IN DEFENSE OF THE MASSES — AN INTERPRETATION OF THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT: *IN RE BABY K*

INTRODUCTION

In 1986, the United States Congress passed the Emergency Medical Treatment and Active Labor Act ("EMTALA") in an effort to prevent hospitals receiving Medicare funds from dumping indigent or uninsured patients.[1] However, in drafting EMTALA itself, Congress used language that allows "any individual" who presents at a hospital emergency room to invoke the protection of EMTALA when a hospital refuses to screen or stabilize the individual's condition.[2] The difference between EMTALA's legislative history and its plain language has sparked judicial debate as to the appropriate scope of EMTALA.[3]

Recently, the United States Court of Appeals for the Fourth Circuit addressed that very question in deciding *In re Baby K* ("*Baby K*").[4] *Baby K* involved a request by the Hospital for court permission to discontinue resuscitation of an anencephalic infant who periodically experienced respiratory distress as a result of her anencephalic condition and presented at the Hospital's emergency room in need of stabilizing treatment.[5] The Hospital argued that such a refusal of treatment would not violate EMTALA because Baby K was not an "individual" as contemplated by the terms of EMTALA.[6] The Fourth Circuit held EMTALA did indeed apply to all individuals, including anencephalic infants, and determined that the Hospital had a duty under EMTALA to prevent a material deterioration in Baby K's condition.[7]

1. 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, 608 (1994); *see* Appendix for the full text of EMTALA.
2. 42 U.S.C. § 1395dd (1993). Fell, 43 CATH. U. L. REV. at 609-10.
3. 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).
4. 16 F.3d 590, 598 (4th Cir. 1994), *cert. denied*, 115 S. Ct. 91 (1994).
5. *See In re Baby K*, 16 F.3d 590, 592 (4th Cir. 1994), *cert. denied*, 115 S. Ct. 91 (1994). Because the parties requested anonymity in these proceedings, all information which could identify them was omitted from the opinion, and the parties are referred to by anonyms. *Id.* at 592 n.1.
6. *Baby K*, 16 F.3d at 603.
7. *Id.* at 596; Elizabeth G. Patterson, *Human Rights and Human Life: An Uneven Fit*, 68 TUL. L. REV. 1527, 1540 (1994).

This Note will begin by discussing how and why the court reached its decision in *Baby K*.[8] This Note will next inquire into the background of the passage of EMTALA, the subsequent circuit court case history interpreting EMTALA's application, and the debate surrounding the legal status of anencephalic infants.[9] This Note will then argue that the court's stance in interpreting *Baby K* was correct because the language of EMTALA is plain as shown by other circuit court decisions.[10] This Note concludes that the court's decision clearly swings the balance of the circuit courts in favor of an interpretation of EMTALA which applies its provisions to all individuals regardless of economic or legal status.[11]

FACTS AND HOLDING

FACTUAL BACKGROUND

Baby K was born on October 13, 1992, at the Hospital.[12] Physicians at the Hospital diagnosed Baby K as anencephalic, having only a brain stem and lacking a major portion of her brain, scalp, and skull.[13] Because she did not have a functioning cerebral cortex, Baby K, like other anencephalic infants, was permanently unconscious upon birth, and could not see, hear, feel pain, or interact with her environment.[14]

8. *See infra* notes 12-78 and accompanying text.
9. *See infra* notes 79-237 and accompanying text.
10. *See infra* notes 243-98 and accompanying text.
11. *See infra* notes 299-324 and accompanying text.
12. *In re* Baby K, 832 F. Supp. 1022, 1024-25 (E.D. Va. 1993), *aff'd*, 16 F.3d 590 (4th Cir. 1994), *cert. denied*, 115 S. Ct. 91 (1994).
13. *In re* Baby K, 16 F.3d 590, 592 (4th Cir. 1994), *cert. denied*, 115 S. Ct. 91 (1994). In anencephalic infants, the brain's development is arrested. Kathleen L. Paliokas, Note, *Anencephalic Newborns as Organ Donors: An Assessment of "Death" and Legislative Policy*, 31 WM. & MARY L. REV. 197, 197 (1989). As a result, the cerebral hemispheres or even the entire brain are missing. *Id.* In most cases, the lower brain stem still develops and can maintain important reflexive functions such as respiration and heartbeat for hours or days following birth. *Id.*

There is a growing debate surrounding the constitutional rights that should be accorded anencephalic infants. Elizabeth G. Patterson, *Human Rights and Human Life: An Uneven Fit*, 68 TUL. L. REV. 1527, 1540 (1994). Because anencephalic infants possess neither a past nor a future as part of a group or community of individuals, their legal status is difficult to define. *Id.* at 1541. The two cases dealing with this issue have accorded anencephalic infants the same legal rights and equal status as indistinguishable from the rights of other infants. *Id.* at 1555; *Baby K*, 16 F.3d at 603; *In re* T.A.C.P., 609 So. 2d 588, 594-95 (Fla. 1992)).

14. Brief of Appellee at 3, *In re* Baby K, 16 F.3d 590 (4th Cir. 1994) (No. 93-1899(L)), *cert. denied*, 115 S. Ct. 91 (1994). Although Baby K is permanently unconscious, she does have a functioning brain stem. *Id.* Therefore, she exhibits a variety of reflexive actions — respiration, feeding (sucking, swallowing, rooting), and avoidance or crying in response to noxious stimuli. *Id.* Additionally, Baby K has normal blood pressure, heart rate, digestion, and liver, kidney, and bladder functions. *Id.* Significantly, Baby K has gained weight in the months following her birth. *Id.*

Immediately following birth, Baby K experienced breathing difficulties, and physicians provided respiratory support by placing her on a mechanical ventilator.[15] This procedure allowed physicians time to confirm their diagnosis of Baby K's condition and to counsel Baby K's mother, Ms. H.[16] Because most anencephalic infants die within hours or days of birth and because the condition of anencephaly is irreversible, the physicians recommended only supportive care (nutrition, hydration, and warmth) as well as a "Do Not Resuscitate" order.[17] However, Ms. H demanded that mechanical assistance be given to Baby K whenever she lapsed into respiratory distress.[18] The Hospital and treating physicians insisted that such extraordinary care for an anencephalic infant was inappropriate and violated the prevailing standard of care for anencephalic infants.[19]

This impasse led the Hospital to attempt a transfer of Baby K to another hospital with pediatric intensive care facilities.[20] All of the other area hospitals refused to accept Baby K.[21] When Baby K's condition stabilized and she no longer required respiratory assistance or

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15. *Baby K*, 16 F.3d at 592.

16. *Id.* Baby K's father, Mr. K, is not married to Ms. H and had no involvement in Baby K's life until the original action was filed in the United States District Court for the Eastern District of Virginia. Brief of Appellee at 5, *Baby K* (No. 93-1899(L)); *Baby K*, 832 F. Supp. at 1025.

17. *Baby K*, 16 F.3d at 592-93; Karen P. Long, *Whose Life is it, Anyway? Debate Rages on Baby K; Kept Alive for Two Years, Child Cannot See, Hear, Think or Feel*, THE PLAIN DEALER, Oct. 9, 1994, at 1A. The Hospital believed and maintains that lifesaving or other extraordinary treatment measures would be futile as such treatment succeeds only in prolonging Baby K's process of dying. Brief of Appellants at 15, *In re* Baby K, 16 F.3d 590 (4th Cir. 1994) (No. 93-1899(L)), *cert. denied*, 115 S. Ct. 91 (1994). After meeting with treating physicians, an Ethics Committee subcommittee consisting of a family practitioner, a minister, and a psychiatrist, concluded on October 22, 1992, that the treatment should be terminated after waiting a reasonable period for the family to help the Hospital end aggressive therapy. *Baby K*, 832 F. Supp. at 1025. The committee's recommendation should Ms. H refuse to accept its conclusion was to resolve the conflict through the legal system. *Id.*

18. *Baby K*, 16 F.3d at 593; Frances H. Miller, *Infant Resuscitation, a US/UK Divide*, 343 THE LANCET 1584 (1994); Jane Bryant Quinn, *This Litigation an Unhealthy Cure for Care*, PITTSBURGH POST-GAZETTE, July 11, 1994, at B8; *Let Baby K Die in Peace*, HARTFORD COURANT, Oct. 7, 1994, at A18. Ms. H's insistence on continued treatment for Baby K stems from her own strong religious convictions that all of life is valuable and should be preserved, that only God and not humans should determine the time of death, and that as Baby K's mother and only guardian, she has the moral and legal right to choose the medical treatment which she believes is in her daughter's best interests. Brief of Appellee at 5, *Baby K* (No. 93-1899 (L)).

19. *Baby K*, 16 F.3d at 593. Standard medical treatment for anencephalic infants is "supportive care in the form of appropriate nutrition, hydration, and warmth, and to permit the devastating condition to take its natural course." Brief of Appellants at 5, *Baby K* (No. 93-1899 (L)). The Hospital stipulated that its position had nothing to do with any lack of resources or Ms. H's ability or inability to pay for the medical treatment that she continued to request. *Baby K*, 832 F. Supp. at 1026.

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

21. *Id.*

other acute care, the Hospital transferred her to a long-term nursing home.[22] After her transfer to the nursing home, Baby K experienced additional episodes of respiratory distress, requiring readmittance to the Hospital for stabilizing treatment.[23]

On March 15, 1993, the Hospital readmitted Baby K, and she underwent a tracheotomy, a surgical procedure in which a breathing tube was placed in her windpipe.[24] The purpose of the surgery was to make mechanical ventilator treatment easier for Baby K to tolerate.[25] Following this surgery and the subsequent stabilization of her condition, the Hospital again transferred Baby K to the Nursing Home, where she currently resides.[26]

THE DECISION OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA

The Hospital, Mr. K, and the guardian ad litem brought a declaratory judgment action in the United States District Court for the Eastern District of Virginia to determine whether the Hospital was required by the Emergency Medical Treatment and Active Labor Act ("EMTALA") to continue to provide ventilator treatment for Baby K when she experienced respiratory distress.[27] The district court first addressed the applicability of EMTALA in determining whether to grant the Hospital's request.[28] The Hospital admitted that Baby K, while experiencing respiratory distress, would meet EMTALA's crite-

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22. *Id.* The maintenance of reflexive functions in anencephalic infants is tenuous. Paliokas, 31 WM. & MARY L. REV. at 197. Because these infants only have, at most, the brain stem, they are not capable of higher brain coordination. *Id.* As a result, the infants frequently forget to breathe. *Id.* These episodes of respiratory distress occur more and more often and cause irreversible damage to the body as organs are deprived of blood and oxygen. *Id.*

23. *Baby K*, 932 F. Supp. at 1025.

24. *Id.* at 1025-26. The operation took place after Baby K's second episode of respiratory distress. *Id.* at 1025. Ms. H consented to this operation. *Id.* at 1026.

25. Brief of Appellee at 3-4, *Baby K* (No. 93-1899 (L)). While Baby K has not required mechanical breathing assistance since the tracheotomy, if she does in the future, the doctors need only to attach an air bag to the surgically implanted breathing tube. *Id.* Additionally, the procedure eased Baby K's breathing difficulties. *Id.*

26. *Baby K*, 832 F. Supp. at 1026. The Nursing Home's acceptance of Baby K was conditioned upon the Hospital's willingness to accept Baby K in the event that she again developed breathing difficulty and needed assistance beyond the facilities available at the Nursing Home. Brief of Appellants at 6 n.2, *Baby K* (No. 93-1899 (L)).

27. *Baby K*, 832 F. Supp. at 1026; 42 U.S.C. § 1395dd (1993); *see* appendix.

The Hospital sought relief under one state statute and four federal statutes: the Virginia Medical Malpractice Act (Va. Code § 8.01-581.1 et seq.), the Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd), the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 et seq.), and the Child Abuse Amendments of 1984 (42 U.S.C. § 5102 et seq.). *Baby K*, 832 F. Supp. at 1026.

28. *Baby K*, 832 F. Supp. at 1026.

ria of an emergency medical condition requiring stabilization to prevent serious impairment of bodily functions.[29] The Hospital also admitted that ventilator treatment was the treatment administered in cases of respiratory distress and would be required to assure no substantial deterioration in Baby K's condition.[30]

However, the Hospital argued that it should be exempted from the requirements of EMTALA because of what it termed the futility and inhumanity of such treatment for anencephalic infants.[31] However, the court, finding no exceptions for futility or inhumanity in the plain language of EMTALA applying to any individual, held the Hospital subject to the treatment requirements of EMTALA.[32]

The district court next turned to the Rehabilitation Act of 1973 ("Rehabilitation Act") which prevents discrimination targeting handicapped individuals solely because of the individual's specific handicap.[33] Under the Rehabilitation Act, the term "handicapped individual" includes infants suffering congenital defects.[34] Because the Hospital admitted that its protests to treatment of Baby K rested solely on her anencephalic handicap and its accompanying respiratory condition, the court found that Baby K was qualified to receive breathing assistance under the Rehabilitation Act, despite her poor future health prospects.[35]

The court also addressed the applicability of the Americans with Disabilities Act ("ADA") because the ADA prohibits places of public accommodation from discriminating against handicapped individu-

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29. *Id.* The Hospital, however, stated that Baby K's breathing difficulties were only a manifestation of her underlying anencephalic condition and evidence of her brain stem's declining ability to control her breathing reflexes. Brief of Appellant at 9, *Baby K* (No. 93-1899(L)).

30. *Baby K*, 832 F. Supp. at 1026-27.

31. *Id.* at 1027.

32. *Id.* The district court stated that "[t]o hold otherwise would allow hospitals to deny emergency treatment to numerous classes of patients, such as accident victims who have terminal cancer or AIDS, on the grounds that they eventually will die anyway from those diseases and that emergency care for them would therefore be 'futile'." *Id.*

33. *Baby K*, 832 F. Supp. at 1027; 29 U.S.C. § 794 (1994). The Rehabilitation Act of 1973 provides in relevant part:

> Nondiscrimination under Federal grants and programs; promulgation of rules and regulations.
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> (a) Promulgation of nondiscrimination rules and regulations; copies to appropriate carriers. No otherwise qualified individual with a disability in the United States, as defined in section 7(8), shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activiity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service. . . .

29 U.S.C. § 794 (1994).

34. 29 U.S.C. § 794 (1994); *see supra* note 33; *Baby K*, 832 F. Supp. at 1027 (quoting Bowen v. American Hosp. Ass'n, 476 U.S. 610, 624 (1986)).

35. *Baby K*, 832 F. Supp. at 1027-28.

als.[36] Specifically, the ADA defines a handicap or disability as "a physical or mental impairment that substantially limits one or more of the [individual's] major life activities."[37] The Hospital argued that the ADA did not apply because of the futility of treating Baby K's inherently fatal anencephalic condition.[38] The court stated that anencephaly constituted a disability within the terms of the ADA because the condition affected an infant's ability to talk, see, and walk as well as an infant's neurological functioning.[39] The court determined that the ADA's plain language protecting individuals and classes of individuals from the denial of an entity's services did not permit the withholding of the mechanical ventilator from Baby K when the Hospital would have provided such treatment at the parents' request to an infant without anencephaly.[40]

The district court also addressed the Child Abuse Amendments of 1984 ("Child Abuse Act").[41] The Child Abuse Act allows state child protective services agencies receiving federal grants for programs involving child abuse and neglect to file legal actions preventing the medical neglect of handicapped infants.[42] This statutory language makes the Virginia Child Protective Services a necessary party to any

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36. *Id.* at 1028; 42 U.S.C. § 12182 (1994). The Americans with Disabilities Act provides in relevant part:

> (a) General rule. No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.

42 U.S.C. § 12182(a) (1994).

37. 42 U.S.C. § 12102(2) (1994); *see supra* note 36.

38. *Baby K*, 832 F. Supp. at 1029.

39. *Id.* at 1028.

40. *Id.* at 1028-29.

41. *Id.* at 1029; 42 U.S.C. § 5102 et seq. (1994). The Child Abuse Amendments of 1984 provide in relevant part:

> (2) Representation. The Secretary shall appoint members from the general public under paragraph (1) (B) who are individuals knowledgeable in child abuse and neglect prevention, intervention, treatment, or research, and with due consideration to representation of ethnic or racial minorities and diverse geographic areas, and who represent —
> (A) law (including the judiciary);
> (B) psychology (including child development);
> (C) social services (including child protective services);
> (D) medicine (including pediatrics);
> (E) State and local government;
> (F) organizations providing services to disabled persons;
> (G) organizations providing services to adolescents;
> (H) teachers;
> (I) parent self-help organizations;
> (J) parents' groups; and
> (K) voluntary groups.

42 U.S.C. § 5102(c)(2) (1994).

42. 42 U.S.C. § 5102(c)(2) (1994).

action filed under the Child Abuse Act.[43] The court found that because the Hospital, the guardian ad litem, and Mr. K had failed to join the Virginia Child Protective Services as a party, it could not rule under the Child Abuse Act that the Hospital could refuse to provide extraordinary care to Baby K without incurring liability.[44]

Finally, the Hospital protested continued treatment of Baby K on the grounds that such treatment violated the Virginia Medical Malpractice Act ("Malpractice Act").[45] The Malpractice Act authorizes Virginia physicians to refuse to prescribe treatment that the physician believes to be ethically and medically inappropriate, provided the physician makes a reasonable effort to procure another physician for those patients who still demand the treatment.[46] Because the Virginia state courts had not addressed the issue of the appropriate standard of care and possible exceptions to that standard for babies with anencephaly and because the state legislature had promulgated no statutes in that regard, the court abstained from ruling on the applicability of the state code provision.[47]

After the court handed down its factual findings, conclusions of law, and denial of relief requested, the Hospital, Baby K's guardian ad litem, and Mr. K perfected their appeal to the United States Court of Appeals for the Fourth Circuit.[48]

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43. *Baby K*, 832 F. Supp. at 1029.

44. *Id.* The Hospital protested that the Virginia Child Protective Services was not a necessary party to the action and that, even if it were, Ms. H failed to raise its absence as an affirmative defense. Brief of Appellants at 35, *Baby K* (No. 93-1899(L)).

45. *Baby K*, 832 F. Supp. at 1029; VA. CODE ANN. § 54.1-2990 (Michie 1994). The Virginia Health Care Decisions Act states in relevant part:

> § 54.1-2990. Medically unnecessary treatment not required; mercy killing or euthanasia prohibited.
>
> Nothing in this article shall be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be medically or ethically inappropriate. However, in such a case, if the physician's determination is contrary to the terms of an advance directive of a qualified patient or the treatment decision of a person designated to make the decision under this article, the physician shall make a reasonable effort to transfer the patient to another physician. Nothing in this article shall be construed to condone, authorize or approve mercy killing or euthanasia, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

VA. CODE ANN. § 54.1-2990 (Michie 1994).

46. VA. CODE ANN. § 54.1-2990 (Michie 1994); *see supra* note 45.

47. *Baby K*, 832 F. Supp. at 1029-30. The district court also addressed the constitutional concerns of parental rights, the right to life, and freedom of religion, stating, "Reflecting the constitutional principles of family autonomy and the presumption in favor of life, courts have generally scrutinized a family's decision only where the family has sought to terminate or withhold medical treatment for an incompetent minor or incompetent adult." *Id.* at 1030-31.

48. *Baby K*, 16 F.3d at 593. The Hospital, Baby K's guardian ad litem, and Mr. K are collectively referred to throughout the United States Court of Appeals for the Fourth Circuit's opinion as "the Hospital". *Id.*

THE DECISION OF THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

In addressing the issue of whether the Hospital was required to provide treatment to Baby K beyond the supportive care of warmth, hydration, and nutrition, the United States Court of Appeals for the Fourth Circuit considered only the duty of the Hospital arising under EMTALA.[49] The Fourth Circuit held that EMTALA obligated the Hospital to provide respiratory assistance to Baby K when she arrived at the Hospital, exhibiting respiratory distress, and when her mother requested treatment for her.[50]

The court reached this conclusion by examining and applying the plain language of EMTALA.[51] The court stated that although the legislative history indicated that Congress passed EMTALA to prevent hospitals from dumping patients because they were unable to pay for medical services, other courts have since ruled that EMTALA applies to all patients.[52]

The court stated that Congress imposed two duties through EMTALA on hospitals receiving Medicare funds.[53] First, hospitals having emergency rooms must appropriately screen every individual who arrives at the emergency room requesting treatment, and these screenings must determine whether the individual suffers from an emergency medical condition.[54] Second, if an emergency medical condition is diagnosed during screening, the hospital must either stabilize the individual or transfer the patient in accordance with EMTALA.[55]

The Hospital admitted that when Baby K suffered respiratory distress and arrived at the emergency room, failure to provide prompt medical services would reasonably be expected to seriously impair her bodily functions.[56] To avoid the result of a plain language interpretation of EMTALA, the Hospital offered four arguments on its appeal to the Fourth Circuit.[57] The Hospital argued that the district court (1) construed EMTALA to require a particular treatment rather than im-

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49. *Baby K*, 16 F.3d at 592.

50. *Id.* The Fourth Circuit refused to address the applicability of the other federal statutes and the Virginia laws addressed by the lower court, because the court held that the Hospital was obligated to render stabilizing treatment according to the plain language of EMTALA. *Id.* at 591 n.2.

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

52. *Id.* at 593 (citing Baber v. Hospital Corp. of Am., 977 F.2d 872, 880 (4th Cir. 1992); Brooker v. Desert Hosp. Corp., 947 F.2d 412, 415 (9th Cir. 1991); Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1040 (D.C. Cir. 1991); Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 268 (6th Cir. 1990)).

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

54. *Id.*

55. *Id.* at 593-94. For transfer provisions, *see* appendix.

56. *Baby K*, 16 F.3d at 594.

57. *Id.* at 595.

posing a prohibition on disparate treatment; (2) ignored the standard of care provided to anencephalic infants as shown by the evidence; (3) failed to recognize that physicians under state law can refuse to administer treatment the physicians believe to be ethically and medically unwarranted; and (4) ignored relevant language applying EMTALA only to patients who, although unstable, are transferred by hospitals.[58]

The court noted that the Hospital's arguments were unpersuasive.[59] First, while the Hospital argued that EMTALA only required the Hospital to provide Baby K with the same care it would provide any other anencephalic infant, the court stated that the plain language of EMTALA did not permit the Hospital to fulfill the duty of administering stabilizing treatment merely by providing uniform treatment.[60] Instead, the court determined that the Hospital had a duty to provide whatever treatment was required to prevent every patient from materially deteriorating as a result of an emergency medical condition.[61]

In response to the Hospital's second argument that the lower court ignored the customary care provided to anencephalic infants as shown by the evidence, the court replied that "[t]he Hospital has been unable to identify, nor has our research revealed, any statutory language or legislative history evincing a Congressional intent to create an exception to the duty to provide stabilizing treatment when the required treatment would exceed the prevailing standard of medical care."[62] Regardless of whether respiratory assistance to Baby K exceeded the prevailing standard of care for anencephalic infants, the court refused to ignore EMTALA's plain language requiring stabilizing treatment for emergency medical conditions.[63]

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58. Brief of Appellants at 11, *Baby K* (No. 93-1899(L)).

59. *Baby K*, 16 F.3d at 595.

60. *Id.* The Hospital suggested that Baby K's treatment could be limited to supportive care — the warmth, hydration, and nutrition the physicians would prescribe for any other anencephalic infant. Brief of Appellants at 14, *Baby K* (No. 93-1899(L)). The court stated that to give credence to this position would allow the Hospital to provide any amount of care it wished to Baby K, including treatment that would lead to a material deterioration of her condition, as long as the Hospital provided the same low level of treatment to other anencephalic infants. *Baby K*, 16 F.3d at 596.

61. *Baby K*, 16 F.3d at 603.

62. *Id.*

63. *Id.* As the appellee stated in her brief:

> What the Hospital wants is court authorization to refuse *acute care* based on a patient's chronic condition. This argument has no support in the language or legislative history of EMTALA, and it runs afoul of judicial decisions requiring hospitals to provide emergency medical care under the statute to patients who have already been admitted.

Brief of Appellee at 14, *Baby K* (No. 93-1899(L)) (emphasis in original).

With regard to the Hospital's third contention that the lower court's interpretation of EMTALA failed to recognize a Virginia physician's right to refuse to provide treatment that the physician deems medically or ethically inappropriate, the court simply concluded that the state law was "pre-empted" by EMTALA.[64] EMTALA itself states that it pre-empts local or state laws that directly conflict with EMTALA.[65]

Finally, in reply to the Hospital's fourth argument that EMTALA applied only to the transfer of unstabilized patients, the court determined that the word "transfer" described the responsibility of hospitals to stabilize the patient prior to discharge or to prevent significant deterioration of the condition during transfer.[66] The court stated that the duty to stabilize should not be limited to those situations in which the patient will be transferred to a different facility.[67] The court determined that to provide for such an interpretation of EMTALA would allow hospitals to sidestep liability by refusing to treat a patient after screening simply because the patient would not or could not be transferred.[68]

The court concluded by stating as follows:

> EMTALA does not carve out an exception for anencephalic infants in respiratory distress any more than it carves out an exception for comatose patients, those with lung cancer, or those with muscular dystrophy — all of whom may repeatedly seek emergency stabilizing treatment for respiratory distress and also possess an underlying medical condition that severely affects their quality of life and ultimately may result in their death. Because EMTALA does not provide for such an exception, the judgment of the district court is affirmed.[69]

Senior Circuit Judge James M. Sprouse dissented from the court's decision.[70] Judge Sprouse pointed to the legislative history of EMTALA in stating that the courts should limit EMTALA to those cases of a hospital's refusal to care for uninsured or indigent emergency pa-

64. *Baby K*, 16 F.3d at 597. By its terms, the Virginia statutory provision relied upon by the Hospital in making this argument is limited to the Health Care Decisions Act. *Id.* at 597 n.10. This Act deals only with medical directives given by adults or surrogate decisions for medical treatment made on behalf of adults. *Id.* The Act does not deal with these types of decisions made for infants. *Id.*

65. *Baby K*, 16 F.3d at 597; 42 U.S.C. § 1395dd(f) (1993).

66. *Baby K*, 16 F.3d at 597-98.

67. *Id.*

68. *Id.* at 598.

69. *Id.*

70. *Id.* (Sprouse, J., dissenting).

tients.[71] Consequently, Judge Sprouse argued that the case fell outside the scope of the anti-dumping provisions of EMTALA.[72]

Additionally, Judge Sprouse argued that Baby K was not suffering from the types of conditions contemplated by EMTALA.[73] Instead of considering the episodes of respiratory failure as the condition to be screened, Judge Sprouse asserted that the court should have reviewed the underlying condition of anencephaly.[74] Judge Sprouse justified his position by stating that anencephaly involves health care choices that are different even from the decisions necessitated by other terminal diseases.[75] Judge Sprouse specifically cited Baby K's permanently unconscious state as evidence that no medical treatment would ever improve her condition and to support his argument that Baby K's treatment was part of a continuum of care rather than part of a series of discrete, individual emergency medical conditions.[76] Given the particular facts surrounding Baby K's anencephalic condition, Judge Sprouse argued that the court should have viewed another instance of respiratory distress as integral to Baby K's anencephaly.[77] In Judge Sprouse's view, failure to stabilize would then not be a violation of EMTALA because any treatment for Baby K's breathing difficulty would be considered part of the continuum of treatment for the non-emergency medical condition of anencephaly rather than for the clearly emergency medical condition of respiratory distress, thereby exempting the Hospital from EMTALA's requirements in the case of Baby K and other anencephalic infants.[78]

BACKGROUND

THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT

Congress passed the Emergency Medical Treatment and Active Labor Act ("EMTALA") in 1986.[79] EMTALA represents Congress' attempt to deal with the increasing problem of patient dumping in hos-

71. *Id.*
72. *Id.*
73. *Id.* at 599 (Sprouse, J., dissenting). Judge James M. Sprouse indicated that those health care emergencies contemplated by the language of EMTALA do not include the continuing emergencies that anencephalic patients experience. *Id.* at 598-99.
74. *Baby K*, 16 F.3d at 599 (Sprouse, J., dissenting).
75. *Id.*
76. *Id.*
77. *Id.* Judge Sprouse advocated a case-by-case approach which could yield different results based upon the condition suffered by the individual presenting at the emergency room of a hospital. *Id.*
78. *Baby K*, 16 F.3d at 599 (Sprouse, J., dissenting).
79. 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, 608 (1994); *see supra* note 1 and accompanying text.

pitals around the country.[80] Patient dumping by hospitals encompasses such actions as blatant denial of emergency room care to transferring unstabilized patients from one hospital emergency room to another simply for economic reasons.[81] These federal restrictions prohibiting inappropriate transfers of emergency care patients apply to all physicians and hospitals receiving funding from the federal government.[82]

EMTALA's legislative history clearly reveals that Congress intended to prevent patient dumping for economic reasons.[83] However, the specific language of EMTALA does not reference economic concerns.[84] Instead, EMTALA applies to "any individual" who seeks emergency medical treatment.[85]

The language of EMTALA enumerates three basic guarantees to individuals seeking emergency medical treatment.[86] First, EMTALA requires hospitals to conduct a screening examination, within the abilities of their emergency staffs and departments, for any individual who demands such an examination, in order to determine whether the requesting individual suffers from an emergency medical condition.[87]

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80. Fell, 43 CATH. U. L. REV. at 608-09. Generally, the hospital accused of patient dumping has refused to treat an emergency room patient although capable of providing the requested care for one of three reasons: first, the patient does not possess sufficient medical insurance; second, the uninsured patient cannot pay for the costs of treatment through non-insurance resources; and third, the hospital considers the patient to be undesirable as a long-term patient for any of a variety of other reasons. Diana K. Falstrom, Comment, *Decisions Under the Emergency Medical Treatment and Active Labor Act: A Judicial Cure for Patient Dumping*, 19 N. KY. L. REV. 365, 365 (1992). Patient dumping may also occur based upon a patient's race, appearance, or ethnicity. Fell, 43 CATH. U. L. REV. at 607 n.1.

81. Fell, 43 CATH. U. L. REV. at 608.

82. *Id.* 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, 1127 (1992). Some researchers suggest that the scope of the Emergency Medical Treatment and Active Labor Act affects 98% of United States hospitals participating in Medicare. 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).

83. Fell, 43 CATH. U. L. REV. 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.

84. Fell, 43 CATH. U. L. REV. at 610; *see* appendix.

85. 42 U.S.C. § 1395dd (1993); *see* apendix.

86. *See infra* notes 87-90 and accompanying text.

87. 42 U.S.C. § 1395dd(a) (1993); *see* appendix.

Second, if the medical screening results in the diagnosis of an emergency medical condition, a hospital must either provide stabilizing treatment within the capabilities of its facilities or transfer the individual to another hospital.[88] Finally, a hospital cannot transfer an individual to another facility before the individual has been stabilized unless the individual requests such a transfer in writing with full information and a physician determines in writing that the benefits of the transfer outweigh the risks or another qualified medical person makes this balancing determination because the physician is not present in the emergency department.[89] Additionally, the transfer must be appropriate; that is, the transferring hospital has to treat the individual within its abilities so as to minimize risks to the individual during transfer, *and* the receiving facility has to have space and qualified personnel and must have agreed to accept the transfer and provide the necessary medical treatment.[90]

Despite the clear and unambiguous language of EMTALA extending its provisions to all individuals, the courts are divided as to whether to follow the plain language of the statute or the legislative history that so heavily emphasizes economic dumping as the impetus for the drafting of EMTALA.[91]

CASE LAW INTERPRETATION OF EMTALA

In the years following the passage of EMTALA, the administrative agencies authorized by Congress with the enforcement of EMTALA have provided little in the way of regulatory policies.[92] This lack of regulations necessitated the reliance by the health care industry and the judicial system on a relatively small portion of federal case law and on the language of EMTALA itself in interpreting the statute.[93]

The Scope of EMTALA Extended to All Individuals

Fourth Circuit Decisions

In *Baber v. Hospital Corporation of America*,[94] the United States Court of Appeals for the Fourth Circuit addressed the scope of EMTALA's application.[95] Brenda Baber, a woman with a history of mental illness, presented herself to the Raleigh General Hospital

88. 42 U.S.C. § 1395dd(b)(1) (1993); *see* appendix.
89. 42 U.S.C. § 1395dd(c)(1) (1993); *see* appendix.
90. 42 U.S.C. § 1395dd(c)(1)(B) (1993); *see* appendix.
91. Stricker, 67 NOTRE DAME L. REV. at 1122.
92. Bitterman, 70 U. DET. MERCY L. REV. at 128.
93. Stricker, 67 NOTRE DAME L. REV. at 1129-30.
94. 977 F.2d 872 (4th Cir. 1992).
95. Baber v. Hospital Corp. of Am., 977 F.2d 872, 881 (4th Cir. 1992).

("RGH") emergency room in the company of her brother, Barry Baber.[96] Brenda exhibited symptoms of nausea, agitation, fear that she might be pregnant, and lack of orderly thought patterns.[97] She refused to remain on the stretcher and could not be restrained without exacerbating her symptoms and, while roaming the hallways, suddenly convulsed and fell, striking her head, losing consciousness for a brief period, and then requiring stitches.[98] The attending physician continued to observe Brenda following her fall and remained convinced that her symptoms were indicative of a psychotic relapse, believing her seizure to be linked to her mental illness.[99] After conferring with her former psychiatrist, the attending physician transferred her to Beckley Appalachian Regional Hospital's ("BARH") psychiatric ward where she had a grand mal seizure.[100] Brenda was transferred back to RGH in a comatose state and later died from an apparent intracerebrovascular rupture.[101]

Barry, as administrator of Brenda's estate, filed suit in the United States District Court for the Southern District of West Virginia against the two physicians, RGH, BARH, and the two hospitals' parent corporations, alleging violations of EMTALA.[102] The parties charged the doctors, hospitals, and the hospitals' parent corporations with a failure to provide Brenda with an appropriate medical screening as defined by EMTALA as well as a failure to stabilize her before transfer.[103] The district court granted summary judgment in the physicians' favor, finding that, while EMTALA did allow for civil suits against participating hospitals, no section of EMTALA gave rise to a private cause of action against treating or attending physicians.[104]

On appeal to the United States Court of Appeals for the Fourth Circuit, Barry argued that RGH's emergency room staff failed to pro-

96. *Id.* at 875-76. Brenda Baber had a past history of severe mental disorder (undifferentiated schizophrenia) associated with lapses into extreme alcohol abuse and had stopped taking her anti-psychosis medications. *Id.*

97. *Baber*, 977 F.2d at 875.

98. *Id.* The patient remained easy to arouse and disturb following her head injury; her disorientation and speech blurrings the doctor attributed to her mental condition. *Id.*

99. *Baber*, 977 F.2d at 875-76. The attending doctor refused to conduct x-rays or a CT scan despite Barry Baber's request that his sister be x-rayed, stating that such procedures were only employed in cases of serious head injury and feeling that such tests would be better conducted after the underlying psychosis was treated at the receiving hospital. *Id.* at 876.

100. *Baber*, 977 F.2d at 875-76. The RGH had no psychiatric facility but did have a neurosurgeon; BARH had a psychiatric ward but no neurosurgeon. *Id.* at 876.

101. *Baber*, 977 F.2d at 876.

102. *Id.* at 873. In this case, RGH was the transferring hospital and BARH was the receiving hospital. *Id.* at 874.

103. *Baber*, 977 F.2d at 874.

104. *Id.* at 877.

vide Brenda with an appropriate medical screening and transferred her prior to stabilization.[105] The Fourth Circuit affirmed the district court's ruling, stating that EMTALA's purpose was not to guarantee proper diagnosis of all patients during the process of medical screening, but rather to provide a satisfactory first response to situations of medical crisis and 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."[106]

The court also noted that EMTALA did not define the elements of an appropriate medical screening.[107] The court then determined that, in the absence of a statutory definition and given EMTALA's emphasis upon identifying critical conditions and applying that screening process equally to all patients with like complaints, EMTALA's requirement of an appropriate medical screening was satisfied as long as every patient suffering from the same problem or demonstrating the same symptoms received identical screening procedures.[108]

In applying this interpretation to Barry's complaint, the court noted that the doctors and hospitals had conducted a medical screening of Brenda which did not deviate in any significant way from its standard screening procedures.[109] The court stated that Brenda was initially evaluated and screened in the emergency room of RGH and was checked and rechecked before and after her fall.[110] The court also commented that the attending physician in his medical judgment determined that Brenda's exhibited symptoms did not indicate a serious head injury but were instead symptomatic of Brenda's mental condition.[111] Additionally, the court noted that Barry made no claims of disparate treatment.[112] The court held that the actions of the hospitals and physicians satisfied the court's definition of an appropriate medical screening and did not result in the diagnosis of an emergency medical condition.[113]

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105. *Id.* at 878.

106. *Id.* at 880 (quoting 131 CONG. REC. S13904 (Oct. 23, 1985) (statement of Sen. Durenberger)).

107. *Id.* at 879.

108. *Id.* at 879 n.6. The court also firmly refused to find that Congress had intended to establish a national standard of medical care. *Id.* at 880.

109. *Baber*, 977 F.2d at 882. The court also affirmed the district court's grant of summary judgment for the defendants with regard to the stabilization and transfer issues, finding that the transfer requirements were not implicated where the hospital's medical screening did not bring to light an emergency medical condition. *Id.* at 883-84.

110. *Baber*, 977 F.2d at 881.

111. *Id.*

112. *Id.* at 880 n.8.

113. *Id.* at 881. The court ended its opinion by stating, "It is enough for the purposes of EMTALA that none of the evidence demonstrates an attempt by RGH or BARH

In *Brooks v. Maryland General Hospital, Inc.*,[114] the court stated that EMTALA does not cover the field of state medical malpractice law, but instead provides a cause of action for plaintiffs who receive disparate treatment in hospital emergency rooms for any reason.[115] Robert Brooks went to the Maryland General Hospital ("MGH") in Baltimore, suffering from acute weakness and an inability to walk that had manifested itself suddenly.[116] Brooks possessed no health insurance.[117] Six hours after arrival, he was examined for the first time but received no evaluation or treatment.[118] Approximately thirteen hours after arrival, he was administered certain tests.[119]

Brooks brought suit in the United States District Court for the District of Maryland under EMTALA, alleging that the delays he experienced in the diagnosis and stabilization of his condition resulted in permanent damage to his spinal cord, necessitated surgery, and necessitated a lengthy rehabilitation.[120] The defendants argued that the Maryland Malpractice Act required the dismissal of Brooks' complaint because he had failed to enter into arbitration.[121] The district court granted the defendants' motion to dismiss.[122]

On appeal, the Fourth Circuit determined that the Maryland Malpractice Act was inapplicable to the case because it applied only to complaints that the community's standard of care had been breached; claims that were not alleged by Brooks.[123] Brooks' claim was aimed at the disparate treatment he allegedly experienced in the MGH emergency room.[124] The court stated the following in a footnote:

> While it appears that EMTALA was enacted because of Congress' concern about the growing practice of hospitals "dumping" emergency room patients who had no insurance and could not afford to pay, the language of EMTALA does not require a showing that a claimant is uninsured or indigent, nor does it provide that the hospital breaches EMTALA's duties only when it acts with economic motives. Rather, the language of EMTALA imposes its duties in re-

to 'dump' Ms. Baber; instead hospital personnel treated her for what they perceived to be her medical condition." *Id.* at 885.

114. 996 F.2d 708 (4th Cir. 1993).

115. Brooks v. Maryland Gen. Hosp., Inc., 996 F.2d 708, 714 (4th Cir. 1993).

116. *Id.* at 709.

117. *Id.*

118. *Id.*

119. *Id.* The tests were not read for three more days, apparently due to some technical difficulties. *Id.*

120. *Brooks*, 996 F.2d at 709.

121. *Id.* at 709-10.

122. *Id.*

123. *Id.* at 713.

124. *Id.*

spect of "any individual" who is presented to an emergency room for examination or treatment of a medical condition.[125]

Additionally, the court stated that EMTALA was not aimed at creating a national standard of care for addressing potential medical malpractice, but instead that EMTALA's core purpose was to address disparate treatment.[126] As the court determined, the legislative history clearly documented that Congress expected to fill a gap found in state law by imposing upon hospitals and their emergency departments a limited duty to provide emergency care to every individual seeking care from the emergency rooms.[127]

Decisions of Other Circuits

In *Cleland v. Bronson Health Care Group, Inc.*,[128] the United States Court of Appeals for the Sixth Circuit held Congress to its chosen language and applied EMTALA to any individual.[129] Mr. and Mrs. Cleland brought their son, who was complaining of vomiting and cramps, to the Bronson Methodist Hospital's emergency room where he was diagnosed with influenza, stabilized, and released with instructions for his care.[130] Later that night, the Clelands' son was returned to the hospital where he experienced cardiac arrest and died of what was posthumously diagnosed as an intussusception, a condition where a part of his intestine telescoped within itself.[131] Subsequently, the Clelands brought suit in the United States District Court for the Western District of Michigan, alleging violations of state medical malpractice laws and of EMTALA.[132]

The district court dismissed the action because it found that the Clelands' son was not indigent or uninsured so as to prevent the application of EMTALA.[133] However, while the Sixth Circuit affirmed the lower court's dismissal of the case, it did so upon different grounds.[134] Instead, the court interpreted EMTALA's requirement of an "appropriate medical screening" as "a screening that the hospital would have offered to any paying patient" and EMTALA's term "emergency medical condition" as "a condition within the actual knowledge

125. *Id.* at 711 n.4.
126. *Id.* at 713.
127. *Id.* at 714-15. For another United States Court of Appeals for the Fourth Circuit opinion involving EMTALA, *see* Vogel v. Linde, 23 F.3d 78, 79 (4th Cir. 1994) (finding that EMTALA violations claims were barred by EMTALA's statute of limitations).
128. 917 F.2d 266 (6th Cir. 1990).
129. Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 268 (6th Cir. 1990).
130. *Id.* at 269.
131. *Id.* at 268-69.
132. *Id.*
133. *Id.* at 268.
134. *Id.*

of the doctors on duty or those doctors that would have been provided to any paying patient."[135] In other words, because the evidence did not indicate the care provided the Clelands' son was based upon anything but the physician's best medical judgment, the court found no deficiency in the patient's screening or treatment.[136] The court specifically stated that, while EMTALA's legislative history revealed Congress' concern about treatment of uninsured and indigent patients, its language plainly exhibited no such limitation in its application, despite the lower court's findings.[137]

The court stated that EMTALA did not apply because the patient's treatment was not based upon the patient's characteristics, such as race, sex, financial condition, national origin, social status, or politics.[138] The court reasoned that the evidence showed that the outcome of the treatment Cleland's son received would have been the same, regardless of any different characteristics so exhibited, and therefore EMTALA was not violated by the attending physician's actions.[139] The court concluded its opinion with a sweeping statement regarding the applicability of EMTALA.[140] According to the court, "[a] hospital that provides a substandard (by its standards) or nonexistent medical screening for any reason (including, without limitation, race, sex, politics, occupation education, personal prejudice, drunkenness, spite, etc.) may be liable under this section."[141]

In *Gatewood v. Washington Healthcare Corp.*,[142] the United States Court of Appeals for the District of Columbia Circuit addressed the scope of the provisions of EMTALA.[143] Mr. Gatewood presented himself to the Washington Hospital Center's ("WHC") emergency room, complaining of pain radiating along his left arm and in his chest.[144] After the attending physician diagnosed the pain as musculoskeletal in nature and instructed him to use a heating pad and Tylenol to alleviate the pain and to call his own physician for an ap-

135. *Id.*

136. *Id.* at 269.

137. *Id.* The court stated that "there is no principle of construction that Congress may not similarly write a statute that is far broader than any area of concern that it has conceived of or has had brought to its attention." *Id.*

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

139. *Id.*

140. *Id.*

141. *Id.* at 272. The court listed other characteristics that constituted unacceptable reasons for differentiated treatment, including prejudice, sex, ethnic groups, personal dislike between personnel and patient, disapproval of the patient's job, political opposition, cultural opposition, or distaste for the patient's condition such as AIDS. *Id.*

142. 933 F.2d 1037 (D.C. Cir. 1991).

143. Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1038 (D.C. Cir. 1991).

144. *Id.* at 1039.

pointment, the physician discharged him.[145] Mr. Gatewood died the following morning from a heart attack.[146]

Mrs. Gatewood sued, alleging a violation of EMTALA for the emergency room physician's misdiagnosis of her husband's condition.[147] The district court dismissed Mrs. Gatewood's case, finding that, because Mr. Gatewood was fully insured, EMTALA did not provide a cause of action for his misdiagnosis during his stay at the emergency room.[148]

While the District of Columbia Circuit affirmed the district court's summary judgment, it did so for different reasons, specifically stating that whether or not an individual has health insurance is not relevant to the success of a claim under EMTALA, because EMTALA by its own terms applies to any individual.[149] Instead, the court concluded that EMTALA simply does not provide an individual with a federal cause of action for state-based allegations of negligence or medical malpractice where a patient has been misdiagnosed.[150]

The District of Columbia Circuit stated that EMTALA's purpose is not to guarantee a correct diagnosis for every emergency room patient, but instead to provide the same procedures for screening and treatment to each patient.[151] Therefore, the court stated that any departure by a hospital or its staff from the institution's usual screening procedures for any reason whatsoever constitutes a violation of EMTALA.[152] The court reasoned that, because Mr. Gatewood was screened according to WHC's standard procedures and was not diagnosed with an emergency medical condition based upon that screening, EMTALA was not violated and no cause of action was alleged under the provisions of EMTALA.[153]

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145. *Id.*

146. *Id.*

147. *Id.* at 1038.

148. *Id.*

149. *Id.* at 1039. The court determined that it was bound by the plain statutory language of EMTALA that clearly made no distinction between insured and uninsured patients who presented themselves to emergency rooms. *Id.* at 1040-41.

150. *Gatewood*, 933 F.2d at 1041. EMTALA was not intended to create a federal pre-emption of existing state tort law causes of action, but instead creates a new cause of action not presently available in state malpractice or negligence law for a failure to treat a patient. *Id.*

151. *Gatewood*, 933 F.2d at 1041. The court emphasized that EMTALA does not seek an outcome based result; that is, the success or failure of treatment in a particular case is not relevant as long as the same screening and treatment procedures were employed. *Id.*

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

153. *Id.*

EMTALA's Civil Suit Enforcement Provisions

The specific enforcement provisions found in the language of EMTALA were addressed in *Burditt v. United States Department of Health & Human Services.*[154] In *Burditt*, the United States Court of Appeals for the Fifth Circuit upheld a $20,000 fine levied against Dr. Michael L. Burditt.[155]

On December 5, 1986, Rosa Rivera presented herself at the DeTar Hospital emergency room, experiencing contractions which were three minutes apart in addition to having ruptured membranes and extremely high blood pressure.[156] After learning over the telephone that Rivera had no regular doctor, no means of payment, and a dangerous condition, Dr. Burditt told the nurse to prepare Rivera for transfer.[157] Evidence showed that Rivera's blood pressure was the highest he had ever seen.[158] Dr. Burditt examined Rivera only once and told the nurse to prepare her for transfer despite the potential of a low birth weight and the strong possibility of delivery complications created by Rivera's high blood pressure.[159] Although presented with EMTALA guidelines, Dr. Burditt refused to read them, signed a certification without looking at the document or listing reasons why the benefits of transfer outweighed the risks, did not conduct a re-examination although he saw Rivera being wheeled out to the ambulance, and did not instruct the ambulance to take along specialized neonatal equipment.[160] Rivera safely delivered a healthy baby enroute to the receiving hospital.[161]

In light of Dr. Burditt's summary transfer of Rivera to another hospital while Rivera was experiencing an arguably emergency medical condition, the Department of Health and Human Services brought an action against Dr. Burditt before an administrative law judge.[162] The administrative law judge fined Dr. Burditt $20,000 for violating the transfer provisions of EMTALA.[163] The Department of Health

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154. 934 F.2d 1362, 1376 (5th Cir. 1991).

155. Burditt v. United States Dep't of Health & Human Servs., 934 F.2d 1362,1366 (5th Cir. 1991).

156. *Id.*

157. *Id.* The hospital that Dr. Michael L. Burditt wanted to accept transfer was over 170 miles from DeTar Hospital. *Id.*

158. *Burditt*, 934 F.2d at 1366.

159. *Id.*

160. *Id.* at 1367.

161. *Id.* The nurse accompanying the patient ordered the ambulance back to DeTar where Dr. Burditt insisted that the patient be dismissed if she was not bleeding excessively. *Id.* After urging from a hospital official, Dr. Burditt allowed the patient to remain at the hospital under another physician's care. *Id.* Three days later, she was dismissed in good condition with a healthy baby. *Id.*

162. *Burditt*, 934 F.2d at 1367.

163. *Id.*

and Human Services affirmed the administrative law judge and Dr. Burditt appealed to the Fifth Circuit, alleging in pertinent part that the record did not evidence conduct violative of EMTALA.[164]

The Fifth Circuit affirmed the Department of Health and Human Services findings that a proper medical screening under EMTALA had occurred as an emergency medical condition (severe hypertension) was diagnosed.[165] The court stated that because Rivera was in active labor and her hypertension might have interfered with the baby's delivery, Dr. Burditt had two options under EMTALA: (1) he could have stabilized her; or (2) he could have transferred her without stabilizing her if he did so in compliance with EMTALA.[166] The court held that the certification lacked legal effect, because Dr. Burditt signed the certification for transfer as a mere formality rather than actually weighing the risks and benefits of transferring this particular patient.[167] As a result, the court affirmed the fine levied against Dr. Burditt.[168]

EMTALA's Stabilization Requirement Defined

The United States Court of Appeals for the Sixth Circuit first addressed stabilization issues under the terms of EMTALA in *Thornton v. Southwest Detroit Hospital*.[169] Elease Thornton, after suffering a stroke, was transferred to the emergency room at Southwest Detroit Hospital ("SDH") and spent ten days in its intensive care unit and eleven additional days in the regular in-patient care department.[170] Despite her request for admission to a post-stroke rehabilitation program, the program refused to accept her because her health insurance would not pay the cost of the program.[171] Although Thornton's physician discharged her to her sister's home with instructions for home

164. *Id.* at 1366-67. Dr. Burditt also alleged that enforcement of EMTALA constituted a taking of physician services without just compensation in violation of the Constitution. *Id.* at 1366.

165. *Burditt*, 934 F.2d at 1368.

166. *Id.* at 1370.

167. *Id.* at 1372.

168. *Id.* at 1376. For other United States Court of Appeals for the Fifth Circuit decisions construing EMTALA, *see* Miller v. Medical Ctr. of Southwest Louisiana, 22 F.3d 626, 629 (5th Cir. 1994) (holding that the words "come to" in EMTALA require that the patient actually physically present himself to the hospital being sued for violations of EMTALA and finding that the refusal of a telephonic request for treatment did not constitute an improper refusal by the standards of EMTALA); Green v. Touro Infirmary, 992 F.2d 537, 539 (5th Cir. 1993) (refusing to find that the physician and hospital had violated EMTALA where uncontroverted evidence indicated that the patient was stabilized, ambulatory, and in no acute distress when she left the emergency room seven hours after presenting herself, even though she died later as EMTALA only requires stabilization of an individual's emergency medical condition and not a cure).

169. 895 F.2d 1131, 1134 (6th Cir. 1990).

170. Thornton v. Southwest Detroit Hosp., 895 F.2d 1131, 1132 (6th Cir. 1990).

171. *Id.*

nursing care, Thornton's condition deteriorated after this discharge until the rehabilitation program admitted her several months later.[172]

Thornton filed suit in the United States District Court for the Eastern District of Michigan under EMTALA, alleging that SDH did not stabilize her as required by EMTALA before discharging her into her sister's care.[173] The district court granted summary judgment to SDH after finding that Thornton's condition had been properly stabilized prior to discharge.[174] On appeal, the Sixth Circuit did not question whether Thornton had suffered an emergency medical condition, because the district court found no dispute among the parties as to that fact.[175] Instead, the key question before the court was whether Thornton was stabilized prior to discharge.[176]

The court relied on EMTALA's definition of stabilization, finding that term to mean that "no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from a [hospital]."[177] The court stated that while the purpose of EMTALA is to ensure receipt of emergency care to patients with emergency medical conditions, it does not require the hospitals ensure complete recovery to patients.[178] The court noted that no material factual dispute existed as to whether SDH had stabilized Thornton prior to her discharge.[179] In applying its definition of stabilization, the court determined that SDH had not violated EMTALA because SDH had provided emergency care to Thornton until her emergency medical condition had stabilized.[180] In *Brooker v. Desert Hospital Corporation*,[181] the United States Court of Appeals for the Ninth Circuit, in holding that EMTALA's stabilization requirement did not demand a complete cure prior to transfer, also stated that EM-

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172. *Id.*

173. *Id.*

174. *Id.* at 1134-35.

175. *Id.* at 1133.

176. *Id.* at 1134.

177. *Id.* (citing 42 U.S.C. § 1395dd(e)(4)(B) (1993)). The Hospital argued that EMTALA did not apply because EMTALA should only govern in those situations where a patient is treated in the emergency room and does not extend to circumstances where the patient is actually admitted to the hospital. *Id.* at 1135.

178. *Thorton*, 895 F.2d at 1134. The court stated that, should it find EMTALA only to apply in emergency room situations, such a decision would only give hospitals the opportunity to circumvent EMTALA's requirements by admitting a patient to the emergency department and then immediately discharging the patient. *Id.* at 1135.

179. *Thorton*, 895 F.2d at 1135.

180. *Id.* For a United States Court of Appeals for the Eighth Circuit decision involving EMTALA, *see* King v. Ahrens, 16 F.3d 265, 271 (8th Cir. 1994) (holding that the statutory language of EMTALA creates a cause of action against a Medicare hospital only and does not create a cause of action against a private clinic physician).

181. 947 F.2d 412 (9th Cir. 1991).

TALA clearly applied to all individuals and not just the uninsured.[182] In January of 1988, Rosalyn Brooker was admitted to the emergency room at Desert Hospital ("DH"), complaining of chest pain, and was diagnosed as having a probable heart attack.[183] During her stay at DH, Brooker's condition rapidly deteriorated and required emergency surgery.[184] Because the surgeon scheduled to perform her surgery later in the week was not present to perform her emergency surgery, Brooker was transferred, with her consent, to another facility for surgery.[185] Tests conducted after her arrival at the receiving facility indicated that she had most probably suffered another heart attack during transfer.[186]

Following her recovery, Brooker brought suit in the United States District Court for the Central District of California against DH for a violation of EMTALA.[187] The district court dismissed Brooker's various causes of action, finding that Brooker was appropriately stabilized prior to transfer as defined by EMTALA.[188] On appeal, the Ninth Circuit affirmed the district court's judgment for DH and stated that EMTALA did not require DH to completely alleviate Brooker's emergency medical condition.[189] Additionally, the court stated that any discrepancies between the legislative history of EMTALA and its language were easily overshadowed by the clarity with which EMTALA addressed its applicability to any individual.[190] The court held that "the Act applies to any and all patients, not just to patients with insufficient resources."[191]

The United States Court of Appeals for the Tenth Circuit applied the provisions of EMTALA to any individual regardless of economic condition and defined the stabilization term in *Delaney v. Cade.*[192] In *Delaney*, the plaintiff, Julie Delaney, was seriously injured in an automobile accident and then transported by ambulance to one Kansas hospital where lacerations on her knees were sutured but no other examination was performed despite her complaints of chest pain.[193] Delaney was then transferred to another hospital where she received

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182. Brooker v. Desert Hosp. Corp., 947 F.2d 412, 414-15 (9th Cir. 1991).
183. *Id.* at 413.
184. *Id.*
185. *Id.* at 413-14.
186. *Id.* at 414.
187. *Id.*
188. *Id.* at 415.
189. *Id.* The court justified its holding by stating that nothing in the record indicated that the attending physicians believed the transfer would have any negative affect on Rosalyn Brooker's condition as she was clinically stabilized. *Id.*
190. *Brooker*, 947 F.2d at 414-15.
191. *Id.* at 415.
192. 986 F.2d 387, 391-92 (10th Cir. 1993).
193. Delaney v. Cade, 986 F.2d 387, 388 (10th Cir. 1993).

some additional medical care prior to transfer to a third hospital.[194] The third hospital was the first to perform an aortagram and discover Delaney's transected aorta.[195] Although physicians performed surgery to repair this injury, Delaney was permanently paralyzed.[196]

Delaney brought suit in the United States District Court for the District of Kansas against the original hospital and the attending physician, alleging a violation of EMTALA because she was transferred prior to stabilization.[197] Delaney also alleged "loss of chance of recovery" and violations of EMTALA against both the hospital and the attending physician.[198] The district court dismissed the case, finding that Kansas did not recognize "loss of chance of recovery," the facts failed to support an EMTALA claim against the hospital, and EMTALA did not provide a private cause of action against a physician.[199]

In determining that the district court's summary judgment on the EMTALA claim against the hospital was premature, the Tenth Circuit first stated that EMTALA did apply to transfers where the patient's economic condition was not at issue.[200] Second, the court stated that "stabilization" required that no material deterioration as defined by reasonable medical probability was likely to occur as a result of transfer from one facility to another.[201] The court stated that the evidence resulted in questions as to whether Delaney was actually stabilized at the time of her first transfer and raised material facts that needed to be addressed by a jury.[202]

EMTALA's Screening Requirement Addressed in Conjunction with EMTALA's Scope

In *Collins v. DePaul Hospital*,[203] the United States Court of Appeals for the Tenth Circuit stated that EMTALA requires hospitals to provide an adequate screening to all patients who come to the hospital's emergency room to determine if an emergency medical condition is present.[204] Charles Collins sustained a fractured skull, a fractured

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194. *Id.* at 388-89. When the plaintiff, Julie Delaney, left the original transferring facility, she had both movement and feeling in her legs. *Id.* at 389. However, by the time she arrived at the second facility, she no longer had that feeling. *Id.* at 389.

195. *Delaney*, 986 F.2d at 389.

196. *Id.*

197. *Id.* at 391-92.

198. *Id.* at 388.

199. *Id.*

200. *Id.* at 391 n.5.

201. *Id.* at 392.

202. *Id.* at 383. The United States Court of Appeals for the Tenth Circuit retained jurisdiction with regard to the "loss of chance of recovery" question and reversed in part/affirmed in part the EMTALA violations questions. *Id.* at 391, 394.

203. 963 F.2d 303 (10th Cir. 1992).

204. Collins v. DePaul Hosp., 963 F.2d 303, 305 (10th Cir. 1992).

hip, and a collapsed lung in an accident.[205] Upon admission to DePaul Hospital ("DPH"), Collins was unconscious and he remained in a coma for approximately fifteen days.[206] Although the attending physicians immediately diagnosed emergency medical conditions as including multiple abrasions and lacerations, pulmonary problems, a shoulder injury, chest injury, and a severe brain injury and then admitted Collins to the intensive care unit where he remained for fifteen days, the physicians failed to note injury to his hip.[207]

When the hip fracture was discovered following a x-ray taken twenty-five days after his admission to the DPH, Collins' attending physician discussed his condition with an orthopedic surgeon and follow-up treatment was arranged for Collins after his discharge from the DPH.[208] The orthopedic surgeon had to fuse Collins' hip, because reconstruction was no longer possible due to the passage of time between the date of injury and the date of surgery.[209]

Collins and his wife brought suit in the United States District Court for the District of Wyoming, alleging that DPH failed to provide him with adequate medical screening upon his arrival at the emergency room.[210] The district court granted summary judgment to DPH, finding that an adequate screening had occurred.[211] Collins appealed to the Tenth Circuit, stating as his only issue that an adequate screening had not taken place because DPH failed to x-ray his hip.[212]

The court first noted that EMTALA demands a medical screening for a single reason — to determine whether or not the individual suffers from an emergency medical condition.[213] The court further stated that the screening requirement does not additionally mandate that the hospital or staff identify each and every emergency medical condi-

205. *Id.* at 304.

206. *Id.* at 306.

207. *Id.* Physicians did discover the hip injury after Charles Collins regained consciousness and was able to communicate in a meaningful way that movement caused him pain and discomfort in his right hip. *Id.* The court accepted as true Collins' assertion that a patient with his injuries would ordinarily have had a hip x-ray upon arrival at the hospital's emergency room, the staff's claims that they mistakenly thought the procedure had been done upon his arrival, and that the delay prevented more conservative treatment. *Id.* at 306 n.3.

208. *Collins*, 963 F.2d at 306.

209. *Id.*

210. *Id.* at 304.

211. *Id.*

212. *Id.* at 306.

213. *Id.* at 306-07. The court's exact words were:

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

Id. (emphasis added).

tion from which an individual patient may be suffering.[214] Hence, the court noted that EMTALA could be violated in two primary ways, both having the prerequisite that a patient exhibit an emergency medical condition.[215] The court reasoned that once the presence of the condition is established, a hospital violates EMTALA by either failing to diagnose the nature of the condition as a result of inadequate screening or by releasing or transferring the patient prior to stabilization.[216]

The court determined that Collins had received a proper screening under the requirements of EMTALA, because Collins was screened and received continuous medical treatment for a multitude of emergency medical conditions at DPH for approximately twenty-six days.[217] Thus, the court affirmed the district court's summary judgment for DPH.[218]

The court also noted that the fact that Collins was able to and did pay for his medical bills did not in and of itself defeat his EMTALA claims.[219] The court determined that EMTALA applies to any individual, regardless of his or her financial situation.[220]

THE DEBATE SURROUNDING THE LEGAL STATUS OF ANENCEPHALIC INFANTS

The legal issue regarding the beginning and ending of human life became a matter of judicial debate in the 1970s with the abortion cases.[221] This debate has become particularly heated when involving the question of appropriate treatment for human beings whose legal status is uncertain.[222] The reason for the controversy is simply stated: "[A] human who has died . . . or . . . has not yet been born . . . is not considered a person in whom human rights inhere . . . . [And] [w]ithout human life, there are no rights; and without rights, there

214. *Collins*, 963 F.2d at 307 n.5. The court also quoted *Cleland* as support for its finding that EMTALA does not encompass the "full panoply of state medical malpractice law." *Id.* at 307 (*quoting Cleland*, 917 F.2d at 271).

215. *Collins*, 963 F.2d at 307-08.

216. *Id.* at 308.

217. *Id.* The court stated that, while EMTALA was not violated by the hospital, Collins might of course have a medical malpractice action. *Id.* Collins had previously instituted a state malpractice action and lost. *Id.*

218. *Collins*, 963 F.2d at 308.

219. *Id.*

220. *Id.* For an additional Tenth Circuit case dealing with EMTALA violations, *see* Abercrombie v. Osteopathic Hosp. Founders Ass'n., 950 F.2d 676, 681 (10th Cir. 1991) (finding that jury instructions requiring negligent violation of EMTALA rather than imposing strict liability were incorrectly drafted but constituted harmless error because the jury was required to answer special interrogatories following deliberation that were correctly stated and resulted in the same rejection of the plaintiffs' claims).

221. Elizabeth G. Patterson, *Human Rights and Human Life: An Uneven Fit*, 68 TUL. L. REV. 1527, 1527-28 (1994).

222. *Id.* at 1528.

are no legally guaranteed claims."[223] The difficulty with this simple statement arises when the body of a human contains indicia of life without brain activity or consciousness, such as is the case with anencephalic newborns.[224] For these human entities that dwell on the margins of life without a future or a past within a community of individuals, the argument has been made by legal commentators that their unique physical attributes may influence their legal status.[225]

This argument centers around what is essentially a quality of life definitional question.[226] Some commentators suggest that the quality of an anencephalic infant's life cannot be measured by medical experts, but is essentially a religious or philosophical question to be decided by the infant's family.[227] Other experts advocate a role for physicians which allows anencephalics to die in a humane and dignified fashion rather than continuing what physicians term unethical, "futile" or "inappropriate" treatment.[228] Medical treatment is deemed futile or inappropriate when the patient's condition cannot be improved or corrected and the treatment does not serve to prevent or relieve suffering.[229] Faced with a circumstance in which "futile" treatment is demanded by a patient's family, one expert in bioethics stated that "[f]or a judge to insist on a treatment that is contrary to all established standards of care is to destroy medicine as a profession and turn physicians into servants of the fantasies of families."[230]

Until 1994, the only case dealing with the rights of anencephalic infants where the infant's family and physicians disagreed about the

223. *Id.* at 1529.

224. *Id.* at 1529-30.

225. *Id.* at 1555.

226. Linda Greenhouse, *Health Care for Anencephalic Baby Stirs Ethics Debate Hospital Seeks to End Treatment Despite Mom's Wishes*, DALLAS MORNING NEWS, Oct. 3, 1993, at 17A.

227. *Id.*; Michael McCarthy, *Anencephalic Baby's Right to Life? Baby K Born in Fairfax Hospital, Virginia*, 342 THE LANCET 8876, 8876 (1993).

228. Miriam Marquez, *Court's Decision Prolongs the Pain in Medical-Ethics Nightmare of Baby K*, SUN-SENTINEL, Feb. 23, 1994, at 23A; Linda Greenhouse, *Court Order to Treat Baby with Partial Brain Prompts Debate on Costs and Ethics*, N.Y. TIMES, Feb. 20, 1994, at 20; *Life and the Law: The Case of Baby K*, VIRGINIAN-PILOT, Oct. 6, 1994, at A18.

229. Diane M. Gianelli, *Doctors Argue Futility of Treating Anencephalic Baby*, AM. MED. NEWS, Mar. 21, 1994, at 5; Diane M. Gianelli, *Getting a Better Fix on Futility; More Providers Seeking Consensus on How to Set Limits*, AM. MED. NEWS, Dec. 6, 1994, at 3. Another definition of futile treatment encompasses the notion that costly care is provided individuals without either psychological or physiological benefit to the individual. Gianelli, AM. MED. NEWS, Mar. 21, 1994, at 5; Gianelli, AM. MED. NEWS, Dec. 6, 1994, at 3.

230. Greenhouse, DALLAS MORNING NEWS, at 17A (quoting the Reverend John J. Paris); Frances H. Miller, *Infant Resuscitation, a US/UK Divide*, 343 THE LANCET 1584 (1994).

appropriate course of treatment was *In re T.A.C.P.*[231] In *T.A.C.P.*, the parents of an anencephalic infant petitioned the trial court for an order declaring the infant dead so that her organs could be donated to other needy children without medical personnel fearing liability.[232] The trial court denied the petition because Florida statutes prohibited the determination of legal death while some brain function still existed.[233]

On appeal, the Florida Supreme Court affirmed the trial court on different grounds.[234] The court determined that Florida statutes did not apply because they did not address themselves specifically to the condition of anencephaly.[235] Although the court recognized the humanitarian concern for others evidenced in the actions of the parents of T.A.C.P., the court found that the condition of anencephaly did not meet the common law definition of cardiopulmonary death and that no public policy concerns existed to equate anencephaly with death where the infant's heart was beating and she was breathing at all times relevant to the case.[236] In other words, the Florida Supreme Court refused to reduce in any way the rights of T.A.C.P. to life because of her hopeless condition and instead equated her rights as an anencephalic infant as indistinguishable from the rights of other healthy infants.[237]

ANALYSIS

In *In re Baby K* ("*Baby K*"),[238] the United States Court of Appeals for the Fourth Circuit applied the Emergency Medical Treatment and Active Labor Act ("EMTALA") provisions, guaranteeing treatment to all individuals, including anencephalic infants, who arrive at an emergency room exhibiting an emergency medical condition requiring stabilization.[239] In *Baby K*, the Fourth Circuit affirmed its earlier decisions by applying the plain language of EMTALA to all individuals, rather than limiting the scope of EMTALA to only indigent or un-

231. 609 So. 2d 588, 594-95 (Fla. 1992); *see* Patterson, 68 TUL. L. REV. at 1555 (discussing the two cases that addressed the rights of anencephalics to date (*In re T.A.C.P.* (1992) and *Baby K* (1994)).

232. *In re* T.A.C.P., 609 So. 2d 588, 589 (Fla. 1992).

233. *Id.* The child died during the appeal process from the trial court, but the Florida Supreme Court heard the case because it involved an "issue of great importance capable of repetition yet evading review." *Id.* at 589 n.2.

234. *In re T.A.C.P.*, 609 So. 2d at 595.

235. *Id.* at 592.

236. *Id.* at 594-95.

237. Patterson, 68 TUL. L. REV. at 1555.

238. 16 F.3d 590 (4th Cir. 1994), *cert. denied*, 115 S. Ct. 91 (1994).

239. *In re* Baby K, 16 F.3d 590, 592 (4th Cir. 1994), *cert. denied*, 115 S. Ct. 91 (1994); 42 U.S.C. § 1395dd (1993); *see* appendix.

insured patients as EMTALA's legislative history suggests.[240] Additionally, *Baby K* marks a shift in the Fourth Circuit's interpretation of EMTALA's requirements for an emergency medical condition and for appropriate stabilization.[241] Perhaps most importantly, *Baby K* accords an anencephalic infant the status of an individual with all the legal rights that accompany individual status under EMTALA.[242]

THE FOURTH CIRCUIT WAS CORRECT — THERE IS NO LONGER ANY DOUBT AS TO EMTALA'S SCOPE

The court in *Baby K* applied the plain language of EMTALA rather than the language used in EMTALA's legislative history.[243] Because the court determined the plain language of EMTALA applied in Baby K's case, it refused to address the Hospital's obligations under the Rehabilitation Act of 1973, the Americans with Disabilities Act, the Child Abuse Prevention and Treatment Act, and the Virginia Malpractice Act.[244]

The Hospital stipulated that its desire to refuse treatment in Baby K's case had nothing to do with any lack of resources or Ms. H's inability to pay for the treatment that she had requested for her daughter.[245] The court, in reply, unequivocably stated that, while EMTALA's legislative history indicated Congress' intent to prevent hospitals receiving Medicare funds from dumping patients based upon their inability to pay, patient dumping motivated by the patient's condition or other characteristics (such as underlying diseases) was distasteful, unacceptable, and violative of EMTALA.[246]

These statements are in accord with the position the court took in the earlier cases of *Baber v. Hospital Corporation of America*[247] and *Brooks v. Maryland General Hospital, Inc.*[248] *Baber* involved a woman who arrived at Raleigh General Hospital's emergency room, exhibiting symptoms that emergency room physicians diagnosed as a psychotic episode but which were in reality an intracerebrovascular rupture.[249] The woman's brother filed suit, alleging that the hospital had failed to

240. *Baby K*, 16 F.3d at 593.
241. *See infra* notes 279-98 and accompanying text.
242. Elizabeth G. Patterson, *Human Rights and Human Life: An Uneven Fit*, 68 TUL. L. REV. 1527, 1555 (1994); *see infra* notes 297-305 and accompanying text.
243. *Baby K*, 16 F.3d at 592-93.
244. *Id.* at 592 n.2.
245. *In re* Baby K, 832 F. Supp. 1022, 1026 (E.D. Va. 1993), *aff'd*, 16 F.3d 590 (4th Cir. 1994), *cert. denied*, 115 S. Ct. 91 (1994).
246. *Baby K*, 16 F.3d at 598.
247. 977 F.2d 872 (4th Cir. 1992).
248. 996 F.2d 708, 709 (4th Cir. 1993); Baber v. Hospital Corp. of Am., 977 F.2d 872, 875-76 (4th Cir. 1992); *see infra* notes 249-54 and accompanying text.
249. *Baber*, 977 F.2d at 875-76.

provide her with an appropriate medical screening as required by the provisions of EMTALA.[250] The court stated that EMTALA's purpose was not to guarantee a proper diagnosis of all patients but rather 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."[251]

Brooks involved a patient who arrived at Maryland General Hospital's emergency room, possessing no health insurance.[252] Brooks experienced significant delays in testing and treatment and later brought suit under EMTALA, alleging the delay exacerbated his condition and resulted in lengthy rehabilitation.[253] The court reversed the lower court's dismissal of the case and remanded for consideration of Brooks' claims of disparate treatment, stating that "the language of [EMTALA] does not require a showing that a claimant is uninsured or indigent . . . [but] [r]ather imposes its duties in respect of 'any individual.' "[254]

Because of the uniformity among all of the courts of appeals which have addressed this issue, there is no longer any serious doubt that EMTALA applies to any individual, regardless of his or her economic status, who seeks emergency medical treatment from a hospital receiving Medicare funds.[255] The United States Court of Appeals for the Sixth Circuit addressed the issue in *Cleland v. Bronson Health Care Group, Inc.*[256] *Cleland* involved a suit brought for violation of EMTALA by the parents of a patient who was misdiagnosed with influenza in the emergency room, stabilized, and discharged, but later died of a telescoped intestine.[257] The lower court dismissed the case because the patient was neither indigent or uninsured, arguing that as a result EMTALA did not apply.[258] The Sixth Circuit affirmed the lower court only because the court found that an appropriate medical screening as defined by EMTALA had taken place.[259] In registering its disagreement with the lower court's limitation of EMTALA to only indigent and uninsured patients, the court stated that "[a] hospital

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250. *Id.* at 878.
251. *Id.* at 880 (quoting 131 CONG. REC. S13904 (Oct. 23, 1985) (statement of Sen. Durenberger)).
252. Brooks v. Maryland Gen. Hosp., Inc., 996 F.2d 708, 709 (4th Cir. 1993).
253. *Id.*
254. *Id.* at 711 n.4.
255. *See infra* notes 256-78 and accompanying text.
256. 917 F.2d 266, 268 (6th Cir. 1990).
257. Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 268-69 (6th Cir. 1990).
258. *Id.* at 268.
259. *Id.*

that provides a substandard (by its standards) or nonexistent medical screening for any reason . . . may be liable under this section."[260] The court noted that "any reason" included race, politics, sex, occupation, personal prejudice, and spite.[261]

Similarly, the United States Court of Appeals for the Ninth Circuit in *Brooker v. Desert Hospital Corp.*[262] found EMTALA to apply to "any and all patients, not just to patients with insufficient resources."[263] *Brooker* involved a heart patient whom the Ninth Circuit found to have been properly stabilized although she suffered another heart attack during transfer to a receiving hospital.[264]

Likewise, the United States Court of Appeals for the Tenth Circuit in both *Delaney v. Cade*[265] and *Collins v. DePaul Hospital*[266] determined that EMTALA applied to transfers where the patient's economic condition was not at issue.[267] *Delaney* involved an automobile accident victim who was transferred multiple times prior to an examination of her chest pain and who was permanently paralyzed as a result.[268] In finding that the lower court's grant of summary judgment for the hospital and attending physician was premature, the Tenth Circuit stated that EMTALA's transfer provisions apply even in cases where the patient's economic condition is not an issue.[269]

Collins involved another accident victim who was diagnosed with multiple critical injuries in the hospital emergency room and who remained in intensive care for days prior to regaining consciousness.[270] Upon regaining consciousness, Collins indicated severe pain in his hip and a subsequent x-ray revealed a fracture that had been missed in screening.[271] Collins brought suit under EMTALA, alleging that improper screening and consequential delay in treatment had prevented more conservative treatment of the hip fracture.[272] The Tenth Circuit affirmed the lower court's finding that a proper screening had taken place and stated in dicta that the fact that Collins was able to and did

260. *Id.* at 272.
261. *Id.*
262. 947 F.2d 412 (9th Cir. 1991).
263. Brooker v. Desert Hosp. Corp., 947 F.2d 412, 415 (9th Cir. 1991).
264. *Id.*
265. 986 F.2d 387 (10th Cir. 1993).
266. 963 F.2d 303 (10th Cir. 1992).
267. Delaney v. Cade, 986 F.2d 387, 391 n.5 (10th Cir. 1993); Collins v. DePaul Hosp., 963 F.2d 303, 308 (10th Cir. 1992).
268. *Delaney*, 986 F.2d at 388-89.
269. *Id.* at 391 n.5.
270. *Collins*, 963 F.2d at 304-06.
271. *Id.* at 306.
272. *Id.*

pay for his medical treatment did not by itself defeat his EMTALA claims.[273]

Furthermore, in *Gatewood v. Washington Healthcare Corp.*,[274] the United States Court of Appeals for the District of Columbia Circuit addressed the scope of EMTALA provisions in a suit brought by the wife of a patient who was misdiagnosed with musculoskeletal pain, discharged, and subsequently died from a heart attack.[275] The District of Columbia Circuit held that a proper screening had occurred and therefore affirmed the lower court's dismissal of the case.[276] However, the District of Columbia Circuit specifically stated that the district court's dismissal of the *Gatewood* case on the grounds that the patient was fully insured was improper, because EMTALA by its own terms applies to any individual.[277]

The uniformity of the Fourth, Sixth, Ninth, Tenth, and District of Columbia Circuits in applying EMTALA to any individual exhibiting an emergency medical condition supports the application of EMTALA's plain language to all individuals and not merely to the indigent or uninsured.[278]

Baby K Marks a Shift in Fourth Circuit Decisions

The Fourth Circuit in Baby K States that a Symptom and Not the Underlying Condition Alone Constitutes an Emergency Medical Condition

A comparison of *Baby K* to the Fourth Circuit's decision in *Baber* brings to light an interesting shift in the Fourth Circuit's approach to EMTALA cases.[279] In *Baber*, the Fourth Circuit evaluated the claims of the patient's personal representative, alleging a failure to provide an appropriate medical screening as well as a failure to stabilize the patient prior to transfer because the physicians misdiagnosed the patient's psychotic episode.[280] The court affirmed the lower court's grant of summary judgment to the hospital, stating that the attending physicians provided standard screening procedures to the patient, determined that her symptoms were indicative of her mental disorder and not a serious head trauma, and appropriately refused her brother's request for a more thorough examination of the patient's head in-

273. *Id.* at 308.
274. 933 F.2d 1037 (D.C. Cir. 1991).
275. Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1038-39 (D.C. Cir. 1991).
276. *Id.* at 1041.
277. *Id.* at 1039.
278. *See supra* notes 243-77 and accompanying text.
279. *See infra* notes 280-86 and accompanying text.
280. *Baber*, 977 F.2d at 876-77.

jury.[281] The doctors also determined that tests requested by the patient's brother for her head injury could be conducted after the underlying psychosis had been treated at the receiving hospital.[282] The court held that, because the doctor's examination did not result in a diagnosis of an emergency medical condition, EMTALA was not implicated and the doctor's subsequent actions failed to constitute a violation of EMTALA, despite the misdiagnosis.[283]

However, in *Baby K*, the Hospital's arguments rested upon its physicians' determination that Baby K's respiratory distress was symptomatic of her anencephalic condition and so did not constitute an emergency medical condition, allowing the Hospital to only provide Baby K with the same treatment it would provide any other anencephalic infant.[284] However, the court refused to accept the argument that the Hospital's action would meet the prevailing standard of care as had the physician's actions in *Baber*, instead determining that the Hospital had a duty to provide respiratory assistance to Baby K even though such action exceeded the prevailing standard of care for anencephalic infants and contradicted the physicians' determination that an emergency medical condition was not present.[285] Instead of holding, as in *Baher*, that the physicians were allowed to make the determination that a condition was symptomatic of an underlying disease that had to be treated first, the court in *Baby K* stated that a symptom which in and of itself constituted an emergency medical condition (Baby K's respiratory distress) had to be stabilized regardless of whether or not the underlying condition (Baby K's anencephaly) was treated or cured.[286]

The Fourth Circuit in Baby K Adopts Other Circuits' Position on Stabilization

In addition to the Fourth Circuit's movement away from *Baber* in its decision in *Baby K*, it also appears that the court has adopted the view of other circuits regarding the definition of stabilization in cases involving EMTALA.[287] The Sixth Circuit, in *Thornton v. Southwest*

281. *Id.* at 880-82.
282. *Id.* at 881.
283. *Id.*
284. *Baby K*, 16 F.3d at 595.
285. *Id.* at 603.
286. *Id.*; *see supra* notes 278-81 and accompanying text.
287. *See infra* notes 288-98 and accompanying text. In *Green v. Touro Infirmary*, the suit was brought in the United States Court of Appeals for the Fifth Circuit on behalf of a patient who was stabilized, ambulatory, and in no acute distress when discharged from the hospital, although she died hours later. Green v. Touro Infirmary, 992 F.2d 537, 538 (5th Cir. 1993). The Fifth Circuit refused to find a violation of EMTALA's stabilization provisions, holding that EMTALA requires only stabilization of an emer-

Detroit Hospital,[288] held that the EMTALA stabilization requirements were not violated where a patient suffered a stroke, spent ten days in intensive care, spent eleven days in regular care, and was released for home nursing care until she could be admitted to a special rehabilitation program several months later.[289] The court determined that "stabilization," according to the definition found in EMTALA, means "no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from a [hospital]."[290] Because EMTALA does not require a complete cure to satisfy the stabilization provision, the court held that the provision was not violated in Thornton's case.[291]

Likewise, the Ninth Circuit in *Brooker* addressed the stabilization issue where a patient was admitted, suffered a probable heart attack, rapidly deteriorated so as to need surgery, and, while being transferred with her consent to another hospital for surgery, suffered another heart attack.[292] The court dismissed the suit, stating that EMTALA does not require a hospital to completely alleviate a patient's emergency medical condition in order to comply with EMTALA's stabilization requirement.[293] Similarly, the Fourth Circuit concluded its decision in *Baby K* by stating:

> EMTALA does not carve out an exception for anencephalic infants in respiratory distress any more than it carves out an exception for comatose patients, those with lung cancer, or those with muscular dystrophy—all of whom may repeatedly seek emergency stabilizing treatment for respiratory distress and also possess an underlying medical condition that severely affects their quality of life and ultimately may result in their death. Because EMTALA does not provide for such an exception, the judgment of the district court is affirmed.[294]

With this language, the court noted that, while the patient may be suffering from an incurable underlying disease, conditions that constitute an emergency medical condition and that may also be symptomatic of an underlying incurable disease must still be treated and stabilized in accordance with the provisions of EMTALA.[295] As in

gency medical condition and not a complete cure. 992 F.2d 537, 539 (5th Cir. 1993); *see supra* note 168.

288. 895 F.2d 1131 (6th Cir. 1990).

289. Thornton v. Southwest Detroit Hosp., 895 F.2d 1131, 1132 (6th Cir. 1990).

290. *Id.* at 1134 (quoting 42 U.S.C. § 1395dd(e)(4)(B) (1993)).

291. *Id.*

292. *Brooker*, 947 F.2d at 413-14.

293. *Id.* at 415.

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

295. *Id.*

Thornton and *Brooker* where the patients suffered material deterioration of their conditions, a complete recovery or a complete cure with regard to Baby K's underlying condition was not necessary to fulfill EMTALA's stabilization requirement.[296] All that was required in these cases is what the court in *Baby K* required of the Hospital — that no material deterioration of the patient's condition would be likely.[297] Hence, it appears that the Fourth Circuit has moved toward the adoption of the definition of stabilization as utilized in other circuits.[298]

THE FOURTH CIRCUIT BREAKS NEW GROUND IN DECIDING FOR THE PLAINTIFF — A PLAINTIFF WHO MAY NOT EVEN BE AN INDIVIDUAL *PER SE*

While the Fourth Circuit in *Baby K* affirmed its earlier holdings that EMTALA applies to any and all individuals as per its specific language, the nature of Baby K's condition places even more significance upon the court's holding in *Baby K*.[299] The debate regarding the

296. *See supra* notes 288-95 and accompanying text.
297. *See supra* notes 288-95 and accompanying text.
298. *See supra* notes 288-97 and accompanying text.
299. *See infra* notes 300-27 and accompanying text. The United States Court of Appeals for the Fourth Circuit determined in this declaratory judgment action that, despite the Hospital's ethical and moral concerns, a failure to treat a diagnosed emergency medical condition in Baby K's case would constitute a violation of EMTALA and ordered the Hospital to continue to treat Baby K in the future should she again lapse into respiratory distress. *Baby K*, 16 F.3d at 592. In comparison, the other Fourth Circuit decisions as well as the decisions decided in other circuits have not been decided decisively in favor of the patient in any case. *Baber*, 977 F.2d at 880 (determining that, despite a misdiagnosis of an intracerebrovascular rupture and transfer that ultimately resulted in the patient's death, EMTALA had not been violated); *Brooks*, 996 F.2d at 709-10 (reversing a lower court's dismissal of the case because the court believed material facts regarding alleged disparate treatment resulting from the patient's uninsured status were in dispute and had to be resolved by a trier of fact; therefore, the court took no decisive action in favor of the patient); *Miller*, 22 F.3d at 626, 629 (deciding in favor of a defendant hospital that refused a telephonic request for treatment); *Green*, 992 F.2d at 538 (deciding for a defendant hospital that discharged a patient who had been treated and was ambulatory but died hours after discharge); *Cleland*, 917 F.2d at 271 (holding in favor of a defendant hospital that had screened, stabilized, and discharged a patient with a condition of a telescoped intestine misdiagnosed as influenza); *Thornton*, 895 F.2d at 1135 (holding in favor of the defendant hospital where the stroke patient was treated, stabilized, and dismissed with instructions for home nursing care until she could be admitted to a rehabilitation program); *King*, 16 F.3d at 271 (deciding the case in favor of the defendant physician because EMTALA does not create a private cause of action against physicians); *Brooker*, 947 F.2d at 415 (holding for the defendant hospital because the court determined that the heart patient had been properly stabilized even though she suffered another heart attack enroute to a receiving hospital); *Delaney*, 986 F.2d at 391 n.5 (reversing a summary judgment for the defendant hospital and remanded the case back to make factual determinations as to whether the accident victim was stabilized prior to the multiple transfers that ultimately resulted in her permanent paralysis, but made no decision in favor of one party or the other); *Collins*, 963 F.2d at 308 (affirming a dismissal in favor of the defendant hospital, finding that an adequate

beginning and ending of human life has become particularly heated when it involves the question of appropriate treatment for human beings such as anencephalic infants whose legal status is uncertain.[300] Legal commentators argue that unique physical attributes may influence legal status when the body of a human contains indicia of life without brain activity or consciousness, such as is the case with anencephalic newborns, but the human has not and never will integrate into a community of individuals.[301] Despite the growing controversy and debate surrounding the legal rights and status of anencephalic infants, the Fourth Circuit simply and without comment accepted the status of an anencephalic infant as an "individual" under the terms of EMTALA.[302]

In fact, only Judge Sprouse, who authored the dissenting opinion, made any argument for prohibiting the application of EMTALA because of Baby K's anencephalic condition.[303] Judge Sprouse argued that Baby K's rights should be limited more than other terminally ill patients so as not to extend EMTALA's protection to her because of her permanently unconscious state.[304] The majority of the court did not even acknowledge Judge Sprouse's argument in its opinion, instead simply and succinctly declaring the "any individual" language of EMTALA to define even anencephalic infants.[305] By extending the provisions of EMTALA to anencephalic infants, *Baby K* became the second case in the United States to both address the legal status of anencephalic infants and accord them equal rights with other healthy infants.[306] Thus, the court broadened the scope of EMTALA's already broad "any individual" language to include even those patients whose legal rights are in question and whose status as persons with rights is unknown.[307]

However, while the court clearly held that EMTALA's provisions extended to anencephalic infants, Judge Sprouse's dissenting opinion and the concerns of bioethics experts question whether the court

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screening had taken place despite the fact that the patient was in the hospital twenty-five days before his fractured hip was diagnosed); *Gatewood*, 933 F.2d at 1041 (dismissing *Gatewood* for the defendant hospital, finding that an adequate screening had taken place in the misdiagnosis of a heart attack as musculoskeletal pain even though the patient died).

300. Patterson, 68 TUL. L. REV. at 1555 n.145; *see supra* note 13 and accompanying text.

301. Patterson, 68 TUL. L. REV. at 1555 n.145.

302. *Id.* at 1555 n.145; *Baby K*, 16 F.3d at 598.

303. *Baby K*, 16 F.3d at 598-99 (Sprouse, J., dissenting).

304. *Id.* at 599 (Sprouse, J., dissenting).

305. *See id.* at 592, 598.

306. *See* Patterson, 68 TUL. L. REV. at 1555 (listing *Baby K* (1994) and *T.A.C.P.* (1992) as the two cases discussing the legal rights of anencephalic infants).

307. *See supra* notes 299-306 and accompanying text.

should have done so.[308] In Baby K's case, the Hospital convened an Ethics Committee which recommended the termination of aggressive therapy.[309] Additionally, a court appointed guardian ad litem and Baby K's own father supported Baby K's treating physicians who voiced strong concerns about the ethical efficacy of continued resuscitative treatment.[310] Each of these parties protested continued respiratory assistance on the grounds that the treatment would be futile, succeeding only in prolonging Baby K's process of dying.[311]

The Hospital's position in this case had and still has strong support from the bioethics community.[312] Physicians and bioethicists argue that aggressive treatment should only be administered in those instances in which the treatment would alleviate pain or suffering or serve to correct the underlying life-threatening condition.[313] For Baby K, continued treatment will serve neither of these purposes.[314] She cannot feel pain or interact in any way with her environment and so she experiences no pain or suffering which requires treatment.[315] As well, medical experts consider anencephaly to be a condition incompatible with life; that is, anencephalic infants are born already in the process of dying, and any treatment only prolongs the dying and cannot correct or reverse that process.[316]

To those who argue, as did the Fourth Circuit majority, that anencephaly can be compared to terminal cancer or AIDS and so warrants the same aggressive (although ultimately futile) treatment and protection under EMTALA's "any individual" language, Judge Sprouse provides a persuasive answer.[317] Judge Sprouse found a clear distinction based upon Baby K's peculiar health problems.[318] He stated that "Baby K's condition presents her parents and doctors with decision-making choices that are different even from the difficult choices presented by other terminal diseases."[319] Baby K has no knowledge even of her own existence, unlike other terminally ill pa-

308. *See infra* notes 309-24 and accompanying text.

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

310. Brief of Appellants at 15, *In re* Baby K, 16 F.3d 590 (4th Cir. 1994) (No. 93-1899(L)), *cert. denied*, 115 S. Ct. 91 (1994).

311. *Id.*

312. *See infra* notes 313-24 and accompanying text.

313. Diane M. Gianelli, *Doctors Argue Futility of Treating Anencephalic Baby*, AM. MED. NEWS, Mar. 21, 1995, at 5.

314. *Id.*

315. *Id.*; Brief of Appellee at 3, *In re* Baby K, 16 F.3d 590 (4th Cir. 1994) (No. 93-1899 (L)), *cert. denied*, 115 S. Ct. 91 (1994).

316. Linda Greenhouse, *Court Order to Treat Baby with Partial Brain Prompts Debate on Costs and Ethics*, N.Y. TIMES, Feb. 20, 1994, at 20.

317. *See infra* notes 318-24 and accompanying text.

318. *Baby K*, 16 F.3d at 598-99 (Sprouse, J., dissenting).

319. *Id.* at 599 (Sprouse, J., dissenting).

tients.[320] Additionally, she has no past from which to draw conclusions as to her own wishes regarding the provision of aggressive therapy.[321] In the interplay between law, philosophy, religion, and medicine, some ethicists believe that the best interests and ultimate welfare of Baby K were sacrificed by the court's decision.[322] As one commentator stated:

> The Court of Appeals has thus taken a statute specifically designed to redress the glaring inequities in America's patchwork system of delivering medical care to the poor, and read it literally, extending the reach of EMTALA deep into clinical autonomy and right-to-die controversies and way beyond the economic reasons for its enactment. The US Congress cannot have intended to inject itself into such a volatile and sensitive bioethical debate with such a clumsy and indiscriminate tool.[323]

In the light of Baby K's case, Congress will ultimately have to clarify EMTALA so that families and courts will know with certainty whether the provision requiring stabilizing treatment for "any individual" is a mandate applicable even in ethically questionable cases such as Baby K's case.[324]

CONCLUSION

In *In re Baby K*,[325] the United States Court of Appeals for the Fourth Circuit once again recognized the applicability of the Emergency Medical Treatment and Active Labor Act ("EMTALA") to all individuals seeking emergency medical treatment, not just to those individuals who are indigent or uninsured.[326] The Fourth Circuit extended its already broad interpretation of the scope of EMTALA to include anencephalic infants whose legal status is currently under debate.[327] The court's decision was significant in several respects: it clarified any remaining doubt as to the scope of EMTALA; it adopted the view of other circuit courts as to the definition of EMTALA's stabilization provisions; and it generated — and is still generating — an ethical debate similar to the United States Supreme Court's decisions

320. Myriam Marquez, *Court's Decision Prolongs the Pain in Medical-Ethics Nightmare of Baby K*, SUN-SENTINEL, Feb. 23, 1994, at 23A.

321. Elizabeth G. Patterson, *Human Rights and Human Life: An Uneven fit*, 68 TUL. L. REV. 1527, 1555 (1994).

322. Frances H. Miller, *Infant Resuscitation, a US/UK Divide*, 343 THE LANCET 1584, 1584 (1994).

323. *Id.*

324. *Let Baby K Die in Peace*, HARTFORD COURANT, Oct. 7, 1994, at A18.

325. 16 F.3d 590 (4th Cir. 1994), *cert. denied*, 115 S. Ct. 91 (1994).

326. *In re* Baby K, 16 F.3d 590, 598 (4th Cir. 1994), *cert. denied*, 115 S. Ct. 91 (1994); 42 U.S.C. § 1395dd (1993); *see* appendix.

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

in other cases involving patients existing in persistant vegetative states and the right to abortion. While the lower courts will no doubt remain in turmoil as to the application and interpretation of EMTALA until the Supreme Court addresses EMTALA or the federal government formulates interpretive regulations, the Fourth Circuit cast a significant vote on behalf of the circuit courts in favor of an interpretation that defends the masses of individuals who seek emergency medical treatment in this nation's hospitals each day.

Pamela K. Epp—'96

APPENDIX

The text of the Emergency Medical Treatment and Active Labor Act provides:

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 title 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) and informs the individual (or 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 inappropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in class (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 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 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 any 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 an 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 individuals 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 title XI of this chapter) to assess whether the individual involved had an emergency medical condition which has 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 re-

view 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 or occur during or from 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 conflict 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 screening examination 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) of this section 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 to this section.

42 U.S.C. § 1395dd (1993).