St. Mary's Law Journal

Volume 27 | Number 3 Article 1

1-1-1996

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ST. MARY'S LAW JOURNAL

VOLUME 27 1996 NUMBER 3

ARTICLES

THE ANATOMY OF EMTALA: A LITIGATOR'S GUIDE

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I. INTRODUCTION

The Emergency Medical Treatment and Active Labor Act[1] (EMTALA), a provision of the Consolidated Omnibus Budget Reconciliation Act of 1986[2] (COBRA), prohibits hospitals from inappropriately transferring or refusing to provide medical care to

1. 42 U.S.C. § 1395dd (1994).
2. Pub. L. No. 99-272, 100 Stat. 82 (codified as amended throughout various titles in U.S.C.).

persons with emergency medical conditions.[3] EMTALA was passed in response to Congress's concerns regarding a practice of transferring or "dumping" seriously ill patients from private to public hospitals.[4] Its purpose is to ensure that all patients, regardless of wealth or status, receive medical treatment in emergency situations.[5] Although concerns regarding the availability of emergency medical care for the poor or uninsured prompted the drafting of EMTALA, the statute applies to the treatment of all patients, regardless of a patient's ability to pay or insurance coverage.[6]

This Article examines EMTALA in the context of litigation brought by private individuals.[7] Part II of this Article discusses the broad contours of a private cause of action under EMTALA and

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3. *See* 42 U.S.C. § 1395dd(a)–(c) (requiring hospitals to provide medical screening and stabilizing treatment for all patients with emergency medical conditions); *see also* Brooks v. Maryland Gen. Hosp., 996 F.2d 708, 710 (4th Cir. 1993) (explaining hospital liability under EMTALA for refusing to treat patients or transferring them before they are stabilized).

4. *Brooks*, 996 F.2d at 710; *see* H.R. REP. No. 241(I), 99th Cong., 1st Sess. 6 (1986) (recognizing Congress's concerns regarding emergency medical treatment); Power v. Arlington Hosp., 42 F.3d 851, 855 (4th Cir. 1994) (reviewing Congress's impetus in passing EMTALA, which was to address practice of patient "dumping," not to create malpractice statute).

5. *See, e.g.*, Thornton v. Southwest Detroit Hosp., 895 F.2d 1131, 1134 (6th Cir. 1990) (reviewing legislative history evidencing concern over numerous hospitals' refusal to treat patients without insurance or other guarantee of payment); McIntyre v. Schick, 795 F. Supp. 777, 781 (E.D. Va. 1992) (noting that one purpose of EMTALA is to provide emergency medical treatment for those who are indigent or without insurance); Karen I. Treiger, Note, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. REV. 1186, 1187 (1986) (asserting that common-law immunity afforded to hospitals accused of refusing to treat indigent patients was significant factor in passage of EMTALA).

6. *See, e.g.*, Correa v. Hospital of San Francisco, 69 F.3d 1184, 1193 (1st Cir. 1995) (noting that presence of insurance coverage is irrelevant for purposes of EMTALA because hospital's motive is not necessary element for establishing liability under statute), *cert. denied*, 116 S. Ct. 1423 (1996); *Brooks*, 996 F.2d at 710–11 (explaining that EMTALA applies to all patients with emergency medical conditions, regardless of whether they have insurance to pay for treatment); Michael S. Cardwell, *Interhospital Transfers of Obstetric Patients Under the Emergency Medical Treatment and Active Labor Act*, 16 J. LEGAL MED. 357, 364 (1995) (reviewing legislative history and noting that Legislature intended EMTALA to apply to all patients, not just those lacking insurance or ability to pay). *But see* Scott B. Smith, Note, *The Critical Condition of the Emergency Medical and Active Labor Act: A Proposed Amendment to the Act After* In the Matter of Baby K, 48 VAND. L. REV. 1491, 1492–93 (1995) (arguing that courts have improperly extended scope of EMTALA to protect paying patients, rather than limiting coverage to poor or uninsured in accordance with original purpose of statute).

7. The focus of this Article is on private litigation concerning EMTALA and not on governmental administrative actions against hospitals or physicians.

analyzes key provisions of the statute. Part III examines the standard of liability under EMTALA and discusses the damages recoverable in a private cause of action under the statute. Part IV explores various jury instructions and questions, both proper and erroneous, that have been submitted in cases brought under EMTALA, and ultimately proposes several questions that would be proper in light of those cases.

II. THE EMTALA STATUTE AND DEFINITIONS

A. *Broad Contours of a Private Cause of Action Under EMTALA*

EMTALA provides a cause of action for private plaintiffs.[8] Specifically, the statute states that "[a]ny individual who suffers a personal harm as a direct result of a participating hospital's violation" of any section of EMTALA may bring a civil suit against the hospital and obtain damages for personal injury and any equitable relief that is appropriate.[9] Any such private cause of action under EMTALA must be brought within two years from the date of the hospital's violation.[10]

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8. *See* 42 U.S.C. § 1395dd(d)(2)(A) (1994) (providing for private cause of action for individual who sustains injury as result of hospital's violation of statute). EMTALA also contains provisions authorizing the enforcement of civil monetary penalties against both hospitals and physicians. *Id.* § 1395dd(d)(1); *see also* Burditt v. United States Dep't of Health and Human Servs., 934 F.2d 1362, 1375 (5th Cir. 1991) (upholding $20,000 fine imposed by Department of Health and Human Services on physician for EMTALA violation); Barry R. Furrow, *An Overview and Analysis of the Impact of the Emergency Medical Treatment and Active Labor Act*, 16 J. LEGAL MED. 325, 326 (1995) (explaining potential for expansion of civil liability for hospitals through imposition of sanctions authorized by statute against both hospitals and physicians); Scott B. Smith, Note, *The Critical Condition of the Emergency Medical Treatment and Active Labor Act: A Proposed Amendment to the Act After* In the Matter of Baby K, 48 VAND. L. REV. 1491, 1502 (1995) (noting that statute provides for enforcement through both civil monetary penalties and private right of action). For a brief discussion of the civil penalty provision and types of fines that can be imposed for violations of EMTALA, see Amy J. McKintrick, Note, *The Effect of State Medical Malpractice Caps on Damages Awarded Under the Emergency Medical Treatment and Active Labor Act*, 42 CLEV. ST. L. REV. 171, 176–77 (1994).

9. 42 U.S.C. § 1395dd(d)(2)(A). A "participating hospital" is defined as a "hospital that has entered into a provider agreement under section 1395cc." *Id.* § 1395dd(e)(2); *see also* Hart v. Mazur, 903 F. Supp. 277, 279 n.3 (D.R.I. 1995) (clarifying that "participating hospital" is "hospital that has reached an agreement with the Secretary of Health and Human Services to provide Medicare services . . . under 42 U.S.C. § 1395cc").

10. 42 U.S.C. § 1395dd(d)(2)(C).

The statute is silent as to the proper forum for an EMTALA claim; however, the legislative history reveals that an aggrieved individual may bring suit "in an appropriate state or Federal district court."[11] Courts have recognized that federal courts have subject matter jurisdiction over actions brought pursuant to EMTALA,[12] and removal of a case from state to federal court is proper.[13] In practice, the majority of reported suits brought under EMTALA have been maintained in federal court,[14] although a few cases have been brought and maintained in state court.[15] While courts have concluded that plaintiffs may file EMTALA claims in either a state or federal forum, courts have rejected the proposition that EMTALA allows plaintiffs the same flexibility with regard to proper defendants.

Plaintiffs have attempted to pursue EMTALA claims against nonhospital defendants, such as physicians, telemetry operators, and utilization-review companies, but courts have consistently disallowed such claims under the statute.[16] Specifically, an over-

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11. H.R. REP. No. 241(I), 99th Cong., 1st Sess. 28 (1986).

12. *E.g.*, Thornton v. Southwest Detroit Hosp., 895 F.2d 1131, 1133 (6th Cir. 1990); Jones v. Wake County Hosp., 786 F. Supp. 538, 542 (E.D.N.C. 1991); Bryant v. Riddle Memorial Hosp., 689 F. Supp. 490, 492 (E.D. Pa. 1988).

13. Federal claims are removable under 28 U.S.C. § 1441. *See* 28 U.S.C. § 1441 (1994) (authorizing removal of cases arising under federal law). A federal court's concurrent jurisdiction over an EMTALA case provides a basis for removal, rather than a ground to defeat it. *See* Dorsey v. City of Detroit, 858 F.2d 338, 341 (6th Cir. 1988) (concluding that congressional grant of concurrent jurisdiction in statute does not imply that removal is prohibited); Baldwin v. Sears, Roebuck & Co., 667 F.2d 458, 459–61 (5th Cir. 1982) (finding that existence of statutory provisions for concurrent jurisdiction does not indicate congressional intent that suit should be prosecuted to final judgment in court in which it was originally filed).

14. *See* Barry R. Furrow, *An Overview and Analysis of the Impact of the Emergency Medical Treatment and Active Labor Act*, 16 J. LEGAL MED. 325, 337–38 (1995) (noting that EMTALA suits are generally filed in federal court, but discussing possible tactical considerations of bringing action in state court, including settlement potential, advantageous procedural rules, and jury pool).

15. *See, e.g.*, Stokes v. Candler Hosp., 453 S.E.2d 502, 505 (Ga. Ct. App. 1995) (affirming summary judgment granted by trial court in favor of hospital because evidence clearly established that patient's condition had been stabilized prior to release); Carleton v. Kinsella, No. 92–450, 1994 WL 878835, at *4 (Mass. Nov. 1, 1994) (concluding that plaintiff properly stated EMTALA cause of action, which was filed in state court); Carodenuto v. New York City Health & Hosps. Corp., 593 N.Y.S.2d 442, 444–45 (N.Y. 1992) (sustaining plaintiff's EMTALA claim brought in state court, but discussing correct interpretation of various terms of statute in light of federal court opinions).

16. *See, e.g.*, King v. Ahrens, 16 F.3d 265, 271 (8th Cir. 1994) (concluding that individual physicians and private clinics are improper parties to EMTALA suits because statute

whelming majority of courts has held that EMTALA does not create a private cause of action against physicians because the statute mentions physician liability only with respect to administrative penalties.[17] Further, in considering whether EMTALA provides for suits against telemetry operators, one court reasoned that no such cause of action exists because a hospital-owned telemetry system is distinct from the hospital's emergency department.[18] Finally, courts have also held that EMTALA does not permit a private cause of action against a utilization-review company, health maintenance organization, or private clinic, because none of these providers fall within EMTALA's limited definition of a "participating hospital," which is a hospital that has entered into a provider agreement under the statute.[19] Therefore, a hospital is the only appropriate defendant.[20]

By limiting the scope of its coverage to hospitals, EMTALA creates a situation unique from ordinary medical malpractice. Generally, hospitals cannot be responsible for diagnosing, prescribing, or directing the clinical decisions of physicians because state law pro-

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clearly applies only to "participating hospitals"); Ballachino v. Anders, 811 F. Supp. 121, 123 (W.D.N.Y. 1993) (holding that EMTALA provides no remedy against individual physicians); Richardson v. Southwest Mississippi Regional Medical Ctr., 794 F. Supp. 198, 200 (S.D. Miss. 1992) (asserting that hospital is proper defendant, as distinguished from group of physicians); *see also* Barry R. Furrow, *An Overview and Analysis of the Impact of the Emergency Medical Treatment and Active Labor Act*, 16 J. LEGAL MED. 325, 327 (1995) (noting that most courts have applied EMTALA to hospitals and not individual defendants).

17. *See, e.g.*, *King*, 16 F.3d at 271 (emphasizing that "participating hospital" under EMTALA does not include private clinics or private physicians); Kaufman v. Cserny, 856 F. Supp. 1307, 1312 (S.D. Ill. 1994) (concluding that no cause of action exists directly against physician under EMTALA, although individual physician may be subject to civil penalties for violations); *Ballachino*, 811 F. Supp. at 123 (dismissing all individual defendant physicians from EMTALA claim, and explaining that statute provides private cause of action only against hospitals); *Richardson*, 794 F. Supp. at 201 (acknowledging that no express provision of statute excludes cause of action against individual physicians, but reviewing legislative history and case law to conclude that statute implicitly excludes individual physicians from being parties to private cause of action).

18. Johnson v. University of Chicago Hosp., 982 F.2d 230, 233 (7th Cir. 1993).

19. *See King*, 16 F.3d at 271 (stating that no private cause of action against private clinic exists under EMTALA); Dearmas v. AV-MED, Inc., 814 F. Supp. 1103, 1108–09 (S.D. Fla. 1993) (holding that EMTALA creates no private cause of action against health maintenance organization); Bangert v. Christian Health Servs., No. 92–613WLB, 1992 WL 464708, at *2 (S.D. Ill. Dec. 17, 1992) (deciding that no private cause of action exists under EMTALA against utilization-review company).

20. *See* 42 U.S.C. § 1395dd(d)(2)(A) (providing that suit may be brought against "participating hospital").

hibits hospitals from engaging in the corporate practice of medicine.[21] Although hospitals may be held liable for negligent credentialing or supervision of physicians practicing on their premises,[22] hospitals are ordinarily not liable for the physicians' conduct or alleged medical malpractice.[23] Within the context of EMTALA, however, statutory liability is imputed to a hospital based on certain actions and decisions of the hospital's physicians and other support staff.[24] Under EMTALA, a hospital is liable for the emergency medicine physician's conduct and decisions regarding screening, stabilization, and transfer, because the hospital can only act, and thereby comply with EMTALA's requirements, by relying on the actions of its licensed physicians and hospital staff.[25] EM-

21. See TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.07(a) (Vernon Supp. 1996) (restricting practice of medicine to persons authorized and licensed under Medical Practice Act); *see also* Hunt v. Hinkley, 731 S.W.2d 570, 572 (Tex. App.—Houston [14th Dist.] 1987, writ ref'd n.r.e.) (concluding that clinic's failure to diagnose plaintiff's pregnancy could not result in liability to clinic because clinic was prohibited by law from practicing medicine, which includes making diagnoses).

22. *See* Park N. Gen. Hosp. v. Hickman, 703 S.W.2d 262, 266 (Tex. App.—San Antonio 1985, writ ref'd n.r.e.) (indicating that negligent credentialing claim may arise when hospital wholly fails to conduct any credentialing of physician).

23. *See Hunt*, 731 S.W.2d at 572 (concluding that hospital was not liable for physician's negligent acts or omissions because physician was independent contractor). It is well established in Texas that no respondeat superior liability attaches for the physician who is an independent contractor of a hospital and not a servant or employee. *See* Gladewater Mun. Hosp. v. Daniel, 694 S.W.2d 619, 621 (Tex. App.—Texarkana 1985, no writ) (finding that hospital was not liable for acts of physician who was member of medical staff and acting as independent contractor); Jeffcoat v. Phillips, 534 S.W.2d 168, 172 (Tex. Civ. App.—Houston [14th Dist.] 1976, writ ref'd n.r.e.) (finding that hospital was entitled to summary judgment because hospital could not be held liable for injuries resulting from negligent acts or omissions of physician who was independent contractor). *But see* Baptist Memorial Hosp. Sys. v. Smith, 822 S.W.2d 67, 74–75 (Tex. App.—San Antonio 1991, writ denied) (explaining that hospital can be liable for negligent conduct of physician if physician is represented to patient as agent of hospital).

24. *See Burditt*, 934 F.2d at 1374 (explaining that hospital is responsible for physician's conduct for purposes of evaluating liability under EMTALA).

25. *See id.* (holding that hospitals act vicariously through physicians). At least two courts have commented on the appropriateness of allowing a hospital to pursue an indemnity action against a physician in cases in which the physician's negligence resulted in the EMTALA violation. *See* Griffith v. Mt. Carmel Medical Ctr., 842 F. Supp. 1359, 1365 n.6 (D. Kan. 1994) (suggesting that indemnity action is appropriate when hospital is sued for doctor's negligence); McDougal v. LaFourche Hosp. Serv. Dist. No. 3, No. CIV.A.92-2006, 1993 WL 185647, at *1 (E.D. La. May 24, 1993) (reasoning that indemnity cause of action by hospital against physician would have desired effect of encouraging compliance with statute by making party actually responsible for violation pay for damages). Decisions to transfer represent one area in which a hospital may incur liability because the statute bases

TALA does not, however, make physicians agents of the hospital for any purpose other than conduct specified by the statute, nor does it impute to the hospital for tort purposes the physician's conduct and decisions regarding diagnosis and treatment.[26]

B. *Basic Elements of EMTALA*

In the broadest terms, EMTALA imposes a legal duty on hospitals pertaining to the care and subsequent transfer of individuals with emergency medical conditions. The first two sections of the statute, 42 U.S.C. §§ 1395dd(a) and (b), outline a hospital's duty to patients who come to the hospital's emergency department and request treatment.[27] The third section, § 1395dd(c), addresses transfer procedures for patients with unstabilized emergency medical conditions.[28]

Under § 1395dd(a), if a person comes to a hospital emergency department and requests treatment[29] for a medical condition, the department must provide an "appropriate medical screening" to determine whether an "emergency medical condition" exists.[30] If the hospital determines that an emergency medical condition exists, whether the individual has "[come] to the emergency department" or is already "at the hospital," the hospital must do one of two things: (1) stabilize the condition, as provided in § 1395dd(b); or (2) transfer the patient to another facility equipped to treat the condition, as outlined in § 1395dd(c).[31] EMTALA permits a trans-

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a hospital's liability on the appropriateness of the transfer decisions made by its physicians. *See* 42 U.S.C. § 1395dd(c)(1)(ii) (conferring responsibility for making decisions pertaining to transfer of unstabilized patients on hospital physicians and staff).

26. *See* Brooks v. Maryland Gen. Hosp., 996 F.2d 708, 711 (4th Cir. 1993) (distinguishing statutory liability imposed by EMTALA, for which hospital is liable, from common-law cause of action for medical malpractice); Baber v. Hospital Corp. of Am., 977 F.2d 872, 879 (4th Cir. 1992) (asserting that EMTALA imposes statutory duty on hospital to comply with provisions, but does not subject hospital to common-law liability for acts of physicians who are independent contractors); *see also* Cooper v. Gulf Breeze Hosp., 839 F. Supp. 1538, 1541 (N.D. Fla. 1993) (explaining that EMTALA does not preempt state malpractice laws).

27. 42 U.S.C. § 1395dd(a)–(b) (1994).

28. *Id.* § 1395dd(c).

29. The duty to provide a medical screening also arises if someone other than the patient makes a request for treatment on the patient's behalf. *Id.* § 1395dd(a).

30. *Id.; see also id.* § 1395dd(e)(1) (defining "emergency medical condition").

31. 42 U.S.C. §§ 1395dd(b)–(c).

fer only if it is an "appropriate transfer"[32] *and* the patient consents to the transfer in writing or a physician or other qualified medical person reasonably believes that the benefits to be received from another facility outweigh the risk of transfer.[33] A hospital that fails to follow the provisions of EMTALA may be subjected to civil liability under the provisions of the Act.[34] The following sections analyze the primary elements of EMTALA in greater detail.

C. *EMTALA Requirements Regarding Medical Screening and Decisions to Stabilize or Transfer*

1. Medical Screening

Before EMTALA imposes a duty to perform an appropriate medical screening, two conditions must exist. First, the hospital must have an "emergency medical department."[35] Second, an individual seeking treatment must "come[ ] to the emergency department" and request "examination or treatment for a medical condition."[36] Thus, the § 1395dd(a) screening requirement applies only to situations involving individuals who enter or attempt to enter the hospital through the emergency department.[37] Con-

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32. Whether a transfer is "appropriate" is governed by § 1395dd(c)(2) of the statute. *See id.* § 1395dd(c)(2) (outlining five general requirements with which transferring hospital must comply to effectuate "appropriate transfer," including efforts by transferring hospital to minimize risk to patient, adequacy of receiving hospital's capabilities, turnover of patient's records to receiving hospital, use of qualified personnel and equipment during transfer, and compliance with any other requirements as established by Secretary of Health and Human Services).

33. *Id.* § 1395dd(c)(1)–(2).

34. *Id.* § 1395dd(d)(2).

35. *See* Miller v. Medical Ctr. of S.W. La., 22 F.3d 626, 628 n.4 (5th Cir. 1994) (explaining that EMTALA applies only to hospitals with emergency department); Barry R. Furrow, *An Overview and Analysis of the Impact of the Emergency Medical Treatment and Active Labor Act*, 16 J. LEGAL MED. 325, 349 (1995) (noting that EMTALA duty to provide medical screening applies only to hospitals with emergency department); *see also* Brodersen v. Sioux Valley Memorial Hosp., 902 F. Supp. 931, 940 (D. Iowa 1995) (explaining that duty to provide screening arises when patient comes to hospital with emergency department and requests treatment).

36. *See Miller*, 22 F.3d at 628 (explaining that both preconditions to duty to perform medical screening must exist, which include coming to emergency department and requesting treatment); Brooks v. Maryland Gen. Hosp., 996 F.2d 708, 710 (4th Cir. 1993) (noting that EMTALA imposes duty on hospital with emergency room to perform medical screening to determine if medical emergency exists).

37. *See* Thornton v. Southwest Detroit Hosp., 895 F.2d 1131, 1134 (6th Cir. 1990) (explaining that screening duty applies only to patients who present to emergency room); *see also* Reynolds v. Mercy Hosp., 861 F. Supp. 214, 221–22 (W.D.N.Y. 1994) (pointing out

versely, the stabilize-or-transfer provisions of §§ 1395dd(b) and (c) apply to all patients diagnosed with emergency medical conditions, regardless of whether they enter the hospital through the emergency department.[38]

a. Defining the Preconditions to the Medical Screening Requirement

For purposes of determining the first precondition, EMTALA does not expressly define what constitutes a hospital with an emergency medical department.[39] Most courts deciding claims brought under EMTALA merely allude to the "emergency medical department" requirement without further defining the provision.[40] The absence of case law addressing or challenging this provision may be

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that screening provision of statute applies to all patients who come to hospital's emergency department, but transfer provision applies to all patients with unstabilized conditions regardless of how they entered hospital).

38. *See Thornton*, 895 F.2d at 1134 (asserting that once patient is admitted and has emergency medical condition, hospital may not transfer patient without stabilizing condition, regardless of whether patient stays in emergency room); Smith v. Richmond Memorial Hosp., 416 S.E.2d 689, 692–93 (Va.) (refuting hospital's argument that stabilization requirements of EMTALA apply only to patients admitted through hospital's emergency department), *cert. denied*, 113 S. Ct. 442 (1992).

39. EMTALA only authorizes a civil cause of action against a "participating hospital." 42 U.S.C. § 1395dd(d)(2)(A) (1994); *see also* Eberhardt v. City of Los Angeles, 62 F.3d 1253, 1256 (9th Cir. 1995) (asserting that EMTALA civil cause of action is enforceable against participating hospitals and not individual physicians); King v. Ahrens, 16 F.3d 265, 270 (8th Cir. 1994) (concluding that EMTALA limits civil cause of action to participating hospitals). Although EMTALA expressly limits the scope of its coverage to claims against "participating" hospitals, the statute's language does not necessarily mean that *all* participating hospitals are subject to EMTALA liability. For example, some courts have indicated that although a hospital may be a "participating hospital" under § 1395cc, it must also have an emergency department to be subject to EMTALA liability under the screening provision. *See, e.g.*, Correa v. Hospital of San Francisco, 69 F.3d 1184, 1190 (1st Cir. 1995) (explaining that to establish EMTALA violation, plaintiff must first show that hospital is "participating hospital" that operates emergency department or similar treatment facility), *cert. denied*, 116 S. Ct. 1423 (1996); Hart v. Mazur, 903 F. Supp. 277, 279 (D.R.I. 1995) (adopting *Correa* holding and clarifying that plaintiff bringing civil cause of action under EMTALA must prove that hospital was participating hospital "that operates emergency department" or its equivalent).

40. *See, e.g., Correa*, 69 F.3d at 1190 (referring to requirement that hospital have emergency department or "equivalent facility," but omitting further clarification of type of facility that equates to emergency department); Repp v. Anadarko Mun. Hosp., 43 F.3d 519, 521 (10th Cir. 1994) (noting that ancillary services available to emergency department are included within purview of EMTALA, but failing to further explain what "ancillary services" include); *Brooks*, 996 F.2d at 710 (discussing requirement that hospital have emergency department without defining "emergency medical department"). *But cf.* John-

due to the fact that the Health Care Financing Administration (HCFA) COBRA Regulations define the provision so broadly. These regulations define "hospital with an emergency department" as "any hospital that offers services for emergency medical conditions within its capabilities to do so."[41] Additionally, the comments to the HCFA COBRA Regulations provide that a hospital that holds itself out to the public as offering emergency treatment twenty-four hours per day is subject to the medical screening requirement.[42] Consequently, the existence of a designated emergency room or department is not required to bring a hospital under the medical screening provision of EMTALA as long as the hospital offers emergency services.[43]

Regarding the second precondition, EMTALA also fails to define the phrase "comes to the emergency department," and a few courts have interpreted this phrase broadly by rejecting the requirement that an individual physically appear at the hospital's emergency room.[44] The courts examining this issue have held that an individual seeking treatment from the emergency department may be present anywhere on the hospital's property.[45] For example, a federal district court in Louisiana recognized that an individual in an ambulance owned and operated by the hospital has come

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son v. University of Chicago Hosp., 982 F.2d 230, 233 (7th Cir. 1992) (explaining that telemetry system operated by hospital is distinct from emergency department).

41. HCFA COBRA Regulations, 42 C.F.R. § 489.24(b) (1995).

42. Comments to the HCFA COBRA Regulations, 59 Fed. Reg. 32,086, 32,101 (1994) (specifying that psychiatric hospital that provides care for psychiatric emergencies on 24-hour basis must provide emergency care within its capabilities).

43. 42 C.F.R. § 489.24(e); *see Correa*, 69 F.3d at 1190 (implying that hospital need not have formal emergency department to be participating hospital under EMTALA as long as it has "equivalent treatment facility").

44. *See* Madison v. Jefferson Parish Hosp. Serv. Dist. No. 1, No. CIV.A.93-2938, 1995 WL 396316, at *2 (E.D. La. June 30, 1995) (concluding that individuals have come to emergency department if they are placed in ambulance owned and operated by defendant hospital); McLaurin v. District of Columbia, No. CIV.A.92-2742NH/DAR, 1993 WL 547193, at *3 (D.D.C. Oct. 21, 1993) (concluding that individual had come to emergency department for purposes of EMTALA when request was made for treatment from ambulance that had arrived on hospital's premises).

45. *See Madison*, 1995 WL 396316, at *2 (acknowledging that individual in ambulance owned by hospital has come to emergency department); *McLaurin*, 1993 WL 547193, at *3 (finding that hospital violated statute by failing to provide medical screening in response to request for treatment made on behalf of plaintiff who was in privately operated ambulance that had arrived on hospital property).

to the hospital's emergency department.[46] Similarly, a federal district court in the District of Columbia found that an individual had come to a hospital's emergency department when a request was made for medical treatment from an independently operated ambulance that had arrived at the hospital's parking lot.[47] The HCFA COBRA regulations are consistent with this interpretation and the comments to the regulations further explain that an individual has come to the emergency department for purposes of EMTALA when the independently operated ambulance in which the individual is being transported physically arrives on the hospital's property, even if the hospital has directed the ambulance to another facility before its arrival.[48] In other words, the screening provision only requires that the ambulance arrive on the hospital's property, not that the ambulance arrive on the property at the direction or with the consent of the hospital.

While actual presentment at the hospital's designated emergency room is not required under the screening provision, courts have refused to extend this provision further to include patients who have requested or attempted to arrange for the treatment of emergency medical conditions from a location not owned or controlled by the hospital.[49] For example, courts have held that when an ambulance not operated or controlled by the hospital requests treatment for a patient, the patient has not come to the hospital's emergency department unless the ambulance ultimately enters the hospital's property.[50] The HCFA COBRA Regulations adopt this

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46. *Madison*, 1995 WL 396316, at *2.

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

48. 42 C.F.R. § 489.24(b); 59 Fed. Reg. 32,086, 32,098.

49. *See Miller*, 22 F.3d at 629 (concluding that patient had not come to emergency department by requesting treatment via telephone); *Johnson*, 982 F.2d at 232–33 (finding that attempt to arrange for treatment through hospital's telemetry operator did not constitute coming to emergency department).

50. *See Johnson*, 982 F.2d at 232–33 (concluding that plaintiff's infant daughter had not come to hospital's emergency department when request was made for admittance from independently operated ambulance while still five blocks from hospital because hospital's telemetry operator diverted ambulance to another facility); *Madison*, 1995 WL 396316, at *2 (explaining that individual is on hospital property when individual is in ambulance operated by hospital, even if ambulance is not actually on hospital grounds); *McLaurin*, 1993 WL 547193, at *2 (concluding that patient had come to hospital's emergency department because ambulance, though independently operated, had entered hospital's property and requested treatment on behalf of patient).

interpretation.[51] Additionally, the United States Court of Appeals for the Fifth Circuit has held that when one hospital requests or attempts to arrange for treatment of a patient's emergency medical condition at another hospital, the medical screening provision is not triggered for the other hospital.[52]

b. Appropriate Medical Screening

If the two threshold requirements described above are satisfied, EMTALA imposes a duty on the hospital to perform an "appropriate medical screening" to determine if a medical emergency exists.[53] Specifically, the medical screening requirement provides:

> 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, including ancillary services routinely available to the emergency department, to determine

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51. 42 C.F.R. § 489.24(b). An individual in an independently operated ambulance located off hospital property has not "come to the emergency department" when the ambulance personnel have contacted the hospital and the hospital refuses to accept the individual because the hospital is in "diversionary status." *Id.* "Diversionary status" means that the hospital does not have the staff or facilities to accept any additional emergency patients at that time. *Id.*; *see also* Comments to the HCFA COBRA Regulations, 59 Fed. Reg. 32,086, 32,098 (1994) (noting that hospital may deny access to nonhospital-owned ambulance when hospital lacks adequate staff or facilities at time of request).

52. *See Miller*, 22 F.3d at 630 (concluding that physician's agreement to accept child for treatment while child was still off premises failed to satisfy provision of EMTALA requiring that individual come to emergency department and request treatment of emergency medical condition). In *Miller*, a child who was severely injured in an automobile accident was taken to the nearest hospital. *Id.* at 627. The hospital did not have the capabilities to treat the child and attempted to transfer him to the closest hospital with a surgical facility and orthopedist. *Id.* The orthopedist agreed to accept the transfer and arrangements were made to transport the child. *Id.* Before the transfer was initiated, however, the administrator of the orthopedist's hospital instructed the transferring hospital not to send the child because the child lacked insurance. *Id.* After a lengthy delay, another hospital accepted the transfer. *Id.* In this situation, the Fifth Circuit held that the child did not have an EMTALA claim against the hospital that refused the transfer because the child had not "come to the emergency department." *Id.* at 630.

53. 42 U.S.C. § 1395dd(a). A hospital's liability under EMTALA arises out of a failure to provide an adequate screening, even though the hospital may later be able to establish that no emergency condition existed. *See Correa*, 69 F.3d at 1192 (explaining that duty to perform medical screening arises whether or not patient in fact has emergency medical condition).

> whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.[54]

EMTALA does not define the phrase "appropriate medical screening"; however, most courts have construed the provision to require a hospital to perform an initial medical screening or examination similar to one the hospital would conduct for any other patient.[55] Consequently, a hospital may provide an appropriate medical screening by applying its own standard screening procedures uniformly to all patients.[56] A minimal variation from a hospital's standard emergency room screening procedures will not establish an EMTALA screening violation.[57] In the absence of a written screening policy, a plaintiff must establish the hospital's failure "to meet the standard of care to which the hospital adheres."[58] Fur-

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54. 42 U.S.C. § 1395dd(a) (emphasis added).

55. *See Correa*, 69 F.3d at 1193 (explaining that hospital's failure to follow its own standards and procedures, which required taking and recording every patient's vital signs, was evidence of failure to provide appropriate screening under EMTALA); Cleland v. Bronson Health Care Group, 917 F.2d 266, 271 (6th Cir. 1990) (defining "appropriate" care as "care similar to care that would have been provided to any other patient, or at least not known by the providers to be insufficient or below their own standards"). The District of Columbia Circuit has adopted essentially the same definition, holding that what is appropriate can be determined by examining the hospital's standard screening procedures. Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1041 (D.C. Cir. 1991). One court has opined that, theoretically, a hospital might violate EMTALA if a screening procedure is so substandard as to amount to no screening at all. *See* Baber v. Hospital Corp. of Am., 977 F.2d 872, 879 n.7 (4th Cir. 1992) (explaining possibility that hospital's own standard could be so low as to amount to no medical screening); *see also Correa*, 69 F.3d at 1193 (explaining that failure to provide screening within reasonable amount of time for patient with obvious medical emergency would fail test for appropriate medical screening). However another court specifically rejected the proposition that a screening procedure can be so substandard as to amount to no screening. *See Repp*, 43 F.3d at 522 n.4 (stating that appropriate inquiry is only whether hospital followed its own procedures, not whether procedures were inadequate if followed).

56. *E.g.*, *Repp*, 43 F.3d at 522; Power v. Arlington Hosp., 42 F.3d 851, 856 (4th Cir. 1994); *Brooks*, 996 F.2d at 710–11; *Baber*, 977 F.2d at 879; *Gatewood*, 933 F.2d at 1041; *Reynolds*, 861 F. Supp. at 220; Lane v. Calhoun-Liberty County Hosp., 846 F. Supp. 1543, 1550 (N.D. Fla. 1994); Holcomb v. Humana Medical Corp., 831 F. Supp. 829, 833 (M.D. Ala. 1993), *aff'd sub nom.* Holcomb v. Monahan, 30 F.3d 116 (11th Cir. 1994); Anadumaka v. Edgewater Operating Co., 823 F. Supp. 507, 510 (N.D. Ill. 1993); Jones v. Wake County Hosp., 786 F. Supp. 538, 544 (E.D.N.C. 1991); Stokes v. Candler Hosp., 453 S.E.2d 502, 504 (Ga. Ct. App. 1995); Carodenuto v. New York City Health & Hosp. Corp., 593 N.Y.S.2d 442, 446 (N.Y. Sup. Ct. 1992).

57. *See Repp*, 43 F.3d at 523 (holding that de minimus variations from hospital's standard operating procedures will not violate hospital policies or EMTALA because to hold otherwise would place liability on hospitals when policy has effectively been followed).

58. *Power*, 42 F.3d at 858.

ther, courts do not focus on a particular result or outcome of a medical condition that occurs after a screening has been performed to determine whether the hospital performed an appropriate medical screening.[59]

A party alleging that a hospital failed to provide an appropriate medical screening must make a prima facie showing of differential treatment in the screening process.[60] Differential treatment occurs "whenever and for whatever reason a patient is denied the same level of care provided others and guaranteed him" by the statute.[61] Most courts hold that the hospital's reason for denying a screening is irrelevant.[62] After the plaintiff makes a threshold showing, one court has suggested that, in defense, a hospital show either that (1) the patient was accorded the same level of treatment that all other patients receive, or (2) a test or procedure was not given because the physician did not believe the test was reasonable or necessary under the particular circumstances of that patient.[63]

2. Decisions to Stabilize or Transfer

The purpose of performing the medical screening described above is to determine whether a medical emergency exists.[64] If

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59. *See Reynolds*, 861 F. Supp. at 220 (stating that "appropriate" screening procedures are determined with reference to hospital's own standard screening procedures, not based on adverse results following discharge or transfer). A negligence standard, whereby a hospital's conduct is compared with generally acceptable conduct in the medical community, has been rejected as a standard of liability under this provision. *See Cleland*, 917 F.2d at 271–72 (concluding that medical malpractice standards of care are insufficient to sustain claims under EMTALA).

60. *See Power*, 42 F.3d at 857–58 (holding that plaintiff must make threshold showing of differential treatment, but noting that plaintiff is not required to allege or prove improper motive with regard to disparate treatment).

61. *Id.* at 857.

62. *See Correa*, 69 F.3d at 1193 (finding that economic concerns are irrelevant in determining EMTALA violation because statute does not impose motive requirement); *see also Gatewood*, 933 F.2d at 1040 (holding that EMTALA extends its protection to "any individual" seeking emergency medical treatment, not just to indigent and uninsured).

63. *See Power*, 42 F.3d at 858 (suggesting new defensive strategy in EMTALA cases that would require defendant to rebut plaintiff's claims).

64. *See Brooks*, 996 F.2d at 713 (explaining that medical screening is performed to discover emergency condition, existence of which triggers duty to stabilize or effect appropriate transfer); Scott B. Smith, Note, *The Critical Condition of the Emergency Medical Treatment and Active Labor Act: A Proposed Amendment to the Act After* In the Matter of Baby K, 48 VAND. L. REV. 1491, 1498–99 (1995) (outlining provisions of EMTALA and explaining that purpose of performing medical screening is to determine whether emergency medical condition exists).

such an emergency condition exists, EMTALA imposes a duty on the hospital to either provide treatment sufficient to stabilize the condition or arrange for a proper transfer of the individual to another medical facility equipped to treat the condition.[65] The stabilization-or-transfer duty is imposed regardless of whether the patient presented to the emergency department.[66] The following sections discuss the duties EMTALA imposes regarding stabilization and transfer, and the requisite "emergency medical condition" that precedes these duties.

a. "Emergency Medical Condition" As a Precondition to EMTALA Duty to Stabilize or Transfer

EMTALA contains a two-part definition of the term "emergency medical condition"; the first part pertains to all individuals receiving treatment at a hospital and the second part relates to pregnant

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65. 42 U.S.C. § 1395dd(b)(1). The requirement to stabilize or appropriately transfer is stated as follows:

> 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 either—
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> (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
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> (B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

Id. EMTALA's provision restricting the transfer of patients applies whether the individual was admitted to the emergency department with the emergency medical condition or came to be in an emergency condition while at the hospital. *E.g., Thornton*, 895 F.2d at 1134; *Reynolds*, 861 F. Supp. at 222; McIntyre v. Schick, 795 F. Supp. 777, 780 (E.D. Va. 1992); Helton v. Phelps County Regional Medical Ctr., 794 F. Supp. 332, 333 (E.D. Mo. 1992); *Smith*, 416 S.E.2d at 692.

66. 42 U.S.C. §§ 1395dd(b)–(c). Most cases hold that an individual may have a claim under EMTALA for improper transfer or inadequate stabilization, regardless of whether the individual presented to the emergency department. *E.g., Thornton*, 895 F.2d at 1134; *Reynolds*, 861 F. Supp. at 222; *McIntyre*, 795 F. Supp. at 780; *Helton*, 794 F. Supp. at 333; *Smith*, 416 S.E.2d at 692. For example, courts have held that a woman in labor who presents to an obstetrical department may bring an EMTALA claim under the stabilization and transfer provisions even though she did not enter the hospital through the emergency department. *McIntyre*, 795 F. Supp. at 780. One court expanded this tenet by holding that a newborn child delivered at the hospital is also protected. Loss v. Song, No. 89C6952, 1990 WL 159612, at *3 (N.D. Ill. Oct. 16, 1990). In addition, the Sixth Circuit has held that a hospital may not circumvent the stabilize-or-transfer provisions of EMTALA "by admitting an emergency room patient to the hospital, then immediately discharging that patient." *Thornton*, 895 F.2d at 1135.

women having contractions.[67] With respect to patients in general, EMTALA defines an emergency medical condition as one that manifests itself "by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in . . . placing the health of the individual . . . in serious jeopardy, . . . serious impairment to bodily functions[,] or . . . serious dysfunction of any bodily organ or part."[68] However, the statute provides little guidance on the meaning of the terms "acute," "sufficient," "reasonable," or "serious."[69] For example, though the term "acute" would seem to describe the type of medical condition that would typically require emergency care, EMTALA fails to indicate whether such treatment may be removed in situations in which continued care is arguably futile.[70] Nonetheless, courts have concluded that the hospital's duty is to provide sufficient care to stabilize the patient, not necessarily to improve the patient's condition.[71]

Some ambiguity also surrounds the portion of the emergency medical condition definition pertaining to pregnant women who

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67. 42 U.S.C. § 1395dd(e)(1)(A).

68. *Id.; see also Eberhardt*, 62 F.3d at 1257 (explaining that emergency medical condition is limited to conditions that are clearly identifiable and evidenced by acute and severe symptoms); *Thornton*, 895 F.2d at 1133 (defining emergency medical condition as one that would likely result in death or serious disability if not treated).

69. Some commentators have suggested that EMTALA be amended to more clearly define an emergency medical condition. *See* Wayne E. Rampage, *The Pariah Patient: The Lack of Funding for Mental Health Care*, 45 VAND. L. REV. 951, 960–61 (1992) (arguing for revised definition of emergency medical condition, and questioning whether current definition protects patients in need of treatment for mental illness); Karen I. Treiger, Note, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. REV. 1186, 1209–11 (1986) (noting vagueness of terms used to define emergency medical condition and suggesting more specific definition that could be incorporated into federal regulations). However, one court has determined that this provision is not void for vagueness. *Jones*, 786 F. Supp. at 547.

70. *See In re* Baby K, 16 F.3d 590, 596 (4th Cir.) (concluding that EMTALA requires hospitals to provide care necessary to stabilize emergency medical condition even if for indefinite period of time, and even though care necessary to stabilize is above prevailing standard of care among hospitals with respect to care of similarly situated patients), *cert. denied*, 115 S. Ct. 91 (1994).

71. *See id.* at 596 (determining that hospital had duty to stabilize patient with emergency medical condition even though treatment of patient's underlying physical condition—anencephaly—was futile); Green v. Touro Infirmary, 992 F.2d 537, 539 (5th Cir. 1993) (providing that EMTALA requires hospital to stabilize rather than cure condition); Brooker v. Desert Hosp., 947 F.2d 412, 415 (9th Cir. 1991) (holding that patient may be in critical condition and still be "stabilized"); *Cleland*, 917 F.2d at 271 (stating that fact that stability proves to be temporary is irrelevant).

are having contractions. EMTALA provides that a pregnant woman is experiencing an emergency medical condition if she is having contractions and one of two situations exists: (1) there is inadequate time to safely transfer the woman prior to delivery; or (2) a transfer poses a threat to the safety of the woman or the unborn child.[72] Although EMTALA does not define the phrase "having contractions," legislative history and case law support the position that this provision contemplates a woman who is in *active* labor.[73]

EMTALA was originally passed as the Emergency Treatment and Active Labor Act.[74] As enacted, the statute was written to protect women in active labor.[75] In 1989, Congress amended the statute, replacing the term "labor" with the phrase "having contractions."[76] However, in using the term "contractions" rather than "labor," Congress recognized that "having contractions" refers to "uterine contractions" or "labor," because "labor begins

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72. 42 U.S.C. § 1395dd(e)(1)(B)(i)–(ii).

73. *See* Burditt v. United States Dep't of Health and Human Servs., 934 F.2d 1362, 1369–70 (5th Cir. 1991) (discussing legislative history of EMTALA and concluding that both original and amended versions limit application with respect to pregnant women to situations involving active labor, which means having contractions or complications with delivery); Peter M. Mellete, *Recent Developments in Medical Malpractice and Health Care Law*, 24 U. RICH. L. REV. 655, 679–80 (1990) (concluding that although amendments to original version of EMTALA eliminated active labor requirement, provision still requires physicians to rule out "active labor and other complications" before releasing or transferring pregnant woman); Diana K. Falstrom, Comment, *Decisions Under the Emergency Medical Treatment and Active Labor Act: A Judicial Cure for Patient Dumping*, 19 N. KY. L. REV. 365, 375 nn.76–77 (tracing EMTALA's legislative history, and noting that although provision expressly defining "active labor" was eliminated by current version, courts still interpret provision to address only women having complications with pregnancy while in active labor). *Compare* 42 U.S.C. § 1395dd(e)(2) (Supp. IV 1987) (providing that "active labor" includes labor in which delivery is imminent or in which there is insufficient time to safely transfer patient before delivery), *amended by* 42 U.S.C. § 1395dd(e)(B) (1994) *with* 42 U.S.C. § 1395dd(e)(1)(B) (1994) (defining emergency medical condition with respect to pregnant women to include woman "who is having contractions").

74. 42 U.S.C. § 1395dd (Supp. IV 1987), *amended by* 42 U.S.C. § 1395dd (1994); *see also* Collins v. DePaul Hosp., 963 F.2d 303, 304 (10th Cir. 1992) (noting original title of statute as enacted in 1986, which included designation for women in active labor).

75. *See Burditt*, 934 F.2d at 1369 (reviewing scope and meaning of term "active labor" as originally provided in statute); Danielle L. Trostorff, *King COBRA Recoils*, 37 FED. B. NEWS & J. 442, 444 (1990) (reporting that statute as originally enacted applied to women in active labor).

76. *See Burditt*, 934 F.2d at 1369 (noting replacement of term "labor" with phrase "having contractions" in 1989 amendment).

with the onset of uterine contractions."[77] Thus, even though Congress changed the wording in the statute, the intended meaning of the provision still contemplates a woman in active labor. Consequently, a woman may not necessarily have an emergency medical condition merely because she is experiencing contractions.[78]

The United States Court of Appeals for the Fifth Circuit has analyzed the two situations in which a pregnant woman having contractions has an emergency medical condition. In *Burditt v. Department of Health and Human Services*,[79] the court determined that EMTALA protects a woman in labor, having contractions, only if (1) her delivery is imminent or (2) she is experiencing complications with her pregnancy.[80] Regarding the first situation, the Fifth Circuit held that a hospital does not violate EMTALA by transferring a woman in uncomplicated labor if she will arrive, within reasonable medical probability, at another hospital before delivery.[81] With respect to the second situation, the Fifth Circuit reasoned that a woman in labor has an emergency medical condition if she is experiencing complications with her pregnancy that could interfere with the normal delivery of a healthy child, regardless of whether the delivery is imminent.[82]

Notwithstanding the ambiguities surrounding EMTALA's definition of an emergency medical condition, it is clear that to establish a violation under EMTALA for failure to stabilize or transfer, a plaintiff must show that the hospital had actual knowledge of an emergency medical condition.[83] The hospital's actual knowledge is

77. *Id.* at 1369 n.5.

78. *Id.* at 1369.

79. 934 F.2d 1362 (5th Cir. 1991).

80. *See Burditt*, 934 F.2d at 1369 (concluding that EMTALA does not restrict transfer of women in uncomplicated labor so long as delivery is not reasonably likely to occur before transfer is completed).

81. *Id.*

82. *Id.* at 1370. *But cf.* Michael S. Cardwell, *Interhospital Transfers of Obstetric Patients Under the Emergency Medical Treatment and Active Labor Act*, 16 J. LEGAL MED. 357, 365 (1995) (arguing that EMTALA applies to nonlabor-related complications such as premature rupture of membranes and other nonlabor conditions if condition is otherwise emergency medical condition).

83. *See, e.g.*, Urban v. King, 43 F.3d 523, 525 (10th Cir. 1994) (requiring plaintiff to prove that hospital had actual knowledge of emergency medical condition of fetus); *Baber*, 977 F.2d at 883 (holding that hospital was not liable under EMTALA for patient's death because examining physicians were unaware of severity of head injury); *Gatewood*, 933 F.2d at 1041 (determining that hospital was not liable for failure to treat patient for heart

determined by the actual knowledge of the emergency medicine physicians on duty.[84] Additionally, whether the hospital should have known of the emergency medical condition is irrelevant in evaluating the hospital's duty to stabilize.[85] Therefore, if a hospital lacks actual knowledge of an emergency medical condition, no duty to stabilize or appropriately transfer arises.[86]

b. Stabilization

Once a hospital has actual knowledge of a patient's emergency medical condition under either of the above definitions, it must stabilize the patient's condition unless a transfer is allowed under the provisions of the statute.[87] In narrow circumstances, a hospital can also be excused from the stabilization requirement when a patient refuses to consent to treatment.[88] The underlying purpose of the stabilization requirement is to ensure that a hospital, after discovering that an emergency medical condition exists, provides emergency care necessary to stabilize the patient.[89]

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disease when hospital diagnosed musculoskeletal pain); *Cleland*, 917 F.2d at 270 (concluding that hospital could not have violated transfer provision without knowledge of emergency medical condition); *Brodersen*, 902 F. Supp. at 943 (holding that hospital must have actual knowledge of emergency medical condition, measured by subjective standard, to violate transfer provision of statute); *Holcomb*, 831 F. Supp. at 833 (holding that party must show hospital had actual knowledge of endometritis to hold hospital liable for patient's death); Coleman v. McCurtain Memorial Medical Management, 771 F. Supp. 343, 346 (E. D. Okla. 1991) (holding that when hospital's screening did not reveal emergency heart problem, hospital was not liable for patient's death).

84. *Cleland*, 917 F.2d at 268–69.

85. *See id.* (finding that misdiagnosis of intussusception as influenza was not failure to treat emergency condition under statute).

86. *See id.* at 271 (noting that hospital's lack of detection of emergency medical condition precludes claim for failure to stabilize).

87. *See* 42 U.S.C. § 1395dd(b) (outlining hospital's duty to stabilize or transfer upon determination that medical emergency exists). If the hospital fails to discover an emergency medical condition, no duty to stabilize arises under the Act. *See Eberhardt*, 62 F.3d at 1259 (asserting that if no emergency medical condition is detected by hospital, hospital has no stabilization responsibility under EMTALA).

88. 42 U.S.C. § 1395dd(b)(2). In this situation, the hospital must: (1) inform the patient of the risks and benefits of the treatment; and (2) document the proposed treatment, taking all reasonable steps to obtain a signed, written, informed refusal of treatment. *Id.*; 42 C.F.R. § 489.24(c)(2).

89. *See Brooks*, 996 F.2d at 710 (determining that EMTALA's legislative history expresses Congress's concern that hospitals were abandoning their practice of providing emergency care to all patients); *Brooker*, 947 F.2d at 414 (discussing EMTALA's legislative history).

EMTALA defines the duty to stabilize with respect to an emergency medical condition as follows:

> [T]o provide such medical treatment . . . as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely *to result from or occur during the transfer* of the individual . . . .[90]

EMTALA does not require that the hospital completely alleviate the patient's medical condition.[91] In fact, a patient may have a critical condition and still be considered stabilized for purposes of EMTALA.[92] Once a patient is stabilized, the hospital's responsibility under EMTALA ends.[93]

To sustain a claim for failure to stabilize in violation of EMTALA, a plaintiff must establish that she was unstable at the time of transfer or discharge.[94] Whether an individual was stable at the time of transfer or discharge is evaluated by determining whether the treatment and release were reasonable under the circumstances that existed at the time the hospital effected the transfer or discharge.[95] A proper evaluation of whether a patient's condition was stable at the time of transfer or discharge does not focus on outcome; thus, a subsequent adverse result regarding the patient's condition following a transfer or discharge is not determinative.[96] In sum, if the plaintiff fails to establish that the hospital would have considered any other patient in the same condition too unstable to

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90. 42 U.S.C. § 1395dd(e)(3)(A) (emphasis added).

91. *Green*, 992 F.2d at 539; *Brooker*, 947 F.2d at 415; *Reynolds*, 861 F. Supp. at 223.

92. *See, e.g.*, *Green*, 992 F.2d at 539 (noting that EMTALA only requires hospital to stabilize, not cure, patient's emergency medical condition); *Brooker*, 947 F.2d at 415 (emphasizing that EMTALA mandates treatment only until patient is stabilized); *see also* Deron v. Wilkins, 879 F. Supp. 603, 608 (S.D. Miss. 1995) (stating that transfer of stabilized patient is not violation of EMTALA).

93. *Green*, 992 F.2d at 539.

94. Hines v. Adair County Pub. Hosp. Dist., 827 F. Supp. 426, 432 n.4 (W.D. Ky. 1993).

95. *See, e.g.*, Delaney v. Cade, 986 F.2d 387, 393 (10th Cir. 1993) (explaining that determination of "reasonableness" of medical personnel's conduct is question for jury); *Brooker*, 947 F.2d at 415 (affirming district court's finding that hospital employees acted reasonably by following doctor's post-treatment instructions); DeBerry v. Sherman Hosp., 741 F. Supp. 1302, 1306 (N.D. Ill. 1990) (defining EMTALA violations as medical decisions made contrary to available information and prudent medical procedures).

96. *See Cleland*, 917 F.2d at 269 (affirming dismissal of plaintiff's claim, notwithstanding fact that patient died shortly after release from hospital, because "to all appearances, the plaintiff's condition was stable" at time of release).

discharge or transfer, dismissal of an EMTALA claim is appropriate.[97]

c. Transfer

If a patient's emergency medical condition has not been stabilized, EMTALA's transfer provision restricts a hospital's movement of the patient.[98] If a patient is stable, however, the hospital may transfer the patient without limitation.[99] EMTALA defines "transfer" as "the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital."[100] The transfer provision is divided into two parts; the first addresses the conditions under which transfer of an unstabilized person is allowed, and the second focuses on the manner of the transfer.

The first part of EMTALA's transfer provision provides that a hospital may not transfer an individual with an unstabilized emergency medical condition unless the individual consents to the transfer, or a hospital physician or other qualified medical person certifies that the risk of transfer is outweighed by the benefits.[101]

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97. *See id.* (noting plaintiff's lack of evidence indicating that "patient's condition at discharge would not have been considered stable for any other patient"); *Brodersen*, 902 F. Supp. at 940 (predicating hospital's duty to stabilize on discovery of emergency medical condition following medical screening and treatment in conformity with level of treatment generally given by hospital to other patients with similar conditions); Gossling v. Hays Medical Ctr., No. 92-1488-PFK, 1995 WL 254269, at *9 (D. Kan. Apr. 21, 1995) (concluding that plaintiff must show that unstabilized condition was evidenced by acute symptoms requiring further care).

98. 42 U.S.C. § 1395dd(c)(1)(A)-(B). Because the transfer provision requires hospitals to stabilize patients with emergency medical conditions, one commentator has concluded that this provision reflects the presumption that hospitals would otherwise transfer unprofitable patients without any treatment. Scott B. Smith, Note, *The Critical Condition of the Emergency Medical Treatment and Active Labor Act: A Proposed Amendment to the Act After* In the Matter of Baby K, 48 VAND. L. REV. 1491, 1499 (1995).

99. *See Urban*, 43 F.3d at 526 (determining that restrictions on transfer of patients apply only to patients with unstabilized medical conditions); *Baber*, 977 F.2d at 883 (asserting that violation of transfer provision cannot occur unless hospital first obtains knowledge of emergency medical condition as outlined in stabilization provision).

100. 42 U.S.C. § 1395dd(e)(4).

101. *Id.* § 1395dd(c)(1)(A)(i)-(iii); *see also Baby K*, 16 F.3d at 596 (explaining that transfer of patient with unstabilized condition is not option under EMTALA unless patient consents or physician signs certificate stating that benefits of transfer outweigh risks). A written consent form signed by the patient is required by the statute, although one court has held that the failure to obtain written consent from the patient will not automatically

Under the consent exception, an unstabilized patient may be transferred if the patient, or someone acting on the patient's behalf, requests the transfer in writing.[102] The person requesting the transfer must first be informed of the hospital's obligations under EMTALA and the risks associated with the transfer.[103] Further, a patient's written request must indicate the reasons for the request and demonstrate that the patient was aware of the risks and benefits of the transfer.[104]

Under the certification exception, an unstabilized patient may be transferred if, after balancing the risks and benefits to the patient, a physician certifies that a transfer is in the patient's best interests.[105] A physician's decision to transfer must be evidenced by a certification signed either by the physician or by a qualified medical person who consulted with a physician prior to effecting the transfer.[106] Notably, the requirement that a physician's decision be based on a reasonable expectation that the benefits of the transfer outweigh the risks to the patient does not subject the physician's conclusion

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give rise to liability under EMTALA. *See* Wey v. Evangelical Community Hosp., 833 F. Supp. 453, 445–46 (M.D. Pa. 1993) (reviewing evidence which established that patient knew of reason for transfer and was informed of risks and benefits, and finding no EMTALA violation despite noncompliance with provision requiring patient's written consent).

102. 42 U.S.C. § 1395dd(c)(1)(A)(i).

103. *Id.*

104. 42 C.F.R. § 489.24(d).

105. 42 U.S.C. § 1395dd(c)(1)(A)(ii). This second part of the transfer provision, which pertains to a physician's decision to transfer a patient with an unstabilized emergency medical condition, reads:

> If an individual at a hospital has an emergency medical condition which has not been stabilized . . . , the hospital may not transfer the individual unless—
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> . . . .
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> (ii) a physician . . . has signed a certification that[,] based upon 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 transfer . . . .

Id.

106. *Id.* If a physician is not present in the emergency department at the time of transfer, qualified medical personnel may sign the certification if a physician consults with the personnel and agrees with the certification. *Id.* § 1395dd(c)(1)(A)(iii); *see also* Michael S. Cardwell, *Interhospital Transfers of Obstetric Patients Under the Emergency Medical Treatment and Active Labor Act*, 16 J. LEGAL MED. 357, 367 (1995) (explaining that provision allowing for nonphysician to sign certificate allows rural hospitals to comply with provisions of statute without necessity of having physician physically present in emergency room). The physician must subsequently countersign the certification. 42 U.S.C. § 1395dd(c)(1)(A)(iii).

to review based on what another physician may have concluded under similar circumstances.[107] Consequently, liability under EMTALA does not arise simply because another physician would have acted differently or reached a different conclusion, as long as the transferring physician has considered the risks and benefits.[108] The process, not the outcome, is determinative of whether a violation has occurred.[109]

Provided that the preconditions for transferring an unstabilized patient are satisfied, the second part of the transfer provision governs the method or process by which an "appropriate transfer" must be effected.[110] Deciding whether a transfer method is appropriate involves several considerations, including the transferring hospital's duty to provide medical treatment within its capacity prior to transfer, the suitability of the receiving hospital's facilities, the transference of relevant medical records, and the use of qualified transportation equipment.[111] If the preconditions are met and an appropriate transfer can be effected, the proposed transferee hospital may be required to accept the transfer.[112]

EMTALA and its implementing regulations prohibit a participating hospital that has specialized capabilities or facilities from refusing to accept an appropriate transfer of a patient whose

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

108. *Id.* However, a physician's certification signature will not automatically insulate a hospital from liability under this section if the physician fails to engage in any risk-benefit analysis prior to signing the certification or signs the certification in contradiction to conclusions actually reached. *Id.*

109. *See Brooker*, 947 F.2d at 415 (explaining that ultimate outcome following transfer of patient is irrelevant for purposes of EMTALA, provided that physician considers risks and benefits of transfer and concludes that no material deterioration is reasonably likely to occur as result). In addition, if the patient refuses to consent to a transfer, even after a physician has properly certified that the benefits outweigh the risks, the hospital's duty to stabilize or transfer ends. *See* 42 U.S.C. § 1395dd(b)(3) (explaining that hospital has met requirements of stabilization and transfer provision if it offers to transfer patient in accordance with statute but patient refuses to consent to transfer). In this situation, the hospital must document the patient's reasons for refusal and take all reasonable steps to obtain a signed, written refusal of transfer. *Id.*; 42 C.F.R. § 489.24(c)(4).

110. *See* 42 U.S.C. § 1395dd(c)(2) (describing process required in transfer of unstabilized patients, which includes transfer of all medical records and use of qualified transportation equipment).

111. *Id.* § 1395dd(c)(2)(C). "Qualified transportation equipment" encompasses all equipment medically necessary to ensure the safe transfer of a patient. *Burditt*, 934 F.2d at 1372.

112. 42 U.S.C. § 1395dd(g); 42 C.F.R. § 489.24(e).

condition requires specialized treatment.[113] Specialized capabilities include, but are not limited to, "burn units, shock-trauma units, neonatal intensive care units, or regional referral centers" in rural areas.[114] In deciding whether a receiving hospital has the capacity to treat a patient, the number of individuals in a specialized unit, the amount of staff on duty, and the quantity of equipment in the hospital are not determinative.[115] If a health care institution has previously accommodated additional patients by transferring patients to other units, bringing in additional staff, or receiving equipment from other facilities, the institution has shown that it can treat patients beyond its occupancy limit.[116]

The receiving hospital is not required to accept the transfer, however, if the patient does not require any treatment beyond the capabilities of or facilities available at the transferring hospital.[117] According to the comments to the HCFA COBRA regulations, this exception prevents a hospital from automatically transferring patients simply because the hospital does not offer a particular service.[118] For example, a hospital with an obstetrical department need not accept the transfer of a woman in labor simply because the transferring facility has no similar department or service.[119] The receiving hospital can refuse to accept the transfer if the patient is having a normal, uncomplicated delivery because the transferring hospital would generally have the capacity to handle such a delivery.[120]

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113. 42 U.S.C. § 1395dd(g); 42 C.F.R. § 489.24(e).

114. *See* Comments to the HCFA COBRA Regulations, 59 Fed. Reg. 32,086, 32,105 (1994) (mandating that receiving hospital accept transfer if hospital has specialized facilities for treatment of patient's condition).

115. *See id.* (explaining that receiving hospital's past record of accommodating patients with conditions similar to condition of patient being transferred would require hospital to accept transfer, even though receiving hospital's facilities were not set up specifically for treatment of that condition). For example, a hospital must accept the transfer of a patient with severe burns if the hospital has demonstrated the ability and willingness to treat similar conditions in the past, even though the hospital does not maintain a specialized burn unit. *Id.*

116. *Id.*

117. *Id.*

118. *See* Comments to the HCFA COBRA Regulations, 59 Fed. Reg. 32,086, 32,105 (1994) (stating that transfers can be refused for failure to meet additional care requirements).

119. *Id.*

120. *Id.*

III. Liability and Damages Under EMTALA

A. *Liability Under EMTALA*

The foregoing provisions of EMTALA culminate in the following elements of proof for an individual claiming that a hospital has violated the statute: (1) the individual went to the hospital's emergency department; (2) the individual had an emergency medical condition; and (3) the hospital either (a) did not adequately screen the individual to determine whether the individual had an emergency medical condition, or (b) had actual knowledge of the emergency medical condition and did not stabilize the individual before transfer (or discharge) or failed to properly transfer the individual.[121] If an individual establishes that the hospital failed to provide a screening examination and an appropriate stabilization or transfer, EMTALA imposes liability. However, it is important to note that the statute does not "provide a guarantee of the result of emergency room treatment and discharge."[122] As the United States Court of Appeals for the District of Columbia Circuit noted in *Gatewood v. Washington Healthcare*,[123] EMTALA was not designed "to ensure each emergency room patient a correct diagnosis, but rather to ensure that each is accorded the same level of treatment regularly provided to patients in similar medical circumstances."[124] In considering the proper level of care, most courts have recognized that Congress did not intend to create a negli-

121. *See* Baber v. Hospital Corp. of Am., 977 F.2d 873, 883 (4th Cir. 1992) (discussing requirements for EMTALA claims based on failure to stabilize or transfer); *see also* Miller v. Medical Ctr., 22 F.3d 626, 630 n.8 (5th Cir. 1994) (noting elements of EMTALA claim).

122. Cleland v. Bronson Health Care Group, 917 F.2d 266, 271 (6th Cir. 1990); *see also* Collins v. DePaul Hosp., 963 F.2d 303, 307 (10th Cir. 1992) (determining that emergency room diagnosis and admission into intensive care unit constituted proper medical treatment); Holcomb v. Humana Medical Corp., 831 F. Supp. 829, 832 (M.D. Ala. 1993) (stating that purpose of EMTALA is to provide "adequate first response to a medical crisis" and to demonstrate to hospital community that all citizens, regardless of financial status, are entitled to medical services in times of "physical distress"), *aff'd sub nom.* Holcomb v. Monahan, 30 F.3d 116 (11th Cir. 1994); Coleman v. McCurtain Memorial Medical Management, 771 F. Supp. 343, 347 (E.D. Okla. 1991) (rejecting wrongful death action against hospital in which doctor's questioning of patient did not indicate health problem that would be classified as requiring emergency medical treatment); Evitt v. University Heights Hosp., 727 F. Supp. 495, 498 (S.D. Ind. 1989) (rejecting plaintiff's claim that defendant hospital turned plaintiff away for economic reasons).

123. 933 F.2d 1032 (D.C. Cir. 1991).

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

gence standard under EMTALA.[125] Although courts sometimes refer to EMTALA as a strict liability statute, this reference is incorrect.[126] Strict liability automatically imposes responsibility for an activity regardless of the care utilized in the act, whereas EMTALA requires hospitals to adhere to a certain level of care.[127]

Courts determining the standard of liability under EMTALA have looked to and applied the duties outlined by the statute itself.[128] When a statute like EMTALA creates a duty of care, a violation of this statutory duty is categorized as "negligence per se" or "statutory liability."[129] EMTALA imposes a duty on hospitals regarding emergency department screening,[130] actual knowledge of medical conditions,[131] stabilization,[132] and transfer,[133] and courts have noted that the statute itself describes the type of conduct re-

125. *See* Correa v. Hospital of San Francisco, 69 F.3d 1184, 1192–93 (1st Cir. 1995) (noting that EMTALA does not create medical malpractice or negligence cause of action), *cert. denied*, 116 S. Ct. 1423 (1996); *Gatewood*, 933 F.2d at 1041 (refuting proposition that Congress intended negligence standard that compares defendant's conduct to that of other hospitals to govern EMTALA).

126. *See* Gregory M. Luce, *Defending the Hospital Under EMTALA: New Requirements/New Liabilities* (noting fallacy of some courts in characterizing EMTALA as strict liability statute), *in* LEGAL ANALYSIS PLUS: A+ 1995, at 28 n.171 (National Health Lawyers Ass'n Monograph Series, 1995).

127. *Id.*; *see* RESTATEMENT (SECOND) TORTS § 282 cmt. f (1977) (contrasting negligence with strict liability).

128. *See, e.g.*, Brooks v. Maryland Gen. Hosp., 996 F.2d 708, 713 (4th Cir. 1993) (explaining that, although EMTALA does not expressly define standard of care with respect to screening procedures, statute implicitly incorporates hospital's own standard screening procedures); Green v. Touro Infirmary, 992 F.2d 537, 538 (5th Cir. 1993) (emphasizing that EMTALA expressly outlines hospital's duty toward individuals who come to emergency room); Abercrombie v. Osteopathic Hosp. Founders Ass'n, 950 F.2d 676, 681 (10th Cir. 1991) (concluding that negligence standard of liability is inapplicable in EMTALA civil causes of action because statute itself outlines standard of care and conduct required for compliance); *see also* RESTATEMENT (SECOND) OF TORTS § 288B(1) (1977) (explaining that statute may define standard of conduct, and noting that unexcused violation of that standard establishes liability for any direct harm that results).

129. RESTATEMENT (SECOND) OF TORTS § 288B (1977); Gregory M. Luce, *Defending the Hospital Under EMTALA: New Requirements/New Liabilities*, *in* LEGAL ANALYSIS PLUS: A+ 1995, at 26–28 (National Health Lawyers Ass'n Monograph Series, 1995).

130. *See* 42 U.S.C. § 1395dd(a) (1994) (describing hospital's duty to provide medical screening within capability of emergency department).

131. *See id.* § 1395dd(b) (requiring hospital to provide explicit stabilizing treatment when it determines patient has emergency medical condition).

132. *See id.* § 1395dd(b), (e)(3)(A) (outlining hospital's duty to stabilize emergency medical condition of which it has knowledge and defining meaning of "stabilize").

133. *See id.* § 1395dd(c) (restricting transfer of unstabilized patients and identifying permissible instances of transfer).

quired with respect to each of these provisions.[134] Thus, in determining whether a hospital has departed from the statutorily imposed duties, courts reduce the statute to its elements and examine the duty of care for each element.[135]

1. Medical Screening

EMTALA first provides a duty of care regarding the requirement that a hospital conduct a medical screening.[136] To satisfy this duty, the screening must be "appropriate."[137] Most courts hold that no EMTALA violation has occurred if the hospital has established screening policies and has followed them for the patient in question, even when there is an adverse or poor result.[138] Consequently, the jury merely determines whether the hospital followed its own standard policies and procedures, without regard to the policies that other hospitals may or may not follow.[139]

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134. *See* Eberhardt v. City of Los Angeles, 62 F.3d 1253, 1257–59 (9th Cir. 1995) (describing standard created by EMTALA for "appropriateness" of medical screening as one that would disclose emergency medical conditions that are manifested by severe and obvious symptoms); *Baber*, 977 F.2d at 882–83 (reviewing standards for transfer provisions outlined by statute, and explaining that violation of standards gives rise to liability); *Cleland*, 917 F.2d at 271 (explaining that duty to perform "appropriate medical screening" is duty created by statute and that meaning of "appropriate" is to be defined and applied by courts in accordance with purpose of statute).

135. *See, e.g., Eberhardt*, 62 F.3d at 1258 (examining language regarding duty to provide appropriate medical screening, and concluding that duty imposed on hospital is to provide screening within its own capabilities); *In re* Baby K, 16 F.3d 590, 595 (4th Cir.) (reviewing language of stabilization section of EMTALA and concluding that applicable standard of care is to provide treatment necessary to prevent deterioration, not simply to provide uniform care such as that applicable to medical screening provision), *cert. denied*, 115 S. Ct. 91 (1994); Burditt v. United States Dep't of Health and Human Servs., 934 F.2d 1362, 1371 (5th Cir. 1991) (explaining that hospital's duty under transfer provision is evaluated by determining whether treating physician completed process of weighing risks and benefits of transfer described in statute).

136. *See* 42 U.S.C. § 1395dd(a) (limiting extent of medical screening duty to that of hospital's capabilities).

137. *See Eberhardt*, 62 F.3d at 1258 (explaining that EMTALA imposes duty on hospital to develop standard for providing appropriate medical screening that will disclose emergency medical conditions manifested by acute and severe symptoms).

138. *See id.* (reviewing decisions of other circuits that have addressed medical screening requirement, and concluding that most courts have interpreted provision to require hospital to provide screening similar to that which it would provide to similarly situated patients).

139. *See Brooks*, 996 F.2d at 713 (emphasizing that only issue in determining whether hospital failed to provide appropriate screening is whether hospital's own standard screening procedure was followed); Lane v. Calhoun-Liberty County Hosp. Ass'n, 846 F. Supp.

2. Actual Knowledge of Emergency Medical Condition

EMTALA also imposes a duty of care in connection with the requirement that a hospital have actual knowledge of the patient's emergency medical condition before it can be liable for failing to stabilize or appropriately transfer the patient.[140] Because whether the hospital should have known that an emergency medical condition existed is irrelevant,[141] EMTALA's actual knowledge element is not subject to a reasonableness inquiry or a negligence analysis.[142] Instead, a hospital's actual knowledge, or lack thereof, is determined by reviewing the patient's medical records and the physician's testimony regarding his determination of whether an

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1543, 1551 (N.D. Fla. 1994) (concluding that violation of screening requirement occurs only if hospital failed to follow its own standard procedures, not merely if hospital failed to follow standard that other hospitals utilize).

140. *See* 42 U.S.C. § 1395dd(b)(1) (triggering stabilization requirement in situation in which hospital actually "determines that the individual has an emergency medical condition"); *see also* Urban v. King, 43 F.3d 523, 526 (10th Cir. 1994) (concluding that hospital had complied with EMTALA's provisions even though patient's condition was later determined to be serious, because hospital did not have actual knowledge of condition at time of discharge); *Baber*, 977 F.2d at 883 (finding that because plaintiff failed to produce any evidence establishing that physician had performed inadequate screening, hospital had no knowledge of plaintiff's emergency condition and summary judgment in favor of hospital was proper); *Gatewood*, 933 F.2d at 1041 (explaining that EMTALA's stabilization and transfer provisions were inapplicable because plaintiff failed to show that hospital knew of patient's emergency medical condition); *Cleland*, 917 F.2d at 268–69 (affirming dismissal of plaintiff's EMTALA cause of action, and explaining that hospital cannot be liable under EMTALA for transferring or discharging patient with emergency medical condition of which it did not have knowledge); *Holcomb*, 831 F. Supp. at 833 (requiring plaintiff to present evidence that hospital actually knew of plaintiff's emergency medical condition before holding hospital liable for failing to stabilize condition); Anadumaka v. Edgewater Operating Co., 823 F. Supp. 507, 510 (N.D. Ill. 1993) (explaining that EMTALA does not require hospital to stabilize condition unless it first discovers that condition exists by performing medical screening).

141. *See, e.g., Urban*, 43 F.3d at 526–27 (concluding that relevant question in determining whether hospital is liable under transfer provision of EMTALA is whether appropriate screening was performed, not whether hospital should have discovered emergency medical condition); *Baber*, 977 F.2d at 883 (explaining that hindsight is irrelevant in determining whether hospital should have discovered emergency medical condition); *Cleland*, 917 F.2d at 271 (asserting that whether hospital should have known of unstabilized condition, within applicable medical malpractice standards, is not appropriate inquiry).

142. *See Anadumaka*, 823 F. Supp. at 509–10 (maintaining that objective standard, which involves inquiry into what hospital should or should not have done with respect to screening, is irrelevant in determining whether hospital is liable under EMTALA for failing to discover medical emergency).

emergency medical condition existed.[143] The issue is whether a determination was in fact made in accordance with the statute, not whether the determination was correct.[144] In other words, the statute imposes a duty on the hospital to determine whether a patient has an emergency medical condition, a duty violated only by a failure to make such a determination.[145]

3. Stabilization

The standard of liability established by EMTALA's stabilization provision is similar to that established by the medical screening and actual knowledge provisions in that it is also statutory liability; however, the duty under the stabilization provision differs because it is evaluated objectively in terms of reasonableness.[146] Liability for failing to stabilize an emergency medical condition focuses on whether a material deterioration of the patient's condition is likely

143. *See Eberhardt*, 62 F.3d at 1258 (observing that evidence presented in lower court, consisting of physician testimony and hospital records of plaintiff, failed to establish that plaintiff was given inadequate screening or that physician failed to make determination pertaining to patient's condition).

144. *See Baber*, 977 F.2d at 881 (reviewing evidence indicating that hospital's physician performed screening and concluded that no emergency medical condition existed, and explaining that such determination precluded liability under EMTALA because literal terms of statute were followed); *Gatewood*, 933 F.2d at 1041 (finding that plaintiff failed to state cause of action by conceding that hospital had performed medical screening according to its internal standards and had concluded that no medical emergency condition existed); *Anadumaka*, 823 F. Supp. at 510 (examining evidence offered in lower court, which established that screening had been performed and attending physician had concluded no medical emergency existed, before finding that hospital complied with requirements of EMTALA).

145. *See, e.g., Gatewood*, 933 F.2d at 1041 (explaining that statute requires only that hospital follow standard screening procedures to determine whether emergency condition exists); Brodersen v. Sioux Valley Memorial Hosp., 902 F. Supp. 931, 943–44 (D. Iowa 1995) (refuting plaintiff's contention that statute imposes objective standard on hospital regarding discovery of emergency medical condition, and explaining that statute only requires appropriate medical screening to be performed); Cunningham v. Fredonia Regional Hosp., No. CIV.A.94–1443–PFK, 1995 WL 580055, at *2 (D. Kan. Sept. 21, 1995) (asserting that EMTALA authorizes claim for failure to provide screening adequate to discover emergency medical condition, not for misdiagnosis).

146. *See Eberhardt*, 62 F.3d at 1259 n.3 (noting that stabilization provision requires treatment necessary to stabilize condition, not simply uniform stabilization treatment); *Baby K*, 16 F.3d at 595–96 (noting that stabilization duty requires treatment appropriate to each case without regard to treatment given to other similarly situated patients); *see also* Delaney v. Cade, 986 F.2d 387, 393 (10th Cir. 1993) (asserting that fact issue remained in case as to whether medical evidence would establish that deterioration of patient's condition was foreseeable).

to occur "within reasonable medical probability" after the patient is discharged or transferred.[147] This analysis examines the patient's condition at the time of discharge or transfer.[148] In this context, the physician's determination that the transfer of a particular patient will not result in further deterioration of the patient's condition must be reasonable.[149]

In evaluating whether a hospital met the duty of care for the stabilization requirement, most courts consider prevailing medical standards and relevant expert medical testimony to determine whether material deterioration of an emergency condition was reasonably likely to occur.[150] For example, in *Cleland v. Bronson Health Care Group*,[151] the United States Court of Appeals for the Sixth Circuit analyzed the patient's condition at the time of discharge to determine whether the physician's conclusion that the patient's condition had been stabilized was reasonable.[152] The Sixth Circuit relied on prevailing medical opinion, the lack of objective evidence indicating acute distress or worsening of the condition, and the "normal meaning of stabilization" to conclude that the patient's condition had been stabilized in accordance with EM-

147. *See* 42 U.S.C. § 1395dd(e)(3)(A)–(B) (stating that terms "to stabilize" and "stabilized" mean that no material deterioration is likely to occur "within reasonable medical probability"); *see also Eberhardt*, 62 F.3d at 1259 n.3 (referring to statutorily created duty to stabilize, which is measured by "reasonable medical probability"); Smith v. Janes, 895 F. Supp. 875, 882–83 (S.D. Miss. 1995) (emphasizing that issue in evaluating plaintiff's claim for failure to stabilize is whether deterioration was likely to occur "within reasonable medical probability").

148. *See Cleland*, 917 F.2d at 271 (analyzing patient's condition at time of discharge); *Janes*, 895 F. Supp. at 881 (examining evidence of patient's condition upon discharge).

149. *See* Brooker v. Desert Hosp., 947 F.2d 412, 415 (9th Cir. 1991) (concluding that physician's belief that patient's condition was stabilized was reasonable because expert testimony established that belief was based on reasonable medical probability that no deterioration would occur during transfer); Deron v. Wilkins, 879 F. Supp. 603, 609 (S.D. Miss. 1995) (explaining that determination of whether patient has been stabilized is based on physician's belief that no deterioration of patient's condition is likely, within reasonable medical probability, to occur, not on whether condition has been alleviated).

150. *See, e.g.*, *Cleland*, 917 F.2d at 271 (considering objective medical standards and general understanding of "stabilize" in evaluating patient's condition at time of discharge); *Janes*, 895 F. Supp. at 883 (explaining that expert medical testimony is relevant in determining whether deterioration of patient's condition was reasonably likely to occur); Howe v. Hull, 874 F. Supp. 779, 786 (N.D. Ohio 1994) (noting that disagreement among expert witnesses pertaining to status of patient's condition and likelihood of deterioration raised fact issue that precluded summary judgment).

151. 917 F.2d 266 (6th Cir. 1990).

152. *Cleland*, 917 F.2d at 271.

TALA.[153] Similarly, in *Smith v. Janes*,[154] a Mississippi district court considered medical expert testimony in determining whether a patient's condition was likely to deteriorate, within reasonable medical probability, during transfer to another facility.[155] The Mississippi court held that the plaintiff's expert witness had raised a material issue of fact regarding the reasonableness of the physician's conclusion that the patient's condition was stable.[156] Finally, in *Howe v. Hull*,[157] an Ohio district court denied summary judgment on a failure-to-stabilize claim because of the disparity between the testimony of the plaintiff's expert witnesses, the defendant's expert witness, and the emergency physician on the issue of whether the patient's condition could reasonably have been considered stable at the time of transfer.[158]

Although the statutory standard of liability applicable to the stabilization requirement may appear similar in many respects to the negligence standard applied in medical malpractice actions, it differs significantly.[159] In some situations a hospital might exercise a *substandard* degree of care when measured against the standard of care other hospitals would employ, and yet incur no liability under EMTALA.[160] For example, a hospital incurs no EMTALA liability for negligently failing to discover the emergency nature of a pa-

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153. *Id.*

154. 895 F. Supp. 875 (S.D. Miss. 1995).

155. *Janes*, 895 F. Supp. at 883.

156. *Id.* at 882–83.

157. 874 F. Supp. 779 (N.D. Ohio 1994).

158. *Howe*, 874 F. Supp. at 786.

159. The Restatement (Second) of Torts provides that statutory liability is the proper standard when a statute establishes a duty that is defined by both legislative enactment and judicial decision, but that requires a jury to determine whether the defendant met the definition under the particular facts. *See* RESTATEMENT (SECOND) OF TORTS § 285 cmt. g, illus. 4 (1977) (providing that act may establish "standard which is partially defined by judicial decision," but that requires determination by jury as to whether standard of conduct was met). Therefore, statutory liability applies to the stabilization element of EMTALA even though the jury determines through expert testimony whether, in reasonable medical probability, no material deterioration was likely to occur.

160. *See, e.g., Cleland*, 917 F.2d at 271 (stressing that compliance with standard of care mandated by EMTALA is determined by evaluating hospital's compliance with own standards, even if those standards are below those generally accepted in medical community); Richmond v. Community Hosp. of Roanoke Valley, 885 F. Supp. 875, 878 (D. Va. 1995) (concluding that EMTALA does not require hospitals to meet any minimum standard of care set by medical community); *Holcomb*, 831 F. Supp. at 835 (holding that EMTALA violation is not established by showing that hospital failed to exercise care in accordance with prevailing medical standards during initial medical screening and treatment).

tient's condition, which would otherwise create a duty to provide further care in the form of stabilization or transfer, provided that the hospital followed uniform screening procedures.[161] Consequently, a hospital may fail to stabilize an emergency medical condition that it negligently failed to discover, and yet incur no EMTALA liability if the hospital performed an appropriate medical screening that did not disclose the condition.[162] Thus, EMTALA imposes liability on a hospital for failing to provide statutorily mandated stabilizing treatment if an emergency medical condition is discovered, rather than for negligently failing to diagnose and treat such a condition.[163]

4. Transfer

In contrast to the objective approach utilized in evaluating the duty under the stabilization provision, the first part of EMTALA's transfer provision incorporates a more mechanical approach. As discussed in Part II of this Article, a hospital may not transfer an unstabilized patient unless: (1) the patient requests a transfer or the hospital completes a certification process attesting that the benefits of the transfer outweigh the risks;[164] and (2) the hospital fol-

161. *See Baber*, 977 F.2d at 880 (concluding that hospital is not liable under EMTALA for failing to properly diagnose patient's condition as long as "appropriate screening" was performed).

162. *See Baby K*, 16 F.3d at 594 (concluding that hospital is not liable under EMTALA for failing to properly diagnose medical condition, and further explaining that hospital only has duty to prevent material deterioration of conditions of which it has knowledge).

163. *See Holcomb*, 831 F. Supp. at 835 (emphasizing that issue in claim for failure to stabilize under EMTALA is whether hospital failed to provide treatment necessary to stabilize condition of which it had knowledge, without regard to whether hospital was negligent in failing to discover emergency nature of condition).

164. The United States Court of Appeals for the Fifth Circuit has indicated that a hospital may violate the technical provisions of the certification process, which requires a determination that the benefits of transfer outweigh the risks, in four ways. *Burditt*, 934 F.2d at 1370. First, the hospital may fail to obtain the required signature on the certificate authorizing the transfer. *Id.*; *see also Baby K*, 16 F.3d at 594 n.5 (concluding that hospital violated transfer provision by failing to procure consent of patient's guardian or obtain certification attesting that benefits of transfer would outweigh risks). Second, evidence may establish that the physician who signed the certificate never actually went through the process of deliberating regarding the risks and benefits of the transfer, but signed the certificate as a mere formality. *See Burditt*, 934 F.2d at 1371 (explaining that physician's signature on certificate of transfer does not establish compliance with certification provision if evidence shows that signature was mere formality and that physician never engaged in any meaningful deliberation with respect to risks and benefits of transfer). Third, even if the

lows the appropriate transfer procedures outlined in § 1395dd(c)(2).[165] In determining whether a hospital has properly executed a certificate authorizing the transfer of an unstabilized patient under the first part of this provision, courts apply a statutory theory of liability similar to that applied to the medical screening requirement.[166] The relevant inquiry is merely whether the transferring physician followed the certification process described in the statute in concluding that the benefits of a transfer outweighed the risks, not whether a reasonable hospital or physician would have arrived at a different decision regarding the advisability of the transfer.[167]

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physician engaged in a risk-benefit analysis before signing the certification, a hospital still violates the transfer provision if the physician considers inappropriate, nonmedical factors in concluding that the transfer is beneficial. *See id.* at 1371 n.10 (concluding that consideration of nonmedical factors, such as attempt to avoid malpractice exposure, violates certification provision). Finally, a hospital violates the certification provision of the statute if the physician signed a certification which purported to conclude that the benefits of the transfer outweighed the risks, when in fact the physician believed the opposite to be true. *Id.* at 1371.

165. *See* 42 U.S.C. §§ 1395dd(c)(1)–(2) (describing restrictions on transfer of patients with unstabilized emergency conditions); *see also Baby K*, 16 F.3d at 594 n.5 (reviewing two-part transfer provision of EMTALA, which requires patient consent or proper certification that benefits outweigh risks, and appropriate transfer procedure); *Janes*, 895 F. Supp. at 883 (noting that in addition to requiring consideration of risks and benefits of transfer, transfer provision outlines specific manner in which transfer must be performed). The transfer provision only applies to the transfer of *unstabilized* patients. *See Correa*, 69 F.3d at 1199 (commenting that transfer provision restricts movement of patients with unstabilized medical conditions); *Baby K*, 16 F.3d at 593 (asserting that EMTALA prohibits transfer of patients *before* hospital stabilizes emergency medical condition). Thus, once a patient's condition has been stabilized, no certification procedure is required. *See Deron*, 879 F. Supp. at 609 n.7 (concluding that physician was not required to sign certification evidencing that risks and benefits of transfer were considered if patient's condition had been stabilized prior to transfer).

166. *Compare Brooks*, 996 F.2d at 713 (explaining that medical screening violation is established by showing that hospital failed to follow express requirements of statute, not by proving that hospital's screening procedure was negligently performed) *with Burditt*, 934 F.2d at 1371 (noting that violation of transfer provision is established by showing that hospital failed to follow process of signing certification of transfer and weighing risks and benefits, not by proving that physician negligently failed to consider factors that another reasonable doctor would have considered).

167. *See Baber*, 977 F.2d at 883 (concluding that hospital compliance with transfer provision only requires consideration of relevant factors and execution of certificate which attests that benefits of transfer outweigh risks); *Burditt*, 934 F.2d at 1371 (explaining that whether reasonable doctor would have employed different factors in evaluating risks and benefits of transfer need not be considered for purposes of EMTALA). As the Fifth Circuit explained in *Burditt*, determining liability for a hospital's procedure in transferring a patient only requires an inquiry into whether the physician signed the certification and

Conversely, the second part of EMTALA's transfer provision, which requires the actual transfer procedure to be "appropriate" as described in § 1395dd(c)(2), returns to a more objective approach in evaluating the applicable duty.[168] Although EMTALA expressly defines the manner in which a transfer should be accomplished, a few courts have employed a reasonableness test, holding that the actual procedure used in transferring an unstabilized patient must be reasonable under the circumstances.[169] For example, one court concluded that because EMTALA expressly requires the use of qualified personnel and transportation equipment when a transfer is effected, a hospital must use personnel and transportation equipment that a reasonable physician would consider appropriate for the safe transport of the patient in question.[170] Thus, while the first part of the transfer provision, addressing the certification process, incorporates a mechanical approach in evaluating the duty applicable under the statute, the second part utilizes a more objective approach. The standard of liability for both parts of the transfer provision, however, remains statutory liability.

B. *Remedies Under EMTALA*

1. Monetary Damages Authorized by State Law

Once a patient establishes liability under a provision of EMTALA, the statute allows for the recovery of monetary damages.[171] The damages provision of EMTALA reads:

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made the proper analysis, not whether the certification was reasonable or whether it was correct in hindsight. *Burditt*, 934 F.2d at 1371.

168. *See* 42 U.S.C. § 1395dd(c)(1)(B) (requiring movement of patient to another medical facility by "appropriate transfer" as defined in § 1395dd(c)(2)).

169. *See, e.g., Burditt*, 934 F.2d at 1371 (holding that EMTALA requires use of personnel and equipment that reasonable physician would utilize to effect transfer); *Janes*, 895 F. Supp. at 883 (adopting reasonableness inquiry regarding appropriateness of transfer method and equipment utilized); Woessner v. Freeport Memorial Hosp., No. 91–C20005, 1993 WL 6983, at *4 (N.D. Ill. Jan. 11, 1993) (holding that equipment used to effect transfer must be reasonable under circumstances).

170. *Burditt*, 934 F.2d at 1372.

171. *See* 42 U.S.C. § 1395dd(d)(2) (1994) (providing that any individual incurring injury as result of hospital's violation of statute may recover monetary damages in accordance with state law); *see also* Power v. Arlington Hosp., 42 F.3d 851, 860 (4th Cir. 1994) (explaining that EMTALA's civil enforcement provision allows for recovery of monetary damages for injuries incurred as result of hospital's violation of statute).

> Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.[172]

In determining the damages available under this provision, the focus must be on state personal injury law.[173] The few courts that have construed this provision have grappled with the issue of whether Congress intended state medical malpractice limits to be included under the personal injury clause.[174] Although EMTALA does not specifically address this issue, most of these courts have applied state laws governing the damages available in medical malpractice claims, including state limitations on such damages.[175] This interpretation seems appropriate in light of the available legislative history. Congress was concerned with the potential for excessive damage awards when it enacted § 1395dd(d)(2)(A), which defers to state provisions governing the recovery of damages in personal injury claims.[176] Though few states limit damages in general personal injury claims,[177] many states have enacted legislation

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172. 42 U.S.C. § 1395dd(d)(2)(A).

173. *See id.* (deferring to state laws governing damages available for personal injury claims).

174. *Compare Power*, 42 F.3d at 862 (reviewing legislative history and concluding that state's medical malpractice damage limitations applied to claims brought pursuant to EMTALA) *with* Cooper v. Gulf Breeze Hosp., 839 F. Supp. 1538, 1543 (N.D. Fla. 1993) (noting Congress's intent not to create malpractice liability under EMTALA, and thus concluding that state limitations imposed on medical malpractice actions do not apply).

175. *See, e.g.*, *Power*, 42 F.3d at 864 (concluding that EMTALA incorporates by reference state limitations on medical malpractice claims); Lane v. Calhoun-Liberty County Hosp., 846 F. Supp. 1543, 1553 (N.D. Fla. 1994) (determining that Florida's substantive law, which limits damages in personal injury claims, applies to EMTALA causes of action); Reid v. Indianapolis Osteopathic Medical Hosp., 709 F. Supp. 853, 855 (S.D. Ind. 1989) (asserting that EMTALA incorporates state damage limitations applicable to both personal injury and medical malpractice claims).

176. *See Power*, 42 F.3d at 862 (reviewing legislative history of EMTALA and noting Congress's concern regarding potential for excessive damage awards under statute); *Reid*, 709 F. Supp. at 855 (noting Congress's awareness of excessive damage awards in medical malpractice claims, and concluding that EMTALA's provision incorporating state law with regard to damages includes state limits applicable to medical malpractice).

177. *See Power*, 42 F.3d at 863 (commenting that few states limit recovery in general personal injury suits).

limiting the amount of damages that can be recovered for noneconomic damages in medical malpractice cases.[178]

Power v. Arlington Hospital[179] is typical of the decisions concluding that state medical malpractice damage caps apply under EMTALA. In *Power*, the United States Court of Appeals for the Fourth Circuit noted that "Congress explicitly directed federal courts to look to state law in the state where the hospital is located to determine both the type and amount of damages available in EMTALA actions."[180] The court explained that the House Committee on the Judiciary was concerned about the impact of excessive damage awards on rural hospitals and the "current medical malpractice crisis."[181] The *Power* court thus concluded that courts must examine the underlying conduct alleged in an EMTALA claim and the legal basis for a challenge to determine whether the claim, "if brought under state law, would be encompassed within the state's personal injury damage limitation, the medical malpractice damages cap, both, or neither."[182] According to the *Power* court, the fact that personal injury and medical malpractice damage caps have different overall purposes than EMTALA is irrelevant because the purposes are not mutually exclusive.[183]

Although most courts, like the *Power* court, have concluded that state law governs the type and amount of monetary damages that can be recovered in an EMTALA claim,[184] at least one court has declined to apply state-law damage limitations to an EMTALA

178. *See* Lynn B. Layne, Casenote, 22 ST. MARY'S L.J. 1155, 1155 (1991) (stating that numerous state legislatures have enacted laws limiting noneconomic damages in medical malpractice cases in response to increasing number of large awards); *see also* Davis v. Omitowoju, 883 F.2d 1155, 1165 (3d Cir. 1989) (reviewing Virgin Islands' medical malpractice damage limit of $250,000, and finding statute constitutional); Fein v. Permanente Medical Group, 695 P.2d 665, 679–80 (Cal. 1985) (upholding constitutionality of California medical malpractice statute, which limits recovery of noneconomic damages to $250,000).

179. 42 F.3d 851 (4th Cir. 1994).

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

181. *Id.* at 862 (quoting H.R. REP. No. 241, 99th Cong., 1st Sess., pt. 3, at 6 (1985)) (internal quotation marks omitted).

182. *Id.* at 863.

183. *Id.* In addition, the court pointed out that federal preemption laws do not apply to the damages section of EMTALA because EMTALA expressly looks to state law for guidance. *Id.* at 864.

184. *See, e.g.*, *Lane*, 846 F. Supp. at 1553 (determining that Florida's wrongful death statute governs damages recoverable by decedent's survivors in claim based on EMTALA violation); Griffith v. Mt. Carmel Medical Ctr., 842 F. Supp. 1359, 1366 (D. Kan. 1994) (holding that state's wrongful death statute governed damages available under plaintiff's

cause of action. In *Cooper v. Gulf Breeze Hospital*,[185] a Florida district court held that while EMTALA "expressly adopts state law limits on personal injury claims, it does not specifically incorporate limits on medical malpractice actions."[186] The court rejected the reasoning in *Reid v. Indianapolis Osteopathic Medical Hospital*,[187] which asserted that Congress implicitly intended to incorporate state malpractice caps in addition to those applicable to personal injury suits.[188] Instead, the *Cooper* court followed the rationale of the district court in *Power*, which the Fourth Circuit ultimately rejected, concluding that state malpractice limits are not applicable because EMTALA expressly incorporates only state law pertaining to personal injury claims.[189] In refusing to incorporate the state medical malpractice limits, the *Cooper* court determined that medical malpractice actions are separate and distinct from EMTALA actions.[190]

2. Equitable Relief—Injunctions

In addition to monetary damages, EMTALA provides that an individual who is harmed by a hospital's violation of the statute may receive "such equitable relief as is appropriate."[191] The few courts addressing this issue have recognized that injunctive relief is proper when necessary to prevent not only continuing injury to a plaintiff, but also subsequent, potential EMTALA violations that may injure others.[192] Thus, a party requesting injunctive relief

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EMTALA claims); *Reid*, 709 F. Supp. at 855 (concluding that EMTALA expressly incorporated Indiana's state law limiting damages in medical malpractice causes of action).

185. 839 F. Supp. 1538 (N.D. Fla. 1993).

186. *Cooper*, 839 F. Supp. at 1542.

187. 709 F. Supp. 853 (S.D. Ind. 1989).

188. *Cooper*, 839 F. Supp. at 1542.

189. *See id.* (approving district court's reasoning in *Power* and determining that medical malpractice actions are separate from EMTALA actions). The district court's conclusion in *Power* regarding the medical malpractice damage cap was overruled by the appellate court. *Power*, 42 F.3d at 861–62.

190. *See Cooper*, 839 F. Supp. at 1542 (explaining that EMTALA and medical malpractice laws tender separate remedies for different wrongs).

191. 42 U.S.C. § 1395dd(d)(2)(A).

192. *See* Jones v. Wake County Hosp. Sys., 786 F. Supp. 538, 545 (E.D.N.C. 1991) (explaining that injunctive relief is available under EMTALA even when hospital's conduct poses no future threat to individual plaintiff); Owens v. Nacogdoches County Hosp. Dist., 741 F. Supp. 1269, 1280–81 (E.D. Tex. 1990) (concluding that although plaintiff seeking injunctive relief must generally show likelihood of future harm, plaintiff seeking such relief under EMTALA need not be in danger of further injury); Maziarka v. Saint Eliza-

need not be in danger of further injury or in need of medical assistance at the time an injunction is requested to have standing to bring the action.[193] In this respect, the elements that a plaintiff must establish to obtain injunctive relief under EMTALA differ from the elements ordinarily required for injunctive relief. Generally, a plaintiff must establish, as one of the elements to an injunction, that irreparable harm will result to the plaintiff if the injunction is not granted.[194] However, if a plaintiff is seeking an injunction to prevent violations of a federal statute such as EMTALA that specifically provides for injunctive relief, it is unnecessary to show irreparable harm.[195]

IV. Instructions and Jury Questions for EMTALA Claims

A. *Jury Instructions*

With the proper standard of liability and appropriate relief in mind, EMTALA litigants should carefully prepare instructions and questions for the jury. Few considerations are as essential to ultimate success at trial as properly formed jury instructions and questions. For EMTALA claims, proper jury instructions should track the definitions provided by the statute itself, and those definitions developed in the courts. A thorough set of instructions should address each provision of the statute separately, and explain the stan-

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beth Hosp., No. CIV.A.88–C–6658, 1989 WL 13195, at *1 (N.D. Ill. Feb. 16, 1989) (refuting defendant's argument, which asserted that plaintiff must establish threat of future injury to have standing to bring claim for injunctive relief under EMTALA).

193. *See Owens*, 741 F. Supp. at 1281–82 (granting injunctive relief based on hospital's "disturbing pattern" of negligent treatment of indigent, pregnant women, even though plaintiff had already received money damages for her injuries).

194. *See* Allied Mktg. Group v. CDL Mktg., 878 F.2d 806, 809 (5th Cir. 1989) (reciting factors necessary for moving party to prove entitlement to injunction, including element of substantial threat of irreparable injury if no injunction is granted); Sun Oil Co. v. Whitaker, 424 S.W.2d 216, 218 (Tex. 1968) (asserting that to prove right to injunction, plaintiff must submit evidence establishing probable right of recovery at trial and irreparable harm to plaintiff absent injunction).

195. *See Maziarka*, 1989 WL 13195, at *1 (concluding that plaintiff had standing to pursue injunction against hospital, not because of threat of continuing injury to plaintiff, but because EMTALA expressly grants remedy to any plaintiff who has been harmed by defendant in violation of statute); *see also* EEOC v. Cosmair, Inc., 821 F.2d 1085, 1090–91 (5th Cir. 1987) (finding that requirements of "irreparable injury" and "inadequate legal remedies" need not be satisfied to enjoin violation of statute specifically providing injunctive relief).

dard of conduct applicable to each. Further, the instructions should carefully explain that liability under the statute does not require a violation of *all* of EMTALA's provisions. For example, the following instruction, submitted by an Oklahoma district court, was deemed erroneous because it conditioned a finding of liability on a combination of provisions and failed to recognize that a hospital may be liable for conduct that violates only one, and not two or more, of the statute's provisions. Specifically, the incorrect portion of the instruction stated:

> If you find that the Hospital did not provide an appropriate medical screening examination *and* that Eileen Pruitt was *negligently* discharged at a time she was in an unstable condition, then you must find in favor of plaintiffs.
>
> However, if you find that the Hospital provided an appropriate emergency screening examination for Eileen Pruitt, and did not discharge her in an unstable condition, then you must find in favor of the hospital . . . .[196]

On appeal from a verdict for the defendants, the court held that this portion of the instructions was incorrect.[197] According to the court, the disjunctive "or" should have been utilized instead of the conjunctive "and" because a violation of either the screening or the stabilization requirement of EMTALA should have resulted in a verdict for the plaintiffs.[198] The court also rejected the use of the word "negligently."[199]

A partial example of proper jury instructions is found in a case from the United States District Court for the Northern District of Florida concerning a suit alleging that the defendant hospital failed to adequately screen and stabilize the plaintiff:

> To prove his claim and establish the Defendant violated this provision of the Act, the Plaintiff must prove the following facts by a preponderance of the evidence:
>
> *First:* That the Plaintiff had an emergency medical condition;

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196. Abercrombie v. Osteopathic Hosp. Founders Ass'n, 950 F.2d 676, 683 (10th Cir. 1991) (emphasis added).

197. *Id.* at 680.

198. *Id.*

199. *See id.* at 681–82 (noting that term "negligently" is not included in statute providing for civil enforcement by person who has suffered personal harm resulting from hospital's violation under EMTALA).

> *Second:* That the Defendant had actual knowledge of the medical condition;
>
> *Third:* That the Plaintiff was not in stable condition at the time he was discharged; and
>
> *Fourth:* That the Defendant had actual knowledge the Plaintiff was not in stable condition at the time of his discharge.
>
> A hospital is liable under the Act only if it had actual knowledge that the patient suffered from an emergency medical condition at the time of discharge and that the patient's condition was not stable. It is not enough that the hospital should have known that the patient had an emergency medical condition which was not diagnosed. Neither is it sufficient that the hospital should have known the patient's condition was unstable at the time he was discharged. Instead, the Plaintiff must prove the hospital (1) in fact knew about the emergency medical condition; and (2) in fact knew the patient was not stable from the symptoms of that condition at the time he was discharged.[200]

These instructions correctly track the statute and the case law interpreting EMTALA by requiring that the hospital have actual knowledge of the plaintiff's emergency medical condition before liability may be imposed.[201] However, because EMTALA does not require actual knowledge of the patient's stability at discharge,[202] the second element of proof in the last sentence of the instructions is unnecessary.

In addition to proper instructions on the elements of the plaintiff's claim, the jury should receive definitions for the statutory terms "emergency medical condition," "appropriate medical screening," "to stabilize," "transfer," and "appropriate transfer." With the exception of the phrase "appropriate medical screening," the definitions provided in EMTALA may be utilized when instructing the jury.[203] Although not statutorily defined, the phrase

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200. Instructions to the Jury, Cooper v. Gulf Breeze Hosp., 839 F. Supp. 1538, 1541 (N.D. Fla. 1995) (No. 93-30507-LAC) (on file with the *St. Mary's Law Journal*).

201. *See* Baber v. Hospital Corp. of Am., 977 F.2d 872, 883 (4th Cir. 1992) (holding that hospital must have actual knowledge of emergency medical condition before EMTALA imposes liability for unlawful transfer or failure to stabilize).

202. *See id.* (discussing actual knowledge requirement).

203. *See* 42 U.S.C. § 1395dd(e) (1994) (providing definitions for many terms used in statute).

"appropriate medical screening" has been clarified by case law,[204] and this Article proposes the following instruction:

> "Appropriate medical screening" means that *DEFENDANT HOSPITAL* followed its standard screening policies and procedures on *DATE* with respect to *PLAINTIFF PATIENT*. You are further instructed that a minimal deviation from *DEFENDANT HOSPITAL*'s screening procedure does not amount to a policy violation or "inappropriate" medical screening. Further, a finding that *DEFENDANT HOSPITAL* failed to provide an appropriate medical screening may not be based upon the fact that *PLAINTIFF PATIENT* suffered a bad result.

B. *Jury Questions*

While proper instructions are important to give the jury an adequate understanding of EMTALA's unique terms and requirements, well-drafted jury questions play an even more important role in ensuring that the judgment ultimately rendered is based on a correct interpretation of the statute's requirements. Drafting thorough jury questions presents a particularly unique challenge in an EMTALA cause of action because of the variety of duties created by the statute. Thus, in addition to making sure that each submitted question is in the correct form, the practitioner must also formulate the questions in a manner calculated to address all of the statutory elements implicated in the case. The following discussion analyzes the few jury questions that have been submitted in actual EMTALA cases, and offers a sample set of questions drafted to address most elements likely to arise in an EMTALA cause of action.

1. Previously Submitted Questions

Because the majority of reported cases brought pursuant to EMTALA have been determined by summary judgment or dismissal,

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204. *See, e.g.*, Repp v. Anadarko Mun. Hosp., 43 F.3d 519, 522 (10th Cir. 1994) (limiting scope of medical screening inquiry to whether hospital followed its own standard procedures); Brooks v. Maryland Gen. Hosp., 996 F.2d 708, 710 (4th Cir. 1993) (asserting that level of care employed during medical screening is measured in accordance with hospital's own customary procedures); Gatewood v. Washington Healthcare, 933 F.2d 1037, 1041 (D.C. Cir. 1991) (explaining that appropriateness of medical screening is determined by examining hospital's own screening procedures).

very few cases have proceeded to a jury verdict.[205] Of the few reported cases in which the summary judgments or dismissals were reversed and the cases were remanded, most were settled prior to trial.[206] Consequently, only a scant number of previously submitted jury questions are available as examples.

One example can be found in *Power v. Arlington Hospital*,[207] in which the court submitted two questions to the jury after numerous instructions, the first question pertaining to EMTALA's medical screening requirement, and the second addressing an improper transfer. With regard to the medical screening claim, the court submitted the following question:

> Do you find from a preponderance of the evidence that
> (1) Arlington Hospital did not provide an appropriate medical screening examination on or about February 24, 1990, and
> (2) this failure to do so was the proximate cause of Ms. Power's damages?[208]

Addressing the plaintiff's second claim, which alleged improper transfer, the court submitted the following question to the jury:

> Do you find from a preponderance of the evidence that
> (1) Ms. Power had an emergency medical condition on July 1, 1990,

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205. *See, e.g.*, Baber v. Hospital Corp. of Am., 977 F.2d 872, 874 (4th Cir. 1992) (affirming summary judgment for hospital on EMTALA claim); Collins v. DePaul Hosp., 963 F.2d 303, 304, 308 (10th Cir. 1992) (affirming summary judgment for hospital based on EMTALA's medical screening requirement); Cleland v. Bronson Health Care Group, 917 F.2d 266, 272 (6th Cir. 1990) (affirming dismissal of failure-to-screen-and-stabilize claim).

206. *See* Telephone Interview with Jeannette Andrews, Attorney, Fuller, Johnson & Farrell, P.A. (May 20, 1996) (discussing pretrial settlement on remand after court's reversal in Lane v. Calhoun-Liberty County Hospital Ass'n, 846 F. Supp. 1543 (N.D. Fla. 1994)); Telephone Interview with John Denson, II, Attorney, Samford, Denson, Horsley, Pettey & Martin (May 20, 1996) (recalling that, following court's reversal in Huckaby v. East Alabama Medical Center, 830 F. Supp. 1399 (M.D. Ala. 1993), case settled prior to trial); Telephone Interview with R. Max Humphreys, Attorney, Carson & Coil, P.C. (May 21, 1996) (commenting on representation of defendants in Helton v. Phelps County Regional Medical Center, 817 F. Supp. 789 (E.D. Mo. 1993), and stating that case settled prior to trial on remand).

207. 800 F. Supp 1384 (E.D. Va. 1992).

208. Jury Charge at 743, Power v. Arlington Hosp., 800 F. Supp. 1384 (E.D. Va. 1992) (No. 92–0005–A), *aff'd in part, rev'd in part*, 42 F.3d 851 (4th Cir. 1994) (on file with the *St. Mary's Law Journal*). The jury questions from the *Power* case, as they appear in this Article, have been summarized from the trial court transcript. The format of the questions excerpted has been slightly altered to present them in a manner consistent with other sample instructions and questions presented in this Article.

(2) the hospital, knowing of this condition, did not stabilize the emergency medical condition before transferring her to Central Middlesex Hospital,
(3) no written consent to transfer her to another medical facility was given, either by Ms. Power herself or a legally responsible individual acting on her behalf,
(4) no physician's certification summarizing the risks and benefits was given,
(5) transfer was not an appropriate transfer as defined by the federal statute, and
(6) transfer was the proximate cause of Ms. Power's personal injuries?[209]

The improper-transfer question submitted in the *Power* case is inadequate because it fails to make a meaningful distinction between EMTALA's stabilization and transfer requirements. The question fails to acknowledge that a hospital complies with the statute if it stabilizes the patient's emergency condition *or* provides for an appropriate transfer. The following question would have appropriately allowed the jury to distinguish between stabilization and transfer:

Do you find from a preponderance of the evidence that
(1) Ms. Power had an emergency medical condition on July 1, 1990,
(2) the hospital, knowing of this condition, did not
  (a) stabilize the emergency medical condition before transferring her to Central Middlesex Hospital, *or*
  (b) provide a lawful transfer by
    (i) obtaining a written consent for the transfer from either Ms. Powell herself or a legally responsible individual acting on her behalf, or through a physician's certification summarizing the risks and benefits; *and*
    (ii) effecting an "appropriate transfer" as defined in the jury instructions given to you, and
(3) the lack of stabilization or inappropriate transfer, if any, was the proximate cause of Ms. Power's personal injuries?

This revised version of the jury question in *Power* more accurately parallels the EMTALA statute.

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209. *See id.* (submitting question to jury regarding plaintiff's claim of improper transfer).

A more complete example of appropriate jury questions may be found in *Griffith v. Mt. Carmel Medical Center*,[210] in which the following five questions were posed to the jury:

(1a) Do you find by a preponderance of the evidence that Mount Carmel Medical Center failed to provide an appropriate medical screening examination within the capabilities of its emergency department to determine whether Jimmy R. Griffith, Jr. had an emergency medical condition on May 10, 1991?

(1b) If your answer to question # 1a is "No," then you must skip this question and proceed to question # 2a. If your answer to question # 1a is "yes," then you must also answer the following question: Do you find by a preponderance of the evidence that Mount Carmel Medical Center's failure to provide Jimmy R. Griffith, Jr. an appropriate medical screening examination on May 10, 1991 directly resulted in Jimmy R, Griffith's death?

(2a) Do you find by a preponderance of the evidence that Mount Carmel Medical Center determined that Jimmy R. Griffith, Jr. had an emergency medical condition on May 10, 1991?

(2b) If your answer to question # 2a is "No," then you must skip this question and proceed to question # 3a. If your answer to question # 2a is "yes," then you must also answer the following question: Do you find by a preponderance of the evidence that Mount Carmel Medical Center discharged Jimmy R. Griffith on May 10, 1991 without providing him such further medical examination and treatment as was necessary to stabilize his emergency medical condition?

(2c) If your answer to question # 2b is "No," then you must skip this question and proceed to question # 3a. If your answer to question # 2b is "yes," then you must also answer the following question: Do you find by a preponderance of the evidence that Mount Carmel Medical Center's failure to provide stabilizing medical treatment prior to discharging Jimmy R. Griffith, Jr. on May 10, 1991 directly resulted in Jimmy R. Griffith's death?[211]

These jury questions accurately reflect the theories of liability under EMTALA and the case law interpreting EMTALA. At the trial in *Griffith*, these questions were preceded by a number of in-

210. 831 F. Supp. 1532 (D. Kan. 1993).

211. Verdict at 6, Griffith v. Mt. Carmel Medical Ctr., 831 F. Supp. 1532 (D. Kan. 1993) (No. 92-1141-MLB) (on file with the *St. Mary's Law Journal*).

structions that paraphrased the EMTALA statute and defined the terms in the statute.[212]

2. Proposed Questions for EMTALA Claims

In determining whether an EMTALA violation has occurred, juries are asked to evaluate a hospital's conduct in relation to the duties imposed by one or more of the statute's three main provisions: medical screening, stabilization, and transfer. The legal issues involved in each case, as raised by the plaintiff's pleadings, dictate which provision(s) the jury must consider. The jury questions cited above, although appropriate for the cases in which they were submitted, addressed only the provisions pertinent to the underlying litigation. The following proposed jury questions are designed to address all three provisions separately, incorporating the appropriate portions of questions presented in the actual cases. The practitioner must determine which questions are proper based on the facts of the case. These proposed questions include examples in broad-form submission and, alternatively, detailed questions drafted to address each section of the statute.

a. Broad-Form Submission

Texas law requires, whenever feasible, a broad-form submission of jury questions.[213] An appropriate broad-form submission should include the following question:

> Do you find from a preponderance of the evidence that *DEFENDANT HOSPITAL's* violation, if any, of the Emergency Medical Treatment and Active Labor Act directly resulted in injury to *PLAINTIFF PATIENT*?
>
> We do _____ We do not _____

Additionally, the jury should be instructed on the statutory definitions of "emergency medical condition," "to stabilize," "transfer," and "appropriate transfer," and the previously proposed definition of "appropriate medical screening." These definitions will assist

212. *See* Instructions to the Jury, Griffith v. Mt. Carmel Medical Ctr., 831 F. Supp. 1532 (D. Kan. 1993) (No. 92-1141-MLB) (on file with the *St. Mary's Law Journal*) (describing standard of care applicable to plaintiff's EMTALA claim).

213. TEX. R. CIV. P. 277; *see* Texas Dep't of Human Servs. v. E.B., 802 S.W.2d 647, 649 (Tex. 1990) (interpreting phrase "whenever feasible" as mandating broad-form submission whenever possible).

the jury in understanding whether a "violation" has occurred, which should be defined as follows:

> "Violation" means that on *DATE*, *DEFENDANT HOSPITAL* failed to provide *PLAINTIFF PATIENT* an appropriate medical screening to determine whether an emergency medical condition existed, or that *DEFENDANT HOSPITAL*, knowing that *PLAINTIFF PATIENT* had an emergency medical condition, transferred *PLAINTIFF PATIENT* in an unstable condition and the transfer was not an appropriate transfer.

The jury should then receive a question and instructions regarding the amount of damages available under EMTALA and the applicable state's law.[214]

b. Alternatives to Broad-Form Submission

If a broad-form submission is not appropriate, the following alternative questions may be used to address violations of specific provisions of EMTALA.

i. Appropriate Medical Screening

A jury question regarding an allegation that a hospital failed to appropriately screen an individual should read as follows:

(1) Did *PLAINTIFF PATIENT* come to *DEFENDANT HOSPITAL*'s emergency department?
(2) If the answer to #1 is yes, did *PLAINTIFF PATIENT* have an emergency medical condition upon arrival at the emergency department?

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214. If the plaintiff sues the hospital for an EMTALA violation and pursues a negligence or medical malpractice claim against the treating physicians, definitions of "negligence" for each defendant should be included in the charge and the following comparative responsibility question is appropriate:

For each person found by you to have caused the injury in question, find the percentage of responsibility of those named below.

"Percentage of responsibility" means that percentage attributed to those named below with respect to causing or contributing to cause in any way the personal injury for which recovery of damages is sought.

Dr. A.	_____
Dr. B.	_____
Defendant Hospital	_____
Plaintiff	_____
TOTAL	100%

See 3 TEXAS PATTERN JURY CHARGES § 51.06 (1994) (providing form of jury question in medical malpractice cases involving negligence of multiple parties).

(3) If the answer to #2 is yes, did *DEFENDANT HOSPITAL* fail to provide an appropriate screening within the capabilities of its emergency department to determine whether *PLAINTIFF PATIENT* had an emergency medical condition?
(4) If the answer to #3 is yes, did *PLAINTIFF PATIENT* suffer damages as a direct result of this failure to provide an appropriate screening?

ii. Failure to Stabilize

A jury question regarding an allegation that a hospital failed to stabilize an individual should read:

(1) Did *PLAINTIFF PATIENT* have an emergency medical condition?
(2) If the answer to #1 is yes, did *DEFENDANT HOSPITAL* have actual knowledge of *PLAINTIFF PATIENT*'s emergency medical condition?
(3) If the answer to #2 is yes, did *DEFENDANT HOSPITAL* fail to provide such further medical treatment as was necessary to stabilize *PLAINTIFF PATIENT*'s emergency medical condition?
(4) If the answer to #3 is yes, did *PLAINTIFF PATIENT* suffer damages as a direct result of this failure to stabilize?

iii. Improper Transfer

The following is an example of an appropriate jury question concerning an allegation of improper transfer:

(1) Did *PLAINTIFF PATIENT* have an emergency medical condition?
(2) If the answer to #1 is yes, did *DEFENDANT HOSPITAL* have actual knowledge of *PLAINTIFF PATIENT*'s emergency medical condition?
(3) If the answer to #2 is yes, did *DEFENDANT HOSPITAL* obtain the proper consent or follow the appropriate certification or transfer procedures in transferring *PLAINTIFF PATIENT*?
(4) If the answer to #3 is no, did this failure directly result in damages to *PLAINTIFF PATIENT*?

The preceding questions are designed to focus the jury's attention on the unique duties of care pertinent to an EMTALA cause of action. Although Congress did not intend for EMTALA to encompass causes of action traditionally addressed by state medical

malpractice and negligence laws, parties filing suit under the statute often assert arguments interjecting such standards of liability.[215] Unless properly instructed, jurors are likely to make the same error. Consequently, it is particularly important for a party defending an EMTALA suit to draft jury questions and instructions that properly outline and define each duty created by the statute. In so doing, the parties will ensure, to the greatest extent possible, that the jury renders a verdict predicated on the proper considerations.

V. CONCLUSION

Congress enacted EMTALA to address the specific problem of patient "dumping," meaning the discharge of patients with unstabilized emergency medical conditions. In furtherance of this narrow objective, EMTALA imposes on hospitals certain duties regarding the treatment of patients in need of emergency medical care. Although the terms of the statute appear to clearly establish the extent of a hospital's duty, both courts and attorneys frequently misconstrue the duties and standards of liability imposed by EMTALA, incorrectly applying medical malpractice or negligence standards of liability to determine whether a violation has occurred.

Consequently, attorneys litigating EMTALA cases must have a clear understanding of the nature and application of every provision in the statute to provide proper representation for their clients. A hospital's conduct must be evaluated based on the specific duty of care associated with each provision of the statute. For example, a hospital's duty to perform an appropriate medical screening requires a subjective analysis that focuses on procedure. In contrast, a determination of whether a hospital has breached the

215. *See, e.g.*, Eberhardt v. City of Los Angeles, 62 F.3d 1253, 1257 (9th Cir. 1995) (refuting plaintiff's contention that hospital violated EMTALA for failing to treat condition of which it should have had knowledge, because statute does not incorporate objective standard of conduct used in negligence causes of action); Urban v. King, 43 F.3d 523, 526–27 (10th Cir. 1994) (declining plaintiff's invitation to implicitly incorporate state malpractice law by holding hospital liable under EMTALA for failing to discover medical emergency condition); Repp v. Anadarko Mun. Hosp., 43 F.3d 519, 522 (10th Cir. 1994) (disagreeing with plaintiff's argument seeking to incorporate minimal standard of care regarding medical screening because such standard would improperly "convert EMTALA into a national malpractice statute").

duty to stabilize a patient's condition prior to transfer utilizes a more objective standard, which focuses on whether deterioration of the patient's condition was likely to occur within reasonable medical probability.

Due to the unique and varied provisions contained in the statute, attorneys must strive to focus the courts' attention on the language in EMTALA's express provisions. Though plaintiffs often seek to interject standards of liability based on negligence or medical malpractice, Congress did not intend for EMTALA to address injuries already redressed by state law. Drafting accurate jury questions and instructions is an effective, if not essential, method of ensuring that EMTALA is not extended beyond its intended scope.