Maurer School of Law: Indiana University
Digital Repository @ Maurer Law

Indiana Law Journal

Volume 73 | Issue 3 Article 2

Summer 1998

Lies, Damned Lies, and Narrative

David A. Hyman
University of Maryland School of Law

Follow this and additional works at: https://www.repository.law.indiana.edu/ilj

 Part of the Health Law and Policy Commons, and the Legal Education Commons

Recommended Citation

Hyman, David A. (1998) "Lies, Damned Lies, and Narrative," *Indiana Law Journal*: Vol. 73: Iss. 3, Article 2.
Available at: https://www.repository.law.indiana.edu/ilj/vol73/iss3/2

This Article is brought to you for free and open access by the Maurer Law Journals at Digital Repository @ Maurer Law. It has been accepted for inclusion in Indiana Law Journal by an authorized editor of Digital Repository @ Maurer Law. For more information, please contact kdcogswe@indiana.edu.


JEROME HALL LAW LIBRARY
INDIANA UNIVERSITY
Maurer School of Law
Bloomington

Lies, Damned Lies, and Narrative

DAVID A. HYMAN*

"When a story is well told, I park my analytic faculties at the door."[1]

"The plural of *anecdote* is not *data*."[2]

I. INTRODUCTION 798
II. NARRATIVE AND ANECDOTAL EVIDENCE 800
III. PATIENT-DUMPING NARRATIVES AND EMTALA 810
A. *Horror Stories and Statutory Salvation* 810
B. *A Closer Look at Some Patient-Dumping Horror Stories* 813
C. *The Perils of Narrative* 832
IV. PATIENT DUMPING AND STATISTICS 842
A. *Assessing the Frequency and Typicality of the Narratives* 842
B. *The Problem of "Advocacy Research"* 844
V. CONCLUSION 847
APPENDIX 852
A. *Highland General Study* 852
B. *Cook County Study* 854
C. *Parkland Study* 858
D. *D.C. Study* 860
E. *Memphis Study* 861
F. *Cook County II* 863
G. *Memphis II* 864

---

* Associate Professor, University of Maryland School of Law. B.A. 1983, J.D. 1989, M.D. 1991, University of Chicago. During the preparation of this Article, I received a summer research grant from the University of Maryland School of Law. Donna Tidwell, Associate General Counsel for the Department of Health of the State of Tennessee, smoothed the process of reviewing records relating to *In re Methodist Hospital*. Tom Prewitt of Armstrong, Allen, Prewitt, Gentry, Johnston & Holmes provided helpful background information regarding the same case. Mark E. Haddad of Sidley & Austin and DeWitt Alsup of Alsup & Alsup graciously provided access to various materials relating to *Burditt v. United States Department of Health and Human Services*, 934 F.2d 1362 (5th Cir. 1991). Bob Condlin, Bill Reynolds, William Brewbaker, Richard Epstein, Mark Hall, Peter Jacobson, Russell Korobkin, Geoffrey Miller, and Bill Richman provided helpful comments. Of course, all responsibility for errors of omission and commission remains my own—a caveat which applies with particular significance when it comes to narrative.

1. Harlon L. Dalton, *Storytelling on Its Own Terms*, *in* LAW'S STORIES 57, 57 (Peter Brooks & Paul Gewirtz eds., 1996).

2. Edith Greene, *A Love-Hate Relationship*, 18 JUST. SYS. J. 99, 100 (1995) (emphasis in original).

I. INTRODUCTION

Narrative is a boom industry. Narrative accounts appear routinely in major law reviews.[3] Proponents of narrative are found at many law schools, including the most prominent.[4] Symposia have been held, and the obligatory books have appeared.[5]

Narrative may have built a new room onto the mansion of legal academics, but that development has been controversial. A number of commentators have questioned the premises and ideological thrust of narrative.[6] Narrative's proponents have defended their field at length and with considerable vigor.[7] These issues have been sharply joined, but the debate has often descended to ad hominem attacks and insults. That result is not particularly surprising; as

---

3. *See* Daniel A. Farber & Suzanna Sherry, *Telling Stories Out of School: An Essay on Legal Narratives*, 45 STAN. L. REV. 807, 807 n.2 (1993) ("The footnotes in this essay confirm that legal stories have been published in most leading law reviews.").

4. *See* Anne M. Coughlin, *Regulating the Self: Autobiographical Performances in Outsider Scholarship*, 81 VA. L. REV. 1229, 1234 n.12 (1995) ("While it would be an exaggeration to claim that everybody is doing autobiography, certainly many law professors, insiders as well as outsiders, have made in their scholarship explicit references to their personal experiences."); Richard Delgado, *Storytelling for Oppositionists and Others: A Plea for Narrative*, 87 MICH. L. REV. 2411, 2411-12 (1989) ("Everyone has been writing stories these days."). Of course, narrative techniques have been used by legal scholars for decades, but the practice has become increasingly prevalent of late.

5. *See, e.g.*, DERRICK BELL, FACES AT THE BOTTOM OF THE WELL (1992); LAW'S STORIES, *supra* note 1; PATRICIA WILLIAMS, THE ALCHEMY OF RACE AND RIGHTS (1991); Symposium, *Legal Storytelling*, 87 MICH. L. REV. 2073 (1989).

6. *See, e.g.*, Coughlin, *supra* note 4, at 1232-59 (cataloguing difficulties with use of autobiographical materials); Farber & Sherry, *supra* note 3, at 831-40 (noting various "validity" issues with narrative scholarship); Randall L. Kennedy, *Racial Critiques of Legal Academia*, 102 HARV. L. REV. 1745 (1989); Richard A. Posner, *Legal Narratology*, 64 U. CHI. L. REV. 737, 742-44 (1997) (noting atypicality and frequency problem with narrative); Mark Tushnet, *The Degradation of Constitutional Discourse*, 81 GEO. L.J. 251 (1992); *see also* Neil A. Lewis, *For Black Scholars Wedded to Prism of Race, New and Separate Goals*, N.Y. TIMES, May 5, 1997, at B9 (noting critical assessment of narrative by some academics; "for Professor Sherry, 'storytelling doesn't bear the slightest pressure once you start to examine it'") (quoting Professor Suzanna Sherry).

7. *See* Kathryn Abrams, *Hearing the Call of Stories*, 79 CAL. L. REV. 971 (1991); Jane B. Baron, *Resistance to Stories*, 67 S. CAL. L. REV. 255 (1994); Jerome McCristal Culp, Jr., *Telling a Black Legal Story: Privilege, Authenticity, "Blunders" and Transformation in Outsider Narratives*, 82 VA. L. REV. 69 (1996); Richard Delgado, *On Telling Stories in School: A Reply to Farber and Sherry*, 46 VAND. L. REV. 665 (1993) [hereinafter Delgado, *On Telling Stories*]; Richard Delgado, *Rodrigo's Final Chronicle: Cultural Power, the Law Reviews, and the Attack on Narrative Jurisprudence*, 68 S. CAL. L. REV. 545 (1995); William N. Eskridge, *Gaylegal Narratives*, 46 STAN. L. REV. 607 (1994); Marc A. Fajer, *Authority, Credibility, and Pre-Understanding: A Defense of Outsider Narratives in Legal Scholarship*, 82 GEO. L.J. 1845 (1994); Alex M. Johnson, Jr., *Defending the Use of Narrative and Giving Content to the Voice of Color: Rejecting the Imposition of Process Theory in Legal Scholarship*, 79 IOWA L. REV. 803 (1994); Robin West, *Murdering the Spirit: Racism, Rights, and Commerce*, 90 MICH. L. REV. 1771 (1992).

Professor Farber has noted, "when someone challenges a story, 'you're not just criticizing someone's scholarship, but you're attacking their life, something that goes to the heart of their identity. . . . That can make a dialogue very difficult.'"[8] The few scholars that have been willing to enter this terrain can confirm the hazards which await.[9]

Unfortunately, the resulting hostility has disabled consideration of the most important question about narrative—is it really just "telling stories," as its critics claim, or does it provide a valid basis for the criticism and improvement of public policy, as its enthusiasts argue?[10] Stated more concretely, can one tell truth from fabrication? Are the unrepresentative stories ignored, and the representative ones embraced? How, if at all, is the frequency of an event factored into the equation?[11] What is the baseline from which the stories are assessed? These

---

8. Lewis, *supra* note 6, at B9 (quoting interview with Daniel A. Farber, Professor, University of Minnesota School of Law); *see also* Baron, *supra* note 7, at 259-60 ("The tone of the debate on the issue of the standards used to evaluate nondoctrinal scholarship at times seems to veer from vehement to, well, nasty. . . . The more personal the tale, the more difficult it can be to criticize it without seeming to engage in a personal attack on its author."); Farber & Sherry, *supra* note 3, at 836.

9. Consider the tone of the responses to Professor Coughlin's article, *see* Coughlin, *supra* note 4, critiquing the efforts of four narrativists. *See* Culp, *supra* note 7, at 79 n.31, 90 ("The length of this response does not permit me to respond to all of the distortions or misperceptions included in Professor Coughlin's 100-page article . . . . There are echoes of what appear to be envy in Professor Coughlin's work—especially in the unfair and ungenerous descriptions of Professor Williams' work."); Richard Delgado, *Coughlin's Complaint: How to Disparage Outsider Writing, One Year Later*, 82 VA. L. REV. 95, 95, 107 (1996) ("[Professor Coughlin's] article is almost wholly negative. Whenever a generous or ungenerous interpretation is equally possible, she unfailingly chooses the latter, often rearranging the evidence to suit her dire conclusion. . . . Coughlin's critique is a patchwork of uncharitable characterizations, imputations of motive, and outright misrepresentations of fact.").

Those who are unpersuaded should assess the remarkable degree of internecine animosity reflected in Gary Peller, *The Discourse of Constitutional Degradation*, 81 GEO. L.J. 313 (1992) (responding to Tushnet, *supra* note 6), and Mark Tushnet, *Reply*, 81 GEO. L.J. 343 (1992).

10. Narrativists vary in the extent to which they claim to be pursuing the latter goal. *See* Coughlin, *supra* note 4, at 1236 ("Although outsider storytellers pursue a variety of legal and political theories and goals, their texts share the following objective: each is concerned with exposing and ultimately overthrowing law's systematic preference for the interests of affluent white men over those of women and people of color."); Culp, *supra* note 7, at 88 ("Stories can alter public policy by adding aspects to the stories currently being told, or by introducing questions that are not being discussed."); Delgado, *On Telling Stories*, *supra* note 7, at 673-74 ("Outsider scholarship is often aimed not at understanding the law but at changing it."). *But see* Coughlin, *supra* note 4, at 1237 ("[Outsiders] are not necessarily seeking to revise the political commitments of our legal system."); Delgado, *supra* note 4, at 2437 (arguing that stories build solidarity and community within an oppressed group and can advance "psychic self-preservation").

11. Most narratives provide no evidence of typicality or frequency, but universality is still claimed, whether implicitly or explicitly. A particularly striking example is Jennifer M. Russell, *On Being a Gorilla in Your Midst, or, The Life of One Blackwoman in the Legal Academy*, 28 HARV. C.R.-C.L. L. REV. 259, 260-61 (1993) (recounting narrative where a picture of a gorilla was placed in the faculty mailbox of a black female professor; "In fairness, I must acknowledge the one-time appearance of the gorilla messenger. But even in the absence of other similarly crude emissaries, the reality is that blackwomen can only expect to have dysfunctional

issues cannot be answered by assertion or by considering matters from a distance; one must get into the trenches and grapple with the stories and statistics.

This Article provides an empirical foundation for addressing these critical issues, and evaluates the consequences of narrative in the legislative arena. The Emergency Medical Treatment and Active Labor Act ("EMTALA") was enacted because stories about "patient dumping" persuaded Congress to take action. Postenactment monitoring also relied heavily on such stories. Empirical research on patient dumping played at best a peripheral role, to the extent it was considered at all. As such, EMTALA offers an opportunity to empirically assess the claims of narrative's enthusiasts and critics. Close analysis confirms both the hopes of narrative's proponents, and the fears of its critics. The Article also documents a hazard neither camp has fully addressed—that empirical research can be partial as well.

Part II provides an overview of narrative and anecdotal evidence. Part III analyzes the narratives which surround the subject of patient dumping, including two which have become paradigmatic examples of the problem EMTALA was intended to solve. Part IV reviews the empirical scholarship regarding patient dumping, and draws some conclusions about the comparative strengths and weaknesses of statistics and narrative. Part V provides a brief conclusion.

II. NARRATIVE AND ANECDOTAL EVIDENCE

Narrative is essentially a vehicle for anecdotal evidence.[12] There is nothing wrong with that; advocates for every conceivable cause are united only by their use of anecdotal evidence.[13] This enthusiasm is no accident; anecdotes can crystallize and mobilize public opinion on even the most dull and arcane subject.[14] Unlike statistics, anecdotes offer simplicity and transparency.[15] Little

---

relationships in the legal academy."). *But see* Johnson, *supra* note 7, at 817 ("The point is not that 99% of the community or the relevant group suffered through the experience related in the Narrative, although that actually may be the case. Indeed . . . part of the strength of Narrative results from its atypical nature.").

12. *See* Tushnet, *supra* note 6, at 260 ("It is tempting to treat real life stories as 'anecdotal evidence' of some social phenomena whose more general existence is established by social surveys, statistical evidence, and the like.").

13. *See infra* notes 28-36.

14. In 1975, when Senator Kennedy held hearings on airline deregulation, he juxtaposed several days of economic testimony with a day of anecdotal consumer complaints regarding overbooking and the abuse of pets shipped as cargo. *See* MARTHA DERTHICK & PAUL J. QUIRK, THE POLITICS OF DEREGULATION 44 (1985). The architect of the hearings was then Special Counsel to the Subcommittee on Administrative Practice and Procedure of the Senate Judiciary Committee (and current Supreme Court Justice) Stephen G. Breyer. *See id.* at 40. The appeal of such anecdotes is made plain by Justice Breyer's shorthand reference to a day of testimony about "frozen dogs." *See id.* at 44.

15. *See* Jill Lawrence, *When Studies Don't Sway, Bring On the Victims*, L.A. TIMES, July 15, 1990, at A18 (quoting U.S. Rep. George Miller of California):

> Capitol Hill hearings are often characterized by the relentless recitation of government statistics, the polite drone of think tank researchers, the familiar

specialized knowledge is necessary to become outraged by a bad anecdote or self-congratulatory about a good one. Effective anecdotes simply speak for themselves, particularly in the legislative context.

Unfortunately, anecdotes provide no mechanism for assessing truthfulness, typicality, or frequency.[16] Without such information, it is exceedingly hazardous to generalize from what may well be an isolated or aberrant observation.[17] Scientists and medical researchers reject anecdotal evidence for precisely these reasons.[18] The rest of the population is less cautious.[19] Independent of the recent boom in narrative scholarship, lawyers are by training and inclination

---

arguments of professional lobbyists.

> Even the most sensitive lawmakers can become numbed. That's when it's time to bring on the victims.
>
> ....
>
> "They're very useful because they're real. They take all the studies and statistics and make them personal," said Rep. George Miller....
>
> ... [T]he consensus is that any cause is strengthened by the testimony of an ordinary person with no ax to grind.

16. *See* Michael J. Saks, *Do We Really Know Anything About the Behavior of the Tort Litigation System—and Why Not?*, 140 U. PA. L. REV. 1147, 1159, 1161 (1992). Saks notes that:

> [A]necdotal evidence is heavily discounted in most fields, and for a perfectly good reason: such evidence permits only the loosest and weakest inferences about matters a field is trying to understand. Anecdotes do not permit one to determine either the frequency of occurrence of something or its causes and effects....
>
> ....
>
> Anecdotes have a power to mislead us into thinking we know things that anecdotes simply cannot teach us.

Id.

17. *See id.* at 1159-62; *infra* note 41; *see also* Posner, *supra* note 6, at 742:

> The significance of a story of oppression depends on its representativeness. In a nation of more than a quarter of a billion people all blanketed by the electronic media, every ugly thing that can happen will happen and will eventually become known; to evaluate policies for dealing with the ugliness we must know its frequency, a question that is in the domain of social science rather than of narrative.

18. *See* Gina Kolata, *On Fringes of Health Care, Untested Therapies Thrive*, N.Y. TIMES, June 17, 1996, at A1 (noting that scientists and medical researchers reject the anecdotal evidence on which alternative medicine is based). Anecdotal evidence is suspect because it cannot distinguish causation from coincidence, reporting error, self-deception, observer bias, or intentional fraud.

19. The gullibility of the public is demonstrated by the repeated use of unrepresentative anecdotal evidence by politicians and the range of "urban legends" which have circulated in recent years. Despite articles debunking these urban legends in a wide range of publications, a remarkable number of people will insist that the incident happened to a "friend of a friend." Access to the Internet and television seems to have intensified the rate at which such legends are created and disseminated. *See* Posner, *supra* note 6, at 742; George Johnson, *Pierre, Is That a Masonic Flag on the Moon?*, N.Y. TIMES, Nov. 24, 1996, § 4, at 4 (decrying role of Internet in propagating conspiracy theories of various sorts).

enthusiastic about anecdotal evidence.[20] Courts have historically embraced anecdotal evidence as well, although there have recently been some encouraging signs of increased skepticism.[21] Legislatures—populated by lawyers and exceedingly attuned to public pressure—are enthusiasts of anecdotal evidence.[22] Members of the executive branch, regardless of political affiliation, share the same sentiments.[23] Newspapers are full of anecdotal evidence.[24] Worst of all is

---

20. *See, e.g.*, Maurice Rosenberg, *Federal Rules of Civil Procedure in Action: Assessing Their Impact*, 137 U. PA. L. REV. 2197, 2211 (1989):

> The tendency of legally-trained minds to prefer thinking to counting is legendary. So is the lawyer's preference for learning by watching for the vivid case rather than tabulating the mine-run cases. The problem is not that watching this case or that is useless. A dramatic case or anecdote may be more informative and more memorable than a tubful of printouts. But the rub is that good anecdotes do not care if they are not representative; they can be badly misleading if generalized.
>
> Nor does the problem end with the misleading anecdote. No matter how carefully the facts or data are gathered to respond to the pivotal questions, there will be great trouble in penetrating made-up minds. . . . [L]awyers, lawmakers, and judges . . . prefer anecdotes to tables.

21. *See, e.g.*, Wells v. Ortho Pharm. Corp., 788 F.2d 741, 745 (11th Cir. 1986) (sustaining $5.1 million bench verdict, despite uniform epidemiological evidence that spermicide could not have caused birth defect in question); Joseph Sanders, *From Science to Evidence: The Testimony on Causation in the Bendectin Cases*, 46 STAN. L. REV. 1 (1993) (arguing that trials are incapable of adequately conveying scientific evidence to juries and that courts systematically fail to get it right in handling epidemiological evidence).

Of late, the courts have increasingly rejected anecdotal evidence. *See* Daubert v. Merrell Dow Pharm., Inc., 43 F.3d 1311 (9th Cir. 1995) (affirming district court's grant of summary judgment for defendant, where expert testimony that drug was "capable of causing" birth defects was inadmissible); Richard B. Schmitt, *Who Is an Expert? In Some Courtrooms, the Answer is 'Nobody'*, WALL ST. J., June 17, 1997, at A1 (reporting that increased "gatekeeping" by judges of "expert" testimony now prevents some cases from going to the jury).

22. Consider the recent enthusiasm for enacting "consumer protection" against managed care. The perception that such legislation is necessary is the direct result of a variety of anecdotal horror stories. *See* Stuart Auerbach, *Managed Care Backlash*, WASH. POST HEALTH, June 25, 1996, at 12. Even legislators with long-standing reputations against regulatory intervention have rushed to the side of the angels. *See* Romesh Ratnesar, *Bad Medicine*, NEW REPUBLIC, July 7, 1997, at 10, 10 ("Something was strange about this Capitol Hill press conference. Here were Republican Senator Alfonse D'Amato and Republican Congressman Charlie Norwood introducing 'The Patient Access to Responsible Care Act' and castigating private enterprise in tones that would make Ralph Nader proud.").

Those with a more jaundiced perspective about such matters might begin by noting the identity of the likely beneficiaries of such legislation. *See* Auerbach, *supra*, at 12 ("Patients who feel wronged by the system have joined in a potent lobby with doctors, nurses, hospitals and other health care providers whose professional survival, incomes and long-held practice patterns are threatened by managed care."); *see also* David A. Hyman, *Consumer Protection in a Managed Care World: Should Consumers Call 911?*, 43 VILL. L. REV. (forthcoming May 1998); David A. Hyman, Drive-Through Deliveries: Is "Consumer Protection" Just What the Doctor Ordered? (unpublished manuscript, on file with author).

23. *See infra* notes 28-29. Difficulties with this issue are not limited to the Oval Office. Consider former Secretary of Labor Reich's memoirs. Although the issue of "creative reconstruction" was noted early on in a book review, *see* Evan Thomas, *Inside the Beltway but*

television, with its ceaseless appetite for sympathetic victims and easily identifiable villains.[25]

Out of the Loop, N.Y. TIMES, Apr. 27, 1997, § 7, at 8 (reviewing ROBERT B. REICH, LOCKED IN THE CABINET (1997)), a full-blown controversy eventually erupted over the degree to which Mr. Reich took liberties with the facts. *See* Lane Kirkland, *Lane Kirkland's Letter*, WASH. POST, June 5, 1997, at A21 ("I did not, in fact, utter the words that you attribute to me in various places, in direct quotation marks, as though you were repeating my words verbatim."); Jonathan Rauch, *Jonathan Rauch on Robert Reich*, WASH. POST, June 5, 1997, at A21 (identifying a variety of errors in Reich's memoirs; "The book reads like good fiction. Unfortunately, some of it is."). For Reich's "poetic license" response, see Robert Reich, *Robert Reich Replies*, WASH. POST, June 5, 1997, at A21 ("I've captured the mood, the tone, the feel of the conversation, even if I got some of the words wrong. And that's the truth."). Similar explanations have been offered on behalf of narrative. *See infra* text accompanying note 44. The Supreme Court is less forgiving of such lapses. *See, e.g.*, Masson v. New Yorker Magazine, Inc., 501 U.S. 496, 511 (1991) ("In general, quotation marks around a passage indicate to the reader that the passage reproduces the speaker's words verbatim.").

24. *See, e.g.*, Steven A. Holmes, *It's Awful! It's Terrible! It's . . . Never Mind*, N.Y. TIMES, July 6, 1997, § 4, at 3. Holmes lists a host of examples of the news media credulously accepting reports of

> a campaign to torch black churches, a surge in juvenile crimes, rampant child abuse in day-care centers, a rape crisis on college campuses and the continued poisoning of the country by cancer-causing chemicals like alar, saccharin or cyclamates or by electromagnetic forces emanating from high-voltage power wires.

Id.; *see also* Karen Frost et al., *Relative Risk in the News Media: A Quantification of Misrepresentation*, 87 AM. J. PUB. HEALTH 842, 844 (1997) ("News reporting is . . . driven by rarity, novelty, commercial viability, and drama more than by concerns about relative risk."); *infra* note 244 (noting inadequacies in newspaper coverage of alleged dramatic rise in domestic violence on Super Bowl Sunday).

25. A recent episode of *Geraldo* focused on an alleged episode of patient dumping involving a two-year-old child who had stopped breathing. *See The Geraldo Rivera Show: Panelists Discuss the Refusal of St. Mary's to Take Two-Year Old Danielle Davis into Their Hospital* (ABC television broadcast, Aug. 8, 1996) (transcript available in LEXIS, News Library, Scripts File). A physician at St. Mary's Hospital ("St. Mary's") ordered the ambulance by radio to take the child to another hospital because St. Mary's lacked pediatric "tools." *Id.* The Fifth and Seventh Circuits have held that such diversions do not violate EMTALA—and the regulations confirm that conclusion, at least so long as the hospital does not own the ambulance. *See* Miller v. Medical Ctr., 22 F.3d 626, 629 (5th Cir. 1994) (holding that telephone call to emergency department does not trigger EMTALA); Johnson v. University Hosps., 982 F.2d 230 (7th Cir. 1992); 42 C.F.R. § 489.24(a)-(b) (1997). Those inconvenient facts, and a few others which came out during the show, did not keep Mr. Rivera from turning the incident into a particularly egregious case of patient dumping on nationwide television. Indeed, Mr. Rivera was so taken with this incident that he subsequently used it in a show entitled *Rivera Live: The Most Incredible 911 Calls in Recent Times: Panelists Discuss the 911 Calls and Their Tragedies* (ABC television broadcast, Dec. 18, 1996) (transcript available in LEXIS, News Library, Scripts File). *See also* Burkhard Bilger, *TV's Power Doctor Shows vs. the HMO*, N.Y. TIMES, Dec. 22, 1996, § 2, at 41 (noting that popular shows like *Chicago Hope* and *E.R.* present atypical anecdote-driven views of managed care). However, Gail Wilensky, former director of the Health Care Financing Administration, observes that such shows are "'less offensive than some of the documentary shows. It's when "60 Minutes" goes after health care that I end up shouting at the T.V.'" *Id.* (quoting Gail Wilensky).

The results can range from comedy to tragedy, as the anecdotes "take[] permanent root in the popular press and the public mind regardless of when [the event] happened—or whether it happened at all."[26] Such legends can be a "public relations nightmare" and "a genuine headache" for those who have to deal with them.[27]

Consider a few examples which make clear the complexities of casual reliance on anecdotal evidence. President Reagan used to complain about (highly unrepresentative) "welfare queens," who drove Cadillacs, and used food stamps to buy steaks.[28] President Clinton used the stories of five (highly unrepresentative) women to justify his veto of a bill banning "partial-birth abortions."[29] Tort-reform proponents use anecdotes to show that the "[l]egal

---

26. Andre Henderson, *Heard the One About the Man-Eating Squirrel?*, GOVERNING, July 1994, at 25, 25.

27. *Id.*; *see also* Roy Furchgott, *Surfing for Satisfaction: Consumer Complaints Go On Line*, N.Y. TIMES, June 8, 1997, § 3, at 8 (noting that urban legends are hard to kill, and reporting that attempts to refute urban legend of $250 Neiman Marcus cookie recipe have been unavailing; "'It's like trying to hug smoke.'") (quoting Neiman Marcus's Internet Director, Mara Harris). Even when the underlying incident is accurately portrayed, public perception of its frequency can be dramatically skewed. *See, e.g.*, Eric Silver et al., *Demythologizing Inaccurate Perceptions of the Insanity Defense*, 18 LAW & HUM. BEHAV. 63, 67-68 (1994) (noting that public systematically overestimates frequency with which insanity defense is raised and its success when raised).

28. *See* Steven V. Roberts, *Food Stamps Program: How It Grew and How Reagan Wants to Cut It Back*, N.Y. TIMES, Apr. 4, 1981, at 11 ("The legend of the so-called 'welfare queen,' a heavy woman driving a big white Cadillac and paying for thick steaks with wads of food stamps, became a rhetorical staple for conservative politicians, including Ronald Reagan."). The anecdote helped to frame public views about welfare and its recipients. *See* Isabel Wilkerson, *The Tallest Fence: Feelings on Race in a White Neighborhood*, N.Y. TIMES, June 21, 1992, § 1, at 18 (recounting views of European-American woman living in the suburbs of Chicago, who worked as a waitress and was the wife of a police officer, and who complained that "blacks buy porterhouse steaks with food stamps, while we eat hamburgers," but also reporting that the woman "had never actually seen any blacks do this. But she had heard and read stories, and that [was] enough."). Such anecdotes are unrepresentative of the lives of those receiving welfare. For a bitter perspective on the disparity, *see* Sylvia A. Law, *Ending Welfare as We Know It*, 49 STAN. L. REV. 471, 474-88 (1997) (collecting five common but erroneous assumptions about welfare).

29. *See* Todd S. Purdum, *President Vetoes Measure Banning Type of Abortion*, N.Y. TIMES, Apr. 11, 1996, at A1. Purdum reports that after vetoing the bill, President Clinton

> held an emotional White House ceremony at which he was flanked by five women who had undergone such abortions and who spoke tearfully about the disorders that threatened their lives and those of their fetuses and led to agonizing decisions.
>
> . . . .
>
> . . . [President] Clinton called the procedure a "potentially life-saving, certainly health-saving" measure for "a small but extremely vulnerable group of women and families in this country, just a few hundred a year."

Id. (quoting President Clinton). In reality, the procedure (which is itself highly unrepresentative of abortions) is performed thousands of times a year, "[i]n the vast majority of cases . . . on a healthy mother with a healthy fetus that is 20 weeks or more along." David Stout, *An Abortion Rights Advocate Says He Lied About Procedure*, N.Y. TIMES, Feb. 26, 1997, at A12; *see also* John Leo, *All the News That Fits Our Biases*, U.S. NEWS & WORLD REP., June 10, 1996, at 26,

[s]ystem [is] [o]ut of [c]ontrol"—including my personal favorite, the minister's wife who sued a guide-dog school for $160,000 for injuries sustained when she stood in the way of a blind man learning to use a seeing-eye dog, and the man stepped on her foot.[30] Opponents of tort reform have their own anecdotes about how trial lawyers have saved Western civilization.[31] Environmental enthusiasts use the threatened extinction of "charismatic" higher-order mammals and birds (for example, bears, wolves, and owls), to build support for a law which in reality primarily protects plants.[32] Property-rights advocates have a series of

---

26 ("two leading practitioners of this procedure have said elective use is not unusual").

30. American Tort Reform Ass'n, *ATRA Horror Stories* (last modified June 28, 1996) <http://www.atra.org/atra/ath.htm>. Returning salvos in the war of anecdotes may be found at the Association of Trial Lawyers of Am., *Civil Justice Facts* (visited Nov. 2, 1997) <http://www.atlanet.org/pubedu/new/othrmenu.ht#anchor882476> (presenting "the other side of the story" of anecdotes involving the tort system). A more statistically oriented perspective is provided by Marc Galanter, *Real World Torts: An Antidote to Anecdote*, 55 MD. L. REV. 1093 (1996), and Saks, *supra* note 16. *But see* Samuel Jan Brakel, *Using What We Know About Our Civil Litigation System: A Critique of "Base-Rate" Analysis and Other Apologist Diversions*, 31 GA. L. REV. 77, 87-160 (1996) (noting that statistical analyses of tort system are helpful, but "playing the numbers game" as designed by apologists for the current tort system is a diversion, and arguing that evidence that civil-justice system works poorly is overwhelming, despite "know-nothing" attitude of system's defenders).

31. *See, e.g.*, Association of Trial Lawyers of Am., *ATLA Net* (visited Oct. 27, 1997) <http://www.atlanet.org/pubedu/new/women.ht#anchor595369> (collecting successes of the tort system from the Association of Trial Lawyers of America). Such anecdotes rarely mention the loading cost of the tort system, the frequency with which its aim is less than perfect, or the extent to which the information surfaced independent of the tort system. *See, e.g.*, Brakel, *supra* note 30, at 129-32 ("[Waves of litigation involving particular products or industries] do not just form through a convergence of natural forces. They are carefully contrived, shaped, nurtured, and set loose by the plaintiffs' bar which has the process pretty much down to a science—however faulty the science behind the charges themselves."); Gina Kolata, *Legal System and Science Come to Differing Conclusions on Silicone*, N.Y. TIMES, May 16, 1995, at D6 (arguing that silicone is latest frontier in misuse of anecdotal evidence by legal system).

32. As of September 30, 1997, there were 542 listed endangered species of plants and 337 listed endangered species of animals. *See U.S. Department of Fish and Wildlife Service: Division of Endangered Species* (last modified Sept. 30, 1997) <http://www.fws.gov/~r9endspp/boxscore.html>. The list is composed of 57 mammals, 75 birds, 9 amphibians, 14 reptiles, 67 fishes, 56 clams, 15 snails, 24 insects, 5 arachnids, 15 crustaceans, 514 flowering plants, 2 conifers and cycads, 26 ferns, and others. *See id.* Whether one accords any significance to this distribution depends entirely on whether one is using higher-order mammals and birds to accomplish an objective the public would be less concerned about if it involved flowering plants, clams, fishes, and the like. *See* Jeffrey J. Rachlinski, *Noah by the Numbers: An Empirical Evaluation of the Endangered Species Act*, 82 CORNELL L. REV. 356, 389 (1997) ("It may well be that our society does not truly value insects, clams, snails, or plants enough to allocate the resources necessary to preserve these species. It may be that only megafauna, like grizzly bears, bald eagles, and grey wolves, merit protection."). Although representatives of the Fish and Wildlife Service ("FWS") appear to believe there is a "philosophic imperative" to save all endangered species, they are savvy enough to lead with their strong suit. *Compare* Verne G. Kopytoff, *A Fly Changes California Builders' Plans*, N.Y. TIMES (nat'l ed.), June 1, 1997, at 38 (noting "philosophic[] imperative"), *with* U.S. Fish & Wildlife Serv., *Endangered Means There's Still Time* (visited Oct. 27, 1997) <http://www.fws.gov/~bennishk/endang/sml/sld01.html> (presenting FWS slide show

anecdotes involving ordinary citizens, senseless laws, and faceless bureaucracies.[33] Some members of Congress have embraced uniform screening for prostate cancer because of their personal (successful) experience with the test.[34] Other members of Congress are ready to cripple or abolish the Internal Revenue Service ("IRS") on the strength of some horrendous anecdotes about taxpayer mistreatment.[35] Finally, do not forget the anecdotes which blamed the

---

supporting the Endangered Species Act which only introduces endangered plants toward the end, after pictures of such endangered species as wolves, tigers, elephants, butterflies, and manatees).

33. See generally JAMES V. DELONG, PROPERTY MATTERS 11-23 (1997), and the web page of the Regulatory Policy Center, *see* Regulatory Policy Ctr., *Stories* (visited Oct. 27, 1997) <http://www. regpolicy.com/stories.html>, for what Mr. DeLong aptly characterizes as "horror stories." The obligatory anecdotal response may be found at National Wildlife Fed'n, *Fairy Tales & Facts About Environmental Protection* (visited Oct. 27, 1997) <http://www.igc.org/nwf/news/archpres/fairy_tl.html> (listing and attempting to debunk the most common anecdotes). To be sure, the National Wildlife Federation ("NWF") has its own rather large axe to grind, demonstrated by the fact that it invariably discounts the burden of any regulation on property owners, and blames the property owner for any and all difficulties.

Remarkably enough, the same incident can give rise to competing anecdotal stories. Did the listing of the Stevens kangaroo rat worsen the damage from the fires which devastated California in 1993? *Compare* RESOURCES, COMMUNITY, AND ECON. DEV. DIV., U.S. GEN. ACCOUNTING OFFICE, GAO/RCED-94-224, ENDANGERED SPECIES ACT: IMPACT OF SPECIES PROTECTION EFFORTS ON THE 1993 CALIFORNIA FIRE 9-10 (1994) (it did not), *with* Ike C. Sugg, Rats, Lies, and the GAO: A Critique of the General Accounting Office Report on the Role of the Endangered Species Act in the California Fires of 1993 (Aug. 1994) (unpublished manuscript, on file with the *Indiana Law Journal*) (it did). DeLong wryly observes that "[h]ere the matter rests, with two contradictory versions of the story circulating, and each side convinced that the other is both malicious and mendacious." DELONG, *supra*, at 14.

34. *See, e.g.*, Sandra G. Boodman, *Self-Interest Yields High Profile on Hill*, WASH. POST, May 23, 1995, at 20 (noting support for Medicare reimbursement for screening by Sen. Richard C. Shelby, whose prostate cancer was caught by a test); Dan Colburn, *Medical Screening Tests Can Be 'a Bit of a Lottery'*, WASH. POST HEALTH, Feb. 18, 1997, at 15 (same); Curt Suplee, *Prostate Cancer Exam Benefits Are Questioned; Association Counsels Against Routine Tests*, WASH. POST, Mar. 15, 1997, at A1 (reporting that case for routine screening is equivocal at best); David Willman, *Prostate Cancer Legislation Poses Dilemma for Dole, Congress*, L.A. TIMES, Dec. 10, 1995, at A34 (noting support for Medicare reimbursement for screening by legislators who are survivors of prostate cancer, although case for universal screening is equivocal at best).

The power of these narratives was such that the 1997 budget act made such screening a covered benefit under Medicare Part B, despite the imminent bankruptcy of Medicare Part A.

35. *See* John M. Broder, *Demonizing the I.R.S.*, N.Y. TIMES, Sept. 20, 1997, at D1 (recounting anecdote of taxpayer who committed suicide because of IRS harassment; "Committee staffers say that while the bleak conclusion of Mr. Kugler's tale is obviously more extreme than most, it is emblematic of the way the I.R.S. operates—inflexible, insensitive, intrusive and, ultimately, ineffective."); *Reforming the Tax Collector*, N.Y. TIMES, Sept. 26, 1997, at A18 ("for many in Congress the anecdotes reflect a hostile, corrupt agency that cannot correct itself").

To the extent there is a problem, Congress should not escape its share of blame, since it drafted the laws which the IRS is enforcing, and gave it the authority to do so. *See* Paul Glastris, *Lien on Congress*, U.S. NEWS & WORLD REP., Oct. 6, 1997, at 32. The Clinton administration initially attempted to finesse the issue by having the IRS Acting Commissioner

near-collapse of the savings-and-loan industry on fraud and abuse by Charles Keating and his ilk.[36]

Some of these anecdotes are true, others are questionable, and some are simply fraudulent. More importantly, those that are true are not necessarily representative. Figuring out which is which is a nontrivial task, but the adverse consequences of generalizing from an unrepresentative anecdote can be severe. Unfortunately, as the underlying subject matter becomes more complex and the trade-offs become tougher, the temptation to use anecdotal evidence becomes overwhelming.

All of these complexities are heightened when narrative is the primary or exclusive source of data on an issue of public concern. Despite these difficulties, proponents argue that narrative puts a human face on a particular problem,[37] brings new voices to the table,[38] makes plain unexamined assumptions and

---

apologize for his agency's conduct in any given case, while the President simultaneously defended the IRS's behavior as a general proposition. *See* Peter Baker, *Clinton Defends IRS*, WASH. POST, Oct. 1, 1997, at A6. More generally, even

> if the IRS hearings were high drama, they failed to shed much light on how widespread such abuses are, where they occur or who's really responsible. The GAO concluded last week that it is impossible to know, because the IRS doesn't keep such records. And over the summer, a probe by the National Commission on Restructuring the IRS, a bipartisan group that interviewed more than 300 IRS agents, found few examples of taxpayer abuse. Even several whistle-blowers said most IRS front-line agents were decent ethical people.

Michael Hirsh, *Behind the IRS Curtain*, NEWSWEEK, Oct. 6, 1997, at 29, 30; *see also* Paul Wiseman, *IRS May Not Be the Monster Critics Say It Is*, USA TODAY, Nov. 5, 1997, at 17A ("Horror stories happen but are relatively rare. Mistakes are inevitable at an agency with more than 100,000 employees who process more than 200 million returns a year.").

36. Lincoln Savings & Loan came "to epitomize the troubles of the savings and loan industry" and Attorney General Barr labelled Keating as the man that "has come to symbolize the excesses that led to the collapse of the thrift industry." Calvin Sims, *Keating Convicted of U.S. Charges*, N.Y. TIMES, Jan. 7, 1993, at D1. By 1996, Mr. Keating's convictions in state and federal courts were overturned, and *The New York Times* observed that

> [d]espite the efforts of Government officials, and the media, to seize on the chicanery of some savings and loan owners, records now show they accounted for a modest portion of the losses—perhaps 5 percent.
>
> Several years ago, a Federal commission concluded that the scale of the crisis resulted largely from "a systematic breakdown in the political system."

James Sterngold, *For Some, It's Still a Wonderful Life*, N.Y. TIMES, Dec. 8, 1996, at E3.

37. *See, e.g.*, Abrams, *supra* note 7, at 1031 ("Narratives are more likely to reveal a neglected perspective or theme that needs to play a role in legal decisionmaking, or to establish a new context or backdrop for legal discussions."); Baron, *supra* note 7, at 268 ("stories employ concrete particulars to depict the human dimensions and consequences of legal problems"); Fajer, *supra* note 7, at 1857; *see also* International Bhd. of Teamsters v. United States, 431 U.S. 324, 339 (1977) (observing that anecdotal evidence brings "the cold numbers convincingly to life").

38. *See, e.g.*, Baron, *supra* note 7, at 263 ("[a]ccounts that are at odds with traditional or dominant assumptions can thus be silenced or rendered implausible"); Coughlin, *supra* note 4, at 1237 ("By producing new evidence about outsiders' lives, storytellers are demanding 'an enlargement of the picture, a corrective to oversights resulting from inaccurate or incomplete vision' . . . .") (footnote omitted) (quoting Joan W. Scott, *Experience*, *in* FEMINISTS THEORIZE

implicit bias,[39] and can enhance the probability of a real solution by transforming the terms of discourse.[40] Critics respond that the narrative format precludes consideration of the critical issues of frequency and typicality,[41] raises difficult issues of professional discourse,[42] and may even represent the rejection of

---

THE POLITICAL 22, 24 (Judith Butler & Joan W. Scott eds., 1992)); Fajer, *supra* note 7, at 1853 (observing "rhetoric of 'excluded voices'" employed by many outsider scholars); West, *supra* note 7, at 1781.

39. *See, e.g.*, Milner S. Ball, *The Legal Academy and Minority Scholars*, 103 HARV. L. REV. 1855, 1859 (1990) (noting that stories "teach us how racism and sexism may be hidden but are nonetheless built into the law of the dominant world and dehumanize it"); Susan Bandes, *Empathy, Narrative, and Victim Impact Statements*, 63 U. CHI. L. REV. 361, 365 (1996) ("Such scholarship seeks to expose the unstated, longstanding privileging of dominant narratives and emotional attitudes in the legal arena."); Baron, *supra* note 7, at 259 ("stories are said to demonstrate something about how power works, especially how it can inhere invisibly in the most apparently 'neutral' of standards"); Mari J. Matsuda, *Public Response to Racist Speech: Considering the Victim's Story*, 87 MICH. L. REV. 2320, 2324 (1989) ("This methodology, which rejects presentist, androcentric, Eurocentric, and false-universalist descriptions of social phenomena, offers a unique description of law.").

40. *See, e.g.*, Coughlin, *supra* note 4, at 1230-31:

> Storytelling . . . has a radical transformative potential. If the experiences of African-Americans and women have been invisible to or misconstrued by lawmakers, then outsider law professors must use their positions of influence to communicate the intangibles of outsider experience, intangibles that are repressed by traditional legal doctrine, analysis and theory. By telling stories about their individual experiences and pain, outsiders strive to transform the legal academy and legal scholarship, the law itself, and ultimately the larger culture.

See also, e.g., Fajer, *supra* note 7, at 1858 (describing effects of using first-person stories); Toni M. Massaro, *Empathy, Legal Storytelling, and the Rule of Law: New Words, Old Wounds*, 87 MICH. L. REV. 2099, 2105 (1989) ("Telling stories . . . move[s] us to care, and hence pave[s] the way to action.").

41. *See* Richard A. Epstein, *Legal Education and the Politics of Exclusion*, 45 STAN. L. REV. 1607, 1617-18 (1993) (arguing that issues of truthfulness, frequency, and typicality preclude generalization); Farber & Sherry, *supra* note 3, at 838-40 (noting problems raised by atypical narratives); *see also* Posner, *supra* note 6, at 744:

> The risk of narratology to which MacKinnon herself succumbs in her writings on pornography is that of atypicality. MacKinnon is a magnet for the unhappy stories of prostitutes, rape victims, and pornographic models and actresses. Even if all these stories are true (though how many are exaggerated? Does MacKinnon know?), their frequency is an essential issue in deciding what if anything the law should try to do about the suffering that the stories narrate.

42. *See supra* notes 8-9; *see also* Abrams, *supra* note 7, at 980 (noting argument that use of stories precludes further discourse); Coughlin, *supra* note 4, at 1281 ("personal stories tend to pre-empt responses other than sympathy or silence, precisely because any critical commentary or desire for clarification may be dismissed as ad hominem—and any criticism necessarily is ad hominem, since the material available for criticism or clarification is the scholar's personal experience") (emphasis omitted) (footnote omitted); Farber & Sherry, *supra* note 3, at 836 ("The norms of academic civility hamper readers from challenging the accuracy of the researcher's account; it would be rather difficult, for example, to criticize a law review article by questioning the author's emotional stability or veracity."); *id.* at 851 n.233 (characterizing storytelling as an "authoritarian conversation-ending move").

rationality.[43] Proponents argue in turn that narrative is only persuasive if its "concreteness, particularity, and internal consistency of the account command the reader's assent" or if the narrative evokes a "flash of recognition" by the reader.[44] Alternatively, narrativists claim that knowledge is socially constructed, and concepts of accuracy, truthfulness, and representativeness are largely irrelevant in a postmodern world.[45]

One way or another, these matters must be sorted out. If narrative is to provide a sound basis for public policy, a series of practical questions must be answered. Is the "flash of recognition" enough to ensure only "good anecdotes" become the basis for laws, or are additional safeguards necessary? Should we ignore narrative unless it is accompanied by an affidavit? Is a single affidavit sufficient, or should we require cross-examination and confirming witnesses? Is a statistical analysis which proves typicality and frequency necessary?

These issues cannot be answered in a vacuum. Unfortunately, by its very nature, narrative is personalized, and there is usually little in the way of external

---

43. Suzanna Sherry has argued that for narrativists,

> [a]necdotal evidence replaces scientific data, and telling stories becomes the equivalent of making rational arguments. Thus, what people say becomes as important as what they can "prove," and the persuasiveness of any given claim rests as much on its noncognitive or emotional appeal as on whether it accords with the dictates of reason and common knowledge.

Suzanna Sherry, *The Sleep of Reason*, 84 GEO. L.J. 453, 459 (1996) (footnote omitted).

44. Abrams, *supra* note 7, at 1023; *see also id.* at 1003 (noting stories "resonate" with personal experiences); Robin West, *Jurisprudence and Gender*, 55 U. CHI. L. REV. 1, 56 (1988) (asserting that narrative carries with it the "unequivocal shock of recognition").

Narrativists are also quick to discount the issue of truthfulness or honesty. *See, e.g.*, Robert L. Hayman, Jr. & Nancy Levit, *The Tales of White Folk: Doctrine, Narrative, and the Reconstruction of Racial Reality*, 84 CAL. L. REV. 377, 400 n.83 (1996) ("But the truth or falsity of autobiographical details is rarely important to the narrative message: the stories themselves are generally metaphors, or stories about subjective impressions."); Johnson, *supra* note 7, at 816 n.65 ("I think it is perfectly acceptable [in legal narratives] if that which is presented as the truth turns out not to be objectively true in the way in which that standard typically is viewed and used."); Kim Lane Scheppele, *Foreword: Telling Stories*, 87 MICH. L. REV. 2073, 2085 (1989) ("The same event can be described in multiple ways, each true in the sense that it genuinely describes the experience of the storyteller, but each version may be differently organized and give a very different impression of 'what happened.'").

45. *See, e.g.*, Coughlin, *supra* note 4, at 1238 ("radical scholars maintain that there is no objective position from which to describe pertinent events because knowledge claims always are conditioned by the historical, cultural, and discursive situation of the person making the claim") (footnote omitted); Delgado, *supra* note 4, at 2416 ("[M]uch of social reality is constructed."); Peller, *supra* note 9, at 330 & n.94 (noting "the inevitable ideological, racial, and cultural 'situatedness' of what poses as objectivity or neutrality in mainstream legal discourse").

It is ironic that narrativists insist that their version of the events in question is accurate and trustworthy, while simultaneously denying the possible of such universality. *See* Baron, *supra* note 7, at 260; Coughlin, *supra* note 4, at 1272. More generally, such denials of objectivity are problematic, no matter how extensive the obligatory footnoting of Thomas Kuhn, Michel Foucault, and Jacques Derrida. Those who really believe that reality is indeterminate because it is socially constructed should get out more often—perhaps to their local emergency department ("ED").

data to confirm or undercut the account, let alone assess its frequency and typicality. EMTALA presents an unusual opportunity to assess these matters, because there is sufficient external data to examine both the narrative and empirical case for the law. Thus, EMTALA presents a natural experiment with which to determine whether narrative's critics or its proponents have the better of the argument.

III. PATIENT-DUMPING NARRATIVES AND EMTALA

A. Horror Stories and Statutory Salvation

As noted previously, EMTALA was enacted because horror stories about patient dumping persuaded Congress to take action.[46] Postenactment monitoring emphasized anecdotal evidence as well—at the only congressional hearing on patient dumping, the first panel featured three witnesses who provided personal anecdotes about their experiences with dumping,[47] and the committee report

---

46. Congressman Stark became convinced that EMTALA was necessary because of a study conducted at Highland Green Hospital in Alameda County, California as well as by a series of articles in the *Oakland Tribune*. *See, e.g.*, Lisa M. Enfield & David P. Sklar, *Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem*, 13 AM. J.L. & MED. 561, 579 n.99 (1988); *see also* 132 CONG. REC. 217 (1986) (noting that articles in the *Oakland Tribune* are "one of the reasons that we have been able to include in the reconciliation bill . . . 'antidumping' language designed to stop hospitals from dumping poor patients on other public and charity hospitals") (statement of Rep. Fortney (Pete) H. Stark); *infra* notes 50-51.

Almost half of the states had enacted laws prohibiting patient dumping, but they were rarely enforced. *See* 131 CONG. REC. 28,569 (1985) ("enforcement of the laws has been poor [and] many of the abuses have occurred in states which already have laws on the books"); Karen H. Rothenberg, *Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care*, 26 HOUS. L. REV. 21, 53-57 (1989) (noting prevalence of state antidumping laws). Although the federal Hill-Burton Act imposed similar obligations on the hospitals which received such funds, the scope of that duty is contested, and its enforcers have been reluctant to enforce its obligations vigorously. *See* James F. Blumstein, *Court Action, Agency Reaction: The Hill-Burton Act as a Case Study*, 69 IOWA L. REV. 1227 (1984); Sylvia A. Law, *A Right to Health Care That Cannot Be Taken Away: The Lessons of Twenty-Five Years of Health Care Advocacy*, 61 TENN. L. REV. 771, 778 (1994).

One could argue that EMTALA flowed from approaching the problem of access to health care from a civil-rights perspective and was not simply a response to a few anecdotes regarding patient dumping. Although some of EMTALA's proponents outside of Congress may have viewed the statute in this light, the legislative history is quite clear that EMTALA was sold to Congress on the basis of a few bad anecdotes. The case for vigorous enforcement of EMTALA was made on exactly the same basis. *See infra* notes 47, 61. As such, EMTALA is a classic example of narrative-driven legislation, and any effort to deny that legacy should be viewed with considerable skepticism.

47. *See Equal Access to Health Care: Patient Dumping: Hearing Before a House Subcomm. on Human Resources & Intergovernmental Relations of the House Comm. on Gov't Operations*, 100th Cong. 14-97 (1987) [hereinafter *Equal Access Hearing*]. The first panel featured Ms. Zettie Mae Hill, another witness to an alleged dumping incident, and a representative of an advocacy group who recounted anecdotes about various alleged episodes of dumping from around the nation. *See id.* The second panel was composed of three long-time physician opponents of economically motivated patient transfers, two of whom had authored

includes no less than seventeen anecdotes on the subject.[48] These trends are reflected in academic assessments of patient dumping; law review articles on the subject almost invariably include horrifying anecdotes about someone who suffered death, permanent disability, or the loss of a child due to the denial of necessary emergency care.[49] The (admittedly limited) empirical evidence on the subject was largely ignored, and all involved admitted that they were legislating on the basis of anecdotes.[50] Not surprisingly, the outcome in these carefully selected anecdotal cases was invariably horrific.[51]

It was one thing for the public to accept a de facto no-duty-to-treat rule when the consequences were distant or unknown.[52] It was quite another when major newspapers started carrying front-page stories about children who died because

---

empirical studies of the issue (Drs. Ansell and Kellerman). *See id.* at 97-191. The third panel was composed of representatives of the administration, who were chided for their failure to enforce EMTALA. *See id.* at 191-303.

48. *See* HOUSE COMM. ON GOV'T OPERATIONS, EQUAL ACCESS TO HEALTH CARE: PATIENT DUMPING, H.R. REP. NO. 100-531, at 5-8, 11-12, 18 (1988).

49. *See, e.g.*, Andrew J. McClurg, *Your Money or Your Life: Interpreting the Federal Act Against Patient Dumping*, 24 WAKE FOREST L. REV. 173, 174 n.3 (1989); Erik J. Olson, *No Room at the Inn: A Snapshot of an American Emergency Room*, 46 STAN. L. REV. 449, 450-51 (1994); Rothenberg, *supra* note 46, at 21-22; William N. Wiechmann, *Language Barrier to Emergency Health Care: Definitional Imprecision Still Plagues the Consolidated Omnibus Budget Reconciliation Act*, 9 T.M. COOLEY L. REV. 161 (1992).

50. At least two empirical studies of patient dumping were available to Congress when EMTALA was enacted, but they seem to have played no significant role. *See* 131 CONG. REC. 35,813 (reviewing highlights of study of patient transfers to Alameda County, California private hospitals and to Cook County Hospital, discussed in greater detail *infra* notes 263-94) (statement of Rep. Stark); *id.* at 28,569 (reviewing highlights of study of patient transfers in Oakland, California, discussed in greater detail *infra* notes 263-76) (statement of Sen. Kennedy).

Instead, all involved acknowledged that they were legislating on the basis of anecdote. *See e.g., id.* at 28,568 ("Frankly, we do not know how pervasive this practice of dumping the sick and the indigent from emergency rooms actually is. The evidence I have seen so far is primarily anecdotal.") (statement of Sen. Durenberger). The committee report reflects a similar assessment.

> There was little evidence available to the Committee during its consideration of H.R. 3128 as to the scope of the problem addressed by § 124, since there have been no hearings in either the House or the Senate on this issue or on the language recommended by the Ways and Means Committee.

HOUSE COMM. ON THE JUDICIARY, SECTION 124 OF THE DEFICIT REDUCTION AMENDMENTS OF 1985 (RESPONSIBILITY OF MEDICARE HOSPITALS IN EMERGENCY CASES), H.R. REP. NO. 99-241, pt. 3, at 6 (1985).

51. The stories reflect that patient dumping usually results in death or severe disability. *See, e.g.*, 131 CONG. REC. 35,813 ("Mr. Speaker, the results of this practice have cost people their health and lives.") (statement of Rep. Stark). Of the 17 anecdotes presented in the House *Equal Access* report, eight provide detailed information about the outcome—which was death in each and every instance.

52. The no-duty rule is a fundamental principle of American tort law. *See* Ernest J. Weinrib, *The Case for a Duty to Rescue*, 90 YALE L.J. 247, 247 (1980) ("No observer would have any difficulty outlining the current state of the law throughout the common-law world regarding the duty to rescue. Except when the person endangered and the potential rescuer are linked in a special relationship, there is no such duty.") (footnote omitted).

they were refused emergency medical attention, and mothers who delivered their babies in hospital parking lots because they were refused admission.[53] Narrative was effective at putting names and faces to the previously invisible morbidity and mortality—and the stories so moved the nation that the law was transformed.

EMTALA requires hospitals (and, to a lesser extent, physicians) to provide all necessary emergency care without regard to ability to pay.[54] Hospitals with specialized facilities must accept transfers if they have the capacity to do so.[55] Compliance is ensured by various enforcement provisions, including civil monetary penalties which may be imposed against a hospital or physicians, a private right of action under certain circumstances, and exclusion from Medicare.[56] A variety of other housekeeping measures also helps ensure compliance, including the mandate that emergency care may not be delayed while hospital personnel are inquiring about insurance status.[57]

EMTALA is seemingly a stunning vindication of the hopes of narrative's proponents. Prior to 1986, Americans seemed perfectly willing to tolerate a "shocking and loathesome" and "barbaric, morally reprehensible" system that denied access to emergency care to those in need.[58] Predictably enough, those

---

53. *Cf.* Eskridge, *supra* note 7, at 614 ("[T]he individual stories reveal the substantial social costs of the exclusionary policy, and also put a human face on the policy's victims. Hearing these victims' stories makes abstract prejudice more difficult to justify.").

54. Although EMTALA has a series of interlocking provisions, its basic structure is reasonably straightforward. Any individual who visits a "qualifying" hospital and requests care is entitled to an "appropriate" medical screening examination to determine whether an "emergency medical condition" is present. If the patient has an emergency medical condition, he cannot be "transferred" until he is "stabilized" or an "appropriate transfer" is performed. EMTALA defines "emergency medical condition," "stabilized," and "transfer" quite expansively, but does not define "appropriate." *Compare* 42 U.S.C. § 1395dd(c)(1) (1994) (noting general prohibition on transfer unless stabilized), *with id.* § 1395dd(c)(1)(a), *id.* § 1395dd(c)(2) (noting that prestabilization transfer allowed if "appropriate transfer" performed), *id.* § 1395dd(e)(4), *and* 42 C.F.R. § 489.24(a)-(b) (1997) (noting that "appropriate" is not defined, and denying the possibility of definition).

55. *See* 42 U.S.C. § 1395dd(g).

56. *See, e.g., id.* § 1395dd(d).

57. *See id.* § 1395dd(h). Additional measures include preemption of conflicting state and federal laws, a requirement that hospitals maintain a log of all patients seen in the emergency room and report all violations of EMTALA to the federal government within 72 hours of their occurrence, a requirement that hospitals post signs in the ED providing notice to all persons of the hospital's obligations under EMTALA, and a prohibition on retaliation against "whistle-blowers" and physicians who refuse to approve the transfer of an unstable patient. *See, e.g., id.* § 1395dd(i).

58. *See, e.g.*, Enfield & Sklar, *supra* note 46, at 577 (describing particular case of patient dumping as "shocking and loathesome"); Jeffrey E. Fine, *Opening the Closed Doors: The Duty of Hospitals to Treat Emergency Patients*, 24 WASH. U. J. URB. & CONTEMP. L. 123, 149 (1983) (arguing that no-duty rule is "barbaric, morally reprehensible, and unworthy of respect"); Leonard S. Powers, *Hospital Emergency Service and the Open Door*, 66 MICH. L. REV. 1455, 1486 (1968) ("The law should not continue to honor such an outworn, unpopular, and barbaric dictum as the one permitting the professional 'Good Samaritan' to keep its doors closed to the victim of a medical emergency.").

who were denied care were the poor and disenfranchised. It was only when voices "from the bottom" were heard that federal reform resulted.[59]

B. A Closer Look at Some Patient-Dumping Horror Stories

Unfortunately, this glowing picture is incomplete—like many narratives. Indeed, a close look at several prominent patient-dumping narratives confirms many of the worst fears of narrative's critics. Consider the legend of Terry Takewell. Mr. Takewell's legend has been infamous in health-policy circles ever since his neighbor, Ms. Zettie Mae Hill, testified before Congress.[60] Ms. Hill was the lead-off witness at the only congressional hearing ever held on EMTALA —and it seems clear that she was chosen because the legend she would relate exemplified the points those holding the hearing wanted to make.[61] Mr. Takewell's legend is prominently featured in academic commentaries on federal health-care legislation.[62]

The standard version of the legend of Mr. Takewell is heart wrenching. Uninsured, unemployed, and afflicted with poorly controlled diabetes since his youth, he had run up a large bill at the local hospital. After his doctor ordered him admitted, he was taken to Methodist Hospital in Somerville, Tennessee by ambulance, gasping for breath, in a diabetic coma, and in dire need of emergency medical attention.[63] He was met in his room by the hospital administrator, who picked him up out of his hospital bed and carried him out of the building and across the parking lot. Mr. Takewell was left under a tree—shirtless, barefoot, and helpless. His friends found him and took him home, where he was found dead the next day. Following an investigation by a state board dominated by

---

59. *See* Mari J. Matsuda, *Looking to the Bottom: Critical Legal Studies and Reparations*, 22 HARV. C.R.-C.L. L. REV. 323, 324 (1987) (defining "[l]ooking to the bottom" as "adopting the perspective" of those who have experienced discrimination and injustice).

60. Mr. Takewell's story was prominently featured in the committee report which resulted from the hearing. *See* HOUSE COMM. ON GOV'T OPERATIONS, EQUAL ACCESS TO HEALTH CARE: PATIENT DUMPING, H.R. REP. NO. 100-531, at 11 (1988).

61. The hearing was convened by Representative Ted Weiss because "he considered the Administration to be lax in its enforcement" of EMTALA, and he believed that "hospitals and physicians needed to have the 'perception' that the law is being vigorously enforced and penalties applied." *Patient 'Dumping' Regulations Offer Little Guidance*, HOSPITALS, Sept. 5, 1987, at 35, 36. The tenor of the hearing was captured by Representative Stark, one of the key figures in EMTALA's enactment, who urged Representative Weiss to "hammer on the table so that hospitals know we mean business." *Id.*

62. *See* David M. Frankford, *Privatizing Health Care: Economic Magic to Cure Legal Medicine*, 66 S. CAL. L. REV. 1, 90 (1992); Law, *supra* note 46, at 779; McClurg, *supra* note 49, at 205 n.173; Olson, *supra* note 49, at 450; Rothenberg, *supra* note 46, at 21; Wiechmann, *supra* note 49, at 161-62.

63. Methodist Hospital of Somerville is part of the Methodist Hospital system—a large nonprofit chain owned and operated by a consortium of three Methodist synods. For purposes of this Article, all references to Methodist Hospital refer to Methodist Hospital of Somerville, unless otherwise indicated.

health-care providers, Methodist Hospital was cleared of any responsibility for the incident.[64]

Academic commentators who have written on EMTALA have swallowed this version of the legend of Mr. Takewell—hook, line, and sinker.[65] A considerably higher degree of skepticism would have been more appropriate. Ms. Hill did not personally witness most of the events in question.[66] Her testimony at the hearing was neither subjected to cross-examination nor supplemented by the testimony of any of the other witnesses to the events in question—of which there were many. Although the "official" version of the legend of Mr. Takewell is partially based on newspaper articles attached to Ms. Hill's written testimony, information in those articles which tends to exculpate Methodist Hospital was omitted from the congressional report, and is never included when the legend of Mr. Takewell is recounted.[67] Thus, the "official" version of the legend of Mr. Takewell's story is based on a highly selective presentation of hearsay evidence.[68] Despite these warning signs, the legend of Mr. Takewell has become the paradigmatic case for the evils of patient dumping.[69]

Some additional facts should be added in the interest of evaluating the legend of Mr. Takewell on the basis of a full record.[70] A psychologist testified that Mr.

---

64. This narrative is drawn from HOUSE COMM. ON GOV'T OPERATIONS, EQUAL ACCESS TO HEALTH CARE: PATIENT DUMPING, H.R. REP. NO. 100-531, at 11 (1988).

65. *See, e.g.*, Frankford, *supra* note 62, at 90; Law, *supra* note 46, at 779; McClurg, *supra* note 49, at 205 n.173; Olson, *supra* note 49, at 450; Rothenberg, *supra* note 46, at 21.

66. Ms. Hill personally witnessed Mr. Takewell's condition before he was taken to the doctor and while he was being examined by Dr. Bishop. She next saw him under a tree in the hospital parking lot, and testified that she spoke to him on the ride back to the trailer park. Thus, she was not present at any of the events involving Methodist Hospital. *See Equal Access Hearing*, *supra* note 47, at 14-20.

67. The newspaper articles reflected that Mr. Takewell had been an uncooperative patient and was not in a life-threatening condition when he left the hospital, that Methodist Hospital had provided free care to Mr. Takewell a dozen times in the years prior to his death, and that Methodist Hospital had given away free care totalling approximately $700,000 in charges per year. *See id.* at 23-24, 429.

68. "'Hearsay' is a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted." FED. R. EVID. 801. Hearsay is inadmissible, unless it falls within an exception to the rule or an exclusion from the definition. *See id.* Rules 802-04. Hearsay is generally excluded because of the "risks that come with relying on the word or say-so of another person," including misperception, failing of memory, shading of the truth, and misunderstanding of the declarant. CHRISTOPHER B. MUELLER & LAIRD C. KIRKPATRICK, EVIDENCE § 8.2, at 787-90 (1995).

69. *See* Frankford, *supra* note 62, at 90 (describing Mr. Takewell's story as "an easy case" and "an actual practice that quite literally drew the distinction between life and death"); Law, *supra* note 46, at 779; McClurg, *supra* note 49, at 205 n.173 ("The tragic case of Terry Takewell, covered at length in the subcommittee hearing, illustrates [a transfer that violates EMTALA]."); Rothenberg, *supra* note 46, at 21 (describing Mr. Takewell's story as a "recent example[] of a problem that will not go away"); Wiechmann, *supra* note 49, at 161 ("Mr. Takewell is an example of thousands of persons who are either unable to pay the high cost of health insurance or who are without adequate coverage.").

70. The more complete version of Mr. Takewell's story contained in this Article is based on the case file of the Tennessee Board for Licensing Health Care Facilities ("Board"). The Board held two days of contentious hearings, at which testimony was taken under oath, and

Takewell's troubled youth[71] had an ongoing impact on his personality and behavior.[72] The same psychologist testified that Mr. Takewell's diabetes was

---

subjected to cross-examination. The newspaper articles attached to Ms. Hill's testimony before the House Committee on Government Operations recapitulate many of the points reflected in the case file. *See Equal Access Hearing, supra* note 47, at 23-24.

From the perspective of one seeking to evaluate the merits of narrative, one strength of the case is the breadth of publicly available data—much of it unfiltered—on whether Mr. Takewell was dumped. Mr. Takewell was contemporaneously evaluated by a physician unrelated to Methodist Hospital; the state licensing board held extensive hearings; two different agencies within the executive branch of the federal government inquired into the case; and all of those who witnessed the incident (other than Mr. Takewell) had an opportunity to tell their story.

In the interest of style, a statement in the case file was treated as factual if two witnesses testified to it, and cross-examination did not shake the testimony, or if the statement was included in an official police report or autopsy record. If only one witness testified to a statement, it is attributed solely to that witness.

71. I do not personally find this observation to be particularly relevant, but I am attempting to provide a full context. Those who do not wish to engage in postmortem voyeurism should skip this footnote. The facts in this footnote are drawn from the testimony of a clinical psychologist who saw Mr. Takewell during the period April-October 1979, and August-September 1981. *See* Hearing Transcript at 131, *In re* Methodist Hosp. (Tenn. Bd. Licensing Health Care Facilities Apr. 28-30, 1987) (No. 17.17-D-87-0028-A) (testimony of Dr. L.D. Hutt). He was referred to the clinical psychologist by the Department of Human Services ("DHS") with the presenting problems of noncompliance with his insulin and diabetic regimen, including diet, nervousness, nightmares, sleep disturbances, and enuresis. *See id.* at 132.

Mr. Takewell was the illegitimate son of his mother's stepfather's brother. *See id.* at 141-42. Mr. Takewell's mother was "neglectful and seemingly disinterested in Terry" to the point that she did not supervise his diet or see that he received his insulin injections. *Id.* at 142. She had periodically left Mr. Takewell with relatives and friends, or in foster care. *See id.* In August 1978, Mr. Takewell's mother left her then husband and left Tennessee with Mr. Takewell (age 13), his 12-year-old sister, and the natural father of Mr. Takewell. Three months later, Mr. Takewell's mother returned to Tennessee and placed his sister in the custody of the juvenile court. *See id.* at 143. Later that month, Mr. Takewell's mother informed the DHS that she would be placing Mr. Takewell in the custody of the juvenile court because Mr. Takewell's natural father would not allow her to keep him. *See id.* at 143-44. Mr. Takewell was left at the home of his natural father's sister, where he was taken into the custody of the juvenile court. *See id.* at 142-43.

Over the intervening five months, Mr. Takewell went through four foster-care placements, because he would leave without permission and had utter disregard for compliance with the regimen of treatment for his enuresis and diabetes. *See id.* at 141, 145. Mr. Takewell ran away from foster homes and Memphis Boys' Town at least eight times, and failed the first, seventh, and ninth grades due to truancy. *See id.* at 146. While in state custody, he had a lengthy history of lying, stealing, and disobedience. *See id.* at 146-48. The psychologist diagnosed his enuresis as an indirect way of expressing anger and resentment toward the foster care/welfare system. *See id.* at 145.

72. Mr. Takewell had an "action orientation," coupled with "attention deficit," with the result that he would "tend[] to act first and think later." *Id.* at 154. Thus, Mr. Takewell "coped with authority figures by denial, avoidance, and more particularly by the mechanism of flight. . . . [I]f an authority figure frustrated him, rather than seeking to work out the problem or think through the problem, he would simply leave." *Id.* The psychologist also explained Mr. Takewell's noncompliance with the regimen for his diabetes by reference to a "denial system" that was so pervasive the psychologist stated he had "never seen a denial and fantasy system as at variance with the facts and as deeply entrenched as with Terry." *Id.* at 152.

poorly controlled because he often did not take his insulin with regularity,[73] that Mr. Takewell would not take his insulin so that he could be "rescued" by medical personnel,[74] and that Mr. Takewell had a distinct pattern of lying about matters large and small.[75] When Mr. Takewell died, there was no insulin in his house—and the Medical Examiner noted on the death certificate that Mr. Takewell would use his insulin money to purchase alcohol and drugs, including cocaine.[76]

During the two years prior to his death, Mr. Takewell had been treated at Methodist Hospital twelve times, including eight hospital admissions, for which he owed Methodist Hospital approximately $9500.[77] Although Mr. Takewell would almost certainly have qualified for free care, he had repeatedly refused to provide the necessary information to allow Methodist Hospital to zero-out his bill.[78] The psychologist testified that this conduct was the predictable result of Mr. Takewell's emotional problems.[79] During his hospitalization in July 1986,

---

73. *See id.* at 145; *id.* at 367 (noting testimony that Mr. Takewell was taking his insulin and eating properly "on and off for a couple of weeks") (testimony of Timothy E. Staton); *see also id.* at 247 ("[A] lot of times he didn't follow his treatment right, and he'd get sick, you know, and get unable to work.") (testimony of Donna H. Whatley). *But see id.* at 32 (noting that Mr. Takewell was taking insulin and following his diet while living in trailer park) (testimony of Ms. Hill).

74. *See id.* at 148-49 (testimony of Dr. Hutt).

> Most of the literature indicates that the noncompliant diabetic—one of the motives, one of the perhaps unconscious motives is to quote create chaos or create a set of crises in which the authority figures in their lives are kind of kept off balance, kind of kept out of balance.
>
> The psychological and psychiatric literature interprets this as an effort to manipulate and to contrive crises such that the patient then has to be rescued . . . .

Id.

75. *See id.* at 147-48. The psychologist testified that such motiveless lying was characteristic of noncompliant diabetics. *See id.* at 148-49, 159.

76. *See* Miscellaneous Information Form, Shelby County Medical Examiner (undated) ("Insulin dependent juvenile diabetes who had been in DKA [diabetic ketoacidosis] several times and was known to be noncompliant. Bought ETOH [alcohol] and drugs incl. cocaine with money for insulin."); Notice of Charges ¶ 26, *In re Methodist Hosp.* (Jan. 20, 1987) (noting two empty insulin vials and a third vial with one milliliter of creamy liquid in refrigerator at time of death).

77. *See* Notice of Charges ¶ 12, *In re Methodist Hosp.* ("By August, 1986, [Mr. Takewell] owed the hospital $9,424.71."). The transcript reflects that Mr. Takewell was seen and admitted on April 14, 1985, August 2, 1985, April 4, 1986, and July 21, 1986. He was seen in the ED on April 25, 1985, April 4, 1986, April 16, 1986, June 21, 1986, June 25, 1986, and July 21, 1986. *See* Hearing Transcript at 191-202, 246, *In re Methodist Hosp.* (testimony of Pat Wheeler and Donna Whatley, respectively). Between May and August 1986, Mr. Takewell received medical care costing approximately $2000. *See id.* at 206 (testimony of Pat Wheeler).

78. *See* Hearing Transcript at 206-07, *In re Methodist Hosp.* (noting that hospital would wipe out Mr. Takewell's bills and qualify him for free care if he provided proof of income) (testimony of Pat Wheeler).

79. *See id.* at 159-60 (testimony of Dr. Hutt).

> [Mr. Takewell's conduct was] entirely consistent with what we saw even back at age 14 with the quote motiveless lying. And here again, I think the underlying

Mr. Takewell left Methodist Hospital against medical advice following a discussion with hospital administrators about completing the forms to qualify him for free care.[80] The psychologist indicated that this pattern was consistent with Mr. Takewell's past behavior of fleeing when faced with authority figures.[81] Prior to the admission which preceded his death, Methodist Hospital personnel had informed Mr. Takewell that they would provide care to him in the future if he was in an emergency situation, but they needed him to provide proof of income for nonemergency care.[82]

On September 16, 1986, an ambulance was summoned to pick up Mr. Takewell from his home because one of his neighbors believed he was sick.[83] Ms. Hill testified that Mr. Takewell attempted to put on his shoes when she told him the ambulance was coming.[84] The emergency medical technician ("EMT") who evaluated Mr. Takewell at the scene did not believe he was ill, although Mr. Takewell was breathing rapidly.[85] Mr. Takewell stated that he had been following his diet and taking his insulin.[86] The ambulance took him to the Morris Clinic, where he was evaluated by Dr. John Bishop, a family practitioner who had never

---

> motivation of the patient is to create crisis, create chaos such that the treatment figures are kept off guard or rather kept off balance. And in so doing it, that he is contriving a situation where he can be quote rescued.
>
> ....
>
> ... Terry tended to, as I mentioned earlier, tended to blame quote the system, particularly the welfare system for most of his problems, most of his difficulties back during the era that we were seeing him, 1979 through 1981. That would be one reason that I think he would tend to react negatively or fail to cooperate to qualify him. Namely, he resented them. In his own mind they were the culprits rather than the individuals who provided whatever stability he had during that period of his life.

Id.

80. *See id.* at 205-08, 210 (testimony of Pat Wheeler).

81. *See supra* note 72; *see also* Hearing Transcript at 163, *In re Methodist Hosp.* ("[Mr. Takewell resented] being considered a welfare case or welfare patient, and handl[ed] that resentment by leaving. Flight.") (testimony of Dr. Hutt).

82. *See* Hearing Transcript at 206-07, *In re Methodist Hosp.* (testimony of Pat Wheeler).

83. *See id.* at 13-15 (noting that Mr. Takewell was moving around "trying to be peaceable," "sweating and felt hot," with cold forehead and hands, and "dark under his eyes") (testimony of Ms. Hill).

84. *See id.* at 15. Ms. Hill also testified that Mr. Takewell tried to take his keys with him. *See id.* at 31-32. Obviously, if Mr. Takewell was in a diabetic coma, he would be unlikely to be putting on his shoes and taking his keys. *See infra* note 89.

85. *See* Hearing Transcript at 343, *In re Methodist Hosp.* (testimony of Phyllis A. Williams). The EMT testified that Mr. Takewell told her "'my head hurts a little and my chest hurts a little. But I've had a cold for several days and that's what I'm attributing that to.'" *Id.* at 350 (quoting Mr. Takewell). The EMT testified that Mr. Takewell was not sweaty, did not have the fruity breath characteristic of diabetic ketoacidosis ("DKA"), was alert and oriented, with reactive pupils and warm and dry skin. *See id.* at 342-46. In short, there was "no medical finding." *Id.* at 346. The EMT did not believe that Mr. Takewell's condition constituted an emergency. *See id.* at 346, 357.

86. The EMT testified to that effect, as did the nurse at Methodist Hospital. *See id.* at 343-44 (testimony of Ms. Williams), 419 (testimony of David Haywood). *But see supra* note 73 (describing intermittent compliance).

treated him previously.[87] Had the EMT believed Mr. Takewell was seriously ill, she testified she would have taken him to the Methodist Hospital ED, and Dr. Bishop would have been summoned to see him there.[88] After observing that Mr. Takewell was hyperventilating slightly, was somewhat lethargic, and had a modestly elevated blood glucose of 250, Dr. Bishop decided that he should be admitted to the hospital for testing.[89] Dr. Bishop did not believe Mr. Takewell was in DKA, although he was not sure how serious his condition was.[90] Dr. Bishop could have admitted Mr. Takewell to Methodist Hospital's intensive care unit ("ICU"), but he did not do so.[91]

When Mr. Takewell arrived at Methodist Hospital, he bypassed the ED (since no one was there and he had already been examined by Dr. Bishop) and was

---

87. *See* Hearing Transcript at 17-18, 42, *In re Methodist Hosp.* (testimony of Ms. Hill and Dr. John N. Bishop, respectively). Dr. Bishop was board-certified in family practice and emergency medicine. *See id.* at 40 (testimony of Dr. Bishop). Mr. Takewell had previously received outpatient treatment at the Morris Clinic, where Dr. Bishop was a partner. However, Dr. Bishop was not Mr. Takewell's doctor, and had never really treated him previously—a point that the congressional report misstated, and subsequent commentators have simply repeated. *Compare id.* at 42, 99, *with* HOUSE COMM. ON GOV'T OPERATIONS, EQUAL ACCESS TO HEALTH CARE: PATIENT DUMPING, H.R. REP. NO. 100-531, at 11 (1988), Frankford, *supra* note 62, at 91, *and* Law, *supra* note 46, at 779.

88. *See* Hearing Transcript at 306-07, *In re Methodist Hosp.* (noting standard procedure to take patients with non-life-threatening conditions to physician's office rather than ED) (testimony of Carlos Smith); *id.* at 346 (noting EMT's assessment that Mr. Takewell was not an emergency case, and that Mr. Takewell had received a routine transport to Morris Clinic) (testimony of Ms. Williams); *see also id.* at 69-70 (noting it was not unusual for nonemergency patient to be brought to Morris Clinic, rather than Methodist Hospital ED) (testimony of Dr. Bishop). There is a dispute in the record as to whether the ambulance used its red lights on the run from the trailer park to the Morris Clinic. *Compare id.* at 17 (indicating that red lights were on) (testimony of Ms. Hill), *with id.* at 346, 357 (noting transport was "routine," with red lights and siren off) (testimony of Ms. Williams).

89. *See id.* at 44, 50, 57-58, 71-73 (testimony of Dr. Bishop). Dr. Bishop noted that Mr. Takewell was conscious and not confused, and he diagnosed Mr. Takewell as suffering from diabetes mellitus/insulin-dependent, and hyperventilation. *See id.* at 74.

A blood glucose of 250 is elevated, but is well below the level for someone in DKA. Indeed, the director of nursing at Methodist Hospital testified that she believed this blood-glucose level was normal for Mr. Takewell, and when he had been admitted previously, his blood glucose was 800-900. *See id.* at 471, 473, 483-86 (testimony of Cindy S. Parker). It is possible that Mr. Takewell could have been breathing rapidly to induce a respiratory alkalosis to compensate for the metabolic acidosis associated with DKA. A blood-gas test would be necessary to sort this matter out, but one was not performed. However, the other evidence regarding Mr. Takewell's mental status undercuts this possibility, since someone in DKA would not be alert and oriented, as Mr. Takewell clearly was. *See id.* at 433-34 ("Usually when you have someone in diabetic keto-acidosis, you have someone who is lethargic, has the fruity breath odor. They have slurred speech. They are close to going into a coma. They are—they're not responsive or as responsive. They have a decreased responsiveness.") (testimony of Mr. Haywood); *id.* at 507 (indicating the same) (testimony of Ms. Parker); *supra* notes 84-85; *infra* notes 98-100.

90. *See* Hearing Transcript at 71-74, *In re Methodist Hosp.* (noting Mr. Takewell was conscious and not confused, and that his only symptoms were lethargy, rapid respirations, and elevated blood glucose) (testimony of Dr. Bishop).

91. *See id.* at 82.

taken directly to a hospital bed.[92] The acting administrator called Dr. Bishop and told him Methodist Hospital would admit Mr. Takewell if it were an emergency, but otherwise would require Mr. Takewell to complete the forms which would qualify him for free care.[93] Dr. Bishop responded that he thought Mr. Takewell "would probably be all right" if he was not admitted.[94] The acting administrator at Methodist Hospital testified that Dr. Bishop told him that Mr. Takewell was "only hyperventilating," and the nursing administrator testified that Dr. Bishop told her the next day he believed Mr. Takewell was "faking" being ill to get admitted—although Dr. Bishop did not remember making either statement.[95]

The acting hospital administrator met Mr. Takewell in the room, and told him that he would be admitted only if he cooperated with Methodist Hospital attempts to qualify him for free care, or if it was a true emergency.[96] Mr. Takewell refused to fill out the necessary forms.[97] The nurse asked Mr. Takewell a number of questions, concluded Mr. Takewell was not in DKA, and left briefly to get a bag for Mr. Takewell to breathe into for his hyperventilation.[98] When the nurse returned with the bag, Mr. Takewell refused it, stating that he had the flu, and the bag would not help with that problem.[99] Mr. Takewell then got up from his bed, walked into and used the bathroom, and walked out of Methodist Hospital.[100] The acting administrator walked with him, attempting to persuade him to stay and execute the necessary forms.[101] When Mr. Takewell refused, the acting administrator offered to drive him to the location of his choosing, including Memphis.[102] Mr. Takewell's lack of attire was not unusual for Somerville, Tennessee in August.[103]

---

92. *See id.* at 101.

93. *See id.* at 77-78, 363-65 (testimony of Dr. Bishop and Mr. Staton, respectively).

94. *Id.* at 87 (testimony of Dr. Bishop); *see id.* at 77-84.

95. *Compare id.* at 77-78, 84, *with id.* at 364-65 (testimony of Mr. Staton), *and id.* at 464-66 (testimony of Ms. Parker).

96. *See id.* at 366-67, 418-19 (testimony of Mr. Staton and Mr. Haywood, respectively).

97. *See id.* at 366-67 (testimony of Mr. Staton). The nurse was not in the room when Mr. Takewell refused, but he testified that Mr. Takewell subsequently indicated nonverbally that he was not interested in completing the forms. *See id.* at 419-20 (testimony of Mr. Haywood).

98. *See id.* at 367-68 (testimony of Mr. Staton), 419-20, 422, 433-34 (testimony of Mr. Haywood).

99. *See id.* at 368 ("'What good is that going to do? I've got the flu.'") (quoting Mr. Takewell) (testimony of Mr. Staton); *id.* at 420 ("'I don't know what good you think that's going to do. All I have is the flu.'") (testimony of Mr. Haywood).

100. *See id.* at 368-69 (testimony of Mr. Staton); *id.* at 397-98 ("He walked. He didn't wobble to the bathroom."); *id.* at 420-23 (noting that Mr. Takewell was alert and oriented throughout his brief stay at Methodist Hospital) (testimony of Mr. Haywood).

101. *See id.* at 369-70 (testimony of Mr. Staton).

102. *See id.* at 368-69, 408-09 (testimony of Mr. Staton), 423 (testimony of Mr. Haywood). Somerville is located approximately 30 miles east of Memphis. The acting administrator testified that his approach to Mr. Takewell was consistent with his degree in Christian missions, and he specifically told Mr. Takewell, "Don't get beyond help. I can help you now. You need, you know, to be helped. You need to help us help you." *Id.* at 408-09 (testimony of Mr. Staton).

103. *See id.* at 408 ("That's not uncommon in our part of the country.") (testimony of Mr. Staton).

After he left Methodist Hospital, Mr. Takewell walked across the parking lot, and waited under a tree in front of the local pharmacy.[104] Ms. Hill testified that she drove past the pharmacy on her way to the hospital, and Mr. Takewell recognized her at "some distance" and "made a racket," or "holler[ed] out" for her to stop and pick him up.[105] After Mr. Takewell was driven back to his home, Ms. Hill testified that she spoke to him several hours later.[106] Although Ms. Hill testified that she called Methodist Hospital to inquire about their reason for "discharging" Mr. Takewell, the substance of her conversations with Mr. Takewell and hospital personnel was excluded as inadmissible.[107]

Dr. Bishop testified he was not "real surprised" that Mr. Takewell had left the hospital, and he made no effort to locate Mr. Takewell, nor did he request Methodist Hospital personnel to track him down.[108] The next day, Methodist Hospital personnel independently attempted to locate Mr. Takewell to check on his condition.[109] The acting administrator testified that he drove out to where he had been told Mr. Takewell lived, but he was unable to find him.[110] Mr. Takewell was found dead by his roommate later that day.[111] After Mr. Takewell's death, Methodist Hospital and Dr. Bishop issued a joint media statement, which bears little resemblance to the conventional version of the legend of Mr. Takewell which was told to Congress and repeated in various law review articles.[112] In full, the statement reads as follows:

> "On Tuesday, September 16th Terry Takewell was brought to Morris Clinic of Somerville, Tennessee by ambulance, as a means of routine transfer and in a non-emergency mode from his home in Somerville. Dr. John Bishop examined Mr. Takewell, felt that he was not in a life-threatening condition at that time and Mr. Takewell was transported via routine transfer ambulance to the Methodist Hospital of Somerville for admission and further tests.
>
> Upon arrival at the hospital, Terry Takewell was taken directly to a patient room, not to the intensive care unit. Due to his history of being an uncooperative patient during several previous admissions and due to the fact that he left the hospital against medical advice during his last admission in July of 1986, acting administrator Tim Staton telephoned Dr. Bishop to verify the need for admission. Dr. Bishop stated that in his opinion Mr. Takewell was not in a life-threatening condition at the time he saw him.
>
> Following the telephone conversation with Dr. Bishop, Staton went to Mr. Takewell's room and explained to him that in order to be admitted, he would

---

104. *See id.* at 21, 371 (testimony of Ms. Hill and Mr. Staton, respectively).

105. *Id.* at 21-22, 33 (testimony of Ms. Hill). Obviously, if Mr. Takewell was in a diabetic coma, it is implausible that he would recognize his neighbor at all—let alone at some distance. *See also supra* note 89 (referencing consistent testimony that Mr. Takewell was alert and oriented during the afternoon of September 16, 1986).

106. *See* Hearing Transcript at 26-27, *In re Methodist Hosp.* (testimony of Ms. Hill).

107. *See id.* at 28-30.

108. *Id.* at 91 (testimony of Dr. Bishop); *see id.* at 83-84.

109. *See id.* at 371-73 (testimony of Mr. Staton).

110. *See id.* at 373. Mr. Takewell was staying at the Middle Coff trailer park, but there were two trailer parks on the same road, and the acting administrator went to the wrong one. *See id.* at 377. Dr. Bishop made no similar effort to contact Mr. Takewell. *See id.* at 83-84 (testimony of Dr. Bishop).

111. *See* Notice of Charges ¶ 26, *In re Methodist Hosp.* (Jan. 20, 1987).

112. *See supra* notes 64-65 and accompanying text.

> be required to sign certain hospital consent forms and provide some standard information. Mr. Takewell refused. Due to Mr. Takewell's refusal to sign such standard admission forms and the fact that he was not in a life-threatening condition requiring immediate hospitalization, he was not admitted to the hospital. Had his condition been assessed as a life-threatening emergency at that time by either Dr. Bishop or the medical personnel at Methodist Hospital of Somerville, he would have been admitted.
>
> Upon leaving the hospital, Takewell was repeatedly offered transportation to any destination, including Memphis, by acting administrator Tim Staton. He refused and left on foot."[113]

Dr. Bishop made certain modifications to the joint media statement before he approved it, and he explicitly affirmed the accuracy of the statement at the hearing before the Board.[114]

Even if one has doubts about the sworn testimony of all of these witnesses, it is also significant that the credibility of the witnesses supporting the "conventional" version of the legend of Mr. Takewell is problematic. Ms. Hill had received free care seven or eight times at Methodist Hospital. In late 1985 she was hospitalized at Methodist Hospital, but she had not paid her bill as of September 1986.[115] Methodist Hospital typically turned such bills over to collection agencies if they were not paid.[116] After Mr. Takewell's death, Ms. Hill wrote a letter to the hospital telling them they should "'forget about my bill or I'm going to split the hospital right open.'"[117] Ms. Hill declined to classify her letter as an attempt to blackmail the hospital.[118]

In like fashion, although the congressional report and law reviews suggested that multiple witnesses had seen Mr. Takewell carried from his hospital bed by the administrator, the sole source for that statement was the testimony of Mr. Takewell's temporary roommate in the hospital, John Murphy.[119] Before relying too heavily on the credibility of Mr. Murphy, one should spend a few moments examining his testimony. He testified in rapid succession that the EMTs who brought Mr. Takewell into the room stayed "three to five minutes," "a minute," "two or three seconds," "two or three minutes," and a "[s]hort period of time," and remained in the room so they could serve supper—or maybe not.[120] Mr. Takewell's bed was either two or three inches or two or three feet from Mr.

---

113. Hearing Transcript at 80-81, *In re Methodist Hosp.* (quoting joint statement prepared by Dr. Bishop and Methodist Hospital and released to the media) (testimony of Dr. Bishop, reading statement into the record).

114. *See id.* at 78-80, 90.

115. *See id.* at 7, 35-36 (testimony of Ms. Hill). Ms. Hill also had an outstanding bill with Baptist Hospital. *See id.* at 36.

116. *See id.* at 193 (testimony of Pat Wheeler).

117. *Id.* at 36 (quoting letter from Ms. Hill to Methodist Hospital) (testimony of Ms. Hill, confirming contents of letter as recited by cross-examining attorney).

118. *See id.* at 36 ("I don't know whether I'd call it blackmail, but I wrote them a letter."); *see also id.* at 37 (noting that Ms. Hill had "told them that [she was] going to lay low, but [that] they had better not push [her] too far") (confirming characterization of cross-examining attorney). Ms. Hill insisted that her testimony was still truthful, and that she had been upset when she wrote the letter. *See id.* at 37-38.

119. *See id.* at 113 (testimony of Johnny Murphy).

120. *Id.* at 108, 115-117, 122.

Murphy's bed.[121] Mr. Murphy testified that one of the people who brought Mr. Takewell into the room was Mr. Luther Scruggs, an African American, when it was actually Mr. Bubba Johnson, a European American.[122] He testified that he learned of Mr. Takewell's death before he actually died, from someone who was not there on that day.[123] He also testified that the nurse had not tried to give Mr. Takewell a paper bag to treat his hyperventilation, when the nurse and acting administrator testified that the nurse had done so, and the Board had included that act in its list of charges against Methodist Hospital.[124] He testified that Mr. Takewell told the nurse he was not eating or taking his insulin, when the nurse and the EMT testified to the opposite.[125] Similarly, Mr. Murphy testified that Mr. Takewell had not gone to the bathroom before his departure, when the nurse and acting administrator testified that he had.[126] Mr. Murphy admitted that at the time of the events in question, he believed his sister, who worked at Methodist Hospital, had been laid off.[127] Finally, at the time in question, Mr. Murphy was receiving a pain medication which affects perception.[128]

If one wishes to credit Mr. Murphy's testimony, he did testify that Mr. Takewell was calm and rational, and the acting administrator never mentioned to Mr. Takewell the bill he owed Methodist Hospital.[129] Of course, it is also significant that Mr. Murphy had repeatedly received free care at Methodist Hospital, including the hospitalization during which he briefly shared a room with Mr. Takewell, and another hospitalization immediately before the hearing before the Board.[130] Not surprisingly, the testimony of Ms. Hill and Mr. Murphy was not credited by those who actually heard it delivered.[131]

---

121. *See id.* at 110.

122. *Compare id.* at 106, 115 (Mr. Luther Scruggs brought Mr. Takewell in) (statement of Mr. Murphy), *with id.* at 15 (Mr. Bubba Johnson brought Mr. Takewell in) (testimony of Ms. Hill), *id.* at 341 (Mr. Bubba Johnson brought Mr. Takewell in) (testimony of Ms. Williams), *and id.* at 348-49 (Mr. Bubba Johnson brought Mr. Takewell in, and was European American, while Mr. Luther Scruggs was African American) (testimony of Ms. Williams).

123. *See id.* at 120-21 (noting Mr. Murphy was "positive" he learned of the death of Mr. Takewell on September 16, 1986) (testimony of Mr. Murphy). Mr. Takewell was found dead the next day. *See id.* at 122. Mr. Murphy also testified that he learned that Mr. Takewell was dead from Gwen Miller, who was not on duty on September 16, 1986. *See id.*

124. *See id.* at 118-19; Notice of Charges ¶ 28(b), *In re Methodist Hosp.* (Jan. 20, 1987).

125. *See* Hearing Transcript at 113, 343-44, 418-19, *In re Methodist Hosp.* (testimony of Mr. Murphy, Ms. Williams, and Mr. Haywood, respectively). At the time of his death, no insulin was found in Mr. Takewell's refrigerator. *See supra* note 76.

126. *See* Hearing Transcript at 119, *In re Methodist Hosp.* (testimony of Mr. Murphy).

127. *See id.* at 123.

128. *See id.* at 108. Tylenol-3 contains codeine, which has a well-recognized effect on perception. However, Mr. Murphy stated that he had not had any Tylenol 3 since early in the morning. *See id.*

129. *See id.* at 117.

130. *See id.* at 121. Although Mr. Murphy had owed Methodist Hospital money for several years, he was admitted for treatment in September 1986 and received free outpatient treatment in April 1987. *See id.*

131. *See* Final Order, Conclusions of Law ¶¶ 2-3, 5, 7, 12, *In re Methodist Hosp.* (June 5, 1987). Our system of procedure accords considerable deference on all factual findings (especially the making of credibility determinations) to those who actually hear the evidence.

Finally, Methodist Hospital policy was to treat and admit indigent patients in need of emergency medical attention.[132] Methodist Hospital had given away a substantial amount of care in each of the years prior to 1987.[133] Dr. Bishop testified that Methodist Hospital had never refused to admit a patient, regardless of ability to pay, in the fifteen years he had practiced there.[134]

The Board held two days of hearings regarding this case. Although the Board was dominated by health-care providers,[135] the hearings were extremely contentious.[136] The Board made eighteen findings of fact which generally recapitulate the more complete version of Mr. Takewell's story provided in this Article. The Board's conclusions of law included the determination that Methodist Hospital had done nothing "detrimental" to Mr. Takewell, and had not violated any significant statutory or regulatory obligations.[137] The Board did

---

This deference is justified on the grounds that those individuals are in the best position to make such determinations. *See* Anderson v. Bessemer City, 470 U.S. 564, 574-76 (1985) ("The rationale for deference to the original finder of fact is not limited to the superiority of the trial judge's position to make determinations of credibility. The trial judge's major role is the determination of fact, and with experience in fulfilling that role comes expertise.").

132. *See* Hearing Transcript at 208, 248, *In re Methodist Hosp.* (testimony of Pat Wheeler and Ms. Whatley, respectively).

133. Like most hospitals, Methodist Hospital calculates its charity care and bad debt using charges, rather than average or marginal costs. In addition, Methodist Hospital was reimbursed by Fayette County for some of its charity care. A contemporaneous newspaper article indicated that Methodist Hospital provided approximately $700,000 in charity care per year. *See Equal Access Hearing*, *supra* note 47, at 23. An exhibit at the Board hearing reflects that Methodist Hospital of Somerville incurred net write-offs (because of charity care, bad debt, and Hill-Burton) of 11.7% of revenue in FY 1986, 23.8% in FY 1985, 12.4% in FY 1984, and 3.9% in FY 1983. *See* Hearing Transcript Exhibit 3, *In re Methodist Hosp.* Methodist Hospital is in Fayette County, which was one of the poorest counties in Tennessee. Historically, the Methodist Hospital system was also the largest provider of services to the Medicaid population of Tennessee.

134. *See* Hearing Transcript at 70-71, *In re Methodist Hosp.* (testimony of Dr. Bishop).

> [T]he hospital in Fayette County, it was conceived as a hospital to take care of the indigents I'm told. You know, that's the history. Fayette County has a high incidence, as you have heard before, of poverty. And it's there to take care of patients and it always has been.
>
> Dr. McKnight has been there every since [sic] the hospital opened. It's never refused admission to a patient.

Id. at 296 (testimony of Mr. Smith).

135. At the time of the hearing, the Board was composed of 13 members: a pharmacist, a dentist, and an administrator who worked at a public hospital, a doctor of osteopathy, a surgeon, and three administrators who worked at a private hospital, the owner of a nursing home, the president of a nursing home, the administrator of a home-health agency, and two consumer representatives. *See Equal Access Hearing*, *supra* note 47, at 207.

136. Indeed, one of the Board members cross-examined the chief administrator of Methodist Hospital as to whether any medical conditions interfered with his ability to answer questions, and demanded that the administrator be held in contempt if he would not answer a question. *See* Hearing Transcript at 315, 319-20, *In re Methodist Hosp.* (testimony of Mr. Smith).

137. *See* Final Order, Conclusions of Law ¶ 5, *In re Methodist Hosp.* (June 5, 1987) ("By a vote of 6 to 3, the Board finds that the conduct of Methodist Hospital of Somerville was *not* detrimental to the welfare of a patient in the institution.") (emphasis in original). Similarly, the Board held by a vote of 8 to 4 that the hospital was not guilty "of conduct or practice

conclude that Methodist Hospital had not proven its nursing service provided "safe, efficient, and therapeutically effective nursing care," and that it should have reported the incident involving Mr. Takewell to the Department of Health.[138] The Board accordingly imposed a corrective-action plan.[139] The Health Care Financing Administration ("HFCA") and the Department of Health and Human Services ("DHHS") Office of the Inspector General also determined that the treatment received by Mr. Takewell was consistent with EMTALA.[140]

Consider another example—the first case under EMTALA in which a fine was imposed by the Inspector General ("IG") of the DHHS against a physician. In *Burditt v. United States Department of Health and Human Services*, the U.S. Court of Appeals for the Fifth Circuit upheld a $20,000 fine imposed by the IG against an obstetrician for violating EMTALA.[141] The patient, Mrs. Rosa Rivera, presented to DeTar hospital in Victoria, Texas, "[a]t or near term . . . experiencing one-minute, moderate contractions every three minutes and her membranes had ruptured. Two obstetrical nurses . . . examined her and found indicia of labor and dangerously high blood pressure."[142] Dr. Michael Burditt was called to attend Mrs. Rivera, but stated on the phone that "he didn't want to take care of this lady," and requested that she be transferred to John Sealy Hospital ("John Sealy") in Galveston, Texas—approximately 170 miles away.[143]

---

detrimental to the welfare of a patient." *Id.*, Conclusions of Law ¶ 12.

138. *See id.*, Conclusions of Law ¶ 1 ("By a vote of 7 to 5, the Board finds that the events of September 16, 1986 constituted an 'incident' that should have been reported by the hospital to the Department within ten (10) days, but was not."). The regulation provides that if any incident "'has, or could reasonably be expected to have, resulted in the death of a patient, life-threatening injury or illness to a patient, or the abuse of a patient, the matter shall be reported to the Department in a timely manner and, in no case, later than ten (10) business days after the incident or accident.'" *Id.* (quoting Tennessee Board for Licensing Health Care Facilities Rule 1200-8-3-01(9)(d)). Similarly, the Board held by a vote of 7 to 6 that Methodist Hospital had violated Rule 1200-8-3-.03(3)(n), which required it to provide evidence "'that the nursing service provides safe, efficient, and therapeutically effective nursing care through the planning of each patient's care and the effective implementation of the plans.'" *Id.*, Conclusions of Law ¶ 8 (quoting Tennessee Board for Licensing Health Care Facilities Rule 1200-8-3-.03(3)(n)).

139. The Final Order required Methodist Hospital to develop and implement various policies and procedures relating to, inter alia, the assessment of the physical condition of all patients who present themselves, the performance of financial assessments, reporting incidents of an unusual nature, the admission of patients, and the like. *See id.*, Order ¶¶ 1, 3-4, 9.

140. *See Equal Access Hearing*, *supra* note 47, at 223.

141. 934 F.2d 1362, 1376 (5th Cir. 1991). The IG had sought $25,000. The administrative law judge ("ALJ") concluded that a fine of $20,000 was appropriate, and that determination was upheld by the DHHS Departmental Appeals Board ("DAB") and the Fifth Circuit. *See id.*

142. *Id.* at 1366.

143. *Id.* The obstetrical nurses told the nursing supervisor and the hospital's administrator that they believed a transfer would put Mrs. Rivera and her baby at risk. The hospital administrator explained to the nurses that it would be against hospital regulations and federal law to transfer Mrs. Rivera unless Dr. Burditt examined her personally and arranged for the transfer with John Sealy. *See id.* One of the obstetrical nurses spoke with Dr. Burditt by telephone to convey the administrator's understanding of hospital regulations and federal law, and to ask for authorization to administer magnesium sulfate as a precaution against convulsive seizures. Dr. Burditt agreed that the nurses should administer the magnesium sulfate, but only if Mrs. Rivera could be transported by ambulance. Dr. Burditt indicated that Mrs. Rivera would

When he arrived at the hospital, Dr. Burditt examined Mrs. Rivera and determined that she had the highest blood pressure he had ever seen (210/130).[144] Dr. Burditt discussed the case with a physician at John Sealy, magnesium sulfate was administered, and arrangements were made for transfer.[145] Dr. Burditt refused to read the hospital's guidelines regarding transfers of ED patients, and signed a certificate authorizing transfer (which he referred to as "that dang piece of paper") only after the nursing supervisor explained that Mrs. Rivera could not otherwise be transferred. Dr. Burditt told the nursing supervisor that "until DeTar Hospital pays my malpractice insurance, I will pick and choose those patients that I want to treat."[146]

Mrs. Rivera left DeTar Hospital by ambulance approximately two hours later, and gave birth to a healthy baby forty miles into the trip to John Sealy. After a brief stop at another hospital, the ambulance returned to DeTar Hospital.[147] Dr. Burditt refused to see her, and told the staff to discharge her if her bleeding was not excessive.[148]

Given these facts, it is clear why DHHS fined Dr. Burditt $20,000. Indeed, like the case of Mr. Takewell, *Burditt* is invariably presented in the law reviews as an egregious and horrifying case of patient dumping.[149] Dr. Burditt simply refused to care for an uninsured pregnant woman in labor with extraordinarily high blood pressure, and sent Mrs. Rivera by ambulance on a perilous trip to a far-away hospital—resulting in her giving birth on the side of the road. This appears to be precisely the sort of conduct EMTALA was intended to prevent.

Some additional facts, only some of which are provided in the Fifth Circuit's opinion, place a considerably less one-sided spin on the case.[150] When she presented to DeTar Hospital, Mrs. Rivera was pregnant and near term with her sixth child. Mrs. Rivera had received no prenatal care during the pregnancy,

---

have to go to John Sealy by private car if an ambulance was not available. *See id.*

144. *See id.*

145. *See id.* at 1366-67.

146. *Id.* at 1367.

147. *See id.* The ambulance stopped at Ganado Hospital to obtain pitocin, which is commonly given postpartum to decrease bleeding. The obstetrical nurse telephoned Dr. Burditt from Ganado Hospital, and he ordered her to continue to John Sealy. However, the ambulance returned to DeTar Hospital per Mrs. Rivera's request. *See id.*

148. *See id.* After a DeTar Hospital official pressed Dr. Burditt, Dr. Shirley Pigott, a family practitioner, took over the case. Mrs. Rivera spent three days in the hospital and left in good health.

149. *See, e.g.*, Ann C. McGinley, *Aspirations and Reality in the Law and Politics of Health Care Reform: Examining a Symposium on (E)qual(ity) Care for the Poor*, 60 BROOK. L. REV. 7 (1994); 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 (1992); Case Note, *In Defense of the Masses—An Interpretation of the Emergency Medical Treatment and Active Labor Act:* In re Baby K, 28 CREIGHTON L. REV. 1209 (1995).

150. The more complete version of Mrs. Rivera's story contained in this Article is based on the record which was created when the case was heard by an ALJ in the DHHS. As with Mr. Takewell's case, one strength of the case is the breadth of publicly available data—much of it unfiltered—on the facts of the case. Although testimony on certain points was hotly disputed, the findings of the ALJ which were not reversed by the DAB are accorded due deference.

although she knew prenatal care was important.[151] Mrs. Rivera had been previously warned that she had hypertension, including when she was pregnant with her fifth child, but she had done nothing about her condition.[152] The records from her prior hospitalizations were not available at DeTar Hospital.[153] The medical records of DeTar Hospital indicate that Mrs. Rivera told the nursing staff that her prior deliveries had required twenty-four hours of labor, although they had, in fact, taken considerably less time.[154]

All physicians with obstetrical admitting privileges at DeTar Hospital alternated providing medical treatment to "unaligned" obstetrical patients.[155] During the year and a half bracketing the events in question, Dr. Burditt had treated twenty-seven unaligned obstetrical patients—and only one of these patients (Mrs. Rivera) was transferred.[156] Indeed, Dr. Burditt was in the midst of delivering the baby of another (considerably sicker) unaligned patient during the time that Mrs. Rivera was in DeTar Hospital.[157] Prior to the events in question, Dr. Burditt had not transferred an obstetrical patient from DeTar Hospital —whether aligned or not—for more than three years.[158] However, high-risk

---

151. *See* Hearing Transcript at 74, 77, Inspector Gen. v. Burditt (Dep't Health & Human Servs. Jan. 24, 1989) (No. C-42) (testimony of Mrs. Rivera). A wide variety of studies have demonstrated that the absence of prenatal care is associated with an increased rate of bad outcomes.

152. *See id.* at 637-38 (testimony of Dr. Shirley Persons Pigott).

153. *See id.* at 58 (testimony of Mrs. Rivera).

154. *See* Hearing Transcript, Joint Exhibit 1, at 12, *Burditt.* Mrs. Rivera did not remember telling the nurse that her previous labors had taken this long. *See* Hearing Transcript at 58-60, *Burditt* (testimony of Mrs. Rivera).

155. DeTar Hospital referred to patients who did not have a preexisting relationship with a physician as "unaligned." *See* Hearing Transcript at 83-84, *Burditt* (testimony of Ms. Jean Herman). Although the record is unclear, it appears that virtually all of these patients were uninsured and indigent.

156. *See* Hearing Transcript, Respondent's Exhibit 6, *Burditt.* The unaligned patients received the following treatments: 10 Caesarean sections, 13 deliveries, 1 dilatation and curettage, 1 care in the ED, 1 care as an inpatient, and 1 transfer (Mrs. Rivera). *See id.*; *see also* Hearing Transcript at 110, *Burditt* (noting that Dr. Burditt was known to treat indigent patients) (testimony of Ms. Herman).

157. *See* Hearing Transcript at 131, 163-64, *Burditt* (testimony of Ms. Donna Kiening); *see also id.* at 681 (providing testimony that "the patient with the abruptial placenta [i.e., Mrs. Ramirez], which from a priority standpoint, the abruptial placenta has to take priority over it") (testimony of Dr. Pigott).

158. Dr. Burditt testified that in 1992 or 1993, he had attempted to transfer a woman with placenta previa at 27 weeks of pregnancy who was "bleeding . . . 'heavier that [sic] what she'd done, to that point.'" *Id.* at 812 (alteration added) (quoting Ms. Carville, the on-duty labor and delivery nurse) (testimony of Dr. Burditt). He was unable to secure helicopter transport, and ground transportation was out of the question. She subsequently began bleeding profusely, and an emergency Caesarean section was performed. The child was badly brain damaged, and eventually died three years later. Dr. Burditt was convinced the child would have done better had it been in a tertiary-care center, since a woman with similar problems six months earlier had been successfully transferred, and the child was alive and well. *See id.* at 811-14; *see also id.* at 638 (testimony of Dr. Pigott); *id.* at 799 (providing testimony that Dr. Burditt has a reputation of not transferring very often, and that Mrs. Rivera was "[t]he only transfer that I'm aware of") (testimony of Dr. William Brian Brendel).

obstetrical patients at DeTar Hospital were routinely transferred to far-away hospitals, and John Sealy was the designated Level III referral facility for Victoria, Texas.[159] For a variety of personal reasons, Dr. Burditt had voluntarily limited his practice to low-risk pregnancies.[160]

During the course of her stay at DeTar Hospital, Mrs. Rivera was examined three times—by Dr. Burditt and two nurses.[161] After his examination, Dr. Burditt concluded that Mrs. Rivera was not in active labor, and told the nursing supervisor his assessment of the case.[162] The obstetrical nurse who was taking care of Mrs. Rivera, and who gave the most damaging testimony to Dr. Burditt's case, also did not believe that Mrs. Rivera was in active labor.[163] Although she was having periodic contractions, Mrs. Rivera's physical examination remained essentially unchanged during her stay at DeTar Hospital.[164]

---

159. *See id.* at 638-39 (providing testimony that Dr. Pigott transferred patients that were not as sick, as well as sicker than Mrs. Rivera) (testimony of Dr. Pigott); Letter from Dr. William J. McGanity, Department of Obstetrics & Gynecology, University of Texas Medical Branch at Galveston, to Mr. Donald F. Garrett, Departmental Grant Appeals Board, DHHS 5 (Feb. 27, 1990) (on file with the *Indiana Law Journal*) [hereinafter McGanity Letter].

160. *See* Hearing Transcript at 806-08, *Burditt* (providing testimony that the break-up of his group practice left Dr. Burditt without back-up; custody of teenage daughter also required a more predictable schedule; and accordingly, Dr. Burditt routinely refers high-risk patients to another physician in town or tertiary-care facility in Houston or Galveston) (testimony of Dr. Burditt).

161. The first examination was performed by a nurse at approximately 4:00 p.m. The second examination was performed by Dr. Burditt around 4:50 p.m. The third examination was conducted between 5:45 and 6:30 p.m. by the nurse who was to accompany Mrs. Rivera to John Sealy. It was standard practice for obstetricians in Victoria to rely on the nursing staff for the results of such examinations, and the IG's experts agreed that it was appropriate to do so. *See id.* at 169 (testimony of Ms. Kiening), 254 (testimony of Dr. Robert Thomas Greene), 362-63 (testimony of Dr. Warren Crosby), 513 (testimony of Dr. Mark Akin), 833, 908 (testimony of Dr. Burditt); *see also id.* at 600 (providing testimony that it is imperative for obstetricians to rely on nurses, and nurses on whom one cannot rely should be fired) (testimony of Dr. D. Clifford Burross). Although the IG and DAB held that it was an aggravating factor that Dr. Burditt did not reexamine Mrs. Rivera before her departure, one of the IG's experts observed such an examination was not necessary, even though he believed it would have been useful. *See id.* at 406 (testimony of Dr. Crosby).

162. *See id.* at 87 (testimony of Ms. Herman):

> [Dr. Burditt] told me that this patient was not in active labor, that she was in early labor, that she had high blood pressure and that it was necessary for us to transfer her, that he felt he could not take care of her here and he couldn't be the doctor for her here, that she needed to be transferred.

163. *See id.* at 171-72 (testifying that Mrs. Rivera was not in active labor when she left DeTar Hospital, but that the nurse could not tell one way or another at 4:30 p.m.) (testimony of Ms. Kiening).

164. The initial examination found that Mrs. Rivera's cervix was dilated to 3 centimeters and 70% effaced. Subsequent examinations found essentially identical results. The only change which was noted was that the fetus was ballottable at -3 station on the initial two examinations, and its head was at -2 station on the final examination. The IG's experts disagreed over whether the fetus was engaged at -2 station, but agreed that there was no significant change in Mrs. Rivera's physical examination. *See id.* at 226 (testimony of Dr. Greene), 362 (testimony of Dr. Crosby), 590 (testimony of Dr. Burross). Dr. Burditt testified that he would not have transferred Mrs. Rivera had her cervix been dilated to 4 centimeters. *See id.* at 913 (testimony

Dr. Burditt's casual attitude about the transfer certification is understandable if one actually reads the form, since it was limited by its terms to emergency-room physicians under contract with the hospital (which Dr. Burditt was not), and to women in active labor (which Dr. Burditt and the nurse concluded Mrs. Rivera was not). There was extensive testimony that the nursing staff at DeTar Hospital took an inordinately long time to administer the magnesium sulfate to Mrs. Rivera, and to secure transportation for the transfer.[165]

Dr. Burditt was charged with two distinct violations of EMTALA: improperly certifying that the benefits of the transfer outweighed the risks, and failing to perform an "appropriate transfer."[166] The ALJ concluded that Dr. Burditt had violated these provisions, and the DHHS DAB and the Fifth Circuit concurred in that determination.[167]

The necessary factual predicate for the IG to prove these violations was proof that Mrs. Rivera had an emergency medical condition which was not stabilized. This issue requires a two-part inquiry: was Mrs. Rivera's hypertension adequately treated prior to transfer, and was Mrs. Rivera transferred while she was in "active labor?"[168] The Fifth Circuit devoted little attention to the former issue, and simply noted that Mrs. Rivera's blood pressure remained substantially elevated throughout her stay at DeTar Hospital.[169] That issue should not have been disposed of so quickly. The IG presented expert witnesses who criticized Dr. Burditt's failure to administer a drug called apresoline to lower Mrs. Rivera's

---

of Dr. Burditt).

165. *See id.* at 132, 160-61 (testimony of Ms. Kiening); *see also id.* at 709 ("[I]t's inexcusable delay from 4:15 to 6:50 for a patient to be taken out of an institution which is being transferred, because you feel that the care can be given better at the other institution.") (testimony of Dr. Burross); *id.* at 799 ("I would say, it looks like there was a lot of time wasted. I don't know what the motivation was.") (testimony of Dr. Brendel).

166. The certification is to the effect 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." 42 U.S.C. § 1395dd(c)(1)(A)(ii) (1994). Among other things, an "appropriate" transfer requires that the transfer be "effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer." *Id.* § 1395dd(c)(2)(D).

167. *See* Burditt v. United States Dep't of Health & Human Servs., 934 F.2d 1362, 1375 (5th Cir. 1991).

168. If Mrs. Rivera did not have an emergency medical condition, or had an emergency medical condition which was stabilized, the certification and appropriate transfer restrictions are moot. *See* 42 U.S.C. § 1395dd(b)(1)(A).

169. *See Burditt*, 934 F.2d 1362.

> Rivera's blood pressure was 210/130 at 4:00 and 5:00. This was the last reading known to Burditt before he facilitated her transfer. Nurses also measured her blood pressure as 173/105 at 5:30, 178/103 at 5:45, 186/107 at 6:00, and 190/110 at 6:50. Experts testified that Rivera's hypertension put her at high risk of suffering serious complications . . . . This is substantial, if not conclusive evidence that Rivera entered and exited DeTar with an emergency medical condition.

Id. at 1368.

blood pressure.[170] Dr. Burditt responded with expert witnesses who testified that the treatment Mrs. Rivera received was appropriate, and that Dr. Burditt had done his best under the circumstances he faced.[171] Dr. Burditt had been taught it was inappropriate to use apresoline under such circumstances, and he instead invariably used magnesium sulfate—and would have done so with any patient that presented with symptoms like Mrs. Rivera's, even if she were not transferred.[172] The transfer of Mrs. Rivera had been approved by a senior resident at John Sealy, who requested that she receive magnesium sulfate and no other medication.[173] The chairman of the obstetrics department at John Sealy sent a letter to the DAB which reflected his views that the treatment Mrs. Rivera received for her hypertension was appropriate in light of the impending transfer.[174] If anything, the question of whether Mrs. Rivera received adequate

---

170. *See* Hearing Transcript at 277-80, 338, 520-21, Inspector Gen. v. Burditt (No. C-42) (testimony of Dr. Greene, Dr. Crosby, and Dr. Akin, respectively). However, the IG's experts had quite different opinions as to the appropriate dosing of apresoline, and the circumstances under which it was necessary. *See id.* at 298, 345-46, 521 (dosing ranging from 2-3 milligrams up to 30 milligrams) (testimony of Dr. Greene, Dr. Crosby, and Dr. Akin, respectively). One of the IG's experts emphasized that Dr. Burditt's failure to treat Mrs. Rivera's hypertension was the important problem, and the fact that Mrs. Rivera delivered in the ambulance by the side of the road was "not really a major issue." *Id.* at 413 (testimony of Dr. Crosby).

171. *See id.* at 605 (testimony of Dr. Burross):

> Dr. Burditt used his best medical judgment to evaluate this patient, to evaluate the risk factors as compared to the benefits that might be derived from such transfer .... I find that that was both reasonable and medically sound for him to make the decision that he did for transfer of the patient.

See id. at 738; *see also id.* at 777-78 (testifying that treatment could have been improved on, but apresoline has thin margin of safety, and physicians who are not trained with it should not use it) (testimony of Dr. Joseph R. Miller); *see also id.* at 634, 656 (testifying that apresoline could cause precipitous drop in blood pressure, with catastrophic consequences and that Dr. Pigott was reluctant to use apresoline antepartum without expert back-up) (testimony of Dr. Pigott); *id.* at 300 (testifying that apresoline is tricky, so IG's expert administers it himself) (testimony of IG's expert, Dr. Greene).

172. *See id.* at 805 (testifying that he was taught that apresoline was contraindicated) (testimony of Dr. Burditt).

> I would not have done any more for her than what I had done to the point at which she got in the [a]mbulance. I would not have given her any other hypertensive or medication .... Magnesium sulfate is what she would have gotten, what she would have remained on till she delivered.

Id. at 857; *see also id.* at 656 (testifying that Dr. Pigott had not ever known Dr. Burditt to use apresoline) (testimony of Dr. Pigott).

173. *See id.* at 831, 888, 900 (testimony of Dr. Burditt).

174. *See* McGanity Letter, *supra* note 159, at 5.

> In order to stabilize her very increased blood pressure and arrest her uterine contractions, we requested she be given a loading dose of magnesium sulphate. ... We will not prescribe hypertensive medications such as apresoline until and if we have physician monitoring on board the transport vehicle. Once the patient is received at U.T.M.B., apresoline is our initial medication of choice to stabilize and regulate the hypertensive pregnant patient.

Id. The letter was not admitted by the DAB.

treatment for her hypertension appears to be a malpractice-type dispute over the appropriate standard of care, which EMTALA was not designed to resolve.[175]

The other inquiry is whether Mrs. Rivera was in active labor when she was transferred. The experts divided on whether it was reasonable to determine that Mrs. Rivera was not in labor at 4:50 p.m., when Dr. Burditt wrote the order to transfer her.[176] However, one of the IG's medical experts and two of Dr. Burditt's medical experts testified that Mrs. Rivera was not in active labor when the ambulance left DeTar Hospital.[177]

Although Mrs. Rivera's condition did not appear to meet the medical definition of active labor, the Fifth Circuit concluded five years later that she satisfied the statutory definition.[178] Unfortunately, with limited exceptions, physicians and hospitals did not know of the existence of EMTALA until well after the events in question. The first time DHHS disseminated *any* information about EMTALA

---

175. Indeed, two of the IG's experts acknowledged that there was considerable disagreement about the use of apresoline among obstetricians. *See* Hearing Transcript at 281, 382, *Burditt* (testimony of Dr. Greene and Dr. Crosby, respectively). The federal courts are unanimous that EMTALA is not intended to be used to resolve malpractice disputes. *See* Summers v. Baptist Med. Ctr. Arkadelphia, 91 F.3d 1132, 1137 (8th Cir. 1996).

176. *Compare* Hearing Transcript, Inspector General Exhibit 7, at 16, *Burditt* (No. C-42) ("Without observing her over a period of time, one cannot, with any degree of certainty determine whether Ms. Rivera was in true or false labor at 5:00.") (testimony of Dr. Akin, expert witness for the Inspector General), Hearing Transcript, Inspector General Exhibit 10, at 14, *Burditt* ("Without observing her over this period of time, one cannot, with any degree of certainty determine whether Ms. Rivera was in true or false labor at 5:00 p.m.") (testimony of Dr. Crosby, expert witness for the Inspector General), *and* Hearing Transcript, Inspector General Exhibit 12, at 16, *Burditt* ("Without observing her over a period of time, one cannot, with any degree of certainty, determine whether Ms. Rivera was in true or false labor at 5:00 p.m.") (testimony of Dr. Greene, expert witness for the Inspector General), *with* Hearing Transcript, Respondent's Exhibit B, at 11, *Burditt* ("Dr. Burditt acted appropriately in this case . . . . His decision . . . is medically sound . . . I do not believe that the action of Dr. Burditt reflects . . . a violation of [state antidumping] laws . . . .") (statement of Respondent Burditt's designated expert witness Dr. Burross), Hearing Transcript, Respondent's Exhibit C, at 2, *Burditt* ("[Dr. Burditt] acted appropriately and in the patient's best interest. . . . Dr. Burditt met the requirements for legal transfer in that he adequately evaluated the patient . . . .") (statement of Respondent Burditt's designated expert witness Dr. Miller), *and* Hearing Transcript, Respondent's Exhibit D, at 2, *Burditt* ("Dr. Burditt made the best medical decision for the patient at the time he saw her. He properly and appropriately made the necessary arrangements to procure a safe-as-possible transport . . . .") (opinion of Dr. Brendel, expert witness for Respondent Burditt).

177. *See* Hearing Transcript at 361, *Burditt* (not in active labor) (testimony of Dr. Crosby); Hearing Transcript, Respondent's Exhibit B, at 8, *Burditt* (same) (statement of Respondent Burditt's designated expert witness Dr. Burross); Hearing Transcript, Respondent's Exhibit C, at 2, *Burditt* (same) (statement of Respondent Burditt's designated expert witness Dr. Miller). *But see* Hearing Transcript at 240-44, *Burditt* (in active labor) (testimony of Dr. Greene); *id.* at 506-07 (more probably than not in labor at 6:30 p.m., with the benefit of hindsight) (testimony of Dr. Akin).

178. *See* Burditt v. United States Dep't of Health & Human Servs., 934 F.2d 1362, 1369-70 (5th Cir. 1991).

was a week after Mrs. Rivera gave birth.[179] One of the IG's experts testified that he learned of EMTALA six months to a year after it was passed, but agreed it was not a "widely publicized piece of legislation among the medical community."[180] Another of the IG's experts testified that he only learned of EMTALA when he was asked to review Dr. Burditt's case, in late 1987, or early 1988.[181]

Dr. Burditt's conduct was exonerated in peer-review proceedings by the Department of Obstetrics Quality Assurance Committee at DeTar Hospital, the Patient and Physician Advocacy Committee of the Texas Medical Association, and the Texas State Board of Medical Examiners.[182] Various amici from the medical establishment argued before the Fifth Circuit that it was inappropriate for EMTALA to be used to second-guess a physician's decision as to appropriate medical care.[183] Dr. Burditt's support was not simply an issue of closing ranks; one of Dr. Burditt's experts was the former president of the TMA, who had been a strong backer of the Texas antidumping law, but believed Dr. Burditt's case was not the kind of situation for which antidumping laws were intended.[184] The TMA felt so strongly about the case that they underwrote the substantial legal

---

179. *See* HOUSE COMM. ON GOV'T OPERATIONS, EQUAL ACCESS TO HEALTH CARE: PATIENT DUMPING, H.R. REP. NO. 100-531, at 8-9 (1988).

> On December 12, HCFA headquarters sent a memorandum to all associate regional administrators "directing them to require States to send all Medicare participating hospitals: (1) a copy of the statute, and (2) a letter describing their new obligation . . . and directing them to sign a revised provider agreement." Before this memo was sent, HHS had not informed hospitals of the existence of the new law and how it affected them.

Id. (omission in original) (quoting Letter from Dr. William L. Roper, Administrator, HCFA, DHHS, to Rep. Ted Weiss, Chairman, Human Resources & Intergovernmental Relations Subcommittee (June 24, 1987)).

Of course, hospitals could learn of EMTALA through their own devices. The nurses at DeTar Hospital learned about EMTALA in a class the week before Mrs. Rivera presented, although the written transfer policy had not been disseminated. *See* Hearing Transcript at 115, *Burditt* (No. C-42) (testimony of Ms. Herman). However, the forms employed by DeTar Hospital misstated the reach of EMTALA (as ultimately determined by the Fifth Circuit), since the forms were clear that EMTALA did not apply to members of DeTar's medical staff.

180. Hearing Transcript at 407, *Burditt* (testimony of Dr. Crosby).

181. *See id.* at 451-52.

182. *See id.* at 557-58 (providing testimony that the Texas Medical Association ("TMA") Committee unanimously decided Dr. Burditt "made a reasonable medical decision based upon the facts that were present to him at the time he saw Ms. Rosa Rivera and that Dr. Burditt acted responsibly in asking for this patient to be transferred to John Sealy Hospital") (testimony of Dr. Burross); Hearing Transcript, Respondent's Exhibit 5, *Burditt* (DeTar Hospital Department of Obstetrics/Gynecology Meeting Minutes, July 22, 1987); Petitioner's Reply Brief, Exhibit B, *Burditt*, 934 F.2d 1362 (Letter from Paul R. Gavia, Director of Enforcement, Texas State Board of Medical Examiners, to Dr. Burditt (Oct. 2, 1990)).

183. Amicus briefs favoring Dr. Burditt were filed by the American Medical Association and the California Medical Association. *See Burditt*, 934 F.2d at 1365.

184. *See* Hearing Transcript at 555, *Burditt* (No. C-42) (noting policy of TMA was to oppose patient dumping, and when Texas passed antidumping statute, Dr. Burross was president-elect and then later president of TMA, and he "supported and endorsed that provision") (testimony of Dr. Burross).

defense fees and paid the $20,000 fine.[185] Finally, although the economic issues raised by EMTALA are beyond the scope of this Article, it is clear that its burdens are disproportionately distributed on those, like Dr. Burditt, who practice in areas where the number of uninsured patients is high.[186]

C. The Perils of Narrative

There is clearly a wide gulf between truth and narrative in these two cases. The attention Mr. Takewell received may have been less than perfect, but the legend of Mr. Takewell bears little or no resemblance to what actually happened. If anything, Mr. Takewell's story belongs in a collection of urban legends, rather than an official report of the U.S. Congress and a half-dozen law reviews on patient dumping.[187] Although the story of Mrs. Rivera is closer to the truth, the unmistakable pattern of selective emphasis and omission, and the systematic slighting of a more global perspective demonstrates the hazards of storytelling. As my colleague, Bob Condlin has written, such inclusion and exclusion of data is the

> story-teller's prerogative, presumably because it is not relevant to the message she wants to convey (in other words to the story she wants to tell). But that is the problem with stories. They are always an advocacy move, used as much to make a point as to discover one, even if the storyteller does not think so.[188]

To be sure, Mr. Takewell and Mrs. Rivera are only two cases of alleged patient dumping—but they are important and revealing cases. Mr. Takewell and Mrs. Rivera were embraced by all and sundry as the "flagship" narratives of patient dumping—and Congress reversed one of the most fundamental principles of tort law[189] on the strength of such stories.[190] If these high-profile narratives are

---

185. *See* Charles D. Bankhead, *MD Loses Patient Dumping Case; Michael L. Burditt*, MED. WORLD NEWS, Aug. 28, 1989, at 26.

186. *See* David A. Hyman, When Bad Laws Happen to Good People: The Case Against a Duty to Rescue (work in progress, Feb. 9, 1998) (unpublished manuscript, on file with author).

187. *Compare supra* note 19 and accompanying text (discussing the prevalence of urban legends), *with supra* notes 64-65 and accompanying text (discussing true believers in the legend of Mr. Takewell in Congress and the halls of academia).

188. Robert J. Condlin, *Learning from Colleagues: A Case Study in the Relationship Between "Academic" and "Ecological" Clinical Legal Education*, 3 CLINICAL L. REV. 337, 349 n.29 (1997) (commenting on narrative account of relationship with client which omits details of horrific crime for which client was convicted and sentenced to death); *see also* Martha Minow, *Stories in Law*, *in* LAW'S STORIES, *supra* note 1, at 24, 31 (noting problem of selectivity in storytelling, and conscious refusal to include "additional stories [which] convey unattractive features of the community that I was trying to paint in a sympathetic light").

189. *See* Weinrib, *supra* note 52, at 247.

190. Neither of the incidents were factors in the original enactment of EMTALA, since both occurred shortly after EMTALA took effect. However, as their citation frequency reflects they have become the paradigmatic examples of patient dumping. *See supra* notes 69, 149 and accompanying text. The timing of these incidents (within a matter of months of EMTALA taking effect) also allowed EMTALA's enthusiasts to provide additional evidence on the consequences of a "no-duty" rule. Finally, these two narratives were employed to help ensure that the government would actually enforce EMTALA. *See supra* note 61 and accompanying

wrong, or at least deceptively incomplete, then EMTALA—and more generally, the edifice of narrative proof on which EMTALA was built—is fairly called into question. The opponents of patient dumping had every incentive to get the best narratives possible—and they came up with Mr. Takewell and Mrs. Rivera. It is no great surprise that these narratives were selected; Mr. Takewell's case obviously triggered a "flash of recognition"—and the exoneration of Methodist Hospital by a provider-dominated Board made the facts even more perfect.[191] The "flash of recognition" must also have blinded everyone in the intervening eight years to clear indications in the record that matters were not what they seemed.[192] Similar observations apply to the case of Mrs. Rivera. Commentators have embraced the conventional (but wrong, or at least badly incomplete) version of these narratives without question or comment.[193]

What lessons can be drawn from these examples of the use and abuse of narrative? For starters, even the most horrific narrative of patient dumping should be approached with considerable skepticism.[194] Complaints about dumping invariably feature the claims of the receiving hospital and patient advocates, each of whom has their own ax to grind.[195] Those who are alleged to have engaged in dumping rarely get an opportunity to tell their side of the story—and even when they do, the original narratives are usually so compelling

---

text. In the absence of such a governmental commitment, EMTALA would have remained a symbolic law. *See* Hyman, *supra* note 186.

191. *See supra* note 44.

192. *See supra* note 67 (summarizing newspaper articles about the true facts of Mr. Takewell's story). As usual, Richard Epstein broke with conventional wisdom, and questioned the legend of Mr. Takewell on the basis of the newspaper articles attached to the hearing record. *See* RICHARD EPSTEIN, MORTAL PERIL 94 (1997).

193. The appearance of the legend of Terry Takewell in an official congressional report goes a long way to explain why so many people were taken in. Similar considerations probably apply to the case of Dr. Burditt. However, in other areas of the law, scholars have been willing to dig behind the "official" version to discover what is really going on. *See, e.g.*, Charles W. Adams, World-Wide Volkswagen v. Woodson—*The Rest of the Story*, 72 NEB. L. REV. 1122 (1993) (reconstructing story behind classic civil procedure case); Judith L. Maute, Peevyhouse v. Garland Coal & Mining Co. *Revisited: The Ballad of Willie and Lucille*, 89 NW. U. L. REV. 1341 (1995) (reconstructing story behind classic contract case).

194. The required degree of skepticism is exemplified by the unsentimental motto of the City News Bureau of Chicago: "If your mother says she loves you, check it out." Laurie Goering, *Journalists Go on Record with Praise of City News*, CHI. TRIB., Oct. 7, 1990, § 2, at 3.

195. As Mark Tushnet noted in criticizing news accounts of political correctness,

> [t]he victim's account of the incident is the only source of evidence. The reports never note that victims have a perfectly understandable desire to present what happened to them in a way that makes them appear best. When the reports are offered by people with a political ax to grind, one can fairly wonder exactly what happened.

Mark Tushnet, *Political Correctness, the Law, and the Legal Academy*, 4 YALE J.L. & HUMAN. 127, 131 (1992). The same observation obviously applies to those alleging patient dumping, or otherwise using anecdotes to further a particular agenda. *See infra* notes 213-16 and accompanying text.

that most people do not seem interested in listening.[196] The issue of the patient's conduct never even comes up.[197]

In this setting, the evidence that is available may be the truth, but it is rarely the whole truth. It is no accident that the legal system generally declines to take action on the say-so of one party,[198] and looks with considerable disfavor on limitations on the right to confrontation and cross-examination.[199] One should not allow the damning (but too easily applied) label of "dumping" to decide matters.[200] The most extreme cases of "patient dumping" can turn out to be nothing of the sort if one actually looks closely at the facts.[201]

---

196. *See, e.g.*, Emily Friedman, *The "Dumping" Dilemma: Finding What's Fair*, HOSPITALS, Sept. 16, 1982, at 75, 77 (noting the storm of protest following the discharge of patient who shortly thereafter collapsed and died; the hospital's efforts to explain that the patient appeared stable, had normal vital signs, and walked out of the hospital were unavailing; the hospital was condemned in newspapers across the nation by a syndicated columnist). In like fashion, Methodist Hospital's vindication was generally dismissed as the result of flawed procedures and biased decisionmaking. *See Equal Access Hearing*, *supra* note 47, at 206 ("My question is, would you expect that a State agency under the control of a board such as the one in Tennessee would be able to conduct an adequate, impartial investigation and render an impartial judgment regarding the private hospital for violating this law?") (question posed by Rep. Ted Weiss to Dr. William L. Roper, Administrator, HCFA).

Although the Due Process Clause requires notice and an opportunity for hearing, the publicity attached to an alleged EMTALA violation does most of the damage—and the stakes are so high that most hospitals opt to settle rather than contest the alleged violation.

197. *See, e.g.*, Burditt v. United States Dep't of Health & Human Servs., 934 F.2d 1362, 1365 (5th Cir. 1991) (noting that Mrs. Rivera had never received prenatal care and presented near-term); *supra* notes 73, 76 and accompanying text (noting that Mr. Takewell was noncompliant with diabetes regimen, and allegedly spent insulin money on alcohol and illegal drugs, including cocaine).

198. *See* Fuentes v. Shevin, 407 U.S. 67, 83 (1972) ("Because of the understandable, self-interested fallibility of litigants, a court does not decide a dispute until it has had an opportunity to hear both sides—and does not generally take even tentative action until it has itself examined the support for the plaintiff's position.").

199. *See* Coy v. Iowa, 487 U.S. 1011, 1016, 1019-20 (1994) ("[T]he Confrontation Clause guarantees the defendant a face-to-face meeting with witnesses appearing before the trier of fact . . . . It is always more difficult to tell a lie about a person 'to his face' than 'behind his back.'").

> If the calling party's opponents cannot subject the witness to cross-examination for reasons that are not his fault, some remedy is necessary . . . . If cross-examination is permanently blocked, the direct testimony usually should be stricken in both civil and criminal cases, or a mistrial declared if the direct testimony is critical and striking it would not be effective.

MUELLER & KIRKPATRICK, *supra* note 68, § 6.29, at 577.

200. *See* Fabreeka Prods. Co. v. Commissioner, 294 F.2d 876, 878 n.2 (1st Cir. 1961) ("Nor do we think a dog is to be hanged simply by giving him a bad name."); *see also* Ralph S. Rice, *Judicial Techniques in Combating Tax Avoidance*, 51 MICH. L. REV. 1021, 1026-30 (1953) (discussing decision by invective).

201. For example, in *Owens v. Nacogdoches County Hospital District*, 741 F. Supp. 1269 (E.D. Tex. 1990), the district court concluded that EMTALA had been violated when a physician at Memorial Hospital sent Ms. Rebecca Owens, an indigent 16-year-old woman with labor pains, to John Sealy in Galveston, 200 miles away. The woman left for John Sealy in an 11-year-old Pinto in bad condition "in the middle of the night" of August 3. *Id.* at 1274. Upon

Mr. Takewell and Mrs. Rivera are all too representative of the difficulties with the use of narrative in the world of public policy.[202] Unfortunately, "even writers who are not ideologically motivated don't let the complexities of actual events stand in the way of a good story"[203]—and those who are ideologically motivated are considerably less scrupulous. Given this dynamic, the "flash of recognition" on which narrativists rely to prove truth and generalizability is clearly an inadequate safeguard.[204] In short, as noted previously, "[t]he plural of *anecdote* is not *data*."[205]

More generally, context (i.e., how the mine run of cases are handled) matters a great deal more than the facts—however bad they may be—of any given

---

arrival at John Sealy the next morning, she was examined and told that she would not be admitted because she was not sufficiently dilated. *See id.* A temporary restraining order was issued by the district court, and the woman ultimately delivered a healthy child at Memorial Hospital on August 7, 1987—a full three days after she was discharged by John Sealy. *See id.* at 1275. Memorial Hospital sought to defend its conduct, in part, on the grounds the three-day delay meant that it could not have violated EMTALA. *See id.* at 1279. The district court rejected this claim and came down hard on the hospital and physician, but did not even attempt to reconcile its determination that EMTALA had been violated with John Sealy's determination that Ms. Owens was not ready to deliver and it was safe for her to return the 200 miles to Nacogdoches using the same 11-year-old Pinto in bad condition in which she went to Galveston. Either both hospitals violated EMTALA (and John Sealy's conduct was worse, since it sent Ms. Owens on the same perilous trip 12 hours further into her labor), or neither of them did.

The overlap of EMTALA with medical malpractice also allows diagnostic mistakes to be condemned as dumping. *See, e.g.*, Power v. Arlington Hosp. Ass'n, 42 F.3d 851 (4th Cir. 1994) (reducing dumping verdict from $5 million to $1 million after physician erroneously diagnosed and treated uninsured septic patient for "musculoskeletal pain"). In a related suit, the judge who had heard the original case expressly acknowledged that the plaintiff had already "recovered $1 million for her malpractice injuries in an EMTALA suit." Power v. Alexandria Physicians Group, 887 F. Supp. 845, 846 (E.D. Va. 1995), *aff'd*, 91 F.3d 132 (4th Cir. 1996). Although the screening examination Ms. Powers received may well have fallen below the standard of care, that does not mean it constituted dumping—unless one is prepared to argue that the physician (a) knew the patient was septic; and (b) decided to diagnose and treat her for musculoskeletal pain rather than sepsis, in an attempt to evade the strictures of EMTALA. To do otherwise renders EMTALA essentially indistinguishable from a medical-malpractice statute.

202. *See supra* notes 28-36 and accompanying text. As such, the "counternarrative" (i.e., the truth) presented in this Article about the cases of Mr. Takewell and Mrs. Rivera is not simply anecdotal evidence about the risks of anecdotal evidence.

203. Paul Brest, *The Disorderly University: A Reply to Mark Tushnet*, 4 YALE J.L. & HUMAN. 381, 382 (1992).

204. *See supra* note 44.

205. Greene, *supra* note 2, at 100 (emphasis in original); *see also* Mark Thompson, *Letting the Air Out of Tort Reform*, A.B.A. J., May 1997, at 64, 69 ("'[T]he plural of anecdote is not evidence.'") (alteration added) (quoting Cynthia Lebow, Associate Director of Rand Institute for Civil Justice).

anecdotal case in assessing the overall merits of the system.[206] As Richard Epstein has noted:

> The capacity of narrative to inflame, inform, or excite depends on its ability to take you away from the peak of the distribution to see what some extraordinary novel and different circumstance is and indeed that is exactly why we call these things novel because of the way in which they take you away from the core. But if you are trying to understand the way in which social reality works then the important thing to remember is that the prosaic and the boring is often far more important in the way in which the world organizes itself than is the exotic and profane. So that if you were to try and understand the way in which supermarkets work you would not want to take the one case out of a thousand where somebody gets in a fight with a cash register operator over the price of a good. You would rather first want to understand how it is that somebody organizes these lines so as to get as many people through as quickly as possible with a minimum of personal interaction . . . . [W]hat literature and narrative do is get you way out there on the fringes.[207]

EMTALA's enthusiasts understand this point perfectly well—and exploit it to considerable effect in opposing "reforms" they do not like.[208] Unfortunately, disregarding this simple point can result in "reforms" which target the .001% of transactions which go poorly, but disrupt the 99.999% of the market which works perfectly well.

From a statistical perspective, any system in which there are approximately 100 million encounters between patients and providers will generate a nonzero

---

206. *See supra* text accompanying note 16; *see also* Michael L. Millenson, *Patient Dumping or Transfer? Blurred Line Plagues Provider*, HEALTH POL'Y WK., Jan. 25, 1988, at 2 (noting determination that University of Chicago Hospitals ("UCH") had violated EMTALA by transferring an insured patient via helicopter to Cook County Hospital because UCH operating rooms were in use, and reporting that the director of planning and budget for UCH had observed that the "$31 million U. of C. will lose in 1987 on uncompensated care—out of an operating budget of $195 million—meant nothing to the federal regulators" in deciding whether EMTALA had been violated).

207. *Discussion*, 45 STAN. L. REV. 1671, 1678 (1993) (remarks of Professor Richard Epstein).

208. *See, e.g.*, *Product Liability Reform: Hearing Before the House Comm. on the Judiciary*, 105th Cong. 54 (1997).

> For the last 16 years, lobbyists for America's biggest corporations have come to Congress with wild claims about out of control juries and junk statistics about a product liability litigation explosion. . . .
>
> . . . .
>
> As in the past, the proponents of federal product liability legislation continue to rely on myths and unrepresentative anecdotes about product liability litigation and its impact on U.S. competitiveness to support disrupting state authority and protecting corporate wrongdoers.

Id. at 54, 56 (statement of Joan B. Claybrook, President, Public Citizen). Public Citizen is an enthusiastic backer of EMTALA, and has issued a number of reports castigating the government for its failure to enforce the law. *See* David A. Hyman, *Patient Dumping and EMTALA: Past Imperfect/Future Shock*, 8 HEALTH MATRIX 29 (1998); *see also* Law, *supra* note 28, at 474-88 (presenting empirical evidence regarding welfare to rebut anecdotal perspectives). Professor Law is also an enthusiast of EMTALA. *See* Law, *supra* note 46, at 779.

failure/error rate.[209] Even the .001% rate of mishap referenced above will result in 1000 bad anecdotes per year.[210] Furthermore, although there may well be bad outcomes associated with certain transfers, it does not follow that all transfers are improper—let alone non-cost-worthy.[211] The possibility of strategic behavior complicates matters further.[212] Narrative provides no way of getting a handle on these problems.

In addition, the narratives which emerge in the public sphere do not surface by accident, but are packaged and presented by policy entrepreneurs, who use them to further their legislative agenda.[213] Advocacy groups expend considerable effort

---

209. In 1995, there were approximately 100 million visits to EDs in the United States. *See* AMERICAN HOSP. ASS'N, HOSPITAL STATISTICS 6 tbl.3A (1996).

210. The most widely circulated estimate of the number of patient-dumping episodes is 250,000. *See infra* text accompanying note 329. This figure is woefully inaccurate. *See infra* text accompanying notes 330-33. However, even if these figures were accurate, they are still only 0.25% of the visits to EDs in 1995—and 250,000 is a modest number compared to the population of uninsured individuals (approximately 40 million) who depend on EDs for care.

211. For example, if more sophisticated care is available at the transferee hospital, it would be hazardous to prohibit all transfers—and might well be hazardous to prohibit even unstabilized transfers. *See, e.g.*, Hearing Transcript at 739, Inspector Gen. v. Burditt (Dep't Health & Human Servs. Jan. 24, 1989) (No. C-42) ("'I have heard the admonition here about transfer. . . . [T]he last four patients before I left Denver, had those patients been "stabilized," they would not have been alive today. They had to be transferred in the unstable condition because they were not going to be able to do better out there in the boondocks where they were.'") (omission and alteration added) (quoting the remarks of an infectious disease expert at a medical-staff meeting regarding the patient-dumping laws) (testimony of Dr. Burross); *see also infra* text accompanying note 293.

212. EMTALA's absence of a financing system is based on the assumptions that its burdens will fall fairly across the board, and that ED utilization is effectively random. These (erroneous) assumptions allow patients to behave strategically, while eliminating the primary response private hospitals would otherwise employ. Remarkably enough, the second witness at the congressional hearings on EMTALA made these points plain. The witness testified that he had previously taken a friend from Brooklyn to Bellevue Hospital, but was dissatisfied with the waiting time and the quality of care. He subsequently took his roommate from Brooklyn to NYU, where he found the facilities much more to his liking, *see Equal Access Hearing*, *supra* note 47, at 25, and had every reason to, since neither he nor his roommate were going to pay a nickel for the care the roommate received. The issue was particularly nicely put in his oral testimony: "I can't believe for 1 minute that half of the people waiting at Bellvue [sic], if they knew that they could go just three blocks away, to NYU's emergency room, if they knew that they would not be turned away, they would not do it." *Id.* at 59 (testimony of Jesse Green).

Our humanitarian instincts naturally incline us to find nothing wrong with such conduct—but our refusal as a society to socialize the resulting cost leaves hospitals with a limited set of options—none of which is particularly appealing. *See* Hyman, *supra* note 186.

213. *See* Tamar Lewin, *Hybrid Organization Serves as a Conductor for the Health Care Orchestra*, N.Y. TIMES, July 28, 1994, at A20:

> Using a careful mix of statistics, hard-luck stories, and staged political events, Families USA has played an important behind-the-scenes role in shaping public perceptions of the nation's health care problems. . . . [W]hen NBC broadcast a two-hour special on the health care debate . . . several of the people who told their stories came from the Families USA "misery bank," a listing of people who have had problems with health insurance. In the four years since the list was compiled, it has been used by scores of reporters looking for examples to use in their reports

in finding good narratives.[214] What they are looking for is "[t]he perfect victim—someone who is genuine, articulate, and sympathetic."[215] If the "spin" sometimes overtakes the facts, most advocacy groups can doubtless convince themselves that they have committed no great sin, since they *know* they are on the side of the angels.[216]

---

on health policy.

214. Advocacy groups troll for such anecdotes through a variety of methods.

> Families USA Foundation is searching for compelling stories of people who have had problems with their existing insurance coverage or with loss of coverage entirely. Bringing to the public's attention the urgent human cost of Congressional inaction on these issues is crucial to our ability as advocates to be persuasive and thus effective.
>
> . . . .
>
> For over 10 years, Families USA has maintained a database of health care hardship stories, now numbering over a thousand. . . . The database is an ongoing project of Families USA, and so we encourage anyone with a hardship story to tell, even one outside this search, to send your name and a brief description of your problem so that we can get in touch with you for more details.
>
> . . . .
>
> Stories will also be checked for accuracy, to protect the integrity of all involved.

Families USA Found., *In Search of Healthcare Hardship Stories* (visited Feb. 9, 1998) <http://www.familiesusa.org/favict.html>; *see also* Consumer Coalition, *The Quality Watchline* (visited Feb. 9, 1998) <http://www.consumers.org/wline.htm> (announcing advocacy group's toll-free phone number and e-mail address to report complaints about managed care); Lawrence, *supra* note 15, at A18 (noting narrative from "[t]he perfect victim . . . often surfaces in a newspaper story, a letter to a lawmaker or a list kept by an advocacy group").

215. Lawrence, *supra* note 15, at A18.

216. *See, e.g.*, Katharine Dunn, *Fibbers: The Lies Journalists Tell*, NEW REPUBLIC, June 21, 1993, at 18, 18.

> Of all the lies that are swallowed and regurgitated by the media, the ones that hurt the most come from the Good Guys, the grass-roots do-gooders, the social work heroes, the non-profit advocacy groups battling for peace, justice and equality. . . . [A] lot of reporters don't check facts provided by non-profit organizations because they assume non-profits don't have anything to gain by lying. . . . The well-meaning grow desperate for results and stoop to the tactics of their enemies. It happens all the time.

See also Daniel Koshland, *Scare of the Week*, 244 SCIENCE 9, 9 (1989):

> It is time to recognize that public interest groups have conflicts of interest, just as do business groups, even though their public positions are orthogonal. Businesses prefer to be out of the limelight; public interest groups like to be in it. Because they are selling products in the marketplace, businesses downplay discussions of hazard. Because public interest groups acquire members by publicity, they emphasize hazards. Each group convinces itself that its worthy goals justify oversimplification to an "ignorant" public. Businesses today have product liability and can incur legal damages if they place a dangerous product on the market. Public interest groups have no such constraints at the moment; it may be time to develop appropriate ones so that the victims of irresponsible information have redress.

The "creative" efforts of public interest groups are not limited to anecdotal evidence, but include statistical gerrymandering as well. *See, e.g.*, Dunn, *supra*, at 18; *infra* text accompanying notes 241-44. Indeed, the "Good Guys" have made inflated claims about the incidence of a host of social ills, including the number of abducted children, suicides during

With sufficiently diligent effort, advocacy groups can even offer simultaneous narratives which support diametrically opposed positions.[217] When empirical studies lead to such situations, there are standard methodological strategies for assessing the disjunctive results.[218] Narrative has no tools for handling such situations, except for the unhelpful instruction that only the "right kind" of stories should be listened to.[219]

As the prior paragraph implies, narrative is an unreliable ally. If a few bad anecdotes were sufficient to persuade Congress to enact EMTALA, should a more complete picture of the same anecdotes force it to reconsider?[220] What if opponents find a more persuasive anecdote which leads to the opposite conclusion?[221] Is it sufficient that those who live by the anecdotal sword will die by it?[222] Credibility issues aside, that would appear to be an inadequate response to the underlying problem with casual reliance on narrative.[223]

---

the holiday season, the rate of domestic violence during and after the Super Bowl, the number of gay teenage suicides, self-esteem, educational bias, and so on. *See* Dunn, *supra*, at 18.

217. *See supra* notes 30-34 (discussing competing anecdotes on tort reform and property rights/environmentalism); *see also* Gina Kolata, *Ethicists Struggle Against the Tyranny of the Anecdote*, N.Y. TIMES, June 24, 1997, at C4 (reporting how ethicists offer competing anecdotes to argue the global appropriateness—or lack thereof—of physician-assisted suicide).

218. *See* Paula Braveman et al., *Early Discharge and Evidence-Based Practice*, 278 JAMA 334 (1997) (employing various forms of statistical analysis to assess two articles which reach apparently conflicting conclusions regarding the safety of short postpartum stays).

219. *See, e.g.*, Bandes, *supra* note 39, at 409 ("The important point, both generally and in regard to victim impact statements, is that not every story should be told, or every voice heard, in the legal context. The question is *always* which narratives we should privilege and which we should marginalize or even silence.") (emphasis in original).

220. *See, e.g.*, Robin West, *Constitutional Fictions and Meritocratic Success Stories*, 53 WASH. & LEE L. REV. 995, 1001 (1996) ("[If a] story did not just symbolize or dramatize but also evidenced the existence of a social injustice and if the story proves to be false, then the evidence of that social injustice is accordingly weakened."); *cf.* David Luban, *The Posner Variations (Twenty-Seven Variations on a Theme by Holmes)*, 48 STAN. L. REV. 1001 (1996) (book review).

> What Posner does expose are a few significant errors and omissions in claims Williams makes about historical and statistical facts having nothing to do with her personal narratives. This is an important distinction, because the personal stories are methodologically central to Williams' book and argument, while her claims about matters of public record are not.

Id. at 1034.

221. *See supra* note 217.

222. *Cf.* Jim Chen, *Untenured but Unrepentant*, 81 IOWA L. REV. 1609, 1616 n.60 (1996) ("Live by the rhetorical sword, die by the rhetorical sword.").

223. Indeed, the hazards of such an approach are illustrated by a series of events in New York City over the past five years. *See* Rudolph W. Giuliani, *Rumor and Justice in Washington Heights*, N.Y. TIMES, Aug. 7, 1992, at A27 (criticizing then Mayor David Dinkins for effectively choosing sides in a police-involved shooting without knowing all the facts, and asserting that Dinkins "used his office to make unjustified rumors and media reports of police brutality appear valid. Now he must untangle the facts and accept responsibility for letting sensationalism overwhelm realism."). Despite attempts by Mayor Dinkins and his aides to defend his conduct, *see* Fritz W. Alexander, *Peace and Provocation in New York City*, N.Y. TIMES, Aug. 12, 1992, at A19; James C. McKinley, Jr., *Dinkins and Giuliani Exchange*

Similar difficulties are raised by narratives that are factually accurate, but unrepresentative. Consider the infamous "Willie Horton" advertisement, aired during the 1988 presidential election campaign.[224] Although there was a minor dispute about peripheral issues, the advertisement accurately presented the following facts: Mr. Horton *was* a convicted African-American murderer, furloughed from state prison during Governor Michael Dukakis's administration, under a furlough program supported by Governor Dukakis, and Mr. Horton subsequently raped a European-American woman and stabbed her fiancé.[225] Critics (including a number of leading narrativists) were unhappy with the surface message of the advertisement (that Mr. Dukakis and the Democratic Party were "soft on crime"). However, they vigorously condemned the subtext of the advertisement, which they contended appealed to stereotypes and racial hatred, by presenting the criminal behavior of a single African-American male and implying representativeness.[226] Of course, if the Willie Horton advertisement is unacceptable because it appeals to preexisting bias and gives the wrong impression of an objectively determinable reality, then narrativists must explain why this same critique does not devastate the entire narrative enterprise.[227]

Charges on Washington Heights, N.Y. TIMES, Aug. 8, 1992, at A27, the episode became a defining issue in the campaign for mayor—especially after the involved police officer was cleared of all charges. *See* Sam Roberts, *Dinkins and the Police: A Campaign Issue*, N.Y. TIMES, Sept. 20, 1992, at A43; Ronald Sullivan, *A Policeman Is Cleared and Street Violence Defused*, N.Y. TIMES, Sept. 13, 1992, § 4, at 2.

Ironically enough, Mayor Giuliani fell into the same trap from the opposite direction. *See* David Firestone, *Benefit of the Doubt*, N.Y. TIMES, Apr. 9, 1997, at B3 (comparing Giuliani's initial support for police officer and subsequent backing away as more facts emerged with earlier incident involving Dinkins); Adam Nagourney, *Ferrer Calls Youth's Death an 'Execution'*, N.Y. TIMES, Apr. 17, 1997, at B1 (explaining that Mayor Giuliani initially suggested that the police had acted properly, but backed away from the remark when the autopsy results revealed a more complicated picture, and that the misstep angered the "community," which viewed his initial remark as a "rush to judgment").

224. *See generally* Regina Austin, *Beyond Black Demons & White Devils: Antiblack Conspiracy Theorizing & the Black Public Sphere*, 22 FLA. ST. U. L. REV. 1021, 1024 (1995).

225. *See* Chris Black, *Amid More Charges of Lies, a Look for the Truth*, BOSTON GLOBE, Oct. 26, 1988, at 17.

226. *See, e.g.*, Stephen Engleberg, *Bush, His Disavowed Backers and a Very Potent Attack Ad*, N.Y. TIMES, Nov. 3, 1988, at A1; Susan Estrich, *The Hidden Politics of Race*, WASH. POST, Apr. 23, 1989, at W20 ("There is no more powerful metaphor for racial hatred in this country than a black man who rapes a white woman."); Andrew Rosenthal, *Foes Accuse Bush Campaign of Inflaming Racial Tension*, N.Y. TIMES, Oct. 24, 1988, at A1 ("'If you were going to run a campaign of fear and smear and appeal to racial hatred you could not have picked a better case to use than this one.'") (quoting Susan Estrich, Michael Dukakis's campaign manager); Catherine Woodard, *Campaigns Counterattack*, NEWSDAY, Oct. 26, 1988, at 4 ("Also condemning Republican tactics was Jackson, who said that GOP commercials' references to black convict Willie Horton played to stereotypes of blacks as prone to crime."). *But see* Stephen Chapman, *Would It Matter if Willie Horton Were White?*, CHI. TRIB., Oct. 27, 1988, § 1, at 23.

227. *See* Farber & Sherry, *supra* note 3, at 836-37 ("The 'flash of recognition' argument is also troubling, creating the risk that the author gains credibility by appealing to the reader's preconceptions and biases."); Catharine MacKinnon, *Law's Stories as Reality and Politics*, *in* LAW'S STORIES, *supra* note 1, at 232, 235 ("Stories break stereotypes, but stereotypes are also

Two-part stories are a particularly effective way of demonstrating the hazards of narrative. Consider the following incident, which occurred more than a decade after EMTALA was enacted.[228] A 42-year-old homeless man presented at a Kaiser Hospital ("Kaiser") ED in California at 2:00 a.m. with the broken end of a four-inch knife blade protruding from his belly. He complained that he was stabbed eight hours earlier. The physicians examined and x-rayed him and tugged on the knife. By 5:30 a.m. he was sent on his way with a note to make an appointment with the surgeons at the county hospital. Instead, he took a bus to another hospital, where he was rushed into surgery and his lacerated intestine was repaired. After a stay of thirteen days, he was discharged home.

If one stops here, the narrative bears a remarkable resemblance to the legend of Terry Takewell. A few additional facts complicate matters considerably. The patient, who had a history of self-inflicted knife wounds, was covered by Medicaid, and was seen by a surgeon and a specialist in emergency medicine. A third physician at the county hospital, who was familiar with the patient was consulted by phone. The patient's vital signs were stable, and the x-ray indicated that his internal organs had not been perforated. The wound was bleeding, but not profusely. The patient had been seen in the Kaiser emergency room five weeks before, apparently with the same problem. On that admission, he was transported by ambulance to the county trauma center. On arrival, he walked out of the hospital. During the next five weeks he repeatedly presented to the county hospital ED complaining of abdominal pain, and then would leave against medical advice. He was also found sleeping in the Kaiser ED earlier that month, and awoke complaining about abdominal pain. He was x-rayed and referred to Highland. The physicians concluded that the knife was lodged in an older, unhealed wound, and posed no immediate threat. The case was investigated by the California Department of Health Service, which concluded the hospital did nothing wrong. An internal review confirmed that identical treatment would have been offered to any patient, Kaiser member or not.

Narrative can pitch this story in a variety of ways, depending on tone, emphasis, and which facts are included (and excluded). The first paragraph presents a remarkably egregious instance of patient dumping. However, the inclusion of the second paragraph softens the picture considerably, even if it does not entirely eliminate our discomfort with the situation. A full picture "reveals a story far more complex than seemingly callous doctor decision making. [The patient's] tale is a window on life at the dangerous margins of society, where health care comes in tiers, and patients can be as difficult and baffling as the judgment calls that doctors sometimes make."[229]

---

stories, and stories can be full of them.").

228. The entire narrative is drawn from Sabin Russell, *Hospital Released Patient with Knife in Belly*, S.F. CHRON., Sept. 13, 1996, at A1.

229. *Id.* For another two-part narrative that raises analogous difficulties, see Eskridge, *supra* note 7, at 621:

> The story I told about Perry Watkins in Part I was for the most part taken from the official record of Watkins' lawsuit and reflects the sort of narrative a conservative pragmatist would most likely appreciate .... It projects a man whom mainstream society can identify with and respect, who performs his job with distinction, who

Those raised on a steady diet of patient-dumping anecdotes will find the first paragraph persuasive. However, it persuades only because it is partial, in every sense of the word. This difficulty is not limited to false or shaded narratives; even scrupulously accurate and complete narratives can be exceedingly unrepresentative.[230]

Narrative can capture the subtleties and nuances of human existence—and does so better than most other forms of discourse. However, as the patient-dumping narratives reflect, there are no guarantees that it will not be used for less-elevated purposes—particularly when narrative enters the policy domain. Narrativists discount these problems—as they almost invariably do when they are busy praising the "right" kind of narrative—at their peril.

IV. PATIENT DUMPING AND STATISTICS

A. Assessing the Frequency and Typicality of the Narratives

Narrative presents the idiosyncratic perspective of one individual. As Part III demonstrates, narrative is not necessarily reliable—but even reliable narrative cannot provide answers to the critical questions of typicality and frequency. Although Congress paid little attention to the matter, there have been a number of empirical studies of patient dumping.[231] These studies provide a baseline from which to assess the picture painted by the patient-dumping narratives. The studies are analyzed in detail in the attached Appendix, but the studies reflect broad consensus on the following points:

a. A substantial number of patients (as many as 250,000 per year) are transferred each year because of economic considerations;
b. A significant percentage of these patients are transferred while "unstable";
c. Patients are likely to be harmed when they are transferred in an "unstable" condition.

Thus, the empirical studies appear to confirm some (but by no means all) of the picture painted by the patient-dumping narratives. However, as the Appendix

---

> is honest, imaginative, and responsible. This version of the Watkins story is the truth and nothing but the truth, but it is not the whole truth. Watkins' story as told by Watkins—and not filtered through pragmatic lawyers, judges and spin doctors—may not meet the accommodationist standards Farber and Sherry establish for narrative scholarship. Cultural insiders are not likely to respond intuitively to those parts of Watkins' story that reveal him as an irreverent drag queen who consistently violated the military's antisodomy laws.

See also DANIEL A. FARBER & SUZANNA SHERRY, BEYOND ALL REASON 112-16 (1997) (presenting two-part story about Professor Sherry's childhood and early career, where the first part is "factually accurate in all its details but terribly misleading in its overall interpretation.")

230. *See supra* text accompanying notes 224-26.

231. *See supra* note 50. A total of seven studies are analyzed in the Appendix. The studies which are analyzed were all published in academic medical journals, or are governmental reports. *See* Daubert v. Merrill Dow Pharm., Inc., 509 U.S. 579, 594 (1993) (stating that "publication (or lack thereof) in peer reviewed journal thus will be a relevant, though not dispositive, consideration" in assessing scientific validity of study).

reflects, closer examination reveals some significant difficulties with the empirical studies. Each of the institutions which were studied was a public or quasi-public hospital in a major metropolitan area—with the responsibilities and obligations which accompanied that position. Each of the hospitals received a large number of economically motivated transfers—only some of which involved unstable patients. Even in this exceedingly unrepresentative sample, relatively few patients (between 1% and 27%, depending on the study) were unstable, and some of the patients received better care as a result of being transferred.

The empirical studies also employ quite different definitions of "stabilized" and of "patient dumping." The former results in a situation where "'one doctor's stabilized is another doctor's dump.'"[232] The latter makes it impossible to decide whether the reported frequency of patient dumping is based on the transfer of unstable patients, the transfer of patients requiring emergency treatment, or the transfer of patients requiring some form of health-care services. EMTALA purports to employ only the first definition, but the empirical studies often use two (and sometimes all three) of the definitions—with predictable consequences on the reported incidence of such conduct.

None of the studies attempted to measure the relative significance of charity care provided by private hospitals for patients they did not transfer. Thus, the empirical studies provide an uncontrolled snapshot of the numerator, but little insight into the denominator—and the denominator is significant because it should inform the framing of policy responses (if any) to the problem. For example, if the denominator is quite large, it may well be that the transferring hospitals are attempting to do their best, and what the transferee hospital perceives as dumping may be miscommunication or misdiagnosis.[233] Even if the denominator is modest, the omission of a financing system from EMTALA should significantly temper our enthusiasm for condemnation of such conduct.[234]

---

232. *Equal Access Hearing*, *supra* note 47, at 94 (quoting an anonymous physician) (testimony of Judith Waxman, Managing Attorney, National Health Law Program); *see also* Arnold S. Relman, *Economic Considerations in Emergency Care: What Are Hospitals for?*, 312 NEW ENG. J. MED. 372, 372-73 (1985) ("'stabilization' of emergency cases is a notion used by hospital managers to justify transfers for economic reasons, but it is an elusive and dangerous concept"). These different perspectives also hinder attempts to create guidelines for transfer. *See, e.g.*, Friedman, *supra* note 196, at 80 (noting that transfer protocol in Phoenix precludes transfer of patients receiving CPR, but no agreement on whether patients who are not breathing should not be transferred).

233. *See infra* notes 304-16 (describing study at D.C. General Hospital in which transferee hospital believed 39 transfers were inappropriate, but ultimately decided there was only one inappropriate transfer (which transferor hospital disagreed was inappropriate) after more complete information received).

234. A more complete examination of the costs and benefits of EMTALA is beyond the scope of this Article. The economic and moral case against EMTALA is made in Hyman, *supra* note 186, and David A. Hyman, Should We Depend on the Kindness of Strangers?: Ethics, Economics, and Emergencies (Feb. 9, 1998) (unpublished manuscript, on file with author). *See also* Norval Morris, *Compensation and the Good Samaritan*, *in* THE GOOD SAMARITAN AND THE LAW 135 (James M. Ratcliffe ed., Peter Smith 1981) (1966).

> It is so easy to talk about the failure of others; of how Good Samaritanship seems to be a dying art among others. There is another parable, something about a mote and an eye, which seems to me to have some relevance. Perhaps we should

In addition, some patients should be transferred when they require services which are not available at the original hospital, or when the services which are available are not as high quality (or, more controversially, low cost) as those provided elsewhere. Most of the studies did not assess whether the transferring hospital in fact had such capacity—and EMTALA does not create capacity where it does not already exist, except in the exceedingly short run.[235] Laws which hinder such referrals are counterproductive, but the empirical studies provide no help in sorting out this issue. Even when the transferring hospital has sufficient capacity, determining the incremental harm which results from transfer is a difficult task. Finally, most of the authors effectively began with a prior assumption that the transferring hospital had an obligation to provide all necessary care—which was not and is not the law, even post-EMTALA.[236]

Although the empirical studies provide a broader perspective than the narratives, they still fail to provide a useful answer to the most preliminary and significant of questions about patient dumping—its frequency. To the extent these studies do provide data on the subject, they demonstrate that the narrative accounts, in which dumping is invariably fatal, or at least results in significant morbidity,[237] are quite unrepresentative.

B. The Problem of "Advocacy Research"

Although empirical research is an improvement on narrative, it is not a panacea.[238] "Statistics can sometimes describe the 'what'; they seldom illuminate the 'why.'"[239] A more intractable problem is that empirical research can be conducted by people who have already made up their minds about the matter—and frame their efforts accordingly.[240] Policy entrepreneurs and

---

> first talk about ourselves, and our failure to provide even minimum conditions financially to protect those amongst us who *are* willing to act the Good Samaritan.

Id. at 138-39 (emphasis in original).

235. *See* Hyman, *supra* note 186.

236. The authors of these studies have thus mastered the technique described by Phil Kurland in the talk he gave to my entering class in law school: "'[T]he key to establishment of an infallible argument has been most fully developed by the Supreme Court of the United States: it is to embed the conclusion in the premise. It is always easier to get from here to here than to get from here to there.'" David F. Levi, *In Memoriam Philip B. Kurland*, 64 U. CHI. L. REV. 1, 4 (1997) (alteration added) (quoting Philip B. Kurland, *Ave Atque Vale*, Address at the First Year Students' Dinner at the University of Chicago Law School 5-6 (Sept. 30, 1986) (on file with the *University of Chicago Law Review*)).

237. *See supra* note 51.

238. *See* John M. Broder, *Big Social Changes Revive the False God of Numbers*, N.Y. TIMES, Aug. 17, 1997, § 4, at 1 ("While numbers have long been used to deceive and to manipulate public opinion . . . the more frequent problem is that they tell only part of the story . . . . Of course, the alternative—reliance on anecdote or the unsupported testimony of 'experts'—is even less useful.").

239. *Id.*

240. As is often the case, Congress has set the standard for outcome-driven statistical misbehavior. *See, e.g.*, Gina Brisgone, *Questionable Questionnaires*, HARTFORD COURANT, May 11, 1991, at A1:

politicians are always on the lookout for helpful statistics that support their positions—no matter how unreliable or speculative the source.[241] The news media are almost always eager to disseminate such statistics.[242] Lawyers do their part

---

> [Representative Pete Stark (who was responsible for EMTALA in the House of Representatives)] believes there is nothing wrong with designing survey questions to get the results he wants, his spokesman says. "Who says it has to be neutral?" asked Perry Plumart, aide to U.S. Rep. Fortney H. "Pete" Stark, D-Calif., who sends surveys in every third newsletter. Recently, when reporters accused Stark of asking biased questions on cable television regulation, Plumart agreed with them. "I said, 'Absolutely. We're proud that it was biased. Our viewpoint is that cable TV should be re-regulated.'"

In the empirical research of EMTALA, the predisposition was most apparent in the Highland General study. *See infra* note 264.

241. For a variety of examples of such (mis)behavior in action, see CHRISTINA HOFF SOMMERS, WHO STOLE FEMINISM? 137-254 (1994) (analyzing statistical gerrymandering in studies of self-esteem, educational bias, sexual harassment, domestic violence, rape, economic success, and women's mental health), Broder, *supra* note 238, § 4, at 1 ("Statistics are tools of the scientist . . . . But when numbers are crunched in politics, axes are usually grinding, too."), Peter Carlson, *The Truth . . . But Not the Whole Truth*, WASH. POST MAG., June 4, 1995, at 12, 36 (collecting examples of statistical misuse by both political parties and advocacy groups; "In Washington, statistics can simultaneously be accurate but misleading, legitimate but bogus, real but fake. In Washington, statistics tell the truth but not the whole truth."), and Christina Hoff Sommers, *The Democrats' Secret Woman Weapon*, WASH. POST, Jan. 5, 1997, at C5 (noting prevalence of false, fanciful, and farfetched statistics in women's magazines, which are in accord with Democratic National Committee's political agenda). *See also* Peter G. Gosselin, *Back to the Future: Conservatives Try to Redeem the Eighties as a Decade of Success, and a Roadmap to the Nineties*, BOSTON GLOBE, May 3, 1992, at 77 (noting that Republicans and Democrats use the same statistics to come to opposite conclusions on the 1980s, and that both sides accuse the other of "cooking the books" on the economy of the 1980s); Christopher S. Wren, *Tracking a Shadowy Crime; Phantom Numbers Haunt the War on Drugs*, N.Y. TIMES, Apr. 20, 1997, § 4, at 1 ("Politicians are said to use statistics the way drunks use lampposts: for support rather than illumination.").

242. *See supra* note 241; *see also* Delia M. Rios, *A Bogus Statistic That Won't Go Away*, AM. JOURNALISM REV., July-Aug. 1997, at 12, 12-13 (recounting widespread dissemination by TV and newspapers of "government statistic that a gay teenager is some three times as likely to attempt suicide as another teenager," and may account for 30% of youth suicides, although there was "no scientifically valid evidence that it's true"; "In fact, it is not a government statistic at all, but rather the interpretation of a social worker."; "[statistical inadequacies have not prevented the use of the figures as] a real attention-getter—often played up in drop quotes, graphics, and cutlines"; "the gay teen suicide [statistic] illustrates an important lesson for journalists"); Ben Wildavsky, *Poll-Watchers Dress Down the Press*, 29 NAT'L J. 1786, 1786 (1997) (criticizing press coverage of polling data for failing to provide context).

to circulate "junk science" as well.[243] The "misuse" of empirical data has become sufficiently routine that *The New York Times* has noted

> a disquieting trend. Call it the "whoops factor," a phenomenon that starts with shoddy research or the misinterpretation of solid research, moves on quickly to public outcry, segues swiftly into the enactment of new laws or regulations and often ends with news organizations and some public policy mavens sounding like the late Gilda Radner's character Emily Litella, as they sheepishly chirp, "never mind!"[244]

Purportedly "value-free" empirical results can be found (or manufactured) to support almost any viewpoint.[245] "Cooked" or flawed empirical research can have

---

243. *See* Peter Huber, *Junk Science and the Jury*, 1990 U. CHI. LEGAL F. 273.

> When junk science is on the table, stratospheric damages are always possible. Such awards may be infrequent, but the mind boggles at their possible size. . . .
>
> . . . .
>
> It is not necessary to win all or even most cases filed: a one in ten chance of winning 20 times your stake produces a very comfortable living if the bet is repeated often enough. There is money to be made on liability futures, and good lawyers know it. Not every part of the pig is certain to appreciate. But plaintiffs' lawyers, able to play the odds again and again, are assured a very comfortable living by investing in the hog as a whole.

Id. at 289, 294; *see also* Michael Rustad & Thomas Koenig, *The Supreme Court and Junk Social Science: Selective Distortion in Amicus Briefs*, 72 N.C. L. REV. 91, 128 (1993) ("Junk social science is characterized by quotes from social scientific research taken out of context, misleading statistical presentations, denigration of studies whose results conflicted with the argument, and anecdotes masquerading as social science findings.").

244. Holmes, *supra* note 24, § 4, at 3 (collecting examples of statistical gerrymandering). One example not mentioned by Mr. Holmes was the infamous 1993 incident involving domestic abuse and the Super Bowl. *See generally* Jean Cobb, *A Super Bowl-Battered Women Link?*, AM. JOURNALISM REV., May 1993, at 33, 35. After a full-court media press by advocacy groups, newspapers and television blanketed the nation with the claim that there was a 40% increase in domestic abuse on Super Bowl Sunday. *See id.*

> If Super Bowl tradition holds, more women than usual will be battered today in their homes by the men in their lives; it seems an inevitable part of the post-game show. A big football game on television invariably becomes the Abuse Bowl for men conditioned by the sports culture to act out their rage on someone smaller.

Robert Lipsyte, *Violence Translates at Home*, N.Y. TIMES, Jan. 31, 1993, § 8, at 5. Some earlier reports also cited anecdotal evidence to the same effect. *See, e.g.*, Anna Quindlen, *Time to Tackle This*, N.Y. TIMES, Jan. 17, 1993, § 4, at 17 ("Talk to administrators or counselors at shelters for battered women, and sooner or later they will tell you the one about the football game and the beating. . . . Some shelters say Super Bowl Sunday is one of the busiest days of the year."). Despite the media feeding frenzy, the empirical facts bear little resemblance to this picture. *See, e.g.*, Cobb, *supra*; Bob Hohler, *Super Bowl Gaffe*, BOSTON GLOBE, Feb. 2, 1993, at 17; Ken Ringle, *Wife-Beating Claim Called Out of Bounds*, WASH. POST, Jan. 31, 1993, at A1.

245. *See* Carlson, *supra* note 241; Timothy B. Clark, *Public Opinion Can Be Putty in Pollster's Hands*, 17 NAT'L J. 979 (1985) (noting that how pollster asks question can radically affect level of public support or opposition); *see also* R.H. COASE, *How Should Economists Choose?*, *in* ESSAYS ON ECONOMICS AND ECONOMISTS 15, 27 (1994) ("[I]f you torture the data enough, nature will always confess."). Professor Coase quotes Thomas Kuhn to the same effect—"'Nature undoubtedly responds to the theoretical predispositions with which she is approached by the measuring scientist.'" *Id.* (quoting Thomas Kuhn). For a more nuts-and-

worse consequences than unrepresentative narrative—and my criticisms of narrative should not be taken to detract from that point.[246]

V. CONCLUSION

As EMTALA demonstrates, an effective narrative can transform the legal landscape.[247] However, the EMTALA narratives raise serious questions about the substantial potential for abuse inherent in this form of discourse.[248] Narrative turns out to be exceedingly effective at transmitting untruthful, incomplete, and unrepresentative anecdotes—particularly those that trigger a "flash of recognition" because they confirm preexisting suspicions or stereotypes—or are themselves simply stereotypes.[249] Consider the impact of similar narratives, endlessly repeated, on the prevalence of belief in "black helicopters" and other conspiracy theories among various fringe groups on the far right.[250] At the other end of the political spectrum, what of the belief in some sectors of the African-American community that AIDS was created by European-American (usually Jewish) doctors as a tool for racial warfare, and that the government's drug policies are designed to the same effect?[251] And what of the belief that UFOs

---

bolts perspective on the matter, see generally DARRELL HUFF, HOW TO LIE WITH STATISTICS (1954).

246. *See* NICHOLAS EBERSTADT, THE TYRANNY OF NUMBERS 15-26 (1995) (noting that some of the most fundamental domestic and foreign policies have been based on misanalysis or misuse of statistical information); Holmes, *supra* note 24, § 4, at 3 ("Often, the unwillingness of reporters to ask hard questions or of policy makers to provide a context for data can lead regulators and lawmakers into broadbrush policies that waste resources and political capital.").

247. At the same time, many narratives are not transformative, at least on a nongeologic time scale.

> It seems likely that almost the entire audience for oppositional legal scholarship, besides a restive and largely unimpressionable captive audience of law students, will consist of persons who are already part of the opposition. I would be interested to learn what function they think they are serving by swapping stories of oppression with each other.

Posner, *supra* note 6, at 743-44; *see* Farber & Sherry, *supra* note 3, at 826 ("Despite the many general assertions about how narratives can transform the political perspective of 'insiders,' conversion stories are notably scarce. As storytelling advocates admit—and as cognitive psychologists would predict—responses by 'insiders' are typically defensive or dismissive.") (footnote omitted).

248. Evidence from a variety of sources suggests the problem of misuse is pervasive. *See, e.g.*, *supra* notes 28-36. Some people do "doctor[] [the] data to fit [the] thesis"—while others simply make up the necessary data. Farber & Sherry, *supra* note 3, at 834; *cf.* Holmes, *supra* note 24, § 4, at 3. More importantly, even truthful anecdotes are not necessarily representative.

249. *See supra* note 227.

250. *See* Timothy Egan, *Inside the World of the Paranoid*, N.Y. TIMES, Apr. 30, 1995, § 4, at 1; Timothy Egan, *Trying to Explain Contacts with Paramilitary Groups*, N.Y. TIMES, May 2, 1995, at A19; Philip Weiss, *Off the Grid*, N.Y. TIMES MAG., Jan. 8, 1995, at 24.

251. *See* Jason DeParle, *For Some Blacks, Social Ills Seem to Follow White Plans*, N.Y. TIMES, Aug. 11, 1991, § 4, at 5:

> Last year, a New York Times/CBS News Poll gauged the sentiment of black New Yorkers. On AIDS, 10 percent of the respondents agreed that the disease "was deliberately created in a laboratory in order to infect black people." Another 19

visited Roswell, New Mexico in 1947, which crosses all political boundaries?[252] Only blind optimism can explain the enthusiasm with which narrative has been embraced, and the degree to which its hazards have been discounted.[253]

Mark Twain attributed to Benjamin Disraeli the insight that there are three kinds of lies: "lies, damned lies, and statistics."[254] Unfortunately, as this Article makes clear, both anecdotes and statistics can lie—but do so in different ways. Significant adverse consequences can follow when laws are based on falsehoods, half-truths, and truths that are not generalizable—whether the source of such

---

> percent thought it "might possibly be true." Only 1 percent of whites said it was true and another 4 percent said it was possibly true. With drugs, 25 percent of blacks agreed that the Government "deliberately makes sure that drugs are easily available in poor black neighborhoods." Another 35 percent said that this was possibly true. Four percent of whites said true and 12 percent said possibly true.

See also Jason DeParle, *Talk of Government Being Out to Get Blacks Falls on More Attentive Ears*, N.Y. TIMES, Oct. 29, 1990, at B7. *See generally* Austin, *supra* note 224 (cataloguing various conspiracy theories circulating in African-American community).

252. *See* Patrick J. Lyons, *U.F.O. Believers and Debunkers Thrive on the Web*, N.Y. TIMES, June 30, 1997, at D8 ("Roswell, Hanger 18, and Area 51 (top-secret spots in Nevada where bits of the ship and its dead occupants supposedly were taken) have become part of American folklore, notwithstanding 50 years of Air Force insistence that all anyone ever found were parts of a secret high-altitude research balloon."); *see also* Huber, *supra* note 243, at 273 (noting that approximately 40% of U.S. population believes UFOs occupied by extraterrestrials have visited the earth, and approximately 9% claim to have seen a UFO); Anne Willette, *Social Security Reform*, USA TODAY, Feb. 18, 1997, at 1B ("A much-cited poll by Third Millennium, a youth advocacy group, says young people have more faith in the existence of UFOs than in getting Social Security benefits.").

253. *See* Hayman & Levit, *supra* note 44, at 421 ("Storytelling promises greater epistemological accuracy than conventional doctrinal analysis, even if it is simply the authenticity of uncertainty."); Johnson, *supra* note 7, at 817 ("An implicit value in storytelling is the rejection of universality and typicality in exchange for the personalization impressing that if one life is lost or one event occurs, as described in the story, that is one too many."); West, *supra* note 7, at 1781 ("If we are to see the world accurately, we must listen to the voices of those who experience it in ways that we have not and will not, and we must listen in spite of the dangers of overpersonalization that such retellings invariably carry.").

254. MARK TWAIN, MARK TWAIN'S AUTOBIOGRAPHY 246 (1928) (attributing the remark to Benjamin Disraeli).

information is anecdotal or statistical.[255] The problem was nicely framed by Professor Saks:

> The trouble with legislation by anecdote is not just that some of them are false or misleading. Even if true and accurate, anecdotes contribute little to developing a meaningful picture of the situation about which we are concerned. It makes a difference if for every ten anecdotes in which an undeserving plaintiff bankrupts an innocent defendant, one, ten, one hundred, or one thousand equal and opposite injustices are done to innocent plaintiffs. The proportion of cases that results in one or the other error, and the ratio of one kind of error to the other, ought to be of greater interest to serious policy-makers than a handful of anecdotes on either side of the issue. Reforms are intended to change that ratio and the tens of thousands of anecdotes the ratio summarizes.[256]

Narrativists gloss over such difficulties, but that strategy is likely to be ineffective—and costly. Because narrative does not aspire to neutrality or typicality, its use in the public sphere is fraught with peril. "Good" narrative appeals directly to our passions and prejudices—and the better it is at doing so, the more likely it is to be credited as truthful and representative—whether it is or not. When statistics disagree, there are ways of sorting out matters—and experts to provide assistance in doing so.[257] When narratives disagree, there is no

---

255. Indeed, EMTALA exemplifies the adverse, unintended, and ultimately counterproductive consequences when good intentions meet bad anecdotes. *See* Hyman, *supra* note 208; Hyman, *supra* note 186; Hyman, *supra* note 234. Interestingly, the record of the *Burditt* case provides some evidence on this point as well. The chairman of the department of obstetrics at John Sealy argued that administrative second-guessing of such transfers would make it impossible to provide high-quality obstetrical care to pregnant women in rural areas of Texas. *See* McGanity Letter, *supra* note 159; *see also* Tamar Lewin, *U.S. Law on Hospital Care of Poor Faces Test*, N.Y. TIMES, Mar. 23, 1991, at A1:

> [EMTALA,] as interpreted by the Federal Government, made no sense in the context of rural Texas hospitals, where high-risk patients are routinely sent far away to more sophisticated hospitals . . . [and] would actually reduce poor women's access to medical care, swamping small hospitals with high-risk babies who needed expensive intensive care, and creating such financial burdens that many hospitals would close.

Two of the medical experts who testified in the *Burditt* case (including one called by the IG) also noted their concern that EMTALA would actually decrease the quality and availability of emergency care.

> [O]n balance I think this law may very well create a situation in which the fear of this sort of a proceeding may outweigh in the minds of many the appropriate transfer because of the question of being second guessed and I think the greater harm may come from that by enforcing this law to its absolute end rather than wiping it from the books.

Hearing Transcript at 414, Inspector Gen. v. Burditt (Dep't Health & Human Servs. Jan. 24, 1989) (No. C-42) (testimony of Dr. Crosby); *see also* Lewin, *supra*, at A1 (noting concerns of AMA and Texas Medical Association that EMTALA is counterproductive).

256. Saks, *supra* note 16, at 1161.

257. Perhaps one study should be given more weight because it was randomized, or the sample size was larger and the confidence intervals narrower. *See, e.g.*, MICHAEL O. FINKELSTEIN & BRUCE LEVIN, STATISTICS FOR LAWYERS (1990); HUFF, *supra* note 245. For an example of such analysis in action, see Braveman et al., *supra* note 218.

appeal, except to innate persuasiveness (i.e., the degree to which the narrative coincides with our passions and prejudice).[258] As the EMTALA narratives demonstrate, the predictable consequence is a tremendous gap between "narrative appeal" and empirical reality.

Barring the unlikely development of a generalized sense of "statistical compassion,"[259] anecdotal evidence will continue to play a major role in the formulation of public policy.[260] As such, we need to develop strategies for dealing with the infirmities of both statistics and narrative. Although it is beyond the scope of this Article to suggest an optimal response, some tentative guidelines may be helpful. For anecdotes, the short version is "be exceedingly skeptical," "consider the source," and "don't generalize without additional (nonanecdotal) evidence." For empirical scholarship, "be skeptical," "consult the

---

258. *See* Anthony Kronman, *Leontius' Tale*, *in* LAW'S STORIES, *supra* note 1, at 54, 54 (noting the "moral indeterminacy of storytelling"). "Some stories have good effects and others bad ones. Some stories strengthen good practices and good institutions, and others do the opposite. Moreover, stories do not contain within themselves the criteria for distinguishing the good ones from the bad." *Id.*

> The biggest check on selectivity problems in storytelling lies in the availability of another story.... But the availability of counterstories does not indicate which counterstories should be elicited, obtained, or heeded. If the counter or alternative stories are simply those told in response to an initial story, we face the specter of warring stories with no methods for testing them or for resolving disputes that they reflect.

Minow, *supra* note 188, at 31 (citation omitted).

259. *See* Elaine Scarry, *Speech Acts in Criminal Cases*, *in* LAW'S STORIES, *supra* note 1, at 165, 166; Irving J. Selikoff, *Statistical Compassion*, 44 J. CLINICAL EPIDEMIOLOGY 141S, 141S (1991) (attributing phrase to Walsh McDermott); *see also* Clark C. Havighurst et al., *Strategies in Underwriting the Costs of Catastrophic Disease*, LAW & CONTEMP. PROBS., Autumn 1976, at 122, 140-41 (1976) (contrasting willingness of society to sacrifice identifiable lives versus statistical lives).

> It is difficult to improve significantly on the more commonplace observations that human beings cannot empathize with faceless abstractions and that "squeaking wheels"—the complaints of known victims, such as the very vigorous lobbying of kidney-disease patients—not the silence of statistical unknowns, will get the government grease. Spending "millions of dollars to save a fool who has chosen to row across the Atlantic has external benefits" lacking from highway safety spending.

Id. at 141 n.81 (quoting Guido Calabresi, *Commentary*, *in* ETHICS OF MEDICAL CARE 48, 53 (Laurence R. Tancredi ed., 1974)).

260. Despite its weaknesses, anecdotal evidence is likely to remain a potent force in the political sphere for the reasons identified *supra* at text accompanying notes 14-15, 37-40. *See also* Victor Cohn, *Vaccines and Risks: The Responsibility of the Media, Scientists, and Clinicians*, 276 JAMA 1917, 1917 (1996) ("The impact of a shocking headline or, even more so, the sight of a brain-damaged child on a television screen can overwhelm a thousand written or spoken explanatory words. 'To reach the public,' explains journalistic observer Stephen Klaidman, 'journalists look for concrete emotional anecdotes to make their stories accessible and compelling.'") (citation omitted); Scarry, *supra* note 259, at 166 ("Public discourse —television, newspapers, radio—thrives on narrative. Given two subjects to report, one of which can be told in story form and the other of which requires some alternative kind of discourse (argument, numerical analysis), the first is usually covered and the second ignored.") (citation omitted).

experts," and "consider the source" are probably sufficient safeguards. These simple rules should help minimize the tendency toward distorted decisionmaking which would otherwise result. Of course, the full effect of these checks and balances will only be felt if the academic community (re)developed a more skeptical stance toward anecdotal advocacy, instead of engaging in it themselves, and calling it "narrative."

APPENDIX

Lawyers and law professors are by training and inclination reluctant to delve into anything involving mathematics and statistics.[261] In the first course I taught as a law professor, one of my students told me if she could do math, she would not be in law school.[262] It is for that reason that the detailed analysis of the empirical studies of patient dumping has been consigned to an Appendix.

A. Highland General Study[263]

This pilot study, published in 1984, presented data from patients transferred from private hospitals to the emergency room of a public hospital in Alameda, California during the first six months of 1981.[264] A total of 458 patients were transferred, 272 of which (almost 60%) were admitted to the hospital, and 22 of which (5%) required intensive care.[265] The reason for transfer was not usually

---

261. *See, e.g.*, Bert Black et al., *Science and the Law in the Wake of* Daubert: *A New Search for Scientific Knowledge*, 72 TEX. L. REV. 715, 716 & n.1 (1994) ("Judges and lawyers usually react to science with all the enthusiasm of a child about to get a tetanus shot."); MacKinnon, *supra* note 227, at 237 (admitting that "she bursts into tears at columns of figures"); Blake Fleetwood, From the People Who Brought You the Twinkie Defense, WASH. MONTHLY, June 1987, at 33, 36 (1987) ("'Many [judges] weren't that good at math or science or statistics' . . . '[which is] why they went to law school.'") (alterations added) (quoting J. Morgan Kousser, author of *Are Expert Witnesses Whores? Reflections on Objectivity in Scholarship and Expert Witnessing*, 6 PUB. HISTORIAN 5 (1984)).

Justice Holmes observed a century ago that "[f]or the rational study of the law the black-letter man may be the man of the present, but the man of the future is the man of statistics and the master of economics." Oliver Wendell Holmes, *The Path of the Law*, 10 HARV. L. REV. 457, 469 (1897). Justice Holmes had the foresight not to specify a time frame, but the lawyers of my acquaintance show no indication of conforming with his prediction.

262. Admittedly, this is anecdotal evidence, but it happens to be both true and representative. *See supra* note 261.

263. *See* David U. Himmelstein et al., *Patient Transfers: Medical Practice as Social Triage*, 74 AM. J. PUB. HEALTH 494 (1984). Highland General Hospital ("Highland General") is the major public acute-care facility in Alameda County. *See id.*

264. *See id.* Although the article appeared as a "public health brief" in the *American Journal of Public Health*, it clearly proceeded from a particular political slant: the first institutional affiliation of the authors is the "Research Group of the Committee to Defend the People's Health." The first two named authors are long-time enthusiasts of a Canadian-style health-care system and were lead authors of the Physicians' National Health Plan. *See* Joseph P. Kahn, *Scalpel, Please: 2 Cambridge Doctors Lead Push for Major Surgery on US Health System*, BOSTON GLOBE, Feb. 1, 1996, at 57; Steffie Woolhandler & David U. Himmelstein, *Universal Care? Not from Clinton*, N.Y. TIMES, June 12, 1994, § 4A, at 7.

265. *See* Himmelstein et al., *supra* note 263, at 495. Of the patients who were not admitted to the hospital, 32 (7%) were referred to the Department of Psychiatry, 9 (2%) were taken into custody by judicial authorities, and 27 (6%) were transferred to other institutions for further care. *See id.* Of the transferred patients, 289 (63%) had no health insurance, 96 (21%) had Medicaid, 60 (13%) had Medicare, and 13 (3%) had private insurance. *See id.* In like fashion, 252 (55%) of the transferred patients were white, 137 (30%) were black, 27 (6%) had Spanish surnames, and 42 (9%) were other. *See id.*

recorded.[266] After in-depth review of the charts of patients thought to be at high risk, the authors concluded that 33 patients (7%) were "inappropriately" transferred and received "substandard" care.[267] The authors noted that some of the transfers were economically motivated,[268] and might also have been influenced by racially discriminatory motives.[269] Accordingly, the authors suggested that regulations and protocols might be appropriate to ensure patient safety.

This study is limited by a variety of factors, only some of which were noted by the authors. The study was retrospective; determined stability based on the application of subjective criteria to data drawn from medical records prepared for a different purpose;[270] did not include an assessment of the numbers of patients treated by private hospitals (and the cost of such treatment) when the patients were uninsured but were not transferred; did not include an assessment of the costs imposed on Highland General by the transfers; failed to assess their results in light of their observation that private hospitals which transferred patients to Highland General also "often admit critically ill patients and do not have policies of routinely transferring such patients";[271] did not evaluate whether the

---

266. *See id.* at 496.

267. The authors identified 111 charts as high-risk patients requiring in-depth review. Charts for 103 patients were ultimately available. The criteria for high risk included admission to an ICU, operating room, or obstetrical suite, or a pretransfer diagnosis of stab wound, gunshot wound, motor-vehicle accident, fracture, or dislocation.

All four clinician authors had to agree that the patient was "*at risk* of life-threatening complications in transit or that accepted practice would require immediate therapy that was delayed by [transit]" in order for the incident to be classified as one involving substandard care. *Id.* at 495 (emphasis added). The authors relied upon the records of Highland General and the transferring hospital in making this determination. *See id.* The authors excluded cases involving patient discomfort or psychological distress, and "[b]orderline cases in which continuous observation or immediate treatment might be preferable." *Id.*

268. Of the 103 charts which were reviewed in detail, 11 indicated that the patient was transferred because of inability to pay. *See id.* Interestingly, 37% of the transferred patients were covered by Medicare, Medicaid, or private insurance—a fact which would seem to undercut an economic motivation for transfer, unless reimbursement was inadequate. *See id.*

269. Minority patients represented 45% of those transferred and 58% of those "jeopardized by transfer," although only 33% of the county's population is "non-White." *Id.* at 495-96. The authors correctly observe that such factors as low rates of insurance, lack of a personal physician, and high rates of use of hospital EDs among minority populations may explain this result. More fundamentally, it is impossible to assess this issue without having data on the patient population which presented to the transferring EDs—and the authors' suggestion that these results constitute evidence of racially discriminatory conduct lacks any statistical foundation. *See id.* at 496.

270. *See id.* at 496. The medical records which were reviewed included those of the receiving hospital, which may have biased the determination that the patient was unstable at the time of transfer. *See id.* at 495.

271. *Id.* at 496.

transferring hospital was able to provide the required care;[272] and did not evaluate whether there were any adverse consequences of transfer.[273]

Finally, the authors' argument that such transfers result in "a *de facto* public subsidy to private hospitals" is inaccurate.[274] A subsidy can only exist if the private hospitals had a preexisting duty to provide such care, and shirked it by transferring such patients to the public ED. Since the lack of such a duty is precisely what the authors are unhappy about, it is inaccurate to claim that transfers result in a subsidy.[275] Indeed, since public hospitals are effectively "paid to be dumped on," it is hard to identify a financial baseline from which to condemn such transfers.[276]

B. Cook County Study[277]

This study, published in 1986, presented data from the 500 patients who were admitted to the medical and surgical services after they were transferred to Cook

---

272. The authors do note the possibility that transferring physicians may have believed that "better care was available at the public hospital" because it has a residency training program. *Id.* However, the authors discount this as an explanation because: (1) local hospitals opposed the designation of Highland General as a mandatory trauma referral center; (2) few patients with private insurance were transferred; (3) "32 of 33 jeopardized patients came from hospitals with full emergency capabilities, including inpatient critical care facilities and specialty surgical backup available within 30 minutes"; and (4) some specialty services were available at private hospitals but not at Highland General. *See id.*

The ability of the private hospital to provide the care should not be dismissed so lightly. Indeed, the authors provide an illustration of the problems in this area in what they label a "particularly disturbing case"—a private hospital was forced to transfer an uninsured comatose victim of a beating to Highland General after two neurosurgeons refused to see the patient. *Id.* at 495. Even post-EMTALA, physicians who are not on call to the ED retain the right to choose their patients.

273. Although the authors repeatedly use inflammatory language to describe the care which was received by the transferred patients (the transfers were "dangerous," and "imperiled" or "jeopardized" the patient), the study expressly disavowed making any determination on whether any harm had resulted from inappropriate transfer. Given the views of the authors on the subject they were studying—one does not create a "Research Group of the Committee to Defend the People's Health," *see supra* note 264, unless one believes that economically motivated transfers and dumping constitute a threat to its health—it is hard to avoid the conclusion the authors would have been happy to include such data had they been able to identify anyone who had been injured as a result of transfer.

274. Himmelstein et al., *supra* note 263, at 496.

275. A minority of states had statutes requiring hospitals to provide emergency care, but state enforcement agencies did not appear to take these provisions seriously. *See supra* note 46.

276. *See, e.g.*, John Barrett & Olga Jonasson, Letter to the Editor, *Transfers to a Public Hospital*, 315 NEW ENG. J. MED. 1421 (1986); David Burda, *Publics Are Paid to Be 'Dumped' On*, HOSPITALS, May 5, 1986, at 158.

277. *See* Robert L. Schiff et al., *Transfers to a Public Hospital: A Prospective Study of 467 Patients*, 314 NEW ENG. J. MED. 552 (1986). Cook County Hospital ("Cook County") was Chicago's only public general hospital. *See id.*

County ED from another ED during a 41-day period in 1983.[278] Cook County employed a telephone protocol for accepting such transfers.[279] Based on the responses to the telephone protocol, the authors concluded that 87% of the transfers were because the patients lacked insurance.[280]

The authors determined that 106 patients (24%) were transferred in an unstable condition, although not all unstable patients required treatment in an ICU.[281] In some of these patients, treatment had been initiated, but "definitive treatment was usually not begun."[282] Fatalities were much higher among those who were transferred in an unstable condition (7.5%) than in a stable condition (1.5%).

Transfer was associated with an average delay in definitive treatment of approximately 5 hours, with delays ranging from 1 to 18 hours. Few of the patients had consented to the transfer, and those that had been told of the transfer

---

278. Thus, the study excluded the obstetrical, gynecologic, and pediatric services. During the study period, 602 medical and surgical patients were transferred to the Cook County ED, and 500 were admitted. Out of the 500 admissions, the authors identified a study population of 484 (the patients were excluded if they had been transferred from an inpatient setting rather than an ED, or if they were not transfers to the medical and surgical services). *See id.* at 553.

The authors were able to locate charts for 467 of the 484 patients. Forty-six percent of those studied were on Medicaid, 46% had no insurance, 4% had private insurance, 3% had Medicare, and 1% had other coverage. For Cook County inpatient admissions as a whole, only 30% were uninsured. Seventy-seven percent of those transferred were black, 12% were Hispanic, 10% were white, and 1% were other. Eighty-one percent of those admitted were unemployed. *See id.*

279. *See id.* at 552. The transfer protocol required the resident at Cook County to fill out a form with the name of the patient and transferring hospital, vital signs, a brief clinical summary, and the reason for the requested transfer. Ninety-three percent of requests for transfer were accepted. Transfer was refused when the resident concluded that hospitalization was not required, the patient was not sufficiently stable to be transferred, or there was noncompliance with Cook County's transfer protocol.

The subsequent studies described in this Article also involved such transfer protocols. Since consent was obtained prior to transfer for the overwhelming majority of patients, one should not assume that such studies are representative of those who would have been transferred in the absence of such a screening mechanism. On the other hand, transferring hospitals were not legally required to participate in the transfer protocol, and the transferring hospital would probably not suffer any significant consequences from such refusal. *See infra* text accompanying note 316. *But see* Friedman, *supra* note 196, at 80 (noting various means of retribution for failure to comply with transfer protocol).

280. *See* Schiff et al., *supra* note 277, at 553. Responses were only available for 243 of the study patients (52%), but the authors believed that "this subgroup was representative of the entire study sample." *Id.* at 555.

281. Stability was determined based on a review of the clinical information available in the records of the transferring hospital, and the application of an extensive list of clinical criteria. *See id.* at 553. Only 435 charts (of the 467-patient population) contained sufficient records from the transferring hospital to perform this analysis. *See id.* at 554. Although 104 patients were admitted to the ICU, only 41 were classified as unstable. However, compared to the transfer population as a whole, a much higher percentage of unstable patients were admitted to the ICU (38.7% versus 14.6%). *See id.* at 555.

282. *Id.* at 554. "Definitive treatment" includes "emergency surgical procedures (e.g., exploratory surgery, repair of vessels or vital organs or both, and craniotomies), antibiotic therapy, and emergency invasive diagnostic tests." *Id.*

were not usually advised of the reasons.[283] The authors estimated that the transfers resulted in a loss for Cook County of $2,818,000 during the period studied, and an average yearly loss of $24,100,000, or 12% of the total 1983 operating budget.[284]

Like the Highland General study, the Cook County study has certain limitations. Although the study was prospective, the analysis focused on patients who were admitted to Cook County.[285] As such, the study reported an artificially high rate of unstable transfers, compared to that which would have been determined with a more inclusive denominator.[286] As with the Highland General study, the authors did not include an assessment of the numbers of patients treated by private hospitals (and the cost of such treatment) when the patients were uninsured but were not transferred, did not assess the extent to which the transferring hospital was able to provide treatment, and did not address certain significant issues when they analyzed the adverse consequences of transfer (which focused solely on mortality statistics).[287]

---

283. *See id.* A signed informed consent for transfer was present in 25 (6%) of the charts. Thirteen percent of patients reported they had not be told of their impending transfer. Of those who were informed, 36% indicated they were not told why they were being transferred. *See id.*

284. The study uses Cook County's package price for inpatients of $630 per day for ward patients and $1500 per day for patients in the ICU. The average patient stayed for 9.5 days, resulting in total charges of approximately $3,350,000. Cook County typically collects 16% of such charges from patients with a similar demographic profile, leaving the hospital with a net loss of $2,810,000. *See id.* at 553-54. On an annual basis, this works out to $24,100,000, or 12% of the total 1983 operating budget. Because of the design of the study, this figure excludes charges for patients transferred to the obstetric, gynecologic, and pediatric services, and inpatient transfers. *See supra* note 278.

285. As noted previously, 602 medical and surgical patients were transferred to the Cook County ED, but only 500 were admitted. In addition, Cook County routinely refuses to accept transfers if the patient does not require hospitalization. *See* Schiff et al., *supra* note 277, at 553.

286. The denominator for determining the 24% rate of unstable transfers was the number of located charts for patients admitted to the medical and surgical services of Cook County in which there was sufficient information to make a determination of stability. If one uses the total number of patients transferred to Cook County (620), the rate of unstable transfers could be as low as 17.6%. *See id.* One should also consider the extent to which Cook County's general refusal to accept transfers of patients who did not require hospitalization has an impact on the pool of transfers—and results in an artificial overstatement of the incidence of unstable transfers.

287. *See id.* The study did not control for severity of illness and case mix in assessing the disparity in mortality rates between stable and unstable transfers. Similarly, the fatality rates were significantly higher among unstable patients transferred to the medical service (10.9%) compared to the surgical service (3.9%)—a result the authors did not attempt to explain. *See id.* at 555. This result is particularly interesting, since surgical-service patients were significantly more likely to require the use of the ICU (60.8% versus 18.2% unstable; 16.5% versus 6.5% stable) than medical-service patients. *See id.*

Similar difficulties are raised if one compares transferred patients to those who commenced their treatment at Cook County. The mortality among transfers to the medical service was 9.4%, compared to a mortality among nontransferred medical-service patients of 3.8%, but the mortality on the surgical service was 1.5% among transferred surgical patients, and 2.4% among nontransferred surgical patients. *See id.* Without adjusting for severity of illness and case mix, it is difficult to know what to make of this disparity. The authors suggest that lower

Although the Cook County study did attempt to determine the cost which resulted from the transfers, the methodology employed greatly overstates the amounts at stake. Only an absolute prohibition on transfers would preclude Cook County from incurring the amounts determined by the authors—and it would do so by forcing the private hospitals to provide the necessary treatment. Since EMTALA only restricts transfer prior to stabilization, Cook County will still incur most of the expenses the authors label as attributable to transfers.[288] More fundamentally, the authors significantly overstate the amounts at issue by basing their computations on Cook County's charges for providing hospital services, rather than its significantly lower average costs—or better yet, its lower-still marginal costs.[289] The scope of the potential disparity is illustrated by the amount Cook County accepts from the Illinois Department of Public Aid for providing inpatient services to patients on General Assistance—$500 per hospitalization.[290] As such, it is simply improper to use Cook County's charges to define the financial burden imposed by such transfers.

The authors also note their concern that these transfers "shift[ed] . . . costs from Chicago's private hospitals to a financially strapped public hospital. . . . [E]xtrapolation to a national level suggests an annual cost shift of hundreds of millions of dollars from private to the public sector."[291] As with the Highland General article, this claim presupposes a prior obligation on the part of the private hospitals to provide such services. Defining a neutral baseline for

---

mortality rates for surgical patients may be attributable to the preponderance of trauma in that population, since the most severely injured patients may have died before transfer—a plausible interpretation, but one that is unsupported by any data. The authors do observe that the higher mortality rates among transferred patients on the medical service may be due to differences in case mix or some aspect of the transfer process—but as with the surgical service, there is no basis in the data to decide which it is. *See also* Jerrold B. Leiken & Kenneth S. Polin, Letter to the Editor, *Transfers to a Public Hospital*, 315 NEW ENG. J. MED. 1421 (1986) (arguing that it is inappropriate to compare transferred and nontransferred patient populations); J. Douglas White, Letter to the Editor, *Transfers to a Public Hospital*, 315 NEW ENG. J. MED. 1421 (1986) (same).

288. If one makes the heroic assumption that all of the unstable patients were treated until discharge by the private hospitals and were not transferred even after they were stable, Cook County would still have to provide treatment to 329 patients, 63 of whom required stays in the ICU. If one assumes that stable patients who were admitted to the ICU stayed 2 days, and uses the overall average length of stay found in the study (7.7 days), one arrives at total charges of $1.7 million, or 60% of the figure computed by the authors.

If one relaxes these conditions, and assumes that the transferring hospital stabilizes all unstable patients and then transfers them after 2 days of hospitalization (decreasing total length of stay by the same amount and lowering the rate of ICU utilization to that of the transfer pool as a whole), the total charges are still more than 70% of the figure computed by the authors. *Cf.* Mark A. Hall, *The Unlikely Case in Favor of Patient Dumping*, 28 JURIMETRICS J. 389 (1988) (noting that EMTALA provides only a temporally limited restriction on transfer of patients).

289. Cook County charged $630 per day for ward patients and $1500 per day for ICU care. *See* Schiff et al., *supra* note 277, at 554.

290. *See id.* at 555.

291. *Id.* at 556.

assessing the issue is problematic, but the study essentially assumes what it must establish.

Finally, members of the department of surgery and the section of trauma at Cook County disagreed with the conclusions of the Cook County study.[292] Since surgical patients accounted for a majority of those transferred to Cook County, their views should be accorded considerable weight. These commentators argued that the capabilities of the transferring hospital needed to be taken into account, and that transfer in an unstable condition was not necessarily indicative of inappropriate care, since "[m]any patients with trauma or other emergency surgical conditions can never be stabilized in the primary hospital because of a lack of facilities, and they therefore must be transferred to Cook County Hospital in an unstable condition."[293] In addition, these authors correctly noted that transfer of stable patients requiring medical care was consistent with the "stated mission of Cook County Hospital . . . to render treatment to the medically indigent in our community."[294]

C. Parkland Study[295]

This study, which was published in 1986, presented data from transfers to Parkland in Dallas during two fiscal years: 1983-1984 and 1984-1985.[296] Parkland had implemented a transfer policy shortly before the study commenced.[297] During the study period, a total of 3684 patients were transferred to Parkland.[298] Of these, 59% were admitted.[299] Relatively few patients were transferred in an unstable condition: 30 patients (or 1.5% of the total) in the first

---

292. *See* Barrett & Jonasson, *supra* note 276, at 1421.

293. *Id.* The authors of the Cook County study argued in response that most of the patients had been transferred for economic reasons rather than medical reasons. *See* Robert L. Schiff et al., Letter to the Editor, *Transfers to a Public Hospital*, 315 NEW ENG. J. MED. 1421, 1422 (1986). Unfortunately, this response misses the point—one must establish a baseline obligation to provide services (and incur the associated expenses) before refusal to do so is significant.

294. Barrett & Jonasson, *supra* note 276, at 1421.

295. *See* William Gary Reed et al., *The Effect of a Public Hospital's Transfer Policy on Patient Care*, 315 NEW ENG. J. MED. 1428, 1428-32 (1986). Parkland Memorial Hospital ("Parkland") is a public acute-care teaching hospital that serves the indigent population of Dallas County. Parkland is well known as a tertiary-care referral center and trauma center. *See id.* at 1429.

296. *See id.* at 1430.

297. The policy required the transferring hospital to obtain medical and administrative approval from Parkland personnel prior to transfer. Parkland personnel were required to factor into their decisions "an awareness of the medical capabilities of the hospital or clinic from which the physician wishes to transfer a patient." *Id.* The article claims that compliance with the policy ranged between 85% to 90%, but observes that a substantial number of patients were transferred without prior notification (28% of all transfers in 1983-1984 and 17% of all transfers in 1984-1985). *See id.* at 1430 tbl.1.

298. *See id.* at 1430. Approximately 20% of these patients were covered by either Medicare, Medicaid, or private insurance; the remaining 80% were indigent or uninsured. *See id.* at 1432 tbl.4.

299. During the first year of the study, 1056 patients (56%) were admitted. During the second year of the study, 1120 patients (63%) were admitted. *See id.* at 1430 tbl.1.

year and 10 patients (or 0.9% of the total) in the second year of the study.[300] The authors believed that the transferring hospital was capable of stabilizing the patient in 27 of these 40 transfers (67.5%).[301] The study does not attempt to quantify the cost to Parkland of such transfers, although it contains a great deal of information about the financial straits of Parkland, the wealth of the surrounding private hospitals, and the fact that many who were transferred did not meet Parkland's standards of indigence.[302]

As with the prior studies, the authors did not include an assessment of the numbers of patients treated by private hospitals when the patients were uninsured but were not transferred; included only a limited assessment of the costs imposed on private hospitals by uninsured patients which were not transferred; ignored the extent to which the transferring hospital was able to provide treatment;[303] and did not address whether there were any adverse consequences of transfer. Finally, the authors inappropriately use "dumping" interchangeably with economically motivated transfers.

---

300. *See id.* at 1431. Stability was determined based on various clinical criteria. The article is unclear whether Parkland's medical records or those of the transferring hospital were used in making this determination. It is likely that the transfer policy impacted on the percentage of unstable patients, since the article observes that Parkland "has been able to decrease the number of inappropriate patient transfers but also has seen an improvement in the stability of patients' conditions during transfer." *Id.* Parkland refused to accept 660 patients, of which 22 were transferred notwithstanding the refusal. Parkland also accepted 216 patients for transfer who were not ultimately transferred. *See id.* at 1431 tbl.1. Only one patient died. *See id.* at 1431.

301. *See id.* at 1431. Interestingly, the authors believed the transferring hospital was capable of providing stabilizing treatment in 56.6% of the unstable cases transferred in 1983-1984 (17 out of 30 transfers), and 100% of the unstable cases transferred in 1984-1985 (10 out of 10 transfers).

302. Parkland receives approximately 55% of its budget from property taxes, and has a legal mandate to provide care to the indigent residents of Dallas County. *See id.* at 1429. However, Parkland typically provides uncompensated care far in excess of the funds it receives from tax revenues. For example, in fiscal year 1985, Parkland received $87.5 million in tax revenues, and provided $107 million in charged charity care and bad debt. *See id.* This imbalance, coupled with Parkland's historical mandate and its identification as the "insurer of last resort," explains Parkland's "tenuous financial and political situation." *Id.*

One-third of Texas hospitals were operated as for-profit institutions. These institutions provided considerably less charity care and were considerably more profitable than nonprofit and public hospitals. *See id.* Transferred patients were far less likely to have insurance or qualify as medically indigent residents of Dallas County (59.5% versus 27.6%). *See id.* at 1431.

303. In addition, the article claims that 166 of the patients transferred with trauma over the two-year period (excluding burns and pediatric trauma) were transferred to Parkland by private hospitals which were capable of providing the necessary care. *See id.* at 1431. It is difficult to know the basis for this determination, or interpret this figure without knowing the total number of trauma patients exclusive of burns and pediatric trauma.

D. D.C. Study[304]

This study, which was issued as a GAO report in 1987, presented data from transfers to D.C. General Hospital ("DCGH") during 1985.[305] There were a total of 868 transfers, of which 83% were made because the patient was indigent or lacked insurance.[306] Sixty-two percent of transfers were admitted. Charges for transferred patients were estimated to total $3.5 million (plus or minus $1.5 million). DCGH recovered only about 14% of these charges, but received a subsidy of approximately $45 million from the D.C. government to compensate it for providing care to the indigent.[307]

Ninety-four transfers were randomly selected for in-depth review.[308] DCGH had a transfer policy which required all transferring hospitals to obtain authorization for the transfer and provide copies of appropriate medical records.[309] Transfers were generally in accord with the policy.

DCGH had recorded 39 cases where it believed its transfer policy was violated.[310] After the GAO reviewed 30 of the cases, the acting director of the ED at DCGH concluded that 14 of the cases were referrals or appropriate transfers, and another 12 constituted technical violations.[311] The acting director believed that the remaining 4 cases were "potentially life-threatening violations."[312] After the GAO provided additional information, the acting director concluded that only one case involved a violation of the transfer policy. Not surprisingly, physicians at the transferring hospital disagreed with the assessment of the DCGH acting director as to whether any of the cases violated DCGH's transfer policy.

The GAO concluded that hospitals appeared to be voluntarily complying with the DCGH transfer protocol, but observed that "communication problems can occur even when there is a policy in place to govern the transfer of patients."[313] One hospital director observed that "'the community must assume some

---

304. *See* GENERAL ACCOUNTING OFFICE, GAO/HRD 87-31, HEALTH CARE: PATIENT TRANSFERS FROM EMERGENCY ROOMS TO D.C. GENERAL HOSPITAL (1987).

305. *See id.* at 2.

306. *See id.* at 38. DCGH actually had recorded 923 transfers, but some turned out not to be transfers. *See id.* at 11.

307. *See id.* at 39-40.

308. The GAO selected 100 transfers, randomly from a pool of 923, which was adjusted to 868, but only 94% of the sample was actually transferred. *See id.* at 11.

309. *See id.* at 14-15. DCGH refuses to accept transfers if the patient does not require admission, if the patient is on "bypass" status, if the patient requires intensive care or has already been admitted to another hospital, or if the patient suffered major trauma in the last 24 hours. *See id.*

310. *See id.* at 22.

311. *See id.* For example, a patient would go to another hospital's ED for emergency care, and would be referred to DCGH for follow-up care. DCGH erroneously recorded a transfer violation in any case where the patient indicated he had made an earlier visit to another hospital. DCGH discontinued this practice during 1985, when it realized its methodology significantly overstated the incidence of alleged violations. *See id.* at 24.

312. *Id.* at 22.

313. *Id.* at 37.

responsibility for payment' for uncompensated care if economic transfers are to stop."[314]

The most extraordinary thing about the study is the extent to which circumstances which DCGH personnel had originally classified as "violations" of the transfer policy were either "technical" violations or nonviolations. One out of thirty is hardly a rate that inspires confidence in DCGH's assessments—particularly in a preselected sample. Miscommunication seems to have accounted for a very high percentage of what was originally labelled "patient dumping."[315]

As with the prior studies, the study did not include an assessment of the numbers (or associated cost) for patients treated by private hospitals when the patients were uninsured but were not transferred. Strikingly, the study also included complaints by transferring hospitals about DCGH's use of "bypass" status as a way to "dump" patients into the private sector, and the lack of legal foundation for DCGH's unilateral creation of a transfer protocol.[316]

E. Memphis Study[317]

This study, which was published in 1988, presented data from transfers to the Med during June, July, and August of 1986. The Med received a total of 854 transfers, of which 266 were studied in detail.[318] Like Parkland and Cook County, the Med had implemented a protocol for securing advance authorization for transfers. However, advance authorization was sought for only 45% of the transfers. Transferred patients required hospitalization at a significantly higher rate than those who presented directly to the Med ED.[319]

Transfer was based on financial reasons (lack of insurance/indigence or no charity beds) in 89% of the patients for which such information was available.

---

314. *Id.* at 19 (quoting Letter from Sister Catherine Norton, President of Providence Hospital, to Richard L. Fogel, Assistant Comptroller General, Human Resources Division, General Accounting Office, Washington, D.C. (Mar. 10, 1987)).

315. *See id.* at 17.

316. *See id.*

317. *See* Arthur L. Kellermann & Bela B. Hackman, *Emergency Department Patient 'Dumping': An Analysis of Interhospital Transfers to the Regional Medical Center at Memphis, Tennessee*, 78 AM. J. PUB. HEALTH 1287 (1988). The Regional Medical Center at Memphis ("the Med") is an adult acute-care hospital owned by the county and operated by a nonprofit health-care corporation. The Med is staffed by residents and faculty from the University of Tennessee. The Med has specialty units for major trauma, burns, and high-risk obstetric patients. The ED at the Med is the busiest in the county, and provides services to all in need, regardless of ability to pay. *See id.* at 1287.

318. *See id.* at 1288. The study sought to identify referrals from other hospital EDs or affiliated free-standing emergency clinics, and excluded patients who were self-referrals, or sent from health-department neighborhood clinics, private physician offices, or nursing homes. *See id.* The other 588 transfers (69%) were sent directly to one of the Med's four special-care areas, and were excluded from the study on the assumption that referrals were for obtaining tertiary care not available at the transferring institution. *See id.*

319. *See id.* at 1289. Over one-third of transferred patients required emergency hospitalization, compared to 10% of those who presented directly. Compared to the general population seen at the Med, transferred patients were younger and were more likely to be uninsured and white. *See id.*

Of the patients which the study concluded were transferred for economic reasons, 27% were classified as unstable on arrival.[320] For those patients for whom data was available, transfer resulted in an average delay in providing definitive care of 4 hours, with delays ranging from 0.2 to 14.2 hours.

The article concluded by noting that the costs imposed by these transfers were substantial. Patient charges (ambulance fees and a second ED evaluation at the Med) averaged out to approximately $200 per transfer. Inpatient charges at the Med totalled approximately $382,000, of which the Med ultimately collected approximately $60,000. Thus, the Med incurred a net loss of $322,000 on treating these patients.[321] Based on these results, the authors estimated that economically motivated transfers annually shifted at least $1,300,000 of uncompensated care from area private hospitals to the Med.[322] Like the Parkland study, this article provided extensive information about the financial straits of the Med and the comparative wealth of other hospitals in the area.[323]

Like the earlier studies, the authors did not include an assessment of the numbers of patients treated by private hospitals (and the cost of such treatment) when the patients were uninsured but were not transferred,[324] only included limited assessment of the extent to which the transferring hospital was able to provide treatment and the adverse consequences of transfer,[325] relied on charges rather than costs to determine the financial implications of the transfers, simply

---

320. *See id.* The study essentially assumed that all patient transfers without prior authorization (243) were economically motivated. "Stability" was determined based on a modification of the criteria used in the Cook County study. A total of 102 patients (42%) needed urgent care but did not require hospitalization; another 76 patients (31%) were classified as stable, but the "need for hospitalization and/or extended observation appeared likely"; and the remaining 65 patients (27%) required stabilization on arrival, and almost all were hospitalized. *Id.* at 1291. Forty-four of the unstabilized patients required admission (68%) versus 41 of the patients which were stable on arrival (23%). *See id.*

321. *See id.* at 1289-90. Of course, since the Med lost money overall, the fact that it lost money on transferred patients is not particularly surprising. *See infra* note 323.

322. *See id.* at 1291. The authors argued that this figure was conservative, since it did not include the Med's opportunity costs (foregone income from patients whose admission was deferred and patients who were transferred by the Med to open up space) and excluded inpatient expenses for transferred patients admitted to specialty units. *See id.*

323. There are 16 major hospitals in Shelby County, one of which is for-profit. *See id.* at 1287. In 1986, these private hospitals reported net revenues (after bad debt and charity care) of $62,000,000, while the Med reported a net operating deficit of $7,000,000. *See id.* The Med receives a subsidy from Shelby County to ensure that all County residents have access to health-care services. In 1986, Shelby County's subsidy amounted to $26,800,000—which covered half of the charges for uncompensated care provided by the Med.

324. *See id.* at 1288. In a subsequent article (analyzed at greater length *infra*) which sought to compare the rate of transfer before and after the enactment of EMTALA, the authors correctly observed that "without access to the charts of indigent patients seen at other hospitals, we cannot judge whether they were better or worse off when transfers to our hospital were restricted." Arthur L. Kellermann & Bela B. Hackman, *Patient 'Dumping' Post-COBRA*, 80 AM. J. PUB. HEALTH 864, 866 (1990).

325. The article observed that the Med provides comparable emergency services to those available from other major hospitals in the county. *See* Kellermann & Hackman, *supra* note 324, at 865-66.

assumed that the private hospitals had an obligation to provide the services, and used "dumping" interchangeably with economically motivated transfers.

F. Cook County II[326]

In 1987, the first two authors of the Cook County study published a "Special Communication" on dumping.[327] The article contained no empirical data but reviewed the status and implications of patient dumping, and proposed several policy changes to ensure access to emergency care.[328] The article contains only two significant numerical observations: that 250,000 patients a year are dumped, and that "[i]f the patients transferred to Cook County Hospital are representative of the patients transferred to public hospitals nationwide," such dumping shifts at least $1.04 billion in uncompensated care "from the private health sector to financially troubled public hospitals."[329] Both of these numerical observations are either wrong or misleading—but that has not stopped them from attaining the status of gospel through repetition in law reviews, congressional hearings, newspaper articles, and the medical literature.[330]

The claim that 250,000 patients a year are dumped is impressive, but is based on generalizing from a skewed sample while simultaneously using an overbroad definition. The authors arrived at this figure by extrapolating from studies conducted in Dallas, Oakland, and Chicago to "estimate" a total for nationwide patient dumping.[331] Each of these areas encompasses large urban populations

---

326. *See* David A. Ansell & Robert L. Schiff, *Patient Dumping: Status, Implications, and Policy Recommendations*, 257 JAMA 1500 (1987).

327. *See supra* note 277.

328. Ansell and Schiff identify a number of shortcomings in existing patient-transfer laws (vague definitions, no mechanism for enforcement, minimal penalties), *see* Ansell & Schiff, *supra* note 326, at 1501, and suggest that the appropriate solution is to make "sweeping changes in health care financing and priorities to reorient the health care system such that all people are granted adequate protection of their health." *Id.* at 1502. They also suggest that "no patient in need of emergency hospitalization be denied admission or transferred to another hospital for economic reasons. . . . [P]atients . . . should be transferred only for medical reasons, i.e., when needed specialty or tertiary care is not available at the transferring hospital." *Id.*

329. *Id.* at 1500. The authors note that the figure "would be substantially higher if patients requiring pediatric, obstetric-gynecologic, and psychiatric care were included." *Id.*

330. *See, e.g.*, Howard S. Berliner, Editorial, *Patient Dumping No One Wins and We All Lose*, 78 AM. J. PUB. HEALTH 1279, 1279 (1988) (repeating Ansell and Schiff's estimate, elicited at a congressional hearing, that 250,000 patients are transferred for solely economic reasons); *Hospitals' Handling of Uninsured Patients Faulted*, N.Y. TIMES, Mar. 30, 1988, at A25 (noting publication of House Committee on Government Operations report, which "said that more than 250,000 patients are dumped yearly"); Rochelle Eden Moore, *Transfer Center Can Control, Manage Admissions*, HEALTHCARE FIN. MGMT., Sept. 1990, at 40, 40 ("Despite the law, hospitals wrongly transfer an estimated 250,000 patients each year."); *U.S. Is Termed Lax on 'Dumping' Patients*, N.Y. TIMES, Apr. 24, 1991, at A20 ("In 1987, a study published in The Journal of the American Medical Association estimated that 250,000 patients nationwide were 'dumped' each year from hospital emergency rooms because they could not pay for their care or were on Medicaid.").

331. *See* Ansell & Schiff, *supra* note 326, at 1500.

with substantial numbers of indigent and uninsured individuals. Even taken in the aggregate, the sample is by no means representative of the country as a whole. Accordingly, a straightforward extrapolation based on population—which is what the authors did—is inappropriate.

The definition of "dumping" employed by the authors—"the denial of or limitation in the provision of medical services to a patient for economic reasons and the referral of that patient elsewhere"—is also overbroad.[332] This definition encompasses emergency, urgent and nonurgent services, for both stable and unstable patients. In essence, this definition would require all hospitals to provide all necessary services to all comers, regardless of whether the patient is stable or not, and regardless of the patient's ability to pay (or to obtain cheaper services elsewhere, as in a managed-care arrangement). EMTALA, for all its breadth, is facially limited to restrictions on the transfer of unstable patients.[333]

The authors' complaints about cost-shifting to public hospitals are equally misleading. The public hospital is required to provide care to all comers, while the private hospital has far more circumscribed obligations. It is a non sequitur to assert that the private hospital is cost-shifting when it refuses to shoulder some of the public hospital's burden—particularly if the private hospital is not tax-exempt.

G. Memphis II[334]

This study, which was published in 1990, presented data from transfers to the Med during the summers of 1986, 1987, and 1988.[335] The Med received a total of 577 transfers during these three summers. Because the study focused on quantifying the impact of EMTALA on patient transfers, it provided only a modest amount of data compared to the earlier study, and provided no data comparing patients who were transferred to the Med with those who first sought

---

332. *Id.* It is unclear whether the authors, in fact, are limiting themselves to this broad definition, since they note that a patient may be dumped for exhibiting "undesirable" conditions, such as intoxication or overdose conditions. *See id.* Obviously, such patients may still be insured.

333. The difference is significant; depending on which study one uses, the percentage of unstable patients ranges between 1% and 27% of economically motivated transfers.

334. *See* Kellermann & Hackman, *supra* note 324, at 864.

335. *See id.* at 865:

> More than half of patients transferred during the summer of 1986 were unauthorized, including four sent despite refusal by the Medical Center. During summer of 1987 (post COBRA) unauthorized transfers declined by only 18 percent, but 10 patients were sent despite refusal by the Medical Center. During summer 1988, unauthorized transfers declined by fully 61 percent compared to 1986; five transfers arrived despite prior refusal by the Medical Center.

This optimistic characterization is somewhat inaccurate; the decline in unauthorized transfers was largely attributable to a decrease in the number of transfers as such. If expressed in terms of the percentage of economically motivated transfers which were unauthorized, the figures are 60% (1986), 60% (1987), and 71% (1988). *See id.* at 865 fig.1.

care at the Med's ED.[336] The Med continued to employ the protocol for accepting and rejecting transfers described in the earlier article.

As with the earlier study, financial reasons (lack of insurance/indigence or no charity beds) accounted for approximately 90% of transfers. Of the patients which the study concluded were transferred for economic reasons, 24% were classified as unstable.[337] Two-thirds of these patients had been categorized as stable, based on "telephone assurances by the sending physician."[338] Transferred patients were admitted to the Med and required emergency surgery and/or critical care at modestly variable rates. Seven transferred patients died during the study period, but all were authorized, and thus were presumably stable at the time of transfer.[339]

This study suffers from all of the deficiencies of the earlier Med study. In addition, the study documents a significant problem little noted by EMTALA's enthusiasts: insufficient capacity. Overcrowding resulted in restrictions on transfers to the Med during some of the study periods.[340] The article asserts that these periods "were generally brief," but Table 1 reflects that transfers were restricted for all or part of 34% of the study period in 1986, 39% of the study period in 1987, and 71% of the study period in 1988.[341]

---

336. The authors concluded that EMTALA had little impact on the number of patient transfers, observed that public hospital officials are reluctant to invoke EMTALA because of "the need to maintain cordial multi-institutional relationships," and suggested that stiffer sanctions would be necessary for EMTALA to have an impact. *Id.* at 866.

337. Out of 522 economically motivated transfers, 123 (64 in 1986, 46 in 1987, and 13 in 1988) were unstable. *See id.* at 865. The percentage of economically motivated transfers which were unstable dropped from 26% (1986) to 23% (1987) to 17% (1988). *See id.* Interestingly, in 1986, the study classified one fewer patient as unstable than had been so classified in the earlier study.

338. *Id.*

339. *See id.* The percentage of transferred patients admitted to the hospital ranged from 34% (1986) to 41% (1987) to 40% (1988). Those requiring intensive care or emergency surgery ranged from 4% (1986) to 8% (1987) to 5% (1988). *See id.* at 865 fig.2.

340. *See id.* at 864.

341. *Id.* As noted previously, transfers declined precipitously in 1988 because of overcrowding.