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# **EMTALA: ITS FIRST DECADE**

**A Retrospective Analysis of 42 U.S.C. § 1395dd**

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A Retrospective Analysis of 42 U.S.C. § 1395dd**

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## INTRODUCTION

by Elliott B. Oppenheim, MD/JD/LL.M. HEALTH LAW<sup>1</sup>

In 1986, two acts revolutionized American health care by creating new duties and obligations for hospitals, organizations, and all health care providers. The Health Care Quality Improvement Act of 1986<sup>2</sup> affected internal operations within the medical community and the Emergency Medical Treatment and Active Labor Act of 1986<sup>3</sup> created a startling new medical duty in a vital discipline, that of emergency medical care. In the ensuing ten years, EMTALA has been thoroughly litigated and has been embroiled in controversy. After ten years it is time to analyze the Act's impact in American health care and law and to review the most important<sup>4</sup> cases in order to better understand this Act.

In general, there is no right to medical care under the American system yet EMTALA created a duty on the part of hospitals, at a minimum, to appropriately treat any person who presented to an emergency room.<sup>5</sup> In an unusual enactment EMTALA created this obligation for hospitals to give medical care and derivatively mandated that

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<sup>2</sup> The Health Care Quality Improvement Act of 1986; 42 U.S.C. § 1101 *et seq.*; 54 Fed. Reg. 42,722, codified at 45 C.F.R. Pt.60 *et seq.*. See generally BERNARD REAMS, THE HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986: A LEGISLATIVE HISTORY OF PUB. L. 99-660 (1990). (granting immunity to persons or institutions which participate in peer review activities and created the National Practitioner Databank).

<sup>3</sup> 42 U.S.C. § 1395dd. (hereinafter the Act)

<sup>4</sup> This paper excludes obstetric cases since their focus is different than the "medical" matters. For a good review of the obstetric aspects, see Michael S. Cardwell, *Interhospital Transfers of Obstetric Patients Under the Emergency Treatment and Active Labor Act*, 16 J. LEG. MED. 357 (1995).

<sup>5</sup> See *e.g.*, *Harris v. McRae*, 448 U.S. 297 (1980), rehearing denied 448 U.S. 917 (1980).

physicians carry out that obligation. When either the hospital or physician refused the appropriate medical care, in violation of the Act, they fell into a strict liability pit.

With that preface, this monograph will give a brief overview of EMTALA including a quick treatment of the policy decisions responsible for its promulgation. Then, it will detail EMTALA's important provisions with which either a plaintiff or defense attorney should be familiar before undertaking client representation in litigation or by way of providing advice to clients. Second, this article will analyze the various holdings which contour the statute paying special attention to the critical provisions as determined by the important case holdings. Thirdly, the article will analyze EMTALA's success in meeting its congressional intent. Finally, in the fourth section, the article suggests amendments to the Act which would fortify it in meeting its purpose through the addition of the sanction of the loss of tax-exempt status when an hospital repeatedly violates the Act.

## I. THE DECADE OF STATUTORY DEVELOPMENT

The Emergency Treatment and Active Labor Act was incorporated as part of the Comprehensive Omnibus Reconciliation Act of 1986<sup>6</sup> and its legislative intent was simple: to prevent hospitals from dumping patients without health insurance. The practice was a dangerous one for the abandoned patients and a costly one for the recipient hospitals which were usually teaching hospitals or county hospitals whose budgets for uncompensated care were already stretched to the breaking point.<sup>7</sup>

EMTALA, therefore, goes by the monikers “The Anti-Dumping Act” and “COBRA”<sup>8</sup> but whether called COBRA, EMTALA or the Act, after ten years, through which the courts have interpreted most of its provisions,<sup>9</sup> it is time to analyze the Act’s substantive provisions, how best to apply the Act in the context of a plaintiff seeking

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<sup>6</sup> Pub. L. No. 99-272 § 9121, 1986 U.S. Code Cong. & Admin. News (100 Stat.) 82, 164-67 (codified as amended at 42 U.S.C.A. § 1395dd) (West Supp. 1987).

<sup>7</sup> For the legislative history, see H.R. REP. NO. 241, 99th Cong., 1st Sess. pt. 1, at 27 (1985).

<sup>8</sup> This is important to know when researching this topic since titles frequently refer to COBRA, Anti-Dumping, or to EMTALA. See Robin E. Margolis, *Patient Dumping Split Developing Among Federal Circuits On Disparate Treatment Claims*, 1 HEALTHSPAN 19 (1995). See also *Hospital Found Liable Under The Emergency Medical Treatment And Active Labor Act*, 1 VERDICTS, SETTLEMENTS & TACTICS 7 (1995); Brenda Strama & Laura Gilchrist, *New Anti-Dumping Regulations Strengthen Patient Protections*, 9 HEALTHSPAN 3 (1994); Mark R. Bower & Charles S. Gucciardo, *Proving A Separate Cause Of Action In Malpractice Cases, For Violation Of The Federal “Anti-Dumping” Act*, 5 VERDICTS, SETTLEMENTS & TACTICS 147 (1994); Heather K. Bardot, Note, *Cobra Strikes At Virginia’s Cap On Malpractice Actions: An Analysis On Power v. Arlington Hospital*, 2 GEO. MASON INDEPENDENT L. REV. 249 (1993); Daniel N. Rosenstein, *Emergency Stabilization For A Wounded Cobra*, 9 ISSUES L. & MED. 255 (1993); William N. Wiechmann, Comment, *Language Barrier To Emergency Health Care: Definitional Imprecision Still Plagues The Consolidated Omnibus Budget Reconciliation Act*, 9 T.M. COOLEY L. REV. 161 (1993). These articles are shorter articles reviewing one case or are now dated in scope and in perspective.

<sup>9</sup> See generally Note, *Preventing Patient Dumping: Sharpening The Cobra’s Fangs*, 61 N.Y.U.L. REV. 1186 (1986). This was one of the earliest law review articles and courts relied upon its insight many early cases.

recovery for injury, and how to achieve litigation success by approaching litigation cautiously, fully aware of the statutory benefits and risks.

Although it is called the “Anti-Dumping Statute” in its organic language, there is no mention or definition of the word “dump”. A court defined what is meant by “dumping” in *Deberry v. Sherman Hospital Association*<sup>10</sup> and the term of art appears to mean a “hospital’s refusal to treat an emergency patient, even though the hospital is physically capable of doing so, simply because the patient may be unable to pay.”<sup>11</sup> The “dump” occurs when the refusing hospital transfers the patient without stabilization.<sup>12</sup> The motive for a “dump” is economic: discrimination against the unprofitable. One need which emerges after an analysis of these cases is that in crafting the Act’s provisions, there is significant drafting imprecision with respect to definitions.<sup>13</sup>

Despite considerable national concern and litigation, the dumping problem persists, indicating that greater protection is needed, not less.<sup>14</sup> Additionally, it appears

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<sup>10</sup> 741 F.Supp. 1302, 1304 (N.D. Ill. 1990).

<sup>11</sup> 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, 1122 (1992).

<sup>12</sup> A “wallet biopsy” is a term of art within the profession which refers to the process of making a determination of a patient’s economic status.

<sup>13</sup> See Karen I. Treiger, Note, *Preventing Patient Dumping: Sharpening The Cobra's Fangs*, 61 N.Y.U. L. REV. 1186, 1223 n.20 (1986). Since the Department of Health and Human Services (HHS) is the executive agency with jurisdiction over the Medicare program, it may promulgate regulations which have the force of law detailing the statute's actual implementation and ask for public comments on these regulations. The Department will then revise the proposed regulations, publish them in the Federal Register at least thirty days before their effective date. The only review permitted of these regulations is through Congress which may amend the statute in order to further clarify the statute's meaning in accord with Congressional intent.

<sup>14</sup> See, *Statelines Florida: Elderly Population Faces Challenges*, 4 AM. HEALTH LINE 5 (Aug. 22 1995). “Florida's emergency rooms have come under increased scrutiny “for violations ranging from turning away anyone who can't pay for treatment to sending patients to other hospitals.” At least four patients have recently died as a result of being “turned away or neglected in the emergency room.” In 1994, federal investigators examined 65 ERs, three times more than the previous year (AP/ORLANDO SENTINEL, 8/18). Florida's ERs currently rank second nationally “for complaints and confirmed violations.” A recent report completed by the Florida Hospital Association (FHA) revealed that 28 hospitals were fined a total of \$170,800 from 1989 to 1994. Understanding the numbers: The federal government enacted a law nine years ago that prohibits hospitals from “dumping” patients based on their ability to pay. MIAMI HERALD

that wrongdoing goes both unnoticed and unpunished under EMTALA.<sup>15</sup> Many cases resolve at the pre-trial or trial level so that the plaintiff's bar does not learn of important developments until after much time has passed.

While other authors have contributed analyses in other aspects of EMTALA,<sup>16</sup> this retrospective, spanning the first decade, will provide a needed academic and practical commentary by visiting the important individual cases from this ten-year perspective.<sup>17</sup> Most cases come from the federal appellate level but some originate from the state trial courts.<sup>18</sup>

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reports that Florida's large number of ER complaints are due partially to the fact that the state's ER facilities must comply with both the federal law and a state statute, unlike many states that report fewer cases. Also, a new federal rule requires hospitals to "snitch" if other hospitals "dump" uninsured patients on them." The author leaves the nonsensical implication that it might be better to reduce complaints by relaxing federal laws.

<sup>15</sup> See *Access/Quality/Cost - Hospitals: "Patient Dumping" Goes Unpunished*, 2 AM. HEALTH LINE 12 (1993). "Public Citizen's Health Research Group 5/19 released a study which found that of 302 reported "patient dumping" violations in 268 hospitals between '86-'92, "only 24 have ever been penalized; seven hospitals were terminated from Medicare (with four later reinstated) and 17 have been fined between \$1,500 and \$150,000." Wash. Post: "Instead of punishing most violators, HHS usually forced them to change their rules and training practices. Final regulations spelling out all of the terms for complying with the law have never been published and HHS has not required institutions to whom a patient was sent improperly by the 'dumping' hospital to report that fact to HHS" (Spencer Rich, 5/20). The practice of denying treatment to patients who are uninsured or unable to pay was outlawed in 1986. Public Citizen's Dr. Sidney Wolfe: "The government is basically telling the hospitals that over 90% of the time, if we catch you, you're not going to be fined. It essentially encourages people to laugh at this law." HHS' Anthony Tirone defends the lack of punishment, "explaining that hospitals are punished only in instances of extreme or uncorrected violations." Wolfe: "There is the horrible specter of the dumping of thousands of patients per year in medically unstable condition from hospital emergency rooms. For many of these patients, dumping means death" (Howard Libit, L.A. TIMES, 5/20).

<sup>16</sup> See Barry R. Furrow, *An Overview And Analysis Of The Impact Of The Emergency Medical Treatment and Active Labor Act*, 16 J. LEGAL MED. 325 (1995). (reviewing The Act, provision by provision.)

<sup>17</sup> See Mark R. Bower & Charles S. Gucciardo, *Proving a Separate Cause of Action in Malpractice Cases, for Violation of the Federal "Anti-Dumping" Act*, 66 N.Y. St. B.J. 34 (1994). (considering this in a much more limited context where the plaintiff was awarded \$50,000 for an EMTALA violation in *Masoner vs. Huntington Hospital*, Supreme Court, Suffolk Co., Index #4565/93).

<sup>18</sup> The plaintiff's bar quickly identified EMTALA as a potential alternate route to recovery but some of the early litigation fell apart when the cause of action was insufficient to bring it under the Act. See Sebastian Rotela, *Health Violations May Cost Hospital License, Funding*, L.A. TIMES, Dec. 3, 1987, at 12. The Inglewood Hospital came under scrutiny when a woman went to the Inglewood Hospital for an abortion and suffered complications. She was transferred to L.A. County- U.S.C Medical Center in unstable condition and without notice. "The hospital, Barke and Dr. Steven Pine are being sued for \$12 million by the family of Belinda Byrd, a 37-year-old Inglewood woman and mother of three who died Jan. 27 after an abortion three days earlier. The lawsuit, filed in Los Angeles Superior Court, alleges that Pine performed an



As an expression of national health care policy, EMTALA intended to create a physician incentive to practice carefully, to perform an adequate examination of every patient who presents himself to the emergency department, and to transfer the patient only when stable. One of the best ways to accomplish this goal and to reduce medical malpractice awards would be to attack the problem at its origin; to encourage excellent medical practice. On the other hand, the defense bar has perceived that there is too much medical negligence litigation and that high awards constitute a national problem in itself. To that end, states reacted by enacting damage caps. These, however, work at the wrong end of the medical conveyor belt; by sticking their respective fingers into the pay-out dike.

Simultaneously, criticism is leveled at the plaintiff's bar that they have attempted to circumvent the damage caps through EMTALA litigation. The damage cap approach is a little like attempting to stem crime by building more prisons. Caps actually provide a bonanza to physicians, hospitals and the insurance industry, allowing them to limit risk, while at the same time punishing the blameless consumer.<sup>19</sup> With damage caps, the injured remain less than whole. As this article will point out, if EMTALA has permitted

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abortion that lacerated Byrd's uterus and that she lay bleeding and unattended for three hours in a hospital bed until she suffered a heart attack. ... "The violations found by the Health Department existed before, during and after Belinda Byrd's death. The hospital is always being audited. They submit a plan of correction and the violations continue." The article made the point, however, that alleged violations did not seem to have been the cause of the death. In another article, Sebastian Rotella, *'Battlefield Conditions' Reported at Hospital in Inglewood*, L.A. Times Dec. 3, 1987, at 3, the author noted, "There is a long record of "battlefield conditions" at Inglewood Women's Hospital, said Ralph Lopez, director of the health facilities division of the county Department of Health Services. The clinic, which also faces a lawsuit over the death of a patient in January, performs about 1,000 abortions a month in its single operating room, according to county and state health officials, who cited the hospital for numerous health violations in a 29-page report sent to the hospital last week."

<sup>19</sup> *Contra*, Scott E. Hamm, Note, *Power v. Arlington Hospital: A Federal Court End Run Around State Malpractice Limitations*, 7 B.Y.U. J. PUB. L. 335 (1993).

circumvention of a state damage cap, the end run was well deserved; well within the Act itself, and well within a general moral sense of just tort recovery.

Ten years into EMTALA though, there are considerable definitional problems in interpreting and in enforcing the statute. In fact, it is unusual for plaintiff's to succeed in recovery under the Act.<sup>20</sup> Therefore, as a beginning, it is important to first analyze the statute: 42 U.S.C. § 1395dd.

### **A. The Major Important Provisions of 42 U.S.C. § 1395dd<sup>21</sup>**

In order to best appreciate the Act's effect, a logical starting point is with the enforcement section<sup>22</sup> which provides for civil money penalties "of not more than \$50,000 (or not more than \$25,000 in the case of a hospital with less than 100 beds) for each ... violation." If an hospital violates EMTALA it may be suspended from the Medicare<sup>23</sup> program but the language is permissive. HCFA then determines whether in the agency's judgment this sanction is warranted according to the scope of the "failure and the hospital's correction or plan for correction of the failure."<sup>24</sup>

### **B. Jurisdiction**

What is the appropriate jurisdiction for an EMTALA claim since the Act itself is silent on this and does not pre-empt other jurisdiction? Some courts make the interpretation that Congress intended federal jurisdiction since the Act is specific with

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<sup>20</sup> See HAMM at 337. (providing background on medical negligence litigation awards).

<sup>21</sup> See Appendix (A) for the Act's current complete text.

<sup>22</sup> 42 U.S.C. § 1395dd(d)(1),(2).

<sup>23</sup> 42 U.S.C. § 1395dd(d)(1)(B)(ii). The hospital would be subject to exclusion under 42 U.S.C. § 1320a-7a(a).

<sup>24</sup> 59 Fed. Reg. 32086, 32091. (under 42 C.F.R. §§ 489.26 and 489.27).

respect to covering only those hospitals which receive Medicare funds.<sup>25</sup> It is clear that federal courts do have subject matter jurisdiction over EMTALA claims<sup>26</sup> but there are at least three options open in the absence of express congressional intent to pre-empt this area.

The plaintiff could ask the federal court to exercise pendent jurisdiction over the state claim,<sup>27</sup> file the EMTALA action in federal court and the negligence action in state court, or file both in state court where the state court would then apply the appropriate law. But why would a plaintiff choose federal jurisdiction when, under the Act there is no private cause of action against the physician, and the main recovery against the physician is under state malpractice law?<sup>28</sup>

The answer is that this is a tactical decision. One effect of filing in two courts would be to greatly increase the defense costs and labor but, according to Furrow,<sup>29</sup> an experienced commentator, there are some other benefits to the federal court venue including jury composition, liberal notice pleading rules, admission of expert testimony, broad subpoena power, and decreased time from filing to trial. Another reason to file in federal court would be to avoid an arbitration requirement of the medical negligence claims under state malpractice statutes.<sup>30</sup>

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<sup>25</sup> Jones v. Wake County Hosp. System, Inc., 786 F.Supp. 538, (E.D.N.C.1991).

<sup>26</sup> Thornton v. Southwest Detroit Hosp., 895 F.2d 1131 (1990).

<sup>27</sup> Fed. R. Civ. P. 18(a).

<sup>28</sup> No cause of action against private physicians or their medical professional corporations may be brought under Emergency Medical Treatment and Active Labor Act (EMTALA). Reynolds v. Mercy Hosp., 861 F.Supp. 214, (W.D.N.Y.1994). See also, Vickers v. Nash General Hosp., Inc., 875 F.Supp. 313, (E.D.N.C.1995).

<sup>29</sup> Barry R. Furrow, *An Overview and Analysis of the Impact of the Emergency Medical Treatment and Active Labor Act*, 16 J. LEGAL MED. 325, 338 (1995). Hereinafter, Furrow, OVERVIEW AND ANALYSIS.

<sup>30</sup> Jef Feeley, *Fed. Patient Dumping Law Clarified*, DAILY REC. (Balt. Md.), 1995 WL 2990470, June 25, 1993, at B3. “The upshot is that if somebody goes to the emergency room and feels they got the bum's rush, they have the ability to file a federal action without having to go through arbitration,” said Cook, an

There are, in addition, two other convincing reasons: deep pockets and settlement leverage. Hospitals fear the possibility of publicity, an HCFA investigation, and ultimately paying a \$50,000 fine and being subject to loss of Medicare provider status if found liable even where they ultimately win the state medical negligence claim. An EMTALA action can be an effective cudgel for defendants who might otherwise delay settlement to “the courthouse steps” or beyond and who have not been convinced to enter into good faith negotiations.

Notice, too, the following interpretations. In *HCA Health Services of Indiana, Inc. v. Gregory*,<sup>31</sup> the court determined that the concurrent jurisdiction in the state court did not mandate the procedural requirements of the state medical malpractice act. Even though EMTALA has a two year statute of limitations, in *Draper*<sup>32</sup> the Act did not preempt Oregon’s one-year notice requirement for wrongful death claims against public bodies. The plaintiff may comply with both laws by giving the required notice under the state statute within one year and by filing suit under EMTALA within its two year statutory requirement.

### C. The Parties

On the patient side, the Act provides<sup>33</sup> recovery under a two year statute of limitations<sup>34</sup> for “[a]ny individual who suffers personal harm as a direct result of a

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associate with Townson's Shaw & Brown.” (discussing the Fourth Circuit’s opinion in *Brooks v. Maryland General Hospital, Inc., et al.*, No. 92-1852). This is in reference to the appellate decisions *Brooks v. Maryland General Hosp., Inc.*, 996 F.2d 708, (1993).

<sup>31</sup> 596 N.E.2d 974, (1992).

<sup>32</sup> *Draper v. Chiapuzio*, 9 F.3d 1391 (1993).

<sup>33</sup> 42 U.S.C. § 1395dd(d)(2)(A).

<sup>34</sup> 42 U.S.C. § 1395dd(d)(2)(C).

participating hospital's violation." That individual "may 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."<sup>35</sup> The Act requires that the person "comes to" the emergency department and "a request is made on the individual's behalf"<sup>36</sup> for treatment of his condition. The individual seeking recovery under the Act need not be poor,<sup>37</sup> indigent, without insurance,<sup>38</sup> or fulfill any more requirements than being an individual<sup>39</sup> who has been directly damaged.

On the provider side, the Act applies only to hospitals<sup>40</sup> which have "entered into a provider agreement under section 1395cc." As a practical matter, this includes all hospitals since 42 U.S.C. § 1395cc is the Medicare agreement section and would, therefore, include any facility under the purview of the Joint Commission on Accreditation of Healthcare Organizations.<sup>41</sup> In New York, for instance, according to Bower and Gucciardo, "[v]irtually every hospital in N.Y. accepts Medicare, and it may be safely assumed that every full-service hospital is a 'provider hospital' within the statutory meaning."<sup>42</sup>

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<sup>35</sup> *Burditt v. United States Dep't of Health and Human Serv.*, 934 F.2d 1362 (5th Cir. 1991).

<sup>36</sup> 42 U.S.C. § 1395dd(a). The "comes to" language is critical to coverage and receives in depth treatment below.

<sup>37</sup> *Ballachino v. Anders*, 811 F.Supp. 121 (W.D.N.Y. 1993). (holding that a patient suing under EMTALA does not need to allege indigence or lack of insurance).

<sup>38</sup> *Lane v. Calhoun-Liberty County Hosp. Ass'n Inc.*, 846 F.Supp. 1543, (N.D.Fla.1994).

<sup>39</sup> It is not necessary for the plaintiff to prove a financial motivation. *See, e.g., Ruiz v. Kepler*, 832 F.Supp. 1444 (D.N.M. 1993).

<sup>40</sup> 42 U.S.C. § 1395dd(a). "In the case of a hospital ..."

<sup>41</sup> *See Timothy S. Jost, The Joint Commission on Accreditation of Hospitals, Private Regulation of health Care and the Public Interest*, 24 B.C.L. REV. 835 (1983).

<sup>42</sup> Mark R. Bower & Charles S. Gucciardo, *Proving a Separate Cause of Action in Malpractice Cases, for Violation of the Federal "Anti-Dumping" Act*, 66 N.Y. St. B.J. 34 (1994). These authors were successful in *Masoner vs. Huntington Hospital*, Supreme Court, Suffolk Co., Index #4565/93 and detailed their case in this report.

Under most interpretations, there is no direct civil liability for physicians<sup>43</sup> under the Act<sup>44</sup> but according to the HCFA, as reported in the Federal Register<sup>45</sup> when the Office of Inspector General detects knowing, willful, and negligent instances of violation, then HCFA could terminate an individual physician's participation and fine the physician \$50,000. In addition, under 42 C.F.R. § 489.53(a) an hospital's failure to report improper transfers "may subject the receiving hospital to termination of its provider agreement."<sup>46</sup> Medical facilities which suffer economic injury as a result of an improper transfer may recover from the dumping hospital.<sup>47</sup>

#### **D. EMTALA Elements**

The major operant provisions of EMTALA require, (1) "in the case of a hospital that has a hospital emergency department" that the hospital must provide an (2) "appropriate medical screening examination within the capability of the hospital's emergency department." This examination's purpose is to "determine whether or not an emergency condition ... exists."

Furthermore, if an emergency condition exists, the hospital must provide

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<sup>43</sup> Carodenuto v. New York City Health & Hospitals Corp., 593 N.Y.S.2d 442 (1992).

<sup>44</sup> 42 U.S.C. § 1395dd(d)(2)(A). *See, also* Urban v. King, 783 F.Supp. 560, (D.Kan.1992).

<sup>45</sup> 59 Fed. Reg. 32086, 32094.

<sup>46</sup> *Id.*

<sup>47</sup> 42 U.S.C. § 1395dd(d)(2)(B). "[a]ny medical facility that suffers a financial loss 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 ... damages" under the respective state law "in which the hospital is located and such equitable relief as is appropriate."

“either (A) within the staff and facilities available at the hospital, for ... medical examination and ... treatment ... to stabilize ... or (B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.”<sup>48</sup>

Note that when an individual refuses treatment, the hospital must “take all reasonable steps to secure” consent to refuse to examination and treatment<sup>49</sup> but when the patient refuses transfer, an hospital meets the requirements of sub-section (b)(1)(A) when it “offers to transfer an individual to another facility ... and informs the individual ... of the risks and benefits ... of the transfer.”<sup>50</sup>

The definitional section, 42 U.S.C. § 1395dd(e), defines emergency medical condition<sup>51</sup> to mean

- (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 ... in serious jeopardy,
  - (ii) serious impairment to bodily functions, or
  - (iii) serious dysfunction of any bodily organ or part<sup>52</sup>

An appropriate transfer must meet stringent requirements of § 1395dd(c)(1),(2) which provide “unless ... the individual ... after being informed of the hospital’s obligations under this section and of the risk of transfer, in writing requests transfer” or “a physician ... has signed a certification that ... the medical benefits [of the transfer]... outweigh the increased risks to the individual.”

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<sup>48</sup> § 1395dd(b)(1)(A),(B).

<sup>49</sup> § 1395dd(b)(2). This applies where the hospital recommends treatment but the patient refuses.

<sup>50</sup> § 1395dd(b)(3). This applies in the case where the hospital recommends transfer, but the patient refuses.

<sup>51</sup> This paper does not concern the pregnant patient.

<sup>52</sup> § 1395dd(e)(1)(A).

EMTALA does not preempt “any State or local law requirement” unless the state law would directly conflict with the federal enactment<sup>53</sup> and, finally, hospitals may not delay the screening examination in order to “inquire about the individual’s” financial status or whether he has insurance.<sup>54</sup>

Once it is determined that the hospital did discharge without stabilizing the emergency medical condition, the standard of liability is that of absolute liability, not negligence or malpractice. None of the words “negligence”, “malpractice”, nor “strict liability” appear within the Act but strict liability is the standard and, furthermore, under the authority of *Abercrombie v. Osteopathic Hosp. Founders Ass’n*.<sup>55</sup> and *Reid v. Indianapolis Osteopathic Medical Hosp.*,<sup>56</sup> the courts have interpreted this wording as precise congressional intent: absolute liability.

There is a perplexing angle to EMTALA. Congress enacted EMTALA in response to perceived harm to the indigent, but the Act fails to mention the patient’s financial status as a prerequisite to eligibility for recovery and it fails to require that the plaintiff prove that the denial of care was motivated by an economic consideration.<sup>57</sup> As will be seen in further analysis, this has provided the courts with another definitional problem.

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<sup>53</sup> § 1395dd(f).

<sup>54</sup> § 1395dd(h).

<sup>55</sup> 950 F.2d 676, 681 (10th Cir., 1991).

<sup>56</sup> 709 F.Supp. 853, 855 (S.D. Ind. 1989).

<sup>57</sup> *Id.* at WESTLAW 2. See *Collins v. DePaul Hospital*, No. 91-8010 (10th Cir. April 28, 1992); *Brooker v. Desert Hospital*, 947 F.2d 412 (9th Cir. 1991); *Gatewood v. Washington Healthcare Corporation*, 933 F.2d 1037 (D.C. Cir. 1991); *Cleland v. Bronson Health Care Group*, 917 F.2d 277 (6th Cir. 1990); *Jones v. Wake County Hospital System*, 768 F.Supp. 538 (E.D.N.C. 1991); *Urban v. King*, 783 F.Supp. 560 (D.Kan. 1992); *Lee v. Allegheny Regional Hospital Corporation*, 778 F.Supp. 900 (W.D. Va. 1991); *Burrow v. Turner Memorial Hospital*, 762 F.Supp. 840 (W.D. Ark. 1991); *Delaney v. Cade*, 756 F.Supp. 1476 (D. Kan. 1991); *Deberry v. Sherman Hospital Association*, 741 F.Supp. 1302 (N.D. Ill. 1990); *Carodenuto v. N.Y.C. Health & Hosp. Corp.*, 156 Misc.2d 361, 593 N.Y.S. 2d 442, 40 Soc. Sec. Rep. Ser. 226 (1992).



### E. The *prima face* Statutory EMTALA Case

The *prima face* EMTALA case requires, at a minimum, satisfying some definitional requirements: (1) the patient must have an “emergency medical condition”;<sup>58</sup> (2) that the condition was not “stabilized”;<sup>59</sup> (3) that the patient was transferred<sup>60</sup> at the direction “of any person employed by ... the hospital.”<sup>61</sup>

Then, (4) , the patient must have suffered a “personal harm as a direct result of a participating hospital’s violation of this section.”<sup>62</sup> The statute uses “direct result” rather than “proximate cause” language which is customarily applied in the negligence setting.

In order to recover under the Act the plaintiff need not prove that the hospital committed malpractice, that the diagnosis was incorrect, or that the hospital knew what the true diagnosis was but discharged the patient despite knowing the true diagnosis.

### F. The Reporting Requirement

When EMTALA was originally enacted there was no reporting requirement on behalf of hospitals. In 1988, however, the Office of the Inspector General conducted a study, *Patient Dumping After COBRA: Assessing the Incidences and the Perspectives of Health Care Professionals*<sup>63</sup> which confirmed reports that a number of patients had been transferred improperly in unstable condition and that there had been no reporting to HCFA. In reaction to this, HCFA promulgated 42 C.F.R. § 489.20(g) and § 489.24(f). These sections mandate that an hospital receiving an improperly transferred individual

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<sup>58</sup> 42 U.S.C. § 1395dd(e)(1).

<sup>59</sup> (42 U.S.C. § 1395dd(e)(4)(B).

<sup>60</sup> Includes discharged.

<sup>61</sup> (42 U.S.C. § 1395dd(e)(5).

<sup>62</sup> 42 U.S.C. s 1395dd(3).

<sup>63</sup> (August 1988). *See* 59 Fed. Reg. 32086, 32094.

promptly report the matter to HCFA and to the State survey agency. Failure to report may subject the receiving hospital to termination of its provider agreement.<sup>64</sup>

HCFA stated in the Federal Register that it would require hospitals to report “any credible complaints”<sup>65</sup> to HCFA under 42 C.F.R. § 489.24 but, at this time, there is no EMTALA requirement that reporting, subsequent investigation, or adverse findings under the Act is a contingency for personal recovery under the Act.<sup>66</sup> In addition, the original enactment applied only to hospitals but the scope is now wider and applies to individual physicians who may be liable under the Act.

A physician is “also subject to a civil money penalty of not more than \$25,000.”<sup>67</sup> The physician is subject to liability for “signing of transfer certifications if the physician knew or should have known that the benefits of transfer did not outweigh the risks, and for “misrepresenting an individual’s condition.” In addition, HCFA can terminate a physician from Medicare and State programs when there are violations which are “gross, flagrant, or repeated.”<sup>68</sup> The standard to exclude a physician under the Medicare reimbursement statute was changed from “knowing and willful or negligent” to “gross and flagrant or is repeated” under § 4027(a)(3) of OBRA 90.<sup>69</sup>

To summarize, then, before beginning the next section, EMTALA prevents inappropriate transfers of patients with an emergency condition and this applies to all physicians and hospitals receiving federal funding from Medicare. By its legislative

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<sup>64</sup> 42 C.F.R. § 489.53(a).

<sup>65</sup> Defined as specific and detailed enough to be investigated. 59 Fed. Reg. 32086, 32094.

<sup>66</sup> 59 Fed. Reg. 32094.

<sup>67</sup> 59 Fed. Reg. 32086, 32089.

<sup>68</sup> Omnibus Budget Reconciliation Act of 1987 § 4009(a)(1) (OBRA 87), Pub. L. 100-203, effective December 22, 1987.

<sup>69</sup> See 59 Fed. Reg. 32086, 32091.

history, Congress intended to prevent economic patient discrimination but the Act does not reference economic concerns. The act applies to “any individual” who “comes to” the emergency department seeking emergency treatment. EMTALA requires hospitals to conduct an appropriate screening examination in a timely manner, so far as their facilities permit, so that the hospital can determine whether an emergency condition exists. If the condition is an emergency, then the hospital must either provide stabilizing treatment or transfer the patient to another facility for definitive treatment. The hospital may not transfer the patient to another facility unless and until they have stabilized the patient’s condition. If the patient refuses treatment or transfer, then the hospital is obligated to attempt to convince the patient to undergo treatment or transfer or inform the patient about the attendant risks and benefits of treatment or transfer and obtain documentation of the refusal. The transfer itself must be an appropriate one so that the risks to the patient are minimized and the transferring facility must determine that the receiving facility has appropriate facilities and consents to the transfer.<sup>70</sup> There was no affirmative reporting requirement but one was added and whistleblowers are immune from hospital retaliation when they refuse to transfer in accordance with the Act or when they do report a violation under the Act.<sup>71</sup>

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<sup>70</sup> Pamela K. Hupp, Casenote, *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, 1219-1221 (1995)

<sup>71</sup> 42 U.S.C. § 1395dd(j).

## II. A DECADE OF MAJOR EMTALA CASE INTERPRETATIONS<sup>72</sup>

### A. Screen, Stabilize, or Transfer

It is clear that Congress responded to a general concern that hospitals were abandoning the time honored policy to provide emergency medical care to all persons since that practice had become unprofitable. In response to rising costs and relatively poor reimbursements from or on behalf of the unemployed and uninsured, and because traditional state tort laws did not require hospitals to provide emergency care, Congress acted in the interest of national health.<sup>73</sup> This legislative purpose is intertwined through all EMTALA litigation and is an important unifying thread in case decisions.

One of the first EMTALA cases was the *Baby K* matter.<sup>74</sup> That perplexing case involved an anencephalic infant<sup>75</sup> who had periodic respiratory difficulties which required resuscitation. The hospital's position was that EMTALA did not apply since Baby K was not "an individual" as contemplated by the Act and the hospital wanted to let the baby proceed according to nature. The hospital couched its position in standard of care language<sup>76</sup> but Baby K's mother opposed this course of treatment and insisted upon

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<sup>72</sup> See Appendix (B) for a list of the major EMTALA cases derived from United States Code Annotated.

<sup>73</sup> *Reynolds v. Mercy Hosp.*, 861 F.Supp. 214 (W.D.N.Y.1994).

<sup>74</sup> *In re Baby K*, 16 F.3d 590, 592 (4th Cir. 1994), cert. denied, 115 S. Ct. 91 (1994).

<sup>75</sup> This child had only a brain stem, scalp and skull. She was without sensory systems and was unconscious. These infants rarely survive more than a few months.

<sup>76</sup> *Baby K*, 16 F.3d at 593. The hospital argued that the standard of care for an anencephalic is "supportive care in the form of appropriate nutrition, hydration, and warmth, and to permit the devastating condition to take its natural course." Brief for Appellants at 5, *Baby K* (No. 93 -1899 (L)). The Hospital denied that its position was without economic motivation. *Baby K*, 832 F. Supp. at 1026.

mechanical ventilation whenever the child had respiratory troubles. The hospital then attempted to transfer the infant but no facility would accept her in the pediatric intensive care facilities.

The United States District Court for the Eastern District of Virginia considered a declaratory judgment action in which the hospital sought to determine whether EMTALA required the Hospital to continue to provide ventilator support during these periods of respiratory distress. The Hospital admitted that it was required to stabilize the child and to assure no substantial deterioration but it argued that it warranted an exemption: Baby K's condition was futile and the treatment was itself inhumane. The District Court found that the Act applied and that the hospital was required to treat the child accordingly.<sup>77</sup>

The hospital appealed to the United States Court of Appeals for the Fourth Circuit where this court affirmed the lower court and held that EMTALA obligated the hospital to provide appropriate respiratory care when her mother requested treatment. The Court concluded that the Act applied to all patients and to all hospitals which receive Medicare funding. Furthermore, the Court identified that, through EMTALA, Congress imposed two duties on hospitals which receive Medicare funds: to appropriately screen every individual who arrives at the emergency room requesting treatment; if an emergency condition is diagnosed, then the hospital must either stabilize or transfer the patient as the Act specifies.<sup>78</sup>

The Fourth Circuit court determined that the Act creates no particular exception which applies to anencephalic infants and affirmed the lower court.<sup>79</sup> In elaborating on

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<sup>77</sup> Id. at 1027.

<sup>78</sup> Baby K, 16 F.3d at 593.

<sup>79</sup> Id. at 598.

the meaning of the term “transfer,” the court concluded that the hospital was responsible to stabilize prior to discharge or to prevent significant deterioration of the patient’s status during the transfer. This duty to stabilize is not limited to those situations where the patient would be transferred to a different facility. In its opinion, the Court determined that such a myopic interpretation would permit the hospital to avoid liability by refusing to treat a patient after the screening when the patient would refuse transfer or where transfer was not possible.<sup>80</sup>

The *Baby K* case has been used as a right-to-life<sup>81</sup> case in a similar way that *Cruzan v. Director, Missouri Department of Health*,<sup>82</sup> has been used as a right-to-die case, but politics aside, it remains as one of the fundamental cases in which the Court interpreted EMTALA and thrust the Fourth Circuit to centerstage for EMTALA interpretations. One important aspect of *Baby K* is that federal agencies, according to Fell,<sup>83</sup> which enforce EMTALA have few guidelines on which to base their actions. As a consequence, they have relied upon judicial interpretations.<sup>84</sup>

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<sup>80</sup> *Id.*

<sup>81</sup> See Mary Jean Fell, Comment, 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 (1994).

<sup>82</sup> 497 U.S. 261 (1990).

<sup>83</sup> *Id.* at 610. EMTALA's legislative history provides that “(b)y imposing affirmative obligations to render emergency treatment to all patients, regardless of financial status, most states have already enacted to (sic) means for attaining (EMTALA'S) objectives.” S. Rep. No. 146, 99th Cong., 2d Sess. 468 (1986), reprinted in 1986 U.S.C.C.A.N. 42, 427. The history continues, “(The American College of Emergency Physicians) has long held to the principle that all patients are entitled to emergency care, regardless of their ability to pay.” *Id.*, 1986 U.S.C.C.A.N. at 42, 430. The House of Representatives' legislative history also evidenced concern about the provision of adequate medical services provided in emergency rooms to individuals seeking care, particularly to the uninsured. H.R. Rep. No. 241, 99th Cong., 2d Sess. 27 (1986), reprinted in 1986 U.S.C.C.A.N. 579, 605.

<sup>84</sup> See Robert A. Bitterman, *A Critical Analysis of the Federal COBRA Hospital “Antidumping Law”*: Ramifications for Hospitals, Physicians, and Effects on Access to Healthcare, 70 U. DET. MERCY L. REV. 125, 132 (1992). (discussing hospital standards necessary to meet EMTALA mandates).

## B. Purpose of the Act

*Baber v. Hospital Corporation of America*<sup>85</sup> was an important Fourth Circuit case upon which the *Baby K* court heavily relied in its reasoning since it reached the courts relatively soon after EMTALA cleared Congress. *Baber* set the stage for much of the litigation under the Act. This decision involved a schizophrenic woman who presented to the emergency department of Raleigh General Hospital where she was disoriented and exhibited loose associations but, while in the emergency room, she refused to remain on her gurney and toured the hospital area. While walking around she had a convulsion, fell, sustained a concussion and an head laceration.

The Raleigh General Hospital ER doctor, after his examination, assumed that she remained disoriented as a result of her psychotic state and transferred her to Beckley Appalachia Regional Hospital where she was admitted to the psychiatric ward. After a seizure she was returned to Raleigh General Hospital where she died from a ruptured intracerebral aneurysm.<sup>86</sup> In the resultant medical negligence action, the decedent alleged two violations of EMTALA: failure to provide an appropriate medical screening; failure to stabilize before transfer. Although the physician was dismissed as a party after summary judgment, the Act did give rise to an action against the participating hospital. *Baber* stands for the proposition that EMTALA does not contain a private cause of action against the treating physician.<sup>87</sup>

*Baber* also supports the proposition that, as the Fourth Circuit stated, the Act was not to guarantee a correct diagnosis, but to provide a satisfactory first response to medical

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<sup>85</sup> 977 F.2d 872, 881 (4th Cir. 1992).

<sup>86</sup> *Id.* at 875-76.

<sup>87</sup> *Id.* at 877.

crises. The Act's purpose, the court concluded, was to "send a clear signal to the hospital community . . . that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress."<sup>88</sup> The court was troubled that the Act failed to define "appropriate medical screening" concluding that such a requirement would be fulfilled by identical screening procedures for similarly situated patients: the standard of care.<sup>89</sup> In reaching this decision, the court relied upon Senator Durenburger's remarks in the Congressional Record<sup>90</sup> where it explicitly noted that Congress did not intend to establish a national standard of care.<sup>91</sup>

Significantly, the trial court did not view the omissions by the ER doctor or hospital staff as an attempt to "dump" this patient. The hospital staff merely sought to treat for the diagnosed medical condition.<sup>92</sup> Therefore, the *Baber* court established that a hospital is not liable under the Act when it does not know that the patient has an emergency medical condition at the time it transfers the patient in an unstable condition. Lastly, here, under *Baber*, a transferee hospital has no duty to provide an appropriate medical screening examination when that patient has not presented to the transferee hospital for treatment at that facility of an emergency condition.

### C. Scope of EMTALA

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<sup>88</sup> *Id.*

<sup>89</sup> *Id.* at 878.

<sup>90</sup> *Id.* at 880 (quoting 131 Cong. Rec. S13904 (Oct. 23, 1985) (statement of Sen. Durenburger)).

<sup>91</sup> *Id.* at 879 n.6. *Id.* at 880.

<sup>92</sup> *Id.* at 885.



In *Gatewood v. Washington Healthcare Corporation*,<sup>93</sup> the influential United States Court of Appeals for the District of Columbia Circuit<sup>94</sup> undertook an analysis of the EMTALA's scope. In this case, Mr. Gatewood presented to the ER, was misdiagnosed with musculoskeletal pain, was discharged, and died from a myocardial infarction. The lower court dismissed on grounds that a proper screening had been done and that Mr. Gatewood was fully insured and, therefore, it was impossible to dump him on financial grounds. The appellate court ruled that the dismissal was improper since the Act applies to "any individual", not only to those without insurance or to those who are indigent.<sup>95</sup>

Under the Act, so long as the hospital provides the same procedures to all for screening and treatment, the provider would not violate the Act. Disparate treatment is what the Act prohibits, reasoned the court, and does not mandate correct diagnosis and treatment. When the patient is screened consistent with hospital protocols or the practitioner adheres to the applicable standard of care then it does not violate EMTALA.<sup>96</sup>

### **C. Enforcement of § 1395dd(d)- Civil Money Penalties**

In one of the earliest<sup>97</sup> and most cold-hearted EMTALA litigation examples of medical care denied, Dr. Michael Burditt<sup>98</sup> was one of the first physicians fined under the

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<sup>93</sup> *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1038 (D.C. Cir. 1991).

<sup>94</sup> Heard before both Judges Ruth Bader Ginsburg and Clarence Thomas prior to their elevation to the United States Supreme Court.

<sup>95</sup> *Id.* at 1039.

<sup>96</sup> *Id.* at 1041.

<sup>97</sup> Amy D. Marcus, *Law on Treating Poor Patients Faces Key Test*, WALL ST. J., May 2, 1991, at B1. "It is the first anti-dumping case against an individual physician brought by the Department of Health and Human Services, and one of the first appeals-court tests of the scope of the law. ... [I]t is being closely

Act. In that case, the Fifth Circuit upheld a \$20,000 fine based upon substandard treatment this physician administered to Ms. Rosa Rivera, a pregnant woman experiencing contractions. Her membranes were ruptured and she had hypertension. Dr. Burditt learned that the patient had no regular doctor, was indigent, and was pre-eclamptic; a perilous condition.<sup>99</sup> Dr. Burditt responded by preparing the patient for transfer but, since EMTALA had recently been enacted, the nurse showed him the new guidelines, which he arrogantly shunned and sent this patient to a facility 170 miles away!<sup>100</sup>

Prior to transfer, the doctor went through the motions of a perfunctory examination, arranged transfer, signed the necessary certification without looking at the document or listing the reasons why the benefits of transfer outweighed the risks.<sup>101</sup> He did not perform another examination. Moreover, he did not instruct the ambulance driver to take along a special delivery pack. While *en route* to the transferee hospital the patient bled and the attendant nurse ordered the ambulance to return to the original hospital.

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watched as a guide to how the law should be enforced. The case comes at a time when many hospitals stand at the brink of financial collapse, but also at a time when more patients are unable to afford needed medical care. In 1989, hospitals provided \$11.1 billion in care for which they received no compensation, up from \$3.9 billion in 1980, says the American Hospital Association. In the interim, 761 hospitals shut down.”

<sup>98</sup> *Burditt v. United States Dep't of Health & Human Servs.*, 934 F.2d 1362 (5th Cir. 1991).

<sup>99</sup> One immediate complication from this could be exsanguinating hemorrhage or stroke.

<sup>100</sup> See *also*, *Owens v. Nacogdoches County Hosp. Dist.*, 741 F.Supp. 1269 (E.D.Tex.1990). This was another distant transfer obstetrics case where the transferee hospital was 200 miles away; where the defendant sent a sixteen year old mother to be, in labor, on an unaccompanied trip through the uninhabited wilds between Nacogdoches and Galveston, Texas. The transferee hospital had a neo-natal unit but the danger to the mother and child in view of the distance was overwhelming and did not warrant the risk of transfer. It is important to fully realize the cruelty and heartlessness Dr. Bruce Thompson exhibited. The court concluded “[t]he explanations proffered by Dr. Thompson for the transfer are best described as inadequate, stumbling, and incredible. The assertion that the risks [Dr. Thompson listed] associated with sending a frightened adolescent girl on a four hour trip by private car ... is entirely unworthy of credence.” 741 F.Supp. 1269, 1278.

<sup>101</sup> § 1395dd(c)(A)(ii).

When the ambulance returned to the original facility, Dr. Burditt insisted on discharging her since she was not bleeding excessively but, after an hospital executive became involved, Dr. Burditt acquiesced, and arranged that time for another physician to take over Ms. Rivera's care. Ms. Rivera delivered a healthy baby in the ambulance during the second ambulance ride and was discharged from the hospital after three days.<sup>102</sup>

The Department of Health and Human Services brought an administrative action against Dr. Burditt before an administrative law judge who fined him \$20,000 for violating EMTALA provisions.<sup>103</sup> The agency affirmed the fine as did the appellate court.<sup>104</sup> Since this patient was severely hypertensive and she was in active labor Dr. Burditt had two options under the Act. He could have stabilized her<sup>105</sup> or arranged for an appropriate transfer<sup>106</sup> in accordance with sub-section (c) without stabilization.<sup>107</sup> His certification lacked legal effect since he merely went through the motions rather than weighing the risks and benefits "reasonably expected from the provision of appropriate treatment at another ... facility," as the Act required.<sup>108</sup>

#### **D. Stabilized**

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<sup>102</sup> *Id.* at 1367.

<sup>103</sup> Organized medicine views this as a "documentation" and public relations matter rather than as a serious quality issue. See Brian McCormick, *MD Sanctioned For Patient Transfer Loses Last Appeal.*, 34 AM. MEDICAL NEWS, July 29, 1991 at p.1. "AMA Associate General Counsel Edward Hirshfeld said the lesson in the case for doctors is to document cases carefully. The case turned mainly on hearsay collected by nurses and other DeTar staff, he noted. "As burdensome as it is, in this environment [such documentation] is essential."

<sup>104</sup> *Id.* at 1370-72.

<sup>105</sup> 42 U.S.C. § 1395dd (b)(1)(A).

<sup>106</sup> 42 U.S.C. § 1395dd (b)(1)(B).

<sup>107</sup> 42 U.S.C. § 1395dd (c)(1)(ii).

<sup>108</sup> 42 U.S.C. § 1395dd (c)(1)(ii).

The United States Court of Appeals for the Sixth Circuit, when faced with determining the meaning of “stabilized,” in *Thornton v. Southwest Detroit Hospital*,<sup>109</sup> looked first to the organic definition of “stabilization.”<sup>110</sup> The court found that the word meant “no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from a [hospital].”<sup>111</sup>

The facts of *Thornton* concerned Ms. Elease Thornton who suffered a stroke and was admitted to the ER at Southwest Detroit Hospital where, after admission to the hospital, she spent twenty-one days. She wanted to be admitted to a stroke rehabilitation center but her health insurance would not pay for this and she was discharged to her sister’s care but, once there, she deteriorated.<sup>112</sup> In her suit, she alleged that the hospital failed to stabilize her prior to discharge but the district court granted summary disposition, finding that her condition had been stabilized prior to the discharge.

The Court of Appeals was then presented with a novel question: whether a patient’s emergency condition is stabilized when that patient is retained in hospital for twenty-one days. The court began its analysis with the Act’s purpose: to ensure adequate emergency care to patients with emergent medical conditions. The hospital need not completely cure the patient in order for the patient to be stabilized but, since the hospital had provided care to the patient until her emergency condition resolved, the hospital had not violated the Act.<sup>113</sup>

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<sup>109</sup> 895 F.2d 1131 (6th Cir. 1990).

<sup>110</sup> 42 U.S.C. § 1395dd (e)(3)(B).

<sup>111</sup> *Id.* at 1135.

<sup>112</sup> *Id.* at 1132.

<sup>113</sup> *Id.* at 1135.

Whether the patient was stabilized prior to transfer was addressed in a different way in *Delaney v. Cade*.<sup>114</sup> In that case, Ms. Delaney was injured in Kansas in a serious motor vehicle accident and the ER physician dutifully repaired her knee lacerations but did nothing to investigate her chest pain. Subsequently, she was transferred to two other hospitals and, at the third hospital, after an aortogram, the doctors discovered her transected aorta.<sup>115</sup> This failure to diagnose and treat in a timely manner resulted in her paraparesis. She sued the first hospital in district court alleging EMTALA violations since she was transferred prior to stabilization.<sup>116</sup> She also alleged “loss of a chance of recovery” since her legs functioned prior to transfer. The district court dismissed this action since Kansas did not recognize the “loss of a chance” doctrine and, according to the court, the facts failed to support an EMTALA action since, as with *Gatewood*, the Act did not provide a private cause of action against the physician. The Act specifies a cause of action against the “hospital,” not a “physician.”<sup>117</sup>

The appellate court in *Delaney* determined that the summary disposition was premature but stated that EMTALA did apply to transfers where the patient’s economic condition was not at issue.<sup>118</sup> In adopting the Act’s<sup>119</sup> unambiguous language, the court noted that the facts required a jury to determine the stabilization issue<sup>120</sup> and permitted the case to continue past summary judgment.

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<sup>114</sup> *Delaney v. Cade*, 986 F.2d 387, 388 (10th Cir. 1993).

<sup>115</sup> *Id.* at 388 - 89.

<sup>116</sup> *Id.* at 389.

<sup>117</sup> *Id.* at 388.

<sup>118</sup> *Id.*

<sup>119</sup> 42 U.S.C. § 1395dd(e)(3)(B).

<sup>120</sup> *Delaney*, 986 F.2d at 383.

## E. Adequate Medical Screening

Under the Act, all patients who present to the ER must be provided with an adequate screening to determine whether they suffer from an emergency condition but what constitutes “adequate” is different than the traditional medical negligence definition based upon what a reasonable practitioner would offer in the same or similar circumstances. The Tenth Circuit interpreted this provision in *Collins v. DePaul Hospital*<sup>121</sup> in the context of a missed hip fracture which should have been detected had an appropriate examination been performed.

Here, Mr. Collins sustained multiple injuries including multiple abrasions and lacerations, pulmonary problems, an injury to his shoulder, and a severe cerebral concussion / contusion. Although he remained in the ICU for fifteen days, the providers missed an hip fracture.<sup>122</sup> Mr. Collins argued that the standard of care mandated an hip x-ray but the doctors erred, thinking that the x-ray had been done. The fracture was diagnosed twenty-five days after injury and as a result, the hip had to be fused rather than to be treated by fixation with metal pins and screws.

The trial court granted summary disposition in favor of the defendants but the appellate court examined the screening requirement. The reason the Act requires the screening is to determine whether or not a patient has an emergency condition which must be treated.<sup>123</sup> In this case there could be tandem violations: failure to diagnose the condition by the appropriate screening examination and discharge or transfer without

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<sup>121</sup> 963 F.2d 303 (10th Cir. 1992).

<sup>122</sup> *Id.* at 306.

<sup>123</sup> *Id.* at 306 - 07. “The stated reason in 42 U.S.C. § 1395dd(a) for requiring a participating hospital to provide an ‘appropriate medical screening examination’ of one suffering from injuries who presents himself

stabilizing the condition.<sup>124</sup> The appellate court affirmed the lower court's interpretation of the examination requirement noting that the patient had received twenty-six days of continuous treatment for a panoply of medical conditions. The hospital did detect an emergency medical treatment after an appropriate screening examination; it only failed to detect a specific condition, an hip fracture. This, the court ruled, was insufficient to sustain an EMTALA action.<sup>125</sup>

Recall, here, too, that under *Gatewood*, so long as the provider performs an adequate screening examination, he will not violate the Act even when he fails to diagnose the condition appropriately. Parenthetically, the court also noted that the ability to pay for care did not defeat the EMTALA claim since the Act applies to any individual without mention of financial status.

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at a hospital is to determine whether an 'emergency medical condition exists.' Nothing more, nothing less." *Id.*

<sup>124</sup> *Id.* at 308.

<sup>125</sup> Notice here that the hospital might be liable under a negligence standard if that failure to diagnose and treat in a timely manner fell beneath the standard of care.

## F. Disparate Treatment, Comes To, and Adequate Medical Screening Examination

One of the key issues in litigation under EMTALA is the disparate treatment claim: provision of a different screening examination for patients on other than a clinical basis. In this context the Fourth Circuit has allied itself with the District of Columbia Circuit “in a split of authority over whether proof of a bad motive or non-medical reason is necessary to create a disparate treatment claim” under the Act.<sup>126</sup> The Act was intended to prevent dumping, not to provide another cause of action for injured plaintiffs for misdiagnosis and mistreatment. In many instances, according to some, EMTALA has been used to expand hospital civil liability. In addition, under the Act, hospitals according to the *Burditt* decision, are subject to private civil lawsuits, personal injury damages, and injunctive relief.<sup>127</sup>

This concern about perverting the statute has been raised in several cases including *Power v. Arlington Hospital Association*,<sup>128</sup> one of the major cases in which the court further sculpted out the disparate treatment facet. The case involved Ms. Susan Power, a 33 year-old British national who attempted to self-treat a facial abscess. She became feverish and presented to the Arlington Hospital emergency department in February 1990. By that time, she had pain in her left hip and lower abdomen; pain

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<sup>126</sup> For comment, see Robin E. Margolis, *Split Developing Among Federal Circuits on Disparate Treatment Claims*, 1(12) HEALTHSPAN 19, 19 (1995).

<sup>127</sup> *Burditt*, 934 F.2d 1362.

<sup>128</sup> *Power v. Arlington Hosp. Ass’n*, 42 F.3d 851 (4th Cir. 1994). The author wishes to thank Mr. William Causey of Washington, DC who was the plaintiff’s attorney and provided the author with the appellate briefs for both the plaintiff and defense.



radiating down her left hip and she experienced rigors. She was unable to walk and the abscess was readily visible on her face.

A nurse determined that Ms. Power was uninsured and unemployed, then two doctors and another nurse evaluated Ms. Power. Hip x-rays were negative as were all other blood tests but a urine test suggested that she may have had a urinary tract infection. No one noticed the facial abscess or, if they did, no one recorded its presence.<sup>129</sup> This patient was discharged with a prescription for pain medicine and an orthopedic referral but the next day she returned to the ER in septic shock. As a consequence of her care at Arlington General Hospital, Ms. Power spent four months in the ICU, much of it on life support, underwent amputation of both legs below the knee, lost sight in one eye, and sustained irreversible pulmonary damage.<sup>130</sup>

She sued under EMTALA for failing to provide an adequate screening examination and alleged that Arlington Hospital violated the Act by transferring her to an hospital in England while she was in unstable condition. While the District Court ruled that the Virginia cap<sup>131</sup> on medical malpractice damages<sup>132</sup> did not apply to her cause of action<sup>133</sup> the court denied the hospital's motion for summary disposition on the ground that there "were genuine issues of material fact."<sup>134</sup> In addition, the district court dismissed the individual physicians and two physician groups since, under the Act, actions may only be maintained against "participating hospitals."<sup>135</sup> Third, the district

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<sup>129</sup> 42 F.3d 851, 853.

<sup>130</sup> For a detailed recitation of the facts, *see Id.* at 854.

<sup>131</sup> *See* Randolph Goode, *Appeals Court Knocks Down \$5 Million Ruling*, RICHMOND TIMES-DISPATCH B3, WL 7128891 (Dec. 13 1994). (discussing 4th Circuit's determination on the damage cap).

<sup>132</sup> Va.Code Ann. § 8.01-581.15 (Michie 1992),

<sup>133</sup> *Power*, 800 F.Supp. 1384, 1392.

<sup>134</sup> *Id.*

<sup>135</sup> 42 U.S.C. § 1395dd(d)(1)(A).

court also dismissed the state law claims since, it held those should be pursued through the applicable Virginia medical malpractice statute.<sup>136</sup>

Arlington Hospital was found liable on the inappropriate screening claim and the jury returned a verdict of \$5 million but the jury found against the plaintiff on the transfer claim.<sup>137</sup> The Hospital raised two unique questions with respect to recovery under EMTALA: whether Virginia damage caps apply and whether the damage limit on tax-exempt hospitals applies; and whether the state administrative procedures for malpractice cases apply to EMTALA claims. The Fourth Circuit court concluded that the state damage caps and tax-exempt limits of recovery were applicable and vacated the jury verdict award. It then remanded the decision to the district court to conform to the applicable caps but affirmed the district court on the other claims.<sup>138</sup>

In reaching its decision, the court relied upon its decisions in *Baber, Brooks v. Maryland General Hospital, Incorporated*,<sup>139</sup> and *Baby K*.<sup>140</sup> The court noted that the purpose of the Act was to prevent patient “dumping,” that the Act “is not a substitute for state law malpractice actions, and was not intended to guarantee proper diagnosis or to

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<sup>136</sup> See Va.Code Ann. §§ 8.01-581.1-.20 (Michie 1992 & Supp.1993).

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

<sup>138</sup> *Id.* at 854.

<sup>139</sup> See Jef Feeley, *Federal Patient Dumping Law Clarified*, DAILY REC. (Balt. Md.) 3 1993 WL 2990470 (June 25, 1993). (discussing the fourth Circuit’s ruling that arbitration was not required under EMTALA even if the state medical negligence statute requires arbitration in medical negligence suits. Judge Niemeyer reasoned that that the Maryland Malpractice Act, “even incorporated or tolerated by EMTALA, does not cover an EMTALA claim.” The Act, according to Feeley, “is aimed at insuring that injured people can get emergency treatment regardless of their financial status and the Medical Malpractice Act is designed to address strictly malpractice cases, which involve breaches of a community’s standard of care.” Mark Herman represented the plaintiff and commented, “It’s good to know that in this world of incredibly shrinking patient rights, when all seems to be lost because you don’t have any insurance, this law is still out there and the courts will enforce it.” Though EMTALA remains obscure in the public realm of consciousness, the lay press has aired its major decisions.

<sup>140</sup> *Baber v. Hospital Corp. of Am.*, 977 F.2d 872, 879-80 (4th Cir.1992), *Brooks v. Maryland Gen. Hosp., Inc.*, 996 F.2d 708, 710-11 (4th Cir.1993), and *Matter of Baby K*, 16 F.3d 590, 593 (4th Cir.1994).

provide a federal remedy for misdiagnosis or medical negligence.”<sup>141</sup> The court acknowledged, consistent with *Baber*, that other than to identify an emergency condition<sup>142</sup> the Act fails to define what constitutes “an appropriate medical screening examination.”<sup>143</sup>

Relying on *Brooks*, the court reasoned<sup>144</sup> that the Act imposes no duty on an hospital to actually make the correct diagnosis. The hospital fulfills its duty if it utilizes a uniform screening procedure with all patients with same complaints: i.e. the hospital provides uniformly negligent care.<sup>145</sup> In considering the disparate treatment claim, the court distinguished *Power* from *Baber* on its facts stating

Power has clearly presented evidence ... that she was treated differently from other patients ... and that the Hospital did not apply its standard screening procedure ... uniformly. ... Her evidence is sufficient to meet the threshold requirement of an EMTALA claim, ... that the screening she was provided by Arlington Hospital deviated from that given to other patients. ... [T]he Hospital contends that evidence of disparate treatment alone is not enough to recover under EMTALA.<sup>146</sup>

The Fourth Circuit opinion then recognized the split of authority between its interpretation and the treatment given this issue by the Sixth Circuit and the D.C. Circuit regarding “whether proof of a bad motive or non-medical reason is required to establish a disparate treatment claim under EMTALA.”<sup>147</sup> Whereas the court was not required to decide that narrow issue in *Baber* it could no longer avoid this in *Power*. The hospital relied upon *Cleland v. Bronson Health Care Group, Inc.*,<sup>148</sup> where that court concluded

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<sup>141</sup> *Id.* at 854 citing *Baber*, 977 F.2d at 880; *Brooks*, 996 F.2d at 710.

<sup>142</sup> 977 F.2d at 879.

<sup>143</sup> § 1395dd(a).

<sup>144</sup> *Brooks*, 996 F.2d at 710-11

<sup>145</sup> *Power*, 42 F.3d 851, 856.

<sup>146</sup> *Id.* at 856-57.

<sup>147</sup> *Id.* at 857 citing *Baber*, 977 F.2d at 880 n.8.

<sup>148</sup> *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 272 (6th Cir.1990).

that disparate treatment, based upon legitimate medical considerations, constituted an “appropriate medical screening examination.”<sup>149</sup> Under the *Cleland* decision, if the hospital screening is “within its capabilities” and it provides an “appropriate” screening then its motives are appropriate: “acting in the same manner as it would have for the usual paying patient.”<sup>150</sup>

Here, the *Power* court concluded that by the terms of the statute, it was precluded from adopting a malpractice or objective standard of care meaning of the term “appropriate.” Here, “appropriate” could not, in this context, mean the standard of care “appropriate” but, instead meant an examination afforded all patients without consideration of their financial status.<sup>151</sup> Other improper motives under EMTALA were suggested by the *Cleland* court and included “race, sex, ethnic group, politics, occupation, education, personal prejudice, drunkenness, and spite.”<sup>152</sup> The *Power* tribunal, though, found none of these.

*Power* argued that “if disparate treatment for any reason is the key to finding a violation of EMTALA, then not even *Cleland* requires proof of a bad motive.”<sup>153</sup> *Power* contended that when a hospital provides substandard care, then it should be liable under EMTALA, and urged the court to follow the D.C. Circuit’s decision in *Gatewood*.<sup>154</sup> There, in *Gatewood*, the D.C. court concluded that motive was unimportant and that

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<sup>149</sup> *Power*, 42 F.3d 851, 857.

<sup>150</sup> *Cleland*, 917 F.2d at 272.

<sup>151</sup> *Power*, 42 F.3d at 857.

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

<sup>153</sup> *Power*, 42 F.3D 851, 857.

<sup>154</sup> *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C.Cir.1991).

EMTALA applies “whenever and for whatever reason a patient is denied the same level of care provided.”<sup>155</sup>

Arlington Hospital also attempted to escape EMTALA liability by claiming that there was some sort of EMTALA pre-requisite that it should have relied upon an HCFA<sup>156</sup> investigation which the agency performed based upon the alleged violations before the trial in this case.<sup>157</sup> The plaintiff, however, pointed out in its appellate brief<sup>158</sup> that an administrative finding is a nullity here since there is no exhaustion of administrative remedies requirement in the Act.<sup>159</sup>

In this regard the defendants argued that the court should admit as dispositive that “the finding of EMTALA compliance by HCFA takes precedence over the jury verdict and judgment in favor of Susan Power, or ... the verdict and judgment ... be set aside and a new trial ordered in which the HCFA investigation ... will be admitted in evidence.”<sup>160</sup>

Power, through her attorneys, had filed a complaint with HCFA on July 18, 1992, about her treatment at Arlington Hospital and the agency began its investigation and requested documents and records from the hospital. The court dismissed this whole line of attack out of hand saying that it was unable to find “any authority for the proposition

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<sup>155</sup> Id. at 857. Power adopted the D.C. Circuit’s approach. *See Jones v. Wake County Hosp. Sys., Inc.*, 786 F.Supp. 538, 544 (E.D.N.C.1991); *Deberry v. Sherman Hosp. Ass’n*, 769 F.Supp. 1030, 1034 (N.D. Ill.1991) (following *Gatewood*, rejecting the motive requirement).

<sup>156</sup> By way of explanation, the Health Care Finance Administration (HCFA) is part of the Department of Health and Human Services (HHS) and the Office of the Inspector General (OIG) is the investigative arm of the HHS entrusted with assessing civil penalties under the Act. *See* 42 C.F.R. § 1003.102 (1992). Under EMTALA, the enforcement provisions of 42 C.F.R. § 1320a-7a are incorporated by reference. *See* 42 U.S.C. 1395dd(d)(1)(A). The OIG alone is charged for determining whether EMTALA violations have occurred.

<sup>157</sup> *See* 42 C.F.R. § 489.24.

<sup>158</sup> Brief for Appellee at 42.

<sup>159</sup> This is supported by the authority of *COIT Independence Joint Venture v. FSLIC*, 489 U.S. 561, 569 (1989).

<sup>160</sup> Brief for Appellant at 39.

that the filing of an administrative complaint with, or issuance of a finding by, the HCFA is a procedural prerequisite to a civil enforcement action under EMTALA.”<sup>161</sup>

The Fourth Circuit resolved the motive issue by stating that the best approach

is to allow a hospital, after a plaintiff makes a threshold showing of differential treatment, to offer evidence rebutting that showing either by demonstrating that the patient was accorded the same level of treatment that all other patients receive, or that a test or procedure was not given because the physician did not believe that the test was reasonable or necessary under the particular circumstances of that patient.<sup>162</sup>

When the hospital offers this rebuttal evidence, the plaintiff should be allowed to challenge the medical judgment of the physicians involved through its own medical experts’ testimony. Arlington Hospital attempted to hide behind an imaginative “lack of standard emergency room procedures,”<sup>163</sup> the court noted. Therefore, under *Power*, an EMTALA claim may be established through “proof of a failure to meet the standard of care to which the Hospital adheres.”<sup>164</sup> This admittedly blurs the lines between a medical negligence claim and an EMTALA claim.

In its analysis of the state caps issue, the court took the position that Congress explicitly directed the federal courts to look at the law of the state where the hospital is located to determine both the types and amounts of damages available. According to the Fourth Circuit, the key inquiries are 1) whether the defendant is a health care provider and 2) whether the alleged tort arises from the provision of health care or professional services. Although the claim was not a malpractice claim, it was a negligence suit or other

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<sup>161</sup> 42 F.3d 851, 867-68.

<sup>162</sup> *Id.* at 858.

<sup>163</sup> *Id.* at 858. (citing *Griffith v. Mount Carmel Medical Ctr.*, 831 F.Supp. 1532, 1542 (D. Kan.1993)).

<sup>164</sup> *Id.* at 858.

tort,<sup>165</sup> and the caps apply<sup>166</sup> to both the medical negligence aspect and the tax-exempt immunity aspect.<sup>167</sup>

Finally, the *Power* court decided congruently with *Gatewood* when it reasoned that that the plaintiff is not required to prove the inner thoughts and prejudices of hospital personnel.<sup>168</sup> Here, the Fourth Circuit was sensitive to the congressional concerns<sup>169</sup> of potentially fueling another “malpractice crisis” when it decided<sup>170</sup> to preserve the state-enacted ceilings on damage amounts in its interpretation of the Act.<sup>171</sup>

After *Power*, in *Miller v. Medical Center of Southwest Louisiana*, the U.S. District Court of the Southern District of Indiana decided that a defendant hospital did not violate EMTALA when the physician did not determine that the patient was suffering from a potentially fatal condition.<sup>172</sup> The court ruled that, although a hospital would violate the Act if it transferred the patient without stabilizing the patient, it must first make the determination that the patient suffered from an emergency medical condition.<sup>173</sup> If the hospital does not know that the patient suffers from an emergency condition, it cannot violate the Act.

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<sup>165</sup> *Id.* at 861, 864.

<sup>166</sup> *Id.* at 860.

<sup>167</sup> *Id.* at 864.

<sup>168</sup> *Id.* at 857.

<sup>169</sup> See Edward Felsenthal, *Plaintiffs Get Around State Limits On Medical-Malpractice Damages*, WALL ST. J., August 30, 1994, at B2. “Plaintiffs lawyers say such broad readings of the law accomplish exactly what Congress wanted, making hospitals think twice before discharging a patient. Congress wanted to “send a message to emergency rooms,” says (plaintiff’s attorney) Mr. (William) Causey. “The courts are finally figuring out what Congress really meant to say.”

<sup>170</sup> The court relied upon H.R. Conf. Rep. No. 99-453, 99th Cong., 1st Sess., 131 Cong. Rec. H13093, H13226 (daily ed. Dec. 19, 1985) in reaching its decision and H.R. Rep. No. 241, 99th Cong., 1st Sess., pt. 3, at 6. *Id.* at 862.

<sup>171</sup> 42 U.S.C. § 1395dd(d)(2)(A).

<sup>172</sup> *Miller v. Medical Center of Southwest Louisiana*, 22 F.3d 626 (1994).

<sup>173</sup> *Harris v. Health & Hospital Corporation*, 852 F.Supp. 701, 703 (1994). (citing 42 U.S.C. § 1395dd(b); and *Deberry v. Sherman Hospital Ass'n*, 769 F.Supp. 1030, 1033 (N.D.Ill.1991)).

*Miller* confronted the “comes to” requirement. Here, nine-year-old Nick Miller was pinned beneath two cars after an auto accident. A passerby rushed the child to Acadia-St. Landry Hospital in Church Point, Louisiana but this hospital is really a small country clinic where two doctors practice. The doctor evaluated the child and realized that he needed an orthopedist and a surgical facility to treat the bony trauma and soft-tissue injuries. Dr. Williams arranged transfer with Dr. Olivier at Hamilton Hospital located in Lafayette but the hospital administrator at the transferee facility discovered that the child was uninsured and canceled the transfer. Dr. Miller investigated several hospitals and discovered that Charity Hospital in New Orleans would accept Miller.<sup>174</sup> The delay involved seven hours during which time the patient’s condition materially worsened.

When presented with these facts, the district court granted the hospital’s motion to dismiss since the plaintiff failed to fulfill the “comes to” requirement within the statute. What the plaintiffs asked the appellate court to do was to construe the statute without the “comes to” clause since, they argued, it is redundant with “request is made.”<sup>175</sup> The plaintiff based its position upon the holdings in *Thornton v. Southwest Detroit Hospital*<sup>176</sup> and *McIntyre v. Schick*,<sup>177</sup> where the patient never entered the facility yet the court brought them under the statute.<sup>178</sup>

The *Miller* court distinguished *Thornton* and *McIntyre* on their facts. In those latter two cases the patient was on hospital property whereas in *Miller* he was not and

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<sup>174</sup> 22 F.3d 627.

<sup>175</sup> 22 F.3d 626, 628.

<sup>176</sup> 895 F.2d 1131 (6th Cir.1990).

<sup>177</sup> 795 F.Supp. 777 (E.D.Va.1992).

<sup>178</sup> *Thornton*, 895 F.2d at 1135; *McIntyre*, 795 F.Supp. at 781.



never reached the hospital.<sup>179</sup> The Court reasoned that the statute is unambiguous in its requirement of “comes to” the emergency room. The gravamen here happened thirty miles from the hospital, it noted, and the court rejected stretching the statutory interpretation thirty miles.<sup>180</sup> The court also concluded that such a liberal interpretation would render the clause a nullity, thereby violating the elementary canon of statutory construction.<sup>181</sup> EMTALA, therefore, after *Miller*, applies as the statute says, to any individual who “comes to” the emergency department but the patient must in some way reach the hospital in more than a figurative way. Dilution of the “comes to” requirement to a meaningless phrase would render a decision inconsistent with an entire line of other cases.<sup>182</sup>

Before leaving *Miller* it is helpful to note that the court created a judicial formulation to decide whether an hospital has violated the Act. It consists of a four-part test considering whether

- 1) the individual went to the defendant’s emergency room
- 2) with an emergency medical condition, and the defendant hospital either
- 3) did not adequately screen him to determine whether he had an emergency medical condition, or
- 4) discharged him before the emergency condition was stabilized.<sup>183</sup>

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<sup>179</sup> Citing *Brooker v. Desert Hospital Corp.*, 947 F.2d 412, 414 (9th Cir.1991).

<sup>180</sup> 22 F.3d 626, 629.

<sup>181</sup> “(A) statute should be interpreted so as not to render one part inoperative.” *Id.* (citing *Mountain States Tel. & Tel. Co. v. Pueblo of Santa Ana*, 472 U.S. 237 (1985)).

<sup>182</sup> See *Id.* at 630 n.7 (citing *Green v. Touro Infirmary*, 992 F.2d 537 (5th Cir.1993); (“individuals who enter their emergency rooms requesting care”); *Baber v. Hospital Corporation of America*, 977 F.2d 872, 884 (4th Cir.1992); *Collins v. DePaul Hospital*, 963 F.2d 303, 305 (10th Cir.1992) (“if ‘any individual’ comes, or is brought, to such emergency department and requests”); *Burditt*, 934 F.2d at 1366 (Hospitals “must treat all human beings who enter their emergency departments in accordance with (EMTALA)”); *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 269 (6th Cir.1990) (“The benefits and rights of the statutes extend ‘to any individual’ who arrives at the hospital”); *Deberry v. Sherman Hospital Ass’n*, 741 F.Supp. 1302, 1305 (N.D.Ill.1990) (“Once it is established that the plaintiff showed up at the hospital’s emergency room”); *Owens v. Nacogdoches County Hospital Dist.*, 741 F.Supp. 1269, 1273 (E.D.Tex.1990) (“an emergency room must provide a medical screening examination to any patient who appears complaining of an emergency medical condition”).

<sup>183</sup> *Id.* at 629.

The *Miller* court derived<sup>184</sup> this from *Ruiz v. Kepler*,<sup>185</sup> *Huckaby v. East Ala. Medical Ctr.*,<sup>186</sup> and *Deberry*,<sup>187</sup> while referencing a slightly different test used in *Stevison*.<sup>188</sup> This is a valuable test to keep in mind in all EMTALA litigation since all four requirements must be met in order to fulfill the basic statutory mandate.

*Repp* is a Tenth Circuit Court of Appeals case<sup>189</sup> in which the court ruled that the hospital violates EMTALA when it fails to follow its own rules with respect to providing an appropriate medical screening when a patient presents to the emergency department. Minor variations, however, from the required screening do not violate hospital regulations and do not violate the Act. The term, then, “appropriate medical screening” is hospital specific. The medical facts in *Repp* serve to flesh out this holding.

Mr. Jessie Repp experienced left arm pain. He went to the ER and told the nurses that he had undergone cardiac bypass surgery and sought emergency care at the hospital.<sup>190</sup> The nurse telephoned his previous primary care physician who instructed the nurse to administer two injections. After the treatment, Mr. Repp went home where he died due to the ischemic cardiac problem.<sup>191</sup> The plaintiffs alleged EMTALA violations in failure to provide an appropriate medical screening<sup>192</sup> and that the defendants failed to stabilize Mr. Repp.<sup>193</sup> In addition, the plaintiffs brought a concomitant state malpractice

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<sup>184</sup> *Id.* n.8.

<sup>185</sup> 832 F.Supp. 1444, 1447 (D.N.M.1993).

<sup>186</sup> 830 F.Supp. 1399, 1402 (M.D.Ala.1993).

<sup>187</sup> 741 F.Supp. at 1305.

<sup>188</sup> *Stevison v. Enid Health Systems, Inc.*, 920 F.2d 710, 712 (10th Cir.1990).

<sup>189</sup> *Repp v. Anadarko Municipal Hosp.*, 43 F.3d 519 (1995).

<sup>190</sup> *Id.* at 521.

<sup>191</sup> *Id.*

<sup>192</sup> § 1395dd(a).

<sup>193</sup> (§§ 1395dd(b) & (c)).

action against all defendants. The district court granted summary judgment in favor of the hospital but on appeal, the court reviewed<sup>194</sup> only the issue of “appropriate medical screening”.<sup>195</sup>

Plaintiffs argued that the court should give substantive form to the term Congress failed to explicitly define and urged the court to require hospitals to provide a minimum level of care to each patient seeking care at the emergency facility. In opposition, the defendants claimed that to adopt that interpretation would create a national malpractice statute out of EMTALA. That result greatly exceeded Congress’ intent since under *Urban v. King*<sup>196</sup> the Tenth Circuit refused to make such an interpretation. Therefore, to do so in the instant case would be inconsistent not only with Tenth Circuit holdings but with those elsewhere.<sup>197</sup>

The court concluded that “appropriate medical screening” varies between health care facilities and means one that is “within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department.”<sup>198</sup>

This next case illustrates a successful claim recently upheld on appeal, based upon the failure to provide an adequate screening examination. In *Correa Gonzalez v. Hospital San Francisco*,<sup>199</sup> the patient died while waiting for care at the defendant’s hospital. Ms. Gonzalez took an accidental overdose of a  $\beta$ -blocker anti-hypertensive medicine and was

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<sup>194</sup> Under 42 U.S.C. § 1395dd(a).

<sup>195</sup> 43 F.3d 519, 521.

<sup>196</sup> No. 93-3331, 1994 WL 617521 at (10th Cir. Nov. 8, 1994).

<sup>197</sup> *Holcomb v. Monahan*, 30 F.3d 116, 117 (11th Cir.1994); *Baber v. Hospital Corp. of America*, 977 F.2d 872, 879 (4th Cir.1992); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C.Cir.1991); *see also Collins v. DePaul Hospital*, 963 F.2d 303, 307 (10th Cir.1992).

<sup>198</sup> 43 F.3d 519, 521.

taken to the first hospital by her son. There, the staff took the patient's information but she waited an hour-and-a-half and was then told to go to her primary care center by her insurer. At that second clinic, the provider took her vital signs, determined that an emergency existed, but, before the patient could have been stabilized prior to transfer, she died from hypovolemic shock. The plaintiffs claimed that the defendant violated EMTALA by their failure to provide an adequate (timely) screening examination.

The evidence is undisputed that Mrs. Gonzalez received absolutely no medical attention at HSF although she waited there over one hour. There is no record of any examination ... Instead of providing the required immediate screening, HSF wasted precious time checking Mrs. Gonzalez's insurance status with Hospmed and apparently intended not to treat her at all.<sup>200</sup>

After a jury trial, the estate recovered \$700,000 which has been upheld by the appellate court.<sup>201</sup> In the appellate opinion, the court sneered at the defense, using rarely seen judicial invective. The court dismissed the defense argument, that that they are not covered by EMTALA, with, "We need not tarry ... This argument has the shrill ring of desperation."<sup>202</sup> Further the court was severely disturbed by the indifferent treatment this patient received and noting that "we agree with the court below that the jury could rationally conclude, absent any explanation or mitigating circumstances, that the Hospital's inaction ... amounted to a deliberate denial of screening. EMTALA should be read to proscribe both actual and constructive dumping of patients."<sup>203</sup> In sustaining the damage amount the court again expressed its distaste for the defendants conduct when it

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<sup>199</sup> U.S. Dist. Ct., D.P.R., No. 92-2240 (PG), May 9, 1994. The author wishes to acknowledge Mr. David Efron, co-counsel for the plaintiff, for assisting in the analysis of this case.

<sup>200</sup> Brief for Appellant at 23, Gonzalez v. Hospital San Francisco, U.S. Dist. Ct., D.P.R., No. 92-2240 (PG), May 9, 1994.

<sup>201</sup> Correa v. Hospital San Francisco, - F.3d-, 1995 WL 627505 (Puerto Rico 1995).

<sup>202</sup> 1995 WL 627505, 3.

<sup>203</sup> *Id.* at 5.

commented, “Our endorsement of the damages ... is fortified by the trial judge's unconditional seal of approval.”<sup>204</sup> This case is distinct and represents the sort of outrage the plaintiff must be able to engender in order to win an EMTALA claim.

In *Harrison v. Paracelsus Healthcare Corp.*,<sup>205</sup> the plaintiff settled with the hospital for \$900,000 and with the doctor for an undisclosed amount. According to the case report<sup>206</sup> the defendants failed to immobilize the patient after he was involved in a vehicle roll-over accident. The patient went to the defendant hospital complaining of pain and left arm numbness. There a nurse placed him on a stretcher and he remained there without an evaluation for about 40 minutes. As part of the evaluation, when the doctor instructed the patient to flex his neck, the patient felt a shock run down his legs, arm, and fingers, and immediately experienced a loss of movement. The resulting quadriplegia could have been prevented by appropriate immobilization and examination techniques.

Mr. Harrison sued under the state’s medical negligence statute and included an EMTALA claim based upon failure to provide an appropriate medical screening or treatment or failure to transfer to another medical facility. Since this case settled there were no trial briefs but Mr. James Matthews, the plaintiff’s attorney, personally advised<sup>207</sup> that it is “extremely difficult to show that hospital emergency personnel treated one patient any differently than ... another.” He counseled that the best way to show this is by requesting through discovery the hospital emergency procedure manual and then attempt to show that the hospital departed from its own rules.

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<sup>204</sup> *Id.* at 14, n.10.

<sup>205</sup> U.S. Dist. Ct., M.D.Ga., No. CV 93-396-4-MAC, Aug. 20, 1994. The author wishes to acknowledge Mr. James Matthews, III of Atlanta, GA, plaintiffs co-counsel for providing insight in this matter.

<sup>206</sup> 10 PNLR 46 (1995).

<sup>207</sup> Mr. James Matthews, letter to author of 15 September 1995.

When taken together, Correa Gonzalez's case and Mr. Harrison's, one can see the difference between these two and others where defendants won. It is this egregious disregard in combination with substantial damages that seem to portend a significant settlement or trial verdict. When a defendant makes a patient wait an unreasonable amount of time and there is a legitimate emergency brewing, or where the defendant says, in effect, "we don't care what happens to you; out the door!" It is in those instances in which the harshest results predictably appear. The next series of cases further confirm these observations.

*Steele v. Anson County Hospital*<sup>208</sup> involved a pregnant patient who reported to her local ER suffering from a cough for a few days. Her respiratory rate was 42/min.<sup>209</sup> and the on-call doctor, without seeing the patient, over the phone, determined that Ms. Steele should go to an obstetric clinic located in an adjacent county. Two hours later, she arrived at the facility and was admitted to that ER with a respiratory rate of 64. Moments later she sustained a cardio-pulmonary arrest and both she and the fetus died. Her cause of death was pneumonia but this would have been amenable to treatment two hours earlier.

In the medical negligence suit, the plaintiffs asserted an EMTALA claim based on the failure to provide a prompt, appropriate medical screening. The *Steele* case represents another instance of indifference in which the on-call physician "did not ask for the patient's vital signs" but he did ask whether she had a private doctor. "[W]ithout further

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<sup>208</sup> U.S. Dist. Ct., W.D.N.C., No.C-C-90-0011-M, Nov. 4, 1993.

<sup>209</sup> Twice normal.

inquiry about the patient's condition, Dr. Staudt ordered that Mrs. Steele be sent to the Women's Clinic in Albemarle, about 30 miles away."<sup>210</sup>

The conduct which constituted the EMTALA violations were: 1) the nurses' failure to report abnormal vital signs to the physician, 2) failure to retake vital signs while the patient waited two-hours, and 3) that no one evaluated this patient prior to discharge from the ER.<sup>211</sup> This conduct exemplifies a failure to perform an adequate screening examination and a failure to stabilize prior to transfer.

An interesting aspect of this case was in the defense where the defendants implausibly claimed that the patient was contributorily negligent since she had allegedly failed to obtain prenatal care and failed to come to the hospital after she developed her cold. The judge ruled for the plaintiff since contributory defense only applies to conduct after a patient seeks medical treatment. This wrongful death action settled at \$865,000.<sup>212</sup>

Finally in this section, we consider the Act's causation requirement<sup>213</sup> where an elderly stroke victim, in *Clark v. Baton Rouge General Medical Center*,<sup>214</sup> arrived at the hospital emergency room and, despite family requests to provide an emergency screening, no such screening was performed. This violated the hospital's own policies and procedures. The patient vomited repeatedly and the hospital personnel did nothing to aid this patient and told the patient's daughter that, since the patient's insurance carrier did not reimburse the hospital due to a recent change in primary care provider contracts, the

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<sup>210</sup> Brief for Plaintiff at 3.

<sup>211</sup> *Id.* at 6.

<sup>212</sup> The author wishes to acknowledge Mr. Burton Craige, co-counsel for the plaintiff who provided assistance and his trial brief. Mr. Craige stated that the defendants did not submit a trial brief.

<sup>213</sup> 42 U.S.C. § 1395dd(d)(2)(A). "Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement ..."

<sup>214</sup> *Clark v. Baton Rouge General Medical Center*, 94 2239 La.App. 1 Cir. 6/23/95, 657 So.2d 741 (1995).

hospital would not treat her. Since the patient did not have the appropriate insurance, the ER doctors refused to treat her, permitting her to suffer until a neurologist arrived. He determined that she was stable enough to transfer, then transferred her to another hospital where she died two days later.

This case illustrates an important EMTALA requirement: causation. While the jury did determine that the hospital breached EMTALA, the breach did not cause death. The EMTALA liability ended when the patient is stable from the emergency condition which brought her to the hospital.<sup>215</sup> EMTALA is not intended to apply in non-emergency care situations, the court reasoned noting, though, that the hospital violated its own procedures. The trial court found the following conduct reprehensible as did the appellate court in sustaining the jury's liability finding and commented:

Despite pleading for assistance, [the daughter] testified medical personnel refused to help [the patient] stating she could not be treated because of her insurance coverage. Instead, bed linen was deposited at the foot of the bed while the patient laid in her vomit. [The patient's daughter] explained how she and her sister ... were cleaning their mother without assistance from any one at [the hospital].<sup>216</sup>

In the damage analysis, where the award was based on the EMTALA violation and not on negligence,<sup>217</sup> the judge awarded interest from the date that they filed the EMTALA claim<sup>218</sup> rather than using the less favorable state medical negligence statute.<sup>219</sup>

### **G. Motions to Dismiss, Jury Questions, HIV, and No Private Right of Action Against Physicians**

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<sup>215</sup> 657 So.2d 741, 741-45.

<sup>216</sup> *Id.* at 746.

<sup>217</sup> La.R.S. 13:4203.

<sup>218</sup> *Id.* at 749.

<sup>219</sup> La.R.S. 40:1299.47(M).



The facts in *Ruiz v. Kepler*<sup>220</sup> are instructive in terms of threshold EMTALA requirements necessary to surmount a motion to dismiss. There, Felix Ruiz sustained an head wound in a fight and arrived at Union County General Hospital<sup>221</sup> where a nurse evaluated him and a doctor sutured an head wound. After examining the x-rays, the doctor did not detect a fracture. The doctor discharged Mr. Ruiz with instructions for a return visit the next day. He actually did have a fracture and sustained injury as a result of the mis-diagnosis. In bringing the EMTALA action, the plaintiff alleged that he suffered irreparable injury as a result of the hospital's failure to provide an appropriate medical screening examination and from discharging him in unstable condition.<sup>222</sup>

The court declined to grant the motion to dismiss since the plaintiff stated a claim which satisfied the Act's threshold requirements. The injured party went to the ER with an emergency condition, and the defendant did not adequately screen him to determine whether he had an emergency condition or discharged him prior to stabilizing the emergency condition.<sup>223</sup> While this case did not contain conduct which shocks the conscience, the claimant presented sufficient evidence to surmount summary disposition.

Another case, *Dearmas v. Av-Med, Inc.*,<sup>224</sup> concerns a patient who brought an EMTALA claim after he was allegedly injured as a result of inter-hospital transfers. He was insured through an employee group medical plan which was an ERISA employee welfare plan. The Court ruled that ERISA preempted employee's Florida law claims

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<sup>220</sup> *Ruiz v. Kepler*, 832 F.Supp. 1444 (D. New Mexico 1993).

<sup>221</sup> *Id.* at 1446.

<sup>222</sup> *Id.*

<sup>223</sup> *See Deberry*, 741 F.Supp. at 1305. *Compare with* *Gatewood*, *supra* where the patient was not diagnosed with an emergency condition and as a result the EMTALA claim failed.

<sup>224</sup> *Dearmas v. Av-Med, Inc.*, 814 F.Supp. 1103 (S.D. Florida 1993).

against HMO and EMTALA did not apply to health maintenance organization since the Act applies only to hospitals, not to insurance plans.<sup>225</sup>

Christopher Wey fell from his bicycle at State College, Pennsylvania and was transported by ambulance to Evangelical Community Hospital in Lewisburg, Pennsylvania where he told the staff that he was HIV positive.<sup>226</sup> He suffered from and auto-immune thrombocytopenia and had been receiving necessary blood transfusions through the Veteran's Administration Medical Center. The hospital determined that he sustained a serious ankle fracture and that he needed surgery but, since he had been receiving care at the Veteran's Administration Medical Center in Wilkes-Barre, the staff decided to transfer him there for further definitive care.

The hospital staff then informed him that the hospital did not provide ambulance service and that he could be responsible for payment of an ambulance bill even though he was eligible for Medical Assistance benefits. With no alternative, his wife transported him by private vehicle.<sup>227</sup> He sued under EMTALA and the Hill-Burton Act<sup>228</sup> but the District Court ruled in the defendant's favor, reasoning that the hospital did not violate EMTALA when it failed to have Wey sign the consent-to-transfer form prior to his discharge and there was no EMTALA violation when it permitted transfer by private auto. The court determined that the hospital did not violate the Hill-Burton Act when it did not provide Mr. Wey with an ambulance which would accept payment by the state's medical assistance program.<sup>229</sup> Here, the court reasoned that Mr. Wey was stabilized

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<sup>225</sup> 814 F.Supp. 1103, 1107.

<sup>226</sup> *Wey v. Evangelical Community Hospital*, 833 F.Supp. 453 (1993).

<sup>227</sup> *Id.* at 454.

<sup>228</sup> Public Health Service Act, 42 U.S.C. §§ 291 et seq..

<sup>229</sup> 833 F.Supp. 453, 455.

when he left the ER so the hospital already fulfilled its EMTALA obligations. Moreover, the hospital made an appropriate transfer and had no obligation to provide a particular ambulance service.<sup>230</sup>

In a case with different results than *Wey*, but involving alleged discrimination based upon HIV status, *Verdicts, Settlements, & Tactics* reported<sup>231</sup> *Howe v. Hull* where a jury awarded compensatory<sup>232</sup> and punitive damages<sup>233</sup> to an HIV positive patient to whom the hospital refused admission. The patient brought his actions against the first hospital and its admitting physician under three federal statutes,<sup>234</sup> including EMTALA, and under the state medical negligence statute. In this action, the patient suffered from “fever, headache, nausea, joint pain and redness of the skin after taking a prescription antibiotic” and the ER doctor determined that the patient should be admitted to the hospital. The doctor was worried that the patient might develop toxic epidermal necrolysis as a consequence of this serious drug reaction. The ER physician called the on-call doctor who stated, allegedly, that “if you get an AIDS patient in the hospital, you will never get him out” and refused to admit the patient.<sup>235</sup> The emergency doctor arranged for transfer and told the patient, “You have to understand, this is a small community, and the admitting doctor does not feel comfortable admitting [the patient].” After transfer, the patient was diagnosed as having a simple drug reaction which could have been treated at the initial hospital.

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

<sup>231</sup> *Physician And Hospital That Refused To Admit HIV-Positive Patient Found Liable Under Federal Statutes*, 14 NO. 12 VERDICTS, SETTLEMENTS & TACTICS 441 (1994). (reporting *Howe v. Hull*, No. 3:92CV7658 (N.D. Ohio June 14, 1994).

<sup>232</sup> \$62,000.

<sup>233</sup> \$150,000 against the physician; \$300,000 against the hospital.

<sup>234</sup> Americans with Disabilities Act (ADA), the Federal Rehabilitation Act (FRA).

<sup>235</sup> *Id.* at 441.

In contrast to the usual case filed in federal court is the *Carodenuto*<sup>236</sup> matter which represents one of the first EMTALA cases heard at the trial level in a New York court. The case arose when Antoinette Carodenuto was mugged and sustained head injuries.<sup>237</sup> She was taken by ambulance to the north Central Bronx Hospital where she complained of headache but she denied losing consciousness. After an examination and diagnosis of post-concussive syndrome, she was discharged 45 minutes after arrival. She returned to the same ER 4 ½ hours after her initial admission with complaints about dizziness, chills, nausea, and vomiting. Various tests and x-rays were done about an hour later but she went into a coma and necessitated neurosurgery.<sup>238</sup>

Ms. Carodenuto then sued under the state malpractice statute alleging that her irreversible brain damage was a result of the hospital discharging her without an appropriate evaluation and that the delay was unreasonable. Later, in an amended complaint she added the EMTALA violations for failure to provide an adequate screening examination and failure to stabilize prior to her original discharge. The plaintiff argued that the statute created an absolute liability, a negligence *per se* for the failure to stabilize the patient prior to discharge or transfer. In order to resolve the issue, Judge Friedman noted the Act's legislative history and intent by stating in his opinion, "EMTALA was passed by Congress in 1986 to address the problem created when hospitals refused to treat, and 'dumped' into the streets, emergency room patients who were unprofitable, uninsured and poor."<sup>239</sup>

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<sup>236</sup> *Carodenuto v. New York City Health & Hospitals Corp.*, 593 N.Y.S.2d 442 (1992).

<sup>237</sup> *Id.* at 443.

<sup>238</sup> *Id.*

<sup>239</sup> *Id.* at 363-64. (citing the applicable EMTALA criteria under 42 U.S.C. § 1395dd(c)(1)).

This patient did not allege denial of appropriate medical care on the basis of being indigent or uninsured. Judge Friedman, therefore, considered whether the Act permits a private right of action in this circumstance.<sup>240</sup> The court concluded that “the statute’s unambiguous language” failed to impose “any limitation on which plaintiffs may seek to invoke it” since the statute includes “any individual who suffers personal harm” as entitled to recover under the Act.<sup>241</sup> The fact that the plaintiff did not allege “dumping” was not fatal to her claim since the statute “may go further than what Congress contemplated, but that is not a reason to distort or excise the words that Congress wrote.”<sup>242</sup>

Further interpreting the statute which provided for recovery against only a “participating hospital”<sup>243</sup> but not specifically against a physician lead to the conclusion that the congressional intent was to preclude enforcement against physicians. There, Judge Friedman, in dismissing the EMTALA claim against the physician, he relied upon the federal case<sup>244</sup> *Delaney v. Cade*,<sup>245</sup> where that court stated “[i]f Congress had intended to create a private cause of action against the physician, it knew how to do so.”<sup>246</sup>

The Ninth Circuit recently dealt with this issue in *Eberhardt v. City of Los Angeles*<sup>247</sup> and emphasized in its opinion that there is no private right of action against physicians. This was a question of first impression for the Ninth Circuit and the opinion noted that the Act “on its face authorizes two types of enforcement, an administrative

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<sup>240</sup> *Id.* at 444-45.

<sup>241</sup> *Id.* 445.

<sup>242</sup> *Id.* (citing *Cleland v. Bronson Health Care Group*, *supra* 917 F.2d at 270).

<sup>243</sup> *Id.* at 445.

<sup>244</sup> He also cited a New York case, *Verhagen v. Olarte*, 89 Civ 0300, 1989 WL 146265 (S.D.N.Y., Nov. 21, 1989).

<sup>245</sup> 756 F.Supp. 1476, 1487 (D.Kan.1991).

<sup>246</sup> *Carodenuto*, 593 N.Y.S.2d at 445.

action for civil money penalties and a private right of action for civil damages.”<sup>248</sup> The court explained that its position was consistent with “every appellate court”<sup>249</sup> and reasoned that the underlying legislative intent, implied or otherwise, prohibited the court from finding such a private right.<sup>250</sup> The plaintiff argued that under *Cort v. Ash*,<sup>251</sup> finding such a right would enable individuals to better enforce EMTALA. The court applied the *Cort* four-part test for determining whether a private remedy is implicit in a statute not expressly providing one:

- (1) Does the statute create a federal right in favor of the plaintiff?
- (2) Is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one?
- (3) Is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff?
- (4) Is the cause of action one traditionally relegated to state law?<sup>252</sup>

The Ninth Circuit concluded that “the legislative history of the EMTALA evinces a clear Congressional intent to bar individuals from pursuing civil actions against physicians.”<sup>253</sup>

The court noted that an earlier draft of § 1395dd(d)(2) contained a provision which did provide a private right of action but it failed because it “did not precisely identify which parties could bring actions under the provision, nor did it identify those against whom they could bring such an action.”<sup>254</sup> The House Judiciary Committee amended the provision to its present form to “clarif[y] that actions for damages may be

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<sup>247</sup> Eberhardt v. City of Los Angeles, 62 F.3d 1253 (1995).

<sup>248</sup> *Id.* at 1256.

<sup>249</sup> *Id.*

<sup>250</sup> *Id.*

<sup>251</sup> 422 U.S. 66 (1975).

<sup>252</sup> *Id.* at 78.

<sup>253</sup> Eberhardt, 62 F.3d 1253, 1256.

<sup>254</sup> *Id.* (citing H.R.Rep. No. 241, 99th Cong., 1st Sess. (1986), reprinted in 1986 U.S.C.C.A.N. 728).

brought only against the hospital which has violated the requirements of [EMTALA].”<sup>255</sup>

At this time, this matter appears settled consistently at the appellate level.

In the analysis of the absolute liability aspect of the EMTALA recovery, the opinion noted that the cause of action does not use the term “negligence”<sup>256</sup> and courts have interpreted that omission as intentional. Judge Friedman concluded that reflected the congressional intent to impose strict liability on a hospital when it fails to comply with EMTALA’s provisions.<sup>257</sup> The court refused to accept the plaintiff’s contention that the Act would be violated whenever there is an inaccurate emergency room diagnosis. Such an interpretation would defunctionalize all state medical negligence statutes since they use the “failure to meet the standard of care” standard, not “inaccurate diagnosis” standard proffered by the plaintiff. Judge Friedman wrote:

Certainly there are ambiguous terms in EMTALA. “‘Appropriate’ 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?’<sup>258</sup> The court declines to interpret the federal statute so as to produce a result far beyond that intended- the transformation of “garden variety” malpractice cases into *per se* causes of action. Misdiagnosis should remain, as it was before EMTALA, a matter for state malpractice law.<sup>259</sup>

In relying upon the *Gatewood* standard, the *Carodenuto* court concluded that the hospital provides an appropriate examination where it conforms to its own standard, hospital specific, screening standards.<sup>260</sup> Appropriateness, in the mind of the *Carodenuto*

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<sup>255</sup> *Id.*

<sup>256</sup> 42 U.S.C. § 1395dd(d)(3)(A).

<sup>257</sup> *Carodenuto*, 593 N.Y.S.2d at 446. (citing *v. Osteopathic Hosp. Founders Assn.*, 950 F.2d 676, 681 (10th Cir.1991); *Reid v. Indianapolis Osteopathic Medical Hosp.*, 709 F.Supp. 853, 855 (S.D.Ind.1989).

<sup>258</sup> (citing *Cleland, supra*, 917 F.2d at 271).

<sup>259</sup> *Carodenuto*, 593 N.Y.S.2d at 445-46.

<sup>260</sup> *Id.* at 446 (citing *Gatewood v. Washington Healthcare Corp.*, *supra*, 933 F.2d at 1041; *Cleland v. Bronson Health Care Group, supra*, 917 F.2d at 271; cf. *Collins v. DePaul Hosp.*, *supra*, 963 F.2d at 307).

court raised an issue of facts which would should be submitted to the jury. Therefore summary judgment should not be granted in this circumstance.<sup>261</sup> Finally, the *Carodenuto* court ruled that EMTALA precluded any private cause of action against individual physicians but that there could certainly be an assessment of civil penalties. The private enforcement action extended only to hospitals.

*Brodersen*<sup>262</sup> exemplifies that sometimes, some issues are too close to call for the purposes of summary disposition and should be sent to the jury. This case was heard in U.S. District Court in North Dakota where the trial court permitted the plaintiff to proceed to trial and allow the jury to decide matters which had been previously dismissed in other cases and which, in those cases, side-tracked or eliminated completely the plaintiff 's case.<sup>263</sup> This summary disposition was brought as a result of a wrongful death action in which the plaintiff brought a medical negligence and EMTALA action for failure to diagnose and treat in a timely manner a pending myocardial infarction. Although the hospital asserts that it followed its standard procedures, the plaintiff was able to raise a genuine issue of material fact by obtaining affidavits from two nurses who treated the patient. Additionally, the defendant claimed that it did not diagnose an emergency condition and therefore should not be required to stabilize the patient before discharge. The court "found this to be an extremely close question"<sup>264</sup> and concluded that "caution requires" a jury to determine this as a matter of fact.<sup>265</sup> Further, the defendant's motive was irrelevant, economic or otherwise, in failing to provide appropriate medical

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

<sup>262</sup> *Brodersen v. Sioux Valley Memorial Hospital*, --F.Supp.--, WL 558592 (N.D.IOWA 1995).

<sup>263</sup> One of the plaintiff's attorneys was Ms. Roxanne B. Conlin, former national ATLA president.

<sup>264</sup> *Id.* at 10.

<sup>265</sup> *Id.* at 23.



treatment<sup>266</sup> and reasoned that the Act applies to “any person denied sufficient emergency medical care regardless of the defendant’s motive.”<sup>267</sup>

Another issue which surfaced in *Broderson* was the knowledge requirement of 42 U.S.C. § 1395dd(b)(1)<sup>268</sup> where, in general, it is the plaintiff’s burden to prove that the hospital personnel had actual knowledge that the patient was suffering from an emergency condition.<sup>269</sup> The court concluded that this knowledge requirement is a jury question.<sup>270</sup> The plaintiff provided the court with medical records and a treating physician’s testimony which made it a question of fact whether the plaintiff was suffering from an emergency condition.

The patient complained of chest pain, nausea, hematemesis, and an inability to eat over two days.<sup>271</sup> This history, the plaintiff contended, raised the question whether he was suffering from an emergency condition and the judge ruled in the plaintiff’s favor. The judge required the plaintiff to prove at trial actual knowledge on “behalf of the Hospital. While the evidence on this question is extremely thin,” the judge wrote, “Brodersen will

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<sup>266</sup> *Id.* (citing *Gatewood*, 933 F.2d at 1041; *Power*, 42 F.3d at 857-58).

<sup>267</sup> *Id.*

<sup>268</sup> “... the hospital determines that the individual has an emergency medical condition ... “

<sup>269</sup> *Id.* at 10. See *Urban ex rel Urban v. King*, 43 F.3d 523, 525 (10th Cir.1994) (holding that “[a] plain reading of the statute reveals actual knowledge of an unstabilized emergency medical condition as a requirement to establish liability. Subsection (c) requires the hospital to meet certain transfer conditions if the individual’s emergency medical condition is not stabilized. The hospital cannot be held to stabilize an emergency situation without knowing an emergency exists.”) See *Gatewood*, 933 F.2d at 1041 (stabilization and transfer provisions “are triggered only after a hospital determines that an individual has an emergency medical condition”); *Cleland*, 917 F.2d at 271 (“[i]f the emergency nature of the condition is not detected, the hospital cannot be charged with failure to stabilize a known emergency condition”); *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131, 1134 (6th Cir.1990) (holding that EMTALA requires hospitals to stabilize patient “[o]nce a patient is found to suffer from an emergency medical condition”); *Coleman v. McCurtain Memorial Medical Mgt., Inc.*, 771 F.Supp. 343, 346 (E.D.Okla.1993) (“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”).

<sup>270</sup> *Id.* at 11.

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

have an opportunity to persuade the jury that the Hospital's denial of knowledge of Kendall's condition is false."<sup>272</sup>

In *Doe v. Roe*,<sup>273</sup> a pregnant patient experienced some medical complications and presented to a local hospital where she was seen by a triage nurse who recorded that the patient had a slight fever, lower abdominal pains, and "urinary pressure."<sup>274</sup> The emergency physician finally saw the patient but did not perform a pelvic examination and made no attempt to contact the patient's physicians. She was then discharged with the diagnosis of "low back strain" and was given instructions to apply Ben-Gay and to "rest knee in a flexed position." The next morning the patient called her doctors but was told she could not see anyone until later that afternoon despite her "immense pain."<sup>275</sup> While this woman was on the phone trying to get someone to listen to her medical complaints she delivered the baby. Rescue personnel responded but the baby died forty-six hours later.

In the initial suit the plaintiff did not appropriately name all defendants and took a non-suit. It then re-filed in order to appropriately name all defendants: one suit was against the hospital under EMTALA and one under state law against the OB/Gyn group and the ER physicians and their respective groups. The court granted the defendant's motion to consolidate all claims. The parties settled at \$325,000 with \$12,183 in special damages.

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

<sup>273</sup> (Hopewell Cir.Ct.Va.1995).

<sup>274</sup> Reported in *Settlement In Suit Alleging Inadequate Prenatal Care And EMTALA Violation*, 15 NO. 3 VERDICTS, SETTLEMENTS & TACTICS 87 (1995).

<sup>275</sup> *Id.* at 87-88.

Plaintiff's counsel in this case placed an ad in the local newspaper and soon discovered that many patients would testify that patients with insurance received different consideration than those without and there were numerous instances where the emergency physicians deviated from hospital protocols and procedures.

### III. COMMENTARY ON A DECADE OF LITIGATION

**W**hat sorts of claims are appropriate to initiate EMTALA litigation and what is necessary for the plaintiff to prevail? In review of ten years of EMTALA litigation, the differences between the successful cases and the ones where the plaintiff lost are clear.

As a general threshold observation, since EMTALA is not another medical negligence statute, only egregious cases merit EMTALA claims. It is important that the claimant precisely fit into the mortise and tenon judicial formulation found in *Miller v. Medical Center of Southeast Louisiana*.

For instance, a patient who comes to the emergency room and dies from negligent conduct was never transferred and would not qualify under that provision. As above illustrated, a patient who never “came to” the facility, even when his care may have been directed from the facility, would not fulfill that requirement. A patient who had an emergency condition, who was diagnosed and stabilized, but who, after discharge, sustained a complication would not qualify. Once a condition is stabilized, that cuts off the hospital’s liability under the Act.

According to the cases, the most favorable and socially meritorious instances would contain some sort of constitutional parameter to them, like *Baby K*, where the denial of medical treatment raised another important set of right-to-life issues. In both *Wey* and *Howe v. Hull*, health care providers discriminated on the basis of the patient’s HIV status. In this constitutional category, too, one would place *Baber*, a deprivation based on mental illness. Although there is no requirement of a bad motive in terms of

denial of the screening examination, under the *Cleland* standard<sup>276</sup> impermissible motives include discrimination based upon race, sex, ethnic group, medical condition (i.e. AIDS), personal animus, and political opinions.

There is a line of cases where the medical care itself was not only negligent but evidenced a reckless disregard for the welfare of another, a callous refusal to care for another person in desperate time of need, culminating in disaster. Some examples would include *Burditt*, where the doctor shipped off an hemorrhaging obstetric patient to another distant facility; *Power*, where the patient was a foreign national without insurance who sustained an avoidable, shocking result; *Harrison v. Paracelsus*, where quadriplegia resulted from the physician's lack of basic care; *Gonzalez*, where the hospital paid more attention to the patient's insurance than to the overdose which killed the patient; and *Steele*, where a mother and child died after a doctor phone-treated the patient for a pneumonia. Each one of these cases fulfills each statutory requirement while at the same time containing this callous indifference which the Act is intended to punish.

The plaintiff, however, will not win the EMTALA claim where there is a complicated clinical scenario with retrospective "garden variety" negligence. This was the issue in *Harris*<sup>277</sup> where the court determined that the hospital did not violate the Act when the discharge diagnosis included myocardial infarction and pulmonary embolus. In this instance, the physician had no evidence that made him conclude the patient suffered from anything more than costochondritis and hyperventilation syndrome.

As part of the formula in deciding whether to move forward under the statute, the next question becomes, Can the plaintiff win? Although EMTALA is not a substitute for

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<sup>276</sup> 917 F.2d at 266.

medical negligence litigation, it does attempt a remedy medical conduct which approaches the intentional. Caution here again, however, since courts will not permit these cases to go forward unless the plaintiff fits the Act's statutory mortices and tenons. In *Gatewood*, for instance, the court determined that the Act does not mandate correct diagnosis and treatment, only that the hospital provided consistent treatment within its own protocols. In *Thornton*, where the patient was retained in the hospital for twenty-one days, she was, for the Act's purposes, stabilized and the providers did not violate the Act in her transfer. There is no requirement that the hospital cure the patient under EMTALA. *Wey* is another example where the EMTALA recovery failed when the plaintiff did not meet its statutory burden even where the defendant attempted to discriminate on the basis of HIV status.

There is no requirement for a bad motive in denial of the emergency care<sup>278</sup> but there is a knowledge requirement. By this standard, the hospital must have actual knowledge that the patient was suffering from an emergency condition.<sup>279</sup> As Mr. Matthews pointed out, this is a very difficult requirement to meet. Under *Broderson*, in addition, knowledge may be regarded as a jury question rather than as a question the court would be willing to resolve in summary disposition for either party but it appears as if the plaintiff will be in the strongest position where it can prove that the hospital violated an internal policy or procedure.

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<sup>277</sup> *Harris v. Health & Hosp. Corp.*, 852 F.Supp. 701, (S.D.Ind.1994).

<sup>278</sup> Note, *The Emergency Medical & Active Labor Act: Denial Of Emergency Medical Care Because Of Improper Economic Motives*, 67 NOTRE DAME L.REV. 1121 (1992).

<sup>279</sup> See *Kaufman v. Cserny*, 856 F.Supp. 1307 (S.D. Ill. 1994).

Whether a patient suffers from an emergency medical condition is pivotal to success. The Act defines emergency medical condition<sup>280</sup> and the courts have further interpreted the term. What becomes an issue in litigation is not whether the patient had an emergency medical condition but, as in *Collins*, whether the hospital knew of the condition. The Act does not apply until the provider knows of the emergency medical condition.

Conflict arises, of course, where the Act imposes no duty for the hospital to make a correct diagnosis, as in *Brooks*. If the hospital is uniformly negligent, applying poor procedures to all of its patients, as in *Repp*, and it does not know of the emergency medical condition, then the Act is not triggered. Absent disparate treatment, there would then be no EMTALA liability although there might be medical negligence liability under the state statutes.

The courts seem unwilling to punish bureaucratic faults, failure to fill out a form, for instance, unless there is some connection to a real-world patient harm. Compare, here, the results in *Burditt* from those in *Hutchinson*,<sup>281</sup> *Wey*, and *Repp*. The court punished the defendant in *Burditt* since he failed to go through the requisite mental processes; he was a medical scofflaw. In the other two cases, in contrast, the physician's performance constituted at least a good-faith statutory compliance and fulfillment: they tried.

The courts do look at intent to dump, however, coming down hard on wrongdoers' conduct exemplified in *Gonzalez*, *Burditt*, and *Steele*. On the other hand, where the defendants sought only to diagnose and treat, even in a poorly thought out manner, the

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<sup>280</sup> 42 U.S.C. § 1395dd(e)(1)(A).

courts do not sustain the EMTALA claim. This was the result in *Baber, Gatewood, Collins* and *Cleland*.

In concluding this section, it is important to dispose of an apparent misconception. Some writers complain<sup>282</sup> that EMTALA has become yet another example of the creative plaintiff's bar making an end run around a statute in order to achieve additional compensation; that somehow the plaintiff's bar has abused the statutory authority of this Act by abusively litigating. Objective review of these cases over ten years does not sustain that contention. Perhaps representatives from the plaintiff or the defense camps could legitimately arrive at divergent conclusions, but when viewed objectively and in its totality, plaintiffs have only been successful when they scrupulously met the Act's criteria in all respects. This is not a perversion of the Act's intent; it is litigating within the Act's provisions and intent.

In a widely quoted Wall Street Journal article Professor Jeffrey O'Connell criticized the plaintiff's bar for extending EMTALA but, although Professor O'Connell may have had an impression that "whammo," an whole new industry has been "imaginatively" created by the plaintiff's bar, case review does not support his impression. Courts do, however, grant summary disposition for the defendants only with appropriate hesitation and plaintiffs have, as with any new statute, appropriately plead

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<sup>281</sup> *Hutchinson v. Greater Southeast Community Hosp.*, 793 F.Supp. 6, (D.D.C.1992). The Act requires no particular documentation of screening examination and mere deviation from documentation requirements does not violate the Act.

<sup>282</sup> Edward Felsenthal, *Plaintiffs Get Around State Limits On Medical-Malpractice Damages*, WALL ST. J., Aug. 30, 1994, B2. "In the past, a patient such as Ms. Power would have brought only one lawsuit, a malpractice case accusing the hospital and doctors of negligence. But Ms. Power also filed a suit contending that the hospital violated her right to emergency treatment under the federal law. the result: she got a \$5 million jury award, even though Virginia caps malpractice damages at \$1 million. ... 'this indicates the tremendous imagination of the plaintiffs bar in finding causes of action,' says Jeffrey O'Connell, a



EMTALA violations in cases involving emergency care. There is no “cottage industry” in this area of litigation that this author was able to detect. In fact, the opposite is true. There have been relatively few cases nationwide over ten years which have reached the appellate levels in state and federal courts combined<sup>283</sup> and there are only 58 cases which appear as the landmark cases in United States Code Annotated.

Furrow<sup>284</sup> characterized the Act as having “stimulated a significant amount of litigation.” After review of these cases against the background of other acts and other matters, one is left with the distinct impression that the significance is that there has not been more litigation than the 58 cases detailed in appendix (B) and the 163 cases nationwide over ten years.

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University of Virginia law professor. Whenever a state enacts legal reforms, ‘you turn around and, whammo, there's a whole new industry built up imaginatively seeking any opening in that dike.’

<sup>283</sup> In ten years of litigation, as of 18 November 1995 there were 151 cases on WESTLAW in the ALLFEDS database which contained 42 U.S.C. § 1395dd. This averages to 15 cases a year over ten years in federal courts. There were only twelve cases in the ALLSTATES database for a grand total of 163 cases.

<sup>284</sup> BARRY R. FURROW *et al.*, HEALTH LAW 540 (1995).

## IV. CONCLUSIONS AND RECOMMENDATIONS

**T**hrough the grueling process of case-by-case litigation over the past ten years, EMTALA appears well defined at this point. One unresolved issue which may be unraveled at the Supreme Court level is the that of the non-medical reason/bad-motive problem. Also, the ethical issues which Baby K raised may require resolution by the Supreme Court as may the complex interdigitations between EMTALA and other acts which create obligations to provide medical care.<sup>285</sup>

There is a confusion as to the appropriate court of jurisdiction. It would strengthen the statute for EMTALA to pre-empt state jurisdiction. This would remove some of the vagaries which have arisen in terms of where and in what forum the action should originate. Since enforcement involves federally granted privileges and involvement with HCFA, a federal agency, this approach would make sense. While the Act mandates reporting to both state and federal authorities, it is primarily rooted in federal authority and federal courts seem to be the best forum for these actions.

That there is no right of private action against the physician appears to be well settled although there are good arguments for the contrary position. In some ways it seems to be incongruent to hold the hospital liable under the Act while the physician

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<sup>285</sup> For instance, Hill-Burton Act, 42 U.S.C. § 291; Title VI, The Civil Rights Act of 1964, 42 U.S.C. § 2000d (1982); § 504, The Rehabilitation Act of 1973, 29 U.S.C. § 794; The Americans with Disabilities Act, 42 U.S.C. §§ 12101-12213.

remains immune. The physician can be fined and terminated from Medicare under the Act so why not make him personally liable? To not do so creates a policy inconsistency. The Act's purpose is to prevent dumping and physicians are responsible to make transfer decisions, not hospitals or even nurses. When a physician is an hospital employee, then the physician is the hospital's alter ego and conversely. But when the physician is an independent contractor, he would avoid liability. Perhaps a better way to proceed would be to define "hospital" to mean "hospital and its agents, whether employee or independent contractor, for the purpose of this statute only." The situation at present constitutes a legal discord since in ordinary negligence litigation, neither hospital nor physicians escape liability by the convenience of agency status in the emergency department situation.

Perhaps the most important direction for EMTALA in the next ten years would be to put some real teeth into the statute in terms of enforcement provisions and sanctions. Frankly, many hospitals' operating budget exceeds \$10 million and an HCFA fine of \$50,000 is equivalent to the kitty for the hospital staff year-end party; it is "parking-meter change." Bad publicity dies away, and even temporary loss of Medicare payments is relatively insignificant at the economic scale at which hospitals operate. What would cause the hospitals to take notice however, would be a potential loss of tax-exempt status. To lose tax-exempt status for repeated violations would be consistent with the intent of the Act. For instance, after an hospital has been found liable for violating EMTALA, in addition to the existent § 1395dd(d) penalties, it should also be subject to IRS review of whether tax exempt status is still appropriate. An amendment to the statute could require a tax reimbursement to the government for the period over which the

EMTALA violation(s) occurred.<sup>286</sup> Threat of loss of tax-exempt status would tend to encourage strict compliance since this loss would be costly at a meaningful scale.

IRS revenue ruling 69-545<sup>287</sup> instructs examining agents to determine whether a patient's admission to the institution is denied due to an inability to pay. If the class of benefited persons is so small and does not constitute a benefit to the community, then the exemption may be subject to revocation.<sup>288</sup> Apparently the IRS and HHS have already agreed to exchange information on dumping hospitals but it does not appear as if much has been done in this respect since litigation has been sketchy over the past twenty years. There appears to be no barriers for Congress to incorporate this penalty under the Act or in the Medicare statute.

The Sixth Circuit examined loss of tax-exempt status in *Lugo v. Miller*,<sup>289</sup> where a group of low income persons brought a class action suit against the Secretary of the Treasury and seven Ohio hospitals. They challenged the revenue ruling which provided that the hospitals were not required to provide free non-emergency care to patients according to financial ability to pay in order to qualify for tax-exemption. Senior Judge

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<sup>286</sup> See *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265 (1985). (determining that 21 hospitals were not meeting their organizational mission to provide charitable care when they refused to admit patients for whom the county refused to pay. When IHC did not relieve the County from this burden, the Utah Supreme Court reasoned that they operated as a for-profit organization and should lose their exemption covering *ad valorem* property taxes. After this case, IHC agreed to expand significantly its charitable services.)

<sup>287</sup> This ruling requires that the hospital provides service to a "broad class of persons"; that it "provides emergency services to patients without regard to ability to pay"; that the emergency department is accessible to all persons; that it maintain an open medical staff; and, finally, that the hospital board of directors represents the community.

Celebrezze dismissed the action since there was no causal connection between issuance of the ruling and “some identifiable deprivation of medical services and where it was only speculative whether an invalidation of the ruling would have afforded relief.”<sup>290</sup>

It appears that very few hospitals have been subjected to revocation of 501(c)(3) status as a consequence of care to the indigent. This may be due to the fact that provision of care to the indigent is only a partial requirement for hospitals to receive tax-exempt status. In *Geisinger v. Commissioner of Internal Revenue*,<sup>291</sup> a more recent a case which contains facts placing it at the outermost margins of tax-exempt status cases, the court ruled against the hospital. This involved a tax-exempt HMO which benefited only its paying subscribers, providing nothing to outsiders. The HMO purportedly operated exclusively for religious, charitable, scientific, testing for public safety, literary or educational purposes but was unable to show any community benefit as the statute requires. The judge remanded the matter back to the Tax Court to determine whether the organization qualified for tax-exempt status under the integral part doctrine.

Under IRS Code,<sup>292</sup> taxpayers seeking exemption have the burden to prove the entitlement and the IRS may disregard a revenue ruling where they conflict with the statute they purport to interpret or where they find it “otherwise unreasonable.”<sup>293</sup> The

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<sup>288</sup> Barker, *Re-Examining the 501(c)(3) Exemptions of Hospitals as Charitable Organizations*, TAX NOTES 339 (7/16/90). (proposing federal legislation which would require the tax-exempt hospitals to accept indigent Medicaid patients in order to qualify for the authority to issue tax-exempt bonds).

<sup>289</sup> 640 F.2d 823 (1980).

<sup>290</sup> *Id.* at 823.

<sup>291</sup> 985 F.2d 1210 (Third Cir. 1993).

<sup>292</sup> § 501(c)(3).

<sup>293</sup> *Geisinger*, 985 F.2d 1210.

Internal Revenue Manual<sup>294</sup> directs auditors to investigate satisfaction of the “community benefit” standard under 501(c)(3) such that the level of charity care is important in this calculus. A recent General Accounting Office study<sup>295</sup> indicates that this concept has already been considered but it seems that such a proposal would be subjected to vigorous opposition.<sup>296</sup>

As with any statute, EMTALA’s purpose and impact reflect public policy but is subject to the winds of congressional personalities and public opinions. EMTALA seems well established and seems to provide a stabilizing force in emergency medical care. The two major enactments in 1986, the National Practitioner Databank and EMTALA, have become a part of the medical landscape. EMTALA appears likely to remain in place since even voluble financial conservatives support a uniform standard of careful medical care in emergency situations.

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<sup>294</sup> Internal Revenue Manual 7(10) 69, HB 333.1(4).

<sup>295</sup> GENERAL ACCOUNTING OFFICE, REP., NON-PROFIT HOSPITALS: BETTER STANDARDS NEEDED FOR THE EXEMPTION GAO/HRD-90-84 (May 1990).

<sup>296</sup> See e.g., *Catholic Hospitals Challenge GAO Report on Tax-Exempt Hospitals*, 90 TAX NOTES TODAY 159-7 (Sept. 1990).

## Post Script

Levine, *et al.* published *Analysis of Federally Imposed Penalties for Violations of the Consolidated Omnibus Reconciliation Act* in July 1996<sup>297</sup> where this University of Arizona group tried to identify the incidence of EMTALA violations. The study concluded that of 1,757 authorized investigations of complaints, 1,729 were completed. Of the completed ones, 412 (24%) were found to be out of compliance with the regulations. Only 27 of those resulted in fines of the involved hospitals which ranged between \$1,500 and \$150,000. Six physicians were fined between \$2,500 to \$20,000. Seven hospitals but no physicians were terminated from Medicare. The authors concluded that these numbers represent low incidences when one considers the number of E.R. visits nationally and the number of transfers.

There is another side to this, of course. If these numbers are low, it may represent a low incidence of reporting and may reflect an high incidence of claim settlement prior to formal complaint. Physicians dislike reporting medical malfeasance and there may not be sufficient incentive for providers to report. A greater *failure to report* incentive may be necessary. Further, injured parties who settle EMTALA claims prior to complaint are not required to report the settlement.

The other important point may be that the law has done what it was intended to do: reduce dumping. In what may represent an unusual Congressional triumph, maybe EMTALA succeeded in doing what needed to be done

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<sup>297</sup> Robert J. Levine, *et al.*, *Analysis of Federally Imposed Penalties for Violations of the Consolidated Omnibus Reconciliation Act*, 28 ANNALS OF EMERGENCY MEDICINE 45 (1996).

## Y2K Update:

The medical record “is” the medical care when an agency reviews the care. There is secondary evidence through witness depositions and statements, but what is in the record is like a concrete bridge between what actually happened and the recounting of the care. EMTALA has been well reviewed elsewhere and was discussed with respect to medical records in *THE MEDICAL RECORD AS EVIDENCE*.<sup>298</sup>

EMTALA itself was reviewed by the author in *EMTALA: Its First Decade; A Retrospective Analysis of 42 U.S.C. § 1395dd*, 43(4) *MED. TRIAL TECH. Q.* 77 (1997) as well as by other authors. Since the first edition of *THE MEDICAL RECORD AS EVIDENCE*, two cases are very import with respect to the Act or to the medical record as evidence.

### ***Cherukuri: Paperwork or Lives?***

The 6<sup>th</sup> Circuit dismissed charges against Theodore Cherukuri analyzed the law with respect to “stabilization,” as defined in the statute and then criticized the ALJ and the DHHS for its obstinacy when confronted with a very good argument to dismiss the charges.

*Cherukuri v. Shalala*<sup>299</sup> represents a doctor’s worst medical and legal nightmare since the case stands as an instance where a physician received harsh treatment for incomplete “paperwork” after he came to the hospital in the middle of the night and saved five patients involved in an horrible automobile accident.<sup>300</sup> The disaster nearly cost Dr. Cherukuri \$100,000. The case is important, too, because it illustrates what may be necessary to achieve a “fix” for incomplete record-keeping, and finally, to illustrate that,

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<sup>298</sup> §1-18, n.132; § 3-7(g), n.166; §4-22, n.433.

<sup>299</sup> 175 F.3d 446; 1999 U.S. App. Lexis 8369 (6th Cir. 1999).

<sup>300</sup> *Id.* at 455.



in some cases where a physician is a defendant, there is a chance that “David” may win; the government can be beaten.<sup>301</sup>

The relevant medical facts were the following:

[F]ive auto accident patients, two with severe head injuries and internal abdominal injuries and bleeding, who were later transferred to another hospital, were brought by ambulance in the early morning hours to the emergency room of a small rural hospital in south Williamson, Kentucky, in the Appalachian Mountains on the border between Kentucky and West Virginia, 85 miles South of Huntington, West Virginia. The Williamson Hospital had no trauma center, had no equipment for monitoring the effect of anesthesia on the brain during surgery, and had a long-standing policy of not performing neurosurgery on injuries to the brain. Rather ... it always transferred such patients to other larger hospitals, often to St. Mary's Hospital in Huntington, a teaching hospital with a trauma center and the medical expertise and equipment to perform brain surgery.<sup>302</sup>

Further, Dr. Cherukuri quickly and in a timely manner made the determination that two patients need urgent surgery, that it was impossible to do the surgery at his facility, and, in order to save the lives of these two boys, he had to transfer the patients to St. Mary's. He then arranged ground transfer to St. Mary's because fog prevented air evacuation.

There is no question of improper motive, "patient dumping" based on uninsured status, or other discriminatory treatment by Dr. Cherukuri in this case. It is also undisputed that the condition of the two patients did not in fact deteriorate during transfer to St. Mary's in Huntington.<sup>303</sup>

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<sup>301</sup> The author is reminded of a billboard advertising toilet paper where a child is seen exiting the bathroom with toilet paper trailing. The tag line is “The job’s not finished until the paperwork is done.” This case stands for the proposition that in a question of paperwork as opposed to a human life, it is the doctor’s duty to save lives ... paperwork is a secondary consideration.

<sup>302</sup> *Id.* at 448.

<sup>303</sup> *Id.*.

The issue before the court was whether Dr. Cherukuri stabilized these patients prior to transfer. What interested federal investigators was the fact that Dr. Cherukuri did not, and never did, appropriately complete the transfer forms.<sup>304</sup>

When HCFA reviewed the matter, charges were filed and

[t]he Inspector General commenced an enforcement action to suspend the surgeon's license and assess the maximum "civil penalty" of \$ 100,000. An administrative law judge employed by the Secretary wrote a 35,000-word opinion finding the surgeon guilty and imposing a fine of \$ 100,000. The "Departmental Appeals Board" in the Office of the Secretary declined to review or comment on the decision and made it final and binding, subject to review in the Court of Appeals.<sup>305</sup>

The Department's conclusion was that the surgeon did not stabilize the patients. The ALJ based her conclusion on the fact that there was an anesthesiologist available to perform anesthesia ... but she ignored the facts that the hospital itself did not have the ability to monitor the patients for cerebral function while anesthesia progressed and that the hospital had never before performed this sort of anesthesia on such gravely injured patients.<sup>306</sup>

In its dismissal of the case, the court found that Dr. Cherukuri did sufficiently stabilize the patients and there was no anesthesia available to safely perform anesthesia. In short, there was no way Dr. Cherukuri could have proceeded; transfer was mandatory.<sup>307</sup>

Here, the court reviewed the documentation and transfer requirements necessary under EMTALA:

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<sup>304</sup> *Id.* at 455.

<sup>305</sup> *Id.* at 448-49.

<sup>306</sup> *Id.* at 449.

<sup>307</sup> *Id.*

Sections (b), (c), (d) and (e), the critical sections in this case, regulate treatment and restrict transfer of emergency patients. Subsection (b) provides:

(b) . . . 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.

*Id.* § 1395dd(b) (emphases added). Under subsection (c), a patient who "has not been stabilized" may be transferred (1) only upon "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 risk to the individual . . . from effecting the transfer" and (2) only if "the receiving facility . . . has agreed to accept transfer of the individual and to provide appropriate medical treatment . . ." *Id.* § 1395dd(c) (emphasis added). Only unstable patients require a certification and consent of the receiving hospital. A patient who has been "stabilized" in the emergency room of the transferring hospital may be transferred to a receiving hospital without a certification, as described above, and without obtaining the express agreement of the receiving hospital. "Stabilized" patients may be transferred without limitation under the language of the statute. In subsection (e), EMTALA's definition subsection, the word "stabilized" is defined, but the definition is not given a fixed or intrinsic meaning. Its meaning is purely contextual or situational. The definition depends on the risks associated with the transfer and requires the transferring physician, faced with an emergency, to make a fast on-the-spot risk analysis. The definition says that "stabilized" means "that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual." *Id.* § 1395dd(d). The bottom line is that under the language of subsections (b) and (c), including the definition of "stabilized" in subsection (e), a physician may transfer any emergency room patient to another hospital without any certifications and without the express consent of the receiving hospital if he reasonably believes that the transfer is not likely to cause a "material deterioration of the patient's condition." *Id.* Obviously a surgeon in Dr. Cherukuri's position must weigh what he can do for the patient at his hospital versus the services available at the receiving hospital, as well as the present condition of the patient and the risk that he will get worse during the transfer.<sup>308</sup>

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<sup>308</sup> *Id.* at 449-50.

In short, the appellate court asked itself, in effect, the same question Dr. Cherukuri must have asked himself in the middle of the night with the lives of two boys hanging in the balance,<sup>309</sup> what else could Dr. Cherukuri have done except to transfer?

This standard is the requirement to assess a civil monetary penalty (CMP) under EMTALA:

In order to prove a transfer violation under sections (b), (c) and (e), the government must show in a civil penalty case not only that the transferred patient was not "stabilized" and not accepted by the receiving hospital. It must show that the doctor was "negligent" in transferring the patient in the sense that, under the circumstances, "the physician knew or should have known that the benefits [of transfer] did not outweigh the risks."<sup>310</sup>

The United States Supreme Court rejected the "improper motive test" to impose CMP's in EMTALA actions in *Roberts v. Galen of Virginia, Inc.*<sup>311</sup> Here the *Cherukuri* court cited Senator Bob Dole, who co-sponsored EMTALA, who said that the statute's intent requires an hospital to provide "an adequate first response to a medical crisis" which "means the patient must be evaluated and, at a minimum, provided with whatever medical support services and/or transfer arrangements that are consistent with the capability of the institution and the well-being of the patient."<sup>312</sup>

The anesthesiologist refused initially to come to the hospital,<sup>313</sup> but he eventually did arrive 2 ½ hours late. One of the most preposterous holdings by the ALJ was that when faced with this refusal "EMTALA required the surgeon to force [the

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<sup>309</sup> ... and the same question posed to DAB when Dr. Cherukuri sought review of their poorly reasoned opinion and analysis.

<sup>310</sup> *Id.* at 450.

<sup>311</sup> 119 S. Ct. 685 (1999). *Id.*

<sup>312</sup> 131 Cong. Rec. 28569 (1985). *Id.* at 450.

<sup>313</sup> *Id.* at 452.

anesthesiologist] to perform by expressly ordering him to administer anesthesia.”<sup>314</sup>

About this flawed conclusion, the appellate court noted, though, that “nothing in EMTALA demands such a confrontation, and for good reasons.”<sup>315</sup> The court concluded that the ALJ’s conclusions were erroneous and fully exonerated Dr. Cherukuri.<sup>316</sup>

Finally, here, and an important appellate point for practitioners to note, the appellate court chastised the DHHS’s handling of this case stating:

It is unfortunate that the errors we have uncovered were not caught earlier in the administrative process. When the administrative "Review Board" established to administer EMTALA cases chooses without explanation to make an ALJ decision in an important case binding without review, the burden on the Court of Appeals to comb the record is substantially increased. We respectfully suggest that the Board should review cases like this one closely and should not simply pass them on to a federal appellate court without providing a reasoned disposition of the objections raised by the parties. Our own close review of the record clearly shows that the decision is not supported by substantial evidence on the record as a whole, does not justify the legal conclusion made by the ALJ that Dr. Cherukuri "knew or should have known that the benefits [of transfer] did not outweigh the risks" ( § 1395dd(d)(1)(B)), and accordingly must be set aside.<sup>317</sup>

*Cherukuri* illustrates how important it is to persist even in the face of great odds when the lawyer, by reading the case law, knows “he’s right.” Dr. Cherukuri’s career would have been adversely affected without this vindication and, had the decision stood, it is hard to imagine what implications this case may have held for professionals who respond every day to similar life-threatening situations. Further, had the flawed ALJ

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<sup>314</sup> *Id.*

<sup>315</sup> *Id.*

<sup>316</sup> *Id.* at 454.

<sup>317</sup> *Id.* To illustrate how sad was the DHHS’s posture here, the ALJ’s decision did not cite one legal citation, not to one EMTALA case, when there were, at the time, about 125 cases which has been published. Dr. Cherukuri submitted a 250 page brief on appeal to DAB providing reasons why the ALJ decision should have been overturned. DAB did not read the brief and let stand the ALJ’s opinion. On behalf of Dr. Cherukuri’s lawyer, Mr. Chad Perry, III, the author wrote the DAB Brief on Appeal and the Petitioner’s Brief on Appeal to the 6<sup>th</sup> Circuit. The author wishes to thank Mr. Chad Perry for the opportunity to work on this matter.

decision been unchallenged, patients everywhere in America would have suffered. What health care professional would be willing to come to the E.R. in the middle of the night only to have his decision-making second guessed by an ALJ sitting in Washington, DC?

***Roberts: No Improper Motive Required***

In another important EMTALA matter, *Roberts v. Galen of Virginia, Inc.*,<sup>318</sup> the United States Supreme Court<sup>319</sup> held that EMTALA does not require proof that an hospital acted with improper motive in failing to stabilize a patient. An improper motive involves a non-medical consideration, on based upon indigency, race, or sex of the patient.<sup>320</sup> Until the Supreme Court decided *Roberts*, there had been an inter-circuit split in the interpretation of whether an improper motive was necessary as an element to recovery under EMTALA.<sup>321</sup>

In one final EMTALA case, *Nieves v. Hospital Metropolitano*,<sup>322</sup> a child was transferred to another hospital after it was discovered that she did not have insurance. She was transferred in stable condition and she sustained no injury because of the transfer. The trial court dismissed the EMTALA action and this was sustained by the appellate court.<sup>323</sup>

The court wrote:

While it would be laudable for private hospitals to never transfer patients to a public hospital based on their inability to pay, EMTALA does not impose such a

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<sup>318</sup> 119 S. Ct. 685 (1999).

<sup>319</sup> The only EMTALA case to reach the United States Supreme Court. All other cases have been decided by lower courts.

<sup>320</sup> *Id.* at 686.

<sup>321</sup> *Id.* at 687 n.1. (citing *Summers v. Baptist Med Ctr. Arkadelphia*, 91 F.3d 1132, 1137-38 (CA8 1996) (en banc); *Correa v. Hospital San Francisco*, 69 F.3d 1184, 1193-94 (CA1 1995); *Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519, 522 (CA10 1994); *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 857 (CA4 1994); *Gatewood v. Washington Healthcare Corp.*, 290 U.S. App. D.C. 31, 933 F.2d 1037, 1041 (CADC 1991)).

<sup>322</sup> 998 F. Supp. 127, 1998 U.S. Dist. LEXIS 3959 (P.R. 1998).

<sup>323</sup> *Id.* at 135.

duty on participating hospitals. If the hospital complies with the adequate screening and stabilization requirements, as HM clearly did in this case, no liability arises under EMTALA. Plaintiffs attempt to impose such a duty on defendants in this case, both under EMTALA and the medical malpractice claims. However, the mere fact that a private hospital transfers a stable patient to a public hospital where she later encounters faulty medical care cannot establish a causal link between the private hospital's actions and the damages suffered by the patient.<sup>324</sup>

#### **EMTALA Conclusions:**

As Y2K approaches, it is now clear that EMTALA does not require an improper motive and that stabilization within the statute means what doctors intend when they treat patients. Further, transfers of patients may be carried out according to medical demands and physicians need not worry about getting hung up in bureaucratic kelp when they make decisions based upon medical needs. Excellent documentation is required, though, and the medical record remains crucial to any EMTALA action. After its judicial spanking following the *Cherukuri* case, DHHS may be more careful in selection of cases to prosecute.

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<sup>324</sup> *Id.*

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## Appendix (A)

### 42 U.S.C. § 1395dd; Current through P.L. 104-18, approved 7-7-95

#### § 1395dd. Examination and treatment for emergency medical conditions and women in labor

##### (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 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 (within the meaning of subsection (e)(1) of this section) exists.

##### (b) 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 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.

###### (2) Refusal to consent to treatment

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

###### (3) Refusal to consent to transfer

A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) of this section and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a

person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

**(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--

(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 (within the meaning of section 1395x(r)(1) of this title) 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 (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), 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 (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

**(2) Appropriate transfer**

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 the 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 (described in subsection (d)(1)(C) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(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.

#### **(d) Enforcement**

##### (1) Civil money penalties

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than \$50,000 (or not more than \$25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a-7a(a) of this title.

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including 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, is subject to a civil money penalty of not more than \$50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a-7a of this title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320a-7a(a) of this title.

(C) 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 (required to be maintained under section 1395cc(a)(1)(I) of this title) 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.

(2) Civil enforcement

(A) Personal harm

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

(B) Financial loss to other medical facility

Any medical facility that suffers a financial loss 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 financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions

No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with peer review organizations

In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1), the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of subchapter XI of this chapter) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review.

**(e) Definitions**

In this section:

(1) The term "emergency medical condition" means--

(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,
- (ii) serious impairment to bodily functions, or
- (iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions--

- (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
- (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term “participating hospital” means hospital that has entered into a provider agreement under section 1395cc of this title.

(3)(A) The term “to stabilize” means, with respect to an emergency medical condition described in paragraph (1)(A), to provide 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 transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term “stabilized” means, with respect to an emergency medical condition described in paragraph (1)(A), 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).

(4) The term “transfer” means 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 a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) The term “hospital” includes a rural primary care hospital (as defined in section 1395x(mm)(1) of this title).

#### **(f) Preemption**

The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

#### **(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) shall not refuse to accept an appropriate transfer of

an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

**(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.

**(i) Whistleblower protections**

A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize 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.

## Appendix (b)

### Major EMTALA Cases- from U.S.C.A.

1. Anadumaka v. Edgewater Operating Co., 823 F.Supp. 507 (N.D.Ill.1993)
2. Baber v. Hospital Corp. of America, 977 F.2d 872 (1992)
3. Ballachino v. Anders, 811 F.Supp. 121 (W.D.N.Y.1993)
4. Brewer v. Miami County Hosp., 862 F.Supp. 305, (D.Kan.1994)
5. Brooker v. Desert Hosp. Corp., 947 F.2d 412 (1991)
6. Brooks v. Maryland General Hosp., Inc., 996 F.2d 708 (1993)
7. Bryant v. Riddle Memorial Hosp., 689 F.Supp. 490 (1988)
8. Burditt v. U.S. Dept. of Health and Human Services, 934 F.2d 1362 (1991)
9. Carodenuto v. New York City Health & Hospitals Corp., 593 N.Y.S.2d 442 (1992)
10. Collins v. DePaul Hosp., 963 F.2d 303 (10<sup>th</sup> Cir. 1992)
11. Cooper v. Gulf Breeze Hosp., Inc., 839 F.Supp. 1538 (N.D.Fla.1993)
12. Dearmas v. Av-Med, Inc., 814 F.Supp.1103 (S.D.Fla.1993)
13. Deberry v. Sherman Hosp. Ass'n, 775 F.Supp. 1159 (N.D.Ill.1991)
14. Delaney v. Cade, 986 F.2d 387 (1993)
15. Deron v. Wilkins, 879 F.Supp. 603 (S.D.Miss.1995)
16. Draper v. Chiapuzio, 9 F.3d 1391 (1993)
17. Evitt v. University Heights Hosp., 727 F.Supp. 495 (1989)
18. Gatewood v. Washington Healthcare Corp., 933 F.2d 1037(1991)
19. Green v. Touro Infirmary, 992 F.2d 537 (1993)
20. Griffith v. Mt. Carmel Medical Center, 826 F.Supp. 382 (D.Kan.1993)
21. Harris v. Health & Hosp. Corp., 852 F.Supp. 701 (S.D.Ind.1994)
22. HCA Health Services of Indiana, Inc. v. Gregory, 596 N.E.2d 974 (1992)
23. Helton v. Phelps County Regional Medical Center, 817 F.Supp. 789 (E.D.Mo.1993)
24. Hines v. Adair County Public Hosp. Dist. Corp., 827 F.Supp. 426 (W.D.Ky.1993)
25. Holcomb v. Monahan, 807 F.Supp. 1526 (M.D.Ala.1992)
26. Howe v. Hull, 874 F.Supp. 779 (N.D.Ohio 1994)
27. Huckaby v. East Alabama Medical Center, 830 F.Supp. 1399 (M.D.Ala.1993)
28. Hutchinson v. Greater Southeast Community Hosp., 793 F.Supp. 6 (D.D.C.1992)
29. Johnson v. University of Chicago Hosp. 774 F.Supp. 510 ( N.D.Ill.1991)
30. Jones v. Wake County Hosp. System, Inc., 786 F.Supp. 538 (E.D.N.C.1991)
31. Kaufman v. Cserny, 856 F.Supp. 1307 (S.D.Ill.1994)
32. King v. Ahrens, 16 F.3d 265 (1994)
33. Lane v. Calhoun-Liberty County Hosp. Ass'n Inc., 846 F.Supp. 1543 (N.D.Fla.1994)
34. Lee v. Adrales, 778 F.Supp. 904 (W.D.Va.1991)
35. Matter of Baby K, 832 F.Supp. 1022 (E.D.Va.1993)
36. McIntyre v. Schick, 795 F.Supp. 777 (E.D.Va.1992)
37. Miller v. Medical Center of Southwest Louisiana, 22 F.3d 626 (1994)
38. Nichols v. Estabrook, 741 F.Supp. 325 (D.N.H.1989)
39. Owens v. Nacogdoches County Hosp. Dist., 741 F.Supp. 1269 (E.D.Te.1990)

- 40. Palmer v. Hospital Authority of Randolph County, 22 F.3d 1559 (1994)
- 41. Petrovics v. Prince William Hosp. Corp., 764 F.Supp. 415 (E.D.Va.1991)
- 42. Power v. Arlington Hosp., 800 F.Supp. 1384 (E.D.Va.1992)
- 43. Reid v. Indianapolis Osteopathic Medical Hosp., Inc., 709 F.Supp. 853 (S.D.Ind.1989)
- 44. Repp v. Anadarko Mun. Hosp., 43 F.3d 519 (1994)
- 45. Reynolds v. Mercy Hosp., 861 F.Supp. 214 (W.D.N.Y.1994)
- 46. Rogers v. Southwest Mississippi Regional Medical Center, 794 F.Supp. 198 (S.D.Miss.1992)
- 47. Ruiz v. Kepler, 832 F.Supp. 1444 (D.N.M.1993)
- 48. Smith v. Richmond Memorial Hosp., 416 S.E.2d 689 (Va.1992)
- 49. Sorrells v. Babcock, 733 F.Supp. 1189 (N.D.Ill.1990)
- 50. Stokes v. Candler Hosp., Inc., 453 S.E.2d 502 (Ga.App.1995)
- 51. Thornton v. Southwest Detroit Hosp., 895 F.2d 1131 (1990)
- 52. Tolton v. American Biodyne, Inc., 854 F.Supp. 505, (N.D.Ohio 1993)
- 53. Urban v. King, 783 F.Supp. 560 (D.Kan.1992)
- 54. Vickers v. Nash General Hosp., Inc., 875 F.Supp. 313 (E.D.N.C.1995)
- 55. Vogel v. Linde, 23 F.3d 78 (1994)
- 56. Wetzel v. Alleghany Regional Hosp. Corp., 778 F.Supp. 900 (W.D.Va.1991)
- 57. Wey v. Evangelical Community Hosp., 833 F.Supp. 453 (M.D.Pa.1993)
- 58. Williams v. Birkeness, 34 F.3d 695 (1994)

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**ELLIOTT BERNARD OPPENHEIM, MD/JD/ LL.M. HEALTH LAW**Former Physician in *Family Practice\*\*/ Emergency Medicine*\*\*Formerly **Board Certified** in Family Practice by the AMERICAN BOARD OF FAMILY PRACTICE**Education**

1965 **Pennsbury High School**, Yardley, Pennsylvania

1969 **B.A.** **Occidental College**, Los Angeles, California 9/65-6/69

1973 **M.D.** **University of California, Irvine, School of Medicine**  
Irvine, California 9/69-6/73 [with Clinical Clerkships at Oxford University (thoracic surgery) Harvard University (general surgery), Stanford University (cardiovascular surgery)]

1995 **J.D.** **Detroit College of Law**, Detroit, Michigan 8/92-6/95  
Jurisprudence Prize in Constitutional Law

1993-summer **University of Washington, School of Law-**  
school Seattle, Washington

1995-summer **Wayne State University, School of Law-**  
school Detroit, Michigan

**1996 LL.M. HEALTH LAW Loyola University School of Law,**  
Chicago, Illinois

- *Thesis: BEFORE AND AFTER: Spoliation of Evidence in Medical Negligence Litigation*
- **Supervising Editor- Journal of the National Association of Administrative Law Judges**
- Note, *Calvin v. Chater: The Right to Subpoena the Physician in SSA Cases; Conflict in the Circuits over the Interpretation of 20 C.F.R. 404.950(d)(1)*, 15 J. NAT. ASSOC. ADMIN. L. JUDGES 143 (1996).

- **CURRENT**

CEO/President- coMEDco, Inc. - a *national* corporation specializing in *medical-legal analysis*, expert referral, medical and legal litigation related research including evidentiary problems, research support, discovery, and trial consultation in advocacy techniques and strategy.

- **MEDICINE**

Family Practice and Emergency Medicine- 18 years active practice (1974-1992); *formerly* BOARD CERTIFIED **American Board of Family Practice**, Diplomate No. 18445; ACLS, APLS, ATLS Certifications; Former Member ACEP, AAFP, AMA. Formerly licensed in California and Washington.

### SIGNIFICANT MEDICAL-LEGAL CONSULTATION PROJECTS

1. *State v. Johnson*, No. 97-1-01564-9 SEA, SUP. CT. WA. (King Co., Wa.) (1997) - criminal defense of plastic surgeon charged with multiple felony counts of inappropriate conduct with patients. Convicted on only one misdemeanor count. (in consultation with Ms. Julie Spector, Attorney at Law of Seattle, WA).
2. *Cherukuri v. Shalala*, 175 F.3d 446, (6th Cir. 1999)- achieved dismissal of charges in defense of physician accused of violation of EMTALA. The doctor was fined \$100,000! (in consultation with Mr. Chad Perry, Attorney at Law, Paintsville, KY) before the Departmental Appeals Board, Washington, DC - wrote both EMTALA appeal before DAB and the brief for United States Court of Appeals for the Sixth Circuit). ("We respectfully suggest that the Board should review cases like this one closely and should not simply pass them on to a federal appellate court without providing a reasoned disposition of the objections raised by the parties." 175 F.3d 446, 455).
3. *Annon. v. Annon.*, Dallas, TX (confidentiality agreement): \$3.85 million recovered in medical negligence case concerning brain injury. Permissible details upon request. (in consultation with Ms. Alicia Slaughter, Attorney at Law, Dallas, TX).
4. *State v. Hudson*, Sedgewick Co. Dist. Ct. No. 00CR1399 (Wichita, KS) (2001) – criminal defense of man charged with child abuse / first-degree murder- acquittal on all charges. (in consultation with Mr. L.J.Leatherman, Topeka, KS).

### Recent Medical or Law Publications

- *New Standards Require Doctors to Admit Mistakes in Care*, NEW MEXICAN, July 2, 2001, B-1.
- *The Law and Ethics of Web Prescribing*, HIPPOCRATES, 44 (September 2000).
- *The Weighted Analysis of Medical Malpractice Cases*, 46(3) MED. TRIAL TECH. Q. 263 (2000).
- *New Rules on Electronic Records: HIPAA's Proposed Patient -Privacy Standards Focus on Principles*, HIPPOCRATES 22 (January 2000).
- *Staying out of Court: Cost-Free ways to Risk-Proof your Practice*, HIPPOCRATES 26 (December 1999).
- *The Law of Evidence and the Medical Record*, 2(2) J.MED.L. 167 (1999).
- *Released Against Advice*, HIPPOCRATES 20 (September 1998).
- *The Medical Record: A New Mexico Lawyer's Litigation Guide*, 4(2) BAR J. (NM) 15 (Summer 1998)
- *When Doctors Doctor the Doctor's Record: Spoliation of Evidence*, 26 N.M. TRIAL LAWYER 1 (1998).
- *A Doctor's Perspective on what the Law Should be for End-Of Life Issues*, 2(1) J.MED.L. 11 (1997).
- *EMTALA: Its First Decade; A Retrospective Analysis of 42 U.S.C. § 1395dd*, 43(4) MED. TRIAL TECH. Q. 77 (1997).
- *Scoping Out the Medical Record: The Key to Understanding Medical Care*, 51 WA. ST. B.J. 22 (1997)
- *A Review of the Emergency Medical Treatment and Active Labor Act*, 85 ILL.BAR J. 212 (1997).
- *The Baseline: Detecting the Doctored Medical Record*, 14(1) Medical Malpractice Law & Strategy 1 (November 1996).
- *A Trial Lawyer's Guide to the Medical Record*, 84 ILL. BAR J. 637 (1996).
- *The Risks of Doctoring Records*, HIPPOCRATES 34 (September 1996).
- Note, *Calvin v. Chater: The Right to Subpoena the Physician in SSA Cases; Conflict in the Circuits over the Interpretation of 20 C.F.R. 404.950(d)(1)*, 15 J. NAT. ASSOC. ADMIN. L. JUDGES 143 (1996).
- Honorable Mention- National Writing Contest of International Association of Defense Counsel (1995) for *Physicians Against Their own Patients: What Happened to the Privilege?* 63(2) DEF. COUNSEL J. 254 (1996).

- *The Trial Lawyer's EMTALA Manual*, 11(4) PROF. NEG. L.REP. 73 (1996).
- *EXAMINING MEDICAL RECORDS: How to Know What is Said When you Read What the Doctor Wrote*, 82 ABA J. 88 (1996).
- *Keeping it on the Record*, 28(2) EMERGENCY MEDICINE 87 (1996)
- *Components of a Hospital Medical Record- A Checklist*, 10 PROF. NEG. L. REP. 196 (1995).
- *The Medical Record Explained*, 6(3) OHIO TRIAL 7-12 (1995).

#### Quoted:

- Brad Burg, *Fined \$100,000 for Dumping Patients he Couldn't Treat*, MEDICAL ECONOMICS 112 (November 22, 1999) (reporting the *Cherukuri* case).

#### PRESENTATIONS / TALKS:

- Brain Fingerprinting: Is it *Daubert*-Proof? 02 May 2001 – Harvard Medical School, Department of Psychiatry, Forensic Research Group; Cambridge, MA.

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Date: 4/17/99 10:49:02 AM Mountain Daylight Time  
From: peter@thezavalettalawfirm.com (Peter M. Zavaletta)  
Reply-to: medmal@www.atlanet.org (Medical Malpractice Forum)  
To: medmal@www.atlanet.org (Medical Malpractice Forum)  
Fellow Med Mal Mates:

I just wanted to recommend Dr. Elliott Oppenheim, a frequent contributor to this list. Despite my best efforts, I was unsuccessful in finding a necessary expert for one of my cases. I contacted Elliott by phone, explained the case and what I needed. Then I overnighted the chart with a check. The next day he called with the name of a specialist and confirmed what I needed. He followed up the call with the name address, phone and email of the expert and overnighted my materials to him. The following day I had not only a 4590i expert report and CV,(required in Texas to 'keep the ball in play') but a thoughtful and passionate expert who had no trouble agreeing to join my team of testifying experts. While Dr. Oppenheim does charge for his services, for me, in this instance, they were well-worth it. Thanks again Elliott.

Peter M. Zavaletta  
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Re: Elliott Oppenheim  
Date: 4/18/99 7:14:34 AM Mountain Daylight Time  
From: AEPedersen@sheller.com (Anne Pedersen)  
Reply-to: medmal@www.atlanet.org (Medical Malpractice Forum)  
To: medmal@www.atlanet.org (Medical Malpractice Forum)

May I join in this recommendation - I had an almost identical experience, and will not take up space with the details, but Dr. Oppenheim's assistance in a short time was incredible. And no, this was not at his suggestion - indeed I haven't heard from him since he put me in touch with the expert.

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