic motives would have conflicted directly with the court's determination that EMTALA should apply to any person regardless of ability or inability to pay.

In order to reconcile the broad application of "any individual" with the term "appropriate" medical screening, the *Cleland* court constructed the *any* improper motive requirement.[146] Yet, nowhere in EMTALA or its legislative history are improper motives other than economic mentioned. This construction illustrates needless confusion and inconsistency. The *Cleland* court had attempted to construe EMTALA as close to its literal language as possible. At the same time, the court had wanted to remain true to the statute's purpose. In trying to balance these two concerns, the *Cleland* court interpreted the statute inconsistently with both the language and the legislative history.[147]

Additionally, the *any* improper motive requirement creates a waste of judicial resources. In construing EMTALA to apply to numerous noneconomic motives, the *Cleland* court stated:

> We can think of many reasons other than indigency that might lead a hospital to give less than standard attention to a person who arrives at the emergency room. These might include: prejudice against race, sex, or ethnic group of the patient; dislike

141 "[I]t is not our place to rewrite statutes to conform with our notions of efficacy or rationality. That is the job of Congress." *Id.*

142 *Id.*

143 *Id.* at 271.

144 "'Appropriate' is one of the most wonderful weasel words in the dictionary . . . ." *Id.*

145 "[T]here is nothing in the legislative history showing that Congress had any concern about the treatment accorded any patients other than the indigent and uninsured." *Id.* at 269.

146 *Id.* at 272.

147 The *Cleland* court admitted that its construction may lie beyond the contemplation of Congress, stating that the ruling "leads to a result considerably broader than one might think Congress should have intended, or perhaps than any or all individual members of Congress were cognizant of." *Id.* at 270.

> for the patient's condition (*e.g.* AIDS patients); personal dislike or antagonism between the medical personnel and the patient; disapproval of the patient's occupation; or political or cultural opposition.[148]

Many of the noneconomic motives cited by the *Cleland* court are already prohibited by other federal laws. A patient who can illustrate denial of care by a federally funded hospital because of race, ethnicity, or AIDS, for example, could sue the hospital under other federal laws.[149] By applying EMTALA to regulate these motives, the *Cleland* court creates an inefficient double regulation of proscribed activity.[150]

Additionally, even as the courts applying EMTALA to any person agree about the statute's scope, they nonetheless disagree about the standard by which to show a violation. *Cleland,* for example, expressly provides that improper motive be a factor in showing a violation.[151] *Gatewood* explicitly states that motive is irrelevant.[152]

B. The Weaknesses of EMTALA As Evidenced by the Case Law

The greatest difficulty with EMTALA at present is that it fosters inconsistent interpretation. As indicated, courts are split upon their interpretation of EMTALA's scope of application. Whether a patient has a cause of action under EMTALA depends upon the jurisdiction in which the plaintiff brings the lawsuit. This inconsistency and confusion prohibit efficient application of the statute. Parties unsure of the statute's scope bring claims that are

148 *Id.* at 272.

149 Discrimination by a federally funded hospital because of race, sex, or ethnicity may be actionable under 42 U.S.C. § 1983 (1988). Similarly, a person who was discriminated against because of AIDS could probably sue under The Rehabilitation Act, 29 U.S.C. § 701 (1988). *See infra* note 179.

150 *See infra* notes 179-80 and accompanying text.

151 *See supra* text accompanying note 124.

152 *See supra* notes 133-34 and accompanying text.

not regulated by EMTALA.[153] Additionally, some courts apply the statute to activity already regulated by other laws.[154]

Evitt,[155] *Stewart*,[156] and *Coleman*[157] illustrate the practical benefit of limiting EMTALA to only improper economic motive. Limiting EMTALA allows courts to classify any claim not alleging improper economic motive as beyond the reach of the statute. The courts' analysis, therefore, becomes relatively straightforward. If economic motive is a factor in the insufficient administration of medical care, there exists an EMTALA violation. Otherwise, the claim lies beyond the regulation of the statute.[158] Such a standard not only directly furthers Congress' major concern in enacting EMTALA,[159] but it does so through a simple, bright line approach.

As EMTALA is presently structured, however, the bright line approach in *Evitt*, *Stewart* and *Coleman* is only possible through complete reliance upon a legislative history that differs from the language of the statute. A standard convention of statutory construction generally holds that reliance upon legislative history is only appropriate if the statute is ambiguous.[160] Because EMTALA requires an emergency medical screening for *any* individual, some courts rule that EMTALA lacks ambiguity, making reliance upon the legislative history improper.[161]

In order to strengthen the narrow construction of EMTALA, the *Evitt* court structured a federal preemption argument. Looking to section 1395dd(f), the court stated that applying EMTALA to any individual would impermissibly preempt state malpractice law.[162] As the *Deberry*[163] court pointed out, however, such a view

153 Most claims currently presented to the courts involve state medical malpractice claims rather than EMTALA violations. *See, e.g.*, Gatewood v. Washington Healthcare Corp., 933 F.2d 1037 (D.C. Cir. 1991); Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266 (6th Cir. 1990); Coleman v. McCurtain Memorial Medical Management, Inc., 771 F. Supp. 343 (E.D. Okla. 1991); Deberry v. Sherman Hosp. Ass'n, 741 F. Supp. 1302 (N.D. Ill. 1990); Stewart v. Myrick, 731 F. Supp. 433 (D. Kan. 1990); Evitt v. University Heights Hosp., 727 F. Supp. 495 (S.D. Ind. 1989); Nichols v. Estabrook, 741 F. Supp. 325 (D.N.H. 1989).

154 *See Cleland*, 917 F.2d at 272 (6th Cir. 1990); *see also infra* notes 179-80 and accompanying text.

155 727 F. Supp. 495 (S.D. Ind. 1989).

156 731 F. Supp. 433 (D. Kan. 1990).

157 771 F. Supp. 343 (E.D. Okla. 1991).

158 *See Coleman*, 771 F. Supp. at 347; *Stewart*, 731 F. Supp. at 436; *Evitt*, 727 F. Supp. at 497.

159 *See supra* note 3.

160 *See supra* note 41.

161 *See supra* note 42 and accompanying text.

162 *See supra* notes 58-64 and accompanying text.

of federal preemption is improper. The result of applying EMTALA to any individual is not federal preemption, but merely double regulation by state and federal law of the same activity.[164] As *Deberry* stated, section 1395dd(a) was not designed to prohibit such double regulation.[165]

Yet, to the extent that any person can currently sue under EMTALA, courts must craft a standard other than economic motive to evidence an EMTALA violation. This forces courts to consider a variety of factors, shifting the courts' attention from the most important issue under EMTALA.[166] As *Cleland*[167] and *Gatewood*[168] illustrate, courts vary on what factors they weigh in determining a statutory violation.[169] In *Cleland,* for example, the court imposed an improper motive requirement for an EMTALA violation.[170] The only basis for such a motive requirement lay in the legislative history's concern for denial of care because of improper economic motive. Because the court felt constrained to apply EMTALA to any individual, however, it would not limit the statute's scope to only economic motive.[171] The result was a requirement that any improper motive exist before an EMTALA violation could be shown.

Conversely, the *Gatewood* court rejected any type of motive requirement for an EMTALA violation.[172] Rather than focus upon why the medical care was insufficient, the court merely ruled that any insufficient care violated EMTALA.[173] In this regard, the court directly contradicted *Cleland.*

The *Cleland/Gatewood* dichotomy illustrates that EMTALA not only engenders confusion about its scope, but it also causes inconsistencies among courts that agree on scope but cannot agree upon the appropriate standard for showing a violation. As a result, court analysis becomes more complicated, and inconsistencies persist as each court attempts to decide the relevant criteria for an EMTALA violation.

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163 741 F. Supp. 1302 (N.D. Ill. 1990).
164 *Id.* at 1307.
165 *Id.*
166 *See supra* note 3 and accompanying text.
167 917 F.2d 266 (6th Cir. 1990).
168 933 F.2d 1037 (D.C. Cir. 1991).
169 *See supra* notes 124 and 134-35 and accompanying text.
170 *Cleland,* 917 F.2d at 270.
171 *Id.* at 272.
172 *Gatewood,* 933 F.2d at 1040.
173 *Id.*

C. Other Problems

In addition to court confusion, the present EMTALA also creates other difficulties. One such difficulty is the confusion that the inconsistent court application engenders among potential parties to an EMTALA lawsuit. Because application of EMTALA depends upon the jurisdiction trying the case,[174] potential plaintiffs and defendants are unsure of EMTALA's application to their activity. To the extent that such uncertainty persists, courts will not efficiently utilize EMTALA.

Another result of the confusion about EMTALA's scope is the medical malpractice claims that parties attempt to bring within the regulations of the statute.[175] In light of the legislative history, EMTALA should not regulate such claims.[176] Courts deciding whether such claims lie within the scope of EMTALA needlessly waste judicial resources.[177]

A final problem with the present statute is the attempt by some courts to apply EMTALA to conduct already regulated by other federal laws. Allowing any person to sue under EMTALA necessarily includes, for example, those denied care because of race, handicap, or AIDS.[178] Federal law may already regulate such claims.[179] To the extent that courts, such as *Cleland*,[180] ap-

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174 *See supra* notes 40-42 and accompanying text.

175 *See supra* note 153.

176 *See supra* note 3 and accompanying text.

177 Although most courts ultimately decide that malpractice claims lie beyond EMTALA, the mere fact that courts need to make such determinations illustrates the waste of judicial resources. *See supra* note 153.

178 *See* Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 270 (1991).

179 Under present federal law, various classes of patients may have a cause of action for discrimination in rendering medical care. For example, the Rehabilitation Act of 1973, 29 U.S.C. § 701 (1988), makes it unlawful for any facility receiving federal funding to discriminate against a handicapped individual. In Bowen v. American Hosp. Assn, 476 U.S. 610 (1986), the Supreme Court dealt with alleged discrimination against handicapped infants. Describing the role the Rehabilitation Act would play in regulating such conduct, the Court stated, "If such an infant is 'otherwise qualified' for benefits under a program or activity receiving federal financial assistance, § 504 [Rehabilitation Act] protects him from discrimination 'solely by reason of his handicap.'" *Id.* at 624. (dictum). This language indicates that other individuals may have a cause of action against federally financed hospitals that deny those individuals medical care because of their handicap. Courts would probably consider an individual with AIDS as handicapped for purposes of the Rehabilitation Act. *See* School Bd. of Nassua County v. Arline, 480 U.S. 273 (1987) (holding that a woman with tuberculosis was a handicapped individual within the meaning of the Rehabilitation Act); Doe v. Dalton Elementary Sch. Dist. Number 148, 694 F. Supp. 440 (N.D. Ill. 1988) (stating that an elementary student with AIDS was likely to be a "handicapped individual" within the meaning of the Rehabilitation Act). The recent

ply EMTALA to those claims, they inefficiently apply the statute to conduct already prohibited by other federal laws. Not only does this place an additional unnecessary burden upon the courts, but it also runs counter to congressional intent.[181]

V. A PROPOSED CURE: AMENDING EMTALA

By amending EMTALA to apply only when improper economic motive is present, Congress could strengthen the statute in two specific ways. First, Congress would eliminate the enumerated difficulties of EMTALA in its present form. Narrowing EMTALA to denial of care because of economic motive would remove the inconsistency between the statute's language and history. Courts would no longer waste judicial resources on claims clearly beyond the statute's scope. Inefficient double regulation of denial of care because of noneconomic motive would also cease. Additionally, parties would be sure of the reaches of EMTALA and would know whether EMTALA regulates their activity. Eliminating these difficulties would strengthen EMTALA, and allow the statute to better achieve its intended goal.

Secondly, narrowing the statute's scope allows Congress to alter the standard for showing an EMTALA violation. By restricting the class of potential plaintiffs, Congress can endorse the use of presumptions in the plaintiff's case without fear of countless lawsuits by those who perceive an easier standard under EMTALA.[182] In enhancing the plaintiff's case with the presumption, the statute poses a greater deterrent to those who would deny care because of improper economic motive.

Americans with Disabilities Act, 42 U.S.C.A. § 12101 (West Supp. 1992), may also prohibit discrimination against patients because of AIDS.

Additionally, any patient who is discriminated against by a federally funded hospital because of race, religion, national origin, or ethnicity may be able to sue for a civil rights violation under 42 U.S.C. § 1983 (1988).

180 *See supra* notes 149-50 and accompanying text.

181 Since the legislative history indicates that Congress wanted to prevent denial of emergency care because of economic factors, allowing denial of care because of noneconomic factors expands EMTALA beyond its intended scope. If Congress deems other factors inappropriate in the denial of emergency care, Congress should act to prohibit such motives. Without express congressional action, courts are utilizing EMTALA to prohibit conduct beyond what Congress contemplated. *See supra* note 3.

182 If EMTALA's scope is not narrowed, plaintiffs with medical malpractice claims would probably attempt to gain the benefit of the presumption. Such a result would counteract the desired goal of eliminating the waste of judicial resources on claims outside the regulation of EMTALA. *See supra* note 153.

A. Changing the Statute's Language

The first change Congress should make to EMTALA is to narrow its scope to only those who are denied emergency medical care because of improper economic motives. Because Congress' intent in enacting EMTALA was to eliminate patient dumping, such a narrowing is a logical result. Congress should amend section 1395dd(a) to provide that no hospital shall refuse to provide an emergency medical screening to any individual because of improper economic motives. The amended section 1395dd(a) could read as follows:

> No hospital that has a hospital emergency department, including ancillary services routinely available to the emergency department, shall refuse, because of improper economic motives, to provide any person with an appropriate medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition exists.[183]

In section 1395dd(e), Congress could then define "improper economic motives" to include a hospital's refusal to screen because a person is indigent, uninsured, or believed to be unable to pay for emergency care.[184] Under such a standard, an indigent or uninsured person would fall within the statute's protected class. An underinsured[185] or insured person would have to show that the hospital either was not aware of this insurance or believed that the person could not pay for emergency care. If the insured or underinsured person could not make this showing, there would be no cause of action under EMTALA.[186] Under such a standard any plaintiff suing under the amended EMTALA would necessarily force improper economic motive to the forefront of any court's analysis.[187]

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183 *Compare* 42 U.S.C.A. § 1395dd(a) (1992).

184 The provision could read: "Improper economic motive means, a refusal to screen, stabilize, or properly transfer because the person is indigent, uninsured, or believed to be unable to pay for emergency medical care."

185 An *underinsured* person could be defined as someone who has insurance, but that insurance is insufficient to pay for the emergency medical care. *See* Friedman, *supra* note 10, at 2492 (estimating that one of every four Americans is either uninsured or underinsured).

186 The scenario contemplated involves, for example, an individual who has insurance, but is unable upon arrival at the hospital to prove the existence of the insurance. If the hospital were to refuse to treat this patient, improper economic motive would necessarily be implicated. An amended EMTALA should not foreclose protection to an individual who is denied emergency care under such a circumstance.

187 Traditional malpractice claims would lie beyond the reach of the amended

B. Creating A Presumption of Improper Economic Motive

1. How the presumption works

Congress could further strengthen EMTALA by creating a standard for showing violations of the statute. This proposed standard would allow the plaintiff to establish a prima facie case.[188] Once the plaintiff had constructed this prima facie case, a rebuttable presumption of improper economic motive would arise.[189] If the defendant then failed to come forward with evidence to rebut this presumption, the court would hold the defendant liable under EMTALA.[190]

EMTALA because they would not involve an allegation of improper motive. Theoretically, a malpractice claim could arise wherein economic motive was a factor in the doctor's negligence. Under such a scenario, the plaintiff would have both an EMTALA claim and a state malpractice cause of action. The critical point is that all claims not alleging improper economic motive—the majority of malpractice claims—would clearly lie beyond EMTALA. Courts would, therefore, not waste valuable judicial resources to decide whether EMTALA should apply. *See supra* note 177 and accompanying text.

188 The prima facie case would be analogous to that of a Title VII discrimination case. 42 U.S.C. § 2000c (1988). *See* McDonnell Douglas Corp. v. Green, 411 U.S. 792 (1973). To build the prima facie case in a Title VII racial discrimination case, the plaintiff must show:

(i) that he belongs to a racial minority; (ii) that he applied and was qualified for a job for which the employer was seeking applicants; (iii) that, despite his qualifications, he was rejected; and (iv) that, after his rejection, the position remained open and the employer continued to seek applicants from persons of complainant's qualifications. *Id.* at 802.

189 In utilizing a rebuttable presumption, the plaintiff is allowed to show fact A (the patient was not examined, stabilized, or properly transferred), which then creates a presumption as to the existence of fact B (the hospital's conduct was motivated by improper economic considerations). The burden of production would then shift to the defendant, who must come forward with sufficient evidence to establish the nonexistence of B in spite of the plaintiff's showing of A. *See* FLEMING JAMES, JR. & GEOFFREY C. HAZARD, JR., CIVIL PROCEDURE 253-61 (2d ed. 1977); MCCORMICK ON EVIDENCE § 343 (Edward W. Cleary ed., 3d ed. 1984).

190 The Federal Rules of Evidence provide:

> In all civil actions and proceedings not otherwise provided for by Act of Congress or by these rules, a presumption imposes on the party against whom it is directed the burden of going forward with evidence to rebut or meet the presumption, but does not shift to such party the burden of proof in the sense of the risk of nonpersuasion, which remains throughout the trial upon the party on whom it was originally cast.

FED. R. EVID. 301. *See* STEPHEN A. SALTZBURG & KENNETH R. REDDEN, FEDERAL RULES OF EVIDENCE MANUAL (4th ed. 1986). In explaining the effect of Rule 301, the authors state that, "The Federal Rule provides that a presumption imposes on the party against whom it is directed the burden of going forward with evidence to rebut the presumption. But the burden of persuasion remains with the party on whom it was originally cast . . . ."

To build the prima facie case, the plaintiff would need to prove by a preponderance of the evidence the following elements:
(1) the plaintiff is a member of the protected class—indigent, uninsured, or believed to be unable to pay;[191]
(2) the plaintiff went to the emergency room for treatment;[192]
(3) the plaintiff had an emergency medical condition;[193]
(4) the plaintiff was not screened, stabilized, or properly transferred.[194]

Upon showing these elements, a presumption would arise that the defendant failed to screen, stabilize, or properly transfer because of improper economic motive. The defendant would then have two options available. First, the defendant could come forward with evidence to disprove one of the elements of the prima facie case.[195] If this occurred, the court would rule for the defendant.[196] Second, the defendant could come forward with evidence to rebut the presumption.[197] If the defendant produces this evidence, the presumption would drop from the case.[198] The plaintiff would then be given the opportunity to show that the

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Id. at 85.

191 *See supra* note 3 and accompanying text.

192 *See* § 1395dd(a).

193 The emergency medical condition is defined by § 1395dd(e)(1). *See supra* text accompanying note 22.

194 *See supra* notes 24-28 and accompanying text.

195 *See* Texas Dept. of Community Affairs v. Burdine, 450 U.S. 248, 252 (1981) (discussing the role of the rebuttable presumption in a Title VII case).

196 If the defendant disproves one of the elements of the prima facie case, the plaintiff would lose the presumption of improper economic motive. In destroying this required element of an amended EMTALA violation, the defendant would prevail. *See infra* note 198 and accompanying text.

197 *See Burdine*, 450 U.S. at 254. In ruling upon the procedural effects of a presumption in a Title VII case, the Court noted the amount of evidence necessary to rebut the presumption. The Court stated, "The defendant need not persuade the court that it was actually motivated by the proffered reasons . . . . It is sufficient if the defendant's evidence raises a genuine issue of fact as to whether it discriminated against the plaintiff." *Id.*

198 The *Burdine* Court illustrates the effect of the presumption dropping from the case:

> In saying that the presumption drops from the case, we do not imply that the trier of fact no longer may consider evidence previously introduced by the plaintiff to establish a prima facie case. A satisfactory exploration by the defendant destroys the legally mandatory inference of discrimination arising from the plaintiff's initial evidence. Nonetheless, this evidence and inferences properly drawn therefrom may be considered by the trier of fact on the issue of whether the defendant's explanation is pretextual.

Id. at 255, n.10.

defendant's noneconomic motives were a mere pretext.[199] This would require giving the plaintiff a "full and fair opportunity to demonstrate by competent evidence that the presumptively valid reasons for his [denial of appropriate care] were in fact a cover-up . . . ."[200] By showing that the noneconomic motives alleged by the defendant were a mere pretext, the plaintiff would show improper economic motive and would win under EMTALA. If the plaintiff could not show a pretextual nature to the defendant's noneconomic motives, the defendant would prevail.

2. Building the prima facie case

In building the prima facie case, the plaintiff would first need to prove membership in the protected class under EMTALA.[201] A showing of lack of insurance or a belief by defendant that the plaintiff could not pay should fulfill this element. Showing the second element of the prima facie case—that the plaintiff went to the emergency room for treatment—should be relatively straightforward.[202] In showing an emergency medical condition, the third element, the plaintiff would need to show an emergency as defined under section 1395dd(e)(1) of EMTALA. Evidence of the plaintiff's severe pain or disfigurement, or evidence of the necessity of later medical attention are possible forms such evidence could take.[203] Proof that the plaintiff was turned away, transferred, or suffered a deterioration of condition are examples of how the plaintiff may prove that the plaintiff was not screened, stabilized, or properly transferred, the fourth element of the prima facie case.[204] Once the plaintiff has made this prima facie case, the focus of the trial would then shift to the defendant.[205]

To disprove an element of the prima facie case, the defendant could come forward with evidence that the defendant be-

199 *See* McDonnell Douglas Corp. v. Green, 411 U.S. 792, 805 (1973).

200 *Id.*

201 *See supra* text accompaying note 191.

202 *See supra* text accompanying note 192.

203 The examples listed are not intended to be the sole means of showing an emergency medical condition as defined by § 1395dd(e)(1). Any evidence that would tend to show the requirements of § 1395dd(e) should be sufficient. This can only be determined on a case by case basis. For the elements of an emergency medical condition, see *supra* note 22 and accompanying text.

204 For the requirements to stabilize or properly transfer the patient, see *supra* notes 25-28 and accompanying text.

205 *See* MCCORMICK ON EVIDENCE, *supra* note 189, § 342, at 965.

lieved the plaintiff could pay for care.[206] Additionally, the defendant could come forward with evidence that no medical emergency existed or that the plaintiff was properly screened, transferred, or stabilized.[207] By destroying an element of the plaintiff's prima facie case, the defendant would prevail.

If the defendant could not destroy an element of the prima facie case, the defendant could seek to rebut the presumption of improper economic motive. To do so, the defendant would have to show a proper motive for its conduct. Such a motive may include showing that the conduct was medically reasonable and devoid of any economic motive. By coming forward with such evidence, the plaintiff would destroy the presumption, and it would drop from the case.[208] If the presumption drops from the case, the plaintiff would then be given the chance to show that the noneconomic motive alleged by the defendant was a mere pretext.[209] If successful in this showing, the plaintiff would overcome the defendant's rebuttal of the presumption and would prevail under EMTALA.

3. Policy for the presumption

Typically, several policy reasons underlie the creation of a presumption.[210] These considerations strengthen the argument for creating the presumption in the EMTALA context. One such consideration is the extent to which the parties have access to the evidence for proof of wrongful conduct. If one party has access to this information, fairness dictates that the party present such evidence.[211] In an EMTALA lawsuit, the physician and hospital have greater access to proof that conduct was medically, rather than

206 Such a showing would disprove the first element of the prima facie case, that the plaintiff was a member of the class to be protected. *See supra* note 191 and accompanying text.

207 This would destroy the last two elements of the prima facie case. *See supra* notes 193-94 and accompanying text.

208 *See supra* note 198.

209 *See supra* text accompanying notes 199-200.

210 *See* FED. R. EVID. 301 advisory committee's note ("The same considerations of fairness, policy, and probability which dictate the allocation of the burden of various elements of a case . . . also underlie the creation of the presumption."); *see also*, MCCORMICK ON EVIDENCE, *supra* note 189, § 345; 9 WIGMORE, EVIDENCE IN TRIALS AT COMMON LAW § 2486 (Chadbourn rev. 1981).

211 "[J]ust as the burdens of proof are sometimes allocated for reasons of fairness, some presumptions are created to correct an imbalance resulting from one party's superior access to proof." MCCORMICK ON EVIDENCE, *supra* note 189, § 343, at 968.

economically, motivated. Fairness then dictates that the defendant hospital or physician come forward with this evidence.[212]

A second policy consideration recognizes the difficulty a plaintiff may encounter in proving certain elements in a lawsuit.[213] Under the proposed amendment to EMTALA, for example, improper economic motive is a required element.[214] Yet, physicians and hospitals wary of the EMTALA penalties may seek to disguise their potential economic motive when transferring or refusing to treat a patient who cannot pay. The presumption would infer this improper motive as long as the plaintiff could show sufficient evidence to raise the presumption.[215] This would relieve the plaintiff of the difficult task of proving the defendant's state of mind. At the same time, the defendant would not be unduly prejudiced. If the defendant could disprove one of the elements of the prima facie case, the presumption of improper economic motive would be destroyed.[216]

A final policy consideration for the presumption lies in the strong social policy behind the statute.[217] Providing emergency care to those who cannot pay is an undertaking Congress has deemed important and just.[218] The presumption serves that just end. A plaintiff will be able to avoid a directed verdict by presenting sufficient evidence to raise the presumption.[219] This will force the defendant to show the court why the course of action taken was proper. If the defendant complied with the requirements of EMTALA, this will be readily provable. In this way, the

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212 *Id.* § 343, at 969.

213 *Id.* ("Usually, for example, a presumption is based not only upon the judicial estimate of the probabilities but also upon the difficulties inherent in proving that the more probable event in fact occurred.").

214 For a discussion of the proposed requirement of improper economic motive, see *supra* part V.A.

215 *See supra* note 189 and accompanying text.

216 *See* FED. R. EVID. 301; *see also* MCCORMICK ON EVIDENCE, *supra* note 189, § 344, at 974 ("[T]he only effect of a presumption is to shift the burden of producing evidence with regard to the presumed fact. If that evidence is produced by the adversary, the presumption is spent and disappears.").

217 "[A]s is the case with initial allocation of the burdens, the reason for the creation of presumptions are often tied closely to the pertinent substantive law. This is particularly true with regard to those presumptions which are created, at least in part, to further some social policy." MCCORMICK ON EVIDENCE *supra* note 189 § 343, at 969.

218 *See supra* note 3 and accompanying text.

219 *See* JAMES & HAZARD, *supra* note 189, at 256; MCCORMICK ON EVIDENCE, *supra* note 189 § 342, at 973.

plaintiff's case is enhanced without denying the defendant the fair opportunity to show appropriate conduct.

Enhancing the plaintiff's case will not only strengthen the plaintiff's position, but, in so doing, will also create a stronger disincentive for hospitals and doctors to deny emergency care because of economic factors. In the marginal case, where the factors concerning transfer, denial of care, or failure to stabilize are fairly balanced, this presumption may be enough to tip the scale in favor of rendering treatment. This result is neither morally reprehensible[220] nor inconsistent with EMTALA's intended goal.[221] In this way, EMTALA will become a more consistent statute, efficiently administered to eliminate refusal of care because of improper economic motive.

VI. AN UNDESIRABLE SIDE EFFECT TO AN AMENDED EMTALA: *BURDITT V. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES*[222]

A counterargument to these suggested amendments to EMTALA may be best illustrated by the most recent EMTALA case, *Burditt v. United States Department of Health and Human Services*.[223] The patient in *Burditt*, Mrs. Rivera, came to the hospital emergency room expecting to deliver her baby. According to the record, Mrs. Rivera had no means of paying for the medical care.[224] Upon examination, the hospital staff determined that Mrs. Rivera was in labor and suffering from extremely high blood pressure. When this information was relayed to Dr. Burditt, the defendant, he stated that he did not want to treat the patient. Nevertheless, Dr. Burditt examined Mrs. Rivera, confirming her high blood pressure and indicia of labor.[225] He ordered her transferred to another hospital and did not examine her again. When presented with a certificate of transfer, Dr. Burditt merely signed it, without reading its contents.[226] According to testimony, Dr. Burditt stated that Mrs. Rivera represented too much of a mal-

220 *See* RAFFELL & RAFFELL, *supra* note 11, at 148 (citing the sense of moral obligation to the poor and sick as the impetus for the early development of hospitals in western Europe and North America).

221 *See supra* note 3 and accompanying text.

222 934 F.2d 1362 (5th Cir. 1991).

223 *Id.*

224 *Id.* at 1366.

225 *Id.*

226 *Id.*

practice liability risk.[227] During transfer to the other hospital, Mrs. Rivera delivered her baby.[228]

In affirming that Dr. Burditt had violated EMTALA, the court focused primarily upon section 1395dd(c)(1)(A)(ii), which requires a physician, when transferring a patient, to sign a certification of transfer.[229] According to the court, Dr. Burditt had violated this provision because he had signed the certification without weighing the risks and benefits of such a transfer.[230] Although Mrs. Rivera had lacked a means to pay for the medical care, the allegations did not include an economic motive in Dr. Burditt's conduct. According to the record, potential malpractice liability appeared to be the driving force behind Dr. Burditt's action.[231] In holding Dr. Burditt liable, however, the court expressly rejected an improper motive requirement for an EMTALA violation.[232]

Under the proposed amendments to EMTALA, the courts approach to the case would have been different. The plaintiff would have first had to prove the four elements of the prima facie case.[233] This would not have been difficult for the plaintiff. First, Mrs. Rivera could not pay and therefore fell within the protected class.[234] Second, she went to the emergency room for treatment.[235] Third, her active labor evidenced an emergency medical condition.[236] Finally, delivering the baby in transit to another facility would have shown that she had not been properly

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227 *Id.*

228 *Id.*

229 The provision states:

> [A] physician . . . has signed a certification that, based upon reasonable risks and benefits to the individual, and 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 . . . .

42 U.S.C.A. § 1395dd(c)(1)(A)(ii) (1992).

230 *Burditt*, 934 F.2d at 1371.

231 *Id.* at 1366.

232 The court reasoned that no requirement of "an improper, or nonmedical, motive for transfer must be proved as an element of all EMTALA transfer violations." *Id.* at 1372.

233 *See supra* text accompanying notes 191-94.

234 Showing that Mrs. Rivera could not pay for emergency medical care would demonstrate that she could be a victim of denial of emergency care because of improper economic motive. *See supra* note 191 and accompanying text.

235 *See supra* note 192 and accompanying text.

236 *See supra* note 193 and accompanying text.

transferred.[237] These four factors would constitute the prima facie case and would create the presumption that Dr. Burditt improperly transferred Mrs. Rivera because of improper economic motive. The focus of the trial would then have shifted to Dr. Burditt to rebut the presumption.[238]

Dr. Burditt would then have had to show that he transferred Mrs. Rivera for fear of liability and not because he thought she could not pay for care. This would rebut the presumption of improper economic motive. The plaintiff would then have had to show that Dr. Burditt's fear of liability was merely pretextual.[239] If the court determined that Dr. Burditt's motive really had been fear of liability, the amended EMTALA would not punish him. Yet, Mrs. Rivera had clearly been denied appropriate medical care. In light of this, one may argue that EMTALA should not be amended.

Not amending EMTALA, however, only furthers the confusion and inconsistency among the courts. Likewise, potential parties will remain unsure of EMTALA's application to their activity. Additionally, malpractice claims will continue to be brought under EMTALA, needlessly consuming judicial resources.[240] Finally, courts will continue to use EMTALA for the unnecessary double regulation of activity already proscribed by other laws.[241]

Although an insured plaintiff in a position similar to that of Mrs. Rivera's would not have a cause of action under an amended EMTALA, she could still attempt to seek relief under state malpractice law. This would protect her without using EMTALA for activity the statute was not intended to regulate. The stated end of EMTALA is to assure that emergency medical care is not denied because of improper economic motive.[242] Failing to amend EMTALA because it may preclude relief to a plaintiff similar to Mrs. Rivera will only impede attempts to effectively utilize the statute to prohibit the denial of emergency care because of economic motive. Congress should, therefore, amend EMTALA so as to most directly and efficiently meet that end.

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237 *See supra* note 194 and accompanying text.
238 *See supra* text accompanying notes 189-90.
239 *See supra* text accompanying notes 199-200.
240 *See supra* note 153.
241 *See supra* note 179 and accompanying text.
242 *See supra* note 3.

VII. CONCLUSION

To date, EMTALA has not effectively curtailed patient dumping. In its present form, the statute fosters inconsistency of interpretation and controversy. Some courts, attempting to further the end expressed in the legislative history, have applied EMTALA only to denials of emergency treatment because of improper economic motive. They do so in spite of the statute's express language. Other courts, unwilling to contradict the statute's express provisions, maintain a cause of action under EMTALA for any person regardless of improper economic motive.

To the extent that these courts differ on EMTALA's application, the statute is weakened. Presently, a plaintiff's standing under the statute depends upon the jurisdiction in which the plaintiff sues. This engenders confusion among potential parties who are unsure of whether EMTALA regulates their situation. As such, plaintiffs attempt to bring claims that clearly lie beyond EMTALA's scope. Adjudication of these claims is a needless waste of judicial resources. An additional waste of resources results from those courts that apply EMTALA to activity already governed by other laws. Those cases that have attempted to apply EMTALA illustrate the needless difficulties and inconsistencies that the statute presently causes.

To eliminate these difficulties, Congress should amend EMTALA. These amendments should include an express narrowing of the statute's scope to insufficient emergency care because of economic motives. To support this narrowing, Congress should allow the plaintiff to build a prima facie case. Accordingly, the plaintiff could raise a rebuttable presumption of improper emergency care because of economic motive by showing that the plaintiff: (1) was a member of the protected class—indigent, uninsured, or believed to be unable to pay; (2) went to the emergency room for treatment; (3) had an emergency medical condition; and (4) was not screened, stabilized, or properly transferred. The defendant could then rebut this presumption of economic motive, giving the plaintiff the opportunity to show that the defendant's noneconomic motives were pretextual.

Such an amendment would strengthen the plaintiff's case without denying the defendant the opportunity to justify its action. Likewise, by enhancing the plaintiff's case, the standard would create a greater disincentive for hospitals to deny emergency care.

Finally, such an amendment would eliminate the confusion that presently exists about the proper application of EMTALA. By amending EMTALA, Congress would more effectively realize the statute's purported end—assuring that emergency medical care is not denied because of improper economic motive.

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