Saint Louis University Law Journal

Volume 46
Number 4 *(Fall 2002)*

Article 7

9-24-2002

Ambulances: Hospital Property or Not? Interpreting the Expanding Boundaries of EMTALA Through Arrington v. Wong

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AMBULANCES: HOSPITAL PROPERTY OR NOT? INTERPRETING THE EXPANDING BOUNDARIES OF EMTALA THROUGH *ARRINGTON v. WONG*

I. INTRODUCTION

Consider a hectic night at the emergency department of a very large inner-city hospital. Doctors, nurses and staff are rushing around to do their jobs quickly and efficiently. Patients and family members are beginning to greatly outnumber the staff. All are complaining about how long they have been waiting and what they need to be doing right now. New trauma patients are arriving every few minutes. Doctors are forced to think quickly about what the best measures would be to help or save a patient. There is little time to rest and think about one's next actions, much less whether there has been a violation of any law. A call comes in from one of the many independently owned ambulances in the city, and the only thing the staff member answering the call knows is that the emergency room has been busy all night. If she allows the ambulance to arrive, one of the many patients already at the hospital will be forced out into the hallway, possibly causing a delay in his or her treatment. She informs the nonhospital-owned ambulance that it should go to the neighboring hospital, even though it is a few blocks away. She concludes that the injured person can survive, without any adverse effects, for the few brief moments it will take to get to the next hospital. Anyway, it is not one of the hospital's ambulances, and they have three of their own ambulances coming in. Unfortunately, this hospital is not *too* busy to be on "diversionary status." Did this staff member do anything wrong by turning away this ambulance, or was it a typical decision made for the benefit of her many patients?

If this hospital was in any of the states in the Ninth Circuit, this woman and the hospital would most likely have been charged with a violation of the Emergency Medical Treatment and Active Labor Act[1] (hereinafter "EMTALA" or "the Act"). On January 22, 2001, the Ninth Circuit in *Arrington v. Wong* dealt with a very similar situation to the one described above—a nonhospital-owned ambulance was turned away from a Hawaiian hospital and told to go to a neighboring hospital.[2] In this case of first

1. 42 U.S.C. § 1395dd (1994 & Supp. 1999).
2. Arrington v. Wong, 237 F.3d 1066, 1069 (9th Cir. 2001).

impression, a divided Ninth Circuit held that a hospital cannot turn away a nonhospital-owned ambulance that calls a hospital (unless the hospital is on diversionary status) without violating the Act.[3] This decision dissolves the distinction between nonhospital-owned and hospital-owned ambulances—a distinction that the Centers for Medicare and Medicaid Services (hereinafter "CMS") specifically included within the regulation.

This Note analyzes the decision of the court in *Arrington v. Wong* and whether the decision extends the reach of EMTALA beyond the intent of Congress. Part II of this Note will give a brief background of EMTALA.[4] Part III will discuss one particular part of the statute—the language of "comes to"—and how past court decisions and regulations handled the language, later construed by the *Arrington* court, especially how the language has been treated in ambulance cases. Part IV will examine the Ninth Circuit decision and how both the majority and dissent reached their conclusions. Finally, Part V analyzes *Arrington's* holding and what the social implications may be of this ruling.

II. BRIEF BACKGROUND OF EMTALA

> [N]o person should be denied emergency health care or hospital admittance because of a lack of money or insurance. I firmly believe the American people should continue to expect that when they see an emergency sign on a hospital or free standing clinic they can expect access to emergency care.
>
> Representative Michael Bilirakis of Florida[5]

> "We cannot allow a health care system as advanced as ours to provide emergency care only to those who can pay. This amendment will ensure that hospitals live up to their fundamental responsibilities to the public."
>
> Senator Edward Kennedy of Massachusetts[6]

In the 1980s, Congress was concerned about the many horror stories being reported by the media regarding indigent patients being turned away because they could not pay for treatment.[7] One story, for example, was reported in the *Washington Post*, which stated that a man with third-degree grease burns was

3. *Id.* at 1074.

4. 42 U.S.C. § 1395dd.

5. MARK M. MOY, THE EMTALA ANSWER BOOK xix (2d ed. 2000) (quoting Representative Michael Bilirakis of Florida).

6. *Id.* at xv (quoting Senator Edward Kennedy of Massachusetts).

7. *See id.* at xvi; N. GENELL LEE, LEGAL CONCEPTS AND ISSUES IN EMERGENCY CARE 138 (2001); Kim C. Stanger, *Private Lawsuits under EMTALA*, 12 HEALTH LAW. 27 (2000).

turned away from three hospitals because he was unable to pay deposits.[8] He finally arrived at a public hospital seven hours later, carrying an IV bottle that had been given to him by one of the private hospitals as a precautionary measure.[9] These horrific stories played on the emotions of members of Congress. As a result, Congress quickly proposed and passed an act dealing with "patient-dumping" without even holding hearings or considering public input.[10] Therefore, on April 7, 1986, President Reagan signed a law entitled the Consolidated Omnibus Budget Reconciliation Act of 1985, which contained EMTALA, that addressed emergency medical care for the very poor.[11]

A. Purpose and Scope of EMTALA

Congress designed EMTALA to prevent "patient dumping"—a "hospital's transfer of an unstable patient or refusal to provide emergency services based on a patient's inability to pay or based on other grounds unrelated to the patient's need or the hospital's ability to provide the services."[12] Although originally passed to help the indigent and poor of the community, EMTALA protects all individuals and is not limited to just those who have no insurance or who lack money.[13] EMTALA applies only to those hospitals that participate in Medicare and have an emergency department.[14] However, since most hospitals rely heavily on Medicare reimbursement, the first requirement does very little to limit the reach of the Act.[15]

8. MOY, *supra* note 5, at xvii (citing Paul Taylor, *Ailing Uninsured and Turned Away; Americans Without Health Coverage Finding Hospitals Doors Closed*, WASH. POST, June 30, 1985, at A1).

9. *Id.*

10. *Id*. at xxi.

11. *Id*. at xv; LEE, *supra* note 7, at 138; Brian E. Kamoie, *EMTALA: Reaching Beyond the Emergency Room to Expand Hospital Liability*, 33 J. HEALTH L. 25, 26 (2000).

12. Kamoie, *supra* note 11, at 26.

13. Julia Ai, *Does EMTALA Apply to Inpatients Located Anywhere in a Hospital?*, 32 RUTGERS L.J. 549, 551 (2001).

14. *See* 42 U.S.C. § 1395dd(e)(2) (1994); Stanger, *supra* note 7, at 27; BARRY R. FURROW, ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 771 (4th ed. 2001); Michael J. Frank, *Tailoring EMTALA to Better Protect the Indigent: The Supreme Court Precludes One Method of Salvaging a Statute Gone Awry*, 3 DEPAUL J. HEALTH CARE L. 195, 198-99 (2000); Kamoie, *supra* note 11, at 26.

15. Frank, *supra* note 14, at 198 n.20 (citing Correa v. Hosp. S. F., 69 F.3d 1184, 1189 (1st Cir. 1995)).

B. Enforcement of EMTALA

Both governmental and private entities share the responsibility of enforcing EMTALA. First, CMS,[16] which runs the federal Medicare program, may terminate a hospital's Medicare provider agreement if it has been found to violate EMTALA.[17] Additionally, the Office of Inspector General (hereinafter "OIG"), which monitors programs of the Department of Health and Human Services (hereinafter "DHHS"), may impose monetary penalties on both the offending hospitals and the physicians.[18] Finally, "an individual who suffers personal harm as a direct result of a participating hospital's violation of [EMTALA]" has a private right of action under EMTALA against the hospital.[19] Similarly, another hospital, that has suffered a financial loss as a direct result of another hospital's violation of EMTALA, can maintain a civil cause of action.[20] Thus, if a hospital is found to have violated EMTALA, it can lead to very serious repercussions for that particular hospital, ranging from a fine of $50,000 to a revocation of a hospital's ability to participate in Medicare.[21]

C. The Elements of EMTALA

Generally, if an individual comes to a hospital and solicits emergency care, a hospital must provide a medical screening examination for that person, within the hospital's capabilities.[22] EMTALA has three basic requirements that must be followed by participating hospitals. First, hospitals must provide every individual seeking medical treatment at the hospital with an "appropriate

16. On June 14, 2001, the Health Care Financing Administration had its name formally changed to the Centers for Medicare and Medicaid Services. *See* UNITED STATES GENERAL ACCOUNTING OFFICE, REPORT TO CONGRESSIONAL COMMITTEES: EMERGENCY CARE—EMTALA IMPLEMENTATION AND ENFORCEMENT ISSUES 1 n.2 (June 2001), *available at* http://www.gao.gov/new.items/d01747.pdf (last visited Nov. 15, 2001) [hereinafter GAO Report]. Thus, in this Note, CMS will be used instead of HCFA.

17. 42 C.F.R. § 489.24(f) (2000); Ai, *supra* note 13, at 556. *See also* Frank, *supra* note 14, at 204.

18. 42 U.S.C. § 1395dd(d)(1) (1994); Ai, *supra* note 13, at 556. *See also* Kamoie, *supra* note 11, at 31; Frank, *supra* note 14, at 204.

19. 42 U.S.C. § 1395dd(d)(2)(A) (1994); Ai, *supra* note 13, at 558. *See also* Kamoie, *supra* note 11, at 32; Alicia K. Dowdy et al., *The Anatomy of EMTALA: A Litigator's Guide*, 27 ST. MARY'S L.J. 463, 466 (1996); Frank, *supra* note 14, at 204.

20. 42 U.S.C. § 1395dd(d)(2)(B) (1994); Ai, *supra* note 11, at 558. *See also* Kamoie, *supra* note 11, at 32-33. For example, a hospital may suffer a financial loss if it was the hospital that received a patient that was "dumped" by another hospital. *Id.* at 33. However, so far hospitals have been very reluctant in reporting EMTALA violations of other hospitals, even though CMS has stated that a failure to report may result in a termination of a hospital's provider agreement. *Id.*

21. Kamoie, *supra* note 11, at 31.

22. MOY, *supra* note 5, at 2.

medical screening examination" to determine whether the individual has an "emergency medical condition" or is in active labor.[23] Second, if the above mentioned medical screening examination reveals that an emergency medical condition or active labor does exist, then the hospital must provide the patient with any treatment necessary to stabilize him or her.[24] Third, and only then, may the hospital appropriately transfer the previously mentioned individual to another hospital or facility that can properly treat the condition.[25]

An EMTALA violation may take place in two ways. First, the violation can occur if the hospital's screening examination for the emergency medical condition was inappropriate.[26] Secondly, the violation can happen if it is shown that, even though the hospital found that an emergency medical condition existed, the hospital still failed to stabilize appropriately or

23. Section 1395dd(a) provides that "if any individual . . . comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department." 42 U.S.C. § 1395dd(a) (1994). *See also* MOY, *supra* note 5, at 1; Dowdy et al., *supra* note 19, at 470.

24. Section 1395dd(b) provides:

> If any individual . . . comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—
>
> (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
>
> (B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

42 U.S.C. § 1395dd(b) (1994). *See also* MOY, *supra* note 5, at 1.

25. Section 1395dd(c) provides:

> If an individual at a hospital has an emergency medical condition which has not been stabilized . . . the hospital may not transfer the individual unless—
>
> (A)(i) the individual . . . after being informed of the hospital's obligations . . . and of the risk of transfer, in writing requests transfer to another medical facility,
>
> (ii) a physician . . . has signed a certification that[,] based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or
>
> (iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person . . . has signed a certification described in clause (ii) after a physician . . . in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and
>
> (B) the transfer is an appropriate transfer . . . to that facility.
>
> A certification described in clause (ii) or (iii) . . . shall include a summary of the risks and benefits upon which the certification is based.

42 U.S.C. § 1395dd(c). *See also* MOY, *supra* note 5, at 1.

26. MOY, *supra* note 5, at 1.

proceeded to transfer the unstable individual without meeting the statutory safeguards.[27]

III. DEVELOPMENT OF "COMES TO" IN 42 U.S.C. § 1395DD(A)

> In the case of a hospital that has a hospital emergency department, if any individual . . . *comes to* the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department . . . .[28]

Like many of the words embedded within the complex statute, the phrase "comes to" has been subjected to many interpretations and caused much confusion. Unfortunately, Congress, while defining much of the language of the statute, failed to explain what it meant by "comes to."[29] Although this simple phrase does not seem to be a pivotal or controversial part of EMTALA, it can have serious implications for determining the situations in which EMTALA applies. Even though regulations and case law have tried to explain further what "comes to" should encompass, there still appears to be some confusion on the true meaning and extent of the phrase, especially when it involves emergency vehicles.

A. The Courts Try to Determine the Meaning of "Comes to"

Almost immediately after EMTALA was passed, courts began to hear cases that questioned the meaning of "comes to" in the statute. However, similar to the statute, the courts also left the term nearly as ambiguous due to the lack of uniformity among the decisions. From these decisions, the translation of "comes to" can be categorized into two types: (1) a literal interpretation that insists on strict physical presence *in the emergency room*; and (2) an interpretation that insists on merely physical presence *on hospital property generally*.

The first set of cases construed the statute very literally. These courts interpreted the statute very narrowly and stated that a person did not fall under EMTALA unless he or she *physically entered the emergency room* and thus *came to* the emergency facility.[30] One such case is *Miller v. Medical Center of*

27. *Id.* at 1-2.

28. 42 U.S.C § 1395dd(a) (1994) (emphasis added). *See supra* note 25 and accompanying text.

29. *See* 42 U.S.C. § 1395dd (1994) (defining other words such as "emergency medical condition," "participating hospital," "stabilize," and "transfer.").

30. Stanger, *supra* note 7, at 28 (citing Baber v. Hosp. Corp. of Am., 977 F.2d 872, 884 (4th Cir. 1992) (rejecting the plaintiff's argument that requested treatment anywhere in hospital should be protected by EMTALA, and holding, instead, that the person must actually present themselves at the emergency department)). For instance, in *McIntyre v. Schick*, 795 F. Supp. 777, 780 (E.D. Va. 1992), a case interpreting the language of the subsection (b) of the statute, the court stated in

Southwest Louisiana.[31] This case concerned a child who became injured in a car accident.[32] His doctor called a nearby hospital requesting that the boy be admitted to it.[33] The hospital stated, however, that since the boy did not have insurance, it would not accept him, and that his doctor should not send him.[34] The Fifth Circuit held that EMTALA did not apply because the boy never physically came to the hospital, and a mere request by telephone did not satisfy the "comes to" requirement.[35]

Additionally, courts have ruled that the statutory language of "comes to" does not always mean that walking into the emergency room automatically satisfies the language. In *Rios v. Baptist Memorial Hospital System*,[36] a primary care physician told his patient that he needed to obtain a second opinion regarding burns on his arms, and, therefore, sent him to a doctor who happened to work in the emergency room.[37] When entering the emergency room with his arm raised over his head, Rios stopped in the emergency room to ask directions to the admitting room.[38] When he was refused admittance due to insurance reasons, he claimed an EMTALA violation against the hospital.[39] The Texas court held that merely walking through the emergency department while en route to another area of the hospital was *not* the equivalent of presenting or coming to the emergency department.[40]

Courts have also viewed the statute more broadly and interpreted EMTALA as meaning that an individual has "come to" a hospital, even though not directly through the emergency room, if he or she enters hospital property.[41] However, even with these court opinions, each plaintiff physically

dicta that under 42 U.S.C. § 1395dd(a), a person has to present himself or herself to a hospital's emergency department in order to state a claim.

31. Miller v. Med. Ctr. of Southwest La., 22 F.3d 626 (5th Cir. 1994).

32. *Id.* at 627.

33. *Id*.

34. *Id.*

35. *Id.* at 628-29. The court stated, as follows:

> The Plaintiffs, however, would have us extend the hospital's duty to require it to accept for emergency treatment any individual who can communicate a request to the emergency department. We see nothing demonstrably at odds with the purpose of the drafters, though, in limiting that duty, in accordance with the unambiguous terms of the statute, to those individuals who come to the emergency department as opposed to any individual who can get to a telephone.

Id. at 629 n.6. *See also* Terry O. Tottenham, *What Constitutes "Dumping?,"* 1 HEALTH L. PRAC. GUIDE § 9:46 n.2 (2001); Stephen A. Frew, *Malpractice by Emergency Department Physician*, 47 AM. JUR. 2D *Proof of Facts* § 7.5 (2000).

36. Rios v. Baptist Mem'l Hosp. Sys., 935 S.W.2d 799 (Tex. App. 1996).

37. *Id.* at 801.

38. *Id.*

39. *Id.* at 800-01.

40. *Id.* at 803.

41. *See* Stanger, *supra* note 7, at 28.

entered hospital property *somewhere*, and therefore, they were not interpreting the statute all that broadly since the person still had to be on the premises of the hospital. In *Thornton v. Southwest Detroit Hospital*, the court ruled that EMTALA applied to an individual who was transferred from the emergency room to the intensive care unit.[42] Additionally the Sixth Circuit stated, "[h]ospitals may not circumvent the requirements of the Act merely by admitting an emergency room patient to the hospital then immediately discharging that patient."[43]

B. CMS's Attempt to Clarify "Comes to"

After becoming aware of the confusion left by the different courts' interpretations of the meaning of "comes to," CMS attempted, in 1994, to clarify what was meant by this language. According to 42 C.F.R. § 489.24, "comes to" has been construed to mean the following:

> [T]he individual is on the hospital property. [Hospital property includes ambulances owned and operated by the hospital, even if the ambulance is not on hospital grounds.] An individual in a nonhospital-owned ambulance on hospital property is considered to have come to the hospital's emergency department. An individual in a nonhospital-owned ambulance off hospital property is not considered to have come to the hospital's emergency department even if a member of the ambulance staff contacts the hospital by telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and treatment. In such situations, the hospital may deny access if it is in "diversionary status," that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregards the hospital's instructions and transports the individual on to hospital property, the individual is considered to have come to the emergency department.[44]

Thus, according to the regulations, an individual has come to the emergency department when the individual is: (1) on hospital property; (2) in any hospital department or facility that is located off the main hospital campus; (3) in an ambulance on hospital ground; or (4) in a hospital-owned ambulance or helicopter, regardless of whether it is on hospital property.[45] Therefore, in order to determine whether an individual has presented himself to the

42. Thornton v. Southwest Detroit Hosp., 895 F.2d 1131, 1135 (6th Cir. 1990). In *Thornton*, the plaintiff had suffered a stroke and was brought to the emergency room of Southwest Detroit Hospital. *Id.* at 1132. Immediately upon entry, she was taken to the Intensive Care Unit of the hospital. *Id.* After twenty-one days at Southwest Detroit Hospital, she was released due to the fact that a rehabilitation center would not accept her. *Id.* When her condition deteriorated upon release, she sued claiming an EMTALA violation. *Id.*

43. *Id.* *See also* Stanger, *supra* note 7, at 28.

44. 42 C.F.R. § 489.24(b) (2000).

45. Stanger, *supra* note 7, at 28. *See also* Dennis M. Barry, *Obligations of Provider-Based Sites*, 2 HEALTH L. PRAC. GUIDE § 15:107 (2001); MOY, *supra* note 5, at 13-14.

emergency department, it is essential to know the individual's physical location, as well as his mode of transportation.[46]

CMS imposed this broad interpretation of the language of EMTALA so that hospitals could not turn patients away simply because they entered through the wrong door or did not make it to the doors but rather stopped at the driveway.[47] Thus, CMS regulations continued to promote the true purpose of EMTALA—ensuring that all people who need emergency care will receive it, regardless of wealth—and making sure hospitals could not escape EMTALA on technicalities.[48]

C. Expansion of "Comes to" Through Use of Administrative Fines

Even when no official violation has been established nor a case brought forth, CMS has fined a hospital for what it determined to be improper actions. Such an instance occurred in Chicago in May 1998.[49] CMS fined a Chicago hospital, even though the injured person did not enter hospital property.[50]

In May 1998, Christopher Sercye, a teenager, was shot in an act of gang violence near Ravenswood Hospital, Chicago.[51] His friends brought him within one-half block of the hospital's emergency department.[52] However, they made it no further when Christopher collapsed.[53] His friends went to the emergency department and requested assistance for Christopher.[54] The medical staff refused to go the one-half block to aid the boy because of a hospital policy that required all staff to remain on hospital grounds.[55] The hospital staff did recommend that the friends call 911, and told the friends that when the boy arrived, they would help him.[56] However, by the time a police

46. Carel T. Hedlund & Patricia M. McGillan, *Noncompliance of Medicare Certified Hospitals with Responsibility to Provide Treatment in Emergency* Cases, 1 HEALTH L. PRAC. GUIDE § 2:35 (2001).

47. Ai, *supra* note 13, at 559 (citing 59 Fed. Reg. 32,086, 32,098 (June 22, 1994) (to be codified at 42 C.F.R. 489.24)). *See also* McIntyre v. Schick, 795 F. Supp. 777, 781 (E.D. Va. 1992) (EMTALA "is not based on the door of the hospital through which a patient enters"); Frew, *supra* note 35, at § 7.5.

48. *See* discussion *supra* Part II.A.

49. *See generally* MOY, *supra* note 5, at 22-24; Kristine Marie Meece, *The Future of Emergency Department Liability after the Ravenswood Hospital Incident: Redefining the Duty to Treat?*, 3 DEPAUL J. HEALTH CARE L. 101 (1999).

50. *See* sources cited *supra* note 49.

51. Jeremy Manier & William Recktenwald, *Boy's Death Forces Shift in ER Policy; Police Say Workers Ignored Dying Youth*, CHI. TRIB., May 19, 1998, at N1. For further discussion of the incident, see MOY, *supra* note 5, at 22-24. *See also* Meece, *supra* note 49, 101-03.

52. *See* sources cited *supra* note 51.

53. *Id.*

54. *Id.*

55. *Id.*

56. *Id.*

officer was able to bring the injured teenager into the emergency room, the condition of the boy was so severe that he died within minutes of arrival.[57]

The hospital policy was found legitimate for the protection of the hospital staff in a very unsafe neighborhood. Moreover, the hospital *technically* did not violate EMTALA since the boy never "came to" the emergency department or hospital grounds. Nevertheless, CMS still chose to take action against the hospital.[58] CMS threatened to revoke Ravenswood Hospital's Medicare participation unless it removed its hospital policy of not allowing employees to leave the premises.[59] Additionally, the hospital was fined $40,000.[60]

Regardless of whether the hospital actually was in violation of EMTALA, CMS chose to extend EMTALA in this circumstance.[61] Since CMS and OIG are the administrative agencies with the power to fine hospitals for EMTALA violations,[62] hospitals should take this example from Chicago very seriously. Hospitals must now assume that EMTALA's coverage also reaches to areas near the hospital property, and not just *on* hospital property.[63] In essence, due to CMS's extension of EMTALA, hospitals must now make the choice of which is more crucial—letting the staff leave the hospital to get *one* injured person or making the staff stay where needed to care for *many* patients and risk being fined by CMS.

D. Defining "Comes to" In Regards to Ambulances

The most troubling aspect of defining "comes to" involves the ambiguity of the statute and federal regulation when discussing hospital-owned ambulances versus independently owned ambulances. Even before the Ninth Circuit decided *Arrington v. Wong*,[64] other courts had discussed the meaning of the concept "comes to" in relation to emergency vehicles.

57. *See* sources cited *supra* note 51.

58. MOY, *supra* note 5, at 23. *See also* Meece, *supra* note 49, at 103.

59. *See* sources cited *supra* note 51.

60. MOY, *supra* note 5, at 23; Frank, *supra* note 14, at 201.

61. MOY, *supra* note 5, at 23.

62. *See infra* Part II.B.

63. MOY, *supra* note 5, at 23. For a further discussion of the implications of this CMS decision, see *id.* at 23-24; Meece, *supra* note 49, at 101. CMS appears to contradict itself by making this decision. When educating hospitals on EMTALA, CMS states that the hospital is responsible for patients coming within 250 yards around the main building. Health Care Financing Administration, *Medicare Learning Network* (Nov. 12, 2001), *at* http://www.hcfa.gov/medlearn/emqsas.htm (last modified July 11, 2001). However, if the facility is a separate entity from the hospital, even though located within the required yards, it is not considered part of the hospital for EMTALA purposes. *Id.* Thus, as stated by CMS, the sidewalk that Sercye collapsed on should not have been considered hospital property, even though within 250 yards, and the hospital should not have been fined.

64. Arrington v. Wong, 237 F.3d 1066 (9th Cir. 2001). For further discussion of this case, see *infra* Part IV.A-C.

1. Johnson v. University of Chicago Hospitals

In *Johnson v. University of Chicago Hospitals*, an infant was on his way to a hospital in an independently owned ambulance.[65] The ambulance called the hospital base station telemetry nurse who diverted the patient to another hospital further away.[66] The infant eventually died and the mother sued the base station hospital under EMTALA.[67]

The Seventh Circuit rejected the mother's claim that the hospital violated EMTALA and stated that the infant never "came to" the hospital or its emergency department.[68] *Johnson* continued by stating that a hospital-operated telemetry system was distinct from the hospital's emergency room. Thus, the infant never arrived on the hospital grounds.[69] The hospital was legally allowed to divert patients if they never reached the hospital property.[70]

2. McLaurin v. District of Columbia

In *McLaurin v. District of Columbia*, the patient, a gunshot victim, was transported by ambulance to the Emergency Care Center at D.C. General Hospital.[71] Before taking the patient out of the ambulance, the nurse directed the ambulance to another hospital.[72] The patient died while undergoing surgery at the second hospital.[73] The court held that the injured patient had "come to" the emergency department according to EMTALA once the ambulance arrived on the hospital property.[74] Additionally, the court concluded that the hospital failed to provide medical screening in response to the request to treat the patient once he arrived on the property.[75]

3. Madison v. Jefferson Parish Hospital Service Dist. No. 1

In *Madison v. Jefferson Parish Hospital Service Dist. No. 1*, the patient was severely burned and was transported by an ambulance owned and operated by West Jefferson Hospital.[76] Although West Jefferson Hospital was closest,

65. Johnson v. Univ. of Chicago Hosps., 982 F.2d 230, 231 (7th Cir. 1993). *See also* Dowdy et al., *supra* note 19, at 474 n.50.

66. *Johnson*, 982 F.2d at 231.

67. *Id.*

68. *Id.* at 233.

69. *Id. See also* Frank, *supra* note 14, at 202.

70. *See Johnson*, 982 F.2d at 231.

71. McLaurin v. District of Columbia, No. CIV.A. 92-2742-NHJ/DAR, 1993 WL 547193, at *1 (D.D.C. Oct. 21, 1993).

72. *Id.*

73. *Id.*

74. *Id.* at *3. *See also* Dowdy et al., *supra* note 19, at 473 n.44-45.

75. *McLaurin*, 1993 WL 547193, at *3.

76. Madison v. Jefferson Parish Hosp. Serv. Dist. No. 1, No. CIV.A. 93-2938, 1995 WL 396316, at *1 (E.D. La. June 30, 1995).

the ambulance brought him to Charity Hospital, which then transferred him to the burn unit at Baton Rouge General Hospital.[77] The court ruled that, since the ambulance was owned and operated by the hospital, West Jefferson Hospital was liable under EMTALA because the patient "came to" the emergency department, considering the ambulance hospital property.[78]

4. Hernandez v. Starr County Hospital District

In *Hernandez v. Starr County Hospital District*, Hernandez was injured in a work-related accident and rendered unconscious.[79] A Starr County Memorial Hospital ambulance arrived at the accident scene, and the Starr County Memorial paramedic was told by the employer to take him to a different hospital.[80] In response to this request, the ambulance took him to a more distant hospital.[81] Hernandez sued Starr County Memorial Hospital under EMTALA.[82] The district court, following the holding in *Madison*, held that the patient "came to" the emergency department, because Starr owned the ambulance.[83]

All of these cases seemed to follow a simple pattern determined by the ownership of the ambulance. The courts concluded that if a patient is transported by a hospital-owned vehicle, then the patient has "come to" the emergency room. However, if the patient is in an independently owned ambulance, the hospital is under no obligation of EMTALA until the ambulance enters the hospital's property. While it appeared that the courts clarified the confusion regarding ambulances by following these two holdings, the Ninth Circuit's decision in the case below disregarded previous distinctions.

IV. *ARRINGTON V. WONG*—FOLLOWING A DIFFERENT PATH

A. Background Facts of the Case

On May 5, 1996, Harold Arrington, a Hawaiian security guard, had trouble breathing during his morning commute to work.[84] When he arrived at work,

77. *Id.*

78. *Id.* at *2. *See also* Dowdy et al., *supra* note 19, at 473 n.44-45.

79. Hernandez v. Starr County Hosp. Dist., 30 F. Supp. 2d 970, 971-72 (S.D. Tex. 1999). *See also* MOY, *supra* note 5, at 29-30; *EMTALA: Patient 'Came to' Emergency Room by Entering Hospital Ambulance, Court Rules*, 8 BNA'S HEALTH L. REP. 663 (Apr. 22, 1999).

80. *Hernandez*, 30 F. Supp. 2d at 972.

81. *See* sources cited *supra* note 79.

82. *Hernandez*, 30 F. Supp. 2d at 972.

83. *Id.* at 972-73. *See also* MOY, *supra* note 5, at 29-30; *EMTALA: Patient 'Came to' Emergency Room by Entering Hospital Ambulance, Court Rules*, 8 BNA'S HEALTH L. REP. 663 (Apr. 22, 1999).

84. Arrington v. Wong, 237 F.3d 1066, 1068-69 (9th Cir. 2001).

his co-workers called an independently owned ambulance to take Arrington to the nearest hospital for emergency care.[85] The ambulance crew contacted the closest hospital by radio, the Queen's Medical Center, to alert the staff that the patient they were bringing in was "in severe respiratory distress speaking 1-2 words at a time and . . . breathing about 50 times a minute."[86] The on-call physician, Dr. Wong, inquired about the patient's primary care physician and informed the paramedics that they should instead take him to Tripler Army Medical Center, his primary hospital, and not to Queen's.[87] The ambulance was then forced to alter its route and go to the more distant hospital.[88] At this point, Arrington's condition became so severe that shortly after arriving at Tripler, Arrington died.[89]

Arrington's family filed a complaint in federal district court claiming, among other things, that the hospital violated EMTALA.[90] On September 23, 1998, the district court dismissed the family's complaint stating that under EMTALA the deceased cannot bring such a claim if he had never "come to" the emergency room.[91] Here, Arrington had never "come to" Queen's emergency department and, thus, could not bring an EMTALA claim.[92] The court also concluded that EMTALA only takes effect in cases where the patient has a "physical presence" in the emergency room.[93]

B. The Ninth Circuit Majority Opinion

The Ninth Circuit Court of Appeals considered whether Arrington's attempt to arrive at the hospital fell within the scope of EMTALA's "comes to" language.[94] In other words, the court phrased the issue, as to whether a hospital must admit patients being transported to the hospital in nonhospital-owned ambulances to meet the EMTALA standard.[95] In order to answer this issue, the court had to determine whether the two asserted meanings of "comes to" used by the two parties[96] could be reconciled by reading the statute, or

85. *Id.* at 1069.
86. *Id.*
87. *Id.*
88. *Id.*.
89. *Arrington*, 237 F.3d at 1069.
90. Arrington v. Wong, 19 F. Supp. 2d 1151, 1153 (D. Haw. 1998).
91. *Id.* at 1156.
92. *Id.*
93. *Id.*
94. *Arrington*, 237 F.3d at 1070.
95. *Id.* at 1072.
96. The appellees argued that the language "comes to the emergency department" in 42 U.S.C. § 1395dd(a) plainly means "arrives at a hospital," which included the entire hospital and its grounds, while the appellants claimed that the phrase means also "the act of traveling to the hospital." *Id.* at 1070.

whether the language in fact was so ambiguous that an alternate source should be consulted for the answer.[97]

After unsuccessfully consulting several dictionaries' definitions of "comes to",[98] the court examined the DHHS's regulation[99] regarding the definition of "comes to," especially the provision dealing with independently owned ambulances.[100] The majority claimed that DHHS gave an "expansive approach" to the meaning of "comes to."[101] It stated that not only does section 489.24 provide that a nonhospital-owned ambulance has "unquestionably" arrived at the hospital when it is on the hospital's premises. Additionally, a hospital must accept a patient being transported towards the hospital in a nonhospital-owned ambulance, unless there is a "valid treatment-related reason" why it should not, for example a diversionary status.[102]

The majority believed that this "plain language" of the regulation demonstrated that upon receiving the radio call from the paramedics, Queen's hospital was obligated to accept Arrington unless it was under "diversionary status."[103] Thus, in order for Queen's hospital to have met the regulations of EMTALA, the hospital would have had to prove that: (1) there was not enough emergency staff at the time of the radio contact; (2) by the time the ambulance would have arrived, there still would not have been adequate staffing; (3) there

97. The court stated:

> When a "statute is silent or ambiguous with respect to the specific issue," courts will generally interpret the statute, unless an agency with the power to construe the statute has already provided a construction . . . . In that circumstance, the court must determine whether the agency's interpretation is "permissible:" if so, that interpretation applies . . . . Where Congress expressly delegates to an agency the power to construe a statute, we review the agency's interpretation under the "arbitrary and capricious" standard; where delegation is implicit, the agency's interpretation must be "reasonable."

Id. at 1070 (citing Chevron v. Natural Res. Def. Council, Inc., 467 U.S. 837, 843-844 (1984)).

98. The court found that Webster's Third New Definition Dictionary's definition was, as follows: "to 'move toward or away from something . . . APPROACH,' or 'to arrive at a particular place.'" *Id.* at 1070-71. Another dictionary definition was

> to move from a place thought of as 'there' to a place thought of as 'here': a) in the second person, with regard to the speaker [*come* to me, will you *come* to the dance *tonight?*] . . . c) in the third person, with regard to the person or thing approached, [he came into the *room*] [;] to approach or reach by or as by moving toward[;] to arrive or appear.

Id. at 1071 n.3. The third dictionary the court reviewed defined the language as "to 'move, be brought towards, or reach a place thought or as near or familiar to the speaker or hearer. *Id*. Therefore, all of the dictionaries' multiple definitions included the different meanings argued by both parties. *Id.*

99. *See supra* Part III.B.

100. *See Arrington*, 237 F.3d at 1071-72.

101. *Id.* at 1072. The court claimed that DHHS made the regulation so expansive so that hospitals could not circumvent the requirements and, thus, prevent patients from gaining access, which would defeat the true intent of EMTALA. *Id.*

102. *Id.*

103. *Id.* at 1072-73.

was improper equipment at the hospital to treat Arrington's condition; or (4) that the necessary equipment was unavailable due to circumstances, such as being in use already.[104] Finally, the hospital would have to prove that Dr. Wong knew about the above criteria and based his decision to send Arrington to another hospital on a treatment-related reason.[105]

The majority concluded that its decision was not contradictory to the two cases cited to in the lower court opinion—*Johnson v. University of Chicago Hospitals* and *Miller v. Medical Center*.[106] The court claimed that *Johnson* was distinct since it was a telemetry unit under "partial bypass." *Arrington*, however, involved an emergency room, which was not under "diversionary status."[107] Therefore, it was proper when the paramedics were turned away from the *Johnson* telemetry unit.[108] It also claimed that *Miller* was distinct since the patient needing admission was already in another hospital's bed. Arrington, rather, was in transit to Queen's.[109] Therefore, the court claimed it did not stray from the meaning and intent of EMTALA.[110]

C. The Dissenting Opinion

1. Statutory Interpretation

The dissent in *Arrington*, unlike the majority, took a rational approach of interpreting the statutory language that was more consistent with the legislative intent. Judge Fernandez declared in his dissenting opinion that the majority interpreted a statute that in fact did not need to be interpreted at all due to its plain, unambiguous language.[111] He stated that the wording of the statute clearly indicated Congress' intent for the person to be physically at the emergency department in order to request services.[112] He claimed that it did not make sense to believe, as the majority did, that "comes to" would mean "move toward" in the context of the sentence.[113] Therefore, since the language was unambiguous and gave a clear answer, the court should not have

104. *Id.* at 1073.

105. *Arrington*, 237 F.3d at 1073.

106. *Id*. *See generally*, *Johnson*, 982 F.2d at 230; *Miller*, 22 F.3d at 626. *See also supra* Parts III.A. & D.1.

107. *Arrington*, 237 F.3d at 1073. *See also Johnson*, 982 F.2d at 231. For further discussion of *Johnson*, see *supra* Part III.D.1.

108. *Arrington*, 237 F.3d at 1073.

109. *Id*. *See also Miller*, 22 F.3d at 628-29. For further discussion of *Miller*, see *supra* Part III.A.

110. *Arrington*, 237 F.3d at 1074.

111. *Id.* at 1075 (Fernandez, J., dissenting).

112. *Id.*

113. *Id.* at 1075 n.2 ("For example, if we say that someone has 'come home,' we mean that he has arrived. We do not mean that he is on the way; to express that, we would say that he is 'coming home.'").

interpreted it any further.[114] Fernandez argued that the cases mentioned above by the majority did actually address the issue at hand and said that the patient did not arrive at the hospital.[115] Additionally, other courts, though not specifically addressing the issue of "comes to," have read the language to mean that the patient must enter or arrive at the hospital itself in order for the hospital to be held liable under EMTALA.[116]

2. Regulatory Interpretation

The majority in *Arrington* read the regulation[117] as stating that the hospital could only turn away an independently-owned ambulance if it was on "diversionary status." Judge Fernandez, however, read the regulation as providing one instance of when a hospital can deny access, and not the *only* time it could deny it.[118] Additionally, he stated that even if the majority was correct about the regulation, then the regulation would be considered invalid due to the fact that it extends the statute beyond the limits of its unambiguous language.[119] He claimed, "[t]he agency simply does not have the authority to extend the statute beyond the plain limits set by Congress. Nor does this court, by the way."[120] In conclusion, the dissent claimed that the decedent's family had no cause of action under EMTALA.[121] In other words, the dissent would only allow an EMTALA claim to be brought if the independently-owned ambulance arrived on hospital property. Otherwise, the hospital has the right to send it elsewhere, regardless of the hospital's status. The dissent's analysis provides the most rational interpretation of EMTALA regarding independently-owned ambulances.

V. ANALYSIS OF THE NINTH CIRCUIT OPINION

In this two to one decision, the often-controversial[122] Ninth Circuit Court of Appeals has again changed the meaning, intent and extent of a law. The court expanded the role of EMTALA to include not only hospital-owned

114. *Id.* at 1075.

115. *Arrington*, 237 F.3d at 1075-76 (citing *Miller*, 22 F.3d at 627-30; *Johnson*, 982 F.2d at 233 n.7).

116. *Id.* at 1076 (citing Bryan v. Rectors & Visitors of Univ. of Va., 95 F.3d 349, 351 (4th Cir. 1996); Correa v. Hosp. San Francisco, 69 F.3d 1184, 1192 (1st Cir. 1995); Green v. Touro Infirmary, 992 F.2d 537, 539 (5th Cir. 1993); Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 269 (6th Cir. 1990)).

117. 42 C.F.R. § 489.24.

118. *Arrington*, 237 F.3d at 1076.

119. *Id.*

120. *Id.* at 1076-77.

121. *Id.* at 1077.

122. For an example of one of its most recent and controversial cases, see Newdow v. U.S. Congress, 2002 WL 1370796 (9th Cir. June 26, 2002) (holding that a teacher who led the Pledge of Allegiance violated the Establishment Clause).

ambulances, but also independently-owned ambulances. With *Arrington*, the Ninth Circuit only added more animosity towards the ever-expanding doctrine of EMTALA. As one critic states, "[a]s in the old sci-fi thriller The Blob, where ultimately everyone within close proximity of the oozing pink goo from outer space is drawn into the expanding morass, EMTALA can reach out and ensnare the unwary and uninitiated medical facility and its emergency department staff."[123] Unfortunately, that critic will be correct if the Legislature or Supreme Court does not restrain the boundaries of EMTALA.

Although the majority properly concluded that "comes to" is an ambiguous term, and, therefore, that it must look to other sources to define the statutory language,[124] the majority opinion, however, analyzed the case incorrectly in a number of ways. The majority has improperly interpreted not only the regulation that governs the statute, but also the case law cited by the lower court. In addition, the court chose to actively exclude other relevant cases and sources that gave important insight on how far this act should be interpreted. Due to the Ninth Circuit's radical opinion, many social ramifications are foreseeable.

A. The Court Incorrectly Read the Language of the Regulations

The majority stated that the regulations "unquestionably state" that a hospital must accept a patient being transported towards the hospital in a nonhospital-owned ambulance, unless there is a "valid treatment-related reason" why they should not, for example a diversionary status.[125] However, a closer look at the intent of the regulatory agency, DHHS, reveals that the court's analysis actually runs contrary to what the agency wanted.

The text accompanying the federal regulation specifically states the following:

> An individual in a nonhospital-owned ambulance on hospital property is considered to have come to the hospital's emergency department. However, an individual in a nonhospital-owned ambulance located off hospital property is not considered to have come to the hospital's emergency department if someone staffing the ambulance contacts the hospital by telephone or

123. James T. Biggs, *Drama in the ER Spills into the Streets—Literally: Federal Law Gives Hospitals an Expanded Scope of Duty to Treat Emergency Patients*, NAT'L L.J., June 18, 2001, at B12.

124. Although, as the dissent stated, it would appear to be odd for Congress to have meant that "comes to" means on his or her way, the author believes the majority correctly concluded that it was an ambiguous term since the statute does not specifically state the definition and the referring dictionaries' meanings only continued the ambiguity. Thus, it was relevant for the majority to look to the regulatory language for clarification. *See supra* Parts IV.B & C.1.

125. *See supra* text accompanying note 102.

> telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and treatment.[126]

The text then discusses the importance of such cases as *Johnson v. University of Chicago Hospital*[127] on the language of the statute. Therefore, it separated these sentences from the following sentence that discusses "diversionary status," implying that these criteria should be considered separately. They should not be read together, which is what the majority attempted to do. As the dissent discussed, it appears that in regard to "diversionary status" the regulation was merely giving one example of when a hospital can turn away an ambulance.[128] Thus, even though the text of the regulation may be confusing as to the nonhospital ambulance issue, the text accompanying the regulation makes it particularly clear: the only time a nonhospital-owned ambulance is covered under EMTALA is when it is *specifically* located on hospital grounds.[129] Therefore, because the independently owned ambulance with *Arrington* was *not* on hospital grounds, the majority should have determined that the "plain language" of the regulatory text did not hold Queen's Hospital liable under EMTALA for directing the ambulance to another hospital.

Additionally, if the court truly examined the "plain language" of the regulation it would have noticed that the regulation specifically distinguishes "nonhospital-owned ambulances" from "hospital-owned ambulances."[130] Thus, common sense shows that a regulatory agency would not discuss nonhospital-owned and hospital-owned separately if it intended to treat them the same. It would not make sense to mention them individually if the agency only meant to provide that "all ambulances are considered to have 'come to' an emergency department."

B. The Ninth Circuit Interpreted Key Case Law Incorrectly

Even though the issue before the court in *Arrington* was never directly addressed by any other court, the cases that the lower court examined could have provided aid to the Ninth Circuit if the court had properly interpreted them. However, the court chose to ignore the similarities of *Johnson v. University of Chicago Hospitals* and *Miller v. Medical Center of Southwest Louisiana* to this particular case.

Although the majority disregarded *Johnson v. University of Chicago Hospitals*,[131] closer scrutiny of the case by the court would have drawn attention to the similarities between the two cases that should not have been

126. 59 Fed. Reg. 32,086, 32,098 (June 22, 1994) (to be codified at 42 C.F.R. 489.24).
127. 59 Fed. Reg. at 32,098.
128. *See supra* Part IV.C.2.
129. 59 Fed. Reg. at 32,098.
130. 42 C.F.R. § 489.24. *See also supra* Part III.B.
131. Arrington v. Wong, 237 F.3d 1066, 1073 (9th Cir. 2001). *See also supra* Part IV.B.

ignored. Although one case discussed a hospital-operated telemetry system and the other discussed an emergency room situation, both deal specifically with a nonhospital-owned ambulance that was turned away after contacting the hospitals.[132] The court in *Johnson* addressed this issue squarely: a hospital is legally allowed to divert patients if they never reach the hospital property even if the nonhospital-owned ambulance has previously contacted the place.[133] Therefore, applying that general rule to *Arrington*, the Ninth Circuit should have seen that the nonhospital-owned ambulance carrying Arrington was not on hospital property, and, therefore, Queen's Hospital should not be liable under EMTALA.

Also, the *Arrington* court read *Miller v. Medical Center of Southwest Louisiana*[134] too literally. Instead, the majority should have focused on the major similarities between the two cases. In *Miller*, the Fifth Circuit explicitly stated that a mere request by a telephone from a doctor did not satisfy the "comes to" requirement.[135] In *Arrington*, the only difference was that the hospital was contacted by radio.[136] A person was not on hospital grounds or property contacted the hospital in both cases. Additionally, the *Arrington* majority argued that in *Miller* the child was already in a hospital bed when his doctor called the other hospital, and, thus, it was a different situation. However, this was not even an issue looked at or considered by the *Miller* court.[137] The only thing that seemed to be important to the *Miller* court was that the "call" was made off of hospital property. In fact, the court stated that it would not:

> [E]xtend the hospital's duty to require it to accept . . . any individual who can communicate a request . . . . We see nothing demonstrably at odds . . . in limiting that duty, in accordance with the unambiguous terms of the statute, to . . . individuals who come to the emergency department as opposed to any individual who can get to a telephone.[138]

Thus, the *Arrington* court should have respected the *Miller* court in determining that it also would not extend EMTALA to any individual who can communicate a request no matter the location of the individual.

132. *Id.* at 1069; Johnson v. Univ. of Chicago Hosps., 982 F.2d 230, 231 (7th Cir. 1993).

133. *Johnson*, 982 F.2d at 233.

134. Miller v. Med. Ctr. of Southwest La., 22 F.3d 626 (5th Cir. 1994). *See also supra* Part IV.B.

135. *Miller*, 22 F.3d at 628-29.

136. *Arrington*, 237 F.3d at 1073.

137. *Id. See also Miller*, 22 F.3d at 628-29.

138. *Miller*, 22 F.3d at 629 n.6.

C. The Court Chose to Disregard Other Crucial Cases

If the majority had looked beyond the two cases discussed above, it would have recognized a common theme in most EMTALA cases throughout the years. In all the cases, regardless of how broadly or strictly the courts interpreted the language, in order to establish an EMTALA violation, the person must have been physically on the hospital's property somewhere.[139] The property could have been at the emergency room,[140] at another door at the hospital,[141] at another department located within the hospital[142] or within hospital-owned vehicles, such as hospital-owned ambulances.[143] In all these circumstances, the courts never ruled that a patient located elsewhere, including in a independently owned ambulance, constituted coming to the hospital.[144]

Additionally, if the majority had examined *McLaurin v. District of Columbia*, the court would have seen that it specifically ruled that the patient had come to the hospital because the nonhospital-owned ambulance had *entered hospital property* and not because the patient had merely entered the ambulance.[145] Because the court ruled this way, it is obvious that nonhospital-owned ambulances are not considered hospital property until having entered on to the premises. Therefore, the *Arrington* majority should have recognized that the independently owned ambulance in the case had never arrived at the hospital, and thus EMTALA was not triggered.

D. The Ninth Circuit Failed to Look at Other Relevant Sources

The Ninth Circuit appears to be the only authority, at this point, which concludes that the DHHS had intended the same treatment of ambulances regardless of the ownership or control of the ambulances. Most other authorities hold the position that nonhospital-owned ambulances are not subject to EMTALA's statutory requirements unless they enter hospital properties.[146] One source, intended to explain EMTALA to medical personnel, states the following:

139. *See supra* Parts III.A & III.D.

140. *See* Baber v. Hosp. Corp. of Am., 977 F.2d 872, 884 (4th Cir. 1992) (patient did not present herself at emergency department); Deberry v. Sherman Hosp. Assn., 741 F. Supp. 1302, 1305 (N.D. Ill. 1990) (patient entered emergency room).

141. *See supra* text accompanying note 47 (discussing *McIntyre v. Schick*, citation omitted).

142. See discussion of *Thorton v. Southwest Detroit Hospital supra* Part III.B.

143. *See supra* Part III.D.3.

144. *See supra* Parts III.-A & III.-D.

145. *See supra* Part III.D.2. *Compare supra* Part III.D.2 *with* Madison v. Jefferson Parish Hosp. Serv. Dist. No. 1, 1995 WL 396316 at *2 (holding that patient is considered to have come to the hospital when entering hospital-owned ambulance).

146. *See* MOY, *supra* note 5, at 29; LEE, *supra* note 7, at 139; Frank, *supra* note 14, at 201.

> [T]he regulation does not extend to leased ambulances or contract ambulance services; therefore, a leased (not owned) ambulance may be diverted elsewhere, even for economic reasons, prior to arrival onto hospital property. On the other hand, ambulances (or helicopters) owned by a hospital could risk violating EMTALA if they transport a patient to another hospital rather than their own hospital before fulfilling EMTALA transfer criteria.[147]

The Ninth Circuit, instead of breaking new ground and risking being overruled by the Supreme Court of the United States, should have looked at the other sources of interpretation to realize the obvious—the regulations do not apply to nonhospital-owned ambulances which are not on hospital property.

E. Social Implications of Arrington v. Wong

The social implications of the Ninth Circuit's expansive interpretation of EMTALA, that hospitals are obligated to accept all ambulances, regardless of ownership, unless under diversionary status, may be substantial and affect everyone within the nexus of emergency health care. Although *Arrington v. Wong* would only effect Ninth Circuit states, many of the district courts and other circuits will look at this case persuasively since it was a case of first impression and possibly opt to rule in accordance.[148] Thus, the ramifications of this decision could affect the whole country—at least until the Supreme Court decides to stop the oozing of EMTALA that the Ninth Circuit has only encouraged.

The people who will be most affected by this new decision will be those working in the emergency departments at hospitals, and the hospitals themselves. Many doctors have already complained that the emergency departments are understaffed.[149] Additionally, many doctors are fearful of the liability risk of being an ER doctor, especially the EMTALA risk, now that risk has increased dramatically.[150] One doctor stated, "We are in a crisis in this country because of this law . . . Doctors have learned that if their name is up on the board in the emergency room and they can't respond in time, they are responsible . . . A lot say, 'Why take on the responsibility?'"[151] Thus, fewer physicians are joining hospital staffs and participating in emergency department on-call panels because "EMTALA leads to on-call physicians

147. MOY, *supra* note 5, at 29. *See also* Hedlund & McGillen, *supra* note 46, § 2:35 ("The patient is not considered to have come to the emergency department if in a nonhospital owned ambulance which is not on the hospital grounds, *even if the ambulance has contacted the hospital by telephone or telemetry communications.*") (emphasis added).

148. *See* Biggs, *supra* note 123, at B12.

149. *See generally* Tanya Albert, *Ruling Extends EMTALA's Reach to Ambulance Contact*, AMERICAN MEDICAL NEWS, Mar. 5, 2001, *available at* http://www.ama-assn.org/sci-pubs/amnews/pick_01/gvsb0305.htm (last visited Oct. 14, 2001).

150. *Id.*

151. *Id.*

providing uncompensated care" and other liability risks.[152] With this expansive court ruling, many more physicians may hesitate before working in the emergency room.

Doctors are also very nervous about this ruling because it will affect the level of patient care in this country in two ways. First, some physicians are worried that the quality of care will actually decrease in this country due to the Ninth Circuit opinion, rather than increase it.[153] They fear that the ruling has taken the decision-making capability away in emergency situations from the people who know best—the doctors—and this will only hurt the quality of patient care.[154] For example, a doctor may be afraid to tell an ambulance to go to another hospital, even though the other hospital may be more suitable for handling the emergency, because he or she is afraid that he will commit an EMTALA violation.[155] In addition, some specialists are limiting the number of procedures for which they have credentials and are not seeking hospital privileges in an effort to avoid being on call.[156] This has resulted in a decrease of services provided at certain hospitals.[157] As one doctor succinctly explains, "If a doctor [does not] accept the patient, even if the judgment was right, it puts him or her under federal scrutiny . . . Why take on the liability if you don't have to?"[158]

Doctors are also fearful that the *Arrington* decision will greatly affect the hospitals that need the most relief—the inner-city hospitals. Inner-city hospitals tend to rely on private or governmental, nonhospital-owned, ambulances instead of owning their own. Smaller, more rural hospitals, however, have their own ambulances.[159] These inner-city hospitals are the hospitals that require the most staff, doctors and financial assistance. However, if the doctors already do not want the extra headache of being an emergency room doctor, then this expansion to EMTALA will most likely

152. GAO Report, *supra* note 16, at 2. The source states that this reduction could also be due to other factors, such as an increase in procedures being done in nonhospital settings; however the source also did not deny that part of the reduction may be due to EMTALA. *Id.* Hospital and physician representatives have stated that physicians already try to limit their time on call or completely avoid being on the on-call panel. *Id.* at 13.

153. *See* Albert, *supra* note 149.

154. *Id*.

155. *Id*. *See also Emergency Care: Estate of Patient Who Didn't Enter Hospital Can Bring EMTALA Claim, Ninth Circuit Rules*, BNA'S HEALTH CARE DAILY REP., Jan. 24, 2001. Doctors have stated that they are frustrated due to the confusing regulations and when they are to be applied. GAO Report, *supra* note 16, at 25. This confusion most likely has increased due to the Christopher Sercye incident and this Ninth Circuit decision. *See supra* Parts III.C & IV.B.

156. GAO Report, *supra* note 16, at 13-14.

157. *Id*.

158. *See* Albert, *supra* note 149.

159. *Emergency Care: Estate of Patient Who Didn't Enter Hospital Can Bring EMTALA Claim, Ninth Circuit Rules*, BNA'S HEALTH CARE DAILY REP., Jan. 24, 2001.

drive them away, leaving the inner-city emergency rooms understaffed.[160] Additionally, if inner-city hospitals are constantly fined for turning down patients due to a of lack of doctors, then the hospitals may not be able to afford to keep their emergency room doors open and have to close down a much needed hospital emergency room in the area. For these reasons, the American Medical Association in December of 2000 voted to develop an action plan to determine how to prevent EMTALA from expanding beyond its original scope intended by Congress.[161] Additionally, the Office of Inspector General has agreed to study the effects of EMTALA due to these recent changes.[162]

This decision will also hurt hospitals in another way. Hospitals have control over their own ambulances, and thus, have the right to hire competent people to work in the ambulances and fire those who appear to put the hospital at risk. However, hospitals do not have this same control over the independently owned ambulances. Therefore, with this decision, hospitals may now be liable for conduct of the paramedics over which they have no control. This appears to put an undue burden on hospitals throughout the country that use independently owned ambulances. This burden may cause many hospitals to stop using contracted ambulatory services or lose enough money so that they are forced to close their emergency room doors.

The Ninth Circuit incorrectly stated in *Arrington* that if it did not rule in such a way, a hospital could easily circumvent EMTALA. The court feared defeating the purpose of EMTALA, including providing indigent care and stopping patient dumping.[163] However, this statement is incorrect. If the court would have ruled opposite, there are other ways in which the Act's purpose would be fulfilled. First of all, the regulations specifically state that if an ambulance, turned away from a hospital, still enters hospital property, the hospital is liable under EMTALA.[164] Therefore, if an ambulance disagrees with the medical personnel at the hospital and thinks that it is detrimental to the patient if it goes to another hospital farther away, the ambulance can *still come to the hospital*, regardless of the advice. Therefore, the patient will still be receiving the proper care under the purpose of EMTALA.

Secondly, if a hospital chooses to send the ambulance to a more distant hospital, there are still many regulations that will hold the hospital accountable for a bad judgment. The refusal to accept the radio request may represent a violation of other federal or state requirements, such as the Hill-Burton Act or

160. *See generally* Albert, *supra* note 149.

161. *Id.*

162. *Id.*

163. *Arrington*, 237 F.3d at 1072.

164. 42 C.F.R. 489.24. *See* discussion *supra* Part III.B.

medical malpractice.[165] In addition, some states have statutes that require hospitals to accept patients in transport by any ambulance, regardless of ownership.[166] Therefore, the hospital will still be wary of making decisions to send away patients, thus promoting the intention of EMTALA without stretching EMTALA.

VI. CONCLUSION

The Ninth Circuit's ruling in *Arrington v. Wong* has only left the already confusing world of EMTALA more inconclusive and ambiguous—the one thing it was trying to prevent. As the lower court stated in its decision, to rule for the plaintiffs that Arrington came to the emergency room would lead down "a slippery slope for which there is no logical end."[167] That is exactly what will happen with this rule. Where is EMTALA's reach to stop? With this decision and the Christopher Sercye incident,[168] EMTALA has already encroached on places that it should never have reached—into the nonhospital-owned ambulance off the property and to patients who are not on hospital grounds. These decisions may very well cause a breakdown in our already ailing emergency care system. The Supreme Court and Congress both need to define the boundaries of this ever-expanding statute and decide that nonhospital-owned ambulances are not hospital property under EMTALA. If they do not take action soon, this statute may eventually be construed by courts to encompass anyone who has had even the most remote connection with a hospital. Such a decision is well beyond the true intentions of Congress when it originally enacted EMTALA in 1986.

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165. MOY, *supra* note 5, at 16. The Hill-Burton Act provides funds to hospitals if the hospitals provide a "reasonable volume of services" to "persons unable to pay therefore" and also services to "all persons residing in the territorial area of the [hospital]." *Id*. at 59 n.44.

166. Richard M. Ellis, *Access to Emergency Services and Care in Florida*, FLA. B.J., Jan. 1998, at 29-30 (1998). A Florida statute requires that its hospitals must accept emergency patients when contacted by a two-way radio en route to the hospital by ambulance, regardless of ownership. *Id.*

167. Arrington v. Wong, 19 F. Supp. 2d 1151, 1156 (D. Haw. 1998).

168. *See supra* Parts III.C & IV.B.

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