

**“WHAT IN THE WORLD IS EMTALA?”: An Introduction to the
Emergency Medical Treatment and Active Labor Act**

INTRODUCTION

In a recent medical malpractice suit, the plaintiffs deposed a hospital employee who worked in the emergency department. The employee’s job included receiving calls from physicians at other hospitals about transferring a patient. The employee would contact an attending physician at her hospital and connect him with the transferring physician. Plaintiff’s counsel asked the employee if the patient in the subject case was stable before he left the transferring hospital. The employee said she hoped so; otherwise, the transferring hospital would have violated EMTALA. Apparently flummoxed by this response (and perhaps not realizing that he was talking out loud), plaintiffs’ counsel remarked: “What in the world is EMTALA?” There was a brief, off-the-record conversation about EMTALA, and then the deposition resumed. EMTALA was not mentioned again during the deposition or, for that matter, during the rest of the case.

It would take much more than a brief, off-the-record conversation to scratch the surface of the Emergency Medical Treatment and Active Labor Act.¹ To be sure, this article does not tackle the myriad regulations and interpretive guidelines applicable to EMTALA. Nor will it address in great detail the regulatory enforcement process for an EMTALA complaint. The goal here is to provide a general overview of the Act itself and cases interpreting it. Part I summarizes what the Act covers, and Part II examines private causes of action for an alleged EMTALA violation. Part III analyzes recent EMTALA decisions. Part IV concludes with practice tips for defending an EMTALA claim.

I. WHAT DOES EMTALA COVER?

A. History of the Act

Congress enacted EMTALA in 1986 namely to address “dumping” patients who did not have health insurance. Patient dumping is the practice “of hospital emergency rooms refusing to treat or transferring indigent patients to public hospitals without first assessing and/or stabilizing the patient’s condition.”³ Several studies in the mid-1980s showed that large numbers of uninsured patients seeking emergency treatment were transferred to public hospitals, oftentimes when they were in serious condition.⁴ Through EMTALA Congress sought to prevent patient dumping by requiring any hospital that had an emergency department and that participated in the Medicare program to “treat any patient in an emergency condition, regardless of the patient’s

¹ 42 U.S.C. § 1395dd. Unless otherwise indicated, all citations to the Act are to the current version, last amended in 2003.

³ *Rodriguez v. American Int’l Ins. Co. of Puerto Rico*, 402 F.3d 45, 47 (1st Cir. 2005); *see*. *See also* *Harry v. Marchant*, 291 F.3d 767, 772 (11th Cir. 2002).

⁴ *Karen I. Treiger, Note, Preventing Patient Dumping: Sharpening the COBRA’s Fangs*, 61 N.Y.U. L. REV. 1186, 1189-91 (1986) (citations omitted).

ability to pay.”⁵ Congress had no trouble in getting hospitals’ attention, as penalties under the Act were potentially severe. An offending hospital faced not only civil monetary penalties (originally \$25,000 per violation, now \$50,000), but also civil actions by a patient and other medical facilities that suffered a financial loss due to the violation.⁶ More significantly, if the hospital “knowingly and willfully, or negligently” violated the Act, it could lose its funding from Medicare.⁷

B. Requirements Under the Act

To prevent patient-dumping, EMTALA imposes “limited substantive requirements” on hospitals participating in Medicare.⁸ There are, in fact, two main requirements: “medical screening” and “stabilization.” The medical screening requirement arises when a patient presents to a “hospital emergency department” and requests (or someone requests for her) an “examination or treatment for a medical condition.”⁹ In such a situation, “the hospital must provide for an appropriate medical screening examination . . . to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.”¹⁰ If the hospital determines an “emergency medical condition” exists, it must provide treatment necessary to stabilize the patient, or it must transfer her as subsection (c) of the Act mandates.¹¹

The Act’s definition of “an emergency medical condition” is key. Subsection (e)(1) defines “emergency medical condition” as:

- (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in –
 - (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
 - (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.¹²

⁵ *Id.* at 1188.

⁶ 42 U.S.C. § 1395dd(d)(2)-(3) (1987 version).

⁷ 42 U.S.C. § 1395dd(d)(1) (1987 version). The First Circuit Court of Appeals has succinctly explained the legislative intent of the penalty provisions: “Needing a carrot to make health-care providers more receptive to the stick, Congress simultaneously amended the Social Security Act, conditioning hospitals’ continued participation in the federal Medicare program – a lucrative source of institutional revenue – on acceptance of the duties imposed by the new law.” *Correa v. Hosp. San Francisco*, 69 F.3d 1184, 1189-90 (1st Cir. 1995).

⁸ *Rodriguez*, 402 F.3d at 47.

⁹ 42 U.S.C. § 1395dd(a).

¹⁰ *Id.*

¹¹ 42 U.S.C. § 1395dd(b)(1).

¹² 42 U.S.C. § 1395dd(e)(1)(A)-(B).

If the hospital determines that no such condition exists, it may transfer the patient and need not comply with the Act’s “transfer rule.”¹³ Several courts have simplified the issue by stating that the Act applies if the patient “is in imminent danger of death of serious disability.”¹⁴

Another important provision is subsection (h). It precludes a hospital from delaying “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.”¹⁵ This goes to the heart of EMTALA: a patient’s ability to pay is totally irrelevant as to whether she is entitled to emergency care.

The Act does provide a hospital with two “outs,” at least regarding the stabilization requirement. First, the hospital satisfies subsection (b)(1) if it offers an examination and stabilizing treatment to a patient with an emergency medical condition, but she refuses the treatment.¹⁶ The hospital also discharges its stabilization duties if it offers to transfer the patient in accordance with the “transfer rule” and she refuses to consent to the transfer.¹⁷ In both situations, the hospital must inform the patient of the “risks and benefits” of the treatment or transfer, and it must “take all reasonable steps to secure the individual’s (or person’s) written informed consent to refuse” the same.¹⁸

As one might imagine, the Act applies to the overwhelming majority of hospitals in the country.¹⁹ This is because most hospitals not only have emergency departments—most also participate in the Medicare program.²⁰ However, it is important to note that the Act does not apply to all hospitals. Obviously, if a hospital does not have an emergency department, it is not subject to the medical screening requirement. In addition, an entity which is not a “hospital” is not subject to EMTALA.²¹

Furthermore, subsection (d), the “enforcement” subsection, merits special attention. The enforcement provisions, which include civil monetary penalties, the private right of action, and funding termination, refer only to “participating hospitals.”²² A “participating hospital” is one “that has entered into a provider agreement under section 1395cc of this title.”²³ In other words,

¹³ 42 U.S.C. § 1395dd(c)(1)-(2).

¹⁴ *E.g.*, Thornton v. Sw. Detroit Hosp., 895 F.2d 1131, 1134 (6th Cir. 1990); Rivera v. Doctors Ctr. Hosp., Inc., 247 F. Supp. 2d 90, 98 (D.P.R. 2003) (citation omitted).

¹⁵ 42 U.S.C. § 1395dd(h).

¹⁶ 42 U.S.C. § 1395dd(b)(2).

¹⁷ 42 U.S.C. § 1395dd(b)(3).

¹⁸ 42 U.S.C. § 1395dd(b)(2)-(3).

¹⁹ Trieger, *supra* note 3, at 1188 n.19., 1207 n.145.

²⁰ *Id.*

²¹ In general, a hospital means an entity that primarily engages in providing diagnostic, therapeutic, and rehabilitation services and care to inpatients. 42 U.S.C. § 1395x(e)(1); Rodriguez v. Am. Int’l Ins. Co. of Puerto Rico, 402 F.3d 45, 48-49 (1st Cir. 2005) (holding that an entity was not a hospital because it did not provide services to outpatients and Puerto Rico law did not characterize or license the entity as a hospital); Jackson v. E. Bay Hosp., 246 F.3d 1248, 1260 (9th Cir. 2001) (holding that a company that provided “administrative, purchasing, and financial services” to a hospital was not a hospital and therefore could not be held liable under EMTALA).

²² 42 U.S.C. § 1395dd(d).

²³ 42 U.S.C. § 1395dd(e)(2).

it means any hospital that receives Medicare funding. Thus, the only hospitals that are *not* subject to the Act's penalties are those that do not have an emergency department or that do not receive Medicare funding. Apparently, there are no specific penalties for a non-participating hospital that violates the Act. This is presently a very small number of hospitals;²⁴ however, in today's health insurance environment, it cannot be overlooked.

Although the Act does subject physicians to civil monetary penalties,²⁵ it does not appear that they can be sued individually under the Act. The plain language of the Act states that the "civil action" provisions refer only to actions against "participating hospitals," not physicians.²⁶ It appears that the majority of jurisdictions have so ruled, with only one court consistently allowing direct actions against physicians.²⁷

II. EMTALA LITIGATION

Before discussing EMTALA litigation, it is paramount to realize what the Act is not: it is not a federal medical malpractice statute.²⁸ Subsection (f) clarifies that the Act is not meant to supplant state law: "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."²⁹ Accordingly, a misdiagnosis in the emergency room or "faulty screening" may be actionable under state malpractice laws, but not under EMTALA.³⁰

As noted above, EMTALA imposes two requirements on participating hospitals: the medical screening requirement and the stabilization requirement. "As an enforcement mechanism for these requirements, EMTALA creates a private right of action for violations."³¹

A. The Medical Screening Requirement

When a patient comes to an emergency room and requests examination or treatment,³² EMTALA requires a participating hospital to provide an "appropriate medical screening

²⁴ Am. Hosp. Ass'n, Underpayment by Medicare & Medicaid Fact Sheet 1, <http://www.aha.org/aha/content/2006/pdf/underpaymentfs2006.pdf> (Oct. 2006) (stating that very few hospitals refuse to participate with Medicare because of tax condition exemptions and the number of Medicare patients requiring care).

²⁵ 42 U.S.C. § 1395dd(d)(1)(B).

²⁶ 42 U.S.C. § 1395dd(d)(2)(A)-(B); *see also* *Frazier v. Angel Med. Ctr.*, 308 F. Supp. 2d 671, 679 (W.D.N.C. 2004) (citation omitted).

²⁷ Melissa K. Stull, Annotation, *Construction and Application of Emergency Medical Treatment and Active Labor Act* (42 USCS § 1395dd), 104 A.L.R. FED. 166 § 8a (1991).

²⁸ *Nolen v. Boca Raton Cmty. Hosp., Inc.*, 373 F.3d 1151, 1154 (11th Cir. 2004) (citation omitted); *Merce v. Greenwood*, 348 F. Supp. 2d 1271, 1274 (D. Utah 2004) (citation omitted); *Dollard v. Allen*, 260 F. Supp. 2d 1127, 1131 (D. Wyo. 2003) (citations omitted).

²⁹ 42 U.S.C. § 1395dd(f). An example of a preempted state statute is *In re Baby "K"*, 16 F.3d 590, 597 (4th Cir. 1994), where the court found that a Virginia statute directly conflicted with EMTALA because it exempted physicians from rendering care that they consider medically or ethically inappropriate.

³⁰ *Reynolds v. MaineGeneral Health*, 218 F.3d 78, 83 (1st Cir. 2000); *Correa v. Hosp. San Francisco*, 69 F.3d 1184, 1192-93 (1st Cir. 1995); *Lane v. Wellmont Health Sys.*, 46 F. Supp. 2d 477, 479 (W.D. Va. 1999).

³¹ *Cruz-Queipo v. Hosp. Espanol Auxilio Mutuo de Puerto Rico*, 417 F.3d 67, 70 (1st Cir. 2005) (citing 42 U.S.C. § 1395dd(d)(1)-(2)).

examination within the capability of the hospital's emergency department.”³³ Although “appropriate medical screening” is not defined by the Act, “[m]ost of the courts that have interpreted the phrase have defined it as a screening examination that the hospital would have offered to any other patient in a similar condition with similar symptoms.”³⁴

Thus, a hospital may violate the EMTALA screening requirement by not applying its own screening procedures uniformly to individuals presenting with similar complaints. Evidence of a hospital’s standard procedures, such as written policies and testimony of hospital staff, will be essential in establishing a violation of the screening requirement.³⁵ In addition, contracts and records of other patients with similar conditions may provide evidence of a hospital’s standard practices.³⁶

On the other hand, mere de minimis deviations from a hospital’s procedure are probably insufficient to constitute violations of the screening requirement.³⁷ A hospital will not violate EMTALA for failing to perform examinations that are not within the particular capabilities of the hospital.³⁸ For instance, a hospital will not violate the Act’s screening requirement where it provides screening for physical but not psychiatric emergencies, so long as the hospital lacks mental health capabilities.³⁹

Furthermore, a discriminatory motive may be necessary to establish that a deviation from screening procedures violates EMTALA. The Sixth Circuit requires proof of a discriminatory motive in order for a hospital to violate the screening requirement.⁴⁰ Discrimination based on “any reason” such as political opinion, medical condition, race, sex, ethnic group, or personal dislike constitutes a discriminatory motive.⁴¹ Other courts hold that a discriminatory motive is not required or is irrelevant in determining whether an appropriate screening has been provided; thus, any variation from standard procedures, whether written or not, may constitute a violation of EMTALA.⁴² The Supreme Court has yet to resolve the issue of whether a discriminatory motive is a prerequisite to a violation of the Act’s screening requirement.

³² “Coming” to an emergency department includes entering a hospital ambulance. *Hernandez v. Starr County Hosp. Dist.*, 30 F. Supp. 2d 970, 973 (S.D. Tex. 1999). However, entering through an emergency room door alone is insufficient to constitute presentation to an emergency room where the patient is not seeking and does not request examination or treatment. *Lopez-Soto v. Hawayek*, 20 F. Supp. 2d 279, 282 (D.P.R. 1998); *Rios v. Baptist Mem’l Hosp. Sys.*, 935 S.W.2d 799, 803-04 (Tex. App. 1996).

³³ 42 U.S.C. § 1395dd(a).

³⁴ *Marshall v. E. Carroll Parish Hosp. Serv. Dist.*, 134 F.3d 319, 323 (5th Cir. 1998) (citations omitted).

³⁵ BARRY R. FURROW ET AL., *HEALTH LAW* § 10-7, 518 (2d ed. 2000).

³⁶ *Id.*

³⁷ *Feighery v. York Hosp.*, 59 F. Supp. 2d 96, 108 (D. Me. 1999).

³⁸ 42 U.S.C. § 1395dd(a).

³⁹ *Baker v. Adventist Health, Inc.*, 260 F.3d 987, 995 (9th Cir. 2001).

⁴⁰ *Cleland v. Bronson Health Care Group*, 917 F.2d 266, 272 (6th Cir. 1990).

⁴¹ *Id.* (“A hospital that provides a substandard (by its standards) or nonexistent medical screening for any reason (including, without limitation, race, sex, politics, occupation education, personal prejudice, drunkenness, spite, etc.) may be liable” for violating EMTALA’s screening requirement.)

⁴² *E.g.*, *Phillips v. Hillcrest Med. Ctr.*, 244 F.3d 790, 798 (10th Cir. 2001); *Romo v. Union Mem’l Hosp., Inc.*, 878 F. Supp. 837, 842 (W.D.N.C. 1995).

A hospital may also violate the Act if no screening is provided or the screening provided is so cursory as to not constitute a screening that is “reasonably calculated” to identify an emergency medical condition.⁴³ For example, in *Correa v. Hosp. San Francisco*,⁴⁴ the First Circuit held that the evidence supported a jury’s conclusion that a hospital effectively denied a patient a screening examination.⁴⁵ The court reasoned that the hospital’s “delay in attending to the patient was so egregious and lacking in justification as to amount to an effective denial of a screening examination.”⁴⁶ In addition, despite internal procedures requiring written documentation of visits, monitoring of vital signs, and treatment of patients with chest pains as critical, the hospital could not provide any records of the patient’s visit.⁴⁷ Therefore, the court upheld the jury’s finding that the hospital failed to provide an “appropriate medical screening.”⁴⁸

B. The Stabilization Requirement

Unless an exception applies,⁴⁹ a hospital violates EMTALA by failing to provide stabilizing treatment at all or, likewise, by failing to provide stabilizing treatment and conducting an inappropriate transfer.⁵⁰ Therefore, once a hospital determines that an emergency medical condition exists, the hospital must provide stabilizing treatment or comply with the transfer rule.⁵¹ Most courts require actual knowledge of an emergency medical condition; the duty to stabilize does not arise and is not violated where no determination of an emergency condition is made, even if the hospital should have known that an emergency medical condition existed.⁵² The key language here is in subsection (b)(1): “if any individual ... comes to a hospital *and the hospital determines that the individual has an emergency medical condition*, the hospital must provide either ... for such further medical examination and such treatment as may be required to stabilize the medical condition, or ... for transfer of the individual to another medical facility in accordance with subsection (c) of this section.” (Emphasis added.)

Additionally, presentment to an emergency room may be necessary in order for a hospital’s duty to stabilize to arise. Some courts apply a conjunctive interpretation of EMTALA; the duty to stabilize and transfer rule apply only when an individual comes to an emergency

⁴³ *Marrero v. Hosp. Hermanos Melendez*, 253 F. Supp. 2d 179, 194 (D.P.R. 2003); *Kilroy v. Star Valley Med. Ctr.*, 237 F. Supp. 2d 1298, 1306 (D. Wyo. 2002).

⁴⁴ 69 F.3d 1184 (1st Cir. 1995).

⁴⁵ *Id.* at 1193.

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ See *supra* notes 15-17 and accompanying text.

⁵⁰ 42 U.S.C. § 1395dd(c)(1)-(2). Transfer includes discharge. 42 U.S.C. § 1395dd(e)(4).

⁵¹ 42 U.S.C. § 1395dd(c)(1)-(2).

⁵² *Broughton v. St. John Health Sys.*, 246 F. Supp. 2d 764, 772 (E.D. Mich. 2003) (“[T]he circuit courts that have addressed this issue have concluded uniformly that liability for transfer or discharge under subsection (c) is predicated upon the hospital’s determination that an individual has an emergency medical condition”) (citations omitted). Suspicions, risks, and differential diagnoses have been held to be insufficient to constitute a determination of an emergency medical condition; therefore, the duty to stabilize did not arise in such circumstances. *Camp v. Harris Methodist Fort Worth Hosp.*, 983 S.W.2d 876, 880 (Tex. App. 1998); *Reynolds v. MaineGeneral Health*, 218 F.3d 78, 85 (1st Cir. 2000); *Harris v. Health & Hosp. Corp.*, 852 F. Supp. 701, 703-04 (S.D. Ind. 1994).

department and is determined to have an emergency condition.⁵³ Other courts, however, apply a disjunctive interpretation and do not require emergency room presentment.⁵⁴ These courts hold that “EMTALA would arguably apply to all hospital inpatients as well as all outpatients who receive treatment outside of the emergency department.”⁵⁵

Assuming the duty to stabilize has arisen, the hospital must provide stabilizing treatment or make an appropriate transfer. 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 from a facility, or, with respect to an emergency medical condition [of a pregnant woman having contractions], that the woman has delivered (including the placenta).”⁵⁶ Unlike the screening requirement, stabilization is not viewed from the hospital’s standard practices; instead, whether a patient is stabilized is viewed from the perspective of professional standards.⁵⁷ Thus, complying with hospital standards alone will not be sufficient to preclude violation of the EMTALA stabilization requirement.

A hospital need not fully treat a condition⁵⁸ or cure a person in order to satisfy the stabilization requirement.⁵⁹ Courts rely on many factors in determining whether a patient has been stabilized. For example, whether a patient was admitted and treated,⁶⁰ the period of time after admission,⁶¹ the judgment of the treating physician,⁶² and whether deterioration has actually occurred may factor into a determination of whether a patient was stabilized.⁶³

On the contrary, a discriminatory motive does not factor into a court’s analysis of whether a person was stabilized as defined by the Act. In *Roberts v. Galen of Va., Inc.*,⁶⁴ the Supreme Court held that proof of a discriminatory motive was not required to establish a violation of EMTALA’s stabilization requirement.⁶⁵ The Supreme Court, however, left open the question of whether a discriminatory motive was required to state a claim for violation of the screening requirement.

⁵³ Lowell C. Brown et al., *The Emergency Medical Treatment and Active Labor Act: Practical Tips and Legal Issues*, BNA § 2900.03(A) (citing *James v. Sunrise Hosp.*, 86 F.3d 885, 888 (9th Cir. 1996); *Bryan v. Rectors & Visitors of Univ. of Va.*, 95 F.3d 349 (4th Cir. 1996)).

⁵⁴ Brown, *supra* note 52 (citing *Lopez-Soto v. Hawayek*, 175 F.3d 170 (1st Cir. 1999); *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131, 1134 (6th Cir. 1990)).

⁵⁵ Brown, *supra* note 52.

⁵⁶ 42 U.S.C. § 1395dd(e)(3)(B).

⁵⁷ FURROW, *supra* note 34, at § 10-8, 520; *see also In re Baby “K,”* 16 F.3d 590, 595 (4th Cir. 1994) (“[T]he duty of the Hospital to provide stabilizing treatment for an emergency medical condition is not coextensive with the duty of the Hospital to provide an ‘appropriate medical screening.’”).

⁵⁸ *Brooker v. Desert Hosp. Corp.*, 947 F.2d 412 (9th Cir. 1991); *Frazier v. Angel Med. Ctr.*, 308 F. Supp. 2d 671, 679 (W.D.N.C. 2004).

⁵⁹ *Bergwall v. MGH Health Servs., Inc.*, 243 F. Supp. 2d 364, 374 (D. Md. 2002) (citations omitted).

⁶⁰ Admitting a patient to the hospital may end a hospital’s obligations under EMTALA, unless admitting the patient was designed to avoid the stabilization requirement. *Mazurkiewicz v. Doylestown Hosp.*, 305 F. Supp. 2d 437, 447 (E.D. Penn. 2004) (citations omitted).

⁶¹ *Bryan v. Rectors & Visitors of Univ. of Va.*, 95 F.3d 349, 352 (4th Cir. 1996).

⁶² *Bergwall*, 243 F. Supp. 2d at 376.

⁶³ FURROW, *supra* note 34, at § 10-8, 520.

⁶⁴ 525 U.S. 249 (1999).

⁶⁵ *Id.* at 253.

III. RECENT EMTALA DECISIONS

In recent cases, courts have addressed a variety of issues relating to EMTALA claims. These issues include litigation involving the screening and stabilization requirements, discovery of peer review materials, and sovereign immunity.

A. Screening

Courts have granted summary judgment to defendant hospitals because the plaintiffs failed to establish a genuine issue of material fact as to the failure to perform an “appropriate medical screening.” For example, in *Spillman v. Sw. La. Hosp. Ass’n*,⁶⁶ the plaintiff argued that the defendant failed to perform an appropriate screening and supported this assertion with expert testimony that once appendicitis is included in the differential diagnosis, it should remain a part of the diagnosis until ruled out or until referral to a surgeon.⁶⁷ The court, however, found that while the facts may support a medical malpractice claim, they did not support an EMTALA screening violation. Specifically, there was no evidence of disparate treatment.⁶⁸

The court also rejected the plaintiff’s argument that evidence of disparate treatment is impossible to obtain.⁶⁹ It may be difficult but is not impossible to obtain.⁷⁰ Evidence of a deviation from the standard treatment could be obtained from the medical records of other patients with similar symptoms.⁷¹ Therefore, the court granted summary judgment to the defendant because the patient failed to establish an issue of material fact as to whether an appropriate screening was provided.⁷²

Similarly, in *Cintron v. Pavia Hato Rey Hosp.*,⁷³ the court granted summary judgment in favor of the defendant hospital on an alleged screening violation because the plaintiff failed to create a genuine issue of material fact as to whether an appropriate screening was provided.⁷⁴ The court relied upon plaintiff’s expert’s admission that a mandatory examination was performed.⁷⁵ In addition, the court rejected plaintiff’s assertion that leaving the patient unattended in an emergency room for several hours violated the screening requirement because this was an issue for a medical malpractice claim, not an EMTALA claim.⁷⁶ Furthermore, the plaintiff failed to argue or show that the alleged essentials of an appropriate screening were within the hospital’s capabilities.⁷⁷

⁶⁶ 2007 WL 1068489 (W.D. La 2007).

⁶⁷ *Id.* at *11.

⁶⁸ *Id.* at *13.

⁶⁹ *Id.* at *12.

⁷⁰ *Id.*

⁷¹ *Id.* at *12-13 (citation omitted).

⁷² *Id.* at *16.

⁷³ 492 F. Supp. 2d 29 (D.P.R. 2007).

⁷⁴ *Id.* at 35.

⁷⁵ *Id.* at 34-35.

⁷⁶ *Id.*

⁷⁷ *Id.* at 35.

Finally, in *Garrett v. Detroit Med. Ctr.*,⁷⁸ the plaintiff created an issue of material fact as to whether a substandard screening was performed in accordance with the defendant hospital's own procedures, where it was alleged that at least one physician suspected a pulmonary embolism but failed to follow hospital procedure to confirm or rule out the diagnosis.⁷⁹ However, the court awarded summary judgment to the hospital because the plaintiff failed to establish a genuine issue of material fact as to whether the hospital had an improper motive for treating the patient differently.⁸⁰ The court rejected the plaintiff's argument that an improper motive was demonstrated by the hospital's "out-of-network" status with the patient's insurance carrier and the hospital's transfer of the patient in accordance with the insurance carrier's request.⁸¹ The court reasoned that there was no evidence that the hospital improperly initiated a transfer, that the hospital delayed treatment, that the procedure was unusual, or that the patient would have been treated differently if he had "in network" insurance.⁸² Furthermore, the evidence showed that several tests were ordered, a diagnosis was made, and a screening was provided shortly after the patient's arrival.⁸³

On the other hand, summary judgment was denied in *Isaac-Burgos v. Rodriguez*⁸⁴ where the plaintiff produced affidavits stating that the patient's wife told a screener and physician the patient was suffering from chest pains and had a prior history of heart disease.⁸⁵ Inferring from this evidence that the hospital "knew" of the patient's chest pains, the court concluded that an issue existed as to whether the hospital's procedures were followed because a patient with chest pains would be classified as a "category 1" patient (not a "category 3") and placed on a "chest pain protocol" with repeat tests.⁸⁶ In addition, despite the emergency department's manual requiring screening by a nurse or physician, the patient was screened by a person who attended a foreign medical school and did not have a license to practice medicine.⁸⁷

Likewise, both parties' motions for summary judgment were denied in *Romar v. Fresno Cmty. Hosp. & Med. Ctr.*⁸⁸ The plaintiff's expert identified thirty patients who she contended were "similarly situated" with the patient but received superior screenings. On the other hand, the defendant's expert contended that no patients in the records produced were "similarly situated" with the patient.⁸⁹ The court distinguished an earlier case, *Hoffman v. Tonnemacher*,⁹⁰ which held that a patient was not "similarly situated" with other patients because they did not share certain "key symptoms."⁹¹ *Hoffman* involved uncontradicted medical testimony, whereas in *Romar*, the plaintiff and defendant presented conflicting expert testimony.⁹² Therefore, the

⁷⁸ 2007 WL 789023 (E.D. Mich. 2007).

⁷⁹ *Id.* at *11.

⁸⁰ *Id.* at *15-16.

⁸¹ *Id.* at *14-15.

⁸² *Id.*

⁸³ *Id.* at *15.

⁸⁴ 485 F. Supp. 2d 14 (D.P.R. 2007).

⁸⁵ *Id.* at 20.

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ 2007 WL 911880 (E.D. Cal. 2007).

⁸⁹ *Id.* at *55-56.

⁹⁰ *Hoffman v. Tonnemacher*, 425 F. Supp. 2d 1120 (E.D. Cal. 2006).

⁹¹ *Romar*, 2007 WL 911880, at *36-37.

⁹² *Id.* at *38.

court concluded that there was a question of fact as to whether the patient received a disparate screening.⁹³

B. Stabilization

Recent cases involving the stabilization requirement have addressed whether the plaintiff provided evidence sufficient to withstand summary judgment regarding the defendant's actual knowledge of an emergency medical condition. In two recent cases, courts have awarded summary judgment to the defendant hospitals. In *Spillman v. Sw. La. Hosp. Ass'n*,⁹⁴ the court rejected the plaintiff's argument that a presumptive diagnosis amounted to actual knowledge and a duty to stabilize. The court was "unable to find nor does the plaintiff cite any cases which support the theory that a presumptive diagnosis triggers a hospital's duty to stabilize or transport under the EMTALA."⁹⁵

Similarly, in *Garrett v. Detroit Med. Ctr.*,⁹⁶ the defendant hospital obtained summary judgment because the plaintiff failed to present evidence that the hospital had actual knowledge of an emergency medical condition.⁹⁷ The plaintiff contended that a differential diagnosis of a pulmonary embolism could be an emergency medical condition. She did not allege "that this condition was an emergency medical condition that was not stabilized at the time of transfer."⁹⁸ In essence, the plaintiff argued that the defendant should have conducted more tests to determine whether such condition existed before the patient's transfer.⁹⁹ The court concluded that this amounted to an assertion that the hospital "should have known" of an emergency medical condition and, therefore, did not constitute a violation of EMTALA's stabilization requirement.¹⁰⁰

However, in *Heimlicher v. Steele*, the court denied defendant's motion for new trial and motion for judgment as a matter of law where a 34-week pregnant patient was brought to the hospital by ambulance complaining of vaginal bleeding, abdominal pain and premature uterine contractions, but was transferred to a facility 100 miles away.¹⁰¹ The court concluded the hospital was imputed with the knowledge of the emergency room physician, who examined the patient, documented her condition was an emergency medical condition and completed the portion of the transfer form for justifying the transfer of an unstabilized patient, as well as the hospital's employed nurse, who witnessed the form.¹⁰² The court further found the patient had not requested transfer, nor had the physician properly certified that the benefits of transfer

⁹³ *Id.* at *39.

⁹⁴ 2007 WL 1068489 (W.D. La. 2007).

⁹⁵ *Id.* at *15.

⁹⁶ 2007 WL 789023 (E.D. Mich. 2007).

⁹⁷ *Id.* at *17-18.

⁹⁸ *Id.*

⁹⁹ *Id.* at *18.

¹⁰⁰ *Id.*

¹⁰¹ 2009 WL 1361164 (N.D. Iowa 2009).

¹⁰² *Id.* at *9.

outweighed the risks.¹⁰³ The court felt the physician “justif[ied] the transfer with nonexistent ‘benefits’ and ‘risks,’ and ignor[ed] the true foreseeable risks of the transfer...”¹⁰⁴

Similarly, in *Isaac-Burgos v. Rodriguez*,¹⁰⁵ the court concluded that a genuine issue of fact existed as to whether a hospital violated the stabilization requirement.¹⁰⁶ As noted above, the court inferred that the hospital “knew” that the patient was suffering from chest pain because the patient’s wife stated that she informed the screener and a physician of this fact.¹⁰⁷ Likewise, the court inferred that the hospital had “the obligation to stabilize the medical condition causing the chest pain.”¹⁰⁸ The court stated that the hospital failed to treat the patient’s chest pain and underlying heart condition and that when the patient left the hospital “he was urinating uncontrollably, disoriented, and ‘could hardly walk.’”¹⁰⁹ Therefore, the court denied defendant’s motion for summary judgment as to the stabilization claim.¹¹⁰

C. Discovery of Peer Review Materials

The Eastern District Court of Michigan addressed the issue of whether peer review materials were relevant and thus discoverable where a patient alleged violations of the screening and stabilization requirements of EMTALA and medical malpractice under state law.¹¹¹ The plaintiff argued that the peer review materials were relevant to the EMTALA claim and that the state statute protecting peer review materials did not apply.¹¹² After stating that federal law governed discovery relating to the EMTALA claim, the court concluded that the documents were not relevant to the alleged screening and stabilization violations “because EMTALA is not intended to be a federal malpractice action.”¹¹³ Therefore, the court denied plaintiff’s motion to compel discovery of peer review materials.¹¹⁴

Regarding stabilization, the court noted that the peer review materials, “which may include a post-mortem conference designed to address whether staff *should have known* of some underlying condition,” were not relevant to whether the hospital had “actual knowledge” of an emergency medical condition.¹¹⁵ The court rejected a broad reading of the Act that would require stabilizing treatment “outside the context of a transfer [or discharge].”¹¹⁶ Thus, because the patient was admitted, treated, and hospitalized for six or seven days, the court found that the peer review documents were not relevant to the stabilization claim.¹¹⁷ The court also noted that some courts have allowed discovery of peer review materials where they did not look to the

¹⁰³ *Id.* at *11-16.

¹⁰⁴ *Id.* at *15.

¹⁰⁵ 485 F. Supp. 2d 14 (D.P.R. 2007).

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Moses v. Providence Hosp. & Med. Ctrs., Inc.*, 2007 WL 1806376 at *5-6 (E.D. Mich. 2007).

¹¹² *Id.* at *7.

¹¹³ *Id.* at *6-7.

¹¹⁴ *Id.* at *11.

¹¹⁵ *Id.* at *8-9 (emphasis supplied).

¹¹⁶ *Id.* at *9-10.

¹¹⁷ *Id.* at *10.

relevance of the subject matter of the claim or concluded there was no basis for recognizing a medical peer review privilege. However, the court stated that even if the documents were relevant, courts would “generally look to state law” as a guide for whether peer review materials are privileged.¹¹⁸

Similarly, the Southern District Court of Texas recently held that if peer review documents at issue are not relevant to an EMTALA claim, but only to a Texas-law negligence claim, then Texas privilege law applies. If peer review documents are relevant to the federal as well as the state claim, then federal privilege law governs.¹¹⁹ The Court further indicated it was “[a]pplying the approach adopted by the majority of courts considering the issue.”¹²⁰

D. Sovereign Immunity

In *Johnson v. Virginia*,¹²¹ the issue arose as to whether the Eleventh Amendment’s sovereign immunity for states barred suit under EMTALA against the state and a state arm, i.e., the operator of a state university hospital.¹²² Sovereign immunity would be unavailable if Congress abrogated the immunity, the state waived its immunity, or in an action for injunctive or declaratory relief against individual state officers.¹²³ After noting that the third exception (injunctive relief against state officers) did not apply, the court addressed the other two exceptions and concluded that Congress had not expressed its intent to abrogate state immunity from suit under EMTALA and that the state had not expressly or impliedly consented to such suit.¹²⁴

Regarding the first exception, the court noted that “all relevant cases” have concluded that Congress has not “unequivocally expressed” its intent to abrogate state immunity from suit under EMTALA and that Congress could not abrogate states’ immunity when acting pursuant to its power for enacting EMTALA.¹²⁵ As to the second exception, the court concluded that the state’s Tort Claims Act did not amount to an express waiver of Eleventh Amendment immunity.¹²⁶

Additionally, the court rejected the argument that the state had impliedly consented to suit under EMTALA by “fil[ing] an agreement with the federal government ‘to adopt and enforce a policy to ensure compliance with the requirements of [EMTALA]’” which is required of participating hospitals by the Social Security Act.¹²⁷ The court reasoned that

[h]ere, Congress is conditioning participation on a hospital's agreeing to adopt and enforce a policy that complies with EMTALA. Failure to do so means only that

¹¹⁸ *Id.* at *10-11 n.4.

¹¹⁹ *Guzman v. Memorial Hermann Hosp. System*, 2009 WL 427268 at *7 (S.D. Tex 2009).

¹²⁰ *Id.*

¹²¹ 2007 WL 1556555 (W.D. Va. 2007).

¹²² *Id.* at *5-6.

¹²³ *Id.* at *7.

¹²⁴ *Id.* at *7 n.3, *22.

¹²⁵ *Id.* at *9-10 (citations omitted).

¹²⁶ *Id.* at *11.

¹²⁷ *Id.* at *11-12.

the hospital may no longer receive federal funds. It cannot be said that a state-run hospital has agreed to be sued based on breach of the agreement; instead, it would be more fair to say that the state-run hospital has agreed to stop receiving federal reimbursement should it breach the agreement.¹²⁸

Finally, the court pointed out that unlike a state's grant of immunity, under the Supremacy Clause Eleventh Amendment immunity "trumps federal law," including EMTALA.¹²⁹ Therefore, while EMTALA may preempt a state's grant of immunity because it directly conflicts with EMTALA, Eleventh Amendment immunity is not preempted by EMTALA.¹³⁰

IV. EMTALA LITIGATION PRACTICE TIPS

Beyond EMTALA's screening and stabilization requirements, issues may arise as to federal jurisdiction, the statute of limitations, and incorporation and preemption of state law. As to jurisdiction, courts have consistently held that an EMTALA claim may be brought in federal or state court.¹³¹ Counsel should keep in mind that a medical malpractice claim alone is insufficient to confer federal jurisdiction; however, a federal court may determine that it has ancillary jurisdiction over state law claims, including medical malpractice claims, if an EMTALA claim is asserted based on the same operative facts.¹³²

EMTALA also provides a two year statute of limitations for claims based on the Act.¹³³ An EMTALA action accrues from the date of violation, and the Act does not contain a tolling provision.¹³⁴ Several courts have held that state tolling provisions are preempted by and do not toll the limitations period for EMTALA claims.¹³⁵ For example, state statutes that toll the running of the limitations period until after discovery have been held not to apply to EMTALA claims.¹³⁶

Finally, issues may arise as to whether the Act incorporates state law such that it applies to EMTALA claims and whether state law directly conflicts with and is preempted by the Act.¹³⁷ Two main questions must be dealt with in this regard. The first issue relates to recoverable damages. EMTALA provides that an individual plaintiff 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."¹³⁸ Some courts have held that EMTALA incorporates state statutory caps on the recovery of malpractice damages, thereby limiting the amount of damages

¹²⁸ *Id.* at *19.

¹²⁹ *Id.* at *21.

¹³⁰ *Id.* at *20-21.

¹³¹ Stull, *supra* note 26, § 3a (citations omitted).

¹³² Stull, *supra* note 26, § 3b (citing Sorrells v. Babcock, 733 F. Supp. 1189 (N.D. Ill. 1990)).

¹³³ 42 U.S.C. § 1395dd(d)(2)(C).

¹³⁴ *Id.*

¹³⁵ Saltares v. Hosp. San Pablo Inc., 371 F. Supp. 2d 28, 35 (D.P.R. 2005) (citations omitted).

¹³⁶ *Id.* at 35 ("State law statute of limitations, accrual principles, and tolling provisions should not be applied when, as here, they run counter to EMTALA's statutory goal of protecting patients rights to emergency medical care.").

¹³⁷ 42 U.S.C. § 1395dd(f).

¹³⁸ 42 U.S.C. § 1395dd(d)(2)(A).

recoverable for EMTALA claims. For example, in *Smith v. Botsford Gen. Hosp.*,¹³⁹ the Sixth Circuit held that Michigan's statutory cap on malpractice damages applied to an EMTALA stabilization claim because such action constituted a malpractice action under Michigan law.¹⁴⁰ Other courts, however, have refused to incorporate state malpractice limits on damages.¹⁴¹ Furthermore, courts have held that state immunity statutes do not apply to¹⁴² or directly conflict with and are preempted by EMTALA's provision for the recovery of damages.¹⁴³

Another issue involves whether state procedural requirements apply to EMTALA claims and whether they are preempted by EMTALA. If a state procedural requirement is broad enough to encompass an EMTALA claim, a court may apply the procedural requirement if it does not directly conflict with EMTALA.¹⁴⁴ However, a court may find that a state procedural requirement is not broad enough to encompass an EMTALA claim or that it directly conflicts with and therefore is preempted by EMTALA.¹⁴⁵

Special attention should be paid to peer review issues. Hospital risk management departments and peer review committees are well-advised not to assume that the protection normally provided by state peer review statutes applies in the EMTALA setting. It does not appear that EMTALA ignores the work product privilege; of course, any material counsel seeks to protect as work product must have been obtained in anticipation of litigation.¹⁴⁶ In any event, hospital defense attorneys should be cognizant of the federal and state case law in his/her jurisdiction regarding peer review and be prepared to advise hospital clients accordingly.

CONCLUSION

EMTALA must always be on the mind of attorneys who represent and defend hospitals. While courts stress that EMTALA is not a federal medical malpractice statute, it nonetheless does focus on the specific acts of health care providers in an emergency department setting. This article hopefully provides a framework for helping hospital attorneys recognize those situations

¹³⁹ 419 F.3d 513 (6th Cir. 2005), *cert. denied*, 126 S. Ct. 1912 (2006).

¹⁴⁰ 419 F.3d at 519; *see also* *Lee v. Alleghany Reg'l Hosp. Corp.*, 778 F. Supp. 900, 903-04 (W.D. Va. 1991) (holding that Virginia's statutory cap on damages in medical malpractice actions applies to EMTALA claims).

¹⁴¹ *Cooper v. Gulf Breeze Hosp., Inc.*, 839 F. Supp. 1538, 1543 (N.D. Fla. 1993) (refusing to apply Florida's statutory limit on medical malpractice damages to EMTALA claims where limits were based on pre-suit procedure).

¹⁴² *Lane v. Calhoun-Liberty County Hosp. Ass'n Inc.*, 846 F. Supp. 1543, 1551-52 (N.D. Fla. 1994) (holding that Florida's Good Samaritan Act, for acts of simple negligence, did not apply to EMTALA claims because EMTALA neither relies on nor incorporates state malpractice law).

¹⁴³ *Helton v. Phelps County Reg'l Med. Ctr.*, 817 F. Supp. 789, 791-92 (E.D. Mo. 1993). However, immunity under the Eleventh Amendment may still apply. *See supra* pp. 11-12; *see also* *Ward v. Presbyterian Healthcare Servs.*, 72 F. Supp. 2d 1285, 1293 (D.N.M. 1999).

¹⁴⁴ For example, where compliance with EMTALA's statute of limitations and state notice-of-claim provisions is possible, courts have concluded that such provisions do not directly conflict with and therefore are not preempted by EMTALA. *Hardy v. N.Y. City Health & Hosps. Corp.*, 164 F.3d 789, 795 (2d Cir. 1999); *Draper v. Chiapuzio*, 9 F.3d 1391, 1394 (9th Cir. 1993).

¹⁴⁵ *E.g.*, *Merce v. Greenwood*, 348 F. Supp. 2d 1271, 1274-77 (D. Utah 2004) (finding that Utah's notice-of-claim requirement combined with tolling of the statute of limitations for a pre-litigation review process directly conflicted with and thus were preempted by EMTALA); *Brooks v. Md. Gen. Hosp., Inc.*, 996 F.2d 708, 717 (4th Cir. 1993) (holding that a state law requiring arbitration procedures for medical malpractice claims does not apply to EMTALA claims).

¹⁴⁶ *See* FED. R. CIV. P. 26(b)(3).

to which EMTALA does and does not apply, as well as practice pointers for handling EMTALA claims.