

## EMTALA: Protecting Patients First by Not Deferring to the Final Regulations

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## I. INTRODUCTION

Terry Takewell died in his home on September 17, 1986 after a hospital administrator dumped him in the parking lot outside of Methodist Hospital in Somerville, Tennessee.<sup>1</sup> Mr. Takewell had suffered from diabetes for several years.<sup>2</sup> The day before he died, Mr. Takewell's neighbors found him suffering from acute ketoacidosis.<sup>3</sup> His neighbor, Mrs. Zettie Mae, sent Mr. Takewell to his doctor, who then ordered him to go to the emergency room immediately.<sup>4</sup> Mr. Takewell arrived at the hospital by ambulance.<sup>5</sup> Later that day, a hospital administrator came to Mr. Takewell's bedside, picked him up in his

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<sup>1</sup> House Subcomm. on Human Resources & Intergovernmental Relations, Equal Access to Health Care: Patient Dumping: Hearing on H.R. REP. NO. 531 Before the House Subcommittee on Human Resources & Intergovernmental Relations, 100th Cong., 2d. Sess. 11 (1988) (statement of Zettie Mae).

<sup>2</sup> *Id.*

<sup>3</sup> *Id.* Ketoacidosis is a complication of diabetes caused by the buildup of ketones, which are by-products of fat breakdown. Medline Plus, *Diabetic Ketoacidosis* (2006), <http://www.nlm.nih.gov/medlineplus/ency/article/000320.htm> (last visited Oct. 27, 2007).

<sup>4</sup> *Id.*

<sup>5</sup> *Id.*

arms, carried him out of bed, and walked him out of the hospital.<sup>6</sup> The administrator left Mr. Takewell in the parking lot without shirt or shoes.<sup>7</sup>

During Mrs. Zettie Mae's testimony at the House Subcommittee on Human Resources and Intergovernmental Relations hearing, she stated that Mr. Takewell told her that the hospital refused him care because he had no health insurance and because he still owed the hospital for previous medical treatment.<sup>8</sup> A community organization in Tennessee later filed a Consolidated Omnibus Budget Reconciliation Act ("COBRA") complaint with the Centers for Medicare and Medicaid Services ("CMS") against Methodist hospital.<sup>9</sup> The Tennessee State Board of Licensure investigated the situation, and found the hospital in compliance with state and federal law.<sup>10</sup> The Board did not even threaten the hospital with the slightest sanction that it could apply.<sup>11</sup>

American common law historically did not provide patients like Mr. Takewell with a legal right to medical treatment, and likewise did not impose on hospitals an obligation to provide treatment.<sup>12</sup> This lack of a legal duty, however, when combined with the rising costs of medical care, resulted in "patient dumping."<sup>13</sup> In particular, "[t]he act of patient dumping occurs when patients [who seek care] in an emergency department are denied emergency medical care or stabilizing treatment based on economic or noneconomic grounds, such as race, ethnicity, sexual orientation, or contraction of a socially unacceptable disease."<sup>14</sup> Simply put, patient dumping is the act of refusing medical treatment to patients who are unable to afford it.

Prior to the 1986 passage of the Emergency Medical Treatment and Active Labor Act ("EMTALA"),<sup>15</sup> many reports detailed the frequency

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<sup>6</sup> House Subcomm. on Human Resources & Intergovernmental Relations, Equal Access to Health Care: Patient Dumping: Hearing on H.R. REP. NO. 531 Before the House Subcommittee on Human Resources & Intergovernmental Relations, 100th Cong., 2d. Sess. 11 (1988) (statement of Zettie Mae).

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> *Hardy v. New York City Health & Hosp. Corp.*, 164 F.3d 789, 792–93 (2d Cir. 1999) ("EMTALA was enacted to fill a lacuna in traditional state tort law by imposing on hospitals a legal duty (that the common law did not recognize) to provide emergency care to all.").

<sup>13</sup> *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1039 (D.C. Cir. 1991).

<sup>14</sup> Thomas A. Gionis, Carlos A. Camargo, Jr. & Anthony S. Zito, Jr., *The Intentional Tort of Patient Dumping: A New State Cause of Action to Address the Shortcomings of the Federal Emergency Medical Treatment and Active Labor Act (EMTALA)*, 52 AM. U. L. REV. 173, 175–76 (2002).

<sup>15</sup> 42 U.S.C. § 1395dd, P.L. 109–208 (2000).

and effects of patient dumping. One report found that almost eighty-seven percent of hospitals that transferred patients admitted that the patient's lack of health insurance was the only motivation for transfer.<sup>16</sup> Another report showed that more than seventy-two percent of transferred patients required emergency medical treatment at the receiving hospital.<sup>17</sup> Hospitals would refuse to treat patients who could not provide proof of insurance or an alternative method of payment.<sup>18</sup> Thus, hospitals were denying care to indigent patients or were transferring patients to another health care facility, oftentimes resulting in worsened medical conditions, or, as in Mr. Takewell's case, even death.<sup>19</sup>

In response to the perceived crisis of patient dumping, Congress passed EMTALA in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act.<sup>20</sup> EMTALA is far-reaching legislation that requires all hospitals that receive federal monies, generally through their Medicare and Medicaid programs, to provide some limited care to every patient who seeks treatment in the emergency department.<sup>21</sup> EMTALA applies to any person seeking emergency treatment in a hospital, but its foremost impact is on people with little or no health insurance who could otherwise not afford health care.<sup>22</sup> Although Congress intended to alleviate the problem of patient dumping through its passage of EMTALA, interpretation of the statute has created splits in the courts of appeals.

Unfortunately, Congress, at times, used vague statutory language when drafting EMTALA,<sup>23</sup> causing courts to diverge in their interpretations of the statute.<sup>24</sup> In particular, the circuits are split over three issues. First, the circuits are split over what constitutes an adequate medical screening; the First and Ninth Circuits require an objectively

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<sup>16</sup> *Arrington v. Wong*, 237 F.3d 1066, 1074 (9th Cir. 2001) (citing Karen I. Treiger, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. REV. 1186, 1190-91) (1986)).

<sup>17</sup> *Id.*

<sup>18</sup> See Michael J. Frank, *Tailoring EMTALA to Better Protect the Indigent: The Supreme Court Precludes One Method of Salvaging a Statute Gone Awry*, 3 DEPAUL J. HEALTH CARE L. 195, 195-96 (2000).

<sup>19</sup> *Id.*

<sup>20</sup> *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1039 (D.C. Cir. 1991).

<sup>21</sup> Kristine Marie Meece, *The Future of Emergency Department Liability After the Ravenswood Hospital Incident: Redefining the Duty to Treat?*, 3 DEPAUL J. HEALTH CARE L. 101, 103-04 (1999).

<sup>22</sup> *Cooper v. Gulf Breeze Hosp., Inc.*, 839 F. Supp. 1538, 1540-41 (N.D. Fla. 1993).

<sup>23</sup> For example, the statute entitles "any individual" to an "appropriate" medical screening examination. 42 U.S.C. § 1395dd(a) (2000).

<sup>24</sup> Caroline J. Stalker, Comment, *How Far is Too Far? EMTALA Moves From the Emergency Room to Off-Campus Entities*, 36 WAKE FOREST L. REV. 823, 829 (2001).

reasonable standard,<sup>25</sup> while the Sixth, Eighth, Tenth, Eleventh and D.C. Circuits hold hospitals to a subjectively reasonable, or nondisparate treatment standard.<sup>26</sup> Second, the circuits are split over whether EMTALA's provisions apply after a hospital initially stabilizes a patient and later admits the patient to the hospital;<sup>27</sup> the Sixth Circuit holds that EMTALA still applies after initial stabilization,<sup>28</sup> while the Ninth Circuit holds that a hospital's EMTALA obligations end upon admittance as an in-patient.<sup>29</sup> Third, the circuits are split over how to interpret EMTALA's requirements.<sup>30</sup> The Fourth, Ninth, and Eleventh Circuits follow the conjunctive approach, by treating the statute's three provisions as interdependent and sequential requirements,<sup>31</sup> while the First Circuit follows the disjunctive approach, interpreting EMTALA as creating two distinct causes of action: one for the medical screening requirement and another for the stabilization requirement.<sup>32</sup> To clarify issues surrounding EMTALA, the Department of Health and Human Services, now referred to as the CMS, promulgated interpretative regulations, coined "the Final Regulations" in 2003.<sup>33</sup> The Final Regulations succeed in resolving some divisive issues among the circuits, but leave open for debate several other pertinent EMTALA issues.

The Final Regulations address three important issues over which the circuits have split.<sup>34</sup> First, the Final Regulations appear to promote a subjective standard for the medical screening requirement, dependent on each individual patient's condition.<sup>35</sup> Second, the Final Regulations clearly state that "a hospital's obligations under EMTALA end once an

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<sup>25</sup> See *Correa v. Hosp. San Francisco*, 69 F.3d 1184, 1193 (1st Cir. 1995); *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1257 (9th Cir. 1995).

<sup>26</sup> See Brian E. Kamoie, *EMTALA: Reaching Beyond the Emergency Room to Expand Hospital Liability*, 33 J. HEALTH L. 25, 37 (2000).

<sup>27</sup> Dana E. Schaffner, Note, *EMTALA: All Bark and No Bite*, 2005 U. ILL. L. REV. 1021, 1032 (2005).

<sup>28</sup> See *Thornton v. Sw. Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990).

<sup>29</sup> See *Bryant v. Adventist Health Sys. West*, 289 F.3d 1162, 1167 (9th Cir. 2002).

<sup>30</sup> See *Gionis*, *supra* note 14, at 264.

<sup>31</sup> *Id.*

<sup>32</sup> *Id.*

<sup>33</sup> See Medicare Program, Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical Conditions, 68 Fed. Reg. 53222, 53222 (Sept. 9, 2003) (codified at 42 C.F.R. Parts 413, 482, and 489).

<sup>34</sup> *Id.*

<sup>35</sup> See *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (6th Cir. 1990) (adopting a subjective, non-disparate treatment standard); see also *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996); *Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519, 522 (10th Cir. 1994); *Harry v. Marchant*, 291 F.3d 767 (11th Cir. 2002); *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991).

individual is admitted for inpatient care.”<sup>36</sup> Third, the Final Regulations address the conjunctive versus disjunctive issue by asserting that EMTALA liability is triggered in one of two ways: (1) “The individual can present at the hospital’s dedicated emergency department and request examination or treatment for a *medical condition*,”<sup>37</sup> or (2) “the individual can present elsewhere on hospital property (that is, at a location that is on hospital property but is not part of a dedicated emergency department), and request examination or treatment for an *emergency medical condition*.”<sup>38</sup> Therefore, the Regulations can be interpreted to support both the conjunctive and disjunctive approaches. These interpretations beg the question of whether the circuit courts must give deference to the Final Regulations.

Despite the release of the Final Regulations, courts will still face issues of statutory interpretation regarding EMTALA, and in such cases, courts will be guided by the Supreme Court’s decision in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*<sup>39</sup> First, a court must ask “whether Congress has directly spoken to the precise question at issue.”<sup>40</sup> If Congress has spoken directly to the issue, “the court gives effect to the statute’s plain meaning, obviating any need to decide whether or not to defer to an administrative agency’s interpretation.”<sup>41</sup> A court need not give deference to an agency’s interpretation if Congress’ intent is entirely clear.<sup>42</sup> However, if “the court determines Congress has not directly addressed the precise question at issue,” the court must ask “whether the agency’s answer is based on a permissible construction of the statute.”<sup>43</sup> Where Congress’ intent is not entirely clear, a court must defer to an agency’s statutory interpretation that is permissible.<sup>44</sup>

The Regulations articulate a subjective standard, requiring that a medical screening be “provided to each individual commensurate with the condition that is presented.”<sup>45</sup> Because the Regulations articulate a

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<sup>36</sup> See Medicare Program, Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical Conditions, 68 Fed. Reg. 53222, 53247 (Sept. 9, 2003) (codified at 42 C.F.R. Parts 413, 482, and 489).

<sup>37</sup> *Id.* at 53243 (emphasis added).

<sup>38</sup> *Id.* (emphasis added).

<sup>39</sup> 467 U.S. 837 (1984).

<sup>40</sup> *Id.* at 842.

<sup>41</sup> Rebecca Hanner White, *Deference and Disability Discrimination*, 99 MICH. L. REV. 532, 541 (2000).

<sup>42</sup> *Id.* at 542.

<sup>43</sup> *Id.* at 587.

<sup>44</sup> *Id.*

<sup>45</sup> See Medicare Program, Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical

subjective, nondisparate medical screening requirement, an interpretation clearly in line with Congress' intent, the Regulations deserve *Chevron* deference. Moreover, because Congress' intent is clear as to protecting patients even after a doctor initially stabilizes and admits them, courts need not accord *Chevron* deference to the Regulations as far as they limit liability under EMTALA when a hospital admits a patient as an inpatient. Finally, because EMTALA's plain language and its legislative history both clearly reflect Congress' intent, courts should not afford *Chevron* deference to the Regulations, insofar as the Regulations construe EMTALA liability conjunctively and require that a patient who presents on hospital property apart from a dedicated emergency department "request examination or treatment for an *emergency medical condition*"<sup>46</sup> in order for EMTALA protection to attach.

This comment argues that the Final Regulations to EMTALA do little to clarify hospitals' obligations under the statute, but instead leave circuits to analyze the Regulation's applicability under *Chevron*. Furthermore, because Congress' intent as to EMTALA was clear, this comment argues that courts need not give deference to the Final Regulations. Part II considers first EMTALA's background and legislative history, in order to elucidate Congress' intent in passing the statute. It next examines the judicial ambiguity that has surrounded the statute since its inception in 1986. In particular, it focuses on three divisive issues over which the circuits have been split. It also examines the Final Regulations promulgated by the CMS in 2003 and the Regulations' effect on the judicial splits. Part III examines how the circuits should interpret the Final Regulations, following a *Chevron* analysis of the Regulations' applicability. Part IV concludes that Congress enacted EMTALA with the clear purpose of preventing hospitals from denying emergency medical treatment to under- and uninsured patients because of their inability to pay. To further this purpose, courts should give *Chevron* deference to the Final Regulations in certain circumstances, while in other instances, *Chevron* deference clearly would be inappropriate.

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Conditions, 68 Fed. Reg. 53222, 53236 (Sept. 9, 2003) (codified at 42 C.F.R. Parts 413, 482, and 489).

<sup>46</sup> *Id.* at 53243 (emphasis in original).

## II. BACKGROUND

## A. EMTALA's Legislative History

Congress enacted EMTALA “in response to a growing concern about ‘the provision of adequate emergency room medical services to individuals who seek care . . . .’”<sup>47</sup> In particular, Congress was concerned “about the increasing number of reports that hospital emergency rooms [were] refusing to accept or treat patients with emergency conditions if the patient [did] not have medical insurance.”<sup>48</sup> Patient dumping resulted in inadequate or nonexistent treatment that ultimately led to an increase in morbidity and mortality rates.<sup>49</sup>

Furthermore, “[i]t is undisputed that the impetus to [EMTALA] came from highly publicized incidents where hospital emergency rooms allegedly . . . failed to provide a medical screening that would have been provided a paying patient . . . .”<sup>50</sup> Congress’ purpose for passing EMTALA was clear, in that it sought to prevent hospitals from turning away without treatment patients with emergency conditions because of their inability to pay.<sup>51</sup> Thus, Congress’ intent was unmistakably clear: it intended to eliminate patient dumping by prohibiting the disparate treatment of patients based on factors such as their economic or insurance status. Congress enacted EMTALA to protect patients from hospitals that provided them with an inadequate medical screening exam in an attempt to cut costs.

Congress passed EMTALA with the unequivocal and clearly stated purpose of preventing patient dumping.<sup>52</sup> In particular, the Committee Report from the House of Representatives indicates that Congress was concerned primarily that patients who sought emergency medical treatment and whose doctors failed to stabilize them were not obtaining adequate care, if any at all.<sup>53</sup> One Committee Report stated that “[t]here

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<sup>47</sup> *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1255 (9th Cir. 1995) (quoting H.R. No. 241, pt.III).

<sup>48</sup> *Bryan v. Rectors & Visitors Univ. Va.*, 95 F.3d 349, 351 (4th Cir. 1996) (citation omitted).

<sup>49</sup> *Id.*

<sup>50</sup> *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 268 (6th Cir. 1990); see also 131 Cong. Rec. S13, 892-01 (1985) (statements of Sens. Durenberger, Kennedy, Dole, Baucus, Heinz, and Proxmire emphasized that EMTALA stemmed from the widely publicized scandal of emergency rooms that were ever increasingly removing indigent patients from one hospital and dumping them onto the next while patients’ emergency medical condition worsened.)

<sup>51</sup> See H.R. REP. NO. 99-241, pt.1, at 27 (1985) as reprinted in 1986 U.S.C.C.A.N. 595.

<sup>52</sup> *Id.*

<sup>53</sup> *Id.*



have been reports of situations where treatment was simply not provided. In numerous other instances, patients in an unstable condition have been transferred improperly, sometimes without the consent of the receiving hospital.”<sup>54</sup> Furthermore, “[n]eeding a carrot to make health-care providers more receptive to the stick, Congress simultaneously amended the Social Security Act, conditioning hospitals’ continued participation in the federal Medicare program—a lucrative source of institutional revenue—on acceptance of the duties imposed by the new law.”<sup>55</sup> Congress, therefore, used its legislative powers to eliminate patient dumping.

### B. EMTALA’s Statutory Provisions

Hospitals that provide Medicare and Medicaid services have a duty under EMTALA to provide to patients who present in an emergency department an appropriate medical screening examination and stabilizing care.<sup>56</sup> Moreover, hospitals may not, under most circumstances, transfer medically unstable patients.<sup>57</sup> EMTALA has two main requirements: (1) a medical screening requirement; and (2) a stabilization or transfer requirement.<sup>58</sup> In addition, a violation of EMTALA carries with it strict penalties for both hospitals and physicians.<sup>59</sup>

#### 1. Medical Screening Requirement

EMTALA’s medical screening requirement gives little guidance as to its true meaning.<sup>60</sup> EMTALA provides that:

In the case of a hospital that has a hospital emergency department, if any individual . . . comes to the emergency department . . . 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 . . . to determine whether or not an emergency medical condition . . . exists.<sup>61</sup>

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<sup>54</sup> *Id.*

<sup>55</sup> *Correa v. Hosp. San Francisco*, 69 F.3d 1184, 1189–90 (1st Cir. 1995); *see also* 42 U.S.C. § 1395dd(a–b), (e)(2) (1986).

<sup>56</sup> 42 U.S.C. § 1395dd(a)–(c).

<sup>57</sup> *Id.*

<sup>58</sup> *Id.*

<sup>59</sup> 42 U.S.C. § 1395dd(1)(A)–(B).

<sup>60</sup> Gerald A. Williams, *How You Could Get Nailed for Patient Dumping*, *Med. Econ.*, Apr. 13, 1998, at 189.

<sup>61</sup> 42 U.S.C. § 1395dd(a) (emphasis added).

If, after an appropriate medical screening, a hospital determines that no emergency medical condition exists, the hospital has satisfied its EMTALA duties.<sup>62</sup> If, however, the hospital determines that an emergency condition in fact exists, the hospital has a duty under EMTALA to either stabilize the patient's condition or to transfer the patient to *another* hospital for further treatment.<sup>63</sup>

The statute does not define an "appropriate medical screening examination," and the law gives limited guidance in determining what constitutes an adequate exam.<sup>64</sup> To satisfy EMTALA's screening requirement, a hospital need only apply a screening process to all patients in a nondisparate manner, such that a hospital does not provide differing levels of care to patients based on such factors as economic position or race.<sup>65</sup> Furthermore, a hospital cannot delay the screening to determine a patient's insurance or financial status.<sup>66</sup> Accordingly, the statute requires a hospital to examine an individual to assess whether a medically emergent condition exists, regardless of that individual's ability to pay.<sup>67</sup>

EMTALA defines an emergency medical condition as one "manifesting itself by acute symptoms of sufficient severity . . . 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 . . ." <sup>68</sup> Additionally, the term "emergency medical condition" also applies to a woman in active labor if "there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or unborn child."<sup>69</sup> Thus, "an emergency medical condition exists only if a patient is in imminent danger of death or a worsening condition that could be life threatening"<sup>70</sup> or is in excruciating pain.<sup>71</sup>

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<sup>62</sup> See Kamoie, *supra* note 26, at 29.

<sup>63</sup> *Id.*

<sup>64</sup> See Williams, *supra* note 60, at 189.

<sup>65</sup> See Kamoie, *supra* note 26, at 27.

<sup>66</sup> 42 U.S.C. § 1395dd(h).

<sup>67</sup> *Id.*, Kamoie, *supra* note 26, at 27.

<sup>68</sup> 42 U.S.C. § 1395dd(e)(1).

<sup>69</sup> *Id.*

<sup>70</sup> Tolton v. Am. Biodyne, Inc., 854 F. Supp. 505, 511 (N.D. Ohio 1993), *aff'd*, 48 F.3d 937 (6th Cir. 1995).

<sup>71</sup> 42 U.S.C. § 1395dd(e)(1)(A).

## 2. Stabilization Requirement

Stabilization of patients is EMTALA's second requirement.<sup>72</sup> This requirement is triggered when a hospital assesses a patient and determines that an emergency medical condition exists.<sup>73</sup> EMTALA then requires that a hospital "provide either (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or (B) for transfer of the individual to another medical facility in accordance with subsection (c) of the section."<sup>74</sup> Stabilization requires either that "no material deterioration of the condition is likely, within reasonable medical probability,"<sup>75</sup> or for a woman in active labor, that she deliver both the child and placenta.<sup>76</sup>

The statute allows a patient with an emergency condition to be transferred to another hospital if the patient, after being informed of the hospital's duty of care and the risks associated with transfer, requests such a transfer in writing or a doctor provides a certification that the medical benefits of another facility outweigh the risks of transfer.<sup>77</sup> Thus, under the language of EMTALA, specifically subsections (b) and (c) and the definition of "stabilized" established in subsection (e), a physician may transfer a patient to another hospital without a certification and without the consent of the receiving hospital if the physician reasonably believes that the transfer will not result in a "material deterioration" in the patient's condition.<sup>78</sup> Transfer of a stabilized patient, therefore, does not implicate EMTALA.<sup>79</sup>

Hospitals are thus required only to provide an appropriate screening, applied in a nondiscriminatory manner, to the extent needed to determine if an emergency medical condition exists.<sup>80</sup> If a healthcare provider determines that an emergency condition is not present, a hospital satisfies EMTALA with the completion of the medical screening.<sup>81</sup> If an emergency condition does exist, the hospital is

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<sup>72</sup> 42 U.S.C. § 1395dd(b) (emphasis added).

<sup>73</sup> *Id.*

<sup>74</sup> *Id.*

<sup>75</sup> 42 U.S.C. § 1395dd(e)(4)(B).

<sup>76</sup> 42 C.F.R. § 489.24(b) (1998).

<sup>77</sup> 42 U.S.C. § 1395dd(c)(1)(A)(i).

<sup>78</sup> *Cherukuri v. Shalala*, 175 F.3d 446, 450 (6th Cir. 1999).

<sup>79</sup> *Id.*

<sup>80</sup> Decanda M. Faulk, *EMTALA: The Real Deal*, 16 A.B.A. SEC. THE HEALTH LAWYER 70 (2003).

<sup>81</sup> *Id.*

obligated to stabilize or transfer the patient to satisfy EMTALA's requirements.<sup>82</sup>

### 3. Penalties

Hospitals and physicians who fail to adhere to EMTALA's statutory requirements face serious financial and legal penalties.<sup>83</sup> In particular, hospitals and physicians may face fines, exclusion from Medicare funds, as well as civil liability from private patients.<sup>84</sup> The CMS and the Office of the Inspector General (OIG) each have the power to enforce the EMTALA statute, and penalize statutory offenders.<sup>85</sup>

The CMS and OIG may impose on a hospital found to have violated an EMTALA provision a civil fine of up to \$50,000<sup>86</sup> and may also fine a physician who negligently violated the statute.<sup>87</sup> Additionally, repeated and flagrant statutory violations may result in the exclusion of the hospital and its physicians from the Medicare program.<sup>88</sup> This is significant, for according to one author, "the real economic weapon of this legislation is not the \$50,000 fine but, rather, the fast track termination from Medicare."<sup>89</sup> Furthermore, a hospital's public image "is likely to be significantly damaged when announcements in local newspapers read that 'the hospital is an immediate and serious threat to patient care and will be terminated from Medicare.'"<sup>90</sup>

Moreover, EMTALA provides an extra incentive to comply with its provisions: hospitals (though not physicians), can be subject to private suit by a patient for a statutory violation.<sup>91</sup> To state a viable claim, a plaintiff must prove that she went to an eligible hospital's emergency department, sought treatment for an emergency condition, and the hospital either failed to provide an adequate, nondiscriminatory screening, or the hospital discharged or transferred the plaintiff before stabilizing her condition.<sup>92</sup> Furthermore, "to prove a violation of EMTALA's screening provisions, a plaintiff need not prove that she

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<sup>82</sup> *Id.*

<sup>83</sup> 42 U.S.C. § 1395dd(1)(A)–(B).

<sup>84</sup> *Id.*

<sup>85</sup> *St. Anthony Hosp. v. HHS*, 309 F.3d 680, 693 (10th Cir. 2002).

<sup>86</sup> 42 U.S.C. § 1395dd(d)(1)(A). "A participating hospital that negligently violates a requirement of [EMTALA] is subject to a civil money penalty of not more than \$50,000 (or not more than \$25,000 in the case of a hospital with less than 100 beds) for each such violation." *Id.*

<sup>87</sup> 42 U.S.C. § 1395dd(d)(1)(B).

<sup>88</sup> 42 U.S.C. § 1395dd(d)(1).

<sup>89</sup> Mikel A. Rothenberg, *Emergency Medical Malpractice* 1.11 (1994).

<sup>90</sup> *Id.*

<sup>91</sup> 42 U.S.C. § 1395dd(d)(2)(A).

<sup>92</sup> *Brenord v. Catholic Med. Ctr.*, 133 F. Supp. 2d 179, 185 (E.D.N.Y. 2001).

actually suffered from an emergency medical condition when she first came through the portals of defendant's facility; the failure appropriately to screen, by itself, is sufficient to ground liability as long as the other elements of the cause of action are met."<sup>93</sup>

Congress enacted EMTALA to curb the growing practice of patient dumping. EMTALA requires that a hospital provide a medical screening to each patient, and if that patient is in an emergency condition, the hospital must stabilize the patient. If a hospital fails to properly screen or stabilize a patient, both the physician and the hospital face stiff penalties. Unfortunately, however, Congress used vague statutory language when drafting EMTALA, which has led to varying interpretations, as well as circuit splits over interpretation, among the federal circuit courts.

### C. *Conflicting Interpretations from the Circuits*

Since EMTALA's inception, federal circuit courts have interpreted the statute with a lack of uniformity.<sup>94</sup> Abundant, contradictory case law dealing with the statute reflects this judicial ambiguity.<sup>95</sup> The circuits have differing views concerning EMTALA's language and specific requirements.<sup>96</sup>

First, the circuits are split over what constitutes an adequate medical screening; the First and Ninth Circuits hold hospitals to an objectively reasonable standard,<sup>97</sup> while the Sixth, Eighth, Tenth, Eleventh and D.C. Circuits, hold hospitals to a subjectively reasonable, or nondisparate treatment standard.<sup>98</sup> Second, the circuits are split over whether EMTALA's provisions should apply after a hospital initially stabilizes a patient, in accordance with the statute, and later admits the patient to the hospital,<sup>99</sup> the Sixth Circuit holds that EMTALA's requirements still apply after initial stabilization,<sup>100</sup> while the Ninth Circuit holds that a hospital's EMTALA obligations end upon admitting a patient.<sup>101</sup> Finally, the circuits are also split over how to interpret EMTALA's requirements.<sup>102</sup> The Fourth, Ninth, and Eleventh Circuits

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<sup>93</sup> *Correa v. Hosp. San Francisco*, 69 F.3d 1184, 1190 (1st Cir. 1995).

<sup>94</sup> *Compare Correa*, 69 F.3d at 1189–90 with *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (6th Cir. 1990).

<sup>95</sup> *Cleland*, 917 F.2d at 271.

<sup>96</sup> *Id.*

<sup>97</sup> *See Correa*, 69 F.3d at 1193; *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1257 (9th Cir. 1995).

<sup>98</sup> *See Kamoie*, *supra* note 26, at 37.

<sup>99</sup> *See Schaffner*, *supra* note 27, at 1032.

<sup>100</sup> *See Thornton v. Sw. Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990).

<sup>101</sup> *See Bryant v. Adventist Health Sys. West*, 289 F.3d 1162, 1167 (9th Cir. 2002).

<sup>102</sup> *See Gionis*, *supra* note 14, at 264.

follow the conjunctive approach, by which courts treat the statute's three provisions as interdependent and sequential requirements.<sup>103</sup> The First Circuit, however, follows the disjunctive approach, and interprets EMTALA as creating two distinct causes of action: one for the medical screening requirement and another for the stabilization requirement.<sup>104</sup> Furthermore, since Congress enacted EMTALA in the 1980s, two key cases have interpreted the statute broadly, and thus have expanded the possibilities for hospitals' and physicians' liability.<sup>105</sup>

### 1. Split over the Medical Screening Requirement

The first division of the circuits concerns what exactly constitutes an adequate medical screening under EMTALA's provisions.<sup>106</sup> The problems arising from the screening requirement surround the use of the word "appropriate."<sup>107</sup> As one court proffered, "[a]ppropriate' is one of the most wonderful weasel words in the dictionary, and a great aid to the resolution of disputed issues in the drafting of legislation."<sup>108</sup> There is no real consensus among the circuits as to what satisfies EMTALA's requirement of an "appropriate medical screening examination."<sup>109</sup> A minority of the circuits, including the First and Ninth Circuits, has adopted an objectively reasonable standard, one that requires more from a hospital and its physicians and also adds a reasonableness requirement to EMTALA.<sup>110</sup> Conversely, a majority of the circuits, including the Sixth, Eighth, Tenth, Eleventh, and D.C. Circuits, has adopted a subjective, nondisparate treatment standard.<sup>111</sup>

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<sup>103</sup> *Id.* at 265–67.

<sup>104</sup> *Id.* at 268–70.

<sup>105</sup> *Roberts v. Galen of Va., Inc.*, 525 U.S. 249, 251 (1999) (per curiam); *Lopez-Soto v. Hawayek*, 175 F.3d 170 (1st Cir. 1999).

<sup>106</sup> The First and Ninth Circuits apply an objectively reasonable standard to EMTALA's medical screening requirement, while the Sixth, Eighth, Tenth, Eleventh, and D.C. Circuits apply a subjective, non-disparate treatment standard.

<sup>107</sup> *See Frank, supra* note 18, at 206.

<sup>108</sup> *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (6th Cir. 1990).

<sup>109</sup> *See Frank, supra* note 18, at 205.

<sup>110</sup> *See Roberts*, 525 U.S. at 252; *see also Correa v. Hosp. San Francisco*, 69 F.3d 1184, 1193 (1st Cir. 1995); *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1257 (9th Cir. 1995).

<sup>111</sup> *See Kamoie, supra* note 26, at 37; *see also Cleland*, 917 F.2d at 271; *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996); *Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519, 522 (10th Cir. 1994); *Harry v. Marchant*, 291 F.3d 767 (11th Cir. 2002); *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991).

*a. Objectively Reasonable Standard*

The First and Ninth Circuits form a minority of circuits that require hospitals and physicians to meet an objectively reasonable standard with regards to EMTALA's medical screening requirement.<sup>112</sup> Under this standard, "[a] hospital fulfills its statutory duty to screen patients in its emergency room if it provides for a screening examination reasonably calculated to identify critical medical conditions that may be afflicting symptomatic patients and provides that level of screening uniformly to all those who present substantially similar complaints."<sup>113</sup> The First and Ninth Circuits thus join to form a minority of circuits that hold hospitals and physicians to an objectively reasonable standard with regards to EMTALA's medical screening requirement, and together have attempted to create a "national standard of emergency care."<sup>114</sup>

The plaintiff in *Correa* arrived at the hospital's emergency room complaining that she felt sick and had chest pains.<sup>115</sup> The defendant hospital did not follow its own standard procedures requiring that a hospital employee check the vital signs of every patient entering the facility.<sup>116</sup> The court held the hospital liable because the "delay in attending to the patient was so egregious and lacking in justification as to amount to an effective denial of a screening examination."<sup>117</sup> Thus *Correa* reflects the First Circuit's promulgation of a reasonable standard with which a hospital must comply to satisfy EMTALA's screening requirement.<sup>118</sup>

In *Eberhardt v. City of Los Angeles*, the plaintiff's son presented in the hospital's emergency room, where a physician examined and then released him.<sup>119</sup> After his release, police shot and killed the plaintiff's son after he yelled "kill me."<sup>120</sup> The plaintiff sued the hospital for failing to provide a medical screening evaluation and claimed that if a physician had done so, the hospital would have detected her son's suicidal tendencies.<sup>121</sup> The Ninth Circuit stated that a "screening examination is 'appropriate' if it is designed to identify *acute* and *severe* symptoms that alert the physician of the need for *immediate* medical attention to prevent

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<sup>112</sup> See *Correa*, 69 F.3d at 1193; *Eberhardt*, 62 F.3d at 1257.

<sup>113</sup> *Correa*, 69 F.3d at 1192.

<sup>114</sup> See Frank, *supra* note 18, at 207.

<sup>115</sup> *Correa*, 69 F.3d at 1188.

<sup>116</sup> *Id.* at 1193.

<sup>117</sup> *Id.*

<sup>118</sup> See Stalker, *supra* note 24, at 831.

<sup>119</sup> 62 F.3d 1253, 1254–55 (9th Cir. 1995).

<sup>120</sup> *Id.* at 1255.

<sup>121</sup> *Id.* at 1257.

serious bodily injury.”<sup>122</sup> The court held that because the plaintiff’s suicidal tendencies were neither acute nor severe the defendant hospital was not liable under EMTALA.<sup>123</sup>

*b. Nondisparate Treatment Standard*

In contrast, a majority of the circuits, in particular the Sixth, Eighth, Tenth, Eleventh, and D.C. Circuits, has adopted a subjective standard to judge the screening requirement.<sup>124</sup> The subjective standard requires that a hospital screen, examine, and treat its patients in a nondisparate manner within that hospital’s individual capabilities.<sup>125</sup> These courts look to legislative intent and to the plain language of EMTALA in determining a subjective standard for an “appropriate medical screening examination.”<sup>126</sup>

The Sixth Circuit held in *Cleland v. Bronson Health Care Group, Inc.*, that “appropriate” requires a hospital to provide each patient with “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.”<sup>127</sup> Specifically, the *Cleland* court determined that a hospital complies with EMTALA’s medical screening requirement “[i]f it acts in the same manner as it would have for the usual paying patient.”<sup>128</sup> Thus, the court found for the defendant hospital because, although the plaintiff “had a condition that was at least conceivably ascertainable by medical science, the condition was not ascertained, and he died within 24 hours,” there was “not the slightest indication that this outcome would have been any different for a patient of any other characteristics.”<sup>129</sup>

The Eighth Circuit in *Summers v. Baptist Medical Center Arkadelphia* arrived at a similar interpretation of the statute’s medical screening requirement with a focus on nondisparate treatment.<sup>130</sup> The

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<sup>122</sup> *Id.*

<sup>123</sup> *Id.* at 1258.

<sup>124</sup> See Kamoie, *supra* note 26, at 37.

<sup>125</sup> See, e.g., *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (6th Cir. 1990).

<sup>126</sup> *Id.* at 268.

<sup>127</sup> *Id.* In this case, the plaintiffs took their son, who suffered from cramps and vomiting, to the hospital’s emergency room. *Id.* at 269. The boy was examined, diagnosed with influenza, and four hours later was discharged from the hospital. *Id.* The next day, the boy died after suffering from cardiac arrest. *Id.*

<sup>128</sup> *Id.* at 272.

<sup>129</sup> *Id.* at 271.

<sup>130</sup> 91 F.3d 1132 (8th Cir. 1996). In this case, the plaintiff presented in the defendant hospital’s emergency department after falling out of a tree stand while deer hunting. *Id.* at 1135. The plaintiff complained of back and chest pains and stated that he heard a popping



court stated that EMTALA entitled a patient, “not to correct or non-negligent treatment in all circumstances, but to be treated as other similarly situated patients are treated, within the hospital’s capabilities.”<sup>131</sup> The *Summers* court went further in its analysis and stated that “EMTALA is not a federal malpractice statute and it does not set a national emergency health care standard; claims of misdiagnosis or inadequate treatment are left to the state malpractice arena.”<sup>132</sup> Thus the Eighth Circuit explicitly rejected the First and Ninth Circuit’s position, which favors the creation of a national standard governing emergency medical care.<sup>133</sup>

The Tenth Circuit in *Repp v. Anadarko Municipal Hospital* agreed with the majority of the circuits that EMTALA “is neither a malpractice nor a negligence statute,”<sup>134</sup> and that EMTALA “precludes the adoption of a standard tantamount to a federal malpractice statute.”<sup>135</sup> Furthermore, the court held that EMTALA “does not require a hospital to provide a medical screening in the abstract, but one that is appropriate within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department.”<sup>136</sup> Therefore, the court proffered that “the statute’s requirement is hospital-specific, varying with the specific circumstances of each provider.”<sup>137</sup>

The Eleventh Circuit followed a similar line of reasoning in *Harry v. Marchant*.<sup>138</sup> The court in *Harry* reiterated the majority consensus that

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noise every time he breathed. *Id.* The emergency room physician ordered x-rays of the plaintiff’s spine, but not his chest. *Id.* The spinal x-rays showed only a previous break, and the plaintiff was discharged. *Id.* Two days later, the plaintiff was in so much pain that he went to another hospital where, upon x-raying his chest, the doctor discovered a broken breastbone and rib. *Id.* at 1135–36. The plaintiff’s principal claim against the hospital was for its failure to “provide for an appropriate medical screening examination within the capability of [its] . . . emergency department.” *Id.* at 1136.

<sup>131</sup> *Id.* at 1138.

<sup>132</sup> *Id.* at 1137.

<sup>133</sup> See Stalker, *supra* note 24, at 833.

<sup>134</sup> 43 F.3d 519, 522 (10th Cir. 1994) (citations omitted). In this case, the patient presented in the hospital’s emergency department suffering from pain in his arm. *Id.* at 521. A hospital employee gave the patient two injections and discharged him. *Id.* The patient went home and died in his sleep that night. *Id.* Plaintiffs sued the hospital for violating EMTALA by not providing the patient with an appropriate medical screening examination. *Id.*

<sup>135</sup> *Id.*

<sup>136</sup> *Id.* (quoting 42 U.S.C. § 1395dd(a)).

<sup>137</sup> *Id.*

<sup>138</sup> 291 F.3d 767 (11th Cir. 2002). In this case, the patient presented in the hospital emergency room, where she was first seen by the defendant, Dr. Marchant. *Id.* at 768. The doctor diagnosed her with “pneumonia rule out sepsis”, *id.*, and requested permission from the on-call attending physician to admit the patient into the intensive care unit (“ICU”). *Id.* The attending physician refused to authorize the transfer. *Id.* Later, the patient’s primary care physician examined her, admitted her to the ICU, and prescribed

Congress did not intend EMTALA's screening requirement to be used as a medical malpractice claim.<sup>139</sup> Furthermore, the Eleventh Circuit again echoed the majority of the circuits by defining an appropriate medical screening examination in terms of nondisparate treatment, such that a hospital is required to treat all similarly situated patients in the same manner.<sup>140</sup>

Finally, the D.C. Circuit recognized an analogous medical screening requirement in *Gatewood v. Washington Healthcare Corp.*, finding that "what constitutes an appropriate screening is properly determined not by reference to particular outcomes, but instead by reference to a hospital's standard screening procedures."<sup>141</sup> Therefore, according to the D.C. Circuit, "a hospital fulfills the 'appropriate medical screening' requirement when it conforms in its treatment of a particular patient to its standard screening procedures. By the same token, any departure from standard screening procedures constitutes inappropriate screening in violation of [EMTALA]."<sup>142</sup>

EMTALA's medical screening requirement has split the circuits. The minority of the circuits, including the First and Ninth Circuits, follow an objectively reasonable standard. This standard requires that a hospital provide its patients with a screening examination "reasonably calculated to identify critical medical conditions that may be afflicting symptomatic patients and provides that level of screening uniformly to all those who present substantially similar complaints."<sup>143</sup> In contrast, the majority of the circuits, including the Sixth, Eighth, Tenth, Eleventh, and D.C. Circuits, follow a subjective standard. The subjective standard requires that a hospital treat each patient in a nondisparate manner, within the individual capabilities of that hospital.<sup>144</sup> Unfortunately, in addition to the statute's medical screening requirement, EMTALA's stabilization requirement has also created a circuit split.

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her antibiotics. *Id.* at 768–69. The ICU nurse never administered the antibiotics, and the patient died that afternoon after lapsing into respiratory and cardiac failure. *Id.* at 769.

<sup>139</sup> *Id.* at 773.

<sup>140</sup> *Id.* at 774.

<sup>141</sup> 933 F.2d 1037, 1041 (D.C. Cir. 1991). In this case, the plaintiff's husband presented in the defendant hospital's emergency room "complaining of pain radiating down his left arm and into his chest." *Id.* at 1039. A hospital physician examined Mr. Gatewood "and performed blood tests, a chest x-ray and an EKG test." *Id.* Both the resident and attending physicians diagnosed Mr. Gatewood with musculoskeletal pain and discharged him. *Id.* Mr. Gatewood died of a heart attack the next morning. *Id.*

<sup>142</sup> *Id.*

<sup>143</sup> *Correa v. Hosp. San Francisco*, 69 F.3d 1184, 1192 (1st Cir. 1995) (citations omitted).

<sup>144</sup> *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (6th Cir. 1990).

## 2. Split over EMTALA's Stabilization Requirement

The Sixth and Ninth Circuits take opposing positions over EMTALA's second requirement concerning patient stabilization.<sup>145</sup> A hospital triggers the statute's second provision, the requirement to stabilize a patient, only after a hospital screens a patient and determines that an emergency condition exists.<sup>146</sup> Thus, EMTALA's stabilization requirement does not apply if a hospital performs an appropriate screening and finds no emergency medical condition.<sup>147</sup> The circuits disagree, however, over whether EMTALA's provisions should apply after a hospital initially stabilizes a patient, in accordance with the statute, and later admits the patient to the hospital.<sup>148</sup>

### *a. In the Sixth Circuit, EMTALA Applies After Initial Stabilization*

In the Sixth Circuit, courts have held that EMTALA's provisions apply after a physician initially stabilizes a patient.<sup>149</sup> In *Thornton v. Southwest Detroit Hospital*, the Sixth Circuit found that a patient who had been admitted as an in-patient to the hospital for three weeks still had a claim against the hospital if her emergency condition was not stabilized upon discharge.<sup>150</sup> The *Thornton* court focused on EMTALA's language and legislative history, and stated that "[a]lthough emergency care often occurs, and almost invariably begins, in an emergency room, emergency care does not always stop when a patient is wheeled from the emergency room into the main hospital."<sup>151</sup> Thus, the court held that "[h]ospitals may not circumvent the requirements of the Act merely by admitting an emergency room patient to the hospital, then immediately discharging that patient. Emergency care must be given until the patient's emergency medical condition is stabilized."<sup>152</sup> Although it found the hospital was not liable because the patient's condition had been stabilized prior to discharge, the court stressed that its holding was not based on the patient's prolonged in-patient status, but rather on the fact that there existed no issue of material fact concerning whether her condition was stabilized upon her release.<sup>153</sup>

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<sup>145</sup> See *Thornton v. Sw. Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990); *Bryant v. Adventist Health Sys. West*, 289 F.3d 1162, 1167 (9th Cir. 2002).

<sup>146</sup> See 42 U.S.C. § 1395dd(b).

<sup>147</sup> *Id.*

<sup>148</sup> See *Schaffner*, *supra* note 27, at 1032.

<sup>149</sup> See *Thornton*, 895 F.2d at 1131.

<sup>150</sup> *Id.*

<sup>151</sup> *Id.* at 1135.

<sup>152</sup> *Id.*

<sup>153</sup> *Id.*

*b. In the Ninth Circuit, EMTALA Liability Ends Upon Admittance*

Conversely, the Ninth Circuit held in *Bryant v. Adventist Health System* that EMTALA's "stabilization requirement normally ends when a patient is admitted for inpatient care."<sup>154</sup> The *Bryant* court focused on EMTALA's definition of "stabilized" and the fact that "the term is defined only in connection with the transfer of an emergency room patient,"<sup>155</sup> to conclude that "the term stabilize was not intended to apply to those individuals who are admitted to a hospital for inpatient care."<sup>156</sup> The court recognized that the Fourth Circuit followed the same approach, and it noted the Sixth Circuit's differing conclusion.<sup>157</sup> The *Bryant* court supported its decision by stating that "Congress enacted EMTALA 'to create a new cause of action, generally unavailable under state tort law, for what amounts to failure to treat' and not to 'duplicate preexisting legal protections'"<sup>158</sup> and "[a]fter an individual is admitted for inpatient care, state tort law provides a remedy for negligent care."<sup>159</sup> Thus, if "EMTALA liability extended to inpatient care, EMTALA would be 'convert[ed] . . . into a federal malpractice statute, something it was never intended to be.'"<sup>160</sup>

The circuits disagree over whether EMTALA's requirements apply after a hospital initially stabilizes a patient, and later admits the patient to the hospital. The Sixth Circuit has held that a hospital remains liable under EMTALA even after the hospital admits the patient as an inpatient.<sup>161</sup> In contrast, the Ninth Circuit has held that a hospital satisfies

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<sup>154</sup> 289 F.3d 1162, 1167 (9th Cir. 2002). In this case, the plaintiffs took their minor son to the defendant hospital's emergency room because he had been coughing up blood and had a fever. *Id.* at 1164. The boy was severely disabled and had a history of asthma, bronchitis, and pneumonia. *Id.* The hospital physician ordered a chest x-ray, but failed to notice a large lung abscess. *Id.* The physician diagnosed the boy with pneumonia and asthma, prescribed an antibiotic, and discharged him. *Id.* Later that day, the hospital called the family, told them they had discovered the abscess, and instructed them to return to the hospital. *Id.* Three days later, the boy was transferred to another hospital and later was released. *Id.* The boy died suddenly and unexpectedly a few weeks later. *Id.* His parents sued, claiming the hospital violated EMTALA's stabilization requirement by failing to diagnose the boy's emergency condition and discharging him before stabilizing the condition. *Id.* at 1163. His parents further alleged that after they returned to the hospital and the boy was admitted for inpatient care, the hospital "again violated EMTALA's stabilization requirement by failing to stabilize his condition during the three days after it admitted him for treatment." *Id.*

<sup>155</sup> *Id.* at 1167.

<sup>156</sup> *Id.*

<sup>157</sup> *Id.* at 1168.

<sup>158</sup> *Id.* at 1168–69 (citation omitted).

<sup>159</sup> *Bryant v. Adventist Health Sys. West*, 289 F.3d 1162, 1169 (9th Cir. 2002) (citation omitted).

<sup>160</sup> *Id.*

<sup>161</sup> *Thornton v. Sw. Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990).

its statutory requirements, and thus EMTALA liability no longer applies, after the hospital admits a patient.<sup>162</sup> Unfortunately, however, the provisions over which the circuits are split do not end there.

### 3. Split over a Conjunctive or Disjunctive Approach

The final circuit split concerns the issue of how to read EMTALA's three requirements of a medical screening examination, stabilization, and transfer, set forth in 42 U.S.C. § 1395dd(a)–(c), either conjunctively or disjunctively.<sup>163</sup> The Fourth, Ninth, and Eleventh Circuits follow the conjunctive approach, by which courts treat EMTALA's three provisions as interdependent and sequential requirements.<sup>164</sup> In contrast, the First Circuit follows the disjunctive approach, and interprets EMTALA as creating two distinct causes of action: one for the medical screening requirement and another for the stabilization requirement.<sup>165</sup>

#### *a. The Conjunctive Approach*

Under the conjunctive interpretation of the statute, only patients who present in a hospital's emergency room are subject to EMTALA protection.<sup>166</sup> Thus, the threshold issue according to this approach is whether a patient arrived in a hospital's emergency room.<sup>167</sup> Accordingly, hospitals are relieved of EMTALA liability after they admit a patient as an in-patient to the hospital. The Fourth Circuit concluded, therefore, in *Bryan v. Rectors and Visitors of the University of Virginia*, that “the stabilization requirement was intended to regulate the hospital's care of the patient only in the immediate aftermath of the act of admitting her for emergency treatment . . . .”<sup>168</sup> Thus, EMTALA “cannot plausibly be interpreted to regulate medical and ethical decisions outside that narrow context.”<sup>169</sup>

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<sup>162</sup> *Bryant*, 289 F.3d at 1167.

<sup>163</sup> See Gionis, *supra* note 14, at 264.

<sup>164</sup> See *Bryan v. Rectors & Visitors Univ. Va.*, 95 F.3d 349, 352 (4th Cir. 1996); *James v. Sunrise Hosp. & Med. Ctr.*, 86 F.3d 885, 889 (9th Cir. 1996); *Harry v. Marchant*, 291 F.3d 767, 771 (11th Cir. 2002).

<sup>165</sup> See *Lopez-Soto v. Hawayek*, 175 F.3d 170 (1st Cir. 1999).

<sup>166</sup> See *Dollard v. Allen*, 260 F. Supp. 2d 1127, 1132 (D. Wyo. 2003).

<sup>167</sup> *Id.*

<sup>168</sup> *Bryan*, 95 F.3d at 352. In this case, the patient presented at defendant hospital's emergency room in respiratory distress. *Id.* at 350. Against the patient's family's wishes, the hospital entered a “do not resuscitate” order. *Id.* Therefore, the patient was not resuscitated and later died. *Id.* The patient's estate sued the hospital for violating EMTALA's stabilization requirement. *Id.*

<sup>169</sup> *Id.* at 352.

Similarly, the Ninth Circuit supported a conjunctive approach in *James v. Sunrise Hospital and Medical Center*.<sup>170</sup> In *James*, the court read all three of EMTALA's requirements together.<sup>171</sup> From this approach, the court concluded "the transfer restrictions of 42 U.S.C. § 1395dd(c) [ ] apply only when an individual 'comes to the emergency room,' and after 'an appropriate medical screening examination,' 'the hospital determines that the individual has an emergency medical condition.'"<sup>172</sup>

The Eleventh Circuit in *Harry* also followed the conjunctive approach and limited EMTALA's stabilization requirement to patient transfers.<sup>173</sup> The court reasoned that EMTALA "is logically structured to set forth two options for transferring a patient with an emergency medical condition: a hospital must either provide stabilization treatment prior to transferring a patient pursuant to subsection (A), or, pursuant to subsection (B), provide no treatment and transfer according to one of the statutorily recognized exceptions."<sup>174</sup> The court listed the elements of a stabilization requirement claim: "(1) the patient had an emergency medical condition; (2) the hospital knew of the condition; (3) the patient was not stabilized before being transferred; and (4) the hospital neither obtained the patient's consent to transfer nor completed a certificate indicating the transfer would be beneficial to the patient."<sup>175</sup>

#### *b. The Disjunctive Approach*

The First Circuit adopted the opposite approach and views EMTALA's requirements in the disjunctive.<sup>176</sup> In *Lopez-Soto*, the First Circuit set forth its disjunctive argument by stating that "subsections (a) and (b) of EMTALA operate disjunctively rather than conjunctively."<sup>177</sup> Under that interpretation, the court allowed the parents of an infant who

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<sup>170</sup> *James v. Sunrise Hosp. & Med. Ctr.*, 86 F.3d 885, 889 (9th Cir. 1996). Here, the plaintiff was admitted to defendant hospital with acute renal failure. *Id.* at 886. The hospital "inserted a synthetic graft into her arm," which caused her "pain and numbness in that forearm, wrist, and hand." *Id.* Two days later, a hospital employee discovered her hand was cool and turning blue, and later, that the pulse in that arm was weak. *Id.* The plaintiff complained of the same symptoms for five more days. *Id.* Nevertheless, she was discharged "without any evaluation of the condition of her veins." *Id.* Her condition was not treated or stabilized, and eventually "caused her hand to be amputated." *Id.* The plaintiff sued the hospital for violating EMTALA's stabilization requirement. *Id.*

<sup>171</sup> *Id.*

<sup>172</sup> *Id.* at 889.

<sup>173</sup> *Harry v. Marchant*, 291 F.3d 767, 771 (11th Cir. 2002).

<sup>174</sup> *Id.*

<sup>175</sup> *Id.* at 774.

<sup>176</sup> *See Lopez-Soto v. Hawayek*, 175 F.3d 170 (1st Cir. 1999); *see also Dollard v. Allen*, 260 F. Supp. 2d 1127, 1134 (D. Wyo. 2003).

<sup>177</sup> *Lopez-Soto*, 175 F.3d at 177.

was born and subsequently died in the operating room to sue under EMTALA's stabilization and transfer requirements.<sup>178</sup> The court proffered that the phrase "comes to the emergency department" in subsection (a) and the phrase "comes to a hospital" in subsection (b), create two separate and distinct duties for hospitals.<sup>179</sup> Furthermore, the court reasoned that the statutory language of subsection (b) supports the disjunctive approach because it "mentions neither an emergency room locus nor a medical screening as a precursor to a hospital's stabilization obligations. Rather, those obligations attach so long as an individual enters any part of the hospital and the hospital determines that an emergency medical condition exists."<sup>180</sup>

The *Lopez-Soto* court continued its analysis. The court stated, "a hospital more often than not will discover the existence of an emergency medical condition by performing the screening required under subsection (a)—but nothing in EMTALA's language or structure makes subsection (b) an adjunct to subsection (a)."<sup>181</sup> Moreover, the court reasoned, "punctuation can provide valuable insights into statutory interpretation,"<sup>182</sup> and thus the court would not "overlook that Congress chose structurally to disconnect the three subsections, closing them off from each other by periods, without any conjunctive links."<sup>183</sup>

In support of its disjunctive approach, the First Circuit pointed to *Smith v. Richmond Memorial Hospital*.<sup>184</sup> In *Smith*, the Virginia Supreme Court allowed a patient who did not present in the defendant hospital's emergency room to nonetheless pursue an improper transfer claim under

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<sup>178</sup> *Id.* In this case, Ms. Lopez-Soto presented in the hospital's emergency department in active labor. *Id.* at 171. The hospital staff took Ms. Lopez-Soto to the maternity ward, where she gave birth to her son. *Id.* The infant was born suffering from extreme respiratory distress. *Id.* The infant's physician arranged for him to be transferred to another, more specialized facility. *Id.* However, the doctor then discovered the infant had an additional medical condition but chose to "send the infant to the receiving hospital without first attempting to stabilize the patient or to treat [the] exigent condition." *Id.* The baby was later admitted to the other hospital and died the next day. *Id.*

<sup>179</sup> *Id.* at 173.

<sup>180</sup> *Id.* at 174.

<sup>181</sup> *Id.*

<sup>182</sup> *Lopez-Soto v. Hawayek*, 175 F.3d 170, 174 (1st Cir. 1999).

<sup>183</sup> *Id.*

<sup>184</sup> *See Smith v. Richmond Mem'l Hosp.*, 243 Va. 445, 452 (1992). In this case, the plaintiff's mother presented in the defendant hospital's emergency room in active labor, with a "premature rupture of the uterine membranes." *Id.* at 447. Several hours later, a physician, without examining her, ordered the plaintiff's mother to be transferred to another hospital. *Id.* at 448. Two ambulance services refused to transfer her until the receiving hospital agreed to be billed for the service. *Id.* The plaintiff's mother suffered substantial injuries and the infant had "cerebral palsy and is severely brain damaged." *Id.* The plaintiff's mother sued the hospital on her child's behalf, claiming a violation of EMTALA's transfer provision. *Id.*

subsection (c).<sup>185</sup> The Virginia court found “nothing in the language of the Act that limits application of [subsections (b) and (c)] solely to a patient who initially arrives at the emergency room.”<sup>186</sup> This argument furthers the *Lopez-Soto* court’s approach because the Virginia court also refused to view EMTALA’s subsections (b) and (c) as one requirement, but instead, the Virginia court permitted a plaintiff to pursue an EMTALA claim after presenting outside of the emergency room.<sup>187</sup>

Finally, the *Lopez-Soto* court drew on *Roberts v. Galen of Virginia, Inc.*, a case where the Supreme Court rejected on textual grounds the Sixth Circuit’s importation of an intent requirement from subsection (a) into subsection (b).<sup>188</sup> The First Circuit in *Lopez-Soto*, utilizing a similar textual approach, found that “subsection (b), unlike subsection (a), contains no requirement of entry through the portals of the emergency department. Thus, by analogy to *Roberts*, the plain language of the statute militates against importation of the ‘emergency department’ requirement from subsection (a) into subsection (b).”<sup>189</sup>

Thus, the circuits remain split over how to read EMTALA’s three requirements of a medical screening requirement, stabilization, and transfer, as set forth in 42 U.S.C. § 1395dd(a)–(c). While the Fourth, Ninth, and Eleventh Circuits follow the conjunctive approach to treat EMTALA’s three provisions as interdependent and sequential requirements, the First Circuit, in contrast, follows the disjunctive approach, and interprets EMTALA as creating two distinct causes of action: one for the medical screening requirement and another for the stabilization requirement.<sup>190</sup>

#### 4. Broad Interpretations of EMTALA Liability

Since EMTALA’s inception in the 1980s, there have been two key cases that have interpreted the statute broadly, and thus have expanded the possibilities for hospitals’ and physicians’ liability.<sup>191</sup> In particular, *Roberts v. Galen of Virginia, Inc.* was the first case in which the Supreme Court addressed EMTALA, and by interpreting EMTALA and hospital liability broadly, the Court refused to import a motive requirement into the statute.<sup>192</sup> Similarly, the First Circuit in *Lopez-Soto*

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<sup>185</sup> *Id.* at 452.

<sup>186</sup> *Id.*

<sup>187</sup> *Id.*

<sup>188</sup> See *Roberts v. Galen of Va., Inc.*, 525 U.S. 249, 251 (1999) (per curiam).

<sup>189</sup> *Lopez-Soto v. Hawayek*, 175 F.3d 170, 174 (1st Cir. 1999).

<sup>190</sup> See Gionis, *supra* note 14, at 264.

<sup>191</sup> *Roberts*, 525 U.S. at 251; *Lopez-Soto*, 175 F.3d at 170.

<sup>192</sup> *Roberts*, 525 U.S. at 253.



also interpreted EMTALA liability broadly by imposing the statute's stabilization requirement on patients that present outside of a hospital's emergency department.<sup>193</sup> Both cases are key to understanding EMTALA's interpretation among the circuits because of their broadening of hospitals' and physicians' liability.

*a. Roberts v. Galen of Va., Inc.*

In 1999, the Supreme Court addressed EMTALA in *Roberts*, the first case in which the Court attempted to interpret EMTALA.<sup>194</sup> In *Roberts*, both of the lower courts, including the Sixth Circuit, held that, "in order to recover in a suit alleging a violation of 42 U.S.C. § 1395dd(b), a plaintiff must prove that the hospital acted with an 'improper motive' in failing to stabilize her."<sup>195</sup> Because both of the courts found that the plaintiff was unable to prove such a motive, the defendant hospital prevailed.<sup>196</sup> The Supreme Court, however, reversed and held that "section 1395dd(b) contains no express or implied 'improper motive' requirement."<sup>197</sup>

The *Roberts* Court drew on another case, *Cleland v. Bronson Health Care Group, Inc.*, in which the Sixth Circuit read EMTALA's "appropriate medical screening" duty "as requiring a plaintiff to show an improper reason why he or she received 'less than standard attention [upon arrival]. . . at the emergency room.'"<sup>198</sup> The Court acknowledged that "there is no question that the text of section 1395dd(b), [the provision at issue in *Roberts*], does not require an 'appropriate' stabilization, [and furthermore, the stabilization provision cannot] . . . reasonably be read to require an improper motive."<sup>199</sup>

The Supreme Court expressly limited its holding in *Roberts* to eliminating the improper motive requirement from subsection (b)'s

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<sup>193</sup> *Lopez-Soto*, 175 F.3d at 170.

<sup>194</sup> See *Roberts*, 525 U.S. at 249. In this case, the patient was taken to defendant hospital's emergency room after being run over by a truck. *Id.* at 251. The patient had severe injuries to "her brain, spine, right leg, and pelvis." *Id.* The patient remained at that hospital in a volatile state for six weeks, and was then transferred to another facility. *Id.* The patient's condition deteriorated rapidly after the transfer. *Id.* The patient's guardian sued the hospital for violating EMTALA's stabilization and transfer provisions. *Id.* at 251–52.

<sup>195</sup> *Id.* at 250. Improper motives include "indigency, race or sex of the patient." Kamoie, *supra* note 26, at 37.

<sup>196</sup> *Roberts*, 525 U.S. at 252.

<sup>197</sup> *Id.* at 253.

<sup>198</sup> *Id.* at 252 (quoting *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 272 (6th Cir. 1990)).

<sup>199</sup> *Roberts*, 525 U.S. at 253.

stabilization provision.<sup>200</sup> The ruling is significant, however, because it “lowered the standard of proof required by plaintiffs, and will open the door to even more private EMTALA actions,”<sup>201</sup> thereby furthering Congress’ intent of protecting patients on a wide-scale. The Supreme Court’s decision in *Roberts* is thus vital in broadening EMTALA’s reach, eliminating the need for a plaintiff to prove malice on the part of the hospital or physician, and refusing to limit the scope of the statute.

*b. Lopez-Soto v. Hawayek*

In 1999, the same year that the Supreme Court decided *Roberts*, the First Circuit interpreted EMTALA broadly by determining that the statute imposes liability on hospitals and physicians beyond the emergency room.<sup>202</sup> The *Lopez-Soto* decision embodied the First Circuit’s disjunctive approach to EMTALA liability.<sup>203</sup> The court’s decision imposed “the stabilization requirement on hospitals for any patient in an emergency medical condition, regardless of how that person enters the hospital or where within the walls of the hospital that person may be when the hospital identifies the problem.”<sup>204</sup> Basing its decision both on the broad language of the stabilization requirement,<sup>205</sup> as well as Congress’ intention to prevent patient dumping, the court reasoned that EMTALA’s medical screening requirement applies to patients who present in the emergency room, but the stabilization requirement applies to patients anywhere in the hospital.<sup>206</sup> Thus, the First Circuit concluded that “the absence of emergency room presentment does not preclude prosecution.”<sup>207</sup>

Despite Congress’ efforts to resolve the problem of patient dumping, EMTALA itself creates further legal issues. The circuit splits that resulted from courts’ differing interpretations of EMTALA, as well as the *Roberts* and *Lopez-Soto* decisions that broadened the scope of previous EMTALA liability, illustrate the judicial ambiguity that surrounds the statute. There is little consensus from the circuits as to the proper interpretation of EMTALA; thus, hospitals and physicians have little guidance as to their liability under the law.

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<sup>200</sup> See Kamoie, *supra* note 26, at 37.

<sup>201</sup> *Id.*

<sup>202</sup> See *Lopez-Soto v. Hawayek*, 175 F.3d 170 (1st Cir. 1999).

<sup>203</sup> *Id.*

<sup>204</sup> See Kamoie, *supra* note 26, at 39.

<sup>205</sup> See *Lopez-Soto*, 175 F.3d at 173–74.

<sup>206</sup> *Id.* at 173.

<sup>207</sup> *Id.* at 177.

*E. The Final Regulations to EMTALA*

“[T]he various interpretations throughout the circuits are evidence of the ambiguity surrounding the statute and the difficulty of arriving at one uniform interpretation.”<sup>208</sup> In September 2003, the CMS published the Final Regulations in an attempt to clarify interpretations of EMTALA.<sup>209</sup> The Final Regulations represent a revision of proposed regulations from May 2002, following a lengthy public comment process, and the CMS promulgated the regulations to clarify the specific obligations of hospitals and physicians under EMTALA.<sup>210</sup> In particular, the Final Regulations address three divisive issues over which the circuits have split: (1) the medical screening requirement; (2) the conjunctive versus disjunctive approach; and (3) the application of EMTALA liability upon a patient’s admittance to the hospital.<sup>211</sup>

1. EMTALA’s Medical Screening Requirement Does Not Impose an Objective Standard

The Final Regulations attempt to clarify what EMTALA’s medical screening provision requires of a hospital.<sup>212</sup> The Final Regulations, while refraining from “dictating what type of medical screening examination is required for each individual who presents to the dedicated emergency department,”<sup>213</sup> proffer that the “screenings should be provided to each individual commensurate with the condition that is presented.”<sup>214</sup> Furthermore, the Regulations state that “the extent of the necessary examination is generally within the judgment and discretion of the qualified medical personnel performing the examination.”<sup>215</sup> The Final Regulations thus appear to promote a subjective standard for the medical screening requirement dependent on each individual patient’s condition, an interpretation that is in accordance with the majority of the

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<sup>208</sup> See Stalker, *supra* note 24, at 829.

<sup>209</sup> Medicare Program, Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical Conditions, 68 Fed. Reg. 53222, 53222 (Sept. 9, 2003) (codified at 42 C.F.R. Parts 413, 482, and 489). The Final Regulations are entitled “Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical Conditions.”

<sup>210</sup> *Id.*

<sup>211</sup> *Id.*

<sup>212</sup> *Id.* at 53236.

<sup>213</sup> *Id.*

<sup>214</sup> Medicare Program, Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical Conditions, 68 Fed. Reg. 53222, 53236 (Sept. 9, 2003) (codified at 42 C.F.R. Parts 413, 482, and 489).

<sup>215</sup> *Id.*

circuits.<sup>216</sup> Moreover, the Regulations further match the majority of the circuits by stating that “EMTALA does not purport to establish a medical malpractice cause of action nor establish a national standard of care.”<sup>217</sup>

## 2. EMTALA Protection Ends upon Admittance as an Inpatient

The Final Regulations clearly state that “a hospital’s obligations under EMTALA end once an individual is admitted for inpatient care.”<sup>218</sup> The reasoning within the Regulations indicates that “should a hospital determine that it would be better to admit the individual as an inpatient, such a decision would not result in either a transfer or a discharge, and, consequently, the hospital would not have an obligation to stabilize under EMTALA.”<sup>219</sup> However, the Regulations clarify that “a hospital cannot escape liability under EMTALA by ostensibly ‘admitting’ a patient, with no intention of treating the patient, then inappropriately transferring or discharging the patient without having met the stabilization requirement.”<sup>220</sup> Thus, if a hospital does not “admit an individual in good faith with the intention of providing treatment (that is, the hospital used the inpatient admission as a means to avoid EMTALA requirements), then liability under EMTALA may attach.”<sup>221</sup> The Final Regulations’ interpretation that EMTALA liability ends upon inpatient admittance is in agreement with the Ninth Circuit’s finding in *Bryant*.<sup>222</sup>

## 3. Both the Conjunctive and Disjunctive Approaches Are Supported by the Regulations

The Final Regulations address and clarify the important issue concerning the point at which EMTALA liability arises. Specifically, the Final Regulations address the phrase “come to the hospital emergency

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<sup>216</sup> See *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (6th Cir. 1990) (adopting a subjective, non-disparate treatment standard); *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1138 (8th Cir. 1996) (same); *Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519, 522 (10th Cir. 1994) (same); *Harry v. Marchant*, 291 F.3d 767 (11th Cir. 2002) (same); *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991) (same).

<sup>217</sup> See Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical Conditions, 68 Fed. Reg. at 53244 (Sept. 9, 2003) (codified at 42 C.F.R. Parts 413, 482, and 489); see, e.g., *Summers*, 91 F.3d at 1137 (“EMTALA is not a federal malpractice statute and it does not set a national emergency health care standard”); *Repp*, 43 F.3d at 522 (EMTALA “precludes the adoption of a standard tantamount to a federal malpractice statute”).

<sup>218</sup> *Id.* at 53247.

<sup>219</sup> *Id.* at 53244.

<sup>220</sup> *Id.* at 53245.

<sup>221</sup> *Id.*

<sup>222</sup> See *Bryant v. Adventist Health Sys. West*, 289 F.3d 1162, 1167 (9th Cir. 2002).

department” and purport that EMTALA liability is triggered in one of two ways: (1) “The individual can present at the hospital’s dedicated emergency department . . . and request examination or treatment for a *medical condition*,”<sup>223</sup> or (2) “the individual can present elsewhere on hospital property . . . (that is, at a location that is on hospital property but is not part of a dedicated emergency department), and request examination or treatment for . . . an *emergency medical condition*.”<sup>224</sup> Therefore, the regulations can be interpreted to support both the conjunctive and disjunctive approaches.

The Final Regulations’ interpretation of EMTALA extends liability to hospitals in accordance with the department where a patient first arrives, as well as with the condition in which that patient presents.<sup>225</sup> The conjunctive approach, with its threshold issue of whether an individual first presented in a hospital’s emergency department, finds support here, in the situation where a patient presents first to a hospital department other than the emergency department with a non-emergency condition. In that case, EMTALA liability would not apply. Similarly, the disjunctive approach draws support in the situation where a patient presents first in a non-emergency department but with an emergency condition. In that case, EMTALA liability would apply. Thus, insofar as the Final Regulations purport to clarify the ambiguities surrounding EMTALA and its interpretation by the circuits, the Regulations somewhat succeed here in clarifying the dispute over conjunctive versus disjunctive.

The Final Regulations attempt to clarify the ambiguity surrounding EMTALA and its interpretation within the circuits. First, the Final Regulations state that EMTALA does not require an objectively reasonable medical screening requirement.<sup>226</sup> Second, the Final Regulations state that EMTALA liability ends when a hospital admits a

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<sup>223</sup> See Medicare Program, Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical Conditions, 68 Fed. Reg. 53222, 53243 (Sept. 9, 2003) (codified at 42 C.F.R. Parts 413, 482, and 489) (emphasis added).

<sup>224</sup> *Id.* (emphasis added). The Final Regulations provide the following example:  
[I]f the individual were to tell the hospital staff at the laboratory or radiology department that he or she needed emergency care, EMTALA would apply. EMTALA also would apply if, in the absence of a verbal request, the individual’s appearance or behavior were such that a prudent layperson observer would believe the individual needed examination or treatment for an emergency medical condition and that the individual would request that examination or treatment if he or she were able to do so.

*Id.* at 53237.

<sup>225</sup> *Id.*

<sup>226</sup> *Id.* at 53236.

patient.<sup>227</sup> Finally, the Final Regulations lend support to both the conjunctive and disjunctive approaches to EMTALA liability.<sup>228</sup> These interpretations, however, beg the question of whether the circuit courts must give deference to the Final Regulations.

### III. ANALYSIS

#### A. Deference to the Final Regulations Under Chevron?

Despite the release of the CMS's Final Regulations, courts will still face issues of statutory interpretation regarding EMTALA. Courts will be challenged with the CMS's interpretation of the statute. In such a case, a court's interpretation will be guided by the Supreme Court's decision in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*<sup>229</sup> Specifically, courts will need to determine whether they will give deference to the agency's interpretation or whether they will choose to rely on the plain meaning of EMTALA and disregard the agency's regulations as void.<sup>230</sup>

*Chevron* is the definitive case on judicial review of agency-promulgated regulations.<sup>231</sup> In *Chevron*, the Supreme Court held that, unless Congress' intent on the matter is entirely clear, courts must defer to an agency's statutory interpretation, so long as such interpretation is permissible and reasonable.<sup>232</sup> The Court identified a two-step inquiry that a court must follow when reviewing an agency's construction of a statute.<sup>233</sup>

First, the court must ask "whether Congress has directly spoken to the precise question at issue."<sup>234</sup> To answer this question, the *Chevron* Court looked to both the plain language of the statute as well as the statute's legislative history.<sup>235</sup> At least one commentator has noted that, "[i]ncreasingly, the Supreme Court has chosen to resolve interpretive questions at Step One of the *Chevron* analysis . . . by using a textualist approach to statutory interpretation that finds in the statute itself an answer to the interpretive question posed."<sup>236</sup> When a court decides that

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<sup>227</sup> *Id.* at 53247–48.

<sup>228</sup> *Id.* at 53243 and 53237.

<sup>229</sup> 467 U.S. 837 (1984).

<sup>230</sup> *Id.*

<sup>231</sup> *Id.*

<sup>232</sup> *Id.* at 843–45.

<sup>233</sup> *Id.* at 842–43.

<sup>234</sup> *Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842 (1984).

<sup>235</sup> *Id.* at 845–53.

<sup>236</sup> Rebecca Hanner White, *Deference and Disability Discrimination*, 99 MICH. L. REV. 532, 536 (2000).

the statute speaks directly to the precise issue under consideration, “the court gives effect to the statute’s plain meaning, obviating any need to decide whether or not to defer to an administrative agency’s interpretation.”<sup>237</sup> If Congress’ intent as to the meaning of the statute is clear, “that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.”<sup>238</sup> However, if “the court determines Congress has not directly addressed the precise question at issue,” the court must proceed to the second step of its inquiry.<sup>239</sup>

Step two of the *Chevron* test requires a court to ask “whether the agency’s answer [to the question at issue] is based on a permissible construction of the statute.”<sup>240</sup> The *Chevron* Court gave little affirmative instruction as to what constitutes a “permissible construction.”<sup>241</sup> Rather, the Court stated that, as part of this analysis, a court “need not conclude that the agency construction was the only one it permissibly could have adopted to uphold the construction, or even the reading the court would have reached if the question initially had arisen in a judicial proceeding.”<sup>242</sup> Thus, a court need not give deference to an agency’s interpretation if Congress’ intent is entirely clear.<sup>243</sup> But, where Congress’ is not entirely clear, a court must defer to an agency’s statutory interpretation that is permissible.<sup>244</sup>

#### 1. Courts Should Give *Chevron* Deference to the Final Regulations’ Interpretation of EMTALA’s Medical Screening Requirement

When faced with the issue of whether to give deference to the Final Regulations’ interpretation of EMTALA’s medical screening requirement, a court must follow step one of the *Chevron* analysis and determine first whether Congress spoke to that precise issue.<sup>245</sup> The statutory text establishes a hospital’s responsibility to “provide for an appropriate medical screening examination within the capability of the hospital’s emergency department . . . to determine whether or not an emergency medical condition . . . exists.”<sup>246</sup> Instead of defining the exact parameters required of the medical screening exam, Congress uses the

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<sup>237</sup> *Id.* at 541.

<sup>238</sup> *Chevron*, 467 U.S. at 842–43.

<sup>239</sup> *Id.* at 843.

<sup>240</sup> *Id.*

<sup>241</sup> *Id.*

<sup>242</sup> *Id.* at 843 n.11.

<sup>243</sup> *Chevron*, U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837, 842 (1984).

<sup>244</sup> *Id.*

<sup>245</sup> *Id.* at 842.

<sup>246</sup> 42 U.S.C. § 1395dd(a).

ambiguous word “appropriate” to describe what it requires of hospitals.<sup>247</sup> EMTALA’s other statutory language does little more to clarify this ambiguity.<sup>248</sup> Thus, a court must turn then to the statute’s legislative history to ascertain Congress’ intent.

As previously discussed, Congress’ intent in passing EMTALA was unmistakably clear—Congress intended first and foremost to prevent patient dumping.<sup>249</sup> *Chevron* instructs that if Congress’ intent as to a particular question is clear, “that is the end of the matter,” and a reviewing court “must give effect to the unambiguously expressed intent of Congress.”<sup>250</sup> Thus, to the extent that the Final Regulations are in agreement with EMTALA’s objective and Congress’ intent in passing the statute, courts should give the Regulations *Chevron* deference.<sup>251</sup> The Regulations articulate a subjective standard, requiring a medical screening be “provided to each individual commensurate with the condition that is presented.”<sup>252</sup> Because this interpretation requires hospitals to tailor a patient’s screening examination in accordance with his medical conditions, as opposed to his financial or insurance status, in this circumstance, the Regulations deserve *Chevron* deference. Furthermore, because Congress’ intent is clear as to preventing hospitals from dumping patients, courts need not reach the second step in a *Chevron* analysis.<sup>253</sup>

## 2. Courts Should Not Give *Chevron* Deference to the Final Regulations’ Interpretation that EMTALA Protection Ends Upon Admittance as an Inpatient

Courts should not give *Chevron* deference to the Final Regulations’ interpretation that EMTALA protection ends upon admittance as an inpatient. Step one of the *Chevron* analysis requires a court to first determine whether Congress has spoken to the precise issue of whether EMTALA protection, and more specifically, its stabilization requirement, ends when a hospital admits an inpatient. A hospital triggers EMTALA’s stabilization requirement when a doctor determines that a patient is suffering from an emergency medical condition; if so, a

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<sup>247</sup> *Id.*

<sup>248</sup> 42 U.S.C. § 1395dd.

<sup>249</sup> *See supra* page 157.

<sup>250</sup> *Chevron*, 467 U.S. at 842–43.

<sup>251</sup> *Id.*

<sup>252</sup> Medicare Program, Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical Conditions, 68 Fed. Reg. 53222, 53236 (Sept. 9, 2003) (codified at 42 C.F.R. Parts 413, 482, and 489).

<sup>253</sup> *Chevron*, 467 U.S. at 842–43.



doctor must either stabilize the condition or transfer the patient, in accordance with EMTALA's transfer requirements.<sup>254</sup> Thus, if a hospital determines that no emergency condition exists, the hospital's EMTALA obligations end after the hospital provides a patient with a nondisparate examination. Additionally, Congress defines the term "stabilize" only "in connection with the transfer of an emergency room patient."<sup>255</sup> Nonetheless, the statute's plain language is unclear as to whether the stabilization requirement attaches when a doctor initially stabilizes a patient and then admits her as an inpatient.<sup>256</sup>

EMTALA's legislative history clearly sets forth Congress' intent in passing the statute. Specifically, the House Committee on Ways and Means reported:

The Committee is greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance. . . . The Committee wants to provide a strong assurance that pressures for greater hospital efficiency are not to be construed as license to ignore traditional responsibilities and loosen historic standards.<sup>257</sup>

In addition, the House Judiciary Committee, which had considered EMTALA's enforcement mechanisms, observed generally:

In recent years there has been a growing concern about the provision of adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured. Although at least twenty-two states have enacted statutes or issued regulations requiring the provision of limited medical services whenever an emergency situation exists, and despite the fact that many state court rulings impose a common law duty on doctors and hospitals to provide necessary emergency care, some are convinced that the problem needs to be addressed by federal sanctions . . . . The Judiciary Committee shares the concern of the Ways and Means Committee that appropriate emergency room care be provided to patients faced with medical emergencies and in active labor.<sup>258</sup>

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<sup>254</sup> 42 U.S.C. §§ 1395dd(b)–(c).

<sup>255</sup> *Bryant v. Adventist Health Sys. West*, 289 F.3d 1162, 1167 (9th Cir. 2002).

<sup>256</sup> *See Schaffner, supra* note 27, at 1032. The current circuit split regarding EMTALA liability after admittance serves as additional proof of a lack of statutory clarity. *Id.*

<sup>257</sup> H.R. REP. NO. 99-241, pt. 1, at 27 (1985), *as reprinted in* 1986 U.S.C.C.A.N. 579, 605.

<sup>258</sup> H.R. REP. NO. 99-241, pt. 3, at 5–6 (1985), *as reprinted in* 1986 U.S.C.C.A.N. 726, 726–27.

Although one could argue that Congress repeatedly used the term “emergency room” to indicate that treatment need not extend to patients outside of the predetermined emergency department, “[a] fairer reading is that Congress sought to insure that patients with medical emergencies would receive emergency care.”<sup>259</sup> Furthermore, “[a]lthough emergency care often occurs, and almost invariably begins, in an emergency room, emergency care does not always stop when a patient is wheeled from the emergency room into the main hospital.”<sup>260</sup>

To immunize hospitals from EMTALA liability merely because hospital personnel move patients from the emergency room to another department would, therefore, be incongruous with Congress’ clearly-stated intent to protect patients from hospitals transferring or dumping them before they are stabilized. If hospitals admit patients in order to treat them fairly and in accordance with standard procedures, the attachment of EMTALA’s requirements will not be problematic for hospitals. Only hospitals seeking to avoid EMTALA’s basic requirements by dumping patients before stabilization would fear liability attaching after admittance. In either case, Congress’ stated intent to protect patients demands that the stabilization requirement remain in effect even after doctors admit patients as inpatients. Thus, a hospital “may not circumvent the requirements of the Act merely by admitting an emergency room patient to the hospital, then immediately discharging that patient.”<sup>261</sup> Instead, “[e]mergency care must be given until the patient’s emergency medical condition is stabilized.”<sup>262</sup>

Nonetheless, the Final Regulations state that EMTALA liability ends upon a patient’s admittance as an inpatient. Because Congress’ intent is clear as to protecting patients even after initial stabilization and admittance, courts need not accord *Chevron* deference to the Final Regulations. Instead, courts should consider the Final Regulations void to the extent they limit liability under EMTALA when hospitals admit patients as inpatients.

### 3. Courts Should Not Give *Chevron* Deference to the Final Regulations in Relation to the Conjunctive Versus Disjunctive Approaches

Courts should not give *Chevron* deference to the Final Regulations in relation to the conjunctive versus disjunctive approaches. Here, the first step of the *Chevron* analysis requires a court to determine if

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<sup>259</sup> Thornton v. Sw. Detroit Hosp., 895 F.2d 1131, 1135 (6th Cir. 1990).

<sup>260</sup> *Id.*

<sup>261</sup> *Id.*

<sup>262</sup> *Id.*

Congress has addressed this precise issue: whether courts should consider the three requirements of EMTALA in the conjunctive, meaning that the provisions are read as interdependent and sequential, or whether courts should consider EMTALA's provisions in the disjunctive, such that courts would read the medical screening and stabilization requirements as separate causes of action.<sup>263</sup> EMTALA's language lends itself to the disjunctive approach for several reasons.<sup>264</sup>

First, the medical screening requirement in subsection (a) attaches when a patient "comes to the emergency room," while the stabilization requirement in subsection (b) is triggered when a patient "comes to the hospital."<sup>265</sup> If Congress had intended to make these two requirements the same, and thus trigger EMTALA only when a plaintiff meets both requirements, it would have drafted the statute to reflect such a desire. However, EMTALA's plain language reflects Congress' intent to create two separate causes of action: one for the medical screening examination, and another for the stabilization requirement. Moreover, nowhere in subsections (b) or (c) does Congress mention a requirement that a patient present first in an emergency room in order for EMTALA liability to attach.<sup>266</sup> Furthermore, by including women in active labor within the gambit of EMTALA's protection, "Congress obviously had a horizon broader than the emergency room in mind,"<sup>267</sup> as most women are admitted to maternity wards, rather than emergency rooms, when they present in active labor.<sup>268</sup>

In addition, the adoption of the disjunctive approach to EMTALA interpretation unequivocally furthers Congress' intent to prevent patient dumping. As the *Lopez-Soto* court reasoned,

After all, patient dumping is not a practice that is limited to emergency rooms. If a hospital determines that a patient on a ward has developed an emergency medical condition, it may fear that the costs of treatment will outstrip the patient's resources, and seek to move the patient elsewhere. That strain of patient dumping is equally as pernicious as what occurs in emergency departments, and we are unprepared to say that Congress did not seek to curb it.<sup>269</sup>

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<sup>263</sup> See Gionis, *supra* note 14, at 264–65.

<sup>264</sup> *Lopez-Soto v. Hawayek*, 175 F.3d 170, 173–74 (1st Cir. 1999).

<sup>265</sup> 42 U.S.C. § 1395dd(a)–(b)(1)(A).

<sup>266</sup> 42 U.S.C. §§ 1395dd(b)–(c).

<sup>267</sup> *Lopez-Soto*, 175 F.3d at 176.

<sup>268</sup> *Id.* at 177.

<sup>269</sup> *Id.*

Because EMTALA's plain language and its legislative history both clearly reflect Congress' intent to prevent patient dumping, courts should not afford *Chevron* deference to the Final Regulations, insofar as the Regulations construe EMTALA liability conjunctively. Thus, the Final Regulations requirement that a patient who presents on hospital property apart from a dedicated emergency department must "request examination or treatment for an *emergency medical condition*"<sup>270</sup> in order for EMTALA protection to attach, is void. Furthermore, courts need not continue to the second step in a *Chevron* analysis here because Congress' intent and the statute's plain language is unambiguous as to support EMTALA's interpretation in the disjunctive.

Thus, courts facing an EMTALA issue today will have one of two possible results. If a court encounters an issue concerning the medical screening requirement, the court should give *Chevron* deference to the Final Regulations' interpretation of EMTALA's medical screening requirement. In contrast, however, courts should not give *Chevron* deference to either the interpretation within the Final Regulations that EMTALA protection ends upon admittance as an inpatient nor to the Regulations' interpretation with regard to the conjunctive versus disjunctive approach.

*B. Mr. Takewell's Case Today*

If Mr. Takewell presented in the Tennessee hospital today, his treatment would have been decidedly different. EMTALA would have required the hospital to tailor Mr. Takewell's screening examination in accordance with his medical conditions, as opposed to his inability to pay. In other words, the hospital would have been required to assess his medical state, and likely would have discovered that he was in an emergency condition. Then, EMTALA would have mandated that the hospital stabilize Mr. Takewell's condition. If Mr. Takewell's doctor had followed the same course of action of removing him from his bed and carrying him out of the hospital without treatment, the doctor and the hospital would have faced statutory penalties, including fines, exclusion from the Medicare program, and possible civil liability. Furthermore, as this comment suggests, even if the Tennessee hospital admitted Mr. Takewell as an inpatient, the hospital still would face statutory liability under EMTALA. Moreover, this comment suggests that Mr. Takewell

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<sup>270</sup> Medicare Program, Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical Conditions, 68 Fed. Reg. 53222, 53243 (Sept. 9, 2003) (codified at 42 C.F.R. Parts 413, 482, and 489) (emphasis added).

should have an EMTALA claim no matter where he presented in the hospital—the emergency department or otherwise.

Thus, Mr. Takewell would have fared much better had he fallen ill today as opposed to when he did in 1986. Not only would EMTALA and the Final Regulations now require the Tennessee hospital to assess and stabilize his emergency condition, but the statute, notwithstanding the issuance of the Final Regulations, would also protect Mr. Takewell, regardless of where he presented in the hospital. Unfortunately for Mr. Takewell and other indigent patients in similar situations, the benefit of EMTALA arrived too late.

#### IV. CONCLUSION

Congress enacted EMTALA to protect patients in need of emergency medical care from doctors and hospitals that turn away such patients because of their inability to pay for treatment. Inconsistent judicial interpretations evidence the need for clarification of the statute. In particular the divisive issues over which the circuits have split highlight the need for a uniform ruling by the Supreme Court. Courts should give deference to the Final Regulations' interpretation of EMTALA's medical screening requirement. Courts, however, should not give *Chevron* deference to the CMS's Final Regulations to the extent that the Regulations conflict with Congress' intent to prevent patient dumping. Therefore, courts should not defer to either the Final Regulations' interpretation that EMTALA protection ends upon admittance as an inpatient nor to the Regulations' view in regards to the conjunctive versus the disjunctive approach. Additionally, although courts faced with EMTALA will need to conduct a *Chevron* analysis for each specific statutory issue, courts should look to Congress' intent and interpret the statute and its purpose broadly. Finally, courts should adhere to Congress' intent, and strive to protect patients like Mr. Takewell first.