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The Critical Condition of the Emergency Medical Treatment and Active Labor Act: A Proposed Amendment to the Act After "In the Matter of Baby K"

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**The Critical Condition of the Emergency Medical
Treatment and Active Labor Act: A Proposed
Amendment to the Act After
*In the Matter of Baby K***

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I. INTRODUCTION

Congress enacted the Emergency Medical Treatment and Active Labor Act ("EMTALA" or "the Act")¹ in 1986 to prevent hospitals from "dumping" patients due to an improper economic motive.² Patient dumping occurs when a hospital emergency room either refuses to admit an indigent and uninsured patient with an emer-

1. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (1988 & Supp. 1993).

2. Deficit Reductions Amendments of 1985, H.R. Rep. No. 99-241 (Part 1), 99th Cong., 1st Sess. 27 (1985).

gency condition or improperly transfers this patient to another hospital.³ Congress enacted EMTALA in response to the widespread practice of hospitals dumping indigent and uninsured patients.⁴ Yet despite the Act's explicit legislative intent to prevent patient dumping, the language of EMTALA extends protection to "any individual" who enters a hospital's emergency room.⁵ Initially, EMTALA requires hospitals to provide emergency patients with an "appropriate medical screening examination."⁶ If the patient is diagnosed with an "emergency medical condition," the hospital must either stabilize the patient's condition or transfer the patient after fulfilling several statutory requirements.⁷

As a result of the inconsistency between the Act's legislative intent and its broad language, the federal courts have used two different standards to define a cause of action under EMTALA. Several federal district courts have narrowly construed the Act in light of its legislative history, allowing a cause of action only in cases involving economic dumping. On the other hand, the federal circuit courts have broadly applied EMTALA's statutory language, permitting "any individual" who alleges improper medical treatment to sue under the statute. This judicial expansion of the Act has encroached upon other federal laws enacted to remedy instances of non-economic discrimination.

Congress designed EMTALA to remedy economic discrimination against indigent and uninsured patients by hospitals; yet, most federal courts have overlooked the Act's legislative purpose by allowing paying patients to challenge their emergency treatment

3. See *Equal Access to Health Care: Patient Dumping*, H.R. Rep. No. 100-531, 100th Cong., 2d Sess. 2 (1988) (stating that the most common form of patient dumping "is the transfer of a patient from one hospital emergency room to another for economic reasons, that is, lack of insurance and inability to pay"); Karen I. Treiger, Note, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. Rev. 1186, 1186-1187 (1986) (stating that patient dumping occurs when a hospital sends a patient to another facility or simply turns the patient away because the patient is unable to pay). Private hospitals have an economic incentive to dump patients on public hospitals, which then bear the brunt of patient dumping. *Id.* at 1187. See also 131 Cong. Rec. S13904 (October 23, 1985) (statement of Senator Kennedy) (stating that public hospitals have reported a 400-percent rise in the number of uninsured patients who have been transferred to their emergency rooms after visiting another hospital).

4. H.R. Rep. No. 91-241 (Part 1) at 27 (cited in note 2).

5. 42 U.S.C. § 1395dd(a) applies to "any individual" who comes to a hospital's emergency department. 42 U.S.C. § 1395dd(b)(1) applies to "any individual" who comes to the hospital. 42 U.S.C. § 1395dd(c)(1) applies to "an individual" at the hospital. Thus the Act's language does not limit its protections to indigent and uninsured patients.

6. 42 U.S.C. § 1395dd(a). See Treiger, 61 N.Y.U. L. Rev. at 1209 (cited in note 3) (pointing out that EMTALA's authorization through Medicare is curious since EMTALA's requirements will have little effect on Medicare patients).

7. 42 U.S.C. § 1395dd(b)-(c).

under the Act. Thus the federal courts have done little to improve indigent patients' access to emergency care. Instead, most of the judicial ink spilled interpreting EMTALA has involved the federal standards of emergency care for paying patients.

In 1994, the Fourth Circuit handed down the surprising opinion of *In the Matter of Baby "K"* ("*Baby K*"),⁸ which extended EMTALA beyond any prior decision. This decision used EMTALA to control the sensitive medical and ethical issues surrounding an infant with anencephaly, a congenital birth defect. The *Baby K* court's interpretation of EMTALA forced a Virginia hospital to stabilize the infant's recurrent respiratory distress even though the hospital considered the treatment medically and ethically inappropriate.⁹ The Fourth Circuit's decision established a troubling precedent because the Act was not designed to determine such specific treatment issues. Notwithstanding the Act's clearly defined goal of improving access for indigent patients, the court transformed EMTALA into an expansive remedy for plaintiffs in search of medical treatment. Consequently, this Note encourages Congress to amend the Act's language to ensure that EMTALA addresses the dumping of indigent and uninsured patients without controlling medical situations unforeseen by Congress. Amending EMTALA will help the federal courts remedy instances of economic discrimination against indigent and uninsured patients without encroaching upon federal laws better designed to control other types of discrimination.

Part II of this Note traces the history of EMTALA's enactment and implementation to investigate the legislative intent supporting the Act. Part III examines the federal courts' inconsistent application of the Act and encourages the circuits that have not interpreted EMTALA to adopt an approach that follows the legislative intent more closely. Part IV discusses the Fourth Circuit's extension of EMTALA in *Baby K*, illustrating how a broad application of the Act's current language controls medical treatment decisions beyond the Act's antidumping purpose. Part V presents some of the troubling ethical and legal ramifications of *Baby K* and argues that the Fourth Circuit's opinion extended EMTALA's protections into areas better governed by federal laws such as the Rehabilitation Act,¹⁰ the

8. 16 F.3d 590 (4th Cir. 1994).

9. *Id.* at 597.

10. 29 U.S.C. § 701 et seq. (1988 & Supp. 1993).

Americans with Disabilities Act ("ADA"),¹¹ and the Child Abuse Amendments of 1984.¹² To address these ramifications, Part VI proposes an amendment to EMTALA that will remove the inconsistency between the Act's anti-dumping purpose and its broad statutory language.

II. THE HISTORY OF EMTALA'S ENACTMENT AND IMPLEMENTATION

A. Legislative History

EMTALA was originally enacted as part of the Comprehensive Omnibus Budget Reconciliation Act of 1986 ("COBRA").¹³ The Act's requirements apply to all hospitals that have entered into a Medicare provider agreement. Prior to EMTALA's enactment, there were no requirements concerning the appropriate treatment of emergency patients in hospitals participating in Medicare.¹⁴ During hearings on this issue, the House Committee on Ways and Means received a disturbing number of reports that hospital emergency rooms were dumping uninsured patients in need of emergency medical treat-

11. 42 U.S.C. § 12101 et seq. (1988 & Supp. 1993).

12. 42 U.S.C. § 5101 et seq. (1988 & Supp. 1993).

13. Pub. L. No. 99-272 § 9121, 100 Stat. 82, 164-67 (1986). Although EMTALA is only one section of COBRA, many courts and commentators have referred to EMTALA as COBRA. See, for example, *Nichols v. Estabrook*, 741 F. Supp. 325, 329 (D. N.H. 1989) (using COBRA to designate EMTALA); *Deberry v. Sherman Hospital Association*, 741 F. Supp. 1302, 1303 (N.D. Ill. 1990) (pointing out that EMTALA is commonly referred to as COBRA although EMTALA is only a small part of COBRA); Andrew J. McClurg, *Your Money or Your Life: Interpreting the Federal Act Against Patient Dumping*, 24 Wake Forest L. Rev. 173, 176 (1989) (stating that COBRA was enacted to prevent patient dumping); Treiger, 61 N.Y.U. L. Rev. at 1188 (cited in note 3) (creating the confusion by abbreviating the new federal antidumping law as COBRA).

14. H.R. Rep. No. 99-241 (Part 1) at 27 (cited in note 2); 59 Fed. Reg. 32086, 32088 (1994). The Hill-Burton Act, 42 U.S.C. § 291 (1988), was an earlier congressional attempt to force hospitals receiving federal building funds to provide indigent patients with free or below-cost health care. Despite its laudable intent, the Hill-Burton Act has been unsuccessful for several reasons. First, Hill-Burton's requirements were unenforced from 1946 until 1972, when Congress enacted enforcement provisions. Second, these enforcement provisions do not provide punitive measures for violations. Third, the statute does not include an express private cause of action for potential plaintiffs. For an extended discussion of Hill-Burton's ineffectiveness, see Treiger, 61 N.Y.U. L. Rev. at 1198-1200 (cited in note 3); Judith L. Dobbertin, Note, *Eliminating Patient Dumping: A Proposal for Model Legislation*, 28 Valp. U. L. Rev. 291, 297-303 (1993).

Several states have enacted statutes that address patient dumping in a variety of ways. For an exhaustive review of these laws, see Thomas L. Stricker, Jr., Note, *The Emergency Medical Treatment & Active Labor Act: Denial of Emergency Medical Care Because of Improper Economic Motives*, 67 Notre Dame L. Rev. 1121, 1124 n.16 (1992); McClurg, 24 Wake Forest L. Rev. at 190-97 (cited in note 13).

ment.¹⁵ Consequently, the House version of EMTALA was drafted to address these concerns. Once this version was introduced, the House deliberation on EMTALA reflected the Act's antidumping intent.¹⁶

The Senate deliberation on the Act also focused on patient dumping and the need to ameliorate this problem. Senator David Durenberger introduced the Senate version of EMTALA, stating that the law "would require hospitals serving Medicare patients to provide

15. The Committee on Ways and Means noted its concern:

The Committee is greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance. The Committee is most concerned that medically unstable patients are not being treated appropriately. There have been reports of situations where treatment was simply not provided. In numerous other instances, patients in an unstable condition have been transferred improperly, sometimes without the consent of the receiving hospital . . . The Committee wants to provide a strong assurance that pressures for greater hospital efficiency are not to be construed as license to ignore traditional community responsibilities and loosen historic standards.

H.R. Rep. No. 99-241 (Part 1) at 27 (cited in note 2). The Committee believed that patient dumping may have worsened since Medicare's prospective payment system went into effect. *Id.* Under the prospective payment system, the hospital is paid a predetermined amount for each medical condition. If the hospital's treatment costs are less than the fixed sum, the hospital profits from the surplus; however, if the hospital's treatment costs exceed the fixed sum, the hospital absorbs the additional cost. Treiger, 61 N.Y.U. L. Rev. at 1194 (cited in note 3). As a result, efficient hospitals make more money, and thus the prospective payment system creates an incentive to treat fewer indigent patients. *Id.*

The House Committee on the Judiciary reiterated the concerns of the Committee on Ways and Means in its report, stating:

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 22 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 not convinced that the problem needs to be addressed by federal sanctions.

Section 124 of the Deficit Reduction Amendments of 1985 (Responsibility of Medicare Hospitals in Emergency Cases), H.R. Rep. No. 99-241 (Part 3), 99th Cong., 1st Sess. 5 (1985) (citations omitted).

16. 131 Cong. Rec. H9503 (Oct. 31, 1985) (statement of Representative Bilirakis). Representative Bilirakis stated:

I introduced legislation which expresses the sense of the Congress that no person should be denied emergency health care or hospital admittance because of a lack of money or insurance. I firmly believe the American people should continue to expect that when they see an emergency sign on a hospital or free standing clinic they can expect access to emergency care. Unfortunately, there are countless examples where this isn't the case. I am pleased that in the bill before us the thrust of my legislation has been included. The quality of American health care is unparalleled throughout the world and it should be the national policy for hospitals and free standing emergency centers to provide high quality emergency care to all patients without discriminating on the grounds of economic status, color, race, religion, sex, or national origin. Judging by the numbers of cosponsors of my legislation this is a view shared by the majority of this body.

Id.

emergency services to individuals with life-threatening or potentially crippling conditions regardless of their ability to pay."¹⁷ Echoing this sentiment, Senator Kennedy reported a four-hundred-percent rise in the number of patients who were sent to the emergency rooms of public hospitals after visiting another, often private, hospital.¹⁸ Senator Dole then urged the Senate to "put an end to certain unsafe practices, often referred to as 'patient dumping', whereby a hospital, for purely financial reasons, refuses to initially treat or stabilize an individual with a true medical emergency."¹⁹

17. 131 Cong. Rec. S13903 (Oct. 23, 1985). Senator Durenberger's statements exclusively addressed patient dumping:

[T]he practice of rejecting indigent patients in life threatening situations for economic reasons alone is unconscionable.

...

All Americans, rich or poor, deserve access to quality health care. . . .

At the same time while we in the Congress and the State legislatures are groping for areas to get quality health care to the uninsured Americans, we cannot stand idly by and watch those Americans who lack the resources be shunted away from immediate and appropriate emergency care whenever and wherever it is needed. The purpose of this amendment is to send a clear signal to the hospital community, public and private alike, that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in distress.

...

Whatever additional steps GAO recommends, whether further Medicare action or refinements in Medicaid, the aim of Congress should be to encourage States to take definite action to guard against "dumping" at the local level.

Id. at S13903-04.

18. Id. at S13904. Senator Kennedy's remarks also reflected his concern over patient dumping:

[D]isturbing reports have surfaced about individuals who have been denied emergency services at hospitals in many locations around the country. They have been denied services because they lacked health insurance or funds to pay cash at the door. In some cases, racial discrimination may have been involved.

These patients have been denied the care they need. Some have been sent to another hospital—usually a public hospital. This practice is often called patient dumping. . . .

[S]tudies done by physicians have documented the danger of this inexcusable practice; death and disability have clearly been the result. . . .

We cannot allow a health care system as advanced as ours to provide emergency care only to those who can pay. This amendment will ensure that hospitals live up to their fundamental responsibilities to the public.

Id.

19. Id. Senator Heinz then stated, "I am pleased to join my colleagues . . . as a cosponsor of this amendment to . . . [COBRA], addressing the critical problem of hospital emergency department dumping of the medically uninsured. . . . Mr. President, the amendment offered today . . . takes a major step toward preventing the 'dumping' of emergency patients." Id. at S13904-05. Senator Proxmire echoed this sentiment, stating: "I am delighted to join as a cosponsor of this antidumping amendment. . . . This amendment deals with one of the most egregious abuses [of Medicare's prospective payment system]: The refusal of hospitals with emergency rooms to provide emergency treatment for critically ill patients or women in labor." Id. at S13905.

As the legislative history reveals, there is no question the legislative purpose behind EMTALA was to prohibit Medicare hospitals from dumping patients due to an improper economic motive. In addition, virtually all federal courts as well as several commentators have agreed that Congress enacted EMTALA to address patient dumping.²⁰ In spite of Congress's clear antidumping intent, EMTALA

20. See *Power v. Arlington Hospital Ass'n*, 43 F.3d 851, 856 (4th Cir. 1994) (stating that Congress enacted EMTALA to address a growing concern with patient dumping); *Holcomb v. Monahan*, 30 F.3d 116, 117 n.2 (11th Cir. 1994) (finding that EMTALA was enacted to prevent patient dumping); *Delaney v. Cade*, 986 F.2d 387, 391 n.5 (10th Cir. 1993) (stating that Congress designed the Act to end patient dumping); *Brooker v. Desert Hospital Corp.*, 947 F.2d 412, 414 (9th Cir. 1991) (finding that the legislative history indicates that Congress intended the Act to prevent hospitals from dumping patients who lack insurance coverage); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1039 (D.C. Cir. 1991) (finding that EMTALA was designed principally to address the problem of patient dumping); *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 269 (6th Cir. 1990) (stating that "there is nothing in the legislative history showing that Congress had any concern about the treatment accorded any patients other than the indigent and uninsured"); *Slabik v. Sorrentino*, 891 F. Supp. 235, 236 (E.D. Pa. 1995) ("EMTALA was enacted . . . amid growing concerns of inadequate emergency room care for poor and uninsured patients"); *Keating v. Tangipahoa Hospital Dist. No. 1*, 1995 U.S. Dist. LEXIS 2559, *2 (E.D. La.) (stating that EMTALA prohibits patient dumping); *Reynolds v. Mery Hospital*, 861 F. Supp. 214, 219 (W.D. N.Y. 1994) (finding that Congress enacted EMTALA in response to the growing concern that hospitals were dumping patients who were unable to pay); *Lanc v. Calhoun-Liberty County Hospital Association, Inc.*, 846 F. Supp. 1543, 1549 (N.D. Fla. 1994) (stating that the legislative history of the Act evinces a concern for patient dumping); *Griffith v. Mt. Carmel Medical Center*, 842 F. Supp. 1359, 1365 n.4 (D. Kan. 1994) (stating that EMTALA was enacted to stop patient dumping); *Ruiz v. Kepler*, 832 F. Supp. 1444, 1447 (D. N.M. 1993) (stating that EMTALA's legislative history reflects an unmistakable concern for the treatment of indigent and uninsured persons); *Hines v. Adair County Public Hospital*, 827 F. Supp. 426, 428 (W.D. Ky. 1993) (finding that the Act proscribes patient dumping, "a phenomenon exacerbated by increasing economic pressures upon for-profit hospitals"); *Coleman v. McCurtain Memorial Medical Management*, 771 F. Supp. 343, 345 (E.D. Okla. 1991) (stating that Congress enacted EMTALA to address and alleviate the problem of patient dumping); *Owens v. Nacogdoches County Hospital District*, 741 F. Supp. 1269, 1271-72 (E.D. Tex. 1990) (stating that the Act was a congressional response to a national epidemic of patient dumping); *Evitt v. University Heights Hospital*, 727 F. Supp. 495, 497 (S.D. Ind. 1989) (stating that EMTALA's legislative purpose is specifically directed toward preventing patient dumping); *Thompson v. St. Anne's Hospital*, 716 F. Supp. 8, 10 (N.D. Ill. 1989) (finding that EMTALA's legislative history "indicates that the statute is aimed at preventing hospitals not only from transferring indigent patients but also from simply rejecting them"); *Nichols*, 741 F. Supp. at 330 (finding that the congressional intent was "to provide some assurance that patients with emergency medical conditions will be examined and treated regardless of their financial resources"); *Bryant v. Riddle Memorial Hospital*, 689 F. Supp. 490, 491 (E.D. Pa. 1988) (stating that EMTALA was enacted in order to combat the growing problem of patient dumping); Pamela K. Epp, Note, *Medical Care: In Defense of the Masses—An Interpretation of the Emergency Medical Treatment and Active Labor Act*, in *Re Baby K*, 28 Creighton L. Rev. 1209, 1220 (1995) ("EMTALA's legislative history clearly reveals that Congress intended to prevent patient dumping for economic reasons"); Mary Jean Fell, Note, *The Emergency Medical Treatment and Active Labor Act of 1986: Providing Protection from Discrimination in Access to Emergency Medical Care*, 43 Cath. U. L. Rev. 607, 608-609 (1994) (showing that Congress enacted EMTALA to prevent patient dumping in response to highly publicized incidents); Dobbertin, 28 Valp. U. L. Rev. at 303 (cited in note 14) (stating that the most recent federal attempt to solve the patient

was enacted without reference to a patient's indigence or lack of insurance. Thus the Act's broad statutory language is inconsistent with its legislative history. Presumably Congress did not limit the Act's application to indigent patients because it believed hospitals would have no economic incentive to dump paying patients. However, extending EMTALA's protections to any emergency patient controls situations beyond the Act's legislative purpose. While indigent and uninsured patients can use EMTALA to remedy instances of economic discrimination, paying patients can also use the Act's requirements to create a federal standard of emergency care.

B. *The Statutory Requirements of EMTALA*

To guarantee all emergency patients equal treatment, Congress drafted the Act to apply to "any individual" who arrives at a hospital with an emergency condition.²¹ While this language certainly applies to indigent and uninsured patients, EMTALA's language covers a far larger class of potential patients than is indicated in the Act's legislative history. In other words, although the Act's language effectuates Congress's anti-discriminatory intent,²² EMTALA's application to "any individual" protects patients who are not indigent and uninsured. This inherent inconsistency between the Act's legislative history and its statutory language is the source of judicial confusion over the Act's application.

EMTALA contains three distinct requirements.²³ First, under section 1395dd(a), the hospital²⁴ must provide every emergency pa-

dumping problem is EMTALA); Stricker, 67 Notre Dame L. Rev. at 1121, 1129 (cited in note 14) (showing that the Act's legislative history clearly indicates that Congress enacted EMTALA to remedy incidents in which patients were denied emergency care due to an improper economic motive); Wayne Edward Ramage, Note, *The Pariah Patient: The Lack of Funding for Mental Health Care*, 45 Vand. L. Rev. 951, 960 (1992) (stating that the Act was Congress's response to the increasing problem of patient dumping); McClurg, 24 Wake Forest L. Rev. at 175-76 (cited in note 13) (stating that EMTALA is directed at curbing patient dumping); Treiger, 61 N.Y.U. L. Rev. at 1206-07 (cited in note 3) (showing that EMTALA's antidumping provisions were enacted in response to congressional concern over patient dumping).

21. 42 U.S.C. § 1395dd(a), (b)(1), (c)(1). See also H.R. Rep. No. 99-241 (Part 3) at 5 (cited in note 15) (stating that EMTALA applies to all individuals for whom care is sought, regardless of whether the patient is covered by Medicare); 131 Cong. Rec. S13904 (Oct. 23, 1985) (remarks of Senator Durenberger) (stating that EMTALA's purpose is to send a signal to hospitals that all Americans should be provided emergency care regardless of their wealth or status).

22. For the broadest legislative statement of EMTALA's anti-discriminatory intent see 131 Cong. Rec. H9503 (Oct. 31, 1985) (remarks of Representative Bilirakis) (stating that EMTALA should be a national policy requiring hospitals to provide emergency care without discriminating on the basis of economic status, color, race, religion, sex, or national origin).

23. See 131 Cong. Rec. S13904 (Oct. 23, 1985) (remarks of Senator Kennedy) (summarizing EMTALA's three requirements); H.R. Rep. No. 99-241 (Part 3) at 6-7 (cited in

tient with an appropriate medical screening to determine whether the patient has an emergency medical condition.²⁵ Second, if the medical screening reveals that an emergency medical condition exists, the hospital must then provide the patient with treatment necessary to stabilize this condition.²⁶ The definition of the phrase “to stabilize” reflects the presumption that a hospital will transfer all unprofitable patients; therefore, the hospital must provide the emergency patient with “such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the

note 15) (stating that individual patients can sue hospitals for failing to appropriately screen, stabilize, or properly transfer them).

24. The term “hospital” includes a rural primary care facility. 42 U.S.C. § 1395dd(e)(5).

25. Section 1395dd(a) states:

In the case of a hospital that has a hospital emergency department, if *any individual . . .* comes to the emergency department and a request is made on the individual’s behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition . . . exists.

42 U.S.C. § 1395dd(a) (emphasis added). The term “emergency medical condition” is defined as:

- (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—
 - (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
 - (ii) serious impairment to bodily functions, or
 - (iii) serious dysfunction of any bodily organ or part; or
- (B) with respect to a pregnant women [sic] who is having contractions—
 - (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
 - (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

42 U.S.C. § 1395dd(e)(1). See Treiger, 61 N.Y.U. L. Rev. at 1210 (cited in note 3) (encouraging Congress to replace EMTALA’s current definition of emergency medical condition with a more comprehensive definition formerly used by the American College of Emergency Physicians); Ramage, 45 Vand. L. Rev. at 961 (cited in note 20) (same).

26. Section 1395dd(b)(1) states:

If *any individual . . .* comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

- (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
- (B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

42 U.S.C. § 1395dd(b)(1) (emphasis added). If the patient refuses to consent either to treatment or to transfer, the hospital satisfies the stabilization requirements of § 1395dd(b)(1). 42 U.S.C. § 1395dd(b)(2)-(3). In these situations, the hospital should take all reasonable steps to secure the patient’s written informed consent. *Id.*

transfer of the individual from a facility.”²⁷ Third, the hospital may transfer²⁸ an unstabilized patient to another facility provided several statutory requirements are satisfied.²⁹

27. 42 U.S.C. § 1395dd(e)(3)(A). If the emergency patient is pregnant and delivery is imminent, the hospital must deliver her child in order to stabilize her. *Id.*

28. The term “transfer” is defined as:

the movement (including the discharge) of an individual outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

42 U.S.C. § 1395dd(e)(4).

29. Section 1395dd(c)(1) states:

If an *individual* at a hospital has an emergency medical condition which has not been stabilized . . . , the hospital may not transfer the individual unless--

- (A) (i) the individual (or a legally responsible person acting on the individual’s behalf) after being informed of the hospital’s obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,
- (ii) a physician . . . has signed a certification that[,] based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or
- (iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person . . . has signed a certification described in clause (ii) after a physician . . . in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and
- (B) the transfer is an appropriate transfer . . . to that facility.

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

The term “stabilized” is defined to mean that:

no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

42 U.S.C. § 1395dd(e)(3)(B).

An appropriate transfer to a medical facility is a transfer—

- (A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual’s health and, in the case of a woman in labor, the health of the unborn child;
- (B) in which the receiving facility—
 - (i) has available space and qualified personnel for the treatment of the individual, and
 - (ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;
- (C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of transfer, including records related to the individual’s emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(a), and the name and address of any on-call physician . . . who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

Accordingly, a potential private plaintiff may sue under EMTALA if the hospital fails to follow any one of the Act's three requirements.³⁰ In other words, an EMTALA cause of action is proper if a plaintiff alleges one or more of the following: (1) the hospital failed to provide an "appropriate medical screening examination" and therefore failed to discover the patient's "emergency medical condition"; (2) after determining the patient had an "emergency medical condition,"³¹ the hospital failed "to stabilize" the patient's condition before transfer; or (3) after determining the patient had an "emergency medical condition" and before the condition was "stabilized," the hospital transferred the patient without fulfilling the statutory transfer requirements.³²

-
- (D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and
 - (E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

42 U.S.C. § 1395dd(c)(2).

30. See *Urban v. King*, 43 F.3d 523, 526 (10th Cir. 1994) (stating that a plaintiff does not have to prove that the hospital violated the screening requirements of § 1395dd(a) in order to succeed in an action brought under the transfer requirements of § 1395dd(c)).

31. EMTALA's stabilization and transfer requirements are triggered only after the hospital diagnoses the patient with an emergency medical condition. See, for example, *Baber v. Hospital Corp. of America*, 977 F.2d 872, 883 (4th Cir. 1993) (holding that the Act's plain language requires actual knowledge of the patient's emergency medical condition); *Gatewood*, 933 F.2d at 1041 (stating that the stabilization and transfer requirements "are triggered only after a hospital 'determines that an individual has an emergency medical condition'") (quoting § 1395dd(b)); *Coleman*, 771 F. Supp. at 346 (concluding that "a plain reading of the Act dictates that the provisions concerning stabilization and transfer are implicated only after the hospital determines that an emergency medical condition exists").

32. It is important to emphasize EMTALA's three separate requirements and their attendant causes of action because many federal courts have misunderstood these requirements. Some federal courts mistakenly believe that EMTALA prevents hospitals from transferring patients before they are stabilized, when in fact, § 1395dd(c) explicitly allows hospitals to transfer unstabilized patients provided the statutory transfer requirements are satisfied. See 59 Fed. Reg. at 32100 (stating, "the Act permits an unstabilized individual to be transferred" if the statutory transfer requirements are satisfied); *id.* at 32104 (stating that the Act "does not regulate the transfer of stabilized individuals"). In fact, another portion of the Act explicitly supports the conclusion that unstabilized patients may be transferred if a physician authorizes the transfer. 42 U.S.C. § 1395dd(i) (preventing a hospital from taking adverse action against a physician who refuses to authorize the transfer of an unstabilized patient). The confusion over unstabilized transfers may be the direct result of the inaccurate title of § 1395dd(c): "Restricting transfers until individual stabilized." See note 200 and accompanying text (proposing an amendment to EMTALA to correct this confusion). Consequently, many courts have mistakenly interpreted § 1395dd(c) to prevent unstabilized transfers. See *Holcomb*, 30 F.3d at 117 (stating that, in order to succeed on a § 1395dd(b) claim, the plaintiff must present evidence that the patient was not stabilized before being transferred); *Collins v. DePaul Hospital*, 963 F.2d 303, 305 (10th Cir. 1992) (reading EMTALA to prevent hospitals from transferring patients if their medical condition has not been stabilized); *Brooker*, 947 F. Supp. at 415 (erroneously stating that the Act prevents hospitals from transferring patients unless they

EMTALA's statutory requirements implicitly reflect an anti-dumping purpose since the Act's language presumes all emergency patients covered by the Act will be transferred. Once an emergency patient is diagnosed with an emergency medical condition, the hospital can either provide the patient with treatment that will prevent any material deterioration of the patient's condition during transfer,³³ or the hospital can transfer the patient in an unstabilized condition provided all transfer requirements are satisfied.³⁴ EMTALA's presumption that all non-paying emergency patients will be transferred is consistent with the Act's congressional intent to protect indigent patients from dangerous transfers.³⁵ When the patient is able to pay, EMTALA's requirements become irrelevant because the hospital will not transfer the patient.³⁶ Instead, economic incentive will provide the impetus for the hospital to stabilize the patient's emergency condition, and the hospital will admit the patient for further care. Therefore, EMTALA operates only in circumstances in which the hospital is determined to transfer an emergency patient, and these

are stabilized); *Reynolds*, 861 F. Supp. at 220 (concluding that EMTALA restricts the transfer of an unstabilized patient); *Owens*, 741 F. Supp. at 1272 (stating that the Act provides that emergency patients cannot be transferred to another facility in an unstable condition).

Many federal courts also mistakenly believe EMTALA contains only two requirements. See *Brooks v. Maryland General Hospital Inc.*, 996 F.2d 708, 710 (4th Cir. 1994) (concluding that EMTALA imposes two duties upon every Medicare hospital: (1) to provide every emergency patient with an appropriate medical screening examination, and (2) to stabilize any emergency medical condition or to transfer the person to another facility if the benefits outweigh the risks); *Urban*, 1994 WL 617521 at 2 (stating that all Medicare hospitals face two requirements under the Act: (1) the screening requirements under § 1395dd(a), and (2) the transfer requirements under § 1395dd(c)); *Cleland*, 917 F.2d at 268 (finding that EMTALA imposes two duties upon hospitals: (1) the screening requirements under § 1395dd(a), and (2) the stabilization requirements under § 1395dd(b)); *Lane*, 846 F. Supp. at 1549 (concluding that EMTALA, at heart, imposes two duties upon hospitals under § 1395dd(a) and (b)); *Cooper*, 839 F. Supp. at 1541 (stating that the Act imposes two duties: screening and stabilization); *Griffith*, 831 F. Supp. at 1537 (stating that most courts have interpreted the Act to create two duties giving rise to two different claims: "improper screening examination" and "transfer before stabilization"); *Hines*, 827 F. Supp. at 431 (stating that the Act imposes two duties upon emergency rooms: screening and stabilization); *Deberry*, 741 F. Supp. at 1305 (stating that the hospital can violate EMTALA by either using inadequate screening procedures or by failing to stabilize the patient's condition). But see *Gatewood*, 933 F.2d at 1040-41 (distinguishing clearly between EMTALA's three statutory requirements: screening, stabilization, and transfer); *Romo v. Union Memorial Hospital, Inc.*, 878 F. Supp. 837, 841 (W.D. N.C. 1995) (same).

33. 42 U.S.C. § 1395dd(b)(1)(A).

34. 42 U.S.C. § 1395dd(c).

35. 131 Cong. Rec. S13904 (statement of Senator Dole) (stating that EMTALA only requires a hospital to provide "an adequate first response to a medical crisis" by evaluating the patient and giving "whatever medical support services and[] transfer arrangements" are necessary to protect the patient's well-being).

36. This will be true in most cases. Some situations will require the transfer of paying patients, however, such as when a hospital transfers an emergency patient to another hospital with specialized facilities like a burn unit.

circumstances most often arise when indigent and uninsured emergency patients come to private hospitals.

The Act provides for enforcement through civil monetary penalties and civil legal actions. Monetary penalties can be assessed against the hospital and the physician. Any hospital that "negligently violates" the Act's requirements is subject to a maximum penalty of \$50,000.³⁷ Any physician "who is responsible for the examination, treatment, or transfer of an individual in a participating hospital" and who "neghigently violates" the Act's requirements is subject to a maximum penalty of \$50,000.³⁸ If the physician's violation is "gross and flagrant or is repeated," the physician can be excluded from federal and state health care programs.³⁹

Civil legal actions can either be brought by an individual against a hospital,⁴⁰ or by one hospital against another.⁴¹ The dam-

37. 42 U.S.C. § 1395dd(d)(1)(A). A hospital with less than 100 beds can only be fined a maximum of \$25,000. *Id.*

38. 42 U.S.C. § 1395dd(d)(1)(B). For a case interpreting the provisions of this subsection, see *Burditt v. United States Department of Health and Human Services*, 934 F.2d 1362 (5th Cir. 1991) (fining a physician \$20,000 for improperly transferring a hypertensive woman in labor). This subsection also covers a physician who:

- (i) signs a certification under subsection (c)(1)(A) of this section that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or
- (ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section.

42 U.S.C. § 1395dd(d)(1)(B). In addition, section § 1395dd(d)(1)(C) provides that:

If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians . . . and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

42 U.S.C. § 1395dd(d)(1)(C).

39. 42 U.S.C. § 1395dd(d)(1)(B).

40. Individual plaintiffs do not have a cause of action against physicians under EMTALA. See H.R. Rep. No. 99-241 (Part 3) at 6-8 (cited in note 15) (stating that private actions for damages can only be brought against the hospital). See, for example, *Delaney*, 986 F.2d at 394 (holding that individuals can bring civil actions only against hospitals under EMTALA); *Baber*, 977 F.2d at 877 (finding that EMTALA does not allow a private individual to recover personal injury damages from a physician); *Lane*, 846 F. Supp. at 1549 (declining to follow the only case that has implied a cause of action against individual physicians); *Ballachino v. Anders*, 811 F. Supp. 121, 123 (W.D. N.Y. 1993) (stating that there is no private cause of action against individual physicians under EMTALA). But see *Sorrells v. Babcock*, 733 F. Supp. 1189, 1194 (N.D. Ill. 1990) (holding that the Act creates a private cause of action against individual physicians).

41. 42 U.S.C. § 1395dd(d)(2)(A)-(B).

ages available to an individual plaintiff are limited to state personal injury awards.⁴² A hospital suffering a financial loss directly resulting from another hospital's violation of the Act can obtain damages under the law of the state in which the hospital is located."⁴³

EMTALA has a two year limitation on civil actions,⁴⁴ and the Act does not preempt any State or local law unless that law directly conflicts with the Act's requirements.⁴⁵ Moreover, hospitals with specialized capabilities cannot discriminate against transfers.⁴⁶ Finally, the Act's last two sections prevent hospitals from delaying examination or treatment to determine a patient's method of payment or insurance status⁴⁷ and from taking adverse actions against whistleblowers.⁴⁸

42. 42 U.S.C. § 1395dd(d)(2)(A). Because this subsection limits a plaintiff's recovery to the personal injury damages recoverable in the state, many federal courts have applied state limits on medical malpractice damages to EMTALA claims. See, for example, *Power*, 42 F.3d at 861 (concluding that Virginia's medical malpractice cap applied to the plaintiff's EMTALA claim because the cap would have applied if the case had been brought under Virginia law); *Reid v. Indianapolis Osteopathic Medical Hospital, Inc.*, 709 F. Supp. 853, 855 (S.D. Ind. 1989) (concluding that a strict interpretation of EMTALA's "personal injury" damage limit would render this clause effectively meaningless since no states limit personal injury damages); *Lee v. Alleghany Regional Hospital Corp.*, 778 F. Supp. 900, 903-04 (W.D. Va. 1991) (following *Reid* and applying Virginia's \$1 million cap on medical malpractice recovery to an EMTALA claim). But see *Cooper*, 839 F. Supp. at 1542-43 (holding that EMTALA and state medical malpractice laws provide distinct remedies for different wrongs).

43. 42 U.S.C. § 1395dd(d)(2)(B). See *Fell*, 43 Cath. U. L. Rev. at 623 n.110 (cited in note 20) (stating that this provision has not been utilized because hospitals are unwilling to turn in another hospital for a violation).

44. 42 U.S.C. § 1395dd(d)(2)(C). Despite this subsection, at least one court has applied a state's one-year tort claim notice requirement to an EMTALA action. *Draper v. Chiapuzio*, 9 F.3d 1391, 1394 (9th Cir. 1993) (affirming the dismissal of the plaintiff's action because he failed to comply with Oregon's one-year notice requirement for wrongful death actions against a public body). But see *Power*, 42 F.3d at 865-66 (holding that Virginia's notice of claim provision directly conflicts with EMTALA); *Reid*, 709 F. Supp. at 854-55 (refusing to incorporate state procedural limitations on a federal cause of action); *Cooper*, 839 F. Supp. at 1543 (following *Reid* in finding that the plaintiff's EMTALA claim does not have to follow Florida's pre-suit procedures).

45. 42 U.S.C. § 1395dd(f). See *Brooks*, 996 F.2d at 714-15 (stating that Congress never intended to preempt state malpractice law; rather, "it was filling a gap in the state law and imposing a limited duty on hospitals with emergency rooms to provide emergency care to all individuals who come there"); *Deberry*, 741 F. Supp. at 1307 (analyzing EMTALA's preemption requirements and concluding that the Act provides for conflict preemption rather than field preemption); *Treiger*, 61 N.Y.U. L. Rev. at 1209 (cited in note 3) (stating that EMTALA imposes federal emergency care standards on the states).

46. 42 U.S.C. § 1395dd(g). Hospitals with specialized capabilities are those with units such as burn units, shock-trauma units, or neonatal intensive care units. *Id.*

47. 42 U.S.C. § 1395dd(h). This subsection states: "A participating hospital may not delay provision of an appropriate medical screening examination . . . or further medical examination and treatment . . . in order to inquire about the individual's method of payment or insurance status." *Id.*

48. 42 U.S.C. § 1395dd(i). This subsection states:

A participating hospital may not penalize or take adverse action against a qualified medical person . . . or a physician because the person or physician refuses to authorize

C. EMTALA's Implementation

In 1988, the House Committee on Government Operations conducted hearings on EMTALA's implementation. The Committee exclusively addressed EMTALA's antidumping intent as indicated by the title of its report—*Equal Access to Health Care: Patient Dumping*.⁴⁹ After describing numerous cases of egregious dumping practices across the country, the Committee found that the Department of Health and Human Services ("HHS") failed to issue regulations implementing EMTALA, placing thousands of patients at risk.⁵⁰ The Committee also found that the Health Care Financing Administration ("HCFA") was not enforcing the Act's monetary penalties against violators, and neither hospitals, physicians, nor patients were notified of the Act's requirements.⁵¹ The Committee's findings substantiated the anecdotal evidence of continued discrimination against indigent patients by hospital emergency rooms.⁵² In response to these findings, the Committee encouraged HHS to immediately publish regulations implementing EMTALA nationwide.⁵³

the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

Id.

49. H.R. Rep. No. 100-531, 100th Cong., 2d Sess. 1 (1988). The Committee stated that the most common form of patient dumping involves the transfer of patients from one hospital emergency room to another for economic reasons, while other forms "involve discrimination on the basis of poverty, race, ethnicity, or appearance." Id. at 2-3.

50. Id. at 8. Although the Act became effective on August 1, 1986, the "proposed rules for the implementation and enforcement of this critical legislation [had] not been published by [March, 1988]." Id.

51. Id. at 11. "During the 18 months between the amendment's effective date . . . and January 31, 1988, only 129 allegations of COBRA violations were filed. When compared with the 250,000 patients transferred annually for economic reasons . . . it appears that the public has little knowledge of the law and that it is not being enforced." Id. (citations omitted).

52. For example:

A 1984 study at Highland Hospital in Oakland, CA, found that of 458 patients transferred to the emergency department from other hospitals, 63 percent had no insurance, 21 percent had Medicaid, 13 percent had Medicare, and only 3 percent had private insurance. This same study found that a disproportionately large number of these patients were minority.

Id. at 4 (citation omitted).

53. The Committee stated that the Act itself or the regulations implementing EMTALA should: (1) prohibit all transfers except those required for adequate medical care; (2) require all patient transfers to comply strictly with the Act's stipulations; (3) prohibit patient transfers unless written, informed consent is obtained from the patient or the patient's representative; (4) require hospitals to maintain a detailed record of each transfer from and to the hospital; (5) require tertiary care hospitals to accept all patients transferred from smaller hospitals that are

Following this report, HHS did not publish regulations implementing EMTALA until June, 1994.⁵⁴ These regulations merely parallel the Act's requirements because the Omnibus Budget Reconciliation Acts of 1989 and 1990 implemented most of the Government Operations Committee's recommendations in the interim.⁵⁵ The only noticeable addition made by the regulations is a definition clarifying when an individual "comes to the emergency department" under section 1395dd(a).⁵⁶

In sum, the regulations issued by HHS do little more than implement EMTALA's current statutory language. Yet, it is important to realize, these regulations explicitly recognized the antidumping intent behind EMTALA's enactment.⁵⁷ Thus, at every legislative step in its enactment and implementation, EMTALA's intent has remained consistent: to correct the practice of dumping indigent and uninsured patients from hospital emergency rooms. Notwithstanding this consistent legislative intent, the interpretation of EMTALA by the federal courts has resulted in confusion, inconsistency, and a circuit split over the interpretation of the Act.

unequipped to treat emergency patients; (6) require HCFA to establish a system for periodic, random reviews of hospital transfer files; and (7) award attorney's fees to successful plaintiffs in civil suits. *Id.* at 21-22.

54. Medicare Program; Participation in CHAMPUS and CHAMPVA, Hospital Admissions for Veterans, Discharge Rights Notice, and Hospital Responsibility for Emergency Care, 59 Fed. Reg. 32086, 32120 ff. (1994) (amending 42 CFR §§ 405, 489, 1003).

55. *Id.* at 32090-91 (summarizing the amendments implemented by the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239, Title VI, §§ 6003(g)(3)(D)(xiv), 6018, 6211, 103 Stat. 2154, 2245 (1989), and the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, Title IV, §§ 4008(b), 4027(a), 4027(k)(3), 104 Stat. 1388-44, 1388-117, 1388-124 (1990)). With respect to enforcement, the regulations follow the Act explicitly and do not allow successful plaintiffs to recover attorney's fees in civil suits, as recommended by the Committee in its report.

56. *Id.* at 32121. Under this section, the regulations define "comes to the emergency department" to mean "that the individual is on the hospital property (property includes ambulances owned and operated by the hospital, even if the ambulance is not on hospital grounds)." *Id.* at 32121 (amending 42 CFR § 489.24). See *Madison v. Jefferson Parish Hospital Service District No. 1*, 1995 U.S. Dist. LEXIS 9420, at *5 (E.D. La.) (applying this regulation and finding an emergency patient was covered by EMTALA even though he was only transported in an ambulance). In addition, the definition of "emergency medical condition" under § 1395dd(e)(1) was expanded to include "psychiatric disturbances and/or symptoms of substance abuse." *Id.* This reflects Edward Ramage's suggestion to expand EMTALA's coverage for mentally ill patients who are dangerous. See Ramage, 45 Vand. L. Rev. at 962 (cited in note 20).

57. *Id.* at 32088. The regulations conclude, however, that since Congress chose not to limit EMTALA's protections to Medicare patients, the provisions of the Act extend to all persons. *Id.* at 32098.

III. THE FEDERAL ADJUDICATION OF EMTALA

Following EMTALA's enactment, its federal adjudication has produced contradictory interpretations and a split among the circuits. The confusion in the federal courts arises from the inconsistency between the Act's antidumping legislative purpose and its broad statutory language that protects "any individual" from improper emergency medical treatment. The first district courts to hear EMTALA cases narrowly interpreted the Act according to its legislative intent. These courts applied EMTALA only to situations involving patient dumping due to an improper economic motive. Other district courts then began broadly applying the Act's language, allowing "any individual" who allegedly received improper emergency care to sue under the Act.

The federal circuits that have decided the issue have adopted the broad interpretation of the Act and have concluded that EMTALA's language applies to any emergency patient, regardless of ability to pay. While the circuits have agreed on the broader interpretation of EMTALA's language, the circuits disagree over whether the hospital's motive is relevant to the cause of action. One circuit has found that a cause of action is proper only if the hospital violated the Act's requirements due to an improper motive. Rejecting this interpretation, five circuits have held, either implicitly or explicitly, that the hospital's motive is irrelevant to the cause of action. The remaining six circuits have not issued opinions interpreting EMTALA. Thus, while Congress enacted EMTALA to redress instances of economic discrimination against indigent patients, only one federal circuit has retained the Act's antidiscriminatory purpose. The other circuits have broadly construed EMTALA's language and have allowed paying patients to challenge their emergency treatment in federal court, thereby creating a federal standard for emergency care.

A. *EMTALA in the Federal District Courts*

The first district courts to decide the EMTALA cases relied heavily upon the Act's legislative history. The first federal case involving an alleged violation of EMTALA was *Bryant v. Riddle*

Memorial Hospital.⁵⁸ The sole issue in the case was whether EMTALA provides for a private cause of action in federal court.⁵⁹ As a case of first impression, the court consulted the legislative history of the Act and found that Congress intended plaintiffs to bring actions arising under EMTALA in federal court.⁶⁰ The court then concluded that its ruling was consistent with the Act's overall purpose of establishing a series of federal guidelines to prevent patient dumping in Medicare hospitals with emergency facilities.⁶¹

*Nichols v. Estabrook*⁶² was the first case in which a federal district court found that EMTALA applied exclusively to cases of patient dumping.⁶³ This case involved the death of a sixteen-week-old infant.⁶⁴ The infant's parents brought him to a hospital emergency room where Dr. Estabrook examined him for vomiting and diarrhea.⁶⁵ After determining the child was suffering from dehydration and a virus, Dr. Estabrook advised the parents to take their child to see a pediatrician at another hospital.⁶⁶ The infant died forty-five minutes after arrival at the other hospital.⁶⁷ Consequently, the parents sued

58. 689 F. Supp. 490 (E.D. Pa. 1988). The plaintiff was an eighty-one year old nursing home patient who was taken to the hospital for a separated shoulder. Riddle Memorial Hospital treated her and sent her back to her nursing home within 24 hours. She subsequently sued Riddle Memorial under EMTALA, claiming that she had been discharged before her condition was stabilized. *Id.* at 491.

59. *Id.* at 491. The court found that the Act allows for civil enforcement through a private cause of action with a two year statute of limitations; yet the court concluded that the Act did not explicitly express what forum would be appropriate for the case. *Id.*

60. *Id.* The court stated that EMTALA was enacted to combat the growing problem of patient dumping, citing the statements of Senator Durenberger and Representative Bilirakis as well as the Ways and Means Committee Report in support. *Id.* at 491-92. See notes 15-17 and accompanying text.

61. *Id.* at 493.

62. 741 F. Supp. 325 (D. N.H. 1989).

63. *Id.* at 330. However, at least one case decided prior to *Nichols* involved a clear case of patient dumping. *Thompson v. St. Anne's Hospital*, 716 F. Supp. 8 (N.D. Ill. 1989), involved an indigent woman who sued two hospitals in connection with the premature delivery of her baby. When the plaintiff arrived at St. Anne's Hospital experiencing premature labor pains, St. Anne's personnel examined her and then transferred her to Cook County Hospital, where she delivered her baby unattended and in unsterilized conditions. *Id.* at 9. Cook County Hospital moved to dismiss this claim based upon the fact that it did not transfer or discharge the plaintiff. The court denied this motion and held that the legislative history of the Act indicates that the statute prohibits hospitals not only from transferring indigent patients, but also from simply rejecting them. *Id.* at 10.

64. *Nichols*, 741 F. Supp. at 326.

65. *Id.* A blood sample was taken from the infant, and Dr. Estabrook told the parents that their baby "was going to be okay" after finding nothing abnormal from the lab results. *Id.*

66. *Id.* When the parents requested an ambulance, Dr. Estabrook told them that their baby's condition was not an emergency and did not require an ambulance. *Id.*

67. *Id.* Upon arrival, a pediatric nurse immediately picked up the infant, slapped him, and called a code. The pediatrician to whom Dr. Estabrook had referred the parents testified that Dr. Estabrook should have known that the results of the blood sample were bad. *Id.*

Dr. Estabrook under EMTALA.⁶⁸ The court granted Dr. Estabrook's motion to dismiss because the plaintiffs did not allege that their son was denied emergency treatment due to their financial condition or lack of insurance.⁶⁹ Based upon EMTALA's legislative history, the court concluded that the Act only assured patients with emergency conditions that they would be examined and treated regardless of their financial resources.⁷⁰

Similarly, *Evitt v. University Heights Hospital*⁷¹ refused to extend EMTALA beyond its legislative purpose.⁷² The plaintiff arrived at University Heights Hospital complaining of chest pain. The attending physician determined that the plaintiff had an inflamed chest wall and released her less than an hour later with instructions to return if her condition worsened.⁷³ Later the same day, the plaintiff returned to the hospital after suffering a heart attack, and she was transferred to another hospital for further treatment.⁷⁴ The plaintiff sued University Heights for allegedly violating all three requirements of EMTALA.⁷⁵ After observing that EMTALA was enacted to combat patient dumping⁷⁶ the court found that the plaintiff's interpretation surpassed the Act's purpose of preventing hospitals from turning away patients for economic reasons.⁷⁷ The

68. *Id.* at 329. The opinion does not specify which of the Act's requirements Dr. Estabrook allegedly violated. The plaintiffs also brought medical malpractice claims for emotional distress, lost services, and hedonic damages. *Id.* at 327-29. Surprisingly, the court did not address the fact that a plaintiff cannot bring a private action against a physician under EMTALA.

69. *Id.* at 330. Additionally, the court stated that Dr. Estabrook's alleged conduct did not invade the interest that Congress sought to protect under EMTALA. *Id.*

70. *Id.* The court cited the Ways and Means Committee Report and Senator Durenberger's remarks in its opinion. See notes 15 and 17.

71. 727 F. Supp. 495 (S.D. Ind. 1989).

72. *Id.* at 497.

73. *Id.* at 496. She arrived at 2:30 a.m., and at 3:05 a.m. the attending physician advised her to return home, stop taking Zydone, take Dolobid as directed, and call her private physician in the morning. She was officially diagnosed with costochondritis (inflammation of the chest wall), a "nonurgent" condition, and she was reportedly in satisfactory condition upon release. *Id.*

74. *Id.* The plaintiff arrived at 1:50 p.m., in critical condition. After determining that a myocardial infarction (heart attack) had taken place, the attending doctors at University Heights transferred the plaintiff to another facility for cardiocatheterization and angioplasty. *Id.*

75. *Id.* The plaintiff claimed that the hospital failed to provide an adequate medical screening during her first visit because the hospital did not perform a 12-lead EKG test. *Id.* at 497. In the alternative, she claimed that the hospital did not stabilize her condition or properly transfer her to another facility during her first visit. *Id.* at 496.

76. *Id.* at 497 (citing *Bryant*, 689 F. Supp. at 491).

77. *Id.* (citing *Reid v. Indianapolis Osteopathic Medical Hospital, Inc.*, 709 F. Supp. 853, 853 (S.D. Ind. 1989)).

court determined that the plaintiff's claim was directed toward the physician's misdiagnosis during her first visit and concluded that her claims fell under state medical malpractice law.⁷⁸ Because EMTALA was not designed to prevent misdiagnosis, the court stated that allowing the plaintiff's claim to proceed would force the hospital to guarantee the physician's diagnosis and treatment.⁷⁹ Had the court sustained the claim, the Act would have applied, regardless of how reasonable the diagnosis may have been when the patient was released, and irrespective of whether the physician dumped the patient or simply found no reason to hospitalize the patient. The court therefore entered summary judgment against the plaintiff because she could not prove the hospital turned her away for economic reasons.⁸⁰

*Stewart v. Myrick*⁸¹ is the last case in which a federal court strictly construed EMTALA according to its anti-dumping purpose.⁸² The plaintiff's husband, George Stewart, went to the emergency room at Hadley Medical Center allegedly complaining of severe chest pain, loss of color, and shortness of breath.⁸³ The attending physician instructed Stewart to return to the hospital the next day for gastroin-

78. *Id.* at 497. The court further concluded that EMTALA was not intended to preempt state medical malpractice law. *Id.* (citing *California v. ARC America Corp.*, 490 U.S. 93, 101 (1989) for the proposition that there is a presumption against federal preemption of areas traditionally regulated by the states). Since EMTALA only provides for preemption of state laws that directly conflict with the Act's requirements, the court found that EMTALA did not preempt the state's medical malpractice law. *Id.* Instead, the court stated that the Act merely adds specifically tailored hospital requirements to prevent patient dumping. *Id.*

79. *Id.* at 497-98. It is precisely this level of judicial restraint that should govern EMTALA, yet the courts have strayed far from this advice.

80. *Id.* at 498. This analysis therefore used EMTALA's legislative history and its preemption clause to support its narrow reading. See Stricker, 67 *Notre Dame L. Rev.* at 1138 (cited in note 14) (observing the weak legal support provided by EMTALA's legislative history in combination with its preemptive effect).

81. 731 F. Supp. 433 (D. Kan. 1990).

82. At least one commentator has argued that a more recent case follows the narrow construction of EMTALA. See Stricker, 67 *Notre Dame L. Rev.* at 1135 (cited in note 14) (contending that *Coleman v. McCurtain Memorial Medical Management, Inc.*, 771 F. Supp. 343 (E.D. Okla. 1991), allowed an EMTALA action only when an improper economic motive exists). Stricker's characterization of the *Coleman* decision is inaccurate. While the *Coleman* court cited both *Evitt* and *Stewart* as controlling precedent, the opinion granted the defendant hospital's motion for summary judgment after finding that the plaintiff's claim was for "misdiagnosis." *Coleman*, 771 F. Supp. at 347. The court therefore never addressed the issue of patient dumping.

83. *Stewart*, 731 F. Supp. at 434. The parties to the case disagreed over Stewart's symptoms. The attending physician, Dr. Myrick, claimed that Stewart did not describe these symptoms to either Myrick or his nurse. Nevertheless, the plaintiff claimed that her husband was under a medical emergency on December 2, the day Stewart first visited the emergency room.

testinal tests.⁸⁴ Following these tests, Stewart did not return to the hospital until eight days later after suffering extreme chest pain. Stewart died shortly after his arrival at the emergency room, and his wife sued the hospital for violating both the medical screening and stabilization requirements of EMTALA.⁸⁵ Relying heavily upon the Act's legislative history,⁸⁶ the court dismissed the plaintiff's claim because it did not involve a case of patient dumping.⁸⁷ Since the plaintiff was not turned away for economic reasons, the court concluded that the plaintiff's action did "not present the type of evil that Congress sought to eliminate in the Act."⁸⁸

The first federal district court to apply the plain language of the Act was *Deberry v. Sherman Hospital Association*.⁸⁹ In *Deberry*, the plaintiff took her daughter to Sherman Hospital's emergency room with a fever, rash, stiff neck, and symptoms including lethargy and irritability.⁹⁰ The hospital treated and released the patient. Two days later, the patient was readmitted by Sherman and diagnosed with spinal meningitis. The patient lost her hearing as a result of the disease,⁹¹ and

84. *Id.* Apparently, these tests were postponed until December 4, but Dr. Myrick was unable to obtain conclusive results because Stewart had eaten prior to the tests. The plaintiff also contended that Stewart was experiencing a medical emergency on December 4. *Id.*

85. *Id.* at 434. It was uncontroverted at trial that Stewart was never denied treatment because he was uninsured. *Id.*

86. The court used the remarks of Representative Bilirakis and Senator Durenberger as well as the Ways and Means Committee Report to support its interpretation. *Id.* at 435. For the content of these remarks, see notes 15-17 and accompanying text.

87. *Id.* at 436. The court also found that the case represented a traditional claim of medical malpractice. *Id.*

88. *Id.* The court supported its decision with the precedent established in *Evitt*, even though neither party had cited the case in its brief. *Id.*

89. 741 F. Supp. 1302, 1306 (N.D. Ill. 1990). Several subsequent federal district cases have applied the plain language of the statute, holding that a patient's indigence or lack of insurance is irrelevant to an EMTALA claim. See, for example, *Lee v. Alleghany Regional Hospital Corporation*, 778 F. Supp. 900, 902 (W.D. Va. 1991) (holding that a plaintiff may state a claim under EMTALA without alleging that the hospital denied care to the patient due to an inability to pay); *Urban v. King*, 783 F. Supp. 560, 562 (D. Kan. 1992) (holding that EMTALA draws no distinctions between persons with or without the means to pay for medical care); *Ballachino v. Anders*, 811 F. Supp. 121, 123 (W.D. N.Y. 1993) (holding that a plaintiff need not allege indigence); *Ruiz v. Kepler*, 832 F. Supp. 1444, 1446-47 (D. N.M. 1993) (holding that EMTALA protects patients other than those who are indigent or uninsured); *Cooper v. Gulf Breeze Hospital, Inc.*, 839 F. Supp. 1538, 1544 (N.D. Fla. 1993) (finding that Congress did not limit recovery under the Act to cases where hospitals discharged people based on financial considerations). But see *Tolton v. American Biodync*, 854 F. Supp. 505, 511 (N.D. Ohio 1993) (granting a motion for summary judgment because it was uncontroverted that the patient was never denied treatment due to his inability to pay or lack of insurance).

90. *Deberry*, 741 F. Supp. at 1303.

91. *Id.*

sued Sherman for violating EMTALA.⁹² Relying on the *Evitt* and *Stewart* decisions, the hospital moved for dismissal since it had not dumped the patient.

The court denied this motion and explicitly refused to follow both *Stewart* and *Evitt*.⁹³ Objecting to *Evitt*'s reasoning,⁹⁴ the *Deberry* court criticized the two grounds for *Evitt*'s narrow reading of EMTALA. First, the court determined that *Evitt*'s use of the Act's legislative history was improper. Instead, the *Deberry* court applied EMTALA's plain language, finding that matters of policy and legislative intent are only relevant when the statutory language is ambiguous.⁹⁵ Since the Act protects "any individual" who claims to have received improper emergency care, the court concluded it was not "free to change that language through a clandestine use of the legislative history."⁹⁶ Second, the court criticized the *Evitt* decision for its discussion of preemption. Although the *Evitt* court determined that EMTALA should not preempt state malpractice law,⁹⁷ the *Deberry* court held that double coverage of a field is not prohibited.⁹⁸

92. *Id.* The opinion does not specify which requirement the hospital allegedly violated. Once it is established that the plaintiff came to the emergency room with an emergency medical condition, the court found that the hospital could have violated EMTALA by either "(1) failing to detect the nature of the emergency condition through inadequate screening procedures . . . , or, (2) . . . by failing to stabilize the condition before releasing the plaintiff." *Id.* The court then inaccurately established the four requirements of a proper EMTALA complaint: the plaintiff must allege that the patient "(1) went to the defendant's emergency room, (2) with an emergency medical condition, and that the hospital either (3) did not adequately screen [the patient] to determine whether [the patient] had such a condition, or (4) discharged or transferred [the patient] before the emergency condition had been stabilized." *Id.* An accurate form complaint, following EMTALA's language, should allege: (1) that the patient went to the defendant's emergency room, (2) with an emergency medical condition, and that the hospital (3) failed to provide the patient with an appropriate medical screening examination, or (4) failed to provide the patient with stabilizing treatment after diagnosing the patient's emergency medical condition, or (5) violated the transfer restrictions after diagnosing the patient's emergency medical condition but before the condition was stabilized.

93. *Id.* at 1306.

94. The *Deberry* court decided that the *Evitt* opinion was more detailed and concluded that *Stewart* employed the same analysis; thus, the court's critique of *Evitt* applies equally to *Stewart*. *Id.*

95. *Id.* (citing *Unexcelled Chemical Corp. v. United States*, 345 U.S. 59, 64 (1953)). The court also found that the Act never mentions "either indigence, an inability to pay, or the hospital's motive as a prerequisite to statutory coverage." *Id.*

96. *Id.* at 1307. The court noted that the *Evitt* court never referred to the text of EMTALA. *Id.* at 1306.

97. *Id.* at 1307 (quoting *Evitt*, 727 F. Supp. at 497). *Evitt* concluded that Congress did not intend EMTALA to preempt state medical malpractice law, which is an area traditionally governed by the states. *Evitt*, 727 F. Supp. at 497. Consequently, the *Evitt* court narrowly construed the Act. *Id.*

98. *Deberry*, 741 F. Supp. at 1307. The *Deberry* court concluded that EMTALA's preemptive power is exactly opposite to the *Evitt* court's analysis. *Deberry* found that the Act's preemption clause, which states that "[t]he provisions of this section do not preempt any state or local law requirement, except to the extent that the requirement directly conflicts with a

The *Deberry* opinion established that a broad interpretation of the Act would not result in the federal preemption of state medical malpractice law; instead, more conduct would be prohibited by both federal and state law.⁹⁹ Anticipating disagreement with its broad interpretation of EMTALA, the *Deberry* court stated that its role was not to rewrite legislation inconsistent with its legislative history.¹⁰⁰ Thus, the plaintiff's claim under EMTALA was proper, regardless of the hospital's motive.¹⁰¹

B. EMTALA in the Federal Circuits

The federal circuit courts that have addressed the issue of indigence in EMTALA claims have followed the broader interpretation used in *Deberry* and have extended protection to all emergency patients who receive improper emergency care.¹⁰² A circuit split has

requirement of this section," shows that Congress intended to provide conflict preemption. Consequently, the court concluded that conflict preemption does not forbid double regulation; it only preempts those state laws "where 'compliance with both federal and state regulations is a physical impossibility.'" *Id.* (quoting *California Federal Sav. & Loan Ass'n v. Guerra*, 479 U.S. 272, 280 (1987)). The court therefore found that state laws that prohibit the same conduct as EMTALA are appropriate. *Id.* See *Stricker*, 67 *Notre Dame L. Rev.* at 1146-47 (cited in note 14) (using *Deberry's* analysis to show how EMTALA's legislative history and its preemption clause are weak foundations for an interpretation consistent with the Act's legislative history).

99. *Deberry*, 741 F. Supp. at 1307. This conclusion implies that states could enact stricter enforcement mechanisms, such as criminal sanctions against physicians, for violations of EMTALA's requirements. See *Treiger*, 61 *N.Y.U. L. Rev.* at 1208-09 and n.157 (cited in note 3) (agreeing with this implication but showing that some believe state criminal sanctions would frustrate the federal standard imposed by EMTALA).

100. 741 F. Supp. at 1307. The court stated, "it is not this court's place to rewrite the language enacted by our duly elected officials. If Congress went too far in § 1395dd, then the statute must either be attacked constitutionally, if that is feasible, or through the same political processes which caused its enactment. Amendment by the judiciary, however, is never proper." *Id.*

101. *Id.* at 1306. Following this decision, the hospital filed a motion for summary judgment based upon the Sixth Circuit's opinion in *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990). *Deberry v. Sherman Hospital Association*, 769 F. Supp. 1030, 1032 (N.D. Ill. 1991). The hospital claimed that *Cleland* established that EMTALA does not provide a civil remedy for mere negligence or misdiagnosis. *Id.* Consequently, the court found that the plaintiff failed to produce any evidence upon which a jury could find the hospital liable under EMTALA. *Id.* at 1034. Because the hospital conducted an appropriate medical screening examination and determined that the patient did not have an emergency medical condition, the court granted the hospital's motion. *Id.* at 1035. Interestingly, while *Cleland* held that the hospital's motive is relevant to an EMTALA claim, the *Deberry* court declined to follow this interpretation, holding that a plaintiff does not have to prove that an improper motive underlies a hospital's denial of care. *Id.* at 1034.

102. See *Brooks*, 996 F.2d at 711 n.4 (4th Cir.) ("the language of the Act does not require a showing that a claimant is uninsured or indigent, nor does it provide that the hospital breaches the Act's duties only when it acts with economic motives"); *Cleland*, 917 F.2d at 268 (6th Cir.) ("We hold Congress to its words, that this statute applies to any and all patients"); *Brooker*, 947

arisen, however, over whether the hospital's motive is relevant to the case. The Sixth Circuit has taken a more conservative approach that emphasizes EMTALA's antidiscriminatory purpose. Five other circuits have either explicitly or implicitly departed from this conservative approach, holding that the hospital's motive is irrelevant to an EMTALA claim. The Seventh Circuit's position on the issue is unresolved since its only opinion interpreting EMTALA consciously avoids the issue of indigence in an EMTALA claim. At present six circuits, including the Seventh Circuit, have not decided the issue of whether the hospital's improper motive is necessary for a successful EMTALA claim.

The Sixth Circuit was the first federal circuit to interpret EMTALA.¹⁰³ *Cleland v. Bronson Health Care Group, Inc.* held that the Act's plain language applies to any and all emergency patients.¹⁰⁴ The Clelands took their fifteen-year-old son to Bronson Methodist Hospital with complaints of cramping and vomiting. An attending physician diagnosed the patient with influenza and discharged him. This diagnosis proved incorrect, and twenty-four hours later the patient died from a heart attack caused by intussusception.¹⁰⁵ The Clelands sued the hospital under EMTALA, and the district court

F.2d at 415 (9th Cir.) ("We hold that the Act applies to any and all patients, not just to patients with insufficient resources"); *Collins v. DePaul Hospital*, 963 F.2d 303, 308 (10th Cir. 1992) ("The fact that Congress . . . viewed [EMTALA] as a so-called "anti-dumping" bill . . . does not subtract from its use of the broad term "any individual"); *Gatewood*, 933 F.2d at 1040 (D.C. Cir.) ("Though the . . . Act's legislative history reflects an unmistakable concern with the treatment of uninsured patients, the Act itself draws no distinction between persons with and without insurance"). Interestingly, most federal circuit opinions on this issue continue to quote EMTALA's legislative history.

103. The first Sixth Circuit case was *Thornton v. Southwest Detroit Hospital*, 895 F.2d 1131 (6th Cir. 1990). Interestingly, this opinion contains several statements that suggest the court was employing a narrow interpretation of the Act. Elese Thornton suffered a stroke and was admitted to the emergency room of Southwest Detroit Hospital. She spent ten days in intensive care and eleven days in regular inpatient care before she was discharged. *Id.* at 1132. She subsequently sued the hospital under EMTALA for failing to stabilize her before her release. In response to this action, the court stated that EMTALA "requires hospitals to give emergency aid to indigent patients who suffer from an 'emergency medical condition' or 'active labor.'" *Id.* at 1132. The court then focused on the Act's language under the stabilization requirements of § 1395dd(b), which applies to "any individual [who] comes to a hospital" rather than a "hospital emergency department," as required under the screening requirements of § 1395dd(a). Consequently, the court held that "once a patient is found to suffer from an emergency medical condition in the emergency room, she cannot be discharged until the condition is stabilized, regardless of whether the patient stays in the emergency room." *Id.* at 1134. Despite this holding, the court upheld the district court's summary judgment since the patient's condition was stabilized before her release. In a concurrence, Judge Nathaniel Jones emphasized that EMTALA was designed to prevent hospitals from dumping indigent patients, stating, "[i]t was not a measure to force hospitals to provide long-term care for uninsured patients." *Id.* at 1135.

104. 917 F.2d at 268.

105. *Id.* Intussusception is a condition that causes a portion of intestine to telescope within itself. *Id.*

dismissed their claim based upon its interpretation that the Act applied only to indigent or uninsured patients.¹⁰⁶ The Sixth Circuit disagreed with the district court's interpretation and instead held that the plain language of the statute contains no such limitation.¹⁰⁷ Although the court noted that nothing in the legislative history shows that Congress intended EMTALA to address anyone other than uninsured or indigent patients, the *Cleland* court concluded, "there is no principle of construction that Congress may not similarly write a statute that is far broader" than its concern.¹⁰⁸ Because the text of a law controls its legislative history, the *Cleland* court followed *Deberry's* analysis and applied the language Congress enacted.¹⁰⁹

Although the *Cleland* court found that congressional intent is irrelevant to a plaintiff's *eligibility* under EMTALA, the court used the antidiscriminatory purpose of the Act to assist its interpretation of EMTALA's ambiguous statutory requirements.¹¹⁰ The court first interpreted the "appropriate medical screening examination" requirements under § 1395dd(a). Respecting the Act's intentions, the court concluded that a hospital's screening would be appropriate if it provided the patient with a screening similar to the one it would provide any other patient.¹¹¹ The court therefore interpreted "appropriate" to refer to the hospital's motive.¹¹² Since the record did

106. *Id.*

107. *Id.* at 269.

108. *Id.* (citing *Williamson v. Lee Optical of Oklahoma*, 348 U.S. 483, 487-88 (1955)). The court went further and found that the legislative history is only relevant when a statute contains ambiguous phrases. Because EMTALA applies to "any individual," the court concluded that the Act's antidumping intent was irrelevant to this unambiguous language. *Id.*

109. 917 F.2d at 270. Recognizing that this broad interpretation "leads to a result broader than one might think Congress should have intended, or perhaps than any or all members of Congress were cognizant of," the court reasoned, "it is not our place to rewrite statutes to conform with our notions of efficacy or rationality. That is the job of Congress." *Id.* By following the analysis of the *Deberry* court, the *Cleland* majority explicitly rejected the narrow interpretation applied in *Evitt* and *Stewart*. *Id.* With respect to its own statements narrowly construing EMTALA in *Thornton*, the Sixth Circuit interestingly stated that it had never faced the issue directly because *Thornton* did not involve a case in which the district court had excluded the claim due to a lack of indigence. *Id.*

110. *Id.* at 271. The court found the terms "appropriate," under the screening requirements of § 1395dd(a), and "stabilize," under the stabilization requirements of § 1395dd(b)(1)(A), to be ambiguous. Thus the court stated, "[i]n attempting to interpret [these] ambiguous phrases, we can look to legislative history." *Id.*

111. *Id.* The court concluded that "[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. Who, after all, can be found to stand up for 'inappropriate' treatment or actions of any sort?" *Id.*

112. *Id.* at 272. The court determined that a hospital's screening exam is "appropriate" if it acts in the same manner as it would have for the usual paying patient. *Id.*

not indicate that the patient was treated differently than a patient of another "sex, race, national origin, financial condition, politics, social status, etc.," the court found the plaintiff's claim improper.¹¹³ Consequently, the *Cleland* decision preserves the Act's anti-discriminatory purpose by focusing on the hospital's motive to determine whether its medical screening exam complies with EMTALA.¹¹⁴

Using similar reasoning, the *Cleland* court interpreted EMTALA's stabilization requirements to prohibit discriminatory treatment. In light of the Act's legislative history, the court concluded that Congress never intended EMTALA to provide a guarantee for emergency room treatment.¹¹⁵ The court therefore found that the hospital satisfied EMTALA's stabilization requirements by treating

113. *Id.* at 271. The court held that "the complaint simply fails to allege any inappropriateness in the medical screening in the sense required by the Act." *Id.* Although the court refers to EMTALA's legislative history, this interpretation extends the Act's purpose beyond patient dumping by inserting additional antidiscriminatory factors unintended by Congress. The court anticipated its critics, stating:

[T]his result does not constitute a backdoor means of limiting coverage to the indigent or uninsured. A hospital that provides a substandard (by its standards) or nonexistent medical screening for any reason (including without limitation, race, sex, politics, occupation, education, personal prejudice, drunkenness, spite, etc.) may be liable under this section. . . . We can think of many reasons other than indigence that might lead a hospital to give less than standard attention to a person who arrives at the emergency room. These might include: prejudice against the race, sex, or ethnic group of the patient; distaste for the patient's condition (e.g., AIDS patients); personal dislike or antagonism between the medical personnel and the patient; disapproval of the patient's occupation; or political or cultural opposition. If a hospital refused treatment to persons for any of these reasons, or gave cursory treatment, the evil inflicted would be quite akin to that discussed by Congress in the legislative history, and the patient would fall squarely within the statutory language.

Id. at 272. But see 59 Fed. Reg. at 32104 (stating the Secretary of HHS's belief that there is no "impermissible motive" requirement in an action brought under EMTALA's transfer requirements).

114. *Hines v. Adair County Hospital District Corp.*, 827 F. Supp. 426, 432 (W.D. Ky. 1993) clarified *Cleland's* interpretation, holding that a discriminatory motive is an essential element of an EMTALA claim. The *Hines* court then described the implications of *Cleland's* holding:

Clearly, a hospital would violate the Act if it declined treatment on the basis of a patient's inability to pay. At the other end of the continuum, a hospital may violate the Act if it declined treatment on a completely arbitrary basis, for example, the one hundredth patient to seek emergency treatment in one day or the patient that arrives shortly before the end of an emergency room physician's shift.

Id. at 432. The *Hines* court observed that *Cleland's* improper motive requirement implicates federal rights in situations unregulated by state common law, since prior to the enactment of EMTALA many hospitals had no duty to treat emergency patients. Consequently, the court agreed with *Cleland's* improper motive requirement because it preempts the common law of no duty to treat while stopping short of creating a federal medical malpractice law. *Id.*

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

the patient in the same way it would have treated a patient with similar symptoms who had different characteristics.¹¹⁶

Despite its attempt to interpret the Act according to congressional intent, the Sixth Circuit's anti-discriminatory interpretation of EMTALA's screening and stabilization requirements has created a circuit split. In *Gatewood v. Washington Healthcare Corporation*¹¹⁷ the District of Columbia Circuit explicitly departed from *Cleland's* improper motive requirement in EMTALA cases. *Gatewood* involved factual circumstances similar to those faced by the Sixth Circuit in *Cleland*. The plaintiff's husband died from a heart attack the day after he was discharged from Washington Hospital Center, where he was diagnosed with musculoskeletal pain.¹¹⁸ The plaintiff sued the hospital under EMTALA, and the district court dismissed the case, after concluding that EMTALA does not provide a cause of action for fully insured patients who are misdiagnosed by emergency medical staff.¹¹⁹ The District of Columbia Circuit applied the Act's plain language and found that a patient's insurance status is irrelevant to an EMTALA claim.¹²⁰ Because the Act's plain language protects "any individual" who seeks emergency assistance, the court concluded that it was bound by the statutory language.¹²¹

116. *Id.* The court concluded, "[i]n the hospital's opinion, the patient was stable, and they would have believed that a patient with any differing characteristics would have been stable." *Id.* In addition, the court correctly observed that the duty to stabilize only arises after the hospital determines that an emergency medical condition exists. If the emergency nature of a patient's condition is not discovered, the court found that a hospital cannot be charged with failing to stabilize the patient's condition. *Id.*

117. 933 F.2d 1037, 1041 (D.C. Cir. 1991).

118. *Id.* at 1038. The patient arrived at the emergency room complaining of pain radiating down his left arm down into his chest. A resident examined the patient and performed blood tests, an EKG, and a chest X-ray. The attending physician reviewed the test results and diagnosed the patient as suffering from musculoskeletal pain. The patient was then discharged with instructions to use a heating pad, take Tylenol, and arrange a follow-up appointment with his physician. *Id.* at 1039.

119. *Id.* at 1038. The district court held that EMTALA was enacted to prevent patient dumping, and found that fully insured patients who were misdiagnosed had no cause of action under the Act. *Id.* at 1039. Consequently, the district court based its dismissal on the fact that the patient's release was not based upon his insurance status, his inability to pay, or other economic factors. *Id.* at 1040.

120. *Id.* at 1039. Despite EMTALA's anti-dumping legislative intent, the court found that the Act's language makes no distinction between persons with and without insurance. *Id.* at 1040. The court qualified this finding by stating that EMTALA does not create a broad federal cause of action for emergency room malpractice or negligence. In the absence of any allegation that the hospital departed from its standard emergency room procedures in treating the patient, the court determined that questions involving the patient's diagnosis remain the exclusive province of state negligence and malpractice law. *Id.* at 1039, 1041.

121. *Id.* at 1040. The court decided that the plain language should govern since EMTALA's language is not manifestly inconsistent with the legislative intent. *Id.* (citing *United Mine*

After resolving the issue of the plaintiff's eligibility, the court focused exclusively on the plaintiff's claim that the hospital violated EMTALA's screening requirements.¹²² Interpreting the word "appropriate," the court found the Act "is intended not to ensure each emergency room patient a correct diagnosis, but rather to ensure that each is accorded the same level of treatment regularly provided to patients in similar medical circumstances."¹²³ The court therefore held that a hospital fulfills the "appropriate medical screening" requirement if it conforms to its standard screening procedures when it treats an emergency patient.¹²⁴ The *Gatewood* court departed from the *Cleland* opinion and held that the hospital's motive for the departure from its standard screening procedures is irrelevant to an EMTALA claim.¹²⁵ Since the plaintiff did not allege that the patient was given differential treatment, the court affirmed the district court's dismissal.¹²⁶

Again, it must be emphasized that Congress enacted EMTALA to prevent economic discrimination against indigent and uninsured patients. Although *Cleland* did not limit the cause of action to instances of economic discrimination, its improper motive requirement requires plaintiffs to prove the hospital discriminated against them in some way. Thus, the Sixth Circuit's interpretation preserves the antidiscriminatory purpose of the Act. The *Gatewood* analysis abandons the improper motive requirement, and thus gives any pa-

Workers of America v. Federal Mine Safety and Health Review Commission, 671 F.2d 615, 621 (D.C. Cir. 1982); *Aviation Consumer Action Project v. Washburn*, 535 F.2d 101, 106-07 (D.C. Cir. 1976). In response to the hospital's argument that the Act's language contradicts EMTALA's purpose, the *Gatewood* court found the Act's language extends beyond its congressional intent, without undermining or conflicting with the Act's legislative history. 933 F.2d at 1041 n.2. The *Gatewood* court also believed that its application of EMTALA's plain language was consistent with the *Cleland* court's decision. *Gatewood*, 933 F.2d at 1040-41.

122. 933 F.2d at 1041. The *Gatewood* court declined to address the scope of the Act's stabilization and transfer requirements because those provisions are contingent on the hospital's discovery of an emergency medical condition. *Id.*

123. *Id.*

124. *Id.* Any departure from the hospital's standard screening procedures consequently constitutes an inappropriate screening in violation of EMTALA. *Id.*

125. *Id.* The court found that EMTALA applies "whenever and for whatever reason a patient is denied the same level of care provided [to] others." *Id.* The court explicitly recognized its departure from the Sixth Circuit's interpretation in *Cleland*, stating, "we do not read subsection 1395dd(a) as referring in any way to the 'motives' with which an emergency room acts when it provides something less than its normal screening procedure." *Id.* at 1041 n.3. Recognizing that some hospital screening procedures may fall below the standard of care established by state negligence and malpractice law, the court refused to incorporate a negligence standard into EMTALA. *Id.* at 1041. The court concluded that EMTALA creates a new federal cause of action for failure to treat, which is generally unavailable under state law, instead of duplicating preexisting legal protections. *Id.*

126. *Id.* at 1041-42.

tient willing to claim differential treatment the ability to sue under EMTALA. Consequently, paying patients can capitalize on the D.C. Circuit's broad interpretation and transform EMTALA into a federal mandate for emergency room care. This result is unfortunate because indigent and uninsured patients are no longer the primary beneficiaries of the Act's protections.

Therefore, the federal circuits are split between the improper motive requirement established in *Cleland* and the strict liability standard established in *Gatewood*. One federal circuit has explicitly followed the *Gatewood* court's interpretation of EMTALA, while three circuits have implicitly applied its analysis. Refusing to follow *Cleland*, the Fourth Circuit expressly sided with *Gatewood* in *Power v. Arlington Hospital Association*,¹²⁷ holding that an improper motive is not an element necessary for an EMTALA claim. The Fourth Circuit believed it would be virtually impossible for a plaintiff to prevail in a civil EMTALA claim if the plaintiff had to prove the hospital violated the Act's screening requirements due to an improper motive.¹²⁸ The Eighth, Tenth, and Eleventh Circuits have implicitly followed *Gatewood* by holding that EMTALA merely requires hospitals to provide uniform screening procedures for all emergency patients.¹²⁹ While the Ninth Circuit has held that the Act applies to all emergency patients regardless of their ability to pay,¹³⁰ it has not decided between *Cleland* or *Gatewood* on the issue of whether the hospital's motive is relevant to an EMTALA claim.

127. 42 F.3d 851, 857-58 (4th Cir. 1994).

128. *Id.*

129. *Williams v. Birkeness*, 34 F.3d 695, 697 (8th Cir. 1994) (citing *Gatewood*, 933 F.2d at 1041, and upholding summary judgment in favor of the hospital because the plaintiffs failed to show that the hospital treated the patient differently from other patients); *Repp v. Anadarko Municipal Hospital*, 43 F.3d 519, 522 (10th Cir. 1994) (citing *Gatewood*, 933 F.2d at 1041, and holding that a hospital violates EMTALA's screening requirements when it does not follow its own standard screening procedures); *Holcomb v. Monahan*, 30 F.3d 116, 117 (11th Cir. 1994) (citing *Gatewood*, 933 F.2d at 1041, and holding that a hospital does not violate EMTALA as long as it applies the same screening procedures to indigent patients that it applies to paying patients). Although the federal circuits understand the reason for the split, they are confused over where the split exists. For example, the Tenth Circuit thinks the Eighth Circuit has sided with *Cleland*. Compare *Repp*, 1994 WL 703458 at 3 n.7 (stating that the Eighth Circuit in *Williams* departed from *Gatewood* and followed *Cleland* because it held that a plaintiff must show the hospital treated the patient differently from other patients), with *Williams*, 34 F.3d at 697 (citing *Gatewood* in support of its holding). The Eleventh Circuit is straddling the fence somewhat, although its holding seems to follow *Gatewood's* requirement for uniform screening. See *Holcomb*, 30 F.3d at 117 (citing both *Cleland* and *Gatewood* in support of its holding).

130. *Brooker v. Desert Hospital Corp.*, 947 F.2d 412, 414-15 (9th Cir. 1991).

Consequently, six federal circuits have not decided whether EMTALA requires an improper motive. Of those six, five have not issued opinions on whether EMTALA protects patients who are not indigent or uninsured.¹³¹ Although the Seventh Circuit found that EMTALA's protections are not limited to indigent or uninsured patients in *Johnson v. University of Chicago Hospitals*,¹³² the court withdrew its opinion *sua sponte*.¹³³ The Seventh Circuit then issued another opinion in *Johnson* a month later, which curiously avoids the issue of indigence in an EMTALA claim.¹³⁴ In fact, the Seventh Circuit seems to have retreated from the issue, stating only that EMTALA was enacted to address patient dumping and that hospitals must accept any patient seeking treatment in their emergency rooms.¹³⁵ Consequently, the Seventh Circuit's interpretation of EMTALA is still uncertain, and this recent retraction might indicate a more conservative alignment with the Sixth Circuit's *Cleland* standard. The First, Second, Third, and Fifth Circuits have not addressed the issues of indigence or improper motive.

Although all the federal circuits to decide an EMTALA case have broadly applied the Act's language to include all emergency patients, the five remaining circuits could take a more conservative approach and limit EMTALA's application exclusively to cases involving patient dumping. While this narrow interpretation would make EMTALA's protections consistent with the Act's legislative history, the Act's broad language presents a formidable obstacle to such a narrow application. If, instead, these remaining circuits follow the Sixth Circuit's interpretation in *Cleland*, they could at least preserve EMTALA's anti-discriminatory purpose by requiring plaintiffs to prove the hospital violated the Act due to an improper motive. Following *Cleland's* improper motive requirement would solidify the current circuit split, and thus pressure Congress to clarify its intent by amending EMTALA.

131. The Ninth Circuit in *Brooker*, *id.* at 414, stated that the Act's language does not specify any economic criteria that limits the type of individuals protected by EMTALA. Nonetheless, the Ninth Circuit has not decided whether a plaintiff must prove the hospital used an improper motive in an EMTALA claim. Thus the Ninth Circuit has not decided its position on the circuit split.

132. 1992 WL 259404, 4 (7th Cir.) (citing *Brooker*, *Gatewood*, and *Cleland* to support its finding that the Act's language does not differentiate potential plaintiffs according to their economic status).

133. *Id.* at 5. In this opinion, the *Johnson* majority found that an allegation that the patient was denied care because of an inability to pay is not necessary under EMTALA. *Id.* at 4.

134. *Johnson v. University of Chicago Hospitals*, 982 F.2d 230 (7th Cir. 1992).

135. Note that this conclusion was relegated to a footnote in the second opinion. See *id.* at 233 n.7.

The Fourth Circuit's recent decision in *Baby K* illustrates the profound ramifications of expanding the Act beyond its legislative intent. By broadly applying the Act's protections in *Baby K*, the Fourth Circuit used EMTALA to determine the sensitive ethical and clinical decisions surrounding the treatment of a terminally ill infant. This holding was the inevitable result of the broad interpretation established in *Gatewood*. Creating strict liability for disparate treatment under EMTALA, without regard to improper economic motive, made it inevitable that EMTALA would be used to challenge a hospital's medical judgments. Rather than merely redressing the economic discrimination against indigent patients, EMTALA can now be used to control the disparate treatment of terminally ill patients. Recognizing the far-reaching ramifications of *Baby K*, the five remaining circuits should preserve EMTALA's antidiscriminatory intent by siding with the Sixth Circuit and refusing to follow the precedent established by the Fourth Circuit in *Baby K*.

IV. IN THE MATTER OF BABY K AND THE FOURTH CIRCUIT'S EXTENSION OF EMTALA

Baby K had anencephaly, an incurable congenital defect that left the child without a major portion of the brain, skull, and scalp.¹³⁶ Consequently, she was permanently unconscious, with only her brain stem to support her organs and reflexes.¹³⁷ Like most anencephalic infants, Baby K had breathing difficulties when she was born.¹³⁸ The hospital placed Baby K on a mechanical ventilator and explained the child's condition to her mother, Ms. H.¹³⁹ The hospital recommended that Baby K be provided with only comfort care in the form of nutrition, hydration, and warmth. Given Baby K's condition, the hospital felt ventilator treatment was medically inappropriate and urged Ms. H to permit a "Do Not Resuscitate Order," which would withhold any lifesaving measures in the future.¹⁴⁰ Ms. H refused and insisted the hospital provide Baby K with mechanical ventilation whenever she

136. *Baby K*, 16 F.3d at 592. Although Baby K had a normal heart rate, blood pressure, liver function, digestion, kidney function, and bladder function, most anencephalic children die within days of birth. *In the Matter of Baby K*, 832 F. Supp. 1022, 1025 (E.D. Va. 1993).

137. *Baby K*, 16 F.3d. at 592. Baby K's condition was diagnosed before birth; yet Baby K's mother, Ms. H, chose to carry the child to term.

138. *Baby K*, 832 F. Supp. at 1025.

139. *Baby K*, 16 F.3d at 592-93.

140. *Id.*

went into respiratory distress.¹⁴¹ When Baby K's condition stabilized, the hospital transferred her to a nursing home.¹⁴²

After her transfer, Baby K had recurrent respiratory distress. Each time this occurred, she was readmitted to the hospital where she received mechanical ventilator treatment.¹⁴³ She was then transferred back to the nursing home when her breathing stabilized.¹⁴⁴ The hospital filed for a declaratory judgment to determine whether it must continue providing Baby K with medical treatment it considered medically and ethically inappropriate.¹⁴⁵ The district court found that the hospital was legally obligated to provide mechanical ventilation to Baby K under EMTALA, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.¹⁴⁶ In addition, the court held that

141. *Id.* at 593. Following Ms. H's refusal, the treating physicians conferred with the hospital's ethics committee to override Ms. H's wishes. The ethics committee, composed of a family practitioner, a psychiatrist, and a minister, met with the treating physicians and concluded that the hospital should withdraw Baby K's ventilator since this treatment was futile in the committee's opinion. Ms. H refused to withdraw aggressive treatment. *Baby K*, 832 F. Supp. at 1025. Ms. H had a firm Christian faith that all life should be protected, and she believed God would work a miracle if that was God's will. Otherwise, she believed that God should decide the moment of Baby K's death, not other human beings. *Id.* at 1026.

142. *Baby K*, 16 F.3d at 593. During her stay at the nursing home, Baby K's breathing had stabilized and thus she no longer needed ventilator assistance. Baby K's transfer to the nursing home was conditioned upon the fact that the hospital would readmit her if she developed respiratory distress again. *Baby K*, 832 F. Supp. at 1025.

143. During one of these visits, Baby K was given a tracheostomy, a procedure in which a breathing tube is surgically implanted in the windpipe to facilitate ventilator treatment. *Id.* at 1025-26.

144. *Baby K*, 16 F.3d at 593.

145. *Id.* The baby's father, Mr. K, and her guardian *ad litem* joined the hospital's request. *Id.* Ms. H and Mr. K had never married, and Mr. K had only been distantly involved in Baby K's circumstances. Neither the hospital nor Ms. H sought Mr. K's opinion or consent in the treatment decisions surrounding Baby K. *Baby K*, 832 F. Supp. at 1025.

146. *Id.* at 1031. Under EMTALA, the court found that Baby K's respiratory distress was an emergency medical condition within the Act's statutory definition, and that ventilator treatment was necessary to stabilize this condition. *Id.* at 1026-27. Because EMTALA does not include an exception for futile or inhumane treatment, the court observed, "[a]ny argument to the contrary should be directed to the U.S. Congress, not the Federal Judiciary." *Id.* at 1027. Even assuming that the Act included such an exception, the court stated that the use of ventilator treatment to assist breathing is not futile or inhumane in relieving the acute symptoms of respiratory distress. "To hold otherwise would allow hospitals to deny emergency treatment to numerous classes of patients, such as accident victims who have terminal cancer or AIDS, on the grounds that they eventually will die anyway from those diseases and that emergency care for them would therefore be 'futile.'" *Id.*

Addressing the Rehabilitation Act of 1973, the court observed that § 504 prohibits federally funded entities from discriminating against "otherwise qualified" handicapped individuals, solely by reason of their handicaps. The court found that anencephaly qualified as a handicap under the Rehabilitation Act, and thus the hospital could not refuse Baby K ventilator treatment solely because she had anencephaly. *Id.* at 1028. "Just as an AIDS patient seeking ear surgery is 'otherwise qualified' to receive treatment despite poor long term prospects of living, Baby K is 'otherwise qualified' to receive ventilator treatment despite similarly dismal health prospects." *Id.*

Ms. H had a constitutional right to demand the treatment.¹⁴⁷ The hospital then appealed the case to the Fourth Circuit.

The Fourth Circuit affirmed the district court's decision exclusively under EMTALA.¹⁴⁸ Although the court determined that Congress enacted EMTALA to prevent hospitals from dumping uninsured patients, the court quickly dismissed the Act's legislative intent by concluding that EMTALA was designed to provide an "adequate first response to a medical crisis" for all patients.¹⁴⁹ After dismissing the legislative intent, the court found that EMTALA

Under the Americans with Disabilities Act, the court found that public accommodations cannot discriminate against disabled individuals. Since anencephaly is a "physical . . . impairment that substantially limits one or more of the major life activities," the court found that the "ADA does not permit the denial of ventilator services that would keep alive an anencephalic baby when those life-saving services would otherwise be provided to a baby without disabilities." *Id.* at 1028-29 (citing § 302 of the Americans with Disabilities Act, 42 U.S.C. § 12182).

The hospital also sought a declaratory judgment under the Child Abuse Amendments of 1984, 42 U.S.C. § 5101 *et seq.* The court declared that there is no private right of action under the Child Abuse Amendments because these amendments only authorize states, which receive federal funds for child abuse programs, to bring legal action through their child protective services. *Id.* at 1029. In addition, the court refused to decide Virginia's standard of care for anencephalic infants. *Id.*

147. *Id.* at 1030-31. The district court first found that Ms. H had a constitutionally protected primary right to raise Baby K grounded in the Fourteenth Amendment's Due Process Clause. *Id.* at 1030 (citing *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923); *Pierce v. Society of Sisters*, 268 U.S. 510, 534-35 (1925); *Wisconsin v. Yoder*, 406 U.S. 205, 232 (1972); *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944)). The court further concluded that Ms. H's decisions affecting Baby K could be based upon the Free Exercise Clause of the First Amendment. *Id.* (citing *Pierce*, 268 U.S. at 534-35; *Yoder*, 406 U.S. at 234). These constitutional principles extend to parental rights to make medical treatment decisions for their minor children, even if these decisions violate a child's liberty interests. *Id.* (citing *Parham v. J.R.*, 442 U.S. 584, 603-04 (1979)). The court concluded that when parents do not agree over whether their child's life support should be terminated, it must yield to the presumption in favor of life, supported by the Fifth and Fourteenth Amendments. *Id.* Since Ms. H's decision was also based upon her religious free exercise rights under the First Amendment, the court found that the hospital's reasons to terminate Baby K's ventilator treatments were not clear and compelling enough to override the constitutional rights of Ms. H and Baby K. *Id.* at 1030-31.

148. See *Baby K*, 16 F.3d at 592 n.2 (finding that EMTALA requires the hospital to provide stabilizing treatment and refusing to address the other federal statutes and the laws of Virginia).

149. *Id.* at 593 (quoting *Abber*, 977 F.2d at 880). It is important to recognize how the court employed creative citation to support its statement that Congress enacted EMTALA to provide an adequate first response for all patients. At first glance, the statement seems to be a direct quotation from the Congressional Record since the Fourth Circuit reiterated its statements from *Abber*, which presumably quoted Senator Dole's statements at 131 Cong. Rec. S13904 (Oct. 23, 1985). Yet upon closer inspection, Senator Dole's statements merely say that EMTALA "provid[es] an adequate first response to a medical crisis." 131 Cong. Rec. S13904 (Oct. 23, 1985). In addition, this statement directly follows Senator Dole's remarks urging Congress to put an end to patient dumping for purely financial reasons. The Fourth Circuit in *Abber* supplemented this language with its interpretation that EMTALA applies to all patients, and the *Baby K* court erroneously used the *Abber* court's addition.

governed Baby K's treatment, without determining whether Baby K's mother was indigent or uninsured.¹⁵⁰

The Fourth Circuit then outlined the hospital's responsibilities under EMTALA. Under section 1395dd(a), the hospital was required to provide Baby K with an appropriate medical screening examination to determine whether she had an emergency medical condition.¹⁵¹ Since Baby K's respiratory distress qualified as an emergency medical condition, the court concluded that the diagnosis of this condition triggered the hospital's duty to stabilize the distress with mechanical ventilation.¹⁵² The hospital first claimed anencephaly, not respiratory distress, was Baby K's emergency condition, and thus EMTALA only required the hospital to provide Baby K with the same treatment it would provide other anencephalic infants.¹⁵³ The majority disagreed.¹⁵⁴ Concluding that Baby K's emergency condition was respira-

150. *Baby K*, 16 F.3d at 593.

151. *Id.* The court determined that a "hospital fulfills this duty if it utilizes identical screening procedures for all patients complaining of the same condition or exhibiting the same symptoms." *Id.* (citing *Baber*, 977 F.2d at 879 n.6).

152. *Id.* at 594-95. Transfer was not an option because all area hospitals with pediatric intensive care units declined to accept a transfer of Baby K. *Id.* at 594. Stabilization was interpreted to mean treatment "necessary to assure within a reasonable medical probability, that no material deterioration of Baby K's condition is likely to occur." *Id.* This conclusion closely mirrors the statutory definition of "to stabilize" in § 1395dd(e)(3)(A), except that the court did not use the last phrase of the definition which states: ". . . no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility." Recognizing the fact that stabilization is defined in terms of transfer, the hospital argued that it did not have to provide Baby K with ventilator treatment because it was not going to transfer her following the treatment. *Id.* at 597. The court rejected this argument since it would allow hospitals to avoid EMTALA's stabilization requirement by refusing to transfer the patient. The court then provided the best explanation of EMTALA's requirements to date:

§ 1395dd(b) requires a hospital to provide stabilizing treatment to any individual who comes to a participating hospital, is diagnosed [with] an emergency medical condition, and cannot be transferred in accordance with the provisions of subsection (c). The use of the word "transfer" to describe the duty of a hospital to provide stabilizing treatment evinces a Congressional intent to require stabilization prior to discharge or that treatment necessary to prevent material deterioration of the patient's condition during transfer. It was not intended to allow hospitals and physicians to avoid liability under EMTALA by accepting and screening a patient and then refusing to treat the patient because the patient cannot or will not be transferred.

Id. at 597-98. The hospital was required to provide Baby K with the ventilator treatment necessary to stabilize her condition because no other hospital would accept Baby K's transfer, a restriction under § 1395dd(c). If, however, another area hospital had agreed to accept the transfer of Baby K, the hospital could have avoided stabilizing Baby K's respiratory distress, provided the other transfer restrictions under subsection (c) were satisfied.

153. *Id.* at 595 (citing *Baber v. Hospital Corp. of America*, 977 F.2d 872 (4th Cir. 1992) and *Brooks v. Maryland Gen. Hospital, Inc.*, 996 F.2d 708 (4th Cir. 1993), two Fourth Circuit decisions that held that the Act requires hospitals to provide uniform screening procedures to all patients exhibiting the same emergency condition). Anencephalic infants are generally provided with limited medical care consisting of warmth, nutrition, and hydration. *Id.* at 596.

154. *Id.* The court distinguished the case at issue from *Baber* and *Brooks*. Those cases involved screening procedures, and neither addressed a hospital's stabilization responsibilities

tory distress, not anencephaly, the court decided that the hospital must provide Baby K with the same treatment given to all patients experiencing respiratory distress.¹⁵⁵ EMTALA therefore required the hospital to provide Baby K with ventilator treatment to stabilize her recurrent respiratory distress.

The hospital also argued that Congress did not intend the Act to require physicians to provide treatment exceeding the medical standard of care for anencephalic infants.¹⁵⁶ In response, the Fourth Circuit stated that neither the statutory language nor the legislative history of EMTALA created an exception when the required treatment exceeded the prevailing standard of care.¹⁵⁷ Ignoring the plain language of the Act would transcend the court's judicial function. Therefore, the court felt that Congress was the appropriate branch to redress the hospital's concerns.¹⁵⁸ Consequently, the court held that a straightforward application of the Act obligated the hospital to provide Baby K with ventilator treatment whenever she arrived in respiratory distress.

In a passionate dissent, Senior Circuit Judge Sprouse expressed his doubt that Congress intended EMTALA to control the sensitive decisions between family and physicians involved in this case.¹⁵⁹ Judge Sprouse stated that the legislative history of EMTALA reveals that Congress designed the Act specifically to correct the dumping of indigent or uninsured emergency patients.¹⁶⁰ Since Baby

once a patient's emergency medical condition has been diagnosed. Criticizing the hospital's interpretation, the court stated that if the Act merely required a hospital to provide uniform treatment, it could provide Baby K with substandard treatment as long as that treatment was consistent with the treatment given to patients with the same condition. *Id.*

155. *Id.* at 596.

156. *Id.*

157. *Id.* The majority concluded that the plain language of EMTALA requires the hospital to provide stabilizing treatment to any individual who comes to a Medicare hospital, who is diagnosed with an emergency condition, and who cannot be transferred. *Id.*

158. *Id.* The court stated: "We recognize the dilemma facing physicians who are requested to provide treatment they consider morally and ethically inappropriate, but we cannot ignore the plain language of the statute." *Id.* In conclusion, the court stated that:

EMTALA does not carve out an exception for anencephalic infants in respiratory distress any more than it carves out an exception for comatose patients, those with lung cancer, or those with muscular dystrophy—all of whom may repeatedly seek emergency stabilizing treatment for respiratory distress and also possess an underlying medical condition that severely affects their quality of life and ultimately results in their death.

Id. at 598.

159. *Id.* (Sprouse, J., dissenting). Judge Sprouse observed that "[t]ragic end-of-life hospital dramas such as this one do not represent phenomena susceptible of uniform legal control." *Id.*

160. *Id.* He expressed his doubt that Congress, even in its weakest moments, would have imposed federal control of the sensitive, private treatment decisions surrounding terminally ill patients. *Id.*

K's circumstances did not involve dumping or disparate treatment, Judge Sprouse believed this case fell outside the scope of EMTALA's anti-dumping provisions.¹⁶¹ In addition, Judge Sprouse agreed with the hospital's argument that Baby K's emergency medical condition was anencephaly, and thus he believed that respiratory distress should be considered as one of many subsidiary conditions of anencephaly.¹⁶² Consequently, he reasoned that the Act was not designed to control the situation at hand since Baby K's respiratory distress merely represented a subsidiary symptom of an incurable condition.¹⁶³

The majority opinion and the dissent in *Baby K* illustrate the confusion over EMTALA's applicability. Although both the majority and the dissent consulted the legislative history of the Act, each came to a different conclusion over whether the Act controlled this case. The facts of *Baby K* presented unique difficulties for EMTALA. As Judge Sprouse's dissent clearly observed, the Act's legislative history reveals Congress never intended EMTALA to govern the medical and ethical treatment decisions surrounding terminally ill patients. Congress enacted EMTALA to prevent patient dumping. *Baby K* would have never created such legal confusion had EMTALA been interpreted to cure only the evils Congress intended to correct. If this were the case, the Act would only protect indigent and uninsured patients, not patients with terminal illnesses like anencephaly.

Nevertheless, the majority's decision in *Baby K* represents the next logical step in a line of federal cases that has broadly construed EMTALA's current language beyond its legislative intent. The precedential step established in *Baby K* may prove to be the Pandora's box of EMTALA's adjudication, releasing a host of ramifications unimagined by Congress. The outcomes made possible by the *Baby K* decision should encourage Congress to amend the Act's language and ensure that its requirements simply prevent patient dumping, as originally intended.

161. *Id.* In fact, Judge Sprouse noted that Baby K was not brought to the hospital with an emergency medical condition; she was born there. *Id.*

162. *Id.* at 599.

163. *Id.* Given Baby K's unique medical condition, Judge Sprouse felt her treatment should be interpreted as a continuum, "not as a series of discrete emergency medical conditions to be considered in isolation." *Id.* He stated that other cases such as those involving trauma, cancer, or other catastrophic illnesses may require different analyses and suggested a case-by-case analysis. *Id.*

V. THE FUTURE RAMIFICATIONS OF *BABY K* FOR EMTALA

The Fourth Circuit's opinion in *Baby K* illustrates the critical condition of EMTALA. Following the *Baby K* precedent, three equally serious results could threaten the Act's future in the federal courts. The first involves statutory interpretation. Although EMTALA's legislative history clearly reveals the Act's antidumping purpose, its broad statutory language protects a potential class of plaintiffs who are not indigent and uninsured. Without congressional amendment of EMTALA's current language, recent opinions by the United States Supreme Court encourage federal courts to disregard the Act's legislative history. The second ramification created by *Baby K* relates to EMTALA's ethical scope. The Fourth Circuit's interpretation of the Act now allows plaintiffs to overcome a hospital's clinical autonomy with federal law. Lastly, the *Baby K* decision produces a profound ramification for other federal laws that govern discriminatory practices beyond the purview of patient dumping. By using EMTALA to correct a hospital's discriminatory treatment of an anencephalic infant, the Fourth Circuit's interpretation effectively preempts laws such as the Rehabilitation Act,¹⁶⁴ the ADA,¹⁶⁵ and the Child Abuse Amendments of 1984,¹⁶⁶ which are better equipped to deal with the issues surrounding the treatment of terminally ill patients.

A. *The Statutory Interpretation of EMTALA*

The Fourth Circuit's opinion in *Baby K* exemplifies the split of opinion between the circuits over EMTALA's statutory interpretation. Like the D.C. Circuit's decision in *Gatewood*,¹⁶⁷ the *Baby K* majority simply applied the plain language of the Act without recognizing the antidiscriminatory purpose behind EMTALA's codified words. Unlike the Sixth Circuit's interpretation of EMTALA in *Cleland*,¹⁶⁸ these circuits feel they are required to follow the enacted language. In other words, if EMTALA's statutory language reaches further than

164. 29 U.S.C. § 701 et seq.

165. 42 U.S.C. § 12101 et seq.

166. 42 U.S.C. § 5101 et seq.

167. 933 F.2d at 1041 n.3 (explicitly disagreeing with *Cleland's* improper motive requirement).

168. 917 F.2d at 271.

congressionally intended, then Congress should amend its sloppy legislation.¹⁶⁹

It is important to note that this strict statutory construction—and its accompanying disregard for an act's legislative history—is consistent with the United States Supreme Court's current position on statutory interpretation. In the past, the Supreme Court employed a looser standard of statutory construction to allow federal courts to investigate an act's legislative history and determine whether the alleged conduct was within the spirit of the law.¹⁷⁰ This older federal standard determined whether the purported actions matched the evil the statute was designed to remedy.¹⁷¹ *Baby K* would have been a very different decision if this looser standard of statutory construction were the prevailing method used today.

Yet the Supreme Court construes statutes much more strictly today. In fact, it seems that Justice Scalia's view of congressional committee reports as insignificant has rendered legislative history irrelevant to statutory interpretation.¹⁷² Since the opinions expressed in committee reports represent only a few members of Congress, the Supreme Court's recent opinions hold that an act's statutory language, and not its legislative history, is the "authoritative expression of the law."¹⁷³ Given this strict federal standard of

169. See *Baby K*, 16 F.3d at 596 (stating that "it is not our role to rewrite legislation passed by Congress").

170. See *Church of the Holy Trinity v. United States*, 143 U.S. 457, 459 (1892) (finding that "[i]t is a familiar rule, that a thing may be within the letter of the statute and yet not within the statute, because not within its spirit nor within the intention of its makers").

171. *Id.* at 463 (advising that an act's purpose is to be found in "contemporaneous events, the situation as it properly existed, and as it was pressed upon the attention of the legislative body"). See also *United Steelworkers of America, AFL-CIO-CLC v. Weber*, 443 U.S. 193, 201 (1979) (holding that Title VII must be "read against the background of the legislative history . . . and the historical context from which the Act arose"). But see *id.* at 216 (Burger, C.J., dissenting) (arguing that this method of statutory construction violates the separation of powers because "under the guise of statutory 'construction,' the Court effectively rewrites Title VII to achieve what it regards as a desirable result").

172. Justice Scalia expressed his opinion of committee reports in his concurrence in *Wisconsin Public Intervenor v. Mortier*, 501 U.S. 597, 617 (1991). In that case, Justice Scalia stated that committee reports are unreliable, "not only as a genuine indicator of congressional intent but as a safe predictor of judicial construction." *Id.* Observing that congressional committees contain a discrete number of senators or representatives, he illustrated how insignificant a committee's opinion on an issue is in relation to the whole Congress. *Id.* at 620. Thus, "[a]ll we know for sure is that the full Senate adopted the text that we have before us here, as did the full House, . . . and that that text . . . became law. . . . [I]t would be better still to stop confusing [the courts], and not to use committee reports at all." *Id.* at 621.

173. *Chicago v. Environmental Defense Fund*, 114 S. Ct. 1588, 1593, 128 L.Ed.2d 302 (1994) (quoting the Court of Appeals' expression: "Why should we, then, rely upon a single word in a committee report that did not result in legislation? Simply put, we shouldn't"). See also *NLRB v. Health Care & Retirement Corp.*, 114 S. Ct. 1778, 1784 (1994) (stating that it is the function of

statutory interpretation, the Fourth Circuit's application of EMTALA in *Baby K* could be correct.

Nevertheless, EMTALA was designed—as an overwhelming majority of federal courts have recognized—to address patient dumping. Congress did not design the Act's protection to determine the sensitive medical and ethical decisions involved in the treatment of a terminally ill infant. In light of the prevailing method of statutory construction, which disregards the statutory purpose contained within legislative history, Congress should remove all doubts and amend EMTALA to eliminate the inconsistency between the Act's original intent and its statutory language. Amendment of the Act represents the only available method to ensure that EMTALA fulfills its antidumping purpose.¹⁷⁴ Otherwise, the federal courts' application of the Act to “any individual” will encourage economically secure individuals to seek EMTALA's protections, while the indigent and uninsured patients for whom the Act's protections were designed will become insignificant parties in an ever-increasing class of plaintiffs.¹⁷⁵

B. The Act's Ethical Scope Following Baby K

The Fourth Circuit's opinion in *Baby K* will cause serious consequences for EMTALA's future application. As Judge Sprouse's dissent in *Baby K* observed, Congress did not enact EMTALA to govern the ethical decisions between a terminally ill patient's family and physicians.¹⁷⁶ Yet the *Baby K* court used EMTALA to force a hospital to continue giving medical treatment it considered ethically and medically inappropriate. This precedent could have profound ethical ramifications in future EMTALA claims. By compelling the hospital to provide Baby K with recurrent ventilator treatment, the Fourth Circuit effectively preempted the advice of Baby K's attending

the courts to say what an enacted statute means, not the legislature—much less a committee of one house of the legislature).

174. The Supreme Court's current position illustrates the necessity for EMTALA's amendment. The principles of *City of Chicago*, 114 S. Ct. at 1593, suggest that unless Congress's antidumping intent is included in the Act's language, it is not in the law. See Stricker, 67 Notre Dame L. Rev. at 1138 (cited in note 14) (encouraging Congress to amend EMTALA to eliminate the weak support of an antidumping interpretation provided by the legislative history).

175. In fact, EMTALA's current language does not allow successful plaintiffs to recover attorney's fees. Consequently, very few indigent and uninsured patients will take advantage of the Act's protections.

176. *Baby K*, 16 F.3d at 598.

physicians. This precedent will allow future federal courts to replace a hospital's medical autonomy with EMTALA's stabilization requirements, regardless of the patient's best interests.¹⁷⁷ Accordingly, the ethical scope of the Fourth Circuit's decision could be boundless.

Consequently, Congress should amend EMTALA to protect only indigent and uninsured patients. This would prevent hospitals from discriminating against indigent and uninsured patients based upon their ability to pay for emergency care. In addition, this amendment would refocus EMTALA's legislative purpose on indigent patients, allowing other federal laws to govern non-economic types of discrimination. Under this framework, *Baby K* would have had a different outcome. Since *Baby K* was not the victim of economic discrimination, EMTALA would not have governed the case. Instead, other federal laws better equipped to determine whether the hospital was attempting to discriminate against Baby K because of her disability would have controlled. Had Baby K been indigent, however, EMTALA would have applied only if her mother felt the hospital was denying the child care based on her inability to pay.¹⁷⁸

Amending EMTALA is the only way to refocus the Act's protections on the indigent and uninsured beneficiaries for whom it was enacted. Otherwise, a patient's ability to pay will become increasingly irrelevant, and paying patients will be able to use EMTALA as a federal weapon with which to challenge any clinical decision a hospital makes. Following *Baby K*, an elderly husband whose wife is in a persistent vegetative state could presumably use EMTALA to compel a hospital to keep his wife alive indefinitely, provided she initially came to the hospital with an emergency condition.¹⁷⁹ In fact, the Fourth Circuit's precedent in *Baby K* could have arguably allowed Ms. H to force the hospital to mechanically ventilate her child indefinitely, even if the child's health deteriorated dramatically. Admittedly,

177. By contrast, a recent case in the United Kingdom held that doctors should not be ordered to treat severely handicapped infants against the doctor's clinical judgment. This more sensitive approach considers the best interest of the child rather than a mechanical application of a law. See Frances H. Miller, *Infant Resuscitation, a US/UK Divide*, *The Lancet* 1584 (June 25, 1994) (discussing *Baby K* in light of the UK approach and arguing that the infant's ultimate welfare as a whole human being should determine the judicial course).

178. Under the framework that this Note proposes, the allocation of public resources would become an issue in cases involving indigent patients with conditions such as anencephaly. The ADA and the Rehabilitation Act suggest, however, that society is willing to absorb these costs to prevent hospitals from discriminating against handicapped patients.

179. Mechanical life support would be removed, of course, once brain death occurred. This situation arose in *In re Helga Wanglie*, PX-91-283 (Minn. Dist. Ct. June 28, 1991), but it did not involve an EMTALA claim.

parents have a right to decide what treatment should be given to their minor children.¹⁸⁰ However, the Fourth Circuit's application of EMTALA allows parents to disregard completely the medical judgment of their child's attending physicians.

EMTALA now infringes on a hospital's legitimate treatment decisions, rather than merely providing an adequate first response to a medical crisis, as was intended. Congress must prevent the expanding ethical scope of EMTALA's protections by amending the Act to effectuate its original antidumping purpose.

C. EMTALA's Effect on the Rehabilitation Act, the ADA, and the Child Abuse Amendments of 1984

The precedent established in *Baby K* could have a profound effect on other federal laws that are better equipped to address the treatment of terminally ill patients like anencephalics. Although the district court in *Baby K* addressed the application of the Rehabilitation Act, the ADA, and the Child Abuse Amendments of 1984 in addition to EMTALA,¹⁸¹ the Fourth Circuit applied only EMTALA.¹⁸² This decision seems unfortunate since these other laws provide courts with a better legal framework for situations like *Baby K*'s.

The Rehabilitation Act prohibits discrimination against "otherwise qualified" handicapped individuals, solely by reason of their handicap, under any program or activity receiving federal funds.¹⁸³ This Act defines a "handicapped individual" as "any person who has a physical or mental impairment which substantially limits one or more of such person's major life activities."¹⁸⁴ Thus, the Rehabilitation Act would require a federally funded hospital to provide a terminally ill patient with respiratory support, regardless of whether the patient was anencephalic or had AIDS.¹⁸⁵ In contrast to

180. See *Bowen v. American Hospital*, 476 U.S. 610 (1986) (vesting primary decisional responsibility in the parents under state law); *Baby K*, 832 F. Supp. at 1030 (holding that parents have a constitutional right to make medical treatment decisions for their minor children).

181. *Baby K*, 832 F. Supp. at 1027-29.

182. *Baby K*, 16 F.3d at 592 n.2.

183. 29 U.S.C. § 794.

184. 29 U.S.C. § 706(7)(B).

185. See *Baby K*, 832 F. Supp. at 1028 (holding that the hospital's desire to withhold ventilator treatment over Ms. H's objections would violate the Rehabilitation Act); *Howe v. Hull*, 874 F. Supp. 779, 789 (N.D. Ohio 1994) (stating that a physician could be held liable under the Rehabilitation Act for failing to admit an AIDS patient); *Woolfolk v. Duncan*, 872 F. Supp. 1381,

EMTALA, the Rehabilitation Act provides terminally ill patients with better protection from the discriminatory practices of hospitals because this act focuses on the patient's disability rather than on the attending symptoms of his or her condition.¹⁸⁶

Similarly, the ADA protects terminally ill patients from hospitals that refuse to treat these patients because of their handicaps. The ADA prohibits public accommodations from discriminating against disabled individuals,¹⁸⁷ and it traces the language of the Rehabilitation Act, defining a "disability" as "a physical or mental impairment that substantially limits one or more of the major life activities," including disorders that affect "the neurological system, musculoskeletal system, or sense organs among others."¹⁸⁸ The ADA therefore protects terminally ill patients, like anencephalics and AIDS patients, from all public medical facilities¹⁸⁹ refusing to treat their medical symptoms because of their disabilities.¹⁹⁰ Like the Rehabilitation Act, the ADA is better equipped than EMTALA to address the treatment of terminally ill patients because the ADA's protections focus on the patient's disability rather than on the symptoms of that disability.¹⁹¹

The Child Abuse Amendments of 1984 also address terminal illnesses and their treatment. The Child Abuse Amendments require state child abuse laws to satisfy federal guidelines in order for state agencies to receive federal funds.¹⁹² Interestingly, the Child Abuse Amendments of 1984 specifically recognize the sensitive issues surrounding the treatment of anencephalic infants. These

1390 (E.D. Pa. 1995) (holding that the Rehabilitation Act prohibits a physician from refusing medical care to an AIDS patient based solely upon the patient's disability).

186. One of the problems with the Fourth Circuit's decision in *Baby K* was that it mechanically applied EMTALA's requirements to the infant's respiratory distress without recognizing her underlying anencephalic condition. It is also important to note that the Rehabilitation Act allows a plaintiff to sue the physician in addition to the hospital, unlike EMTALA which does not allow a plaintiff to assert a cause of action against a physician. Compare *Howe*, 874 F. Supp. at 789 (stating that a physician can be held liable under the Rehabilitation Act) with 42 U.S.C. § 1395dd(d)(2)(A).

187. 42 U.S.C. § 12182.

188. 42 U.S.C. § 12102(2); 28 C.F.R. § 36.104 (1994).

189. The ADA's scope is even broader than the Rehabilitation Act because it applies to public facilities. 42 U.S.C. § 12182.

190. See *Baby K*, 832 F. Supp. at 1029 (holding that the ADA does not permit the denial of ventilation to an anencephalic when this treatment would otherwise be provided to a baby without disabilities); *Woolfolk*, 872 F. Supp. at 1389-91 (denying summary judgment to a physician who allegedly refused to treat an HIV positive patient).

191. The ADA likewise allows a patient to sue a physician, unlike EMTALA. See *Howe*, 873 F. Supp. at 77 (holding that individual liability is consistent with the plain language of the ADA).

192. 42 U.S.C. § 5101.

amendments encourage the states to protect the lives of handicapped infants by requiring state child protective services to initiate civil actions that will prevent hospitals from withholding medical treatment from disabled infants with life-threatening conditions.¹⁹³ Yet, these amendments also recognize that aggressive life support is sometimes inappropriate or inhumane. Consequently, the amendments allow the states to permit hospitals to withhold treatment from infants such as anencephalics if that treatment would merely prolong death.¹⁹⁴

The Child Abuse Amendments of 1984 provide federal guidance to the states, recognizing that state legislatures are the appropriate bodies to govern the treatment of handicapped children. By indiscriminately applying EMTALA to the circumstances surrounding Baby K, the Fourth Circuit made the Child Abuse Amendments of 1984, as well as the resultant state laws, irrelevant in the context of anencephaly and other similar conditions. Certainly, Congress did not intend EMTALA to invalidate the extensive legislative resources expended at the federal and state levels to adequately address the medical and ethical dimensions of neonatal treatment.

As this discussion has shown, the *Baby K* precedent has extended EMTALA's protections into areas better governed by other federal laws like the Rehabilitation Act, the ADA, and the Child Abuse Amendments of 1984.¹⁹⁵ Responding to the Fourth Circuit's statement in *Baby K*, Congress should therefore redress these policy concerns by eliminating the inconsistency between EMTALA's legisla-

193. 42 U.S.C. § 5106a(10)(C).

194. 42 U.S.C. § 5106g(10)(B). This subsection allows physicians to withhold treatment if, in the physician's reasonable medical judgment:

- (A) the infant is chronically and irreversibly comatose;
- (B) the provision of such treatment would—
 - (i) merely prolong dying;
 - (ii) not be effective in ameliorating or correcting all of the infant's life-threatening conditions; or
 - (iii) otherwise be futile in terms of the survival of the infant; or
- (C) the provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.

Id. § 5106g(10).

195. In addition, any discrimination by a hospital based upon a patient's race, gender, religion, or national origin would be governed by 42 U.S.C. § 1983 (1988 & Supp. 1993) and Title VI of the Civil Rights Act of 1964, as amended. See H.R. Rep. No. 100-531 at 2 (cited in note 49) (stating that Title VI prohibits discrimination on the basis of race, color, or national origin in any federal facility, and the Rehabilitation Act forbids federally funded facilities from discriminating against persons based upon their handicaps); Stricker, 67 Notre Dame L. Rev. at 1148 (cited in note 14) (arguing that federal courts inefficiently apply EMTALA to conduct already prohibited by other federal laws).

tive history and its current language. Amending EMTALA to prohibit patient dumping would not only allow the appropriate federal laws to govern situations like those addressed in *Baby K*, but it would also ameliorate any confusion over statutory interpretation of the Act and limit the Act's ethical scope.

VI. PROPOSED AMENDMENTS TO EMTALA

The amendments proposed in this Note will remove the inconsistency between EMTALA's legislative history and its actual language by limiting the Act's application to indigent and uninsured individuals.¹⁹⁶ The confusion over EMTALA's application centers around the Act's application to "any individual." To prevent further confusion and expansion, EMTALA's broad statutory language should be limited to bring the Act in line with the congressional intent on which it rests. Many courts have focused on the statutory usage of "any individual" to support their broad application of EMTALA, yet these courts have ignored the congressional intent encapsulated within the Act's language. Section 1395dd(h) explicitly prohibits hospitals from delaying the medical screening or necessary stabilizing treatment while the hospital inquires about the patient's ability to pay. Congress should use this section to emphasize its legislative intent in addition to amending the overly broad phrase, "any individual." Consequently, section 1395dd(a) should read as follows:

(a) Medical screening requirements.

(1) In general:

In the case of a hospital that has a hospital emergency department, if any indigent and uninsured individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services

196. This Note uses "indigent and uninsured individual" rather than "indigent or uninsured individual" to prevent EMTALA from protecting patients who are able to pay for their treatment but who do not have medical insurance. This amendment therefore only protects those patients who are both indigent and uninsured. This approach focuses on the patient's characteristics rather than the hospital's motive because it would be difficult for a plaintiff to prove the hospital's motive for denying treatment. In contrast, the plaintiff can easily prove his or her economic and insurance status. But see Stricker, 67 Notre Dame L. Rev. at 1150-51 (cited in note 14) (proposing an amendment to § 1395dd(a) that would read: "No hospital . . . shall refuse, because of improper economic motives, to provide any person with an appropriate medical screening . . ." and recommending the use of a rebuttable presumption of improper motive once the plaintiff builds a prima facie case).

routinely available to the emergency department, to determine whether or not an emergency condition (within the meaning of subsection (e)(1) of this section) exists.¹⁹⁷

(2) No delay in screening.

A participating hospital may not delay provision of an appropriate medical screening examination in order to inquire about an individual's method of payment or insurance status.¹⁹⁸

Congress should also amend EMTALA's stabilization requirement to remove the inconsistency between the Act's legislative history and its current language. Section 1395dd(b) should therefore read as follows:

(b) Necessary stabilizing treatment for emergency medical conditions and labor.

(1) In general.

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

- (A) within the staff and facilities available at the hospital, for such further medical examination and such as may be required to stabilize the medical condition, or
- (B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.¹⁹⁹

197. The current language of § 1395dd(a) reads as follows:

(a) Medical screening requirement.

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capabilities of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

198. This amendment segments and transposes the language of the current § 1395dd(h), which reads:

(h) No delay in examination or treatment.

A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) of this section in order to inquire about the individual's method of payment or insurance status.

Amending EMTALA in this way will eliminate § 1395dd(h), and thus the current § 1395dd(i) will become § 1395dd(h).

199. § 1395dd(b) currently reads:

(h) Necessary stabilizing treatment for emergency medical conditions and labor.

- (1) In general.** If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the

(2) No delay in necessary stabilizing treatment.

A participating hospital may not delay provision of further medical examination and necessary stabilizing treatment in order to inquire about the individual's method of payment or insurance status.

Many federal courts have been confused by the transfer requirements of EMTALA, interpreting these requirements to prohibit unstabilized transfers when in fact section 1395dd(c) explicitly permits unstabilized transfers. Congress should dispel this confusion by amending section 1395dd(c)(1) to read as follows:

(c) Restrictions on unstabilized transfers.**(1) Rule.**

If an indigent and uninsured individual at a hospital has an emergency medical condition that has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless—²⁰⁰

Amending EMTALA in the preceding ways protects only patients who can show they are indigent and uninsured and who allege that the hospital violated one or more of the Act's three requirements. To ensure that these patients will pursue civil actions under the Act, the civil enforcement section should be amended to award attorney's fees to successful plaintiffs.²⁰¹ Congress should amend section 1395dd(d)(2)(A) as follows:

(A) Personal harm.

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

individual has an emergency medical condition, the hospital must provide either —

- (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
- (B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

200. § 1395dd(c)(1) currently reads:

(c) Restricting transfers until individual stabilized.

- (1) Rule.** If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless—

201. See H. R. Rep. No. 100-531 at 19, 22 (cited in note 49) (recommending that EMTALA or the regulations implementing it should award reasonable attorney's fees to successful plaintiffs).

equitable relief as is appropriate. Successful plaintiffs may recover reasonable attorney's fees in such an action.²⁰²

Congress should amend the nondiscrimination section of EMTALA to explicitly state that the Act is intended only to redress economic discrimination. Section 1395dd(g) should thus be amended to read as follows:

(g) Nondiscrimination.

(1) Intent.

This Act is intended to redress only economic discrimination against individuals with emergency medical conditions by participating hospitals. Any noneconomic discrimination against individuals with emergency medical conditions is governed by 42 U.S.C. § 1983; Title VI of the Civil Rights Act of 1964; The Rehabilitation Act, 29 U.S.C. § 701; The Americans with Disabilities Act, 42 U.S.C. § 12101; and the Child Abuse Amendments of 1984, 42 U.S.C. § 5101.

(2) Acceptance of appropriate transfers.

A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an indigent and uninsured individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.²⁰³

These proposed amendments to EMTALA should help correct the unsettling ramifications of the Fourth Circuit's opinion in *Baby K*. First, these amendments will prevent any further confusion over the statutory interpretation of the Act because the plain language of the amendments communicates the Act's antidumping purpose. Second, these amendments will limit the ethical scope of EMTALA because they express EMTALA's purpose to redress only economic discrimination by hospitals; thus the clinical autonomy of a hospital

202. § 1395dd(d)(2)(A) currently reads:

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

203. § 1395dd(g) currently reads:

(g) Nondiscrimination. A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation [sic]) shall not refuse to accept an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

and its physicians is not implicated by the Act's requirements. Last, these amendments recognize that other federal laws, like the Rehabilitation Act, the ADA, and the Child Abuse Amendments of 1984, are better equipped to govern noneconomic discrimination by hospitals and their physicians.

VII. CONCLUSION

To reiterate a point this Note has attempted to address comprehensively: the federal adjudication of EMTALA reveals that the Act is in critical condition. Although its legislative history and implementation soundly reflect its antidumping purpose, the Act's plain language created the potential for deterioration because it applies to individuals who are not indigent and uninsured. The federal judiciary recognized this weakness early on but exacerbated EMTALA's condition by broadly construing the Act's protections. A disagreement among the federal circuit courts has created a split of opinion over whether EMTALA's antidiscriminatory history is relevant. Those circuits that disregarded the Act's history allowed the Fourth Circuit to inflict EMTALA's most serious injury to date in *Baby K*. This precedent may prove fatal without immediate congressional intercession. This Note therefore recommends the action necessary to reverse EMTALA's current crisis. Amending EMTALA to protect only indigent and uninsured individuals should heal the wound inflicted by the Fourth Circuit and place EMTALA on the road to recovery.

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