The Enduring Role Of The Emergency Medical Treatment And Active Labor Act

Sara Rosenbaum

The online version of this article, along with updated information and services, is available at:

http://content.healthaffairs.org/content/32/12/2075

For Reprints, Links & Permissions:
http://content.healthaffairs.org/1340_reprints.php

Email Alertings:
http://content.healthaffairs.org/subscriptions/etoc.dtl

To Subscribe:
https://fulfillment.healthaffairs.org
The Enduring Role Of The Emergency Medical Treatment And Active Labor Act

ABSTRACT The Emergency Medical Treatment and Active Labor Act (EMTALA) is a seminal law that imposes screening, stabilization, and transfer duties on all Medicare-participating hospitals that have emergency departments. More than twenty-five years after its enactment, EMTALA continues to generate controversy over the scope and depth of its obligations on issues ranging from the nature of the screening obligation and rules regarding on-call specialists to whether EMTALA’s stabilization protections exclude emergency inpatients. Despite ongoing questions that flow from its detailed provisions, EMTALA is an enduring testament to society’s evolving views that hospitals must provide emergency care not only to their established patients but to the broader communities they serve.

In general, laws either compel or prohibit activities on the part of people, institutions, and governments and, in so doing, exert power over them. Some laws, however, seem to transcend their immediate purpose and reflect deeply held social values and beliefs. The Emergency Medical Treatment and Active Labor Act (EMTALA), enacted under the Consolidated Omnibus Budget Reconciliation Act of 1986,1 is one such law. EMTALA requires all Medicare-participating hospitals with emergency departments (EDs) to provide certain enforceable standards of emergency care, including screening; stabilization; and, in certain cases, transfer of unstable patients. In doing so, EMTALA departs from common-law principles by providing a legal duty on the part of hospitals toward people who are not yet their patients.

The Affordable Care Act reaffirmed EMTALA’s preeminent position in American health policy that in her dissent in National Federation of Independent Businesses v. Sebelius, Supreme Court Justice Ruth Bader Ginsburg cited preservation of EMTALA’s promise of nationwide emergency care access as a basis of Congress’s power under the Commerce Clause to regulate the health economy by requiring people to maintain affordable health insurance coverage.4

EMTALA’s Legal Origins

Far from being a dramatic departure from prior law, EMTALA was the culmination of a generational shift in how courts and legislatures viewed hospitals’ emergency care obligations, not only toward their established patients but, just as important, to people who had not yet been accepted into care. This transformation of the legal relationship between hospitals and community residents began in the state courts, whose decisions on matters of tort, contract, and property constitute the core of the common law—the backbone of the American legal system. In redefining hospital duties during medical emergencies, the courts rejected the “no duty of care” principle,5 a
foundational tenet of health care law that gives hospitals and physicians enormous power to select their patients.

To be sure, the no-duty principle has been softened over the years. Physicians, hospitals, and other health care providers today routinely relinquish their autonomy over patient selection when they join insurers’ provider networks and contract to furnish services to all plan members. Federal civil rights laws limit the power of providers to select patients based on certain grounds, such as disability, race, or national origin. Lawmakers have established health care safety-net providers, such as community health centers and public hospitals, which have a legal duty to treat all residents of their service areas. And once the provider-patient relationship is established, common law recognizes fundamental obligations, including the duty of reasonable care and a prohibition against patient abandonment.

In the main, however, the no-duty principle remains controlling law. Legally speaking, health care providers enjoy broad latitude over whom they will treat—a fact that allows them to reject patients for any number of reasons, including the lack (or type) of insurance or a desire to avoid patients perceived as difficult. The power of medical providers to select their patients is exemplified by Hurley v. Eddingfield, an early common-law case in which the Indiana Supreme Court absolved a physician from liability for refusing “for no reason whatsoever” to attend a woman who previously had been his patient and who was dying in childbirth.

In the case of hospitals, however, by the mid-twentieth century, state courts began to carve out a medical emergency exception to the no-duty principle. This important shift in legal doctrine underscores the extent to which, as Oliver Wendell Holmes observed in The Common Law, experience shapes the law. The social position of hospitals was transformed by extraordinary technological advances in medical care generally and emergency care in particular. These advances were accompanied by a concomitant growth in public financing for hospitals. These intertwined developments exponentially expanded the size and power of hospitals while embedding their existence in public policy. Hospitals were effectively transformed from modest, economically fragile community institutions into medical powerhouses whose size derived in no small part from public investment.

A leading case that captures the impact of this transformation on legal doctrine is Manlove v. Wilmington General Hospital. Manlove involved the death of a four-month-old baby who had been brought to the hospital with a medical emergency and had been turned away because, according to the Delaware Supreme Court, “[the parents] failed to account for the formality of admission requirements” and lacked a referral from their baby’s personal physician. At the time, a referral was a requirement of hospital emergency departments—a custom that existed for the convenience of the medical staff, not the needs of the community.

In the ensuing wrongful death action, plaintiffs, seeking to prevent dismissal of the case in accordance with the no-duty principle, argued that the hospital had begun treatment before turning the family away. The hospital, invoking the no-duty principle as a shield, argued that however morally repugnant its actions, it did nothing wrong legally.

In its precedent-setting decision, the Delaware Supreme Court observed that time had transformed hospitals’ role in society and that this reframing inevitably led to a basic rethinking of how the law should treat the relationship between hospitals and the community: “It is...argued that the applicable common law rule is that [a physician] is under no legal duty to accept any person for treatment, no matter how extreme the emergency.... Assuming...that a private physician may refuse to aid or treat in emergency cases...such a similarity cannot be said to exist in respect to the defendant. The...defendant’s acceptance of direct tax benefits, together with financial subsidies from the State, has...changed its characterization to that of a quasi public institution [that] should be required at all times to render reasonable needed aid in those instances where an emergency involving death or serious bodily impairment might reasonably be said to exist.”

Other state courts eventually adopted Manlove’s reasoning into their common-law rulings. Furthermore, the Manlove doctrine found its way into state licensure law and judicial decisions enforcing licensure standards.

Federal policy trends also began to emerge. In 1969 the Internal Revenue Service issued Revenue Ruling 69-545, which established the “community benefit” standard that governs the operations of nonprofit hospitals that seek tax-exempt status. In its ruling, the Internal Revenue Service cited emergency care to the community as an example of a community benefit, stating explicitly that limiting emergency departments to the “convenience” of hospitals’ medical staff would contravene community benefit obligations. In the 1970s the Hospital Survey and Construction Act of 1946 (popularly known as the Hill-Burton Act) was reinterpreted through regulations to require all hospitals subject to its community service obligation to offer emergen-
EMTALA might be thought of as an “in the moment” statute, a law whose obligations cease as soon as the emergency condition is stabilized.

As important as these federal policy developments were, their provisions were ambiguous. For example, the 1979 Hill-Burton rules failed to define the term emergency. Furthermore, the provisions applied only to public and private non-profit hospitals—a notable limitation given the emerging growth of the for-profit hospital industry.

The Legislative Response: EMTALA

As crafted by Congress, EMTALA was a legislative response to several distinct developments. The first was evidence of “patient dumping”—that is, EDs’ refusal to treat indigent people seeking care for emergencies and the medically inappropriate transfer of unstable patients. The second was the failure of existing laws to reach for-profit hospitals. A third consideration was the potential for Medicare’s inpatient hospital prospective payment system, established in 1983, to trigger the discharge of unstable Medicare inpatients. This third concern was reflected in EMTALA’s legislative history, in which the House of Representatives noted that evidence of unstable discharges had “worsened since the prospective payment system for hospitals became effective” and, therefore, that it was necessary 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.”

With the exception of a provision in the House bill allowing private individuals to sue to enforce the law, EMTALA was passed in virtually the same form by a Democratic House and a Republican Senate and signed into law by President Ronald Reagan in 1986. (The Senate acquiesced to the House on the question of private enforcement rights.) EMTALA was drafted as a highly detailed statute. Its ten subsections spell out the emergency care obligations of all Medicare-participating hospitals with EDs and establish both governmental and private enforcement.

EMTALA creates two basic obligations: screening and stabilization. In limited circumstances, the law also permits transfers of unstable emergency patients.

**Medical Screening Exam Obligation** Rejecting the no-duty principle, EMTALA obligates Medicare hospitals to initiate care in potential medical emergencies through the crucial screening requirement, codified in its opening subsection (a). Hospitals must provide an “appropriate” screening exam to “any” individual who “comes to” the “emergency department” and on whose behalf a request for care is made. The screening exam must be performed “within the capabilities” of the emergency department, including “ancillary services routinely available” to the emergency department. A web of regulations provides additional definitions, and as with rules interpreting statutes generally, these definitions are designed to both specify and limit the scope of the law. But despite the regulatory constraints placed on terms such as comes to and emergency department, the power of subsection (a) remains undeniable: Hospitals must screen people who request their help for a possible emergency.

**Necessary Stabilizing Treatment and Medically Appropriate Transfer Obligations** In contrast to subsection (a), subsection (b), which addresses hospitals’ stabilization duties, refers to the “hospital” rather than the hospital’s “emergency department.” The law specifies that when an individual “comes[es] to a hospital” and is determined to have an emergency medical condition, the “hospital” must provide for further examination and treatment “as may be required to stabilize the medical condition,” using “the staff and facilities available at the hospital.” The term to stabilize means to provide such treatment for an emergency medical condition “as may be necessary to assure, within reasonable medical probability, that no material deterioration … is likely to result from or during the transfer… from a facility.” The term transfer means “the movement, including a discharge of an individual outside a hospital’s facilities” at the direction of staff.

Under limited circumstances, EMTALA permits a hospital to transfer an unstable patient. These circumstances entail a signed physician certification that the benefits of a transfer outweigh its risks, coupled with a medically appropriate transfer as defined in the law.
Despite highly detailed and often limiting regulations, EMTALA litigation has been intense and extensive.

Despite highly detailed and often limiting regulations, EMTALA litigation has been intense and extensive.

Implementation And Enforcement

EMTALA Liability Versus Liability for Poor-Quality Care Perhaps the most common EMTALA case involves a person who alleges that a hospital failed to provide an “appropriate” screen. Because EMTALA’s purpose is to ensure emergency treatment, not to federalize malpractice law, a key question becomes whether a “failure to appropriately screen” amounts to an EMTALA claim or a medical liability claim of poor-quality care. (Although medical liability claims can be very serious, an EMTALA infraction directly threatens a hospital’s standing in federal insurance programs.)

In wrestling with this question, courts have developed a legal rule of thumb: EMTALA applies when the facts show either an actual or effective failure to conduct a medical examination or a discriminatory examination that effectively fails to meet the hospital’s own policies regarding the appropriate response to identified symptoms. By contrast, a malpractice claim is one that is professionally subpar—that is, the exam fails to reasonably recognize (and act on) symptoms. As a result, an EMTALA claim was proper in a case...
involving a young woman who lost both legs and vision in one eye and experienced severe lung damage when a hospital failed to follow standard procedures for her presenting symptoms, which indicated a blood test to diagnose possible sepsis. On the other hand, a hunter’s EMTALA claim amounted to malpractice when evidence showed that an ED physician missed certain symptoms entirely and failed to perform necessary tests to diagnose a broken back following a hunting accident.

WHEN DOES A PERSON ‘COME TO’ A HOSPITAL EMERGENCY DEPARTMENT? The statute’s screening obligation is triggered when a person comes to an emergency department. Federal regulations issued in 2003 attempt to parse both what constitutes a hospital “emergency department” (as opposed to other departments and services of a hospital) and when a person is considered to have “come to” the emergency department. The regulations establish the concept of a “dedicated emergency department,” which consists of “any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus,” which is licensed as an emergency department, held out to the public as being “available for emergency or urgent care without an appointment,” or effectively functions in this manner at least one-third of the time. Thus, how the facility conducts itself in relation to the public—a throwback to Manlove’s focus on how the hospital relates to a community—becomes part of the “comes to” test. In this vein, outpatient labor and delivery units, psychiatric units, and sites that treat unscheduled cases all may qualify as emergency departments. Federal regulations also clarify that “comes to” does not necessarily require literal entry into the ED; simply being on a hospital’s main campus (for example, a parking lot or sidewalk) can satisfy the “comes to” test.

Because the history of hospital discrimination shows that some hospitals historically used ambulance systems to cherry-pick desirable patients, the 2003 rules established an elaborate hierarchy for determining when patients in ambulances are considered to have come to a hospital. Under the rules, a patient effectively belongs to the hospital that owns the ambulance. But the rules also specify that when a hospital’s ambulance is operating as part of a community-wide emergency medical services (EMS) protocol that directs the ambulance elsewhere, the patient is not considered to have “come to” the hospital if the hospital is on “diversionary status” and directs the ambulance elsewhere. Even then, however, if the ambulance ignores the instruction and proceeds to the hospital, its EMTALA duty prevails.

STABILIZATION OF PATIENTS WHOSE LONG-TERM PROGNOSIS IS FUTILE One of the most legally and ethically complex questions to have arisen under EMTALA is the extent of a hospital’s stabilization duties when a patient with a medical emergency has an underlying condition that renders treatment ultimately futile. As is frequently the case, it is the extreme and tragic cases that shape the law. One case that wrenchingly wrestled with the question, In the Matter of Baby K, involved a baby born with anencephaly (the absence of much of the brain). Her prognosis was fatal, but her mother insisted that she be placed on a respirator. Periodically over the course of her short life, Baby K would stop breathing and would be rushed to the hospital from the nursing home in which she resided. Faced with this situation, the hospital sought a judicial declaration that Baby K’s underlying condition made resuscitation futile. Ultimately the US Court of Appeals for the Fourth Circuit ruled that EMTALA’s stabilization duties in the face of an emergency medical condition are absolute, even when professional norms would dictate the withdrawal of active treatment for the underlying condition. Here, the medical emergency was apnea, and the appropriate treatment was resuscitation. It did not matter, for purposes of EMTALA’s stabilization requirement, that Baby K’s underlying condition dictated warmth and comfort. The decision reflects a clear viewpoint regarding EMTALA’s absolute command of stabilization treatment for all people during times of emergency. The law contains no exceptions to permit deliberations over futility at the point of emergency treatment.

DOES EMTALA’S STABILIZATION DUTY EXCLUDE INPATIENTS? One of the most contentious issues is whether EMTALA’s stabilization duty excludes inpatients. The federal appeals courts are divided on the matter; one appeals court has explicitly rejected the legality of CMS regulations, which deny stabilization protection once a patient is admitted as an inpatient.

EMTALA’s statutory text is a starting point for understanding the issue. As previously described, EMTALA’s screening provision clearly applies only to hospital emergency departments. By contrast, the stabilization requirement refers to hospitals generally, providing that if “any individual comes to a hospital” and an emergency medical condition is diagnosed, then “the hospital” must stabilize the patient (or appropriately transfer the unstable patient). The difference in wording between the two subsections is apparent.

As noted, the statute’s definitions of to stabilize and transfer both express the duty of hospitals in relation to movement from a hospital “facility”
and do not restrict their scope to movement from a hospital’s emergency department.

Proposed EMTALA regulations published in 2001 would have clarified that the stabilization requirement protects inpatients admitted through the ED: “Admitting an individual whose emergency medical condition has not been stabilized does not relieve the hospital of further [EMTALA] responsibility to the individual.” The agency noted that its proposal was consistent with Roberts v. Galen of Virginia. In Roberts, the US Supreme Court ruled that improper motive need not be proven to win an EMTALA stabilization claim against a hospital and assumed without discussion that the stabilization provision extended to inpatients.

Between the proposed and final rule however, the US Court of Appeals for the Eleventh Circuit ruled en banc in Harry v. Marchant that the EMTALA stabilization obligation ended upon inpatient admission. In so ruling, the court reversed and vacated an earlier decision by an Eleventh Circuit three-judge panel, which had extended the stabilization obligation to emergency inpatients. The full court concluded that the term to stabilize contained an ED limitation, even though the definition lacks any reference to the ED and instead references the “facility.” The impact of reading the stabilization definition in this fashion was to terminate the hospital’s stabilization duty at the point at which the patient was moved to inpatient status.

The final 2003 EMTALA rules adopted the en banc Marchant holding, specifying that the stabilization duty ends upon inpatient admission unless an individual can demonstrate bad faith on the part of the hospital—that is, an inpatient admission for the express purpose of being able to transfer the patient without raising EMTALA issues. Taking matters a step further, the final rule stated that the transfer obligations of hospitals with specialized capabilities also cease upon inpatient admission, because inpatient admission ends the patient’s EMTALA protections, and specialized hospitals are no longer under a duty to accept a transfer case. In other words, under the final rule, the right to gain access to a hospital with specialized capabilities under EMTALA depends on the patient’s remaining in the emergency department (potentially indefinitely), regardless of the implications for health care quality or outcome.

Because the federal government has conducted no empirical research on the health and health care consequences of the 2003 rules, there is no way to reliably measure their impact. CMS proposed to revise the rule in its fiscal year 2009 inpatient prospective payment system rule to restore the obligations of specialized capability hospitals following inpatient admission. The agency did not adopt the final rule in the wake of objections by hospitals. CMS again sought additional information in 2010 on the question of whether its rule should be revised but in 2012 issued a statement retaining its 2003 policy because “very few comments” favoring revision had been received. The absence of comments probably comes as no surprise, given the absence of evidence developed by the government on the rule’s impact on hospital behavior, the quality of patient care, or patient health.

One court has flatly rejected the 2003 inpatient rule. In Moses v. Providence Hospital and Medical Centers, the US Court of Appeals for the Sixth Circuit held that a hospital could face liability for the death of a woman murdered by her mentally ill husband who had been discharged ten days earlier in an allegedly unstable condition, following an emergency inpatient admission. In its ruling, the Sixth Circuit concluded that the 2003 rule was “contrary to EMTALA’s plain language.” The 2010 CMS solicitation came in the wake of the Providence Hospital decision and followed a recommendation by the solicitor general of the United States that the Supreme Court not hear Providence Hospital’s appeal on the ground that the agency was reassessing its regulation. Thus, as of 2013, the end of EMTALA stabilization protections following an emergency inpatient admission remains official agency policy. Presumably because of this, no data are collected on the impact of the rule, since the rule is that no protections are available. The Sixth Circuit has signaled its intent not to apply agency policy, although other circuits that have considered the issue to date appear to have adopted it.

EMTALA remains a sweeping testament to the fundamental proposition that in the wealthiest nation on Earth, no person should be denied emergency medical care.
Whether the Supreme Court ultimately will hear an appeal remains to be seen. There is no evidence of formal congressional interest in the matter.

**On-Call Specialists** A final area of controversy involves the question of on-call specialists. The statute does not explicitly specify on-call specialists as an EMTALA requirement, although sanctions can be applied if an on-call specialist fails or refuses to respond to a request for assistance with an emergency case. In what was seen as a major victory for specialists, the 2003 rule relaxed previous requirements, specifying only that hospitals maintain an on-call list that “best meets the needs of” the hospital’s patients receiving emergency care. A subsequent revision eliminated the “best meets the needs” standard, which granted enormous discretion to hospitals in favor of tighter requirements over hospitals’ on-call policies and practices. But these tighter requirements do not bar such practices as permitting specialists to perform elective surgery while on call, perform on-call services for multiple institutions, or participate in community-wide on-call systems. In other words, hospitals are expected to adopt formal standards, but these standards can accommodate the reality of attempting to maintain on-call capacity in today’s health care system.

**Conclusion**

EMTALA occupies a unique place in the nation’s health care system. Despite its singular nature, though, the law did not appear as some sort of deus ex machina; to the contrary, its statutory commands are a culmination of a seminal shift in the law following the transformation of the role of hospitals in American society.

Since EMTALA’s enactment, its terms have been softened through both administrative policy and extensive judicial interpretation. But EMTALA remains a sweeping testament to the fundamental proposition that in the wealthiest nation on Earth, no person should be denied emergency medical care.