The Effect of State Medical Malpractice Caps on Damages Awarded under the Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395dd)

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I. INTRODUCTION

The Emergency Medical Treatment and Active Labor Act ("EMTALA" or the "Act")\(^1\) was passed by Congress in 1986 as part of the Comprehensive Omnibus Budget Reconciliation Act ("COBRA").\(^2\) EMTALA was enacted to address the problem of "patient dumping", a practice whereby hospitals either send a patient in need of medical care to another facility (most often a public hospital) or simply turn the patient away, due to the patient’s inability to pay.\(^3\) Congress, acting in response to its concern over the marked increase in the practice of

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\(^3\) Karen I. Treiger, Note, Preventing Patient Dumping: Sharpening the COBRA’s Fangs, 61 N.Y.U. L. REV. 1186, 1187 (1986) (citing Friedman, The "Dumping" Dilemma: The Poor Are Always with Some of Us, HOSPITALS, Sept. 1, 1982, at 51 ("Depending on who is describing it, [patient dumping] is known as ‘transfers of patients for economic reasons’, ‘demarking of services’, ‘management of patient mix’, and by other terms. Those who are less kind call it dumping.")).
patient dumping by hospitals across the country, enacted EMTALA,\textsuperscript{4} which provides certain specific requirements for hospitals for the treatment of patients in emergency conditions, regardless of their ability to pay.\textsuperscript{5}

Although EMTALA was passed in 1986, there have been relatively few cases reported which aid in establishing the scope and boundaries of the Act. The legislature itself has attempted to clarify EMTALA's provisions, and has amended the Act nearly every year since its enactment, the most recent amendments in 1990 and the most extensive amendments taking place in 1989.\textsuperscript{6} These amendments, however, have not changed the Act significantly from its original purpose and objectives\textsuperscript{7} and thus, much of the case law remains

\textsuperscript{4}H.R. REP. No. 241, 99th Cong., 1st Sess., pt. 1, at 27 (1985), reprinted in 1986 U.S.C.C.A.N. 597, 605, states, The [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 an unstable condition have been transferred improperly, sometimes without the consent of the receiving hospital.

\textsuperscript{5}The requirements under EMTALA apply to "participating" hospitals, defined as those that receive federal funding through a Medicare provider agreement, pursuant to 42 U.S.C. § 1395cc. 42 U.S.C. § 1395dd(e)(2) (Supp. 1992). According to statistics provided by the American Hospital Association and the Health Care Financing Administration at the time of EMTALA's enactment, approximately 98% of all hospitals in the United States and its territories are "participating hospitals" within the meaning of the Act. Treiger, supra note 3, at 1188 n.19.

\textsuperscript{6}The 1989 amendments added three additional sections to EMTALA. The first provision added under these amendments is a nondiscrimination provision requiring that a participating hospital with specialized capabilities (such as trauma centers or burn units) shall not refuse an appropriate transfer of an individual in need of such capabilities if the hospital has the capacity to treat the individual. 42 U.S.C. § 1395dd(g) (Supp. 1992); see Christine A. Fedas et al., Emergency Treatment Act: A Federal Response to Patient Dumping, 76 MASS. L. REV. 110, 114 (1991). The second provision prohibits the delay by a participating hospital in providing the required appropriate medical screening examination or required treatment of a patient in order to inquire about the patient's insurance status or payment ability. 42 U.S.C. § 1395dd(h) (Supp. 1992); see Fedas, supra, at 114. The third provision is a whistleblower provision which protects a physician against any adverse action taken by a facility in response to a refusal on the part of the physician to authorize an inappropriate transfer. 42 U.S.C. § 1395dd(i) (Supp. 1992); see Fedas, supra, at 114. The 1990 amendments extend the whistleblower protections to qualified medical persons under the Act and to any hospital employee who reports a violation of the Act. Id.

\textsuperscript{7}See supra note 4. Apart from the substantive additions of the 1989 and 1990 amendments, the amendments to EMTALA have been primarily related to the clarification of certain terms or phrases used in the Act with respect to the scope of its requirements. See 42 U.S.C. § 1395dd (Supp. 1992). Throughout these amendments, EMTALA's overall purpose of ensuring emergency medical treatment for all individuals, as well as its objectives of deterring hospitals from engaging in the conduct
pertinent to a current analysis of the application of state medical malpractice caps to claims under EMTALA.

Part II of this Note examines the current state of the law with respect to EMTALA's enforcement. Section A of Part II looks at EMTALA itself and illustrates the differences between the concerns discussed by Congress in the Act's legislative history and the somewhat ambiguous language of the statute. This illustration provides the basis for what has resulted in a wide variety of interpretations of the Act by the judicial system, examples of which are more closely examined in Section B of Part II — Case Law.

With respect to the applicability of state medical malpractice caps on damages awarded under EMTALA, further debate continues among the courts as to what is or should be preempted under the Act, according to EMTALA's specific preemption provision.8 While some courts believe that EMTALA's federal cause of action may coincide with any pendent state law medical malpractice claims or requirements and, therefore, be subject to any state caps on malpractice damages,9 other courts believe that the incorporation of these damage caps frustrate the underlying purpose and objectives of EMTALA and are, therefore, preempted by the Act.10 Due to the relatively few cases reported which specifically address the issue of state cap applicability, it is necessary to analyze the judicial system's overall enforcement of EMTALA, which more clearly defines the boundaries of the Act, in order to make an inference with respect to the effect of state medical malpractice caps on damages awarded under EMTALA.

Part III of this Note analyzes the effect of state medical malpractice law on federal claims under EMTALA, and examines the opposing viewpoints held by the federal courts on the preemption of these state laws to the extent they conflict with the enforcement of the provisions of the Act. A final analysis of EMTALA follows Part III, including an evaluation of the Act's overall effectiveness since 1986 in addressing the patient dumping epidemic for which it was enacted.

II. EMTALA AND THE CURRENT STATE OF THE LAW

A. EMTALA

EMTALA was passed by Congress in 1986.11 Through its enactment, Congress attempted to address the issue of patient dumping by requiring

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8 42 U.S.C. §1395dd(f) (1988). Subsection (f) of EMTALA provides as follows: "The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section." Id.

9 See infra notes 97–109 and accompanying text.

10 See infra notes 110–115 and accompanying text.
participating hospitals12 to adhere to certain provisions as set forth in the Act. The first section of EMTALA requires a participating hospital to provide an "appropriate medical screening" to any individual who comes to such hospital seeking treatment.13 More specifically, 42 U.S.C. § 1395dd(a) requires:

[I]f any individual . . . 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 . . . to determine whether or not an emergency medical condition . . . exists.14

The statute does not define "appropriate medical screening." Such definition has been left to the judiciary to determine.15

An "emergency medical condition" under the statute is defined as:

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

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

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1142 U.S.C. § 1395dd (Supp. 1992) (Table 1); see supra notes 1–5 and accompanying text.

12 Under EMTALA, a "participating hospital" is defined as a "hospital that has entered into a [Medicare] provider agreement under section 1395cc of this title." 42 U.S.C. § 1395dd(e)(2) (Supp. 1992); see supra note 5.

13 42 U.S.C. § 1395dd(a) (Supp. 1992). Although no definition is included in the statute as to what constitutes an "appropriate" medical screening, the language following this term, which refers to such appropriate screening as that which is "within the capability of the hospital’s emergency department," has led some courts to conclude that a subjective standard should be applied to determine a violation of this section of the Act. Id.; see also infra note 88.

14 Unlike the standard of care which is applied in cases concerning negligence or medical malpractice, most courts have determined that the use of the term "appropriate" in this subsection does not focus on the outcome of the examination performed by the hospital but, instead, concerns itself with whether or not the examination performed was considered standard procedure by the hospital. In this respect, a subjective standard would be applied to determine a hospital's liability under the Act. See infra note 88.

15 One of the most recent examples of this is found in Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 272 (6th Cir. 1990). In Cleland, the court determined that the term "appropriate", as used in the requirements of subsection (a) of EMTALA, would be defined by means of a subjective standard rather than the objective standard of a malpractice–based claim. Id.; see infra notes 88–89 and accompanying text.
(B) with respect to a pregnant woman who is having contractions —

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.16

If an emergency medical condition is determined to exist within the meaning of § 1395dd(e)(1), the participating hospital must then follow the requirements of subsection (b)(l) of the Act. This subsection offers the hospital two options:

"(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize17 the medical condition, or (B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section."18

Should the hospital choose to transfer the patient to another facility, EMTALA provides certain requirements to be followed by the transferring hospital in order to effectuate a proper transfer.19 These requirements include

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16 42 U.S.C. § 1395dd(e)(1) (Supp. 1992). This section somewhat overlaps the elements of a traditional medical malpractice action as, although the subsection delineates the various types of medical emergencies, an inadequate screening by a hospital resulting in the failure to identify one of these conditions (conduct which could be found to constitute negligence in a local malpractice action) would not violate the requirements of the Act, if the screening performed conformed to the hospital’s own standards. See infra notes 90-92 and accompanying text.

17 "To stabilize" is defined as "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility or . . . to deliver (including the placenta)." 42 U.S.C. § 1395dd(e)(3) (Supp. 1992).

18 42 U.S.C. § 1395dd(b)(1) (1988 & Supp. 1992). Subsection (c) prohibits a hospital from transferring a patient if a patient has not been stabilized (within the meaning of the Act) unless (i) the patient requests the transfer in writing, after being informed of the hospital’s obligations and of the risk of such transfer; (ii) a physician determines that the "medical benefits reasonably expected from the [transfer] outweigh the increased risks to the individual"; or (iii) in the absence of a physician at the time of transfer, a qualified medical person (as defined in the Act’s corresponding regulations), following a prior consultation with the physician, signs a certification of the physician’s determination under clause (ii) which is subsequently countersigned by such authorizing physician. 42 U.S.C. § 1395dd(c)(1)(A) (Supp. 1992).

19 42 U.S.C. § 1395dd(c)(1)–(2) (1988 & Supp. 1992). If an individual is found to have an emergency medical condition under subsection (a) of the Act, subsection (c)(1) prohibits the hospital from transferring the individual (including a discharge) if that individual has not been stabilized, unless,

(A)(i) the individual . . . after being informed of the hospital’s obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician . . . has signed a certification that . . . the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual . . . or
such procedural elements as the procurement of a confirmation of availability for and acceptance of the transfer patient by the receiving hospital, the transfer of all medical records to the receiving hospital, and the requirement to provide qualified equipment and personnel during such transfer, as well as a subjective determination that the transferring hospital has provided medical treatment to the patient "which [will minimize] the risks to the individual's health. . . ."20

A participating hospital may, then, violate EMTALA by either (i) failing to provide an "appropriate medical screening," as required under subsection (a), or, should an emergency medical condition be detected by the hospital's initial screening, (ii) failing to either stabilize or effectuate an appropriate transfer within the requirements delineated in subsections (b) and (c) of the Act.21 Liability for these violations is addressed by EMTALA's enforcement provisions.

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person . . . has signed a certification described in clause (ii) after a physician . . . in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and (B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.


20 42 U.S.C. § 1395dd(c)(2) (Supp. 1992). Specifically, subsection (c)(2) sets forth the procedural elements of an appropriate transfer under the Act, which is primarily a transfer:

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health . . . ;

(B) in which the receiving facility —

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records . . . related to the emergency condition for which the individual has presented [him/herself], available at the time of transfer, . . . and the name and address of any on-call physician . . . who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer;

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

Id.

21 42 U.S.C. § 1395dd(a)–(c) (1988 & Supp. 1992). Recent interpretations of EMTALA by the Sixth Circuit have concluded that the language of the Act indicates that a hospital's stabilizing requirements are activated only when an emergency medical condition is detected during the hospital's initial medical screening examination. See infra notes 90–92 and accompanying text. If a hospital fails to detect such a condition in its "appropriate" screening, it cannot be held liable under EMTALA's stabilizing requirements. See infra notes 90–92 and accompanying text.
The enforcement provisions of EMTALA, as amended, include both civil money penalties and private causes of action. Under the civil money penalties provision, negligent violations of EMTALA's requirements, by either a hospital, a physician, or both, are subject to money penalties not to exceed $50,000. In addition, EMTALA provides for the exclusion of a physician from both state and federally funded health care programs for "gross and flagrant" or repeated violations of the Act.

EMTALA's provision for civil enforcement of the Act offers two possible private causes of action under the statute. These causes of action attempt to accommodate the relief sought by either (i) an individual who is harmed by a hospital acting in violation of the Act or (ii) a medical facility that experiences a financial loss as a result of a participating hospital's violation of the Act. Specifically, sections (d)(2)(A)–(B) provide as follows:

(A) Personal harm

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

(B) Financial loss to other medical facility

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those

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22 42 U.S.C. § 1395dd(d) (Supp. 1992). The civil money penalties are imposed by the U.S. Department of Health and Human Services for negligent violations of any EMTALA requirement. Id. With respect to physicians, the enforcement provisions of subsection (d)(1) allow for the imposition of civil money penalties by the Secretary of the Department of Health and Human Services to

... any physician who is responsible for the examination, treatment, or transfer of an individual, ... and who negligently violates a requirement of [the Act], including a physician who —

(i) signs a certification under subsection (c)(1)(A) of this section that the medical benefits ... expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under the section.


23 42 U.S.C. § 1395dd(d)(1) (Supp. 1992). The 1990 amendments lowered such penalty to $25,000 for violating hospitals which have fewer than 100 beds. Id.

24 42 U.S.C. § 1395dd(d)(1)(B) (Supp. 1992). The courts have determined that a hospital also may have its Medicare provider agreement terminated; however, such sanction may not be sought in a private cause of action under the Act but, instead, must be imposed at the initiative of the Secretary of Health and Human Services. Deberry v. Sherman Hosp. Ass'n, 775 F. Supp. 1159, 1162 (N.D. Ill. 1991).
damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.\textsuperscript{25}

An individual or facility asserting a claim under EMTALA must do so within a two-year period from the date of the alleged violation.\textsuperscript{26}

Finally, the preemption provision of EMTALA is worth noting as this provision directly affects the applicability of state laws limiting medical malpractice damages to damages awarded pursuant to EMTALA. Subsection (f) of EMTALA deals with preemption and sets forth that the "provisions of this section [1395dd] do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section."\textsuperscript{27} The courts are split as to whether the application of state medical malpractice caps "directly conflicts" with EMTALA and is therefore preempted, or whether such an application does not conflict and, therefore, may be permitted to limit damages awarded under EMTALA. A detailed examination of case law with respect to EMTALA is in order to understand the varied interpretations of this statute, as well as the theories presented in addressing the issue of the applicability of state medical malpractice caps on damages awarded under EMTALA.

\textbf{B. Case Law}

Relatively few cases have been brought under EMTALA since its enactment in 1986. With few decisions determining the scope of the relief granted under the Act in the early years of its enforcement, some differences in opinion exist as to what constitutes a valid claim under EMTALA. One of the principal differences among EMTALA decisions involves the issue of whether or not an economic motive must be present in an EMTALA claim.\textsuperscript{28} Due to the scarcity of EMTALA reported opinions, courts have often looked outside their own jurisdictions to find support for rendering a decision under EMTALA. This section will examine the fundamental theories behind EMTALA's leading cases to understand the cause of action created by EMTALA for purposes of addressing the issue of this Note, that is, the applicability of a state law's medical malpractice damages cap to damages awarded under EMTALA.

\textbf{1. Strict Interpretation of the Statute}

One of the schools of thought with respect to EMTALA favors a strict reading of the text of the statute for its interpretation, giving no relevance to the legislative history involved in its enactment. Interestingly, by limiting their

\begin{itemize}
\item \textsuperscript{26}42 U.S.C. § 1395dd(d)(2)(C) (Supp. 1992).
\item \textsuperscript{27}42 U.S.C. § 1395dd(f) (1988).
\end{itemize}
reading of the statute to its actual text only, thereby ignoring EMTALA's legislative history in defining the Act's purpose and objectives in enforcing its provisions, these courts have actually broadened the scope of EMTALA in their determination that the phrase "any individual" (used throughout the Act) serves to expand EMTALA's protections to all individuals, not solely the indigent or uninsured.29

In *Gatewood v. Washington Healthcare Corp.*, the plaintiff's husband presented himself to the defendant's emergency room, complaining of pain in his chest and down his left arm. Following an exam, blood tests, a chest x-ray and an EKG test, the plaintiff's husband was sent home. The following morning the plaintiff's husband died of a heart attack. The plaintiff brought an action against the hospital under EMTALA along with pendent local claims for malpractice.

The defendants argued that no EMTALA claim existed because the plaintiff's husband was fully insured and the Act was intended to provide "emergency room access to uninsured and indigent patients only." The *Gatewood* court interpreted the statute strictly, finding that, despite a legislative history noting concern for the treatment of indigent patients, EMTALA's specific language extended protection to "any individual" and thus refused to dismiss the claim based on the economic status of the claimant. The strict interpretation of EMTALA found in *Gatewood* is followed by several courts, including many outside the D.C. Circuit.

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29 See infra notes 30–47 and accompanying text.

30 933 F.2d 1037 (D.C. Cir. 1991).

31 *Id.* at 1039.

32 *Id.* The diagnosis of the attending physician was that the plaintiff's husband was suffering from musculoskeletal pain. He was discharged with instructions to take Tylenol pain medication, use a heating pad, and contact his personal physician in the morning. *Id.*

33 *Gatewood*, 933 F.2d at 1039.

34 *Id.* at 1038.

35 *Id.* at 1040.

36 "Though the Emergency Act's legislative history reflects an unmistakable concern with the treatment of uninsured patients, the Act itself draws no distinction between persons with and without insurance. Rather the Act's plain language unambiguously extends its protection to 'any individual' who seeks emergency room assistance." *Id.* (citing 42 U.S.C.A. § 1395dd(a), (b)(1) (emphasis added)). The EMTALA claim, however, was dismissed by the court upon its ruling that the allegations of the plaintiff's complaint were traditional state-based claims of negligence or malpractice and were simply not cognizable under the Act. *Gatewood*, 933 F.2d at 1041.

In *Deberry v. Sherman Hospital Association*, a claim was asserted under the stabilizing requirement of EMTALA. The plaintiff’s daughter had been brought to defendant’s emergency room with various symptoms of spinal meningitis, including fever, rash, stiff neck, and her head tilted to the left. Although she did receive treatment at the emergency room, the plaintiff’s daughter was discharged and was not diagnosed with spinal meningitis until two days later, after her condition worsened, ultimately causing deafness.

In ruling out a requirement of indigence for a cause of action under EMTALA, the *Deberry* court, while recognizing that "perhaps the principal reason for [EMTALA’s] enactment was the refusal to treat indigents by certain hospitals," decided that "the language of the statute quite plainly goes further. Thus, it nowhere mentions either indigency, an inability to pay, or the hospital’s motive as a prerequisite to statutory coverage." *Deberry*, therefore, refused to expand the requirements of a cause of action under EMTALA by allowing the language of the legislative history of the Act, concerning improper economic motives on the part of hospitals refusing to treat patients, to be read into the language of the statute itself.

Such strict reading of the statute continued in *Burditt v. United States Department of Health and Human Services*. In *Burditt*, a physician who was fined under the civil money penalties provision of EMTALA challenged this sanction. The plaintiff physician was found to have previously violated the transfer provisions of EMTALA when he ordered a hypertensive woman in active labor to travel to another hospital because he did not want to take the

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39 *Id.; see* 42 U.S.C. § 1395dd(b)(1) (Supp. 1992). Count I of the plaintiff’s complaint alleged that the defendant, by discharging the plaintiff’s daughter without stabilizing her medical condition, had violated subsection (b)(1) of the Act. 741 F. Supp. at 1303; *see also supra* notes 17 and 18 and accompanying text.

40 741 F. Supp. at 1303. Additional symptoms noted in the complaint included “dispositional aberrations” involving irritability and lethargy. *Id.*

41 *Id.*

42 *Id.* at 1306.

43 934 F.2d 1362 (5th Cir. 1991). This action is somewhat different from the other cases examined in this section as it involves a civil enforcement proceeding under subsection (d)(1) of the Act rather than a private cause of action under subsection (d)(2). *Id.* A similarity, however, is found between the assertions made by the plaintiff in his challenge to the U.S. Department of Health and Human Services and the defenses raised by defendants in the various private causes of action brought under EMTALA. These assertions with respect to the Department’s earlier sanctions imposed against the plaintiff included the argument that an improper (economic) motive must be proven as an element of any EMTALA violation. *Id.* at 1373.


risk of performing the delivery.\textsuperscript{46} The \textit{Burditt} court imposed a strict interpretation of the statute and declined to incorporate a showing of improper economic motive for an EMTALA violation.\textsuperscript{47}

Overall, the courts which have held to a strict interpretation of the Act have served to expand its enforcement with respect to the classes of patients protected by its provisions. As a result of this interpretation, whereby the courts have chosen to disregard EMTALA's legislative history, a cause of action is not limited by a necessary showing of economic motive on the part of the violating physician or hospital.

2. Liberal Interpretation of the Statute

In addition to examining the text of the statute, some courts have chosen to review its legislative history in order to interpret EMTALA's requirements. These courts give credence to such history by finding an additional requirement of economic motive, a showing of which is essential to a cause of action under the Act.

One of the earlier cases which tested the scope of EMTALA was \textit{Nichols v. Estabrook}.\textsuperscript{48} The \textit{Nichols} court looked to the legislative history of EMTALA to determine the validity of the plaintiffs' contention that a physician's misdiagnosis of the plaintiffs' baby violated a standard of conduct established by EMTALA, the violation of which thus constituted negligence per se.\textsuperscript{49} The plaintiffs' baby had been examined in an emergency room by the defendant who failed to detect the existence of an emergency medical condition.\textsuperscript{50} The baby died a few hours later.\textsuperscript{51}

Upon reviewing the legislative history of EMTALA, the court determined that the statute was enacted by Congress as an attempt to ensure emergency

\textsuperscript{46} 934 F.2d at 1366-67. Part of the evidence presented of the plaintiff's violation of the Act's transfer requirements included the authorization certificate which had been signed by the plaintiff but contained no explanation for the patient's transfer. \textit{Id.} at 1367. Court testimony revealed that the plaintiff had remanded to the nursing supervisor (in reference to the explanation section which had been left blank) that "until [the hospital] pays my malpractice insurance, I will pick and choose those patients that I want to treat." \textit{Id.}

\textsuperscript{47} The court noted that, "[a]s written, EMTALA prevents patient dumping without such a requirement[,]" and thus refused to "alter the statutory scheme [of the Act]." \textit{Id.} at 1373.


\textsuperscript{49} \textit{Id.} at 329.

\textsuperscript{50} \textit{Id.} at 326; \textit{see supra} note 16 and accompanying text.

\textsuperscript{51} 741 F. Supp. at 326. Prior to the baby's death, the defendant had advised the plaintiffs to take their baby to another hospital where, he told them, a pediatrician would be waiting. Upon the plaintiffs' arrival at the second hospital, however, an emergency code was immediately called by the receiving pediatrics nurse while the pediatrician, who was said to have been waiting for the plaintiffs, did not arrive until 35 to 40 minutes later, approximately five minutes before the baby's death. \textit{Id.}
treatment despite economic resources and to put an end to the practice of patient dumping.\textsuperscript{52} As patient dumping was the conduct EMTALA sought to eliminate, the plaintiffs, in its assertion that the defendant's alleged misdiagnosis had violated the Act (without any such showing of patient dumping on the part of the defendant), did not provide the basis for negligence per se.\textsuperscript{53} The \textit{Nichols} court held that "[t]he interest which Congress sought to protect by enacting 42 U.S.C. \textsection{}1395dd was not invaded by the defendant's conduct as here alleged," which, therefore, precluded the plaintiffs' assertion of any negligence per se theory of liability.\textsuperscript{54}

Another "misdiagnosis" complaint brought under EMTALA which led to a liberal interpretation of the statute is found in \textit{Evitt v. University Heights Hospital}.\textsuperscript{55} The plaintiff in this action was examined in the emergency room of the defendant hospital for complaints of severe chest pain. She was discharged with instructions for home treatment and returned later the same day, having suffered a heart attack.\textsuperscript{56} In her complaint, plaintiff alleged that the initial failure by the defendant to detect her serious condition violated the "appropriate medical screening" requirement under 42 U.S.C. \textsection{}1395dd(a).\textsuperscript{57} In establishing whether or not the defendant had indeed violated EMTALA, the court looked to the Act's legislative history\textsuperscript{58} and determined that, because the statute is "specifically directed toward preventing prospective patients from being turned away for economic reasons,"\textsuperscript{59} the plaintiff's interpretation of "appropriate" attempted to expand its statutorial meaning and, instead, more closely resembled a definition related to a medical malpractice claim.\textsuperscript{60} The

\begin{itemize}
  \item \textsuperscript{52}Id. at 329–30. In addition to its review of EMTALA's legislative history, the court also made reference to the significant amount of media attention which was gained by the patient dumping issue at the time of the Congressional proceedings prior to EMTALA's enactment, providing further indication of the Act's Congressional intent. \textit{Id.}
  \item \textsuperscript{53} "A claim of negligence may be founded on a failure to satisfy such a standard of conduct 'when the consequences contemplated by the statute have actually resulted from the violation.'" \textit{Id.} at 329 (quoting \textit{Collier v. Redbones Tavern & Restaurant, Inc.}, 601 F. Supp. 927, 931 (D.N.H. 1985)); see also \textit{Restatement (Second) of Torts \textsection{}286 cmt. b} (1965).
  \item \textsuperscript{54} 741 F. Supp. at 330.
  \item \textsuperscript{55} 727 F. Supp. 495 (S.D. Ind. 1989).
  \item \textsuperscript{56}Id. at 496.
  \item \textsuperscript{57}\textit{Id.} In addition, the plaintiff alleged alternative violations by the defendant of subsections (b) or (c) of EMTALA, also alleged to have occurred during her first visit, by the defendant's failure to stabilize the plaintiff's condition or properly transfer her to another facility. \textit{Id.}
  \item \textsuperscript{58}Id. at 496–97.
  \item \textsuperscript{59}727 F. Supp. at 497 (citing \textit{Reid v. Indianapolis Osteopathic Medical Hosp.}, 709 F. Supp. 853 (S.D. Ind. 1989)).
  \item \textsuperscript{60}727 F. Supp. at 497. As the court stated, "[c]laims regarding diagnosis and treatment lie in the area of medical malpractice, an area traditionally regulated by state law. To
The court ultimately held that such an allegation went beyond the scope of EMTALA, which seeks only to prevent patient dumping through "specifically tailored hospital requirements" and "presents no direct conflict to general principles of state medical malpractice law." 61

Stewart v. Myrick 62 is one of the leading cases supporting the more liberal interpretation of EMTALA. In Stewart, the plaintiff's husband arrived at the emergency room with apparent complaints of chest pain, loss of color, and shortness of breath. 63 After seeing the defendant doctor, the plaintiff's husband was sent home and scheduled for various tests which were conducted two days later. These tests were inconclusive and the plaintiff's husband was released; he did not seek further treatment until approximately eight days later, when he arrived at the facility by ambulance and died shortly thereafter. 64

In her claim for relief under EMTALA, the plaintiff alleged violations of both its screening and transfer provisions. 65 Citing extensive legislative history to support its interpretation of the statute, 66 the Stewart court dismissed the plaintiff's EMTALA claim because it did not "represent a case of patient dumping, in which the plaintiff was turned away from medical care for economic reasons" and, thus, did not "present the type of evil that Congress sought to eliminate in the Act." 67 The findings of Stewart have been followed

adjudicate these issues under the anti-dumping provision would lead to federal preemption not contemplated under this Act." Id.

61 Id. The court noted that the statutorial interpretation proposed by the plaintiffs in their argument would, in effect, lead to a result which would allow any patient dissatisfied with an emergency room diagnosis and release to file an action for recovery of damages under the anti-dumping provisions of EMTALA. This interpretation, the court offered, "would, in effect, make the hospital the guarantor of the physicians' diagnosis and treatment, irrespective of how reasonable such diagnosis [or treatment] may have appeared at the time [it was administered]. . . ." Id. The Evitt court concluded that EMTALA does not go this far. Id.


63 Id. at 434. The defendant contended that the plaintiff did not make such complaints either to the defendant or to his nurse. Id.

64 Id.

65 Id. at 434–35 (citing 42 U.S.C. § 1395dd(a)-(b)(1) (Supp. 1992)).

66731 F. Supp. at 435 (citing Treiger, supra note 3). The court also cited to the several committee reports and debates noted at H.R. Rep. No. 241, 99th Cong., 1st Sess., pt. 1, at 27 (1985), reprinted in 1986 U.S.C.C.A.N. 597, 605; 131 Cong. Rec. H9503 (daily ed. Oct. 31, 1985); 131 Cong. Rec. S13903 (daily ed. Oct. 23, 1985), which provide evidence of Congress' intent behind EMTALA's enactment. Primarily, the Stewart court observed that the legislators had stressed that the underlying purpose of the Act was to "ensure that indigent persons were not denied emergency health care due to their financial status." Id.

67 Id. at 436. As in the holding of Evitt v. University Heights Hosp., 727 F. Supp. 495 (S.D. Ind. 1989), the court in Stewart found that the plaintiff's claim "[fell] within the ambit of state negligence law, not the federal anti-dumping law[,]" and, since there was
by other jurisdictions seeking support for their more liberal reading of EMTALA, in order to uphold, in enforcing the Act, the principles which originally motivated its enactment by Congress. In contrast to the expansive class of patients protected under the strict interpretation of EMTALA, a liberal interpretation of the Act, which permits the legislative history of the statute to be considered in determining its application, narrows its coverage to protect only those patients who are indigent or uninsured.

3. Sixth Circuit Alternative

The Sixth Circuit has combined the previous strict and liberal interpretations of EMTALA by prior courts to provide an alternative reading of the statute, recognizing the legislative history of the Act in addressing the problem of patient dumping without limiting claims to those with a showing of economic motive. The Sixth Circuit accomplishes this by focusing its examination of EMTALA claims on the refusal or denial of treatment rather than inadequate treatment or mistreatment as the basis for recovery under the Act, while expanding the definition of patient dumping to include refusals of treatment by hospitals for any reason, not solely economic. In Thornton v. Southwest Detroit Hospital, one of the earlier Sixth Circuit decisions regarding EMTALA, the plaintiff was admitted to the defendant hospital after suffering a stroke. Following a lengthy stay in the hospital, consisting of ten days in the intensive care unit of the hospital followed by an additional eleven days in regular care, the plaintiff was discharged by her doctor to her sister’s home when a local rehabilitation center refused to accept her for therapy. The plaintiff’s condition deteriorated at home, and she was

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69 See Cleland v. Bronson Health Care Group, 917 F.2d 266 (6th Cir. 1990); Thornton v. Southwest Detroit Hosp., 895 F.2d 1131 (6th Cir. 1990). In Thornton, for example, the court interpreted EMTALA as simply requiring a hospital to screen individuals who come to its emergency department to determine whether they suffer from an emergency condition; if such a condition is found to exist, the hospital must provide treatment to stabilize the condition unless the patient can be transferred without danger of the condition deteriorating. 895 F.2d at 1134. The Cleland court expanded these requirements through its own interpretation of the Act that both the screening and treatment to be provided by the hospital must be such as would be provided to any paying patient. 917 F.2d at 268–69.

70 895 F.2d 1131 (6th Cir. 1990).

71 Id. at 1132.

72 Id. The rehabilitation center refused to accept the plaintiff because her health insurance would not cover the cost. Id. Although this appears to be a blatant denial of medical treatment of an uninsured patient in direct violation of EMTALA, the rehabilitation center is not the type of medical facility which is subject to the
finally admitted to the local rehabilitation center more than three months after her discharge. 73

In her lawsuit against the hospital, the plaintiff in *Thornton* alleged that the hospital had violated the stabilizing requirements of EMTALA 74 by transferring (discharging) her in a condition which, according to the provisions of the statute, was likely to materially deteriorate as a result of such transfer. 75 The defendant argued that EMTALA governed the activities of a hospital in its emergency treatment facilities only, citing the repeated use of the term "emergency room" in the Act's legislative history as evidence of this contention. 76 The court, however, arrived at a different conclusion upon its examination of EMTALA and its corresponding legislative history. The *Thornton* court observed that the Act did not limit its requirements to emergency rooms only, but that the more likely intent of Congress in enacting EMTALA was to "insure that patients with medical emergencies would receive emergency care," 77 wherever such emergencies may occur within a participating hospital. The court noted that the need for "emergency care does not always stop when a patient is wheeled ... into the main hospital." 78

It is this somewhat simple and straightforward summary of EMTALA by the *Thornton* court which later provided the foundation for a refining of the Sixth Circuit's alternative interpretation of EMTALA in *Cleland v. Bronson Health Care Group, Inc.* 79 The court in *Cleland* combined the previous strict and liberal interpretations of EMTALA by federal courts into a balanced alternative reading of the statute which has since been followed more consistently than either of the prior readings of the Act. 80 In *Cleland*, the plaintiffs brought their
15-year-old son to the defendant's emergency room where he, after complaining of cramps and vomiting, was diagnosed with influenza and discharged four hours later. This diagnosis, however, was incorrect and, in actuality, the plaintiffs' son was suffering from intussusception, a condition whereby a part of the intestine telescopes within itself, and he suffered cardiac arrest and died less than 24 hours later.

The plaintiffs brought their subsequent action against the hospital under the "appropriate medical screening" requirement of EMTALA in addition to a pendent medical malpractice claim. The district court had originally dismissed the action under Rule 12(b)(6) of the Federal Rules of Civil Procedure, based on its finding that EMTALA applied to indigent and uninsured patients only. The Cleland court upheld the district court's dismissal of the case, but on different grounds. The court agreed with the district court's finding that EMTALA was enacted to address the increasing problem of hospitals' alleged failure to treat patients based solely on the patient's financial inadequacy and was not intended to be used as a general malpractice action. However, it was the Cleland court's interpretation of the phrases "appropriate medical screening" and "emergency medical condition" which led to its affirming the district court's dismissal.

The Cleland court reviewed the legislative history of EMTALA and determined that "appropriateness" in the sense required by EMTALA "must more correctly be interpreted to refer to the motives with which the hospital


811917 F.2d at 268.

82Id.


84917 F.2d at 268.

85Id. Although the Cleland court agreed with the district court finding that the plaintiffs had failed to state a claim upon which relief could be granted, it found that this failure by the plaintiffs occurred with respect to the meaning behind the appropriate medical screening requirement, and not because of any requirement of indigence. Id. at 268-69.

86917 F.2d at 268-69.

87Id.
It is here that the Sixth Circuit expanded the previous liberal interpretations of EMTALA which upheld an economic motive requirement for claims under the Act by its refusal to disregard any other motives that a hospital may have when it has engaged in patient dumping activity. Instead, the Cleland court found, in determining the Act, that EMTALA speaks only to the differential treatment of patients rather than the mistreatment or misdiagnosis of such patients, and concluded that "[a] hospital that provides substandard (by its standards) or nonexistent medical screenings for any reason . . . may be liable under this section." 89

The Cleland court continued its alternative interpretation of EMTALA by limiting the stabilizing requirements of the Act to those situations where an "emergency medical condition" (as defined in the Act) has been discovered by the hospital's screening exam. 90 According to its holding, the Cleland court found that "[i]f the condition was not ascertained even though an appropriate screening was provided, then the hospital could not have violated its duty to stabilize." 91

The significance of this holding, that the stabilizing duties under EMTALA are "triggered" only upon the discovery of an emergency condition, lies with the realization that, in effect, conduct by a hospital which may be deemed "inappropriate" by a local negligence standard may be held to be "appropriate" under EMTALA and thus in compliance with the requirements of the Act. 92

This interpretation by the Sixth Circuit provides the basis for its finding that EMTALA claims and state malpractice claims are mutually exclusive causes of action; a showing of the required elements of a local malpractice cause of action

88917 F.2d at 272. The court refers to the statute's language, with respect to the appropriate screening requirement, of "within its capabilities" as precluding a negligence or objective standard of care to determine what is "appropriate" for purposes of determining a basis for relief under the Act. Id.

89 Id. at 272 (emphasis added). In illustrating this finding, the court noted that a patient may be refused treatment by a hospital for a number of reasons in addition to economic, including race, drunkenness, AIDS, etc., all of which, by the court's reasoning, would be prohibited under the Act. The court concluded from the evidence presented that the treatment received by the plaintiffs' son would have been given to any other patient of any other characteristics and, therefore, was not "inappropriate" by the hospital's standards as to have violated the requirements of EMTALA. Id. at 271.

90917 F.2d at 271.

91 Id. at 271 n.2.

92 Thornton v. Southwest Detroit Hosp., 895 F.2d 1131, 1133 (6th Cir. 1990) ("A cause of action under the Act is not analogous to a state medical malpractice claim because it creates liability for a refusal to treat, which state malpractice law does not."); see also Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1041 (D.C. Cir. 1991) ("[T]here may be some instances in which a hospital's normal screening procedure will fall below the standard of care established by local negligence or malpractice law. Nevertheless, we decline the . . . invitation to incorporate a malpractice or negligence standard into subsection 1395dd(a).".).
may not necessarily contain those elements essential to a federal cause of action under the Act.93

The opinion that malpractice claims and EMTALA claims are distinct and mutually exclusive causes of action is commonly held among the majority of the courts that have heard cases brought under the Act.94 This belief, considered in conjunction with an analysis of (i) EMTALA's language concerning damages and (ii) the findings of the limited number of cases addressing the issue of the effect of state medical malpractice law on claims asserted under the Act, provide the foundation for a determination that the application of state medical malpractice caps on EMTALA claims in order to limit those damages awarded under the Act is not provided for under EMTALA and should not be permitted by those courts empowered to issue rulings under the Act.

III. ANALYSIS OF EMTALA v. STATE MEDICAL MALPRACTICE LAW

The issue concerning the applicability of state medical malpractice caps on damages awarded under EMTALA was created by the language of the statute itself and its subsequent interpretations by the court system. It is EMTALA's language, therefore, which should be examined first in order to conduct an

93917 F.2d at 271.


http://engagedscholarship.csuohio.edu/clevstlrev/vol42/iss1/7
analysis of this issue intended to reveal the most logical or reasonable interpretation of the Act, as it relates to these state caps.95

A. Damages Under EMTALA

With respect to private causes of action provided for under EMTALA, an individual seeking relief may "obtain those damages available for personal injury under the law of the State in which the hospital is located." 96 This phrase appears to be straightforward and unambiguous, but it has been broadly interpreted by some courts as permitting the limitations on awards delineated in certain state law caps on medical malpractice damages.97 The reasoning behind such an expanded interpretation of this phrase is explained by the court in Reid v. Indianapolis Osteopathic Medical Hospital, Inc.98 (later followed by Lee v. Alleghany Regional Hospital Corp.).99 Although noting that the legislative history of the Act contains nothing with which to answer the question of whether the phrase "damages available for personal injury"100 should incorporate state caps on medical malpractice damages, the Reid court concluded that the Indiana statute specifically limiting malpractice awards was applicable to limit EMTALA awards; otherwise, the incorporation clause of § 1395dd(d)(2)(A) would be rendered meaningless.101

In Reid, the state law in question provided a procedural requirement and a damage limitation to medical malpractice actions.102 The court determined that the preemption clause of EMTALA barred the procedural requirement of the Indiana statute, as it directly conflicted with EMTALA's requirements concerning the point at which a cause of action under the Act is said to arise.103 However, the Reid court concluded that the language of subsection (d)(2)(A),

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95 See Power, 800 F. Supp. at 1388 ("Since this is a question of statutory interpretation, it is fundamental that the 'starting point in every case involving construction of a statute is the language itself.'" (quoting Blue Chip Stamps v. Manor Drug Stores, 421 U.S. 723 (1975))).


101709 F. Supp. at 855.

102 id. at 854 (citing IND. CODE 16-9.5-9-2, 16-9.5-2-2(b) (repealed 1993)).

103 id.; see also infra note 116 and accompanying text.
permitting "those damages available for personal injury," served to incorporate the substantive state limitation on medical malpractice damages.\textsuperscript{104}

The court arrived at this conclusion by recognizing that (i) the plaintiff in \textit{Reid} was "unable to cite a single state with a statute that generally limited personal injury damages" only;\textsuperscript{105} (ii) Congress was, at the time EMTALA was drafted, "clearly aware of a growing concern in some states that excessive damage awards were fueling a medical malpractice crisis,"\textsuperscript{106} which had resulted in the enactment of numerous state laws limiting such damages; and (iii) Congress, therefore, must have wished to preserve these state caps through \textsection{1395dd(d)(2)(A)} to limit EMTALA awards as well.\textsuperscript{107}

In addition, the \textit{Reid} court chose to incorporate the state medical malpractice cap on damages awarded pursuant to EMTALA by reasoning that the language of the Indiana statute provided the only basis for damages "available for personal injury" in an action against a health care provider.\textsuperscript{108} This statement by the court is not entirely accurate, however, as the statute limits awards against health care providers for occurrences of malpractice and does not address any other type of action which may be initiated against a health care provider, such as an EMTALA claim.\textsuperscript{109}

In a more recent interpretation of \textsection{1395dd(d)(2)(A), the court in \textit{Power v. Arlington Hospital}\textsuperscript{110} uncovered the errors of the \textit{Reid} decision and provided its own reasoning as to why such state medical malpractice caps are not applicable to damages awarded under EMTALA. In \textit{Power}, the issue before the court with respect to state law was whether to limit the damages previously awarded the plaintiff to the one million dollar medical malpractice cap of the State of Virginia.\textsuperscript{111}

\begin{flushleft}
\textsuperscript{104}709 F. Supp. at 855.
\textsuperscript{105}\textit{Id.}
\textsuperscript{106}\textit{Id.}
\textsuperscript{107}\textit{Id.}
\textsuperscript{108}\textit{Reid}, 709 F. Supp. at 855. The specific language of the Indiana statute to which the court referred states that a "health care provider . . . is not liable for an amount in excess of one hundred thousand dollars [$100,000] for an occurrence of malpractice." \textsc{Ind. Code} \textsection{16–9.5–2–2(b)} (repealed 1993).
\textsuperscript{109}\textit{Reid}, 709 F. Supp. at 855 (quoting \textsc{Ind. Code} \textsection{16–9.5–2–2(b)} (repealed 1993)).
\textsuperscript{110}800 F. Supp 1384 (E.D. Va. 1992).
\textsuperscript{111}\textit{Id.} at 1385. The action involved a British subject living in the United States (without health insurance) who, when she arrived at the defendant hospital, was unable to walk, in pain and suffering from chills (later diagnosed as septic shock). \textit{Id.} at 1386. Her vital signs and a hip x-ray were taken, along with a urinalysis test. \textit{Id.} Although doctors were unable to ascertain the cause of her condition, no additional tests were run and, before the results of the urinalysis were available, the plaintiff was discharged, still unable to walk. \textit{Power}, 800 F. Supp. at 1386. The plaintiff subsequently returned to the defendant hospital and was then admitted, but her condition had so worsened that her stay lasted four months, during which time the plaintiff lost both of her legs below the knees and the sight in one eye. \textit{Id.} The plaintiff's action against the hospital cited violations of both
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The Power court first examined the language of § 1395dd(d)(2)(A) and read the phrase "damages available for personal injury" as providing a basis for recovery under each of the eight personal injury elements reflected in Virginia's Model Jury Instructions. In so doing, the Power court determined as significant the fact that not only did the state place no dollar limit on personal injury damages but, in addition, the EMTALA provision itself contained no limiting language. Specifically, the court noted that the fact that subsection (d)(2)(A) allows an individual to recover damages "available" for personal injury and does not, for example, allow "damages for personal injury, except as may be limited in certain states by medical malpractice statutes," indicates an intent by Congress not to limit such damages awarded under the Act. The Power court concluded, then, that recovery under EMTALA (in the State of Virginia) included damages for any of the personal injury elements recognized by the State but would not be limited to any dollar amount.

When this reasoning is considered as to the applicability issue concerning state medical malpractice law, the damages available under a particular state for personal injury determine the recovery available in a private cause of action under EMTALA. The reasoning of Reid with respect to its assumption that Congress, because it was aware of the malpractice insurance crisis at the time of EMTALA's enactment, intended to preserve the award limits established by state legislatures is persuasive as well, allowing for a conclusion that recovery under EMTALA may be limited to the extent such personal injury damages are limited within a state. However, the Reid court's "jump" in logic, by incorporating medical malpractice caps to such damages, is unreasonable; such medical malpractice caps apply to a specific type of tort action within a state and cannot be interpreted to limit general personal injury damages under § 1395dd(d)(2)(A).

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112Power, 800 F. Supp. at 1388. The court went on to specifically identify these elements, which referred only to the type of injury sustained, containing no references to causal conduct. Id.

113Id. at 1388–89.

114Id. at 1389 (quoting Jones v. Wake County Hosp. Sys. Inc., 786 F. Supp. 538, 543 (E.D.N.C. 1991)) (emphasis added). The Power court went on to cite the observation by the court in Jones, that "had Congress desired to enact a more restrictive statute, presumably it would have done so." Power, 800 F. Supp. at 1388 (citing Jones, 786 F. Supp. at 543).

115800 F. Supp. at 1389. In its attempt to cite to authority supporting its interpretation of EMTALA's recovery language, the Power court uncovered an error in Reid with respect to state laws which limit general personal injury damages. While the Reid court determined that since the plaintiff had failed to a cite a single state having general personal injury caps, Congress must have intended to incorporate medical malpractice caps in EMTALA's damage provision, Power cited to eight states having enacted such caps. Id. at 1390 n.16.
B. Conflicting Statutory Purposes

Section 1395dd(d)(8), the "preemption clause", of EMTALA notes that no state or local law requirement is preempted by any provision of the Act unless such local requirement directly conflicts with a requirement of the Act.116 Prior courts, including the Reid court, have used this provision to preempt procedural requirements under state laws concerning medical malpractice actions which they found to conflict with the requirements of EMTALA.117

In Reid, the procedural requirement which was ruled to be preempted by EMTALA was a state law requiring that any action against a health care provider be brought initially before a review panel before its commencement in any court.118 The court determined that, because such a review was required before an action against a health care provider could arise, a direct conflict existed with EMTALA's provision that a cause of action arises whenever "any individual . . . suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section."119 In addition, the state-required medical review panel based its findings on a negligence standard, whereas liability under EMTALA is based on a strict liability standard, thus further justifying a preemption of such state requirement as any findings by such panel would be completely irrelevant to a determination concerning EMTALA.120

The Power court acknowledged this finding by the Reid court and agreed that the procedural requirement of Indiana's malpractice statute provided an obstacle which was contrary to EMTALA's purpose and, therefore, should be preempted.121 However, the Power court observed that the same reasoning could be applied to those state laws enacted to limit medical malpractice damages. In addition to the fact that state caps limiting medical malpractice damages correspond to a cause of action which is distinct and mutually exclusive of that arising under EMTALA,122 the statutory purposes of such caps directly conflict with that of EMTALA.

117 See Power, 800 F. Supp. at 1384 (concurring with holdings of other jurisdictions precluding state procedural laws in EMTALA actions); Reid v. Indianapolis Osteopathic Medical Hosp., 709 F. Supp. 853 (S.D. Ind. 1989) (preemption of a state requirement that an action against a hospital must first be brought before a medical review panel is proper); Smith, 416 S.E.2d at 689 (preemption of state malpractice action notice provisions is proper).
118 709 F. Supp. at 854. A similar requirement was preempted in the Smith court. See 416 S.E.2d at 695.
119 Reid, 709 F. Supp. at 855 (citing 42 U.S.C. § 1395dd(d)(2)(A)).
120 Id.
121 Power, 800 F. Supp. at 1390.
122 See supra note 94.
According to EMTALA's legislative history, Congress enacted this statute in response to its "growing concern about . . . hospital emergency rooms refusing to accept or treat patients with emergency conditions."\(^{123}\) Its purpose remains that of deterring the conduct proscribed under the Act and compensating the victims of such conduct.\(^{124}\) The purpose behind the enactment of state laws limiting medical malpractice damages is completely different. The \textit{Power} court examined the medical malpractice cap enacted by the State of Virginia and, as an example, its purpose is representative of such state caps in general.\(^{125}\) The purpose of the Virginia medical malpractice cap\(^{126}\) is to combat the availability and affordability problems of health care providers with respect to medical malpractice insurance.\(^{127}\) It is not concerned with the deterrence of any proscribed behavior nor the compensation of victims. The application of these state damage caps arguably conflicts with EMTALA's purposes by (i) frustrating the desired deterrent effect of damages against those hospitals found to be in violation of its requirements, and (ii) limiting the compensation available to its victims.\(^{128}\) In this respect, the preemption provision of § 1395dd(f) should serve to prohibit the application of state medical malpractice caps.

Although reported authority concerning this issue is sparse, the reasoning of authority discussed in Part II of this Note concerning the overall interpretation of EMTALA is helpful. As previously noted, the cause of action created under EMTALA is "a new cause of action, generally unavailable under state tort law . . . ."\(^ {129}\) Even though the courts have disagreed as to how strictly or liberally EMTALA should be interpreted with respect to the issue of whether EMTALA is fundamentally a federal malpractice act, the courts have consistently agreed that a cause of action under EMTALA is \textit{not} a medical malpractice action, but one that addresses specific requirements of health care providers while imposing a strict liability standard.\(^ {130}\)

A review of the leading opinions of \textit{Gatewood} and \textit{Cleland}, which have served to establish the general basis for recovery under the Act, indicate as much. It is the emphasis with which each of these cases notes the separateness of an


\(^{125}\)See \textit{id.} at 1389–90.

\(^{126}\)\textit{id.} at 1387 (citing VA. \textit{CODE ANN.} § 8.01-58.15 (Michie Supp. 1992)).


\(^{130}\)See cases cited \textit{supra} note 94.
EMTALA claim from state malpractice claims, as well as their loyalty to the text of the statute itself, which permits the inference that, faced with the issue of whether a state medical malpractice cap should limit damages awarded under EMTALA, the holding of the Power court would be followed by both the District of Columbia Circuit in Gatewood and the Sixth Circuit in Cleland.131

The Gatewood court provides the most emphatic language from which to draw this inference in its opinion concerning the difference between local malpractice law and EMTALA.132 Initially, Gatewood acknowledged that EMTALA does not provide recovery for emergency room negligence or malpractice when it ruled that questions relating to the diagnosis of the patient "remain the exclusive province of local negligence and malpractice law."133 The court's analysis continued to clarify its interpretation of EMTALA and how it relates to state medical malpractice law.134 Gatewood noted the differences in the conduct addressed by each type of law and refused to incorporate a malpractice or negligence standard into the requirements of subsection (a) of the Act.135

With respect to Gatewood's interpretation of EMTALA's text, the court's holding that the statutorial phrase "any individual" failed to limit recovery solely to the indigent and uninsured patients for which, as the court acknowledged, EMTALA was enacted, is also indicative of the court's presumable findings regarding the applicability of state medical malpractice caps to claims under the Act.136 Gatewood's conclusion that EMTALA provides a cause of action separate and apart from malpractice law, in conjunction with its somewhat literal interpretation of the text of the Act, establishes a foundation for such reasonable inference to be drawn that state medical malpractice caps would not be incorporated into the "damages available for personal injury" provision of EMTALA.137

Although the decision in Cleland does not clearly indicate the court's opinion concerning the applicability of state medical malpractice caps, an analysis of its discussion regarding what provides the basis for claims under EMTALA as opposed to state malpractice laws also supports a conclusion that such caps would be preempted by the court.138 Perhaps the strongest indication of this

131 For a discussion of the holding in Power, see supra notes 110–115, 121–128, and accompanying text.

132 See generally Gatewood, 933 F.2d 1037.

133 Id. at 1039. This statement was made by the court in expressing its agreement with such earlier determination by the federal district court.

134 Id.; see supra notes 92 and 94.

135 933 F.2d at 1040–41.

136 Id. at 1041.


is found in the court's dicta with respect to the Act's definition of the term "appropriate."\textsuperscript{139} Specifically, the \textit{Cleland} court noted that, in reference to the medical screening required to be performed by a hospital, the Act's use of the qualifying phrase "within its capabilities" precluded the resort to a malpractice or other objective standard of care in determining what constituted an "appropriate" screening.\textsuperscript{140}

In addition, however, \textit{Cleland} interprets the language of subsection (f) of EMTALA as specifically negating preemption of any malpractice claims joined with an EMTALA claim.\textsuperscript{141} This interpretation, along with the court's preclusion of a malpractice standard as noted above, arguably invokes a preemption of state medical malpractice caps when the language of subsection (d)(2)(A) of the Act is subjected to the court's preemption reasoning.\textsuperscript{142} Although such preemption would appear to be negated by the \textit{Cleland} court, a following of the "plain words" of subsection (f) (EMTALA's preemption clause) would "lead to an absurd result" with respect to the "plain language" of subsection (d)(2)(A) (EMTALA's enforcement clause), thus providing a basis for the court to allow a preemption of state medical malpractice caps under the Act.\textsuperscript{143}

Based on these analyses, as an EMTALA cause of action is deemed to be mutually exclusive of state medical malpractice actions, it cannot be limited by the provisions of a state medical malpractice cap. Just as such a cap would not be applicable to damages awarded under a cause of action for breach of contract, for example, neither should it be applicable to damages awarded under EMTALA. Each cause of action deals with separate and distinct conduct providing the basis for recovery and it is illogical to incorporate a state law limiting damages awarded for a specific type of action to a federal law addressing different conduct held to a separate standard of liability by those courts in granting relief.

\textbf{IV. CONCLUSION}

Patient dumping continues to be a serious problem in the United States nearly eight years after EMTALA's enactment. In 1991, it was estimated from statistics contained in the \textit{New England Journal of Medicine} that approximately

\textsuperscript{139}Id. at 272.

\textsuperscript{140}Id.; see also 42 U.S.C. § 1395dd(a) (Supp. 1992).

\textsuperscript{141}1917 F.2d at 270. The \textit{Cleland} court offers support for its conclusion by citing numerous authorities that suggest that courts should follow the plain words of the statute so long as it does not lead to an absurd result. \textit{Id}.

\textsuperscript{142}See 42 U.S.C. § 1395dd(d)(2)(A) (Supp. 1992) (an individual may obtain those damages "available for personal injury" in the State in which the hospital is located).

\textsuperscript{143}See supra notes 141 and 142.
250,000 patient dumping incidents occur each year in American hospitals.\textsuperscript{144} In contrast, the Department of Health and Human Services had identified only 140 hospitals as having violated the Act, penalizing only 19 of these offenders.\textsuperscript{145} These statistics indicate a nearly complete failure on the part of EMTALA to effectively address patient dumping, contravening the intent of Congress in 1986. Congressional attempts to resolve the patient dumping problem, however, did not begin with the enactment of EMTALA. As early as 1946, the Hill–Burton Act\textsuperscript{146} provided the incentive of federal funding to hospitals for their construction and modernization, as long as the hospital agreed to provide care (including emergency medical care) to certain indigent patients.\textsuperscript{147} This act, too, was found to be an inadequate solution and hospitals, under the ever–increasing pressure to cut costs and increase profit margins, brought patient dumping to its highest level ever during the mid–1980’s.\textsuperscript{148}

The magnitude of this problem suggests that Congress alone cannot alleviate patient dumping by hospitals. Approximately 25 states, in fact, have enacted their own statutes in response to this growing problem\textsuperscript{149} and a report by the Public Citizen’s Health Research Group (“Public Citizen”) credits these local enactments with the tremendous variation in statistics concerning the enforcement of EMTALA throughout the country.\textsuperscript{150}

The decisions of the judicial system regarding EMTALA cases provide additional assistance to the enforcement of the Act. So long as the courts remain split with respect to its liability and enforcement provisions, EMTALA will remain an ineffective attempt to address this critical health care issue.

Recommendations offered by Public Citizen include the use of a broader scope of penalties in EMTALA’s enforcement, in order to create a "clear finan-


\textsuperscript{145}Id.


\textsuperscript{147}Id.

\textsuperscript{148}Id.

\textsuperscript{149}See Stricker, Jr., supra note 28, at 1124–26 n.16.

\textsuperscript{150}HHS’ Enforcement, supra note 144, at A–14. The violations of EMTALA identified by the regional offices of the U.S. Department of Health and Human Services range from zero in Regions I and II (which include New York, New Jersey and Massachusetts) to sixty–seven in Region VI (including Texas, which contains fifty–two of the sixty–seven violations reported). Id. Of these states, only New York and Texas have enacted laws prohibiting the denial by a hospital of emergency medical treatment to indigents or uninsured. See supra note 149.
cial deterrent" to those hospitals found to be in violation of the Act. An amendment to EMTALA by Congress which would specifically prohibit the application of state medical malpractice caps to damages awarded under the Act would provide such recommended deterrent. The analysis presented in Part III of this Note provides support for the suggestion that such an amendment would be proper.

Although the differences in interpretations of EMTALA by the federal courts have lessened the Act's overall effectiveness, EMTALA remains the most direct attempt yet by Congress to provide necessary medical treatment for its citizens. Until such additional actions are taken by Congress, either by amendments to EMTALA or through the enactment of additional health care reforms, the Act's overall interpretation by the judiciary will determine the future assurance of emergency medical treatment in the United States.

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151HHS' Enforcement, supra note 144, at A-14.