STRADDLING THE LINE OF MEDICAL MALPRACTICE: WHY THERE SHOULD BE A PRIVATE CAUSE OF ACTION AGAINST PHYSICIANS VIA EMTALA

Lawrence Bluestone*

INTRODUCTION

On October 29, 1996, at 9:00 A.M., Chitina Williams, an uninsured woman, pregnant with twins, came to the Provident Emergency Room in active labor. Without assessing her condition, the on-call emergency room physician and obstetrician recommended her transfer to St. Anthony’s Hospital and instructed Ms. Williams to wait in the lobby for transportation. Ms. Williams waited for three hours without being treated or transferred. At noon, she began to deliver the baby but was still not treated. At 12:30 P.M., the feet of the first baby began to protrude from Ms. Williams’ birth canal, and only then did the doctors approve of her admission to Provident. When the baby was finally delivered it was decapitated, the torso being delivered and the head remaining inside of Ms. Williams. The doctors did not tell Ms. Williams about this, and at 1:30, after having been left unattended, Ms. Williams expelled the decapitated head of the first baby onto the bathroom floor while using the bathroom. The second baby was born hours later and died later that day. The hospital did not explain the cause of death to Ms. Williams and did not give her the opportunity to conduct a funeral service. Later that month, the hospital performed an autopsy on the babies without receiving Ms. Williams’ consent.1

On December 25, 2000, Mr. Marrero, an uninsured sixty-three-year-old man with a history of diabetes, hypertension, asthma, and psychiatric conditions, woke up vomiting and feeling dizzy. Mrs.

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Marrero drove her husband to the Diagnostic and Treatment Center of Naranjito, which referred them to the Hospital Hermanos Melendez. After waiting for a half an hour at the Hospital, a triage nurse took Mr. Marrero’s vitals. After another forty-five minutes, Mr. Marrero began fainting and a triage nurse took him inside for evaluation. Mr. Marrero was categorized as “green,” or stable, but requiring treatment. After another hour and a half, Dr. Norma S. Lopez gave Mr. Marerro Tylenol and did not order any further tests. After another hour, Dr. Lopez ordered an electrocardiogram (EKG) and CBC laboratory test. Mr. Marerro was never given the EKG. After five hours of receiving no medical treatment, Dr. Juan A. Maldonado Saravia examined Mr. Marerro and told him that the CBC would have to be repeated. After three more hours, Dr. Maldonado Saravia returned and discharged Mr. Marerro over Mrs. Marerro’s fervent protests. Mr. Marerro died three days later of a cerebral edema associated with diabetes.

Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986 in an effort to curb growing concerns that hospital emergency rooms were “dumping” indigent patients. Patient dumping occurs when a hospital refuses to provide medical services to a patient for economic or any other non-medical reason.

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2 A CBC or “Complete Blood Count” is “a combination of the following determinations: red blood cell count, white blood cell count, erythrocyte indices, hematocrit, differential blood count, and sometimes platelet count.” STEMDAN’S MEDICAL DICTIONARY 51,930 (27th ed. 2000)

3 A “cerebral edema” is “brain swelling due to increased volume of the extravascular compartment from the uptake of water in the neuropile [gray matter] and white matter.” Id. at 12,4770.


“EMTALA” is somewhat of a misnomer as the word “active” was deleted from the title of the law in 1989, Pub. L. No. 101-239 §6211(h)(2), after commentators noted that there was no real difference between “active” labor and any other type of labor. Joan M. Stieber & Linda J. Spar, EMTALA in the ’90s—Enforcement Challenges, 8 HEALTH MATRIX 57, 58 (1998). However, most commentators refer to the act by the easier to say acronym of EMTALA. Id.


Under EMTALA, an individual who has suffered personal harm resulting from a violation can sue the hospital, but not the doctor responsible. Yet after twenty years, people like the Williamses and Marreros are still being turned away or transported without proper treatment, with disastrous results. Scholars have frequently charged that EMTALA is ineffective because of inconsistent judicial interpretation of a vague statute. One group of scholars has even proposed eliminating the federal statute altogether and creating a new intentional tort of patient dumping under state law in its stead.

This Note will argue that the one area where the Courts have most consistently interpreted EMTALA—the recognition of a private cause of action for EMTALA violations, as against hospitals and not against individual physicians—is what prevents EMTALA from working
effectively. That is, the limitation of private party defendants strips EMTALA of its effectiveness. Ultimately, courts have rested the conclusion to limit private causes of action to ones against hospitals, not physicians, on what appears to be an accurate interpretation of the statute’s legislative history. The legislative history appears organized around two goals: primarily to prevent patient dumping,¹³ and secondarily to do so without creating a federal medical malpractice action.¹⁴ However, this Note will urge a reanalysis of the congressional history and the priorities it creates in an effort to harmonize the enforcement of EMTALA with the congressional goal of preventing a federal malpractice action.¹⁵ In the end, this Note will conclude that a private cause of action against individual physicians must be allowed to effectuate Congress’s first goal and that this can be done without thwarting Congress’s second goal.

Part I will briefly describe EMTALA’s twenty-year history, including a discussion of the phenomenon of patient dumping and its continued existence. Part II will discuss the current public and private enforcement regime, how it works, and how the courts have limited its effectiveness. This Part will also discuss the almost unanimous case law eliminating a private cause of action against an individual physician and the origin of this rationale in the congressional record. Finally, it will also discuss two important proposals to improve deterrence of patient dumping.¹⁶ Part III will analyze the language of the statute and its congressional history to see if the courts could infer a private right of action against individual physicians. This Part will then examine such a private right of action and explain why it would fall short of a medical malpractice action. The Note will conclude with an explanation of how this interpretation of EMTALA is well within the understanding of the statute as interpreted by the current case law and regulations.

¹⁵ Even early on in EMTALA’s history, commentators seemed to recognize that in order for the statute to be effective, the courts would have to be more active in fashioning adequate relief. See Karen I. Treiger, Note, Preventing Patient Dumping: Sharpening COBRA’s Fangs, 61 N.Y.U. L. REV. 1186, 1223 (1986) (“If the Hill-Burton experience is any guide to HHS enforcement of COBRA, the courts will have to assume a primary role in fashioning remedies in order to ensure compliance with the statute.”); see infra note 25 for more on the Hill-Burton act and its relation to EMTALA.
¹⁶ The two proposals are found in Gionis, supra note 9, at 295 and Michael J. Frank, Tailoring EMTALA to Better Protect the Indigent: The Supreme Court Precludes One Method of Salvaging a Statute Gone Awry, 3 DEPAUL J. HEALTH CARE L. 195 (2000).
I. BACKGROUND: A BRIEF HISTORY OF EMTALA

A. The 1985 COBRA

The 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA) found its origins in an increasing deficit, particularly in the Medicare and Medicaid program, coupled with increasing reports that hospitals—almost all of which were receiving large amounts of funding from the government via Medicare and Medicaid—were “dumping” indigent patients. Patient dumping occurs when a hospital refuses to provide emergency screening and stabilization services to a patient for non-medical reasons. These reasons are typically linked to the indigent patient’s insurance status, but there have also been reports of patient dumping linked to other non-medical factors, such as the patient’s race, ethnicity, sexual orientation, or contraction of a socially unacceptable disease. Congress responded to a number of academic studies conducted in the mid-1980s, including the Harvard Medical School Study and the Cook County Study, which found patient

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18 Id. at 726-27; Gionis, supra note 9, at 181.
19 Kamoie, supra note 7, at 42.
20 Id.
21 Gionis, supra note 9, at 176 (citing Seth M. Manoach et al., Social Bias and Injustice in the Current Health Care System, 9 ACAD. EMERGENCY MED. 241, 242 (2002), available at http://www.aemj.org/cgi/content/full/9/3/241; see 131 CONG. REC. S13892-01 (1985) (statement of Sen. Kennedy) (“[O]ver the last few years, disturbing reports have surfaced about individuals who have been denied emergency services at hospitals in many locations around the country. They have been denied services because they lacked health insurance or funds to pay cash at the door. In some cases, racial discrimination may have been involved.”)).
22 David U. Himmelstein et al., Patient Transfers: Medical Practice as Social Triage, 74 AM. J. PUB. HEALTH 494 (1984) [hereinafter HARV. MED. SCH. STUDY]. In legal literature, this study is referred to as the “Harvard Medical School Study,” despite the fact that the study was conducted at Highland General Hospital in Alameda County, California, because of the university affiliation of the researchers. Gionis, supra note 9, at 190 n.82; HARV. MED. SCH. STUDY, supra at 494-95. The Harvard Medical School Study reviewed the logs of Highland General’s emergency room to find patients who had been transferred from other hospitals. HARV. MED. SCH. STUDY, supra at 495. During a six month period, 458 patients were transferred from private hospitals to Highland, a public hospital. Id. Of these patients, sixty-three percent of those transferred were uninsured, twenty-one percent had Medicaid and thirteen percent had Medicare, while only three percent had private insurance. Id. Of these patients, four doctors reviewed those patients they thought were identified as high risk, which amounted to 103 patients. Id. In thirty-three cases, “transfer was judged to have jeopardized the patient,” id., six of whom had central nervous system trauma, eight of whom were at high risk for exsanguination during transfer, five of whom had pneumothoraces (build up of air or gas in the pleural cavity in the lungs) or
dumping in alarming numbers.

From this concern, Congress enacted EMTALA in an attempt to deter patient dumping.\textsuperscript{24} EMTALA imposes two main requirements on hospitals that receive funding from Medicare and Medicaid. First, if a patient comes to a hospital emergency room and requests treatment, the patient must be given an “appropriate medical screening examination.”\textsuperscript{25} There is wide disagreement as to what standard of care should apply in order to meet this “appropriate” requirement, with some

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hemothoraces (build up of blood in the pleural cavity in the lungs) and ten of whom had orthopedic injuries that the reviewing doctors found would have been desirable to treat immediately. \textit{Id.} at 495-96; \textsc{Stedman’s Medical Dictionary}, supra note 2, at 323,250, 178,340.

\textsuperscript{23} Robert L. Schiff et al., \textit{Transfers to a Public Hospital: A Prospective Study of 467 Patients}, 314 N. ENG. J. MED. 552 (1984). The Cook County study looked at 467 transfer patients to the Cook County public hospital from various private hospitals. \textit{Id.} at 553. Of these patients, forty-six percent received insurance from an Illinois state program, forty-six percent were uninsured, three percent had Medicaid, and only one percent had private insurance. \textit{Id.} In an instance of remarkable candor, in eighty-seven percent of the cases, the transferring hospital gave as a reason for the transfer “lack of insurance.” \textit{Id.} The clinical reviewers in the study found that twenty-four percent of the patients were unstable. \textit{Id.} at 554. Among some of the conditions that these patients suffered were pneumonia with hypoxia, blunt head trauma accompanied with vomiting in the emergency room, first and second degree burns over eleven percent of the body, a fall from a third story building, and hypertension. \textit{Id.} at 555. The study concluded that patients are transferred to Cook County Hospital from other hospital emergency departments predominantly for economic reasons. The fact that many patients are in a medically unstable condition at the time of transfer raises serious questions about the private health sector’s ability to consider the condition and well-being of patients objectively, given the strong economic incentives to transfer the uninsured. The delay in providing needed medical services as a result of the transfer process represents a serious limitation of the access to and quality of health care for the poor.

\textit{Id.} at 556.


\textsuperscript{25} 42 U.S.C. § 1395dd(a) (2000) provides:

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

\textit{See also} Kamoie, supra note 7, at 46. An emergency medical condition is defined as 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 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, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

42 U.S.C. § 1395dd(e)(1)(A). EMTALA was not the federal government’s first attempt to try to provide wider access to emergency services—the 1946 Hill-Burton Act was the first to address this issue. \textit{See} 42 U.S.C. § 291c(e); \textit{see also} Kamoie supra note 7, at 42.
district courts within circuits applying different tests. Hospitals are further required to stabilize patients that are experiencing an emergency medical condition before transporting them or refusing treatment.

B. Regulatory Amendments in 2003

Amid rising discontent about vagueness in the statute, the Centers

26 Gionis, supra note 9, at 217-18. Some districts apply an objective standard, others a subjective standard, and still others a burden shifting standard. Id. at 217. See, e.g., Eberhardt v. City of Los Angeles, 62 F.3d 1253 (9th Cir. 1995) (objective standard); Power v. Arlington Hosp. Ass’n, 42 F.3d 851, 858 (4th Cir. 1994) (burden shifting standard); Baber v. Hosp. Corp. of Am., 977 F.2d 872, 879 (4th Cir. 1992) (subjective standard).

27 42 U.S.C. § 1395dd(b)(1) reads:

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

The term “stabilize” is defined as:

with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

Id. § 1395dd(e)(3)(B). An “appropriate transfer” is one:

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual’s health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility—

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

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

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual’s emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

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

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

Id. § 1395dd(c)(2).

28 See Frank, supra note 16, at 197-217 for a discussion of the pre-2003 ambiguities in the
for Medicare and Medicaid Services (CMS)\textsuperscript{29} issued a new set of regulations in 2003 in an attempt to clarify the provisions of EMTALA for health care professionals.\textsuperscript{30} Importantly, CMS attempted to clarify the outer bounds of EMTALA liability. If an individual comes to an emergency department for what is clearly not emergency care, EMTALA still applies, but “the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.”\textsuperscript{31}

Additionally, the two EMTALA requirements are to be read conjunctively.\textsuperscript{32} EMTALA requires both an appropriate medical screening examination\textsuperscript{33} and stabilization of those patients who are determined to have an emergency medical condition.\textsuperscript{34} The question that plagued hospitals and courts was whether the stabilization requirement applied to those patients who did not come to the hospital through the emergency department. If the statute is interpreted disjunctively, a hospital is required to comply with EMTALA stabilization requirements for an inpatient even though this patient did not enter the hospital through the emergency department and therefore could not have received a screening examination.\textsuperscript{35} CMS clarified, however, that the statute is to be read conjunctively. That is, hospitals must only meet the second EMTALA requirement, stabilization, for patients who enter through the emergency department, and who therefore have already received a screening examination.\textsuperscript{36}

\textsuperscript{29} CMS is the group within the Department of Health and Human Services (HHS) responsible for enforcing the Medicaid and Medicare programs. See CMS, Overview, http://www.cms.hhs.gov/History/ (last visited Feb. 14, 2007), for a discussion of CMS’s history since the passage of the Medicaid and Medicare programs during the Johnson administration. EMTALA was an amendment to the Medicaid and Medicare Act and is only applicable to hospitals that receive funding from either Medicaid or Medicare. 42 U.S.C. § 1395dd(e)(2) (“The term ‘participating hospital’ means a hospital that has entered into a provider agreement under section 1395cc of this title.”); see also Stieber & Spar, supra note 5, at 59-60 (“EMTALA applies only to hospitals that participate in Medicare (which is almost all hospitals) and that offer emergency services. However, it applies to all patients who come to the hospital seeking emergency care, not just those who are Medicare beneficiaries.”) (footnotes omitted).


\textsuperscript{31} 42 C.F.R. § 489.24(c) (2006).

\textsuperscript{32} See id. § 489.24(d)(2)(i)-(iii).

\textsuperscript{33} 42 U.S.C. § 1395dd(a); see also supra note 25 and accompanying text.

\textsuperscript{34} Id. § 1395dd(c)(1)-(2); see also supra note 27 and accompanying text.

\textsuperscript{35} See Gionis, supra note 9, at 264-73 for an explanation of the circuit split that existed before the 2003 regulations in interpreting EMTALA either as conjunctive or disjunctive.

\textsuperscript{36} 42 C.F.R. § 410.2(5) (An outpatient is “a person who has not been admitted as an inpatient
C. Patient Dumping: A Continuing Phenomenon

Since the passage of EMTALA, statistical compilations as to the continued existence of patient dumping in hospital emergency rooms but who is registered on the hospital . . . records and receives services (rather than supplies alone) directly from the hospital . . . ”).

CMS clarified that “EMTALA does not apply to outpatients—even if during an outpatient encounter they are found to have an emergency medical condition and are transported to the hospital’s dedicated emergency department. Instead of EMTALA protection, the outpatient is protected by state malpractice law and Medicare conditions of participation.” Kamoie, supra note 7, at 51-52. CMS further clarified that EMTALA does not apply to patients that have already been admitted as inpatients. However “the hospital cannot admit the patient to end the EMTALA obligation and then immediately discharge the individual.” Id. at 52.

Additionally, CMS clarified what it means for a person to “come to an emergency department.” CMS described three conditions that would be considered to trigger EMTALA duties. First, EMTALA duties are triggered if a person comes to a hospital’s “dedicated emergency department,” defined more broadly than before as:

- any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:
  1. It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;
  2. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
  3. During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

42 C.F.R. § 489.24(b)(4). Second, EMTALA duties are triggered if a person presents himself or herself anywhere else on hospital property. “Hospital property” is defined as the entire main hospital campus . . . including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the hospital’s main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities.

Id. Third, EMTALA duties are triggered if the person is in a ground or air ambulance owned and operated by the hospital, unless a community Emergency Medical Services group operates the ambulance independently of the hospital, or it is operated by an independently affiliated physician. Id. § 489.24(b)(3)(i)-(ii) (2006).

Finally, CMS clarified EMTALA’s oft-criticized on-call requirements. EMTALA requires hospitals “to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition.” 42 U.S.C. § 1395cc(a)(1)(I)(iii). CMS, responding to the concerns of the medical community, reiterated that they allow “hospitals flexibility to comply with EMTALA obligations by maintaining a level of on-call coverage that is within their capability.” Medicare Program; Clarifying the Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 Fed. Reg. 53,222, 53,251 (Sept. 9, 2003) (codified at 42 C.F.R. pts 413, 482, and 489). Many media sources and private groups have reacted with concern to what seems to be a relaxing of EMTALA standards. Kamoie, supra note 7, at 53; see also e.g., Robert Pear, Emergency Rooms Get Eased Rules on Patient Care, N.Y. TIMES, Sept. 2, 2003, at A1.
have been sparse.\textsuperscript{37} However, the data that is available, along with well reasoned inferences, suggest that the phenomenon persists.\textsuperscript{38} The first source of data comes from the Office of Inspector General (OIG), one of the departments within the Department of Health and Human Services (HHS) responsible for EMTALA enforcement.\textsuperscript{39} In 2001, as part of an internal review, the OIG released two reports based on a survey of random hospital emergency departments throughout the country, and a review of HHS data.\textsuperscript{40} According to the OIG there were 100.4 million emergency room visits in the representative year, 1998.\textsuperscript{41} The OIG collected data from the years 1994-1997, reproduced below.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Investigations Conducted</th>
<th>Number of Confirmed Violations</th>
<th>Percentage of Investigations Resulting in Confirmed Violations</th>
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<tr>
<td>1994</td>
<td>370</td>
<td>102</td>
<td>27.57%</td>
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\textsuperscript{38} Gionis, supra note 9, at 203 (“Notwithstanding discrepancies in nomenclature utilized by the various reporting organizations concerning the number of patient dumping EMTALA violations per year, the reported trend is clear: not only does patient dumping continue to exist throughout U.S. emergency departments, but there is overwhelming evidence that it is increasing.”) (footnotes omitted).

\textsuperscript{39} See infra Part II.A.

\textsuperscript{40} Office of Inspector Gen., OEI 09-98-00220, The Emergency Medical Treatment and Labor Act: Survey of Hospital Emergency Departments (2001), available at http://oig.hhs.gov/oei/reports/oei-09-98-00220.pdf [hereinafter OIG Survey Report]. The OIG Survey Report was a companion report to the OIG Enforcement Report, supra note 37. The stated purpose of the Survey Report was “[t]o determine whether staff and directors of hospital emergency departments are aware of the various provisions of [EMTALA] and find out how they believe the Act affects them, their hospitals, and their patients.” OIG Survey Report, supra, at 1. OIG conducted a telephone survey of 100 randomly selected hospitals to ascertain hospital employees’ reactions to EMTALA enforcement. Id.

\textsuperscript{41} OIG Survey Report, supra note 40, at 8.

\textsuperscript{42} OIG Enforcement Report, supra note 37, at 8. The U.S. General Accounting Office also released some data in 2001, which varies slightly from the data released by OIG. See U.S. Gen. Accounting Office, Emergency Care: EMTALA Implementation and Enforcement Issues 18 (2001), available at http://www.gao.gov/new.items/d01747.pdf [hereinafter GAO Report]. The GAO’s data ran from 1995 to 1999. Id. In 1995, they report 455 investigations, with 195 confirmed violations; in 1996, 434 investigations and 201 confirmed violations; in 1997, 452 investigations and 183 confirmed violations; and in 1998, 379 investigations and 193 confirmed violations. Id. The discrepancies are only slight and because OIG is the actual enforcement agency this Note will take their numbers as definitive.
Perhaps more tellingly, the Public Citizen’s Health Research Group (PCHRG)\(^43\) has published various reports since 1991 documenting the number of patient dumping violations, calculated independently. These findings indicate, first, that patient dumping has continued to occur in increasing numbers since the passage of EMTALA, and that CMS’s attention to complaints “clearly underrepresent[s]” the frequency with which the patient dumping occurs.\(^44\) Second, throughout the PCHRG studies, several repeat offender hospitals existed, and this issue was not adequately addressed by penal action on the part of OIG.\(^45\) Third, PCHRG has noted that EMTALA enforcement differs greatly by region.\(^46\) In a detailed analysis of all of the data, one study concluded that patient dumping is on the rise and that such practices are 1.7 times more likely to occur in a for-profit hospital than a not-for-profit hospital.\(^47\) Alarmingly, this study concluded that between the inception of EMTALA and 1998 patient dumping had increased 683%, with investigations increasing by approximately 390%.\(^48\)

As can be concluded from this data, patient dumping continues to exist in steady numbers. This suggests that EMTALA has not worked

<table>
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<th>Year</th>
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<th>Percentage</th>
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<td>1995</td>
<td>467</td>
<td>185</td>
<td>39.61%</td>
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<td>1996</td>
<td>349</td>
<td>191</td>
<td>54.73%</td>
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<tr>
<td>1997</td>
<td>448</td>
<td>174</td>
<td>38.84%</td>
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<tr>
<td>1998</td>
<td>412</td>
<td>168</td>
<td>38.35%</td>
</tr>
</tbody>
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\(^{43}\) Public Citizen “is a national, nonprofit consumer advocacy organization founded in 1971 to represent consumer interests in Congress, the executive branch and the courts.” About Public Citizen, http://www.citizen.org/about/ (last visited Mar. 27, 2007). The organization’s stated goal is to

- fight for openness and democratic accountability in government, for the right of consumers to seek redress in the courts; for clean, safe and sustainable energy sources; for social and economic justice in trade policies; for strong health, safety and environmental protections; and for safe, effective and affordable prescription drugs and health care.

\(^{44}\) Gionis, supra note 9, at 200 (quoting Lauren Dame & Sidney M. Wolfe, Patient Dumping in Hospital Emergency Rooms: An Update Based on Complaints Received by HHS Between April 1, 1994 and March 31, 1995 1 (1996)).

\(^{45}\) Id. at 201.

\(^{46}\) Id. at 201-02 (“For instance, HCFA Regions I and II found no patient dumping violations in the first four and one-half years that EMTALA was in effect.”).

\(^{47}\) Id. at 176-77.

\(^{48}\) Id. at 203; see also id. at 204-07 (further graphical representations of the data that Gionis et al. collected and analyzed).
to deter future violations. While approximately five hundred reported incidents a year in over one hundred million hospital visits annually seems to be a small proportion of total hospital visits, one could reasonably infer from the low rate of EMTALA complaints that result in civil fines that patient dumping is, not surprisingly, underreported.\(^49\) Further, because of the egregious nature of this conduct, any incidence seems too much. After all, hospitals are not required by EMTALA to cure these patients, but only to screen and stabilize them. This data raises the question of why EMTALA is not effectively enforced. To understand this, one must understand the current enforcement regime.

II. ANALYSIS: PUBLIC AND PRIVATE ENFORCEMENT OF EMTALA

A. Government Enforcement

Enforcement under EMTALA involves two governmental agencies within the HHS: CMS and OIG.\(^50\) Initially, a complaint is made by an individual, either a harmed individual or member of the hospital staff, to a state survey agency (SA).\(^51\) The SA reports the complaint to one of the regional CMS offices.\(^52\) If the regional office authorizes an investigation, the SA will conduct an unannounced emergency department visit, the purposes of which are “to determine whether a violation occurred, to assess whether the violation endangers patient health and safety, to identify any patterns of violations at the facility, and to assess whether the hospital has policies and procedures that


\(^{50}\) OIG ENFORCEMENT REPORT, supra note 37, at 6.

\(^{51}\) Id.

implement EMTALA’s provisions.” Few investigations result in a confirmed dumping violation, almost always less than fifty percent. Ten to fifteen days after its investigation, the SA will send a report to the regional CMS office. If the report involves a technical medical issue beyond lay expertise, the regional CMS office will involve a Peer Review Organization (PRO) and will ultimately decide whether or not an EMTALA violation has occurred.56

If the hospital is found to be in compliance, no action is taken. If the hospital is found to be in compliance but a past violation is found, CMS will refer the case to OIG for a possible civil fine. If the hospital is found not to be in compliance but there is no imminent threat to patient safety, CMS will refer the case to OIG for a possible civil fine and the hospital is granted ninety days in which to draft a corrective plan of action. If a violation is found and it poses an immediate threat to patient safety, CMS refers the case to OIG for potential civil fines, as well as to the Office of Civil Rights for potential action under the Hill-Burton Act, and the hospital is granted twenty-three days to implement a plan of action to avoid termination of the hospital’s Medicare/Medicaid agreement. It is noted by many commentators, including OIG itself, that this enforcement system is used rarely and sporadically. This, in combination with a significant lack of

53 OIG ENFORCEMENT REPORT, supra note 37, at 8.
54 Id.; see supra Table 1. While it may be argued that this suggests few violations, the data suggest that the phenomenon is underreported and underenforced. See Gionis, supra note 9, at 203.
55 OIG ENFORCEMENT REPORT, supra note 37, at 7.
56 Id.
57 Id. at 10.
58 Id.
59 Id.
60 The Hill-Burton Act, 42 U.S.C. § 291c(e) (2000), was Congress’s first attempt to provide wider access to emergency care. It provides funding for states to open hospitals, but requires such hospitals to be “available, for all persons residing in the State, and adequate hospitals (and such other facilities) to furnish needed services for persons unable to pay therefor.” Id. Enforcement is provided through state agencies within HHS. 42 C.F.R. § 53.111 (2006).
61 OIG ENFORCEMENT REPORT, supra note 37, at 10.
62 Id. at 15-16. OIG identified a number of problem areas in its 2001 report. First, OIG concluded that the enforcement process is “compromised by long delays and inadequate feedback.” Id. at 12. While the initial investigation at the state agency level was subject to strict guidelines, the CMS itself is under no external or self-imposed time constraint, which “defeat[s] the purpose of the 23-day termination process.” Id. In 1998, an average of 103 days passed between when CMS received the SA investigation and the determination of when a violation occurred. Id. at 13. OIG also reported that many SAs complained about a lack of feedback from the regional CMS office as to the outcome of the case they had previously sent up. Id.

Second, OIG noted a wide discrepancy in the number of investigations between regions. Id. In addition, OIG noted that the percentage of cases resulting in confirmed violations varies greatly from region to region. Id. at 14. For instance, over the period of 1994-1998, Region IV, which investigated the most claims (768), confirmed violations 21.88% of the time. In region IX, which investigated 176 cases over that period, 68.18% of the investigations resulted in confirmed
transparency in the enforcing agencies, creates what ultimately is a highly bureaucratized and ineffective system of enforcement.

After the case has been referred to OIG, the agency will attempt to reach a settlement; however, if settlement cannot be reached, OIG must prove to an Administrative Law Judge (ALJ) by a preponderance of the evidence, that an EMTALA violation has occurred. Civil monetary penalties are, in the words of OIG, “relatively uncommon.” OIG closes more than half of the cases it receives without taking action. As of 2001, OIG had received 677 cases, 353 of which it declined to act on, only 226 of which have settled. If an adverse result is reached by the ALJ, the opinion is appealable to an administrative appeals board and then to the court of appeals in the circuit of the hospital being fined. The review by the administrative appeals board, however, has been categorized as “sometimes cursory,” and the court of appeals review is constrained by the normal strict standard set by statute.

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63 It is rare that OIG does not reach a settlement before it must institute an administrative hearing, with one source reporting that only ten such hearings occurred between 1995 and 2000. GAO REPORT, supra note 42, at 24.
64 Frank, supra note 16, at 219.
65 OIG ENFORCEMENT REPORT, supra note 37, at 8.
66 Id.
67 Id. at 8-9.
69 Id.; see Cherukuri v. Shalala, 175 F.3d 446, 455 (6th Cir. 1999) (“It is unfortunate that the errors we have uncovered were not caught earlier in the administrative process. When the administrative ‘Review Board’ established to administer EMTALA cases chooses without explanation to make an ALJ decision in an important case binding without review, the burden on the Court of Appeals to comb the record is substantially increased. We respectfully suggest that the Board should review cases like this one closely and should not simply pass them on to a federal appellate court without providing a reasoned disposition of the objections raised by the parties.”).
70 42 U.S.C. § 1320a-7(a)(4) (2000) (“The findings of the Secretary with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive.”) “Substantial evidence” means more than a mere scintilla of evidence; it means such evidence as a reasonable mind might accept as adequate to support a conclusion.” Inspector General v. Bowen, DAB No. 1720, 2000 HHSDAB LEXIS 22 (Dep’t of Health & Human Servs., App. B. Mar. 23, 2000) (citing Universal Camera Corp. v. Nat’l Labor Relations Bd., 340 U.S. 474 (1951)).
B. Private Enforcement

It is a generally accepted proposition that EMTALA provides for a private cause of action against a participating hospital but not against a physician.\(^71\) One need not go further than the amended text of EMTALA to see the barrier to private causes of actions against physicians. EMTALA provides:

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.\(^72\)

This section is cited with emphasis in many of the opinions finding that there is no private right of action against an individual physician.\(^73\) But *expressio unius*\(^74\) is rarely enough, and “[a] cause of action may be implied in a statute if Congress intended to create a private remedy but did not expressly do so.”\(^75\) Most of the courts that have disallowed a private right of action against a physician did so only after analyzing the

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\(^71\) See, e.g., Harry v. Marchant, 291 F.3d 767, 773-74 (11th Cir. 2002); Eberhardt v. City of Los Angeles, 62 F.3d 1253, 1257 (9th Cir. 1995); King v. Ahrens, 16 F.3d 265, 271 (8th Cir. 1994); Baber v. Hosp. Corp. of Am., 977 F.2d 872, 876 (4th Cir. 1992); Gatewood v. Wash. Healthcare Corp., 933 F.2d 1037, 1040 n.1 (D.C. Cir. 1991).

\(^72\) 42 U.S.C. § 1395dd(d)(2)(A) (2000) (emphasis added). The statute also provides for a cause of action for the hospital to which the patient was transferred, against the participating hospital:

Any medical facility that suffers a financial loss as a direct result of a participating hospital’s violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate. *Id.* § 1395dd(d)(2)(B) (emphasis added). This provision has rarely, if ever, been used. Sara Rosenbaum & Brian Kannoie, *Finding a Way Through the Hospital Door: The Role of EMTALA in Public Health Emergencies*, 31 J.L. MED. & ETHICS 590, 593 (2003) (“A search of case law and relevant literature reveals no judicial decisions in cases brought by a hospital against another for an EMTALA violation.”). This Note will not address the issues raised by this provision.

\(^73\) *King*, 16 F.3d at 271 (“The plain language indicates that section 1395dd(d)(2)(A) creates a cause of action only against a ‘participating hospital.’ The statutory definition of ‘participating hospital’ does not encompass an individual physician.”); *Baber*, 977 F.2d at 877 (“Although the statute clearly allows a patient to bring a civil suit for damages for an EMTALA violation against a participating hospital, no section permits an individual to bring a similar action against a treating physician.”) (footnotes and citation omitted); Marrero v. Hosp. Hermanos Melendez, 253 F. Supp. 2d 179, 183 n.2 (D.P.R. 2003) (referring to the limitation as created by the language of the statute).

\(^74\) *Expressio unius est exclusio alterius* is a “canon of construction holding that to express or include one thing implies the exclusion of the other . . . .” BLACK’S LAW DICTIONARY 265 (2d pocket ed. 2001).

\(^75\) *King*, 16 F.3d at 271 (citing Zajac v. Fed. Land Bank of St. Paul, 909 F.2d 1181, 1182 (8th Cir. 1990); see also Cort v. Ash, 422 U.S. 66 (1975)); see infra Part III.A.
congressional history of EMTALA, assuming that Congress could have intended to include a private cause of action against individuals, even if it did not expressly state as much.\textsuperscript{76} This analysis illuminates not only the reasoning behind finding that there is no private cause of action, but also explains the line that Congress intended to draw between the creation of this new federal right, on the one hand, and avoiding the creation of a federal malpractice cause of action, on the other.

1. The Minority View—\textit{Thompson v. St. Anne’s Hospital} and \textit{Sorrells v. Babcock}—Finding a Cause of Action

Early in EMTALA’s history, district courts, faced with the ordeal of interpreting the text of what most considered a vague statute,\textsuperscript{77} confronted the questions of how Congress intended the statute to be enforced. In \textit{Thompson v. St. Anne’s Hospital},\textsuperscript{78} the Northern District of Illinois was faced with the question of whether EMTALA provided a cause of action for failure to stabilize as well as improper transfer.\textsuperscript{79} Plaintiff Michelle Thompson had presented to St. Anne’s Hospital at midnight.\textsuperscript{80} Thompson was seventeen weeks pregnant at the time and was experiencing “labor pains and vaginal bleeding.”\textsuperscript{81} According to Ms. Thompson, St. Anne’s transferred her to Cook County Hospital at around 3:30 A.M. without properly stabilizing her condition.\textsuperscript{82} Ms. Thompson’s premature baby survived only five hours at Cook County Hospital, where, Ms. Thompson alleged, “the hospital personnel left her unattended to deliver her baby in unsterilized surroundings.”\textsuperscript{83} Faced with a motion to dismiss by all of the individual physician-defendants at Cook County, the court held that EMTALA supported such a private

\textsuperscript{76} See infra Part II.B.2.

\textsuperscript{77} See Treiger, supra note 15, at 1209 (noting that strong federal regulations would be necessary to clarify the vague language in EMTALA); Alicia K. Dowdy, Gail N. Friend & Jennifer L. Rangel, \textit{The Anatomy of EMTALA: A Litigator’s Guide}, 27 ST. MARY’S L.J. 463, 479 (1996) (noting that the statute fails to define a number of key terms essential to its enforcement.)

\textsuperscript{78} 716 F. Supp. 8 (N.D. Ill. 1989).

\textsuperscript{79} Id. at 9.

\textsuperscript{80} Id.

\textsuperscript{81} Id.

\textsuperscript{82} Id. The same Cook County hospital was made famous by the study that was the impetus for the passage of EMTALA. See supra note 23.

\textsuperscript{83} Thompson, 716 F. Supp. at 9.
cause of action under the facts alleged. The court’s denial of the motion to dismiss allowed actions to go through against the individual physicians at Cook County Hospital for what seems to be a claim of negligence. Arguably, the only hospital responsible for “dumping” Ms. Thompson was St. Anne’s. Cook County Hospital, on the other hand, according to the Court, “simply reject[ed]” the plaintiff, which suggests negligent treatment rather than a failure to treat at all.

The Northern District of Illinois again faced the question of whether there is a private right of action against physicians in Sorrells v. Babcock. The plaintiff, Barbara Sorrells, claimed that she came to the emergency room of the Swedish American Hospital in Rockford, Illinois, with what was later diagnosed as gastrointestinal bleeding. Ms. Sorrells claimed that she was discharged despite the fact that she still “exhibited dizziness, recurrent vomiting, diffuse abdominal pain, and diffuse abdominal tenderness.” Plaintiff asserted both EMTALA claims and pendent state claims against the hospital and treating emergency room physician. Defendant, the treating emergency room physician, moved to dismiss for failure to state a claim. The court found that EMTALA’s legislative history and the statutory language itself suggested that a private cause of action against individual physicians was proper. As authority the court cited, inter alia, Thompson, the fact that the statute explicitly provides for sanctions against a “responsible physician,” and the fact that the House Judiciary Committee was considering an amendment that would have provided for criminal sanctions against responsible physicians.

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84 Id. at 10.
85 Id.
87 Id. at 1190.
88 Id.
89 Id. at 1191.
90 Id. Defendant also argued that the federal courts had no jurisdiction to enforce EMTALA. The question of whether the federal courts were empowered to hear EMTALA claims points again to Congress’s hesitance to create a malpractice action. The Sorrells court cited extensively to a district court case in the Eastern District of Pennsylvania, Bryant v. Riddle Memorial Hospital, 689 F. Supp. 490 (E.D. Pa. 1988). In Bryant, the Court noted that in the initial bill, EMTALA had provided that “[a]ny persons or entity adversely and directly affected by a participating hospital’s violation . . . may bring an action, in an appropriate state or Federal district court, for damages . . . . ” Sorrells, 733 F. Supp at 1192 (quoting Bryant, 689 F. Supp. at 492 (citing H.R. Rep. 99-241, pt. 1, 1986 U.S.C.C.A.N. 42, 606)). This language was removed, suggesting a concern that litigants would use EMTALA to create a federal malpractice action. The court went on to find that the district courts did have subject matter jurisdiction, however, because the Judiciary Committee rejected an amendment that would have explicitly stricken a federal cause of action. Id. (citing Bryant, 689 F. Supp. at 493 (citing H.R. REP. 99-241, pt. 3, 1986 U.S.C.C.A.N. 726, 730)).
91 Id. at 1193.
92 Id. at 1193-94. The Judiciary Committee rejected the amendment because “it is unnecessary, and unwise, and raises serious Constitutional questions under the due process
The *Sorrells* decision has been referred to by defendants as the most questioned EMTALA decision in the history of the statute.\textsuperscript{93} There are two glaring substantive flaws in the court’s reasoning. First, the court infers from the existence of government mandated civil fines against physicians that Congress intended to allow for private suits against the same people.\textsuperscript{94} Logically, this assumes too much. The same provision could just as easily imply that Congress intended to take away from individuals the right to sue by vesting the fining power in a government agency.\textsuperscript{95} Second, the court reads the fact that the Judiciary Committee had been contemplating criminal sanctions to imply only that Congress wanted harsh punishment against offending physicians.\textsuperscript{96} However, this assumption suffers the same logical flaw as the first in that it tends to prove the opposite conclusion—that Congress did not want harsh punishment against individual physicians—just as easily as it proves the first.\textsuperscript{97} In addition, the court clearly ignores parts of the legislative history that explicitly express the fear of the creation of exactly the type of action that the *Sorrells* court approved.\textsuperscript{98} *Sorrells* has been impliedly overruled by other courts in the circuit. While courts within the Seventh Circuit have not expressly overruled *Sorrells*, they have noted that this blip in EMTALA analysis may have been caused by the fact that the *Sorrells* court was looking at an earlier version of the statute, and have hinted that *Sorrells* was, if not improperly decided, then improper under the current version of EMTALA.\textsuperscript{99} This explanation, however, is implausible given the fact

\textsuperscript{93} Reply Brief in Support of Motion to Dismiss by Defendant James O. Steele, M.D. at 2, Heimlicher v. Steele, 442 F. Supp. 2d 685 (N.D. Iowa 2006) (“In arguing at pages 3-6 of their Resistance that their claim for damages against Dr. Steele should not be dismissed, Plaintiffs rely solely on what is perhaps the most discredited case in all of EMTALA jurisprudence, [Sorrells].”).


\textsuperscript{95} See Baber v. Hosp. Corp. of Am., 977 F.2d 872, 878 (4th Cir. 1992) (“This dictum [in *Sorrells*], however, confuses administrative enforcement proceedings and monetary penalties with personal injury actions and civil damages.”).


\textsuperscript{97} Eberhardt v. City of Los Angeles, 62 F.3d 1253, 1257 (9th Cir. 1995) (“The only case that has adopted a contrary view [*Sorrells*] misconstrued the EMTALA’s legislative history. . . . The court relied on a statement made by the House Judiciary Committee explaining why it rejected a provision which authorized criminal sanctions. . . . However, any implication of an intent to authorize a private right of action against physicians is quickly dispelled by reading the next sentence, in which the Committee described these “other sanctions”. . . . Thus, read in context, the statement upon which the *Sorrells* court relied shows that the Committee clearly meant that the other sanctions, taken as a whole, may be imposed against both hospitals and doctors, but that a private right of action may be maintained only against hospitals.”) (internal quotation omitted).

\textsuperscript{98} See infra Part II.B.2.

that Sorrells bases its opinion on the congressional record. Ultimately, the Sorrells court simply got it wrong, avoiding certain parts of the congressional history and misinterpreting others.

2. The Majority View—Reading the Congressional History and Finding No Private Cause of Action

The majority of the courts that reach the conclusion that individual physicians cannot be held liable in a private lawsuit under EMTALA, cite particular aspects of the legislative history that, taken as a whole, strongly suggest that such a limitation is the correct reading of the EMTALA. First, the courts note that the House amended EMTALA to clarify the enforcement provisions stating:

[T]he Committee amendment makes it clear that the section authorizes only two types of actions for damages. The first of these could be brought by the individual patient who suffers harm as a direct result of a hospital’s failure to appropriately screen and stabilize, or properly transfer the patient . . . (within the meaning of [the act]) or a woman in active labor. It also clarifies that actions for damages may be brought only against the hospital which has violated the requirements of [the Act].

Additionally, Congress clarifies explicitly that it is concerned about “the potential impact of these enforcement provisions on the current medical malpractice crisis.” Congress was concerned that adding a federal cause of action would increase the liability that doctors already face and would decrease the availability of emergency care because of the potential costs. That is, Congress did not want EMTALA to become so costly to physicians and hospitals that it would

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100 See, e.g., Harry v. Marchant, 291 F.3d 767, 773 (11th Cir. 2002).
102 Id. Submission of the Law Firm of Kenny, Nachwaltier & Seymour, id. at *16, reprinted in 1986 U.S.C.C.A.N., at 733 (“I am concerned, however, that its enactment may signal a new and dramatic departure from the basic philosophical approach of the Medicare Act and that the practical operation of Section 124 may unavoidably result in some confusion and ambiguity and may lead to a degradation in the quality of American medical care and particularly in the availability of health care services to the poor.”)
be economically unfeasible to even maintain an emergency room.

In identifying these parts of the congressional record, the courts have noted two specific goals of EMTALA: (1) to prevent patient dumping;\(^{104}\) (2) to accomplish the first without burdening the medical community and the courts with the creation of a federal malpractice action.\(^{105}\) Assuming that the anti-patient dumping goal can only be achieved by abandoning the anti-malpractice goal, it is not so clear what the congressional response would be.\(^{106}\) However, if the scenario were that Congress could accomplish the anti-patient dumping goal by a different, more effective, means that did not violate the anti-malpractice goal, it would be almost perverse to suggest that this scenario would not be pursued. The remainder of this Note argues that Congress should choose making EMTALA effective over shielding the federal courts from increased litigation; moreover, allowing a cause of action against individual physicians would nonetheless not result in a federal malpractice action.

C. Previous Proposals to Make EMTALA More Effective

Before discussing the creation of a private cause of action against individual physicians, it is helpful to discuss some previous proposals that have laid the foundation for this step. Over the years, dissatisfaction with the lack of effectiveness of EMTALA has lead to a number of proposals varying from further federal legislation and further regulatory guidance to criminal sanctions.\(^{107}\) One proposal, with its eye towards deterrence, argues for the elimination of EMTALA altogether and the creation of a state intentional tort of patient dumping. The second proposal, with its eye towards preventing federal claims that resemble medical malpractice, urges for strict and narrow interpretation of the statute.

\(^{104}\) See 131 CONG. REC. S13892-01 (Oct. 23, 1985) (statement of Sen. Durenberger) (“The purpose of this amendment is to send a clear signal to the hospital community, public and private alike, that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress.”).

\(^{105}\) See, e.g., Marchant, 291 F.3d at 773; Eberhardt v. City of L.A., 62 F.3d 1253, 1257 (9th Cir. 1995); King v. Ahrens, 16 F.3d 265, 271 (8th Cir. 1994); Baber, 977 F.2d at 877; Heimlicher v. Steele, 442 F. Supp. 2d 685, 690-91 (N.D. Iowa 2006).

\(^{106}\) For this proposition, one must look generally to the cyclical nature of Congressional attitudes. See Chadha v. INS, 634 F.2d 408, 432 (9th Cir. 1980), aff’d 462 U.S. 919 (1983) (suggesting that horizontal separation of powers between the legislature, which can change its mind at a whim, and the executive, is effective because “[t]he Executive evolves its skills and expertise from the administration of a statute over time. This process can be thwarted if legislative interference, constant in its potentiality, can be exercised in any given case without a change in the general standards the legislature has initially decreed.”).

\(^{107}\) See Gionis, supra note 9, at 296 & nn.777-82.
1. Effectiveness in Deterrence:
   An Intentional Tort of Patient Dumping

The first proposal concludes that patient dumping is an intentional rather than negligent tort. The proponents argue that this tort should be remedied not through a federal statutory scheme but through state tort law. The Intentional Tort proposal\textsuperscript{108} begins with two complementary notions: first, that the purpose of tort law is both to recompense those who are harmed and to deter future wrongful action;\textsuperscript{109} second, that “without potential tort liability, profit driven entities may find it cost-effective to engage in behaviors that pose unreasonable threats to human society.”\textsuperscript{110} With these notions in mind, the group of scholars concluded that the current EMTALA regulatory scheme provides little incentive for compliance and as a result, little deterrent effect.\textsuperscript{111} Citing Justice Oliver Wendell Holmes, Jr.,\textsuperscript{112} the scholars found that violating EMTALA should be an intentional tort because it attempts to impose not a duty to avoid foreseeable harm—negligence\textsuperscript{113}—but rather, the creation of a new affirmative duty: “to avoid harm that is foreseeable with substantial certainty when a patient is transferred solely for economic or non-economic, non-medical discriminatory reasons.”\textsuperscript{114} The elements of this new tort would include the intent to injure, which would require the plaintiff to prove under an objective standard “that the defendant have [sic] acted with substantial certainty that injury would occur.”\textsuperscript{115} Second, the plaintiff would have to prove that defendant lacked justification, or that the standard of care in the situation fell

\textsuperscript{108} There are three authors and proponents of this theory. Thomas A. Gionis, M.D., J.D., M.B.A., M.H.A., was at the time a research fellow at the Massachusetts General Hospital. He is currently the chairman of the American Board of Healthcare Law and Medicine, “a private research, educational and consulting organization which functions as a ‘think tank.’” American Board of Healthcare Law and Medicine, About the ABHLM, http://www.abhlm.com/index.htm (last visited Mar. 27, 2007). Carlos A. Camargo, Jr., MD, PhD, is Associate Professor of Medicine at Harvard Medical School and Associate Professor of Epidemiology at Harvard School of Public Health, Cambridge, Massachusetts. Anthony S. Zito, Jr., JD, LLM, is Professor of Law at John Marshall Law School, Chicago Illinois.

\textsuperscript{109} Id. (quoting Tamsen Douglass Love, Deterring Irresponsible Use and Disposal of Toxic Substances: The Case for Legislative Recognition of Increased Risk Causes of Action, 49 VAND. L. REV. 789, 793 (1996)).

\textsuperscript{110} Gionis, supra note 9, at 297.

\textsuperscript{111} Id. at 300.


\textsuperscript{113} Gionis, supra note 9, at 299.

\textsuperscript{114} Id. at 300.

\textsuperscript{115} Id. at 301.
“below the standard demanded by the reasonable person on public policy grounds.” The final two elements would be the ordinary tort elements of causation and damages.

While this proposal is inventive and insightful, it ignores that EMTALA was passed only after Congress realized that state attempts to cure the patient dumping problem were proving ineffective under both the common law and statutory law. Nonetheless, the proposal recognizes explicitly two notions that seem to evade EMTALA analysis. First, patient dumping is an intentional act committed by an individual against another individual. Second, and related to this first point, is that the harm at which EMTALA is aimed is “completely distinct from a patient’s medical care or medical transfer decision.” Thus, the decision to illegally transfer presents a claim entirely separate from a claim of negligent treatment. As this Note will explain, this is an important recognition if one is to allow a private cause of action under EMTALA without crossing the medical malpractice line.

2. Preventing Federal Claims Resembling Medical Malpractice: Motivation Requirement

The second proposal bases its theory on an overturned Sixth Circuit decision, which found an “improper motive” requirement in EMTALA claims. The Supreme Court granted certiorari in Roberts v. Galen of Virginia, Inc. ostensibly to correct the Sixth Circuit’s erroneous reading of EMTALA’s text, but also to resolve a circuit split. The Sixth Circuit in Roberts became the only circuit to read an “improper motivation” requirement into proving an EMTALA claim.

116 Id. at 302.
117 Id. at 303-04.
118 Treiger, supra note 15, at 1196-97, 1201-04 (first noting that under the common law most states still follow the no-duty rule, whereby there is no relief for a patient who is turned away by a hospital; second, describing various state legislative responses, none of which have been especially effective, and only one—Texas—which has promulgated rules to enforce the statute).

Further, as the proposal discusses at length, Gionis, supra note 9, at 273-95, the only state court that has attempted to create such a tort, Louisiana, was reversed by that state’s supreme court. Coleman v. Deno, 813 So. 2d 303 (La. 2002).
119 Gionis, supra note 9, at 300.
120 Id.
121 See infra Part III.B.
124 Id. at 253 n.1 (“We note, however, that . . . [the Sixth Circuit’s] interpretation of subsection (a) is in conflict with the law of other Circuits.”).
125 Roberts, 111 F.3d at 409-10 (requiring “proof of the existence of any improper motivation such as those listed above to make out a case of inappropriate screening or improper discharge.”);
In so holding, the Sixth Circuit required a plaintiff in an EMTALA claim to show that the doctor in the hospital against whom the EMTALA claim is directed acted with “an improper motivation involving indigency or lack of insurance” or “other improper reasons includ[ing] race, sex, politics, occupation, education, personal prejudice, drunkenness, or spite; that is, anything except medical negligence.”

The Sixth Circuit held as such in order to distinguish an EMTALA claim from an ordinary medical malpractice claim, which only requires negligence. In reversing the Sixth Circuit, however, the Supreme Court noted that at least in so far as the stabilization requirement goes, the plain language of the text requires no improper motive.

One proponent of the improper motivation view notes that the plain meaning approach of the Supreme Court may be technically correct; however, because it misconstrues the purpose behind EMTALA this interpretation makes it easier for actions under EMTALA to be construed as a medical malpractice action. By imposing an improper motivation requirement, the Sixth Circuit was trying to prevent “liability for EMTALA claims merely alleging physician negligence, and not the intentional dumping of indigent individuals.”

This proposal focuses on the potential economic pressure this would put on hospitals, which would lead to disincentives to keep valuable emergency room facilities open. Importantly, before even the future consequences are calculated, this type of interpretation could lead to a conflict with both of Congress’ identified purposes, namely preventing patient dumping and preventing a federal medical malpractice action.

The Sixth Circuit view, on the other hand, would require the cause

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see also Cleland v. Bronson Health Care Group, Inc. 917 F.2d 266, 272 (6th Cir. 1990) ("[A]ppropriate must more correctly be interpreted to refer to the motives with which the hospital acts.").

126 Roberts, 111 F.3d at 409.

127 Id.

128 Roberts, 525 U.S. at 253.

129 The proponent, Michael J. Frank, was law clerk to Hon. Daniel A. Manion, United States Court of Appeals for the Seventh Circuit, at the time of the article’s publication. Frank, supra note 16, at 195.

130 Id. at 231.

131 Id. at 233.

132 Id. at 234. Frank notes that this may create further pressure on state-run urban hospitals which have been found to be immune from EMTALA prosecution under the Eleventh Amendment. Id; see Drew v. Univ. of Tenn. Reg’l Med. Ctr. Hosp., No. 99-5070, 2000 U.S. App. LEXIS 8936, at *9-10 (6th Cir. May 1, 2000) (finding that EMTALA contains no express or implied abrogation of state sovereign immunity); Ward v. Presbyterian Healthcare Servs., 72 F. Supp. 2d 1285, 1290 (D.N.M. 1999) (same); Cheromiah v. United States, 55 F. Supp. 2d 1295, 1301 (D.N.M. 1999) (same); Lebron v. Ashford Presbyterian Cmty. Hosp., 975 F. Supp. 407, 410 (D.P.R. 1997) (same); Perez-Bourdon v. Commonwealth of Puerto Rico, 951 F. Supp. 22, 24 (D.P.R. 1996) (same). This, Frank theorizes, could perversely provide state run hospitals with an incentive to dump patients in order to save costs. Frank, supra note 16, at 234.
of action to be one of intentional patient dumping, and would therefore stop actions that claim that the doctor or hospital negligently treated the patient. Further, if the proposal is correct, not only would this goal be thwarted, but the primary goal of deterring patient dumping would be more difficult to accomplish. With these two proposals in mind, this Note now turns to a new proposal for allowing a private cause of action against physicians in lieu of the current ineffective enforcement regime.

III. PROPOSAL: ALLOWING FOR A CAUSE OF ACTION AGAINST PHYSICIANS—EFFICIENCY WITHOUT A FEDERAL MALPRACTICE ACTION

Accepting that the majority of courts have correctly read the congressional history to bar private suits against individual physicians, it is still valid to propose permitting such a private action if doing so stays truer to the primary congressional aim in enacting EMTALA. Congress’s primary aim in enacting EMTALA was preventing and deterring patient dumping. Not permitting private actions against physicians, on the other hand, was only one step along the way to Congress’s subsidiary goal, preventing the creation of a federal malpractice action and all of the dangers that would follow. The following sections argue that by permitting certain private causes of action in the federal courts, the statute would not create a federal malpractice action and would make enforcement of the primary aim—preventing and deterring patient dumping—easier to accomplish.

A. Inferring a Cause of Action: The Cort Test

In 1975 the Supreme Court in Cort v. Ash 133 articulated a four part test for determining whether a specific federal statute has created an implied right of action in the courts. These factors are: (1) whether the plaintiff is one of the class that the statute was intended to protect; (2) whether there is evidence of a legislative intent, in the text or otherwise, to create a private remedy; (3) whether a private action is consistent with the underlying purposes of the legislative scheme; and (4) whether the cause of action is one traditionally relegated to state law. 134

To be sure, the rule announced in Cort has been narrowed by later cases and by a shift in the judicial philosophy of the Court. 135 But, the

133 422 U.S. 66 (1975).
134 Cort, 422 U.S. at 78.
Cort test, read in light of later decisions, still exists. As a threshold matter, a court must first read the text of the statute and legislative history, and determine whether, as a matter of statutory construction, Congress intended to imply a cause of action, which seems to be the second and third factors.\(^\text{136}\) Only then, if the answer is “yes,” will the courts look to the other Cort factors, namely whether the party is a person whom the statute was meant to protect, and whether the area in the statute is not one that state law traditionally protects, the first and fourth factors.\(^\text{137}\)

B. Application to EMTALA

1. Plain Language and the Legislative History

The Cort test first directs the court to look at the plain language and legislative history of the statute. Initially, as many courts note, the legislative history of EMTALA is relatively straightforward: it was created to address a “distinct and narrow problem—namely, the national concern that uninsured, underinsured, and indigent patients were being ‘dumped’ onto other hospitals, [or] dumped [or] discharged by hospitals who did not want to treat them.”\(^\text{138}\) Plainly then, the primary goal of the statute is to deter such actions. While it is also true that the plain language of the statute limits private action as against the participating hospital,\(^\text{139}\) this is a means by which Congress intended to prevent the creation of a malpractice action.

Necessarily, if the only way to honor the primary goal (preventing

\(^{136}\) This emphasis reflects the narrowing of the Cort test both under separation of powers grounds, and on philosophical grounds of textualism and judicial restraint. See Transamerica Mortgage Advisors, Inc. v. Lewis, 444 U.S. 11, 23 (1979) (holding that the factors in Cort are not entitled equal weight, with the language, express legislative history, and purpose of the statute getting priority); Northwest Airlines Inc. v. Transp. Workers Union of Am., 451 U.S. 77, 95 n.31 (1981) (“In a case in which neither the statute nor the legislative history reveals a congressional intent to create a private right of action for the benefit of the plaintiff, we need not carry the Cort v. Ash inquiry further.”); Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134 (1985) (finding no implied cause of action when the text of the statute and legislative intent suggest none even when the other Cort factors were met).

\(^{137}\) See supra note 136 and accompanying text.


\(^{139}\) See supra Part II.B and note 72.
and deterring patient dumping) can be accomplished more effectively by permitting a private cause of action—and doing so would not defy the secondary intent (not creating a federal malpractice action)—then such a private cause of action ought to be permitted. Needless to say, the strict plain language approach would make it difficult to find an implied right of action.  

But what is even clearer in the statute is a dedicated commitment to eradicating the practice of patient dumping. In addition, it is clear from the face of the statute that Congress recognized fault not only in the hospital policy, but in the intentional act of the physician. As it is a basic canon of statutory construction that “[t]he plain meaning of legislation should be conclusive, except in the ‘rare cases [in which] the literal application of a statute will produce a result demonstrably at odds with the intentions of its drafters,’” it

141 See id. § 1395dd(a) (“If any individual (whether or not eligible for benefits under this [subchapter]) comes to the emergency department and a request is made on the individual’s behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital’s emergency department.”) (emphasis added); id. § 1395dd(c)(1) (“If an individual at a hospital has an emergency medical condition which has not been stabilized . . . , the hospital may not transfer the individual.”) (emphasis added); id. § 1395dd(c)(2)(A) (“An appropriate transfer to a medical facility is a transfer . . . in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual’s health and, in the case of a woman in labor, the health of the unborn child.”) (emphasis added).
142 The statute makes civil fines applicable to “any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section.” Id. § 1395dd(d)(1)(B). This was the section that the Sorrells court mistook to suggest that the statute explicitly permitted such an action. Sorrells v. Babcock, 733 F. Supp. 1189, 1193-94 (N.D. Ill. 1990); see supra Part II.B. This interpretation has been discredited, the fact remains that Congress intended to punish physicians in some way.

Note further that the statute refers to this as negligent conduct. Courts have interpreted this provision in varying ways, including various objective and subjective standards, a burden shifting standard, as well as some courts applying a strict liability standard. See Gionis, supra note 10, at 242-64 (discussing the various standards applied by courts for both the duty to screen and the duty to stabilize patients). While the language explicitly refers to negligence it is laden with the language of intentional tort. See id. at 296-97.
143 United States v. Ron Pair Enter., 489 U.S. 235, 243 (1989) (second amendment to text in original) (quoting Griffin v. Oceanic Contractors, Inc., 458 U.S. 564, 571 (1982)). The quote continues: “those intentions [of the statute’s drafters] must be controlling.” Griffin, 458 U.S. at 564. The Griffin court also remarked that “interpretations of a statute which would produce absurd results are to be avoided if alternative interpretations consistent with the legislative purpose are available.” Id. at 575. See also Clinton v. City of N.Y., 524 U.S. 417 (1998) (“Acceptance of the Government’s new-found reading of [the statute] would produce an absurd and unjust result which Congress could not have intended.”); Hayden v. Pataki, 449 F.3d 305, 322-23 (2d Cir. 2006) (“In light of this wealth of persuasive evidence that Congress has never intended [the statute to extend to a certain result] we deem this one of the rare cases [in which] the literal application of a statute will produce a result demonstrably at odds with the intentions of its drafters.”) (citation omitted); Olden v. LaFarge Corp., 383 F.3d 495, 506 (6th Cir. 2004) (interpreting statutorily codified exception narrowly “where a literal application of unambiguous statutory language would have absurd results”); Oxy USA, Inc. v. Babbitt, 268 F.3d 1001, 1006
follows that the courts should interpret the statute so as to give effect to the primary congressional purpose.

2. The Other Cort Factors:
State Law Role and the Respective Role of the Federal Courts

The Cort test next directs the court to look at the cause of action and determine whether it is within the province of state law and thus, as a matter of federalism, the courts should refrain from enforcing it through federal court action. Medical malpractice is a cause of action traditionally (and exclusively) within the powers of the state courts. But by enacting EMTALA, Congress has given the federal courts a role in remedying a separate harm—the failure to treat or stabilize. EMTALA caps civil damages against participating hospitals at the level available for personal injury damages under the tort law of the state where the hospital is located.\footnote{42 U.S.C § 1395dd(d)(2)(A).} However, this recognition does not change the fact that EMTALA remedies not negligent medical treatment, but rather the intentional failure to treat a patient.\footnote{Gionis, supra note 9, at 300 (“That is, [the failure to treat] is an intentional act of depriving a person of emergency medical care not based upon any medical reason, but rather based on discrimination; either economic or non-economic non-medical grounds.”).} At this point, what Congress has created is a statute that purports to be an “anti-patient dumping” statute. The statute creates a right to receive treatment free from discrimination, but carries a secondary purpose of not creating a federal malpractice action.

C. Straddling the Line, but Stopping Short of Medical Malpractice

1. Efficiency and Effectiveness of Private Action
   Versus Administrative Enforcement

The current enforcement regime imposes a number of costs that
can be eliminated by putting the onus of enforcement in the hands of those who wish to reap its immediate benefits. First, the current enforcement program involves a series of communications between the SAs, the regional offices, and national office of CMS and OIG. Each agency transaction adds costs both to the agency and the complaining individual. These costs are not only pecuniary; the system of transfers also involves a large amount of time and uncertainty both for the complaining party and the hospital that awaits a decision.

In addition, the way that EMTALA is set up provides little incentive for the individual to report an incident of patient dumping. After filing a complaint with a state agency, the complaining party is essentially left without remuneration for the alleged harm. The statute provides for civil monetary penalties to be paid to the government. This lack of personal recovery would seem to create a disincentive for reporting and pursuing EMTALA claims even in cases of obvious harm. Further, the decision of whether or not to prosecute an EMTALA claim is made from the outside by an agent within CMS. This lack of input is even more pronounced than in the case of prosecutorial discretion in criminal prosecutions. In EMTALA, the complaint to the SA disappears into a bureaucratic regime that is nearly impenetrable to the outsider, and especially to the victim. Indeed it seems highly unlikely

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146 See supra Part II.A.

147 The notion of costs of the exchange or transaction costs has been attributed to and associated with the work of the economist Ronald Coase. See R. H. Coase, The Nature of the Firm, 4 ECONOMICA 386, 390-91 (1937) (arguing that firms are created in order to minimize and internalize “[t]he costs of negotiating and concluding a separate contract for each exchange transaction which takes place on a market . . . .”). The application of transaction costs to this situation is not so straightforward. Yet, analogizing the EMTALA complaint system to the market, “the operation of . . . [which] costs something,” id. at 392, makes sense when you consider the cost of transferring the case between the various offices. It may be that centralizing the EMTALA functions would be impossible given the geographic size of the country. This would be another strong reason for privatization of the enforcement mechanism.

148 42 U.S.C. § 1395dd(d)(1)(A). There have been no decisions on whether an EMTALA administrative determination would bar a future court action on res judicata grounds. Generally, an administrative adjudication will have the same preclusive effects as court judgments. See U.S. Postal Serv. v. Gregory, 534 U.S. 1, 17 (2001); RESTATEMENT (SECOND) OF JUDGMENTS § 83(1) (2006) (“[A] valid and final adjudicative determination by an administrative tribunal has the same effects under the rules of res judicata, subject to the same exceptions and qualifications, as a judgment of a court.”). This may not be applicable in terms of EMTALA at least in so far as the Restatement is concerned, because such res judicata effect is conditioned on “[t]he right on behalf of a party to present evidence and legal argument in support of the party’s contentions and fair opportunity to rebut evidence and argument by opposing parties.” Id. § 83(2)(b). Since EMTALA claims do not even involve the party, except perhaps as a witness, it would seem the Restatement and common sense would not attach claim preclusive effect.

149 Compare 18 U.S.C. § 3771(c)(1) (granting victims a right to participate in the prosecution process and requiring “[o]fficers and employees of the Department of Justice and other departments and agencies of the United States engaged in the detection, investigation, or prosecution of crime . . . [to] make their best efforts to see that crime victims are notified of, and accorded, the rights described in . . . [the statute].”).
that such a system can have the deterrent effect that Congress intended.\textsuperscript{150}

In a practical sense, private pursuit of claims would control for the potential of misguided prosecutorial discretion. As of now, less than half of EMTALA claims that are reported are actually investigated. This leads clearly to a lack of liability and by definition a lack of deterrence. It goes without saying that “with perfect deterrence there will be no victims.”\textsuperscript{151} Allowing a private right of action against individuals would in fact keep truer to the original two goals behind EMTALA than not doing so. When one recognizes patient dumping as an intentionally tortious activity, the economics of allowing personal recovery for the victim seem to make sense. As Landes and Posner noted, “if victims are not compensated [for their losses], potential victims have an incentive to expend resources to avoid being victimized.”\textsuperscript{152} Damages to the victim are more efficient than state fines because they prevent victims from “over-investing” in “self-protection.”\textsuperscript{153}

\textsuperscript{150} Gionis, \textit{supra} note 9, at 307 (“As there is little incentive for compliance with EMTALA, some healthcare professionals and facilities have disregarded their obligations and engaged in patient dumping, on the basis of purely economic or non-economic, non-medical discriminatory grounds, without apparent fear of punishment.”); Treiger, \textit{supra} note 15, at 1200 (“Without fear of punishment, hospitals feel free to disregard their obligations.”).

\textsuperscript{151} LANDES \& POSNER, \textit{supra} note 112, at 155.

\textsuperscript{152} Id. at 155.

\textsuperscript{153} Id. The model is as follows: There are two potential types of cases. (1) Cases where the damages to the victim (D) are greater than the gains experienced by the tortfeasor (G) (D $\geq$ G), and (2) cases where the damages to the victim are less than the potential gain (D $<$ G). \textit{Id}. This is illustrated by the example of theft from a cabin, the thing taken is more valuable to the thief than to the victim, in the sense . . . that the thief is willing to pay more for the thing than the victim, its proper owner, would demand to give it up, but transaction costs prevent the transaction from being made voluntarily. There is an intentional injury but it is value-maximizing. The law does not want to encourage potential victims to spend recourses on preventing this kind of taking so it treats the taking as a tort, with the victim entitled to compensation and not subject to a defense of contributory negligence.

\textit{Id}. at 156. Oftentimes, it is difficult to distinguish between the two types, at least before the fact. \textit{Id}.

In the cases like (1), damages are obvious. In the cases like (2), on the other hand, one would think that the transaction, which resulted in net efficiency should only carry liability for the amount of costs, G, to the victim in order to ensure that the act is only committed when the benefits exceed the costs. \textit{Id}. at 155. If victims receive damages they will not over-invest in protection in order to prevent potentially socially beneficial torts and yet will still be compensated. \textit{Id}.

In EMTALA, the cases where D $<$ G, are those cases where transfer would cause some harm to the patient, but the transfer is necessary for proper treatment. In this case, the hospital will receive the benefit from not having to treat the patient and this will be greater than the slight increase in injuries to the patient being transferred. The appropriate remedy would be compensation for this slight loss but it would still result in a net gain for the hospital. In the cases where D $\geq$ G, the only way in which the hospital will be deterred is if they are forced to compensate the potential victim.
Finally, this type of deterrence must be enforced against the individual who is causing harm. It was recognized early on that hospitals, despite punishment, may have the economic incentive to dump patients. Individual physicians on the other hand would not have the economic incentive to do so if they are appropriately deterred. While the hospital may be liable for a policy that encourages such action, it is the doctor who is guilty of intentional wrongdoing in the tortious sense. Intentional torts occur when one “deliberately inflict[s] an injury that the injurer knows is wrongful.” In order for any action to have a deterrent effect, it must take away the potential pecuniary benefit from the individual that is being deterred.

2. Stopping Short of Federal Medical Malpractice

These damages would include punitive damages. “Punitive damages may be awarded for conduct that is outrageous, because of the defendant’s evil motive or his reckless indifference to the rights of others.” RESTATEMENT (SECOND) TORTS § 908(2) (1979); see, e.g., Hintz v. Roberts, 121 A. 711, 713 (N.J. Ct. Err. & App. 1923) (“[I]n an action for trespass committed against the property of another, which involved malice or a wanton and reckless disregard of the rights of the person against whom the tortious act is committed, exemplary damages may be recovered.”); Sebastian v. Wood, 66 N.W.2d 841, 845 (Iowa 1954) (“[T]he purpose of exemplary damages [is] the punishment, and prevention of similar future offenses. The allowance of such damages is wholly within the function and province of the jury, to be granted or denied in the exercise of a wise discretion, whether the moving cause be effected by malice, oppression, wantonness, recklessness or gross negligence . . .”). There are a number of efficiency rationales for allowing such recovery. First, it may be very difficult to identify the tortfeasor and collect damages from him. LANDES & POSNER, supra note 112, at 160. This is particularly so in the case of maliciously committed torts such as robbery where the activity comes with criminal sanctions. Id. The optimal compensation then would be a multiple of the actual amount of damages. Id. “For example, if A’s actual damages are $100 but people who commit these torts are identified and successfully sued only half the time, then, assuming risk neutrality and ignoring detection and legal costs, the injurer who is found liable should be made to pay A $200.” Id. at 160 n. 12.

How the damages would be measured in terms of loss of life is beyond the scope of this Note. Landes & Posner found “one very important respect [in which tort damages] seen out of phase with economics. This is the matter of valuing life in a tort case where the victim dies.” Id. at 186. The common law may not have originally even recognized a right of action for loss of life. See Joellen Lind, Valuing Relationships: The Role of Damages for Loss of Society, 35 N.M. L. REV. 301, 316 (2005). This was later amended by various English and American statutes, which had varying approaches. Id. Needless to say, some recovery would have to be permitted, at least in terms of the pecuniary loss (i.e., the decedent’s future earnings), if not more. LANDES & POSNER, supra note 112, at 187 (“This limitation of damages [to only pecuniary damages] . . . assumes—if, as we generally believe to be the case, tort law seeks to internalize the costs of accidents—that the average person derives no utility from living. He does not work for himself, he works solely for his family. This cannot be right, and it results in systematic underestimation of damages in wrongful-death cases.”).

This is simply not being achieved in the current regulatory enforcement regime.

154 See Treiger, supra note 15, at 1187; see also HARVARD MEDICAL SCHOOL STUDY, supra note 22; Schiff, supra note 23.
155 LANDES & POSNER, supra note 112, at 150.
Allowing for a private action against individual physicians will not lead the courts down the road of creating a federal medical malpractice action, and will therefore not thwart the second congressional aim of EMTALA.\footnote{See generally Alexee Deep Conroy, Note, Lessons Learned from the “Laboratories of Democracy”: A Critique of Federal Medical Liability Reform, 91 CORNELL L. REV. 1159 (2006), for a general discussion to state and federal medical malpractice reform and the continuing problems that still remain. The phrase “Laboratories of Democracy” “is a reference to Justice Brandeis’s view that individual states can choose to experiment with novel social programs, and, as such, can serve as models for the nation.” \textit{Id.} at 1159 n.1 (citing New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (“It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”)); \textit{see also} Christina O. Jackiw, The Current Medical Liability Insurance Crisis: An Overview of the Problem, Its Catalysts and Solutions, 13 ANNALS HEALTH L. 505 (2004).} The current interpretation of the statute already allows for this private right of action. The case law and regulations limit EMTALA to claims of patient dumping and do not permit EMTALA to extend to negligent treatment claims. A private cause of action against individual physicians, construed as proposed, falls short of medical malpractice, keeping true to the congressional intent, and is a better solution than the two proposals, the intentional tort and motivation requirement proposals outlined above.

a. Support in the Case Law and Regulations

Early on in EMTALA’s history, the D.C. Circuit in \textit{Gatewood v. Washington Healthcare Corp.} faced the question of when, in the course of admission and treatment, hospitals would be required to “stabilize” patients.\footnote{933 F.2d 1037 (D.C. Cir. 1991).} William Gatewood, fully insured, presented to the Washington Healthcare Corp. Emergency Room.\footnote{\textit{Id.} at 1039.} Mr. Gatewood was admitted and diagnosed with musculoskeletal pain, after which he was discharged with instructions to take Tylenol and call his primary care physician for a follow up.\footnote{\textit{Id.}} Mr. Gatewood died the following morning.\footnote{\textit{Id.}} Alleging that the hospital had failed to stabilize her husband, Mrs. Gatewood brought an action in federal court under EMTALA, with pendent state law claims.\footnote{\textit{Id.}} In affirming the dismissal of the action for failure to state a claim,\footnote{\textit{Id.}} the court of appeals reasoned...
that “appropriate medical screening” could not be intended to ensure correct diagnosis. The hospital has fulfilled its EMTALA duties for an appropriate medical screening “when it conforms in its treatment of a particular patient to its standard screening procedures.” After this point, state malpractice law governs.

The Gatewood court applied EMTALA in a way that prevents plaintiffs from bringing an ordinary state malpractice claim under federal question jurisdiction. This approach has been followed in other circuits. Indeed what seemed to be incorrect about the Sorrells

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163 Id. at 1041.

164 Id. The D.C. Circuit relied on Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 271-72 (6th Cir. 1990). However, it should be noted that unlike the court in Cleland, see supra Part II.C.2, the Gatewood court explicitly rejected an improper motivation requirement. Gatewood, 933 F.2d at 1041 n.3.

165 Gatewood, 933 F.2d at 1041. Seemingly anticipating the Intentional Tort proposal, the court notes:

We recognize, of course, that there 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 appellant’s invitation to incorporate a malpractice or negligence standard into subsection 1395dd(a). The federal Emergency Act is not intended to duplicate preexisting legal protections, but rather to create a new cause of action, generally unavailable under state tort law, for what amounts to failure to treat. Though there may arise some areas of overlap between federal and local causes of action, most questions related to the adequacy of a hospital’s standard screening and diagnostic procedures must remain the exclusive province of local negligence law.

Id. (emphasis added).

166 After dismissing the EMTALA claim, all that remained before the district court were the pendent state law claims; the district court subsequently dismissed for lack of subject matter jurisdiction. Id. at 1039.

167 See Bryant v. Adventist Health System/West, 289 F.3d 1162, 1167 (9th Cir. 2002) (“[T]he term ‘stabilize’ was not intended to apply to those individuals who are admitted to a hospital for inpatient care.”); Reynolds v. MaineGeneral Health, 218 F.3d 78, 83 (1st Cir. 2000) (“Congress manifested an intent that all patients be treated fairly when they arrive in the emergency department of a participating hospital and that all patients who need some treatment will get a first response at minimum and will not simply be turned away. . . . The fact that Mr. Reynolds was in the hospital receiving treatment is a prima facie showing that the purpose of . . . [EMTALA] was satisfied; any failures of diagnosis or treatment were then remediable under state medical malpractice law.”); Hardy v. N.Y. City Health & Hosps. Corp., 164 F.3d 789, 792-93 (2d Cir. 1999) (“EMTALA is not a substitute for state law on medical malpractice. It was not intended to guarantee proper diagnosis or to provide a federal remedy for misdiagnosis or medical negligence. Instead, EMTALA was enacted to fill a lacuna in traditional state tort law by imposing on hospitals a legal duty (that the common law did not recognize) to provide emergency care to all.”) (citations omitted); Bryan v. Rectors & Visitors of the Univ. of Va., 95 F.3d 349 (4th Cir. 1996); Mazurkiewicz v. Doylestown Hosp., 305 F. Supp. 2d 437, 443-44 (E.D. Pa 2004) (adopting the Fourth Circuit’s reasoning in Bryan).

The Fourth Circuit’s decision in Bryan seemed to be a reversal of approach in that circuit. In its heavily controversial decision, In re Baby K, 16 F.3d 590 (4th Cir. 1994), the Fourth Circuit held that a hospital was required to provide respiratory support to an anencephalic baby, a child born with “a congenital malformation in which a major portion of the brain, skull, and scalp are missing,” and because of a missing cerebrum, “is permanently unconscious.” Id. at 592. The court held that treatment was required despite the fact that the baby had been born in the
decision is not that the court allowed an EMTALA claim to go through against a physician, but rather that the EMTALA claim was allowed altogether. Recall that the plaintiff in Sorrells was admitted to, rather than turned away from, the hospital. Applying the analysis of Gatewood to this circumstance, the court should have dismissed the EMTALA claim not on jurisdictional grounds, but rather because the plaintiff had attempted to raise an issue of negligent treatment under the anti patient-dumping statute.

To be sure, there will be cases where the distinction between failure to admit and negligent care is not so clear. Marrero v. Hospital Hermanos Melendez is a case where the patient was not admitted to the hospital officially, but nonetheless the patient received some treatment—albeit deficient treatment. In both Marrero and Gatewood the end result was the same: the patient was shipped off with instructions to take Tylenol and the patient subsequently died. In Marrero, however, it is ambiguous whether the harm was caused by an intentional failure to treat or because of negligent treatment, the former an EMTALA violation, and the latter a violation of state tort law. But these types of ambiguities can be resolved by a jury or finder of fact. Indeed, this type of situation seems to be precisely the case where it would be efficient for a federal court to exercise supplementary jurisdiction over the state medical malpractice claim. A jury would


169 Sorrells, 733 F. Supp. at 1190.
170 253 F. Supp. 2d 179 (D.P.R. 2003); see supra Introduction for a more detailed description of the facts in Marrero.
171 Id. at 184.
172 Id.
174 There are a number of factual questions in Marrero that cast doubt on the failure to treat claim. For example, Mr. Marrero was triaged as being “green” or stable upon entry into the hospital, Marrero, 253 F. Supp. 2d at 184, and the hospital doctor actually ordered two tests, one of which was administered, in order to assess his condition. Id.
175 See 28 U.S.C. § 1367(a) (2000), which grants District Courts discretion to exercise jurisdiction over state law claims if they form part of the same “case or controversy.” In this case
be in the position, after hearing all of the facts, to make a reasoned judgment as to whether there was wrongdoing in this case, and if there was, whether denying admission to the hospital was an intentional act or a case of negligent treatment.

Surprisingly, CMS regulations at least partially support such a view of the statute. In the 2003 Regulatory Amendments, CMS clarified the extent that EMTALA obligations apply to inpatients. The regulations conclude first that, “EMTALA . . . [applies] to admitted emergency patients until they have been stabilized.” This interpretation raises the same concerns raised by the Sorrells decision. Allowing EMTALA obligations to follow the patient blurs the line between wrong-doing that is explained by an intentional failure to treat as opposed to negligent choices in medical care. The justification for this seems to be a fear that hospitals will use admission to the hospital as a way around EMTALA responsibility. Yet, arguably this can be controlled for by finding EMTALA violations if the admission of the patient was clearly a charade. If it is not certain whether the admission was intended to thwart EMTALA liability, then certainly such a low level of medical care would be tortious and sufficient for recovery under state malpractice law.

Perplexingly, a year after writing this rule, CMS clarified that EMTALA obligations do not apply to an inpatient who has been admitted for non-emergency conditions. In deciding whether or not to extend EMTALA obligations to inpatients, CMS noted that “a hospital may face liability for negligent behavior that results in harm to persons it treat[s] after they are admitted as inpatients, but such potential liability would flow from medical malpractice principles, not from the hospital’s obligations under EMTALA.” This is exactly the recognition that would keep only the proper EMTALA claims in the courts. To be sure, patients who are negligently treated by doctors after

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the Court’s exercise of supplemental jurisdiction would be efficient as it would negate the need for two trials on intent and negligence.

176 See 42 C.F.R. § 489.24(d)(2)(i)-(iii) (2006); see also Scope of EMTALA Applicability to Hospital Inpatients, 68 Fed. Reg. 53,222, 53,243-248 (Sept. 9, 2003) for CMS’s discussion on the rationale behind the rule.

177 See supra Part I.B.


181 See CMS, Scope of EMTALA Applicability to Hospital Inpatients, 67 Fed. Reg. 31,404, 31,475-76 (May 9, 2002) (codified at 42 C.F.R. § 489.24(d)).

182 42 C.F.R. § 489.24(2)(ii); see discussion at 68 Fed. Reg. 53,222, 53,244.

183 68 Fed. Reg. 53,222, 53,244. CMS relied heavily on the various Courts of Appeals that had found the same. They cited to Bryant v. Adventist Health System, 289 F.3d 1162 (9th Cir. 2002), Harry v. Marchant, 291 F.3d 767 (11th Cir. 2002), and Bryan v. Rectors & Visitors of the Univ. of Va., 95 F.3d 349 (4th Cir. 1996).
having been admitted do not lack protection; this protection, however, should not come from EMTALA.184

This interpretation of EMTALA seems to recognize the intentional nature of patient dumping as a separate harm than medical malpractice. This is consistent with the Intentional Tort Proposal.185 However, the approach of allowing a cause of action under EMTALA instead of through state tort law recognizes that Congress has created a right to be screened and stabilized at hospital emergency rooms, the violation for which there ought to be a remedy: money damages.186 Additionally, while it is not necessary for such a cause of action to include an improper motivation requirement,187 such a requirement seems almost to be inevitable when one looks closely at the distinction between the anti-patient dumping tort and the negligent treatment tort. It would be difficult to understand the difference between EMTALA and a normal medical malpractice action if one could negligently commit the tort. Indeed the court in Cleland seemed to recognize this, noting that “neither the normal meaning of stabilization, nor any of the attendant legislative history or apparatus, indicates that Congress intended to provide a guarantee of the result of emergency room treatment and discharge.”188 The Cleland court concluded that this consideration would require the “appropriate” requirement of EMTALA189 “to refer to the motives with which the hospital acts.”190 Thus the recognition in the intentional tort proposal and the improper motivation proposal are honored in an approach that allows the courts to properly enforce the statute as it is. This third proposal does not create a federal malpractice cause of action.

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184 One concern that commentators raised with this type of interpretation is that doctors may do a sham admission to escape the potential of EMTALA liability. CMS addressed this and noted:

[A] hospital cannot escape liability under EMTALA by ostensibly “admitting” a patient, with no intention of treating the patient, and then inappropriately transferring or discharging the patient without having met the stabilization requirement. If it is discovered upon investigation of a specific situation that a hospital did not admit an individual in good faith with the intention of providing treatment (that is, the hospital used the inpatient admission as a means to avoid EMTALA requirements), then liability under EMTALA may attach. 68 Fed. Reg. 3222, 93,245.

185 See Gionis, supra note 9, at 205-97; see supra Part II.C.1.

186 See Marbury v. Madison, 5 U.S. (1 Cranch) 137, 163 (1803) (“[I]t is a general and indisputable rule, that where there is a legal right, there is also a legal remedy by suit or action at law, whenever that right is invaded.”) (quoting WILLIAM BLACKSTONE, 3 COMMENTARIES *23).

187 See Gatewood v. Washington Healthcare Corp., 93 F.2d 1037, 1041 n.3 (D.C. Cir. 1991) (rejecting the improper motivation requirement of the Sixth Circuit); see supra note 164.

188 Cleland v. Bronson Health Care Group, 917 F.2d 266, 271 (6th Cir. 1990).


190 Cleland, 917 F.2d at 272.
b. Stopping Short of the Medical Malpractice Line

It is relatively easy to identify the reasons that Congress feared the creation of a federal malpractice cause of action. There are two basic problems that would arise with the creation of a federal malpractice cause of action: traditional tort and insurance issues, and court efficiency issues. The first set of problems, those issues traditionally associated with medical malpractice torts, would only be magnified if there was an additional avenue for liability and rising insurance costs. A federal cause of action would magnify these issues at the same time that Congress has proposed federal tort reform because it would create a new way for increased recovery despite Congress attempting to limit such recovery. 191 The second issue arises because of an increased case load in the federal courts. Presently, traditional malpractice claims will only be heard in the federal courts if the court has diversity jurisdiction over the parties. 192 The concern is that litigants will bring malpractice claims under EMTALA calling on federal question jurisdiction. 193

If, however, the district courts are vigilant in permitting only those actions that allege a failure to treat or stabilize, the traditional issues associated with malpractice tort recovery will be minimized. The traditional problems of medical malpractice, including high insurance premiums and exorbitant punitive damages awards may still occur, but will do so in the context of a different right. This will, therefore, not be a duplication or exacerbation of the current malpractice. Further, if the intentional nature of the act is emphasized, it is unlikely that the insurance repercussions that have followed from malpractice law will follow since most malpractice insurance policies do not cover intentional torts. 194 In terms of court efficiency, claims that allege negligence and which are clearly not an intentional failure to treat will be thrown out for failure to state a claim. 195 If there is a supplemental

192 28 U.S.C. § 1332(a) (requiring complete diversity of citizenship and a claim worth over $75,000).
193 28 U.S.C. § 1331. (“The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.”).
194 See APPLEMAN ON INSURANCE LAW AND PRACTICE § 130.1 (2d ed. 2006) (“Medical malpractice liability policies contain some exclusions common to other types of liability insurance, such as exclusions for discrimination and contractually assumed liability. They also include a number of exclusions that are found only in professional or medical liability policies. The exclusions most often found include those for dishonest, fraudulent or criminal acts, punitive damages and intentional torts.”).
195 See FED. R. CIV. P. 12(b)(6) (stating as a defense the plaintiff’s “failure to state a claim
state law malpractice claim, this can also be kept out of the federal courts by the district court’s careful discretionary exercise of supplemental jurisdiction.\textsuperscript{196}

One possible conclusion is that vicarious liability or respondeat superior would render private claims against individual physicians nonsensical. It is relatively well settled that an employer can be held liable for the intentional torts committed by employees acting within the scope of their employment.\textsuperscript{197} It is also true that doctors who violate EMTALA to cut costs for the hospital or to decrease their work load are certainly acting within the scope of their employment.\textsuperscript{198} However, individual employees are still individually liable despite the fact that the plaintiff is able to recover from the deeper pockets of the hospital employer. Further, the insurance ramifications for physicians who commit such acts would arguably have a significant deterrent effect. Additionally, even if the recovery ends up coming from the same place, the aim of this proposal is to place the control of enforcement back into the hands of the private individuals who were wronged in the first place.

One other potential concern is the possibility of multiple liability stemming from the same action, and thus double recovery.\textsuperscript{199} As with the previous concerns, double recovery will not occur if the courts are vigilant in allowing private claims only when they involve patient dumping. One could certainly think of an example where a patient is refused at hospital $A$’s emergency room and then negligently treated at hospital $B$’s emergency room. In this case, the physicians at $A$ and $B$ would be liable for different torts: $A$ would be liable for intentionally failing to treat the patient and $B$ for negligently treating her. The jury would at that point be charged with assessing both the damages to the patient, and how much each doctor’s tort contributed to those damages.\textsuperscript{200} While this may seem complicated, it is not any more than ordinarily expected of jurors in cases with joint tortfeasors.\textsuperscript{201}

\footnotesize

upon which relief can be granted.

\textsuperscript{196} 28 U.S.C. § 1367(a); see supra note 175.

\textsuperscript{197} See Restatement (Third) of Agency § 7.03 (2006).

\textsuperscript{198} Id. § 7.07 (“An employee acts within the scope of employment when performing work assigned by the employer or engaging in a course of conduct subject to the employer’s control.”); see Kelley v. Rossi, 481 N.E.2d 1340, 1343 (Mass. 1985) (“The general rule is that a resident [physician] is a servant of the hospital.”).

\textsuperscript{199} To exacerbate this concern, EMTALA gauges private recovery by the amount allowed for personal injury recovered under the relevant state’s tort law. 42 U.S.C. § 1395dd(d)(2)(A).

\textsuperscript{200} Restatement (Third) of Torts: Apportionment of Liability § 26(a) (2000) (“When damages for an injury can be divided by causation, the factfinder first divides them into their indivisible component parts and separately apportions liability for each indivisible component part.”).

\textsuperscript{201} Id. § 26(a), cmt. f (“Whether damages can be divided by causation is a question of fact. The fact that the magnitude of each indivisible component part cannot be determined with precision does not mean that the damages are indivisible. All that is required is a reasonable basis
CONCLUSION

EMTALA was created to remedy a specific harm: patient dumping, the practice whereby doctors in busy hospital emergency rooms turn away patients for non-medical, primarily economic reasons. In so doing, Congress recognized the dangerous potential that private enforcement would lead to a new federal medical malpractice cause of action, compounding the problems already associated with malpractice liability. Consequently, the majority of courts have recognized that EMTALA was created without a private cause of action against physicians.

Yet, after twenty years of existence, EMTALA has not eradicated this abhorrent practice. Patient dumping continues to happen in busy hospital emergency rooms, with dramatic and unsavory results to patients, normally minorities and normally poor. This Note argues for the judicial recognition of a private cause of action against individual physicians who intentionally “dump” a patient. Previous proposals have noticed the intentional nature of patient dumping, but have failed to propose remedies within the confines of EMTALA, fearing that permitting a private right of action against physicians would automatically lead to increased malpractice liability as Congress feared. This Note has argued that allowing a private right of action would accomplish the goal of increased deterrence better than the current enforcement regime, and would do so without leading to the creation of a federal medical malpractice cause of action. In this light, permitting a private cause of action against individuals would work to accomplish Congress’s goal in enacting EMTALA—eradicating the practice of patient dumping—while staying true to Congress’s second mandate, not creating more malpractice liability. Only when the threat of punishment

for dividing the damages . . . . Divisible damages can occur in a variety of circumstances. They can occur when one person caused all of the damages and another person caused only part of the damages. They can occur when the parties caused one part of the damages and nontortious conduct caused another part. They can occur when the nontortious conduct occurred before or after the parties’ tortious conduct. They can occur in cases involving serial injuries, regardless of the length of time between the injuries. They can occur when the plaintiff’s own conduct caused part of the damages.”) (internal references omitted). If dividing liability is not possible, tort law may permit recovery of the full amount from either individual. See id. § 10; see, e.g., Capaldi, Inc. v. Feldman, 249 F.3d 54, 62 (1st Cir. 2001) (“[Joint and several liability] means that damages are a single sum specified in the judgment, that each wrongdoer is liable for the full amount, but the wronged party cannot collect under the judgment more than the single sum.”); Coney v. J.L.G. Indus., 454 N.E.2d 197, 204 (Ill. 1983) (“The common law doctrine of joint and several liability holds joint tortfeasors responsible for the plaintiff’s entire injury, allowing plaintiff to pursue all, some, or one of the tortfeasors responsible for his injury for the full amount of the damages.”).
for violating the terms of EMTALA is real in the eyes of those who violate its terms, the physicians who decide to dump patients, will the horrific stories like those of Ms. Williams and Mr. Marrero cease to be told.