

Maurer School of Law: Indiana University

Digital Repository @ Maurer Law

Articles by Maurer Faculty

Faculty Scholarship

1995

Did Congress Intend to Give Patients the Right to Demand and Receive Inappropriate Medical Treatments?: EMTALA Reexamined in Light of Baby K

Elizabeth Larson Goldberg
Indiana University School of Law

Follow this and additional works at: <https://www.repository.law.indiana.edu/facpub>



Part of the [Health Law and Policy Commons](#), and the [Legislation Commons](#)

Recommended Citation

Goldberg, Elizabeth Larson, "Did Congress Intend to Give Patients the Right to Demand and Receive Inappropriate Medical Treatments?: EMTALA Reexamined in Light of Baby K" (1995). *Articles by Maurer Faculty*. 1897.

<https://www.repository.law.indiana.edu/facpub/1897>

This Article is brought to you for free and open access by the Faculty Scholarship at Digital Repository @ Maurer Law. It has been accepted for inclusion in Articles by Maurer Faculty by an authorized administrator of Digital Repository @ Maurer Law. For more information, please contact rvaughan@indiana.edu.



LAW LIBRARY
INDIANA UNIVERSITY
Maurer School of Law
Bloomington

NOTE

DID CONGRESS INTEND TO GIVE PATIENTS THE RIGHT TO DEMAND AND RECEIVE INAPPROPRIATE MEDICAL TREATMENTS?: EMTALA REEXAMINED IN LIGHT OF *BABY K*

ELIZARETH A. LARSON*

I. INTRODUCTION

In 1986, Congress amended the Social Security Act to prohibit hospitals that receive Medicare funds from engaging in the practice of patient "dumping."¹ Patient dumping is the refusal by a hospital to provide necessary emergency medical treatment to someone based upon that person's inability to pay.² Because this amendment was part of the Congressional Omnibus Budget Reconciliation Act, it was commonly referred to by the acronym COBRA for some time³ but is now known as EMTALA, short for "Emergency Medical Treatment and Active Labor Act."

While legislative history shows that EMTALA was meant to protect the indigent and uninsured,⁴ Congress did not explicitly limit coverage to those people in the language of the Act,⁵ leaving the courts to determine whether EMTALA should apply to that class of people exclusively or to everyone. Relying on the intent expressed in legislative history, some courts have limited EMTALA's coverage to the indigent

* B.A. 1990, M.L.S. 1992, UCLA; Class of 1996, University of Wisconsin Law School. Thanks to Andy Aligne for suggesting the topic, to Jeff Brown for critiquing the final draft, and to Matthew Weber for much-needed recent encouragement.

1. Emergency Medical Treatment and Active Labor Act, Pub. L. No. 99-272, 100 Stat. 164 (1986) (codified at 42 U.S.C. § 1395dd (1994)).

2. The patient is sometimes said to have "failed the wallet biopsy." DAVID U. HIMMELSTEIN & STEFFIE WOOLHANDLER, *THE NATIONAL HEALTH PROGRAM BOOK: A SOURCE GUIDE FOR ADVOCATES* 52 (1994). For a discussion of America's dumping dilemma, see *infra* part II.B.

3. See, e.g., Karen I. Treiger, Note, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. REV. 1186 (1986).

4. If a person's insurance does not cover the care he needs, he is effectively uninsured for that care. Therefore, the underinsured are implicitly included in the category of people who cannot pay for the medical care they need. For the sake of simplicity, I will use the description "indigent and uninsured" throughout this Comment.

5. Read literally, the statute applies when "any individual" seeks emergency medical treatment. 42 U.S.C. § 1395dd(a) (1994).

and uninsured.⁶ However, the majority of courts that have decided this issue have relied upon the plain meaning of EMTALA's text and ruled that it applies to everyone.⁷ Pointing to this division among the courts, other commentators have called upon Congress to amend EMTALA to clarify this matter once and for all.⁸ In June 1994, the U.S. Department of Health and Human Services promulgated interim final regulations to implement EMTALA. Under the Department's regulations, EMTALA is applicable when any individual comes to an emergency department, "regardless of [his] ability to pay."⁹

This Comment focuses on the courts' and the Department of Health and Human Services' interpretations of EMTALA's stated coverage, specifically the question of who can bring suit under the Act. This Comment argues that the majority rule (i.e., the rule established by the Department of Health and Human Services and the majority of federal courts that have decided this issue) is unwise. Under the majority rule, even the fully insured may bring suit under EMTALA. However, with the element of economic discrimination absent from such a case, it is difficult to determine exactly what role EMTALA should play. The courts that have adopted this rule have established a variety of tests for finding a violation in such cases. While these tests differ from one another, they share a common goal: to determine whether a particular hospital failed to adequately screen the patient for an emergency medical condition and, if such a condition was found, whether the hospital stabilized it before releasing or transferring the patient.

The goal of these tests is effectively indistinguishable from that of state malpractice laws: to determine whether the established standard of care was breached. But while the common law of malpractice takes

6. *Urban v. King*, 783 F. Supp. 560, 562 (D. Kan. 1992); *Coleman v. McCurtain Memorial Medical Management, Inc.*, 771 F. Supp. 343, 347 (E.D. Okla. 1991), *overruled by Collins v. DePaul Hosp.*, 963 F.2d 303, 308 (10th Cir. 1992); *ZaiKaner v. Danaher*, No. 4-89-749, 1990 WL 264721, at *3 (D. Minn. Oct. 21, 1990); *Stewart v. Myrick*, 731 F. Supp. 433, 436 (D. Kan. 1990); *Nichols v. Estabrook*, 741 F. Supp. 325, 329-30 (D.N.H. 1989); *Evitt v. University Heights Hosp.*, 727 F. Supp. 495, 497-98 (S.D. Ind. 1989).

7. *See, e.g., Collins*, 963 F.2d at 308; *Brooker v. Desert Hosp. Corp.*, 947 F.2d 412, 414 (9th Cir. 1991); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1040 (D.C. Cir. 1991); *Cleland v. Bronson Health Care Group*, 917 F.2d 266, 269-70 (6th Cir. 1990); *Deberry v. Sherman Hosp. Ass'n*, 741 F. Supp. 1302, 1306 (N.D. Ill. 1990).

8. *See Timothy D. Krugh, The Federal Anti-Dumping Act After Five Years: A Critical Analysis of Medical COBRA*, 1991 LEGAL MED. 287, 316; 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, 1149 (1992).

9. 42 C.F.R. § 489.24(a) (1994).

individual factors into account, EMTALA is brief, vaguely written, and provides no guidance for determining a standard of care. The courts have recognized these ambiguities and, until the recent case of *In re Baby K*,¹⁰ have been hesitant to find a violation when the plaintiff was fully insured.

In deciding the case of *Baby K*, the United States Court of Appeals for the Fourth Circuit became the first court to find a (potential) EMTALA violation in a case involving a fully insured patient. However, by pointing out that EMTALA makes no exception for treatment outside the prevailing standard of care or for treatment that is medically and ethically inappropriate,¹¹ the court helped to illustrate the shortsightedness of the majority rule and the unsuitability of EMTALA as a means of deciding cases that involve no allegation of economically motivated dumping. This case highlights the need for clarification of EMTALA's scope—more specifically, the need to limit its coverage to cases of true dumping.

Part II of this Comment examines legislative history which shows that EMTALA's true purpose was to prevent economically motivated patient dumping. Part II also presents a brief history of America's patient dumping crisis. This part concludes with an argument that, because EMTALA's legislative history shows that its purpose was to end the despicable practice of patient dumping, it should be used only in cases with evidence of true dumping.

Part III details the division among the courts in interpreting EMTALA's coverage and concludes that the majority rule duplicates malpractice law in its goal but not in its methods, and that EMTALA's methods are not sophisticated enough to play this role. This part also examines the case of *Baby K*, the first case in which a hospital was found to have (potentially) violated EMTALA in its dealings with a fully insured patient. In this case, a federal court used EMTALA to override a legitimate medical and ethical decision, despite the fact that the Act was intended to override economic decisions only.

Part IV argues that the majority rule is unwise in theory and in practice, as evidenced by the case of *Baby K*. Because EMTALA's language is so vague, results similar to those in *Baby K* could be seen again. Furthermore, the majority rule, by allowing the fully insured to bring suit under both EMTALA and state malpractice law, could prove to defeat the very purpose Congress intended for the Act. By potentially increasing the number of lawsuits resulting from emergency room visits, the majority rule could add to the cost of health care and ultimately give hospitals more incentive to dump patients. Part V concludes with a

10. 16 F.3d 590 (4th Cir.), *cert. denied*, 115 S. Ct. 91 (1994).

11. *Baby K*, 16 F.3d at 597.

recommendation to amend EMTALA by limiting its coverage to cases of true dumping only or, at the very least, by incorporating into it the test established in the later case of *Power v. Arlington Hospital*.¹² As discussed in Part IV, the *Power* test takes legitimate medical judgment into account by allowing a physician or hospital to show that the test or procedure at issue was not conducted because of medical, rather than economic, reasons.

II. EMTALA

A. How EMTALA Works

EMTALA imposes a duty on hospitals that accept Medicare funds¹³ (ninety-eight percent of American hospitals)¹⁴ to appropriately screen¹⁵ and stabilize¹⁶ any individual who comes to their emergency departments

12. 42 F.3d 851 (4th Cir. 1994).

13. 42 U.S.C. § 1395dd(e)(3) (1994); *Coleman v. McCurtain Memorial Medical Management, Inc.*, 771 F. Supp. 343, 345-46 (E.D. Okla. 1991).

14. Douglas S. Diekema, *What Is Left of Futility? The Convergence of Anencephaly and the Emergency Medical Treatment and Active Labor Act*, 149 ARCHIVES PEDIATRICS & ADOLESCENT MED. 1156, 1156 (1995).

15. 42 U.S.C. § 1395dd(a) (1994). The exact language of the screening requirement reads:

(a) Medical screening requirement

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

16. 42 U.S.C. § 1395dd(b) (1994). The exact language of the stabilization requirement reads:

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

(1) In general. If any individual (whether or not eligible for benefits under [Medicare]) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or (B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

seeking examination or treatment for an emergency medical condition.¹⁷ A hospital may choose to transfer a patient to another hospital *if* it first complies with the requirements of the Act.¹⁸ A hospital that fails to comply with EMTALA is subject to a civil money penalty of up to \$50,000 for each violation (or only \$25,000 if the hospital has fewer than 100 beds).¹⁹ Physicians are subject to a civil money penalty of up to \$50,000 per violation.²⁰ Patients who suffer personal harm as a direct result of a hospital's violation can bring a civil action against that hospital.²¹ Hospitals that suffer a direct financial loss as a result of another hospital's violation of the Act can also bring a civil action against the violating hospital.²²

This Comment focuses on the courts' and the Department of Health and Human Services' interpretations of EMTALA's stated coverage, specifically the question of who can bring suit under the Act. The language of EMTALA is vague in this regard. While the language makes it clear that hospitals have a duty to screen and stabilize "any individual"²³ who comes to an emergency room, nowhere does it explicitly say whether or not plaintiffs must prove economic

17. 42 U.S.C. § 1395dd(e)(1) (1994). The Act defines an emergency medical condition as follows:

(e) Definitions

In this section:

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

(A) a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in—

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- (ii) serious impairment to bodily functions, or,
- (iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant wom[a]n who is having contractions—

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

18. 42 U.S.C. § 1395dd(e) (1994).

19. 42 U.S.C. § 1395dd(d)(1)(A) (1994).

20. 42 U.S.C. § 1395dd(d)(1)(B) (1994).

21. 42 U.S.C. § 1395dd(d)(2)(A) (1994). The statute limits damages to those "available for personal injury under the law of the State in which the hospital is located."

42 U.S.C. § 1395dd(d)(3)(A) (1994).

22. 42 U.S.C. § 1395dd(d)(2)(B) (1994).

23. 42 U.S.C. § 1395dd(a) (1994).

discrimination. When the House Judiciary Committee was debating EMTALA prior to its enactment, it expressed concern that the language "did not precisely identify which parties could bring actions under the provision" and that the "vagueness of the provision would not only leave the rights and liabilities of the parties unclear, it also would place an unnecessary burden on the courts to define these rights and liabilities."²⁴ The Judiciary Committee amended EMTALA, but even its changes did not resolve this issue once and for all; the pertinent amendment merely limits the pool of potential plaintiffs to two types: "the individual patient who suffers harm as a direct result of [a] hospital's failure to appropriately screen, stabilize, or properly transfer" her, and "a medical facility which received an improperly transferred" patient.²⁵ This bit of legislative history does not answer the question of whether insured patients should be allowed to bring EMTALA claims.

In fact, legislative history suggests that Congress never anticipated that EMTALA would leave the courts guessing as to who could bring claims under the Act. The very lack of an explicit effort to clarify EMTALA's coverage can arguably be read to indicate that Congress thought the matter too obvious to merit attention. The record shows that the purpose of EMTALA was to prevent emergency rooms from dumping the indigent and uninsured. The purpose of EMTALA was explained as follows:

The [House Ways and Means] Committee is greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance. The Committee is most concerned that medically unstable patients are not being treated appropriately. There have been reports of situations where treatment was simply not provided. In numerous other instances, patients in unstable condition have been transferred improperly, sometimes without the consent of the receiving hospital.²⁶

The House Judiciary Committee added, "[i]n recent years there has been a growing concern about the provision of adequate emergency room services to individuals who seek care, particularly as to the indigent and uninsured."²⁷ In Senate debate, Senator Orrin Hatch put it this way:

24. H.R. REP. NO. 241, 99th Cong., 1st Sess., pt. 3, at 6, *reprinted in* 1986 U.S.C.C.A.N. 42, 728.

25. *Id.*

26. *Id.* pt. 1, at 27.

27. *Id.* pt. 3, at 5.

The intent of this bill is honorable, that is to address concerns about inadequate health care for our citizens who do not have health insurance or who are 'underinsured' There have been disturbing reports about hospitals referring, and in some instances refusing to treat patients who present themselves for care, but who don't have health insurance. Others apparently require a substantial cash deposit from uninsured patients before admitting the individual for care. This has been referred to as taking a 'wallet biopsy' before determining if the individual merits treatment.²⁸

Because the stated purpose of EMTALA is to prevent emergency rooms from dumping the indigent and uninsured, it is reasonable to assume that Congress meant to limit the Act's coverage to those patients. It is unfortunate that Congress overlooked the possibility of the current controversy and chose such vague language. In choosing the phrase "any individual," Congress set the stage for the courts to rule that anyone, even the fully insured, may bring an action under EMTALA.

B. The Story Behind EMTALA: America's Patient Dumping Problem

Congress passed EMTALA for the express purpose of ensuring that those who seek emergency room medical services receive adequate care, regardless of their ability to pay.²⁹ This action was considered necessary to combat a despicable and growing phenomenon known as patient "dumping."³⁰ A hospital "dumps" a patient when it either denies her emergency care altogether or transfers her to another hospital's emergency room without having stabilized her emergency condition, despite being perfectly capable of treating her itself.³¹ Hospital administrators euphemistically refer to this practice as "demarketing of services" and "management of patient mix."³² Due to the unique market-oriented nature of America's health care system, we are currently

28. S. REP. NO. 146, 99th Cong., 1st Sess. 460-61 (1985).

29. H.R. REP. NO. 241, *supra* note 24, pt. 3, at 5, *reprinted in* 1986 U.S.C.C.A.N. 42, 726.

30. *See e.g.*, Mary Jean Fell, Comment, *The Emergency Medical Treatment and Active Labor Act of 1986: Providing Protection from Discrimination in Access to Emergency Medical Care*, 43 CATH. U. L. REV. 607 (1994); Treiger, *supra* note 3.

31. *Reid v. Indianapolis Osteopathic Medical Hosp.*, 709 F. Supp. 853, 853-54 (S.D. Ind. 1989).

32. Emily Friedman, *The "Dumping Dilemma": The Poor Are Always With Some of Us*, HOSPITALS, Sept. 1, 1982, at 51.

the only Western industrialized nation whose people are at risk of being dumped.³³

Why does dumping occur? The answer is complicated. Traditionally, American hospitals treated all the indigent and uninsured who came to them.³⁴ They were able to do this and still stay in business thanks to the process known as "fee shifting."³⁵ This meant that hospitals treated the indigent and uninsured free of charge or for a reduced fee and then made up for the resulting economic loss by charging paying patients more than the actual cost of their own care.³⁶

While the system of fee shifting worked well for many years, a combination of forces has dramatically limited our hospitals' freedom to compensate themselves for charity care losses this way. The first is the huge increase in the number of uninsured Americans.³⁷ The number increased by fifty percent between 1976 and 1991 and totaled thirty-seven million in 1992.³⁸ The cost of providing uncompensated care for them went up along with their numbers. American hospitals provided an estimated \$10 billion in health care to the indigent and uninsured in 1989.³⁹

Coupled with this overwhelming expense was pressure from both the federal government and the insurance industry to cut medical costs.⁴⁰ Prior to 1983, Medicare reimbursed hospitals practically any amount they requested for patient care. Because there was no limit on reimbursement, hospitals would sometimes keep Medicare patients longer than necessary and give them every available test and treatment in order to maximize

33. Howard S. Berliner, *Patient Dumping: No One Wins and We All Lose*, 78 AM. J. PUB. HEALTH 1279, 1279 (1988); see also VICENTE NAVARRO, DANGEROUS TO YOUR HEALTH: CAPITALISM IN HEALTH CARE (1993); Milan Korcok, *Patient Dumping: The Ignoble Face of American Medicine*, 132 CANADIAN MED. ASS'N J. 1064 (1985).

34. L.M. Beitsch, *Economic Patient Dumping: Whose Life Is It Anyway?*, 10 J. LEGAL MED. 433, 441 (1989).

35. *Id.*

36. See, e.g., DEAN C. CODDINGTON ET AL., THE CRISIS IN HEALTH CARE: COSTS, CHOICES, AND STRATEGIES (1990); PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 387-88 (1982).

37. HIMMELSTEIN & WOOLHANDLER, *supra* note 2, at 22-24.

38. *Id.*

39. Beitsch, *supra* note 34, at 443.

40. Congress explicitly mentioned this pressure in its explanation of EMTALA's purpose: "There is some belief that [dumping] has worsened since the prospective payment system for hospitals became effective. The Committee wants to provide a strong assurance that pressures for greater hospital efficiency are not to be construed as license to ignore traditional community responsibilities and loosen historic standards." H.R. REP. NO. 241, *supra* note 24, pt. 1, at 27.

profit.⁴¹ In 1983, this cash cow was taken away. Medicare funding was switched from a cost-based reimbursement system to a prospective payment system.⁴² Under the new system, the amount of money that Medicare pays a hospital for a patient's care depends exclusively upon the patient's diagnosis.⁴³ Amounts for payment are assigned to diagnosis-related groups (DRGs), and the hospital receives only that amount.⁴⁴ If the actual cost to the hospital is less than that amount, the hospital can keep the excess; if the actual cost is more than that amount, the hospital must absorb the loss.⁴⁵ Under this new system, hospitals can no longer overcharge Medicare to make up for the costs of treating the indigent and uninsured.

Pressure to keep costs down has also come from the insurance industry.⁴⁶ In the United States, most insured people obtain their health insurance through their employment or that of a family member.⁴⁷ Employers, facing ever-increasing health insurance costs, have pitted insurance companies against one another in fierce competition to reduce the cost of insurance.⁴⁸ The insurance companies, in turn, have put pressure on the hospitals to keep costs down.⁴⁹ One sure-fire way for hospitals to lower costs for insurers is to refuse treatment to those who cannot pay, thereby reducing the need for fee shifting. Everybody wins, except the indigent and uninsured.

The result of all this pressure on hospitals has been an increase in the incidence of dumping.⁵⁰ In Dallas, for example, transfers of patients from one hospital's emergency room to another's (presumably motivated, in most cases, by economic concerns) increased from 70 per month in 1982 to more than 200 per month in 1983.⁵¹ In Washington, D.C., patient transfers rose from 169 per year in 1981 to 930 per year in 1985.⁵²

41. MARC A. RODWIN, *MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST* 15 (1993).

42. LINDA BRUBAKER ROPES, *HEALTH CARE CRISIS IN AMERICA: A REFERENCE HANDBOOK* 8 (1991).

43. *Id.*

44. Beitsch, *supra* note 34, at 444.

45. ROPES, *supra* note 42, at 8.

46. Beitsch, *supra* note 34, at 445.

47. Nancy De Lew et al., *A Layman's Guide to the U.S. Health Care System*, HEALTH CARE FINANCING REV., Fall 1992, at 151, 151-52.

48. Beitsch, *supra* note 34, at 445.

49. *Id.*

50. Leo Uzych, *Patient Dumping*, J. FLA. MED. ASS'N, Feb. 1990, at 97, 98.

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

52. *Id.*

Dumping can be very dangerous, even fatal, for those who are dumped. While most dumping involves an actual transfer to another hospital's emergency room, some hospitals have done as little as hand out maps with directions to the local public hospital.⁵³ Even when a patient is physically taken to another hospital, the transfer itself can delay treatment for hours.⁵⁴ Because emergency medical conditions by their very nature require immediate attention, any delay in treatment can have serious consequences in terms of increasing the likelihood of permanent disability or even death.⁵⁵

Dumping is an unconscionable disgrace to the American health care system. While the pressure to cut costs is undeniably overwhelming, hospitals and physicians who dump patients endanger lives. Through EMTALA, Congress made a noble attempt to end this contemptible practice. But it did not pay careful enough attention to the statute's language, and the courts have been left to clear up the resulting confusion themselves.

III. THE DIVISION AMONG THE COURTS IN INTERPRETING EMTALA'S COVERAGE

Because Congress phrased EMTALA to apply to "any individual,"⁵⁶ after having stated that the purpose of the statute was to prevent hospitals from dumping the indigent and the uninsured,⁵⁷ the courts have been left to determine for themselves whether "any individual" really means *any* individual or, rather, any individual who is unable to pay for the emergency medical treatment he needs. Of the federal courts that have decided this issue, a minority, comprised only of district courts, has ruled in favor of limiting EMTALA's application to cases of economically motivated dumping. The majority, including all the federal appellate courts that have addressed this question, has decided in favor of universal coverage.

53. Friedman, *supra* note 32, at 55.

54. Ansell & Schiff, *supra* note 51, at 1501.

55. *Id.*; Friedman, *supra* note 32, at 52.

56. 42 U.S.C. § 1395dd(a) (1994).

57. See *supra* notes 26-28 and accompanying text.

A. The Minority Rule

At least five district courts have ruled that EMTALA applies only in cases of economically motivated dumping.⁵⁸ Because two of those five decisions have been overruled,⁵⁹ only the three that still stand will be discussed here. In order to emphasize the level of confusion present in this debate, a sixth decision with an ambiguous holding⁶⁰ will also be discussed.

In the first case, *Nichols v. Estabrook*,⁶¹ the parents of a deceased infant brought suit in the United States District Court for the District of New Hampshire against Dr. Estabrook, the emergency room physician who examined their son shortly before their son's death.⁶² The parents brought the baby to the emergency room because he was suffering from vomiting and diarrhea.⁶³ Dr. Estabrook examined the baby, conducted a blood test, and diagnosed dehydration along with a flu or other virus.⁶⁴ He recommended that the parents drive their baby to another hospital, fifteen minutes away, where they would meet their usual pediatrician.⁶⁵ The baby died forty-five minutes after arriving at the second hospital.⁶⁶ The baby's pediatrician testified that the results of the blood test were "really bad" and that Dr. Estabrook should have started an intravenous line in the baby immediately.⁶⁷

The parents argued that the court should have imposed liability on Dr. Estabrook based on an alleged statutory duty (created under EMTALA) to make correct diagnoses.⁶⁸ The court rejected this

58. *Urban v. King*, 783 F. Supp. 560, 562 (D. Kan. 1992); *Coleman v. McCurtain Memorial Medical Management, Inc.*, 771 F. Supp. 343, 347 (E.D. Okla. 1991), *overruled by Collins v. DePaul Hosp.*, 963 F.2d 303, 308 (10th Cir. 1992); *ZaiKaner v. Danaher*, No. 4-89-749, 1990 WL 264721, at *3 (D. Minn. Oct. 21, 1990); *Stewart v. Myrick*, 731 F. Supp. 433, 436 (D. Kan. 1990); *Nichols v. Estabrook*, 741 F. Supp. 325, 329-30 (D.N.H. 1989); *Evitt v. University Heights Hosp.*, 727 F. Supp. 495, 497-98 (S.D. Ind. 1989).

59. *Coleman*, 771 F. Supp. 343, *overruled by Collins*, 963 F.2d 303. The court in *Urban v. King*, 783 F. Supp. 560, 562 (D. Kan. 1992), rejected the holding of *Stewart*, 731 F. Supp. 433, and refused to follow it.

60. *Tolton v. American Biodyne, Inc.*, 854 F. Supp. 505 (N.D. Ohio 1993).

61. 741 F. Supp. 325 (D.N.H. 1989).

62. Section 1395dd(d) of the statute allows for the imposition of civil monetary penalties against both the hospital and the physician responsible for the examination or transfer (depending upon the nature of the violation). 42 U.S.C. § 1395dd(d) (1994).

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

64. *Id.*

65. *Id.*

66. *Id.*

67. *Id.*

68. *Id.* at 329.

argument.⁶⁹ Because the parents were essentially alleging that Dr. Estabrook had misdiagnosed their baby and not that the transfer was motivated by economic reasons, the court granted Dr. Estabrook's motion for summary judgment on the EMTALA claim.⁷⁰ The court examined EMTALA's legislative history and held that Congress' intent in passing the Act was "to provide some assurance that patients with emergency medical conditions will be examined and treated regardless of their financial resources."⁷¹ In light of this legislative history, the court held that the interest which Congress sought to protect by enacting EMTALA was not an issue present in this case.⁷²

The second case, *Evitt v. University Heights Hospital*,⁷³ also involved a misdiagnosis. The plaintiff, Willette Faye Evitt, went to the emergency room at Indianapolis' University Heights Hospital because she was experiencing severe chest pain.⁷⁴ There, a physician on duty diagnosed costochondritis (inflammation of the chest wall), ordered her to stop taking one medication and to start taking another, and advised her to return to the hospital if the pain worsened.⁷⁵ She returned to the emergency room later that same day, after the pain had increased.⁷⁶ At that time, the physicians who examined her determined that she had suffered a heart attack.⁷⁷

Evitt's claims involved only her first visit to the emergency room.⁷⁸ She claimed that the hospital violated EMTALA at that time either by not providing her with a proper screening exam or by not stabilizing her condition and properly transferring her to another hospital.⁷⁹ In essence, she accused the hospital of incorrectly diagnosing her ailment. She did not allege that the hospital's misdiagnosis was economically motivated.⁸⁰

The United States District Court for the Southern District of Indiana examined EMTALA's legislative history and ruled that EMTALA did not ensure correct diagnoses for emergency room patients.⁸¹ The court reasoned:

69. *Id.* at 330.

70. *Id.*

71. *Id.*

72. *Id.*

73. 727 F. Supp. 495 (S.D. Ind. 1989).

74. *Id.* at 496.

75. *Id.*

76. *Id.*

77. *Id.*

78. *Id.*

79. *Id.*

80. *Id.* at 498.

81. *Id.* at 497-98.

The plaintiff's interpretation reaches beyond the purpose of the statute, which is specifically directed toward preventing prospective patients from being turned away for economic reasons Taking the plaintiff's argument to its logical conclusion would lead to the result that any patient dissatisfied with an emergency room diagnosis and release could sue the hospital under the anti-dumping provision. This construction would, in effect, make the Hospital the guarantor of the physicians' diagnosis and treatment irrespective of how reasonable such diagnosis may have appeared at the time of the patient's release We do not believe that the federal statute goes so far.⁸²

The court granted the hospital's motion for summary judgment⁸³ and held that Evitt's allegation that the diagnosis was incorrect "obviously states a mere malpractice claim which should be resolved in state court."⁸⁴ The court also ruled that allowing Evitt's suit under EMTALA would result in federal preemption of state malpractice law.⁸⁵

In the third case, *ZaiKaner v. Danaher*,⁸⁶ the daughter of yet another misdiagnosed patient brought suit against Dr. Danaher, the physician who examined Mr. ZaiKaner in an emergency room. Ms. ZaiKaner had persuaded her father to visit the emergency room after he complained of not feeling well.⁸⁷ After arriving at the emergency room, he was examined and then moved into the hospital's coronary care unit.⁸⁸ Because Ms. ZaiKaner was unsatisfied with the care, attention, and treatment that her father was receiving there, she demanded that he be transferred to another hospital.⁸⁹ Mr. ZaiKaner died in the ambulance en route to the other hospital.⁹⁰

Ms. ZaiKaner brought suit under EMTALA against the first hospital. Because it was undisputed that Mr. ZaiKaner was never denied treatment or involuntarily discharged and that his transfer was initiated at his daughter's request, no evidence of economically motivated dumping

82. *Id.*

83. *Id.* at 498.

84. *Id.*

85. *Id.* at 497. Besides the fact that this ruling was unnecessary to keep Evitt's claim out of federal court, the court's concerns about preemption proved to be unfounded. Several courts have allowed plaintiffs to bring suit under both EMTALA and state malpractice laws. *See, e.g., Collins v. DePaul Hosp.*, 963 F.2d 303, 308 (10th Cir. 1992); *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 268 (6th Cir. 1990).

86. No. 4-89-749, 1990 WL 264721 (D. Minn. Oct. 21, 1990).

87. *Id.* at *1.

88. *Id.*

89. *Id.*

90. *Id.*

existed.⁹¹ The United States District Court for the District of Minnesota, pointing to “the availability of state tort remedies for negligence claims and the clear legislative history of [EMTALA],” ruled that a plaintiff must allege economically motivated dumping in order to bring a claim under that statute.⁹² The court granted the hospital’s motion for summary judgment based on a lack of subject matter jurisdiction.⁹³

In another case, *Tolton v. American Biodyne, Inc.*,⁹⁴ the U.S. District Court for the Northern District of Ohio granted summary judgment to the defendants in an EMTALA suit based, among other reasons, on the fact that the plaintiff did not allege economically motivated dumping.⁹⁵ The court reasoned that:

this claim for improper emergency room diagnosis and treatment is a traditional medical malpractice claim not cognizable under EMTALA because it is uncontroverted that Tolton was never denied treatment due to inability to pay or lack of insurance, known as “patient dumping,” the central problem sought to be addressed by the Act.⁹⁶

This was despite the fact that the United States Court of Appeals for the Sixth Circuit had already ruled in *Cleland v. Bronson Health Care Group, Inc.* that economically motivated dumping need not be alleged in order to bring an EMTALA claim.⁹⁷ The *Tolton* court cited language from the *Cleland* decision and claimed to be following that case, yet it held the exact opposite.⁹⁸ In light of the fact that the circuit court had already ruled differently, *Tolton* is not binding law. However, the fact that the *Tolton* court claimed to be following *Cleland* when it actually held the reverse points to the level of confusion among the courts in deciding the extent of EMTALA’s coverage.

B. The Majority Rule

The courts that have ruled that EMTALA applies to everyone do not follow the same neat pattern that the limiting cases have followed. While

91. *Id.* at *3.

92. *Id.* at **2-3.

93. *Id.* at *3.

94. 854 F. Supp. 505 (N.D. Ohio 1993).

95. *Id.* at 511.

96. *Id.*

97. 917 F.2d 266, 268 (6th Cir. 1990).

98. *Tolton*, 854 F. Supp. at 511.

these courts have all ruled that the relevant portion of the statute should be read literally, their reasons for doing so have sometimes taken very different turns.

The first case to come out on the side of the debate that argues that anyone can bring a claim under EMTALA was *Deberry v. Sherman Hospital Ass'n*.⁹⁹ Ms. Deberry's daughter was complaining of a fever, rash, irritability, lethargy, and a stiff neck tilted to the left. Because of these symptoms, Ms. Deberry's brought her daughter to the defendant's emergency room.¹⁰⁰ The girl received treatment but returned two days later and was diagnosed with spinal meningitis.¹⁰¹ The disease left her deaf.¹⁰² The mother sued the hospital under both state malpractice law and EMTALA.¹⁰³

The hospital argued that EMTALA applies only when a patient is refused any treatment at all (as opposed to inadequate treatment) based on her inability to pay.¹⁰⁴ The U.S. District Court for the Northern District of Illinois rejected both prongs of this argument. It ruled that the statute should be read literally and that, because "indigency" (or any synonym for it) never appears in the statute, EMTALA should be construed to cover everyone.¹⁰⁵ Under this rule, a hospital's motive is irrelevant.¹⁰⁶ The court also ruled that a hospital does not have to refuse treatment altogether to violate the statute.¹⁰⁷ The court denied the hospital's motion to dismiss the EMTALA portion of the case.¹⁰⁸ The court also explicitly rejected the *Evitt* court's assertion that a broad interpretation of EMTALA's application would preempt state malpractice law.¹⁰⁹

Under the *Deberry* rule, a cause of action under EMTALA might be difficult, if not impossible, to distinguish from a common law malpractice complaint. One would only need to allege that he was misdiagnosed in order to claim an EMTALA violation. The United States Court of Appeals for the D.C. Circuit took a step towards distinguishing these causes of action with its decision in *Gatewood v. Washington Healthcare Corp.*¹¹⁰ The plaintiff, Mrs. Gatewood, sued after her husband was

99. 741 F. Supp. 1302 (N.D. Ill. 1990).

100. *Id.* at 1303.

101. *Id.*

102. *Id.*

103. *Id.*

104. *Id.* at 1305.

105. *Id.* at 1306.

106. *Id.*

107. *Id.*

108. *Id.* at 1307.

109. *Id.*

110. 933 F.2d 1037 (D.C. Cir. 1991).

misdiagnosed by the defendant's hospital.¹¹¹ Mr. Gatewood, who was fully insured, visited the emergency room because he was experiencing chest pain that radiated down his left arm.¹¹² Physicians there performed blood tests, a chest X-ray, and an EKG test before diagnosing Mr. Gatewood with musculoskeletal pain.¹¹³ They advised him to use a heating pad, take Tylenol, and make a follow-up appointment with his personal physician.¹¹⁴ The next morning, Mr. Gatewood died of a heart attack.¹¹⁵

Mrs. Gatewood brought actions under both EMTALA and state malpractice law.¹¹⁶ The United States District Court for the District of Columbia granted the defendant's motion to dismiss the EMTALA claim.¹¹⁷ It relied on EMTALA's legislative history and held that Mrs. Gatewood could not bring an action under the statute because her husband was fully insured.¹¹⁸ The court of appeals reversed that ruling, reasoning that, because "the Act itself draws no distinction between persons with and without insurance," it should be construed to cover everyone.¹¹⁹ However, the court affirmed the district court's decision on other grounds. It held that Mrs. Gatewood's allegation of a misdiagnosis was not actionable under EMTALA.¹²⁰ The court ruled that EMTALA does not create "a sweeping federal cause of action with respect to what are traditional state-based claims of negligence or malpractice."¹²¹ It further reasoned that EMTALA is not intended "to ensure each emergency room patient a correct diagnosis" but rather "to create a new cause of action, generally unavailable under state tort law, for what amounts to failure to treat."¹²²

The court offered guidelines for separating the two types of claims. It ruled that "what constitutes an appropriate screening is properly determined not by reference to particular outcomes, but instead by reference to a hospital's standard screening procedures."¹²³ In other words, if a hospital screens a plaintiff the same way it would screen anyone else, it does not violate EMTALA. If, despite the standard

111. *Id.* at 1039.

112. *Id.*

113. *Id.*

114. *Id.*

115. *Id.*

116. *Id.*

117. *Id.*

118. *Id.*

119. *Id.* at 1040.

120. *Id.* at 1041.

121. *Id.*

122. *Id.*

123. *Id.*

screening procedure, a physician makes a mistake in diagnosis or treatment, the plaintiff must look to state malpractice laws to determine whether the physician acted negligently.

The United States Court of Appeals for the Tenth Circuit followed the same reasoning in *Collins v. DePaul Hospital*.¹²⁴ The plaintiff, Mr. Collins, was involved in a near-fatal all-terrain vehicle accident.¹²⁵ He sustained serious injuries, including a fractured skull, a collapsed lung, a fractured hip, and numerous abrasions and lacerations.¹²⁶ After he was taken to the hospital, the emergency room staff did not take an X-ray of his hip and, because they were unaware that it was fractured, did not treat it.¹²⁷ Mr. Collins was unconscious when brought to the emergency room and remained so for more than two weeks.¹²⁸ When he finally woke up and began to move around, he complained of pain in his hip.¹²⁹ By that time, it was too late to treat the fracture at DePaul Hospital. Mr. Collins was referred to a hospital in Colorado, where a hip fusion was performed.¹³⁰ One of Mr. Collins' legs was made permanently shorter than the other during the hip fusion operation.¹³¹

Mr. Collins brought suit under both state malpractice law and EMTALA.¹³² His EMTALA claim was based on a theory that the hospital, in failing to X-ray his hip, violated EMTALA by providing an inadequate screening exam.¹³³ The district court granted the hospital's motion for summary judgment.¹³⁴ The court of appeals affirmed. Although the court held that Mr. Collins, who could and did pay his hospital bills,¹³⁵ was eligible to bring an EMTALA action, it followed the reasoning set forth in *Gatewood* and held that Mr. Collins' claim was a malpractice claim, not an EMTALA claim.¹³⁶ The hospital screened Mr. Collins, determined that an emergency medical condition did exist, and placed him in the intensive care unit, where it treated him for twenty-

124. 963 F.2d 303 (10th Cir. 1992).

125. *Id.* at 306.

126. *Id.* at 304.

127. *Id.*

128. *Id.* at 306.

129. *Id.*

130. *Id.*

131. *Id.*

132. *Id.* at 308. He lost in the malpractice case. *Id.* at 304 n.2.

133. *Id.* at 306.

134. *Id.* at 304.

135. *Id.*

136. *Id.* at 307.

six days.¹³⁷ While the hospital did miss diagnosing the hip fracture, it did not dump Mr. Collins.¹³⁸

In *Brooker v. Desert Hospital Corp.*, the United States Court of Appeals for the Ninth Circuit followed the reasoning from *Collins* and *Gatewood* and found that the defendant had complied with EMTALA's requirements.¹³⁹ The plaintiff, Ms. Brooker, visited the defendant hospital's emergency room because she was experiencing chest pains.¹⁴⁰ She was diagnosed with a probable heart attack, and the attending physician recommended emergency surgery.¹⁴¹ The hospital's cardiac surgeon was unavailable to perform the surgery, so the attending physician recommended transferring Ms. Brooker to another hospital.¹⁴² Ms. Brooker consented to the transfer.¹⁴³ She claimed in her suit that an EKG performed at the second hospital showed that she suffered yet another heart attack as a result of the transfer.¹⁴⁴ Her EMTALA claim rested upon an alleged failure to stabilize her emergency medical condition prior to the transfer.¹⁴⁵

The hospital argued that there could be no EMTALA claim unless the patient is indigent or uninsured.¹⁴⁶ The court, citing *Gatewood* and *Cleland*, ruled that EMTALA's coverage is not so limited.¹⁴⁷ However, the court affirmed the district court's holding that Ms. Brooker had not proven that the hospital violated EMTALA's stabilization requirement.¹⁴⁸

The rules from *Gatewood*, *Collins*, and *Brooker* can be explained fairly simply: a hospital must use the same screening procedure for every patient who seeks emergency care. If an emergency medical condition exists, and the hospital detects it and proceeds to treat or stabilize it before transferring a patient, the hospital has complied with EMTALA's requirements. If an emergency medical condition exists, and the hospital uses a substandard screening procedure that prevents it from detecting the condition, the hospital has violated EMTALA. If the hospital uses its standard screening procedure but nevertheless fails to detect the condition,

137. *Id.*

138. *Id.*

139. 947 F.2d 412, 415 (9th Cir. 1991).

140. *Id.* at 413.

141. *Id.*

142. *Id.* at 413-14.

143. *Id.* at 414.

144. *Id.*

145. *Id.* at 415.

146. *Id.* at 414.

147. *Id.*

148. *Id.* at 415.

it has complied with EMTALA, and state malpractice law should decide the case.

Put into practice, however, the rule might not always be so simple to apply. A potential problem with the rule could be determining what constitutes an adequate or standard screening. Another problem is overlap with state malpractice law. Both share the same goal: to decide whether treatment has fallen below a certain standard. With no need to prove an economic motive, an EMTALA action is indistinguishable from a malpractice claim.

In *Cleland v. Bronson Health Care Group, Inc.*,¹⁴⁹ the United States Court of Appeals for the Sixth Circuit attempted to distinguish EMTALA claims from malpractice claims by allowing a broad examination of a defendant's motive. The plaintiffs in *Cleland* brought their adolescent son to the defendant's hospital because he was experiencing cramps and vomiting.¹⁵⁰ A physician in the emergency room diagnosed influenza and discharged him.¹⁵¹ This diagnosis was incorrect.¹⁵² In truth, the boy was suffering from intussusception (a condition where the intestine slides into itself, like a telescope) and died the next day.¹⁵³ His parents sued the hospital under both EMTALA and state malpractice law.¹⁵⁴ Because plaintiffs alleged no economically motivated dumping, the district court dismissed their complaint under the theory that EMTALA applies only to indigent and uninsured patients.¹⁵⁵

The court of appeals, however, ruled that the statute should be read literally, unless doing so would lead to an absurd result.¹⁵⁶ The court ruled that EMTALA does not apply only to the indigent and uninsured.¹⁵⁷ The court also ruled that courts should not use a malpractice standard of care to determine the appropriateness of the screening a plaintiff received; instead, courts should examine the hospital's *motives* for screening the patient the way it did.¹⁵⁸ If the hospital screened the patient the same way it would have screened any other patient, then the screening was "appropriate" within the meaning of the statute.¹⁵⁹ The court claimed that this was not "a backdoor means

149. 917 F.2d 266 (6th Cir. 1990).

150. *Id.* at 268.

151. *Id.*

152. *Id.*

153. *Id.*

154. *Id.*

155. *Id.*

156. *Id.* at 270.

157. *Id.* at 268.

158. *Id.* at 272.

159. *Id.*

of limiting coverage to the indigent or uninsured” because non-financial motives could cause a hospital to provide substandard care, such as racism, sexism, or prejudice based on the patient’s drunkenness or HIV-positive status.¹⁶⁰ Any improper motive, whether monetary or not, would be enough to violate EMTALA under *Cleland*. However, proving a non-economic motive could be quite difficult. This is precisely the reason that the United States Court of Appeals for the Fourth Circuit explicitly rejected the *Cleland* rule in *Power v. Arlington Hospital Ass’n*.¹⁶¹

C. *The Case of Baby K, A Recent Majority Rule Decision*

1. INTRODUCTION

In the case of *In re Baby K*,¹⁶² the United States Court of Appeals for the Fourth Circuit followed the majority rule and used EMTALA to settle a dispute between a hospital and an insured patient’s mother and, in doing so, discounted the hospital’s legitimate medical and ethical expertise. The patient was born with anencephaly, a fatal absence of most or all of the brain. Her mother, citing religious beliefs, insisted that the hospital resuscitate the baby every time she stopped breathing on her own. The court held that EMTALA required the hospital to provide ventilator treatment,¹⁶³ despite the fact that it is universally considered medically and ethically inappropriate to resuscitate anencephalics.

This decision poignantly highlights the problem with the majority rule that allows the fully insured to bring suit under EMTALA. Whereas the earlier majority decisions were arguably *dicta* in that no EMTALA violations were actually found, the hospital in *Baby K* was warned by the court that its planned course of action (to refuse to resuscitate Baby K) would violate EMTALA. Here, the Fourth Circuit used EMTALA to override a legitimate medical and ethical decision, despite the fact that EMTALA was meant to override financial decisions only.

160. *Id.*

161. 42 F.3d 851, 857 (4th Cir. 1994).

162. 16 F.3d 590 (4th Cir.), *cert. denied*, 115 S. Ct. 91 (1994).

163. *Id.* at 592.

2. SOME NOTES ON ANENCEPHALY

Anencephaly is a fatal birth defect. It is the absence of most or all of the brain, as well as much of the skull and scalp.¹⁶⁴ The brainstem, which regulates the most basic bodily functions (for example, breathing), may be anywhere from relatively normal to totally absent.¹⁶⁵ No medical treatment can improve the condition of anencephalic babies: they are born dying, if they are born alive at all.¹⁶⁶

Anencephaly can be detected through amniocentesis and via ultrasound. Amniocentesis detects a type of alpha-fetoprotein in a mother's amniotic fluid if her fetus is anencephalic.¹⁶⁷ Ultrasound reveals the irregularity of an anencephalic fetus' head.¹⁶⁸ Because of the danger present in delivering a baby whose skull is imperfect and because anencephalic babies are certain to die soon after birth (if they are even born alive), most anencephalics detected *in utero* are aborted.¹⁶⁹ Anencephaly is one of the few cases in which third trimester abortions are encouraged by physicians.¹⁷⁰ Of those not aborted, it is estimated that from fifty to ninety-five percent are stillborn.¹⁷¹ Those born alive do not live very long, usually dying within a matter of hours or days.¹⁷² The cause of death varies from case to case but generally involves one or more of the following: injuries to the head and nerve tissue sustained during birth (because of the open skull), infection, poor temperature regulation, or organ failure (one-third to one-half of anencephalics are born with gross malformations of at least one other organ system).¹⁷³

164. David A. Stumpf et al., *The Infant with Anencephaly*, 322 NEW ENG. J. MED. 669, 669 (1990).

165. D. Alan Shewmon, *Anencephaly: Selected Medical Aspects*, HASTINGS CENTER REP., Nov. 1988, at 11.

166. PAUL RAMSEY, *ETHICS AT THE EDGES OF LIFE: MEDICAL AND LEGAL INTERSECTIONS* 213 (1978); see also Alexander M. Capron, *Anencephalic Donors: Separate the Dead from the Dying*, HASTINGS CENTER REP., Feb. 1987, at 5.

167. M.A. Ferguson-Smith, *The Reduction of Anencephalic and Spina Bifida Births by Maternal Serum Alpha-fetoprotein Screening*, 39 BRIT. MED. BULL. 365, 365 (1983).

168. *Id.* at 367.

169. One study found the rate of abortion to be 95%. Shewmon, *supra* note 165, at 12.

170. Frank A. Chervenak et al., *When Is Termination of Pregnancy During the Third Trimester Morally Justifiable?*, 310 NEW ENG. J. MED. 501, 501 (1984).

171. Shewmon, *supra* note 165, at 13.

172. P.A. Baird & A.D. Sadovnick, *Survival in Infants with Anencephaly*, 23 CLINICAL PEDIATRICS 268, 270 (1984).

173. Norman Fost, *Organs from Anencephalic Infants: An Idea Whose Time Has Not Yet Come*, HASTINGS CENTER REP., Nov. 1988, at 6; Shewmon, *supra* note 165, at 15.

The standard treatment given to anencephalics consists of warmth, hydration, and nutrition.¹⁷⁴ Physicians and bioethicists agree that prolonging an anencephalic's life is medically inappropriate and unethical.¹⁷⁵ This is the main reason for the controversy surrounding the use of anencephalics as organ donors, an experimental practice which began in the 1960's, died out quickly, and was revived again during the 1980's.¹⁷⁶ Ethically speaking, organs cannot be taken from a person who is not completely brain-dead.¹⁷⁷ Because many anencephalics' brain stems function for a while after birth, these babies cannot be used as organ donors until they die of natural causes. If they are allowed to die a natural death, their organs usually suffer damage by the time the babies reach full cardio-respiratory arrest.¹⁷⁸ In order to facilitate transplants from anencephalic babies, some physicians have proposed keeping the babies on ventilators to keep their organs intact until they can be harvested.¹⁷⁹ Their proposals, along with the very notion that

174. DECISION MAKING AND THE DEFECTIVE NEWBORN 599 (Chester A. Swinyard ed., 1978); ROBERT F. WEIR, SELECTIVE NONTREATMENT OF HANDICAPPED NEWBORNS: MORAL DILEMMAS IN NEONATAL MEDICINE 138 (1984).

175. Even Dr. C. Everett Koop, former Surgeon General, pediatric surgeon, and well-known proponent of aggressive measures to save defective babies, believes that anencephalics should not be treated:

Medicine may *never* have all the solutions to all the problems that occur at birth. I personally foresee no medical solution to a cephalodymus or an anencephalic child In these cases the prognosis is an early and merciful death by natural causes. There are no so-called "heroic measures" possible, and intervention would merely prolong the patient's process of dying. Some of nature's errors are extraordinary and frightening . . . but nature also has the kindness to take them away. For such infants, neither medicine nor law can be of any help. And neither medicine nor law should prolong these infants' process of dying.

Treatment of Infants Born with Handicapping Conditions: Hearings Before the Subcomm. on Select Education of the House Comm. on Education and Labor, 97th Cong., 2d Sess. 5 (1982) (statement of C. Everett Koop), quoted in REM B. EDWARDS & GLENN C. GRABER, BIOETHICS 511 (1988); see also RAMSEY, supra note 166, at 212-24; Chervenak et al., supra note 170, at 502; Committee on Bioethics, American Academy of Pediatrics, Treatment of Critically Ill Newborns, 72 PEDIATRICS 565, 565 (1983).

176. James W. Walters & Stephen Ashwal, *Organ Prolongation in Anencephalic Infants: Ethical & Medical Issues*, HASTINGS CENTER REP., Nov. 1988, at 19-20.

177. Michael R. Harrison, *The Anencephalic Newborn as Organ Donor*, HASTINGS CENTER REP., Apr. 1986, at 21. At least one case has gone to trial on this issue. In that case, the parents of an anencephalic baby wanted the court to declare their baby dead so that they could donate her organs. The court refused their request. *In re T.A.C.P.*, 609 So. 2d 588, 595 (Fla. 1992).

178. *T.A.C.P.*, 609 So. 2d at 595; George J. Annas, *From Canada with Love: Anencephalic Newborns as Organ Donors?*, HASTINGS CENTER REP., Dec. 1987, at 36.

179. This proposal was actually carried out in at least one case. Annas, *supra* note 178, at 36.

anencephalics should be used as organ donors, have been swiftly rejected by bioethicists and the medical profession because of the universally held belief that ventilator support for anencephalics is medically and ethically inappropriate.¹⁸⁰

3. THE FACTS OF THE CASE

Baby K was diagnosed with anencephaly before birth.¹⁸¹ Her mother, Contrenia Harrell, belonged to the Kaiser Permanente Health Maintenance Organization, which covered the cost of Baby K's medical care.¹⁸² Despite recommendations from her obstetrician and a neonatologist that she abort the fetus, Ms. Harrell insisted on carrying the baby to term.¹⁸³ Baby K was delivered via cesarean section on October 13, 1992, at Fairfax Hospital in Falls Church, Virginia.¹⁸⁴ Because the baby was experiencing difficulty breathing at birth, she was placed on mechanical ventilation in order to give the hospital time to explain her prognosis to her mother.¹⁸⁵

Baby K's physicians explained to Ms. Harrell that no treatment was available for the condition, that ventilator support served no therapeutic or palliative purpose, and that such treatment was considered medically unnecessary and inappropriate. Despite these statements, when the physicians attempted to persuade Ms. Harrell to allow them to place a "Do Not Resuscitate" order on Baby K's chart, she refused.¹⁸⁶ She based her refusal on her religious beliefs. She realized that physicians could not make her daughter better but believed that God would work a miracle to heal her¹⁸⁷ and allow her to grow up to be just like other

180. *Id.* at 37; see also *Fost*, *supra* note 173.

181. *In re Baby K*, 832 F. Supp. 1022, 1024-25 (E.D. Va. 1993), *aff'd*, 16 F.3d 590 (4th Cir.), *cert. denied*, 115 S. Ct. 91 (1994).

182. Bill Miller, *Baby K's Mother Gives Her the Prayer That Many Deny She Has*, WASH. POST, Oct. 7, 1994, at A1.

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

184. *Id.* at 1024-25.

185. Mechanical ventilation is considered medically and ethically inappropriate for anencephalics, who are seen as receiving no benefit from such assistance, other than prolonged death. *Id.* at 1025; see also Chervenak et al., *supra* note 170, at 502; Shewmon, *supra* note 165, at 15. At least one commentator has suggested that the hospital should have simply allowed Baby K to die at birth. By placing her on mechanical ventilation, the hospital gave her mother the impression that it was willing to provide this inappropriate treatment. George J. Annas, *Asking the Courts to Set the Standard of Emergency Care: The Case of Baby K*, 330 NEW ENG. J. MED. 1542, 1543 (1994).

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

187. *Id.* During a television interview, she explained, "I'm also believing that God is going to heal Stephanie. If the doctors can't do anything to fix her condition, I believe that God can." *Today Show* (NBC television broadcast, Nov. 14, 1994).

children.¹⁸⁸ She believed that "God, and not other humans," should decide the moment of her daughter's death.¹⁸⁹

After Ms. Harrell refused to allow the "Do Not Resuscitate" order, the baby's physicians sought guidance from the hospital's ethics committee.¹⁹⁰ An ethics subcommittee composed of a family practitioner, a psychiatrist, and a minister recommended that Baby K's ventilator treatment should end.¹⁹¹ They recommended that, should Ms. Harrell refuse to consent, the hospital should seek permission through the legal system.¹⁹²

Before pursuing legal action, the hospital decided to transfer the baby to another facility.¹⁹³ The only other area hospitals with pediatric intensive care units, Children's Hospital and Georgetown University Medical Center, both refused to accept Baby K.¹⁹⁴ The hospital eventually found a nursing home willing to accept her.¹⁹⁵ Ms. Harrell agreed to the transfer once the hospital promised to readmit Baby K for emergency treatment should she stop breathing on her own again.¹⁹⁶ She was transferred to the nursing home on November 30, 1992 but again experienced respiratory difficulties on January 15, 1993, and was returned

188. Carol J. Castaneda, *Baby K—Now Stephanie—Turns 2*, USA TODAY, Oct. 13, 1994, at 3A.

189. *Baby K*, 832 F. Supp. at 1025-26. Although Ms. Harrell has every right to her religious beliefs, this argument is illogical. Humans put her baby on a ventilator. Humans operate that ventilator. This use of man-made machinery to artificially support the baby's life arguably has nothing to do with God's will. When confronted with this fact during a television interview, she replied, "I can't accept that [Baby K's death] is his will." *Dateline NBC* (NBC television broadcast, Mar. 14, 1995). Ms. Harrell has also expressed a belief that the hospital's attempt to refuse treatment was motivated by financial concerns. Miller, *supra* note 182, at A1. This makes no sense, either. The hospital was reimbursed in full by Ms. Harrell's HMO and quite probably made a profit. And by involving itself in this legal battle, it was certain to lose money.

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

191. *Id.*

192. *Id.* at 1025-26. Bioethicist George Annas argues that this move was a mistake. He suggests that the hospital should have simply refused to perform the next resuscitation, a move that would not have violated the established standard of care for anencephalics. Annas, *supra* note 185, at 1543.

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

194. *In re Baby K*, 16 F.3d 590, 594 n.5 (4th Cir.), *cert. denied*, 115 S. Ct. 91 (1994); Brief for Appellants at 6, *Baby K* (No. 93-1899(L)). Interestingly enough, the only expert to testify that hospitals do have a duty to resuscitate anencephalics was an ethicist from Georgetown University, one of the hospitals that refused to admit Baby K for care. *Id.* at 6 n.1.

195. The nursing home costs, which totalled almost half a million dollars as of November, 1994, are being paid by Ms. Harrell's HMO and by Medicaid. Miller, *supra* note 182, at A1; *Today Show* (NBC television broadcast, Nov. 14, 1994).

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

to the hospital.¹⁹⁷ The hospital tried once more to persuade Ms. Harrell to discontinue the ventilator treatment, but again she refused.¹⁹⁸ Baby K remained on a ventilator until February 12 and then returned to the nursing home.¹⁹⁹ Baby K experienced breathing difficulties once more on March 3 and returned to the hospital.²⁰⁰ During that visit, a breathing tube was surgically implanted into her trachea so that she would not need to be intubated every time she returned to the hospital.²⁰¹ She was transferred to the nursing home again on April 13.²⁰²

The hospital proceeded to file for declaratory and injunctive relief in the U.S. District Court for the Eastern District of Virginia.²⁰³ The hospital sought relief under EMTALA and an array of other statutes: the Rehabilitation Act of 1973,²⁰⁴ the Americans with Disabilities Act of 1990,²⁰⁵ the Child Abuse Amendments of 1984,²⁰⁶ and Virginia's Medical Malpractice Act.²⁰⁷ The hospital also requested that a guardian *ad litem* be appointed for the baby.²⁰⁸ Both the guardian *ad litem* and the baby's father, Mr. K,²⁰⁹ agreed with the hospital's position in the case.²¹⁰

4. THE DISTRICT COURT'S DECISION

The district court characterized Baby K's respiratory distress as an emergency medical condition covered by EMTALA and held that the hospital would be acting in violation of EMTALA if it were to refuse to resuscitate Baby K.²¹¹ While the hospital had argued that prolonging

197. *Id.*

198. *Id.*

199. *Id.*

200. *Id.* at 1025-26.

201. *Id.*

202. *Id.* at 1026. Baby K finally died in early April, 1995. Marylou Tousignant & Bill Miller, *Death of "Baby K" Leaves a Legacy of Legal Precedents*, WASH. POST, Apr. 7, 1995, at B3.

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

204. 29 U.S.C. § 794 (1994).

205. 42 U.S.C. §§ 12101-12213 (1994).

206. 42 U.S.C. §§ 5101-5119c (1994).

207. VA. CODE ANN. §§ 8.01-581.1 (Michie 1994).

208. *In re Baby K*, 832 F. Supp. 1022, 1026 (E.D. Va. 1993).

209. Mr. K and Ms. Harrell have never been married. *Id.* at 1025. Mr. K has explained his position: "What chance does this child have to live or grow up or have any fun in life? Lying on her back, 365 days a year, that's no life. She's just a vegetable. How can anybody let the child she loves be a vegetable?" Miller, *supra* note 182, at A1.

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

211. *Id.* at 1026-27.

the life of an anencephalic is medically futile and inhumane,²¹² the court ruled that this matter is irrelevant, given that the statute makes no exception for futile or inhumane treatment.²¹³ The court further reasoned that, following the hospital's logic, hospitals should refuse to treat people with AIDS or cancer who are injured in an accident because they are just going to die someday, anyway.²¹⁴

5. THE FOURTH CIRCUIT COURT OF APPEALS' DECISION

The hospital, Mr. K., and the guardian *ad litem* appealed the decision to the United States Court of Appeals for the Fourth Circuit. The American Academy of Pediatrics and the Society of Critical Care Medicine filed amicus briefs in support of the appellants' position. The Department for Rights of Virginians with Disabilities filed an amicus brief in support of Ms. Harrell.²¹⁵ The appellants appealed all the district court's holdings, but the court of appeals held that it need look no further

212. The hospital's characterization of ventilator treatment for anencephalics as futile and inhumane comports with medical standards. *See, e.g.,* Annas, *supra* note 178, at 37; Chervenak et al., *supra* note 170, at 502; R.A. McCormick, *To Save or Let Die*, 229 JAMA 172 (1974).

213. *Baby K*, 832 F. Supp. at 1027.

214. *Id.* The court also held that it could not decide whether the Child Abuse Act would prohibit refusal to treat unless the Virginia Child Protective Services were to join as a party to the case. *Id.* at 1029. In fact, however, the Department of Health and Human Services, in its regulations promulgated to administer the Child Abuse Amendments of 1984, specifically declared that medical treatment beyond nutrition, hydration, and medication should not be given to chronically and irreversibly comatose infants like Baby K. 45 C.F.R. § 1340.15(b)(2) (1994). The court also held that the hospital was prohibited from refusing to treat Baby K based on her handicapped status by the Rehabilitation Act and the Americans with Disabilities Act. *Baby K*, 832 F. Supp. at 1028-29. The court declined to decide whether Virginia's malpractice statutes or common law would prohibit refusal to treat, citing the fact that neither had established a standard of care for anencephalics. *Id.* at 1029-30.

The court also held that Ms. Harrell's right to bring up her child as she saw fit was protected by the Fourteenth Amendment's Due Process Clause. *Id.* at 1030. The court further held that the Due Process Clause extended to a parent's right to make medical treatment decisions for her child. *Id.* In light of the fact that Mr. K sided with the hospital, the court held that in a dispute between two parents regarding the termination of life support, the court must decide in favor of the parent who wants to continue life support. *Id.* (citing *In re Janc Doe*, 418 S.E.2d 3 (Ga. 1992)). The court also held that the guardian *ad litem*'s opinion was irrelevant. *Id.* at 1031 n.2. In addition, the court held that the Fifth and Fourteenth Amendments and the Virginia Constitution all guaranteed Baby K's right to life. *Id.* The court also held that the First Amendment's Free Exercise Clause protected Harrell's right to her religious convictions. *Id.*

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

than EMTALA, as that statute's requirements alone were sufficient to impose a duty on the hospital to resuscitate Baby K.²¹⁶ While the appellants did not argue that EMTALA should not apply to Baby K due to her insured status, the court did speak to this point. The court cited *Brooker, Gatewood, Cleland, and Baber v. Hospital Corp. of America*²¹⁷ as authority for the proposition that EMTALA applies to *all* patients who have an emergency medical condition.²¹⁸

The appellants offered four arguments. Relying on *Baber* and *Brooks v. Maryland General Hospital*,²¹⁹ they first argued that EMTALA merely requires hospitals to provide the same treatment to patients in the same medical condition.²²⁰ Under this theory, the hospital would not violate EMTALA if it were to provide Baby K with the same treatment it provides to all other anencephalics. The court rejected this argument, reasoning that the language referred to in *Baber* and *Brooks* concerned EMTALA's screening requirement, not its stabilization requirement.²²¹ Contrary to standard medical opinion, the court held that Baby K's emergency medical condition was respiratory distress, not anencephaly, and that EMTALA requires the hospital to provide stabilizing treatment (that is, resuscitation) to anyone who has stopped breathing on her own.²²²

The appellants also argued that Congress could not have intended for EMTALA to require physicians to provide treatment outside the prevailing standard of medical care.²²³ Under this argument, the hospital would not be required to provide ventilator support to Baby K, as that treatment falls outside the prevailing standard of medical care for anencephalics. The court rejected this argument, reasoning that the plain language of the Act makes no exceptions for treatment outside the prevailing standard of medical care.²²⁴ The court reiterated EMTALA's language that requires hospitals to provide stabilizing treatment to *any* individual who presents an emergency medical condition.²²⁵

The appellants further argued that an interpretation of EMTALA that requires physicians to provide ventilator support to anencephalics against

216. *Id.* at 592.

217. 977 F.2d 872, 880 (4th Cir. 1992). In *Baber*, the Fourth Circuit did not explicitly address the issue of EMTALA's application.

218. *Baby K*, 16 F.3d at 593-94.

219. 996 F.2d 708 (4th Cir. 1993).

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

221. *Id.*

222. *Id.* at 596.

223. *Id.* at 595.

224. *Id.* at 596.

225. *Id.*

their will ignores a Virginia law²²⁶ that allows physicians to refuse to provide treatment they consider medically or ethically inappropriate.²²⁷ The court rejected this argument as well, reasoning that EMTALA's plain language makes no exceptions for treatment that physicians consider to be medically or ethically inappropriate.²²⁸ The court held that because EMTALA preempts state and local laws that conflict with its purpose,²²⁹ the Virginia law was preempted.²³⁰ The appellants also argued that EMTALA's requirement of stabilization applies only when a hospital is going to transfer a patient.²³¹ This argument ignored some of EMTALA's language,²³² and the court rightly rejected it.²³³

The court concluded its opinion with a statement that deciding the moral or ethical propriety of providing treatment of this kind to anencephalics is beyond the limits of the court's judicial function.²³⁴ The court further reasoned that it is bound to follow the plain language of EMTALA and any expressed congressional intent, and neither of those provided exceptions for anencephalics.²³⁵ The court then compared Baby K's anencephaly to the condition of comatose patients, people with lung cancer, and people suffering from muscular dystrophy. Those people all might require repeated sessions of respiratory assistance, but they are not denied that treatment even though they will ultimately die as a result of their conditions.²³⁶

Senior Circuit Judge Sprouse filed a dissenting opinion. He reasoned that Congress could not have intended for EMTALA to supersede physicians' sensitive decision-making process at the end of a patient's life.²³⁷ He also reasoned that EMTALA should not apply in Baby K's case for two other reasons. First of all, there was no allegation of true patient dumping.²³⁸ Second, Baby K was not the type of emergency patient contemplated by the statute.²³⁹ Judge Sprouse held that anencephaly, and not respiratory distress, was Baby K's relevant

226. VA. CODE ANN. § 54.1-2990 (Michie Supp. 1993).

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

228. *Id.* at 597.

229. 42 U.S.C. § 1395dd(f) (1994).

230. *Baby K*, 16 F.3d at 597.

231. *Id.* at 595.

232. 42 U.S.C. § 1395dd(b)(1)(a) (1994) requires hospitals to stabilize an emergency medical condition (or to provide for treatment of a pregnant woman's labor).

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

234. *Id.* at 598.

235. *Id.*

236. *Id.*

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

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

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

condition.²⁴⁰ Respiratory distress is one of the conditions or symptoms that accompany this birth defect. Her symptoms should have been viewed as being found along a continuum rather than as being a series of discrete emergency medical conditions to be considered in isolation.²⁴¹ Because there was nothing physicians could do to improve Baby K's condition, she represented a special class of patients whose care should be decided not by EMTALA, which makes no exceptions for extraordinary circumstances, but rather by state malpractice law, which is better equipped to answer such complicated questions.²⁴² Judge Sprouse concluded by opining that the hospital's refusal to stabilize Baby K's respiratory distress should not have been considered a violation of EMTALA.²⁴³

IV. WHY THE MAJORITY RULE IS UNWISE

A. Congress and the Courts Should Not Be Making Medical Decisions

In *Baby K*, the Fourth Circuit's literal reading of EMTALA's language led to an inarguably absurd result. The court's arguments rest on its decision to characterize Baby K's respiratory distress, rather than her anencephaly, as her emergency medical condition. The court compared anencephaly to coma, lung cancer, and muscular dystrophy, all conditions which can lead to respiratory distress and to eventual death.²⁴⁴ This comparison is far more valid than the district court's analogy to people with AIDS or cancer who are injured in an accident and seek emergency medical care.²⁴⁵ The cancer or AIDS did not cause the accidental injury, whereas Baby K's anencephaly did cause her respiratory distress. Furthermore, when an accident victim receives prompt emergency care, he generally will recover from his condition. If he never gets into another accident, he will not need emergency care for that reason again. Baby K, on the other hand, would undoubtedly experience repeated episodes of respiratory distress. They were caused by her anencephaly, from which she was certain to suffer as long as she lived; resuscitation could not make her anencephaly go away. In forcing the hospital to resuscitate Baby K, the court did nothing but prolong her inevitable death.

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

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

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

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

244. 16 F.3d at 598.

245. 832 F. Supp. at 1027.

The appellate court's analogy to a person in a coma or plagued with cancer or muscular dystrophy is more appropriate.²⁴⁶ When such a person experiences respiratory distress, it is caused by her disease or condition, just as Baby K's respiratory distress was caused by her anencephaly. Similarly, a cancer patient's respiratory distress may present an end-of-life decision. Treatment decisions in these situations are complicated, delicate matters that often depend upon the accepted standard of care for the particular stage of the illness involved. Under *Baby K*'s literal interpretation of EMTALA, hospitals are required to resuscitate every patient who stops breathing on her own, no matter how futile or inhumane such aggressive treatment may be in some cases. Aggressive treatment in every case, no matter how advanced the disease, cannot be the result that Congress intended when it passed the act. Such a result leaves no room for professional medical judgment and defies the economic realities of the health care system.²⁴⁷ There are only so many beds available and so many dollars to be spent. For this reason and the very personal nature of each case, each decision should be made separately.

When conflicts arise between families and physicians, malpractice law should decide these cases. Malpractice law is much more refined and more capable of handling these complicated decisions than EMTALA. While the result of *Baby K* under malpractice law would be impossible to predict with absolute certainty, it is likely that the hospital would have prevailed. The heart of a malpractice suit is the question of whether the physician acted in conformity with the common practice within his profession.²⁴⁸ The standard treatment for anencephalics is warmth, hydration, and nutrition.²⁴⁹ Because the standard treatment does not include such aggressive therapies as ventilator support, it is not likely that the hospital would have been found negligent had it refused to resuscitate Baby K.

The hospital would also have prevailed if the court had interpreted EMTALA using either of the two minority rules. Under the indigent-and-

246. 16 F.3d at 598.

247. During a television interview, a spokesman for the American Academy of Pediatrics said of the *Baby K* case: "We're spending thousands and thousands of dollars with no hope of benefiting the patient. The question here is the extent to which an individual's religious views or other personal beliefs can command important social resources." *Today Show* (NBC television broadcast, Nov. 14, 1994). The reported total cost of Baby K's medical care as of November 1994 was \$247,872, and the cost of her nursing home care was about \$500,000. *Id.*

248. *Robbins v. Footer*, 553 F.2d 123, 126 (D.C. Cir. 1977).

249. See *supra* notes 171-77 and accompanying text.

uninsured-only rule,²⁵⁰ this case would not have been decided by EMTALA, as Baby K's medical care was paid for by her mother's HMO. Under the *Cleland* rule,²⁵¹ the hospital would have prevailed because it did not have an improper motive in wanting to refuse Baby K aggressive treatment. The hospital did not want to refuse treatment based upon Baby K's race, for example; it wanted to refuse treatment in order to comport with standard medical practice and ethical guidelines.

The hospital would also have prevailed if the court had followed the approach it later used in *Power v. Arlington Hospital Ass'n*,²⁵² when it adopted the following test:

We believe the best approach, and the standard we now adopt, is to allow a hospital, after a plaintiff makes a threshold showing of differential treatment, to offer evidence rebutting that showing either by demonstrating that the patient was accorded the same level of treatment that all other patients receive, or that a test or procedure was not given because the physician did not believe that the test was reasonable or necessary under the particular circumstances of that patient. If the hospital offers such rebuttal evidence, fairness dictates that the plaintiff should be allowed to challenge the medical judgment of the physicians involved through her own expert medical testimony.

250. *Urban v. King*, 783 F. Supp. 560, 562 (D. Kan. 1992); *Coleman v. McCurtain Memorial Medical Management, Inc.*, 771 F. Supp. 343, 347 (E.D. Okla. 1991), *overruled by* *Collins v. DePaul Hosp.*, 963 F.2d 303, 308 (10th Cir. 1992); *ZaiKaner v. Danaher*, No. 4-89-749, 1990 WL 264721, at *3 (D. Minn. Oct. 21, 1990); *Stewart v. Myrick*, 731 F. Supp. 433, 436 (D. Kan. 1990); *Nichols v. Estabrook*, 741 F. Supp. 325, 329-30 (D.N.H. 1989); *Evitt v. University Heights Hosp.*, 727 F. Supp. 495, 497-98 (S.D. Ind. 1989).

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

252. 42 F.3d 851 (4th Cir. 1994). The plaintiff in *Power*, uninsured and unemployed, was misdiagnosed and, as a result, lost both legs beneath the knee as well as the sight in one eye and also suffered permanent lung damage. *Id.* at 855. The court ruled that the hospital violated EMTALA by inadequately screening Ms. Power. *Id.* at 859. The hospital argued that the *Cleland* rule, which requires an improper motive on the hospital's part, should apply. *Cleland*, 917 F.2d at 272. The court rejected this argument, explaining that "having to prove the existence of an improper motive . . . would make a civil EMTALA claim virtually impossible. We do not believe that proving the inner thoughts and prejudices of attending hospital personnel is required in order to recover under EMTALA." *Power*, 42 F.3d at 858. The approach adopted in *Power*, which takes legitimate medical judgment into account, was perhaps inspired by the uproar over the *Baby K* decision.

Because this test allows for legitimate medical judgment, the hospital would certainly have prevailed. Instead, the court's decision to follow the majority rule led to the absurd result that now stands.

In the case of *Baby K*, Congress and federal judges used EMTALA to take medical decision-making out of the hands of physicians by overriding a legitimate medical and ethical decision, something Congress surely never intended to do. The United States District Court for the Eastern District of Virginia and the United States Court of Appeals for the Fourth Circuit both held that a literal reading of EMTALA required Fairfax Hospital to provide medical treatment that is considered medically and ethically inappropriate by the medical profession. According to an American Academy of Pediatrics attorney, this is the first case in which the courts have ordered physicians to render medical care under protest.²⁵³ This is a very dangerous precedent, and similar results could be seen again if EMTALA is not amended. Congress could not reasonably have intended to force physicians to provide treatment under protest when their treatment decision was motivated by legitimate medical judgment. Physicians are intensively and specially trained to make medical decisions; congressional representatives and judges are not.

In *Baby K*, the district court ruled that EMTALA makes no exceptions for futile or inhumane treatment.²⁵⁴ The court of appeals ruled that EMTALA makes no exceptions for care that is outside the prevailing standard of medical care or that is medically and ethically inappropriate.²⁵⁵ Congress could not have intended to force physicians to provide futile or inhumane treatment, medically and ethically inappropriate treatment, or treatment that falls outside the prevailing standard of care. Nor could Congress have intended a precedent that could force hospitals to provide dying patients with every measure of aggressive treatment, no matter how dismal their prognoses.

In enacting EMTALA, Congress wanted to prevent dumping,²⁵⁶ not to override legitimate medical decisions. Even if it had wanted to enter the decision-making arena, it is difficult to believe that it would have created a tool for the job as vague as EMTALA. In attempting to create tests to determine when violations have occurred, the courts have been left to grope in the dark, ultimately ruling on tests with goals indistinguishable from those of malpractice law.²⁵⁷ Yet EMTALA is

253. Castaneda, *supra* note 188, at 3A.

254. 832 F. Supp. at 1027.

255. *Baby K*, 16 F.3d at 595, 597.

256. H.R. REP. NO. 241, *supra* note 24, reprinted in 1986 U.S.C.C.A.N. 42, 726-27.

257. See, e.g., *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991); *Deberry v. Sherman Hosp. Ass'n*, 741 F. Supp. 1302, 1306 (N.D. Ill.

not sophisticated enough to decide what is essentially a malpractice case. Malpractice law takes into account accepted standards of care and the characteristics, diagnosis, and prognosis of each patient. Because EMTALA takes none of these into account, it should not be interpreted in a way that allows it to override legitimate medical decisions. Congress enacted EMTALA for the purpose of overriding economic decisions only; its use should be limited to cases of true dumping.

B. *The Dangers of Overlap with Malpractice Law*²⁵⁸

Under the majority rule as it now stands, plaintiffs do not need to allege that the hospital acted with improper economic motives.²⁵⁹ Under the majority rule, a hospital is liable when it fails to provide a patient with the same screening it gives everyone else or when it fails to stabilize an emergency medical condition.²⁶⁰ The majority rule also holds that EMTALA does not guarantee a correct diagnosis and that EMTALA does not create a federal malpractice law.²⁶¹ Despite the courts' claims, plaintiffs seem to have noticed that the majority rule does in effect create a federal malpractice law. Plaintiffs understandably want to increase their chance of collecting damages by bringing suit under as many theories as possible, and many have done just that.²⁶²

The incidence of EMTALA suits might increase as the statute and its interpretations become more familiar to the plaintiffs' malpractice bar. One practitioners' journal recently featured an article promoting EMTALA as a "little-known but valuable separate cause of action" for plaintiffs in malpractice actions.²⁶³ The authors declare: "[t]he list of

1990).

258. For a more detailed discussion of this issue alone, see Demetrios G. Metropoulos, Note, *Son of COBRA: The Evolution of a Federal Malpractice Law*, 45 STAN. L. REV. 263 (1992).

259. See, e.g., *Collins v. DePaul Hosp.*, 963 F.2d 303, 308 (10th Cir. 1992); *Brooker v. Desert Hosp. Corp.*, 947 F.2d 412, 414 (9th Cir. 1991); *Gatewood*, 933 F.2d at 1040; *Cleland v. Bronson Health Care Group*, 917 F.2d 266, 269-70 (6th Cir. 1990); *Deberry*, 741 F. Supp. at 1306.

260. See, e.g., *Gatewood*, 933 F.2d at 1041.

261. *Id.*

262. See, e.g., *Collins*, 963 F.2d at 308; *Gatewood*, 933 F.2d at 1039; *Power v. Arlington Hosp.*, 800 F. Supp. 1384, 1389 n.15 (E.D. Va. 1992), *aff'd*, 42 F.3d 851 (4th Cir. 1994); *Coleman v. McCurtain Memorial Medical Management, Inc.*, 771 F. Supp. 343, 344 (E.D. Okla. 1991), *overruled by Collins*, 963 F.2d 303; *Deberry*, 741 F. Supp. at 1303; *ZaiKaner v. Danaher*, No. 4-89-749, 1990 WL 264721, at *1 (D. Minn. Oct. 21, 1990); *Nichols v. Estabrook*, 741 F. Supp. 325, 326 (D.N.H. 1989); *Evitt v. University Heights Hosp.*, 727 F. Supp. 495, 498 (S.D. Ind. 1989).

263. Mark R. Bower & Charles S. Gucciardo, *Proving A Separate Cause of Action in Malpractice Cases for Violation of the Federal "Anti-Dumping" Act*, VERDICTS,

things the plaintiff need not prove is more impressive than the short list of what [the] plaintiff must prove."²⁶⁴ They conclude by predicting that "with growing experience, more and more EMTALA actions will reach trial" and by advising "all members of the plaintiff's malpractice bar" to "study the EMTALA cause of action and consider its application to their pending and future emergency room cases."²⁶⁵

An enormous number of EMTALA suits would be justified if, in fact, numerous violations are occurring. People have the right to be compensated for their injuries, and physicians and hospitals who dump the uninsured should be punished for the sake of both retribution and deterrence. But the majority interpretation leaves too much room for abuse. The cost to hospitals of defending themselves against numerous unnecessary²⁶⁶ suits will drive up the cost of running a hospital. As a result, the price of health care could go up, leaving fewer people who can actually pay for their care individually or through insurance. More emergency rooms might close, forcing more of the indigent and uninsured into the few that remain. The final result could be an increase in economically motivated dumping, the very tragedy that Congress tried to prevent by enacting EMTALA.

V. CONCLUSION

The majority of courts interpreting EMTALA, along with the Department of Health and Human Services, have ruled that anyone can bring a claim under the Act. The majority has been unable to effectively distinguish an EMTALA violation from a malpractice violation, despite claims to the contrary. The result in at least one case, *Baby K*, is inarguably absurd and offensive to the medical profession.

Furthermore, broad application of EMTALA could end up defeating the very purpose Congress had in mind when creating it. Increased litigation for hospitals, automatic provision of aggressive treatment in every end-of-life decision, and care beyond the normal standard for religious reasons all add up to increased costs for hospitals. Increased costs for hospitals translate to increased costs for patients. Increased costs for patients will result in fewer patients able to pay. With fewer patients able to pay, hospitals will have more incentive to dump emergency room patients. The resulting decrease in access to emergency health care

SETTLEMENTS & TACTICS, May 1994, at 147.

264. *Id.* at 148.

265. *Id.* at 151.

266. I am characterizing EMTALA suits that involve no evidence of true dumping as "unnecessary."

services would be the very antithesis of Congress' laudable goal of ensuring access to such care for those who are unable to pay.

In light of these arguments and the apparent confusion in the federal court system over the proper construction of EMTALA's application, the need for Congress to clarify EMTALA's scope is undeniably urgent. Congress should limit EMTALA's application to cases of true dumping.²⁶⁷ If only the indigent and uninsured were allowed to bring EMTALA claims, much of the current confusion would be resolved. Patients and families would bring fewer EMTALA claims to trial, and the overlap with malpractice law would be eliminated. While less desirable, an alternative solution would be to amend EMTALA to allow for legitimate medical judgment with a test similar to the one suggested in *Power*, in order to prevent another *Baby K* catastrophe. Under *Power*, a hospital may rebut an allegation of dumping by showing that its decision not to conduct a test of procedure was based on medical, not economic, reasons.²⁶⁸

Because patient dumping is an extremely dangerous and all too common practice, EMTALA is undeniably a necessary law. Its necessity was demonstrated by the Public Citizens' Health Research Group's recent report stating that eighty-six hospitals in twenty-two states were cited for violating the Act during 1993 and the first quarter of 1994.²⁶⁹ Dumping is a contemptible practice that causes real harm to vulnerable people. But Congress, in its noble attempt to end this practice, did not provide the courts with adequate directions to really tackle this problem. The time has come for Congress to correct its mistake.

267. 42 U.S.C. § 1395dd(d) (1994) might be amended (as shown in italics) to look something like this:

(d) Enforcement

(2) Civil enforcement

(A) Personal harm

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

268. *Power*, 42 F.3d at 858.

269. Paul Recer, *Group Says Hospitals Still "Dump" Patients*, Boston Globe, Oct. 27, 1994, at 9A. Interestingly enough, Recer states that these hospitals "were cited by the government for rejecting patients *for nonmedical reasons . . .*" *Id.* (emphasis added).

