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EMTALA: Its Application to Newborn Infants

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I. Introduction

The application of the Emergency Medical Treatment and Labor Act (EMTALA)[1] to extremely premature newborn infants has long been a source of concern to pediatricians and neonatologists.[2] Preston v. Meriter Hospital[3] is the first case to directly address the special status of newborns. In *Preston*, the Wisconsin Court of Appeals effectively narrowed the application of EMTALA to newborn infants, holding that EMTALA categorically does not apply to any infant born to an inpatient mother.[4]

On November 9, 1999, Shannon Preston arrived at Meriter Hospital in Madison, Wisconsin. She was 23 and 2/7th weeks pregnant. She was admitted to the hospital's birthing center and gave birth the next morning. The baby, Bridon Michael Johnson, weighed just one and one-half pounds. Although he could not survive without resuscitation and the administration of oxygen and fluids, Meriter did not resuscitate or treat him, and Bridon died two and one-half hours later.

Preston sued Meriter for violating EMTALA, among other causes of action.[5] The Wisconsin Circuit Court granted summary judgment for Meriter, reasoning that EMTALA's screening requirement[6] applies only to patients who present themselves at a hospital's emergency department, and does not provide a cause of action under the Act for patients like Bridon, whose mother checked in at the hospital's birthing center.[7]

In the first round of appeals in 2005, the Wisconsin Supreme Court reversed, rejecting the lower court's analysis, and holding that EMTALA's screening requirement applied to the hospital's birthing center.[8] It held that by being born on hospital property (even if not in the emergency department), baby Bridon "arrived" at Meriter Hospital, which triggered Meriter's duty to screen under EMTALA.[9]

On remand, Wisconsin's Circuit Court again granted summary judgment to Meriter. The court of appeals affirmed, this time resting its holding on two new premises:. *First*, the court of appeals held that EMTALA does not apply to patients *admitted* to the hospital. *Second*, the court held that since Preston was admitted as an inpatient when taken to Meriter's birthing center, then Bridon necessarily was simultaneously admitted as an inpatient.[10] Since he was an inpatient, EMTALA imposed no duty on Meriter with respect to Bridon.

II. EMTALA Does Not Apply to Inpatients

While the statutory language is silent, the overwhelming majority of state and federal courts to address the issue have held that EMTALA does not apply to inpatients.[11] After all, one of the goals of EMTALA is to get patients "into the system."[12] Once there, patients are protected both by state tort law and by the Medicare Conditions of Participation.[13] EMTALA, as is widely repeated, is not a federal malpractice statute.[14]

Furthermore, in 2003, the Centers for Medicare and Medicaid Services (CMS) issued regulations expressly clarifying that when "a hospital admits [an] individual as an inpatient in good faith …. to stablize the emergency medical condition, the hospital has satisfied its special responsibilities under [EMTALA] with respect to that individual."[15] Since the statute is ambiguous, and Congress expressly delegated to CMS the authority to make rules concerning EMTALA, under applicable rules of construction, CMS' interpretation is controlling.[16]

Notwithstanding the weight of this authority, two federal circuit courts of appeal have construed EMTALA to apply to inpatients—albeit in older holdings that preceded CMS's regulations in 2003. In 1990, the Sixth Circuit held that EMTALA applied to the discharge of an individual who had been an inpatient for 21 days.[17] Later, in 1999, the First Circuit held that EMTALA applied to an infant who was born in the hospital maternity ward.[18] And a recent First Circuit district court held that EMTALA applied to an to an infant who had himself been admitted as an inpatient.[19] But in most jurisdictions the inpatient exception is now well-established. And since the operative facts in the First and Sixth Circuit cases predate the 2003 regulations, it seems likely that even these courts will apply the inpatient exception when presented with the issue on appeal.[20] Indeed, the Supreme Court recently denied certiorari on the inpatient issue, implying that its clarification was unnecessary.[21]

III. A Newborn Infant Is an Inpatient if Its Mother Is an Inpatient

While the inpatient exception is well-settled, its application to a newborn infant was a novel question for the Wisconsin Court of Appeals in *Preston:* "The issue of whether a newborn infant is considered an inpatient upon his or her mother's admission has yet to be determined by this, or to our knowledge any other, court."[22] Consequently, the court looked to "common sense" to conclude that "when a hospital provides inpatient care to a woman that involves treating her fetus simultaneously, the unborn child is a second inpatient, admitted at the same time as the mother."[23]

While *Preston* has limited precedential authority, its persuasive impact could be quite significant. Preterm birth is the leading cause of newborn death and its incidence continues to increase.[24] Because hospitals must comply with EMTALA regardless of the standard of care, providers have often been compelled to provide newborn infants with treatment that they considered medically inappropriate. For example, in one of the most infamous EMTALA cases, the U.S. Court of Appeals for the Fourth Circuit held that EMTALA obligated a Virginia hospital to provide stabilizing respiratory treatment to Stephanie Keene ("*Baby K*"), an anencephalic infant, even though experts on both sides agreed that the standard of care was to provide comfort care only.[25] *Baby K* predates the inpatient exception.[26] But it is telling to apply its facts under the holding in

Preston. Since Stephanie's mother gave birth as an inpatient, EMTALA would not require the hospital to treat or resuscitate Stephanie upon her birth.

IV. The Impact of BAIPA

Because the operative facts in *Preston* occurred in 1999, the Wisconsin Court of Appeals interpreted the law as it applied at that time.[27] But, in 2002, EMTALA was materially amended by the Born Alive Infant Protection Act (BAIPA).[28] Primarily intended as an anti-abortion measure,[29] BAIPA provides that, as used in any federal statute or regulation, the words "person," "human being," "child," and "individual" include all "born alive" infants.

In April 2005, the Director of the CMS Survey and Certification Group issued a Guidance on how to apply EMTALA when BAIPA is potentially impacted.[30] The Guidance asserts that were an infant born alive "anywhere on the hospital's campus," and a prudent layperson observer concluded that the infant were suffering from an emergency medical condition, then the hospital would have an obligation to "admit the patient" or comply with the stabilization or transfer requirement. This implies that the infant was not already an inpatient.[31] Indeed, the Guidance explains that the inpatient exception would apply only if the infant were "born alive *and then admitted* to the hospital."[32]

While the Guidance is not binding, it is consistent with CMS' formal interpretation of EMTALA. The 2003 regulations define "inpatient" as "an *individual* who is admitted to a hospital bed for the purposes of receiving inpatient hospital services . . . with the expectation that he or she will remain at least overnight . . . ."[33] And they state that the inpatient exception applies only where the hospital "admits that *individual*."[34] Since BAIPA defines "individual" as a "born-alive infant," an unborn fetus cannot be an inpatient for purposes of EMTALA.[35]

Furthermore, since almost no other element of the inpatient exception is satisfied, treating a newborn infant as an inpatient based solely on its mother's inpatient status may come close to constituting a subterfuge.[36] Meriter Hospital, for example, never intended to treat Bridon.[37] It never admitted him to a bed or bassinet. And it never expected him to remain overnight.[38] In most cases applying an inpatient exception, the individual had been admitted for several days.[39] In contrast, with newborn infants like Bridon, the cessation of treatment follows immediately from the inpatient status.

V. Conclusion

Preston is the first case to directly address the inpatient status of newborn infants. It holds that EMTALA categorically does not apply to the infants born to inpatient mothers. But the operative facts in *Preston* predate BAIPA. In light of BAIPA's alteration of key statutory terms, it is prudent to comply with EMTALA obligations for all newborn infants anywhere in the hospital unless or until a good faith decision is made to admit the infant after its birth.

[1] 42 U.S.C. § 1395dd.

[2] *See generally* A.R. Weiss et al., *Decision Making in the Delivery Room: A Survey of Neonatologists*, 27 J. Perinatology 754 (2007); Sadath A. Sayeed, *Baby Doe Redux: The Department of Health and Human Services and the Born Alive Infant Protection Act of 2002: A Cautionary Note on Normative Neonatal Practice*, 116 Pediatrics 576 (2005).

[3] Preston v. Meriter, No. 2006AP3013, 2008 WI App. 25, 2008 WL 191806 (Jan. 24, 2008), available at http://wicourts.gov/ca/opinion/DisplayDocument.pdf?content=pdf&seqNo=31610, *petition for review filed*, (Feb. 25, 2008).

[4] The only exception left open by the court is where the admission is a subterfuge, made in bad faith specifically to evade EMTALA obligations.

[5] Preston also brought claims for neglect, informed consent, and malpractice. But the trial court granted summary judgment in favor of Meriter on those claims. Preston v. Meriter Hosp., 700 N.W.2d 158, 163 (Wis. 2005). The malpractice claim was dismissed because her attorney could not find an expert witness to testify that the standard of care required resuscitation and the administration of oxygen to such a premature infant.

[6] 42 U.S.C. § 1395dd(a) ("[I]f any individual . . . *comes to the emergency department* and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department,...to determine whether or not an emergency medical condition...exists.").

[7] Preston v. Meriter Hosp., 678 N.W.2d 347 (Wis. App. 2004) (affirming summary judgment).

[8] *Preston*, 700 N.W.2d 158.

[9] The Wisconsin Supreme Court's reasoning largely tracks that in 2003 regulations interpreting EMTALA. 42 C.F.R. § 489.24(b) (defining "comes to the emergency department" functionally rather than spacially as including presenting anywhere "on hospital property"); *see also* U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Final Rule: Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions*, 68 Fed. Reg. 53,222, 53,247 (Sept. 9, 2003) (observing that a hospital's birthing center will often be part of its dedicated emergency department).

[10] *Preston*, 2008 WI App. 25 ¶ 55 ("Birth, the very treatment for which Preston presented, was also treatment affecting Bridon.").

[11] *See, e.g.*, Bryant v. Adventist Health Systems/West, 289 F.3d 1162, 1167 (9 th Cir. 2002); Harry v. Marchant, 291 F.3d 767, 775 (11 th Cir. 2002); Bryan v. Rectors & Visitors of UVA, 95 F.3d 349 (4 th Cir. 1996); Causey v. St. Francis Med. Ctr., 719 So. 2d 1072, 1075 n.2 (La. App. 1998); Rideout v. Hershey Med. Ctr., 30 Pa. D. & C.4th 57, 87-91 (Pa. Common Pleas Ct., Dauphin Cty. 1995).

[12] *See Final Rule*, 68 Fed. Reg. at 53,246 (citing H.R. Rep. No. 99-241, pt. 1, at 27 (1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 605).

[13] *Final Rule*, 68 Fed. Reg. at 53,244; 42 C.F.R. part 482 (COPs).

[14] *See generally Final Rule*, 68 Fed. Reg. at 53,244; Marshall v. East Carroll Parish Hosp. Service Dist., 134 F.3d 319, 322 (5 th Cir. 1998); Vickers v. Nashville Gen. Hosp., 78 F.3d 139, 142 (4 th Cir. 1996); Summers v. Baptist Med. Ctr., 91 F.3d 1132, 1136-37 (8 th Cir. 1996) (en banc); Eberhardt v. City of Los Angeles, 62 F.3d 1253, 1255 (9 th Cir. 1995) (citing H.R. Rep. No. 241).

[15] 42 C.F.R. § 489.24(d)(2); *see also Final Rule*, 68 Fed. Reg. 53,222.

[16] Chevron USA, Inc. v. Natural Resources Defense Council, 467 U.S. 837, 842-43 (1984); St. Anthony Hosp. v. U.S. Dept. Health & Human Services, 309 F.3d 680, 691-92 (10 th Cir. 2002) (applying *Chevron* to DHHS' enforcement of EMTALA).

[17] Thornton v. Southwest Detroit Hosp., 895 F.2d 1131 (6 th Cir. 1990).

[18] Lopez-Soto v. Hawayek, 175 F.3d 170 (1 st Cir. 1999).

[19] Lima-Rivera v. UHS of Puerto Rico, Inc., 476 F. Supp. 2d 92 (D.P.R. 2007).

[20] The First Circuit has already recognized that it must impose some temporal limit on EMTALA. *Lopez-Soto*, 175 F.3d at 177 n.4.

[21] Morgan v. N. Miss. Med. Ctr., 128 S. Ct. 888 (2008) (denying certiorari). The hospital had argued, apparently successfully, that the 2003 regulations "clarify any perceived conflict among the Circuits" and "alleviate the need

for review." Brief in Opp., No. 07-508, 2007 WL 4132897 (Nov. 15, 2007).

[22] *Preston*, 2008 WI App. 25 ¶ 9; *see also Preston*, 700 N.W.2d at 171 (Crooks, J., concurring).

[23] *Preston*, 2008 WI App. 25 ¶¶ 55-57.

[24] B.E. Hamilton et al., *Annual Summary of Vital Statistics: 2005*, 119 Pediatrics 345 (2007); Maria A. Morgan et al., *Obstetricians-Gynecologists' Knowledge of Preterm Birth Frequency and Risk Factors*, 20 J. Maternal-Fetal & Neonatal Med. 895 (2007); CDC National Center for Health Statistics, http://www.cdc.gov/nchs/datawh/vitalstats/VitalStatsbirths.htm. These cases are very expensive and likely to be uncompensated. *See* Rebecca B. Russell, *Cost of Hospitalization for Preterm and Low Birthweight Babies in the United States*, 120 Pediatrics e1 (2007).

[25] In re Baby K, 16 F.3d 590 (4 th Cir. 1994).

[26] Other cases that predate the inpatient exception have also assumed that a hospital owes EMTALA duties to an infant born to an inpatient mother. *See, e.g.*, Williams v. County of Cook, No. 97-C-1069, 1997 WL 428534 (N.D. Ill. July 24, 1997).

[27] Furthermore, as the court observed, " Preston [did] not argue that Bridon was not admitted because he did not meet the definition of 'inpatient' in 42 C.F.R. § 489.24." *Preston*, 2008 WI App. 25 ¶ 57 n.10.

[28] Pub. L. No. 107-207, § 2(a), 116 Stat. 926 (Aug. 5, 2002) (codified at. 1 U.S.C. § 8(a)).

[29] H. Rep. No. 107-186, 107 th Cong., 1 st Sess. (Aug. 2, 2001); Laura Hermer, *The "Born-Alive Infants Protection Act" and Its Potential Impact on Medical Care and Practice*, University of Houston Health Law Perspectives, Sept. 27, 2006, available at http://www.law.uh.edu/healthlaw/perspectives/2006/(LH)BAIPA.pdf.

[30] Center for Medicaid and State Operations/Survey and Certification Group, *Interaction of the Emergency Medical Treatment and Labor Act (EMTALA) and the Born Alive Infant Protections Act of 2002*, Ref. S&C-05-26 (Apr. 22, 2005) [hereinafter CMS BAIPA Memo], available at http://www.ashrm.org/ashrm/aboutus/pdf/Born-AliveAct.pdf.

[31] Obviously, if the hospital admits the newborn infant itself, then it is then relieved of EMTALA obligations to that infant. *See, e.g., In re AMB*, 640 N.W.2d 262, 289 (Mich. App. 2001).

[32] CMS BAIPA Memo, *supra*.

[33] 42 C.F.R. § 489.24(b).

[34] 42 C.F.R. § 489.24(d)(2).

[35] CMS appears to have confirmed that interpretation when it noted it is "unclear" whether the baby in *Lopez-Soto* was an inpatient, *Final Rule*, 68 Fed. Reg. at 53,246, while the mother in that case clearly was herself an inpatient, *Lopez-Soto*, 175 F.3d at 171.

[36] *Cf.* Sadath A. Sayeed, *The Marginally Viable Newborn: Legal Challenges, Conceptual Inadequacies, and Reasonableness*, 34 J. L. Med. & Ethics 600, 601 (2006) (suggesting that "admission of a marginally viable born-alive infant only in order to let her die without ongoing resuscitation efforts could be regarded as a sham"); BNA Health Law & Business Series 2900.02, *The Emergency Medical Treatment and Active Labor Act: Practical Tips and Legal Issues* (May 2007) ("[T]he meaning of 'in good faith' . . . raises additional compliance questions for hospitals."). The subterfuge issue was waived by Preston in the circuit court. *Preston*, 2008 WI App. 25 ¶ 53 n.7.

[37] *Preston*, 700 N.W.2d at 171 (Crooks, J., concurring) (observing that the "hospital never intended to, nor did it, provide any treatment to Bridon"). *But see id.* at 172 (Roggensack, J., dissenting) (observing that Bridon was treated both prenatally and postnatally when he was resuscitated and had his APGAR score).

[38] *See id.* at 163 ("Meriter physicians had determined, based on the prebirth ultrasound, that Bridon's lungs were so underdeveloped that he would likely die shortly after being born."); *see also* H. Rep. No. 107-186, at 13 (noting that untreated infants live for only hours). *But see Preston*, 2008 WI App. 25 ¶ 3 (suggesting that since Bridon's emergency medical condition was labor, Meriter expected to keep him and did keep him overnight in his mother's bed).

[39] *See, e.g., Bryant*, 289 F.3d at 1162 (3 days); *Bryan*, 95 F.3d at 349 (12 days); Morgan v. N. Miss. Med. Ctr., 403 F. Supp. 2d 1115 (S.D. Ala. 2005) (9 days), *aff'd*, 225 Fed. Appx. 828 (11 th Cir. 2007), *cert. denied*, 128 S. Ct. 888 (2008); Mazurkiewicz v. Boyleston Hosp., 305 F. Supp. 2d 437, 447 (E.D. Pa. 2004) (5 days); *AMB*, 640 N.W.2d at 289 (10 days).