Health Law: Quality & Liability

Professor Thaddeus M. Pope

Reading Packet for Week 4 (Fall 2018)

Weekly Summary

In week three, we examined the basic operation of EMTALA by walking through the statute and regulations. This week, we examine the two primary enforcement vehicles of EMTALA: private lawsuits for damages and civil monetary penalties.

Private Enforcement. EMTALA is primarily enforced by private litigants bringing lawsuits for money damages. Note that such lawsuits can only be brought against hospitals and not against individual physicians.

Agency Enforcement. In addition to private litigation, EMTALA is enforced by the DHHS which can fine either hospitals or physicians. DHHS can also exclude providers from participation in Medicare.

Reading

All the following materials are collected into this single PDF document:

Private lawsuits for damages:

- Elmhirst v. McLaren Northern Michigan Hospital (cert. petition July 2018) (typically no motive element).
- In re Baby K (4th Cir. 1994) (8 pages) (EMTALA duties ae unrelated to medical standards of care).
- Kaufman v Franz (E.D. Pa. 2009) (9 pages) (duty to screen based on ***known*** symptoms).
- Torretti v. Main Line Hosp. (3d Cir. 2009) (11 pages) (duty to stabilize only ***known*** emergency medical conditions; current patient exception).
- Smith v. Einstein Med. (3d Cir. 2010) (3 pages) (inpatient exception).

Administrative actions:

- Burditt v. DHHS (5th Cir. 1991) (13 pages) (against physician).
- US DHHA OIG, Recent CMP for EMTALA (3 pages).

Objectives

By the end of this week, you will be able to:

- Analyze and apply key statutory, regulatory, and caselaw principles regarding EMTALA, including the duty to screen, the duty to stabilize, and the duty to accept transfers (2.1).
- Analyze and apply key principles regarding how EMTALA is enforced by private litigants and how it is enforced by the DHHS (2.2).
- Distinguish EMTALA enforcement against hospitals from enforcement against individual Physicians (2.3).

No. _____

In The
Supreme Court of the United States

JAMIE ELMHIRST,

Petitioner,

v.

McLAREN NORTHERN MICHIGAN HOSPITAL,
d/b/a NORTHERN MICHIGAN
EMERGENCY MEDICINE CENTER,

Respondent.

**On Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Sixth Circuit**

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

The Emergency Medical Treatment and Active Labor Act of 1986 ("EMTALA") requires that any hospital with an "emergency department" provide an "appropriate medical screening examination" to "any individual" who requests it. 42 U.S.C. § 1395dd(a). In determining what constitutes an "appropriate" medical screening, the Sixth Circuit held, in *Cleland v. Bronson Health Care Group, Inc*., 917 F.2d 266, 272 (6th Cir. 1990) that "appropriate" should be interpreted with reference to "the motives with which the hospital acts." No other circuit has adopted that standard and this Court appeared to question it in *Roberts v. Galen of Virginia*, *Inc*., 525 U.S. 249 (1999), a case applying the adjoining subsection of the statute, 42 U.S.C. § 1395dd(b).

The question presented is:

> Whether, when determining if a hospital has complied with the "appropriate medical screening" requirement of the Emergency Medical Treatment and Active Labor Act, the court should hold that liability attaches independent of the defendant's motivation, as five circuits have held, or impose the requirement of malicious intent found only in the Sixth Circuit's cases and questioned by this Court.

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CASES

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Petitioner, Jamie Elmhirst, respectfully asks that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Sixth Circuit, docket number 17-1949, filed on March 9, 2018.

OPINION BELOW

The opinion of the Sixth Circuit, which was unpublished, was issued on March 9, 2018, and is attached as App. pp. 1-12, 2018 WL 1220732.

The order denying rehearing en banc is attached as App. pp. 27-28. The district court's opinion is attached as App. pp. 13-26.

JURISDICTION

The judgment of the Court of Appeals was entered on March 9, 2018. A petition for rehearing en banc was denied on May 8, 2018. (App. p. 27.)

The jurisdiction of this Court is properly invoked pursuant to 28 U.S.C. § 1254(1). This petition is filed within 90 days of the denial of petitioner's petition for rehearing en banc, under Sup. Ct. R. 13.1 and Sup. Ct. R. 29.2.

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

42 U.S.C. § 1395dd

(a) MEDICAL SCREENING REQUIREMENT

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under 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)) exists.

(b) NECESSARY STABILIZING TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND LABOR

(1) IN GENERAL 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).

* * *

(d) ENFORCEMENT

(2) CIVIL ENFORCEMENT

(A) Personal harm

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

STATEMENT OF THE CASE

1. ***Factual background.*** Plaintiff went to the emergency department of a hospital operated by defendant with symptoms that developed after she had been treated by a chiropractor. (App. pp. 14-15.) Although her symptoms were consistent with vertebral dissection, a known sequela of chiropractic manipulation, she was discharged without further examination. She later suffered a stroke and became permanently disabled. (App. p. 15.)

42 U.S.C. § 1395dd ("EMTALA"),[1] requires that any hospital with an emergency department provide

[1] Section 1867 of Pub. L. 99-272, 100 Stat. 82. The descriptive "act" is routinely employed even though the statute occupied only one section of the Consolidated Omnibus Budget Reconciliation Act of 1985.

anyone who comes to the emergency department with a "screening examination" to "determine whether or not an emergency medical condition" exists. 42 U.S.C. § 1395dd(a). If a person is found to have an "emergency medical condition," the hospital must either "stabilize the medical condition" or "provide for" transfer of the person to another facility. 42 U.S.C. § 1395dd(b)(1).

Plaintiff filed suit, alleging that defendant failed to comply with EMTALA, in that it did not conduct "an appropriate medical screening examination" to determine if "an emergency medical condition existed" and that the failure to do so caused her damages.

2. ***Proceedings below.*** Plaintiff's complaint was filed in the United States District Court for the Western District of Michigan, a subordinate court within the Sixth Circuit. (App. p. 14.)

The Sixth Circuit was the one of the first United States Courts of Appeals to construe EMTALA's requirement of an "appropriate" medical screening. In *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990), the court held that "appropriate" should be "interpreted to refer to the motives with which the hospital acts." 917 F.2d at 272. As discussed more fully *infra*, no other circuit has adopted the *Cleland* standard and this Court itself has signaled some dissatisfaction with it.

Defendant moved for judgment on the pleadings, based on the fact that plaintiff's complaint did not allege any "improper motive" on defendant's part. The district court, constrained by *Cleland*, granted the

motion. (App. pp. 22-23.) Because plaintiff could not support a claim under the "screening" requirement, she was also unable to maintain a claim for violation of the "stabilization" provision of the act. (App. pp. 23-24.)

Plaintiff appealed to the United States Court of Appeals for the Sixth Circuit. That court noted the "apparent lopsidedness of the circuit split" and the "force of the arguments" in support of a less-restrictive interpretation adopted in other circuits' courts. (App. p. 10.) Nonetheless, it affirmed. (App. p. 10.) The panel, however, "suggest[ed] that an en banc review of this decision would be appropriate." (App. p. 10.)

Plaintiff petitioned for en banc review. The petition was denied in a form order, stating that "[n]o judge has requested a vote on the suggestion for rehearing en banc." (App. p. 26.)

Plaintiff submitted a timely petition for a writ of certiorari.

REASONS FOR GRANTING THE PETITION

a. This Court should resolve the circuit split.

Federal laws are, by definition, "federal." It is appropriate that they be interpreted consistently across the *United* States. This case is an example. In the interests of uniform application of law, this Court should step in.

The statute in question, 42 U.S.C. § 1395dd, has been in effect since 1986. The Sixth Circuit was one of the first to construe the language at issue here, that is, the requirement of an "appropriate" medical screening. That court, in *Cleland*, *supra*, read into the statute a requirement that the court examine the hospital's motivation for its actions. "If [the hospital] acts in the same manner as it would have for the usual paying patient, then the screening provided is 'appropriate' within the meaning of the statute." 917 F.2d at 272. "[I]f . . . a hospital provides care to the plaintiff that is no different than would have been offered to any patient, and, from all that appears, is 'within its capability' (that is, constitutes a good faith application of the hospital's resources), then the words 'appropriate medical screening' in the statute should not be interpreted to go beyond what was provided here." *Id*.

Cleland was decided in 1990. Both before and after that point, other circuits were faced with applying the same language. None of them reached a comparable conclusion.

The Tenth Circuit became a leader in EMTALA cases. Post-*Cleland*, in *Phillips v. Hillcrest Med. Ctr*., 244 F.3d 790 (10th Cir. 2001), that court held that "[t]his circuit, like many others, does not require any particular motive for EMTALA liability to attach . . . *EMTALA looks only at the participating hospital's actions, not motives*." *Id*. at p. 798 (emphasis supplied). *See also Repp v. Anadarko Mun. Hosp*., 43 F.3d 519 (10th Cir. 1994), distinguishing *Cleland*.

The First Circuit also dealt with the "motive" requirement in *Correa v. Hospital San Francisco*, 69 F.3d 1184 (1st Cir. 1995). The Court of Appeals affirmed a verdict for the estate of a patient whose treatment was delayed by an insurance issue, stating:

> Every court of appeals that has considered this issue has concluded that a desire to shirk the burden of uncompensated care is not a necessary element of a cause of action under EMTALA. . . . We think that these cases are correctly decided, and that *EMTALA does not impose a motive requirement*.

Id. at 1193-94; (emphasis supplied).

A "motive" requirement was similarly rejected by the Fourth Circuit in *Power v. Arlington Hospital Assn.*, 42 F.3d 851, 857-58 (4th Cir. 1994) ("having to prove the existence of an improper motive on the part of a hospital, its employees or its physicians, would make a civil EMTALA claim virtually impossible"); the Fifth Circuit in *Burditt v. U.S. Dept. of Health & Human Serv.*, 934 F.2d 1362, 1373 (5th Cir. 1991), an appeal from an administrative fine under 42 U.S.C. § 1395dd(d)(1)(B) (court noted that a "motive" requirement "[is] *found nowhere* in the statute"); the Eighth Circuit in *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1137-38 (8th Cir. 1996) (en banc) ("the statute contains no . . . requirement [of improper motivation]"); and the D.C. Circuit in *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991) (motive is not important, expressly disagreeing with *Cleland*).

In short, the *Cleland* decision's "motive" requirement, rather than becoming the standard for interpretation of "appropriate" medical screening examination, devolved into a branch of the EMTALA case law with no progeny outside the Sixth Circuit.

To date, no case interpreting 42 U.S.C. § 1395dd(a) has reached this Court. A case involving 42 U.S.C. § 1395dd(b), however, is of great interest.

Roberts v. Galen of Virginia, Inc., 525 U.S. 249 (1999), was one of several opinions in the same case. The underlying plaintiff was injured in a motor vehicle accident and transported to a hospital operated by the defendant in Kentucky. She was treated there, but her condition was described as "volatile" and she was later moved to a different facility, in Indiana. She was transferred from there to another hospital, also in Indiana. She incurred very high medical bills but was deemed ineligible for Medicaid in Indiana because she was not a resident. Her guardian filed an EMTALA action. The district court dismissed the case and the Sixth Circuit affirmed. This Court reversed, but without addressing the *Cleland* rule:

> The Court of Appeals' holding—that proof of improper motive was necessary for recovery under § 1395dd(b)'s stabilization requirement—extended earlier Circuit precedent deciding that the "appropriate medical screening" duty under § 1395dd(a) also required proof of an improper motive. . . .

> Unlike the provision of EMTALA at issue in *Cleland*, § 1395dd(a), the provision at issue in this case, § 1395dd(b), contains no requirement of appropriateness. Subsection (b)(1)(A) requires instead the provision of "such further medical examination and such treatment as may be required to stabilize the medical condition." 42 U.S.C. § 1395dd(b)(1)(A). *The question of the correctness of the Cleland court's reading of § 1395dd(a)'s "appropriate medical screening" requirement is not before us, and we express no opinion on it here*. But *there is no question that the text of § 1395dd(b) does not require an "appropriate" stabilization, nor can it reasonably be read to require an improper motive.* This fact is conceded by respondent, which notes in its brief that "the 'motive' test adopted by the court below . . . lacks support in any of the traditional sources of statutory construction." . . . Although the concession of a point on appeal by respondent is by no means dispositive of a legal issue, we take it as further indication of the correctness of our decision today, and hold that § 1395dd(b) contains no express or implied "improper motive" requirement.

525 U.S. at pp. 252-53 (footnote omitted; emphasis supplied).

In a footnote, the Court made a point of stating that "*Cleland*'s interpretation of subsection (a) is in conflict with the law of other Circuits which do not read subsection (a) as imposing an improper motive requirement." 525 U.S. at 253, n. 1.

The unevenness of the weight of authority, then, is apparent.

b. The legislative history of EMTALA does not support imposing a "motive" requirement.

The history of what became EMTALA, §124 of H.R. 3128, 99th Cong. (1985), is relatively limited. There were no hearings on the bill. H.R. Rep. No. 99-241, pt. 3 (1985), p. 6. Although there are some references to concerns about care for the "indigent and uninsured," *e.g.*, *id*. at p. 6, nothing confining the rule to "indigent" or "uninsured" patients was incorporated into the final language.

It is of interest that the Judiciary Committee acknowledged the "vagueness" of the word "appropriate." As originally proposed, the bill provided for criminal penalties against physicians who violated the requirement. *Id.* at p. 4. The lack of definition of "appropriate" led to the deletion of this proposal by the Judiciary Committee. *Id.* at pp. 7-8. A comment, from an attorney representing a group of health care providers, also criticized the vagueness of "appropriate." *Id.* at p. 17. Similar comments were made by other groups. *Id.* at pp. 23, 33.

This Court will take note where Congress could have taken action but did not. *See*, *e.g.*, *Millbrook v. United States*, 569 U.S. 50, 56-57 (2013) (Congress could have further limited tort liability of law enforcement officers but did not).

That Congress had the opportunity to require an "improper motive" as an element of a claim for "inappropriate medical screening examination" but did not include it supports an argument that *Cleland*'s imposition of it was unwarranted.

c. This case is a suitable vehicle for resolving the circuit split.

The Sixth Circuit was given the opportunity to "revisit" *Cleland* in *Romine v. St. Joseph Health Syst*., 541 Fed.Appx. 614 (6th Cir. 2013), where the plaintiff based an EMTALA action on a delay in treating his hand injury. The district court dismissed the case, because the plaintiff did not allege an "improper motive" and because of a lack of evidence that the alleged EMTALA violation caused the injury.

The Sixth Circuit affirmed, in part because the "plaintiff's failure to adduce evidence of causation provides *an independent ground for granting summary judgment*" (emphasis supplied). 541 Fed.Appx. at p. 621.

In the case at hand, however, there would be no "independent ground for granting summary judgment" of plaintiff's "screening" claim. Plaintiff's complaint detailed the connection between the chiropractic treatment, her presenting symptoms of vertebral dissection and the connection between vertebral dissection and stroke. (App. p. 15.)

Elmhirst, then, would be a suitable vehicle for examining the "motive" requirement under 42 U.S.C. § 1395dd.

d. This Court has an interest in granting certiorari.

This Court has recognized an interest in uniform application of federal laws. "[F]ederal statutes are generally intended to have uniform nationwide application." *Mississippi Band of Choctaw Indians v. Holyfield*, 490 U.S. 30, 43 (1989) (citations omitted). "[R]ights which depend on federal law 'should be the same everywhere' and 'their construction should be uniform.'" *United States Term Limits, Inc. v. Thornton*, 514 U.S. 779, 812 (1995), quoting *Murdock v. Memphis*, 20 Wall. 590, 632, 22 L.Ed. 429 (1875).

Claims of failure to provide an "appropriate medical screening" continue to accrue and cases asserting these claims reach the courts on a regular basis. Under the current distribution of interpretation of 42 U.S.C. § 1395dd(a), only residents of four States (Michigan, Kentucky, Ohio, and Tennessee) must prove that a hospital acted with an "improper motive" in order to obtain relief under EMTALA.

The "institutional role [of this Court] properly is focused on ensuring clarity and uniformity of legal doctrine." *United States v. Young*, 470 U.S. 1, 34 (1985) (Brennan, J., dissenting in part). The "uniformity" and "clarity" of this federal statute are involved in this case. This Court should be as well.

CONCLUSION

For the foregoing reasons, petitioner requests that this Court grant the petition for certiorari.

Dated: July 27, 2018

Respectfully submitted,

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In the Matter of BABY "K" (Three Cases).

Nos. 93–1899, 93–1923 and 93–1924.

United States Court of Appeals, Fourth Circuit.

Argued Oct. 26, 1993.

Decided Feb. 10, 1994.

Hospital brought action for declaratory judgment that it was obliged under Emergency Medical Treatment and Active Labor Act (EMTALA) to provide respiratory support to anencephalic infant. The United States District Court, Eastern District of Virginia, Claude M. Hilton, J., entered judgment against hospital, 832 F.Supp. 1022, and it appealed. The Court of Appeals, Wilkins, Circuit Judge, held that hospital was not authorized to decline to provide stabilizing

treatment by simply refusing to transfer patient. Social Security Act, § 1867(b), (e)(3)(A), as amended, 42 U.S.C.A. § 1395dd(b), (e)(3)(A).

ARGUED: Julia Krebs–Markrich, John E. Coffey, Hazel & Thomas, P.C., Falls Church, Virginia; Pleasant S. Brodnax, III, Alexandria, Virginia, for Appellants. Ellen Joanne Flannery, Covington & Burling, Washington, D.C., for Appellee. **ON BRIEF:** Jennifer L.W. Korjus, Hazel & Thomas, P.C., Falls Church, Virginia; Kenneth E. Labowitz, Young, Goldman & Van Beek, Alexandria, Virginia, for Appellants. Debra Ann Palmer, Richard W. Buchanan, Theodore M. Hirsch, Georgia Kazakis, Covington & Burling, Washington, D.C., for Appellee. Alison Paige Landry, ReNee D. Brooks, Department for Rights of Virginians with Disabilities, Richmond, Virginia, for Amicus Curiae Department for Rights of Virginians with Disabilities; Walter A. Smith, Jr., Stephan E. Lawton, Anne M. Dellinger, Laura E. Loeb, Hogan & Hartson, Washington, D.C., for Amici Curiae American Academy of Pediatrics and Society of Critical Care Medicine.

Before WILKINS and WILLIAMS, Circuit Judges, and SPROUSE, Senior Circuit Judge.

OPINION

WILKINS, Circuit Judge:

[1] The Hospital[1] instituted this action against Ms. H, Mr. K, and Baby K, seeking a declaratory judgment that it is not required under the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C.A. § 1395dd (West 1992),[2] to provide treatment other than warmth, nutrition, and hydration to Baby K, an anencephalic infant. Because we agree with the district court, 832 F.Supp. 1022, that EMTALA gives rise to a duty on the part of the Hospital to provide respiratory support to Baby K when she is presented at the Hospital in respiratory distress and treatment is requested for her, we affirm.

I.

Baby K was born at the Hospital in October of 1992 with anencephaly, a congenital malformation in which a major portion of the brain, skull, and scalp are missing. While the presence of a brain stem does support her autonomic functions and reflex actions, because Baby K lacks a cerebrum, she is permanently unconscious. Thus, she has no cognitive abilities or awareness. She cannot see, hear, or otherwise interact with her environment.

When Baby K had difficulty breathing on her own at birth, Hospital physicians placed her on a mechanical ventilator. This respiratory support allowed the doctors to confirm the diagnosis and gave Ms. H, the mother, an opportunity to fully understand the diagnosis and prognosis of Baby K's condition. The physicians explained to Ms. H that most anencephalic infants die within a few days of birth due to breathing difficulties and other complications. Because aggressive treatment would serve no therapeutic or palliative purpose, they recommended that Baby K only be provided with supportive care in the form of nutrition, hydration, and warmth. Physicians at the Hospital also discussed with Ms. H the possibility of a "Do Not Resuscitate Order" that would provide for

1. Due to the parties' request for anonymity, all identifying information has been omitted from this opinion and anonyms are used to refer to the parties.

2. The Hospital also sought declaratory relief under § 504 of the Rehabilitation Act of 1973 (Rehabilitation Act), 29 U.S.C.A. § 794 (West Supp. 1993); the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C.A. §§ 12101 *et seq.* (West 1993); the Child Abuse Prevention and Treatment Act (Child Abuse Act), 42 U.S.C.A. §§ 5101–5106h (West Supp.1993); and the statutes and common law of Virginia. In addressing these provisions, the district court concluded that a failure to provide respiratory support to Baby K because of her condition of anencephaly would constitute discrimination in violation of the ADA and the Rehabilitation Act but declined to rule on the application of the Child Abuse Act or Virginia law. Because we conclude that the Hospital has a duty to render stabilizing treatment under EMTALA, we need not address its obligations under the remaining federal statutes or the laws of Virginia.

the withholding of lifesaving measures in the future.

The treating physicians and Ms. H failed to reach an agreement as to the appropriate care. Ms. H insisted that Baby K be provided with mechanical breathing assistance whenever the infant developed difficulty breathing on her own, while the physicians maintained that such care was inappropriate. As a result of this impasse, the Hospital sought to transfer Baby K to another hospital. This attempt failed when all of the hospitals in the area with pediatric intensive care units declined to accept the infant. In November of 1992, when Baby K no longer needed the services of an acute-care hospital, she was transferred to a nearby nursing home.

Since being transferred to the nursing home, Baby K has been readmitted to the Hospital three times due to breathing difficulties. Each time she has been provided with breathing assistance and, after stabilization, has been discharged to the nursing home. Following Baby K's second admission, the Hospital filed this action to resolve the issue of whether it is obligated to provide emergency medical treatment to Baby K that it deems medically and ethically inappropriate. Baby K's guardian *ad litem* and her father, Mr. K, joined in the Hospital's request for a declaration that the Hospital is not required to provide respiratory support or other aggressive treatments. Ms. H contested the Hospital's request for declaratory relief. After the district court issued its findings of fact and conclusions of law denying the requested relief, the Hospital, Mr. K, and Baby K's guardian *ad litem* (collectively referred to as the "Hospital") noticed this appeal.

II.

[2] Congress enacted EMTALA in response to its "concern that hospitals were 'dumping' patients [who were] unable to pay, by either refusing to provide emergency medical treatment or transferring patients before their emergency conditions were stabilized." *Brooks v. Maryland Gen. Hosp. Inc.*, 996 F.2d 708, 710 (4th Cir.1993). Through EMTALA, Congress sought "to provide an 'adequate first response to a medical crisis' for all patients," *Baber v. Hospital Corp. of America*, 977 F.2d 872, 880 (4th Cir.1992) (quoting 131 Cong.Rec. S13904 (daily ed. Oct. 23, 1985) (statement of Sen. Dole)); *see also Brooker v. Desert Hosp. Corp.*, 947 F.2d 412, 415 (9th Cir.1991) (holding that EMTALA applies "to any and all patients"); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1040 (D.C.Cir. 1991) (same); *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 268 (6th Cir.1990) (same), by imposing two duties on hospitals that have entered into Medicare provider agreements.

[3] First, those hospitals with an emergency medical department must provide an appropriate medical screening to determine whether an emergency medical condition exists for any individual who comes to the emergency medical department requesting treatment. 42 U.S.C.A. § 1395dd(a).[3] A hospital fulfills this duty if it utilizes identical screening procedures for all patients complaining of the same condition or exhibiting the same symptoms. *See Baber*, 977 F.2d at 879 n. 6.

[4] An additional duty arises if an emergency medical condition is discovered during the screening process. *See* 42 U.S.C.A. § 1395dd(b). EMTALA defines an "emergency medical condition" as including:

> 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—

> > 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.

42 U.S.C.A. § 1395dd(a).

3. The full text of subsection (a) 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

(i) placing the health of the individual ... in serious jeopardy,

(ii) serious impairment to bodily functions, or

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

42 U.S.C.A. § 1395dd(e)(1)(A).[4] When an individual is diagnosed as presenting 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 the transfer of the individual to another medical facility in accordance with subsection (c) of this section.

42 U.S.C.A. § 1395dd(b)(1). The treatment required "to stabilize" an individual is that treatment "necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility." 42 U.S.C.A. § 1395dd(e)(3)(A). Therefore, once an individual has been diagnosed as presenting an emergency medical condition, the hospital must provide that treatment necessary to prevent the material deterioration of the individual's condition or provide for an appropriate transfer to another facility.

In the application of these provisions to Baby K, the Hospital concedes that when Baby K is presented in respiratory distress a failure to provide "immediate medical attention" would reasonably be expected to cause serious impairment of her bodily functions. *See* 42 U.S.C.A. § 1395dd(e)(1)(A). Thus, her breathing difficulty qualifies as an emergency medical condition, and the diagnosis of this emergency medical condition triggers the duty of the hospital to provide Baby K with stabilizing treatment or to transfer her in accordance with the provisions of EMTALA. Since transfer is not an option available to the Hospital at this juncture,[5] the Hospital must stabilize Baby K's condition.

The Hospital acknowledged in its complaint that aggressive treatment, including mechanical ventilation, is necessary to "assure within a reasonable medical probability, that no material deterioration of Baby K's condition is likely to occur." Thus, stabilization of her condition requires the Hospital to provide respiratory support through the use of a respirator or other means necessary to ensure adequate ventilation. In sum, a straightforward application of the statute obligates the Hospital to provide respiratory support to Baby K when she arrives at the emergency department[6] of the Hospital in

4. A pregnant woman who is having contractions also qualifies as being in an "emergency medical condition" if:

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

42 U.S.C.A. § 1395dd(e)(1)(B). This portion of the statute is not applicable to the appeal before us.

5. In order for a hospital to transfer a patient prior to stabilization, EMTALA requires: (1) the patient or a person acting on the patient's behalf to request a transfer in writing after being informed of the risks involved and the obligations of the hospital under EMTALA; or (2) a proper certification that the medical benefits expected from the transfer outweigh the risks involved. 42 U.S.C.A. § 1395dd(c)(1). In addition, the transfer must meet the criteria for an appropriate transfer which include the requirement that a qualified receiving facility agree to accept the patient and to provide appropriate medical treatment. 42 U.S.C.A. § 1395dd(c)(1)(B), (c)(2). Since Ms. H objects to the transfer of Baby K, since the Hospital has not obtained a certification that the benefits of a transfer would outweigh the medical risks involved, and since no qualified medical facility has agreed to accept Baby K, the requirements for transfer prior to stabilization have not been met. If Ms. H requests a transfer or the Hospital obtains a certification that the benefits of a transfer would outweigh the risks involved, and all of the requirements for an appropriate transfer are met, then the Hospital could, of course, transfer Baby K to another qualified medical facility prior to stabilization.

6. It is not clear from the record whether the movement of Baby K from the nursing home to the Hospital constitutes a discharge from the nursing home and presentation at the emergency department of the Hospital or a transfer to the Hospital. Subsection (g) of EMTALA provides that participating hospitals that have "specialized capabilities or facilities (such as ... neonatal intensive care units ...) *shall not refuse* to accept an appropriate transfer of an individual who requires such specialized capabilities or fa-

respiratory distress and treatment is requested on her behalf.[7]

III.

In an effort to avoid the result that follows from the plain language of EMTALA, the Hospital offers four arguments. The Hospital claims: (1) that this court has previously interpreted EMTALA as only requiring uniform treatment of all patients exhibiting the same condition; (2) that in prohibiting disparate emergency medical treatment Congress did not intend to require physicians to provide treatment outside the prevailing standard of medical care; (3) that an interpretation of EMTALA that requires a hospital or physician to provide respiratory support to an anencephalic infant fails to recognize a physician's ability, under Virginia law, to refuse to provide medical treatment that the physician considers medically or ethically inappropriate; and (4) that EMTALA only applies to patients who are transferred from a hospital in an unstable condition. We find these arguments unavailing.[8]

A.

Relying on the decisions of this court in *Baber v. Hospital Corp. of America*, 977 F.2d 872 (4th Cir.1992), and *Brooks v. Maryland Gen. Hosp. Inc.*, 996 F.2d 708 (4th Cir.1993), the Hospital contends that it is only required to provide Baby K with the same treatment that it would provide other anencephalic infants—supportive care in the form of warmth, nutrition, and hydration. The Hospital quotes language from *Baber* and *Brooks* as supporting the proposition that EMTALA only requires participating hospitals to provide uniform treatment to all patients exhibiting the same emergency medical condition. Advancing the proposition that anencephaly, as opposed to respiratory distress, is the emergency medical condition at issue, the Hospital concludes that it is only required to provide uniform treatment to all anencephalic infants. We disagree.

In *Baber* and *Brooks*, this court addressed the "appropriate medical screening" requirement of EMTALA. In the absence of a statutory definition for this term, we concluded that it should be defined as requiring participating hospitals to apply uniform screening procedures to all individuals coming to the emergency room of the hospital requesting treatment. *Baber*, 977 F.2d at 880; *Brooks*, 996 F.2d at 710–11. These cases dealt with screening procedures; neither addressed a hospital's duty to provide stabilizing treatment for an emergency medical condition.

[5] With this issue now before us, we conclude that the duty of the Hospital to provide stabilizing treatment for an emergency medical condition is not coextensive with the duty of the Hospital to provide an "appropriate medical screening." Congress has statutorily defined the duty of a hospital to provide stabilizing treatment as requiring that treatment necessary to prevent the material deterioration of a patient's condition. 42 U.S.C.A. § 1395dd(e)(3)(A). If, as the Hospital suggests, it were only required to provide uniform treatment, it could provide any level of treatment to Baby K, including a level of treatment that would allow her condition to materially deteriorate, so long as the care she was provided was consistent with the care provided to other individuals. *See Baber*, 977 F.2d at 879 n. 7 ("[H]ospitals could theoretically avoid liability by providing very cursory and substandard screenings to

cilities if the hospital has the capacity to treat the individual." 42 U.S.C.A. § 1395dd(g) (emphasis added). When she experiences respiratory distress, Baby K requires specialized facilities and capabilities that the nursing home does not possess. The Hospital admittedly does possess these facilities and capabilities, including mechanical ventilators and a pediatric intensive care unit. Thus, irrespective of whether the movement of Baby K between the two facilities constitutes a discharge and presentment or a transfer, acceptance and treatment by the Hospital is required.

7. The provisions of EMTALA would not, of course, be limited to the condition of respiratory distress or the provision of respiratory support. Any diagnosed "emergency medical condition" experienced by Baby K would require stabilizing treatment unless an appropriate transfer could be effected.

8. Because the issues presented raise questions of statutory interpretation, we conduct a de novo review. *Baber*, 977 F.2d at 876.

all patients....''). The definition of stabilizing treatment advocated by the Hospital directly conflicts with the plain language of EMTALA.

As we have previously stated, "it is not our role to rewrite legislation passed by Congress. When a statute is clear and unambiguous, we must apply its terms as written." *Baber*, 977 F.2d at 878. The terms of EMTALA as written do not allow the Hospital to fulfill its duty to provide stabilizing treatment by simply dispensing uniform treatment. Rather, the Hospital must provide that treatment necessary to prevent the material deterioration of each patient's emergency medical condition. In the case of Baby K, the treatment necessary to prevent the material deterioration of her condition when she is in respiratory distress includes respiratory support.

Even if this court were to interpret EMTALA as requiring hospitals to provide uniform treatment for emergency medical conditions, we could not find that the Hospital is only required to provide Baby K with warmth, nutrition, and hydration. As the Hospital acknowledged during oral argument, Baby K resides at the nursing home for months at a time without requiring emergency medical attention. Only when she has experienced episodes of bradypnea or apnea [9] has Baby K required respiratory support to prevent serious impairment of her bodily functions. It is bradypnea or apnea, not anencephaly, that is the emergency medical condition that brings Baby K to the Hospital for treatment. Uniform treatment of emergency medical conditions would require the Hospital to provide Baby K with the same treatment that the Hospital provides all other patients experiencing bradypnea or apnea. The Hospital does not allege that it would refuse to provide respiratory support to infants experiencing bradypnea or apnea who do not have anencephaly. Indeed, a refusal to provide such treatment would likely be considered as providing *no* emergency medical treatment. *See Baber*, 977 F.2d at 879 n. 7 (stating that the provision of cursory medical screenings might be considered a failure to screen).

B.

[6] The second argument of the Hospital is that, in redressing the problem of disparate emergency medical treatment, Congress did not intend to require physicians to provide medical treatment outside the prevailing standard of medical care. The Hospital asserts that, because of their extremely limited life expectancy and because any treatment of their condition is futile, the prevailing standard of medical care for infants with anencephaly is to provide only warmth, nutrition, and hydration. Thus, it maintains that a requirement to provide respiratory assistance would exceed the prevailing standard of medical care. However, the plain language of EMTALA requires stabilizing treatment for any individual who comes to a participating hospital, is diagnosed as having an emergency medical condition, and cannot be transferred. 42 U.S.C.A. § 1395dd(b). "[I]n the absence of 'a clearly expressed legislative intent to the contrary,' " unambiguous statutory language is ordinarily conclusive. *United States v. Blackwell*, 946 F.2d 1049, 1052 (4th Cir.1991) (quoting *Russello v. United States*, 464 U.S. 16, 20, 104 S.Ct. 296, 299, 78 L.Ed.2d 17 (1983)). The Hospital has been unable to identify, nor has our research revealed, any statutory language or legislative history evincing a Congressional intent to create an exception to the duty to provide stabilizing treatment when the required treatment would exceed the prevailing standard of medical care. We recognize the dilemma facing physicians who are requested to provide treatment they consider morally and ethically inappropriate, but we cannot ignore the plain language of the statute because "to do so would 'transcend our judicial function.' " *Baber*, 977 F.2d at 884 (quoting *Iselin v. United States*, 270 U.S. 245, 250–51, 46 S.Ct. 248, 250, 70 L.Ed. 566 (1926). The appropriate branch to redress the policy concerns of the Hospital is Congress.

9. Bradypnea is an "abnormal slowness of breathing." Dorland's Illustrated Medical Dictionary 230 (27th ed. 1988). In an infant who has established and sustained spontaneous breathing, apnea describes the cessation of respiration for more than 60 seconds. *Id.* at 112.

C.

[7] The Hospital further argues that EMTALA cannot be construed to require it to provide respiratory support to anencephalics when its physicians deem such care inappropriate, because Virginia law permits physicians to refuse to provide such care. Section 54.1–2990 of the Health Care Decisions Act (HCDA) of Virginia provides that "[n]othing in this article shall be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be medically or ethically inappropriate." Va.Code Ann. § 54.1–2990 (Michie Supp.1993). The Hospital maintains that EMTALA only obligates a hospital to provide stabilizing treatment "within the staff and facilities available at the hospital," 42 U.S.C.A. § 1395dd(b)(1)(A). It reasons that because its physicians object to providing respiratory support to anencephalics, it has no physicians available to provide respiratory treatment for Baby K and, therefore, is not required by EMTALA to provide such treatment. We disagree.

The duty to provide stabilizing treatment set forth in EMTALA applies not only to participating hospitals but also to treating physicians in participating hospitals. 42 U.S.C.A. § 1395dd(d)(1)(B). EMTALA does not provide an exception for stabilizing treatment physicians may deem medically or ethically inappropriate. Consequently, to the extent § 54.1–2990 exempts physicians from providing care they consider medically or ethically inappropriate, it directly conflicts with the provisions of EMTALA that require stabilizing treatment to be provided.

It is well settled that state action must give way to federal legislation where a valid "act of Congress, fairly interpreted, is in actual conflict with the law of the state," *Savage v. Jones*, 225 U.S. 501, 533, 32 S.Ct. 715, 726, 56 L.Ed. 1182 (1912), and EMTALA provides that state and local laws that directly conflict with the requirements of EMTALA are preempted. 42 U.S.C.A. § 1395dd(f). The Hospital does not allege that EMTALA is an invalid act of Congress. Therefore, to the extent that § 54.1–2990 applies to medical treatment decisions on behalf of infants [10] and to the extent that § 54.1–2990 exempts treating physicians in participating hospitals from providing care they consider medically or ethically inappropriate, it is preempted—it does not allow the physicians treating Baby K to refuse to provide her with respiratory support.

D.

[8] The final contention advanced by the Hospital is that EMTALA only applies to patients who are transferred from a hospital in an unstable condition. The Hospital grounds this argument on the definition of stabilizing treatment as that treatment "necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the *transfer* of the individual from a facility." 42 U.S.C.A. § 1395dd(e)(3)(A) (emphasis added). According to the Hospital, the use of the word "transfer" limits the duty of hospitals and physicians to provide stabilizing treatment to situations in which the patient is to be subsequently transferred to another facility. The end result of this reasoning would allow hospitals and physicians to avoid providing stabilizing treatment by simply refusing to transfer the patient or, as in the case of Baby K, elect not to provide stabilizing treatment because other hospitals will not accept a transfer.

As previously stated, § 1395dd(b) requires a hospital to provide stabilizing treatment to any individual who comes to a participating hospital, is diagnosed as presenting an emergency medical condition, and cannot be transferred in accordance with the provisions of subsection (c). The use of the word "transfer" to describe the duty of a hospital to provide stabilizing treatment evinces a Congressional intent to require stabilization prior

10. By its terms the application of § 54.1–2990 is limited to the HCDA, Va.Code Ann. §§ 54.1–2981 to 54.1–2993 (Michie Supp.1993). The HCDA governs advance medical directives by adults and surrogate medical treatment decisions on behalf of adults. No part of the HCDA sets forth provisions for dealing with medical treatment decisions on behalf of infants. Therefore, the Virginia legislature presumably did not intend § 54.1–2990 to apply to medical treatment decisions on behalf of infants.

to discharge or that treatment necessary to prevent material deterioration of the patient's condition during transfer. It was not intended to allow hospitals and physicians to avoid liability under EMTALA by accepting and screening a patient and then refusing to treat the patient because the patient cannot or will not be transferred. *See, e.g., Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131, 1134 (6th Cir.1990) ("Once a patient is found to suffer from an emergency medical condition, the hospital must give the patient treatment to stabilize that condition unless the patient can be transferred without danger of the patient's condition deteriorating."); *Burditt v. U.S. Dept. of Health & Human Services*, 934 F.2d 1362, 1368 (5th Cir.1991) ("Patients diagnosed with an 'emergency medical condition' ... must either be treated or be transferred...."). The argument of the Hospital to the contrary is without merit.

IV.

It is beyond the limits of our judicial function to address the moral or ethical propriety of providing emergency stabilizing medical treatment to anencephalic infants. We are bound to interpret federal statutes in accordance with their plain language and any expressed congressional intent. Congress rejected a case-by-case approach to determining what emergency medical treatment hospitals and physicians must provide and to whom they must provide it; instead, it required hospitals and physicians to provide stabilizing care to any individual presenting an emergency medical condition. EMTALA does not carve out an exception for anencephalic infants in respiratory distress any more than it carves out an exception for comatose patients, those with lung cancer, or those with muscular dystrophy—all of whom may repeatedly seek emergency stabilizing treatment for respiratory distress and also possess an underlying medical condition that severely affects their quality of life and ultimately may result in their death. Because EMTALA does not provide for such an exception, the judgment of the district court is affirmed.

AFFIRMED.

SPROUSE, Senior Circuit Judge, dissenting:

I respectfully dissent.

I have no quarrel with the majority's conclusion that the duty imposed on hospitals by EMTALA to provide stabilizing treatment for an emergency condition is different from its duty to provide "appropriate medical screening." There is no question that once a medical condition is characterized as an "emergency medical condition" contemplated by EMTALA, the patient must be stabilized to prevent material deterioration of the condition. 42 U.S.C.A. §§ 1395dd(b)(1)(A), (e)(3)(A) (Supp.1991).

I simply do not believe, however, that Congress, in enacting EMTALA, meant for the judiciary to superintend the sensitive decision-making process between family and physicians at the bedside of a helpless and terminally ill patient under the circumstances of this case. Tragic end-of-life hospital dramas such as this one do not represent phenomena susceptible of uniform legal control. In my view, Congress, even in its weakest moments, would not have attempted to impose federal control in this sensitive, private area. Rather, the statute was designed narrowly to correct a specific abuse: hospital "dumping" of indigent or uninsured emergency patients. *Brooks v. Maryland Gen. Hosp., Inc.*, 996 F.2d 708, 710 (4th Cir.1993); *Baber v. Hospital Corp. of America*, 977 F.2d 872, 880 (4th Cir.1992). There is no indication in the legislative history of EMTALA that Congress meant to extend the statute's reach to hospital-patient relationships that do not involve "dumping." Clearly, there is no suggestion of patient "dumping" in this case. To the contrary, Baby K's introduction to the hospital was not for emergency treatment—she was born there. She was twice readmitted and after her subsidiary medical condition was stabilized, transferred back to a nursing home. In light of the purposes of the statute and this child's unique circumstances, I would find this case to be outside the scope of EMTALA's anti-dumping provisions.

I also submit that EMTALA's language concerning the type and extent of emergency treatment to be extended to all patients was

not intended to cover the continued emergencies that typically attend patients like Baby K. The law was crafted to effect the purpose of preventing disparate treatment between emergency patients. *See* H.R.Rep. No. 241, 99th Cong., 2d Sess., pt. 1 at 27 (1986), *reprinted in* 1986 U.S.C.A.A.N. 42, 579, 605. In my view, Baby K is not that kind of emergency patient contemplated by the statute, although by the very nature of her terminal illness, she will suffer repeated medical emergencies during her day-to-day maintenance care. The hospital argues that anencephaly, not the subsidiary respiratory failure, is the condition that should be reviewed in order to judge the applicability *vel non* of EMTALA. I agree. I would consider anencephaly as the relevant condition and the respiratory difficulty as one of many subsidiary conditions found in a patient with the disease. EMTALA was not designed to reach such circumstances.

The tragic phenomenon Baby K represents exemplifies the need to take a case-by-case approach to determine if an emergency episode is governed by EMTALA. Baby K's condition presents her parents and doctors with decision-making choices that are different even from the difficult choices presented by other terminal diseases. Specifically, as an anencephalic infant, Baby K is permanently unconscious. She cannot hear, cannot see, and has no cognitive abilities. She has no awareness of and cannot interact with her environment in any way. Since there is no medical treatment that can improve her condition, she will be in this state for as long as she lives. Given this unique medical condition, whatever treatment appropriate for her unspeakably tragic illness should be regarded as a continuum, not as a series of discrete emergency medical conditions to be considered in isolation. Humanitarian concerns dictate appropriate care. However, if resort must be had to our courts to test the appropriateness of the care, the legal vehicle should be state malpractice law.

In my view, considering the discrete factual circumstances of Baby K's condition and previous treatment, if she is transferred again from the nursing home to the hospital in respiratory distress, that condition should be considered integral to the anencephalic condition, and I would hold that there has been no violation of EMTALA. I emphasize that this view contemplates a case-by-case determination. Individual cases involving victims of trauma, cancer, heart attack, or other catastrophic illness, who are denied potentially life-saving treatments, may well require different analyses.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

AARON KAUFFMAN	:	
	:	
Plaintiff	:	CIVIL ACTION
	:	
vs.	:	
	:	NO. 07-CV-5043
PAMELA FRANZ, ET AL.	:	
	:	
Defendants	:	

MEMORANDUM OPINION & ORDER

Before the Court are Defendants Pottstown Memorial Medical Center and Pottstown Hospital Company, LLC.,'s Motion for Judgment on the Pleadings (Doc. No. 23) and the "Joinder Motions" of Defendants Dr. Pamela Franz, M.D., and Dr. Stephen Spencer, M.D., (Doc. Nos. 24, 25). The Defendants have asked the Court to determine whether they are entitled to judgment as a matter of law, based on the pleadings, as to Plaintiff's sole federal claim,[1] which arises under the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd. For the following reasons, the Court will grant Defendants Franz and Spencer's Joinder Motions[2] and deny Defendants Pottstown Memorial Medical Center and Pottstown Hospital Company, LLC.,'s Motion for Judgment on the Pleadings.

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[1] The Plaintiff's Complaint contains eight causes of action including negligence claims and claims under Pennsylvania's Wrongful Death and Survival Acts.

[2] The Joinder Motions are granted only in so far as they seek dismissal of the EMTALA claims against Defendants Franz and Spencer. The Court, however, will continue exercising supplemental jurisdiction over the remaining claims against Defendants Franz and Spencer because those claims are "so related to the [pending claims against Defendants Pottstown Memorial Medical Center and Pottstown Hospital Company, LLC, over which the Court has original jurisdiction,] that they form part of the same case or controversy under Article III." 28 U.S.C. § 1367.

BACKGROUND

At approximately 5:00 a.m. on [March] 23, 2007,[3] John Kauffman ("Kauffman") contacted a friend to take him to the hospital. (Compl. ¶ 21.) He was complaining of chest pain, difficulty breathing, clamminess, and swollen feet. (Id. ¶ 21.) Kauffman was fifty-one years old. (Id. ¶ 4.) By 5:39 a.m., Kauffman arrived in the emergency room at Defendant Pottstown Memorial Medical Center,[4] seeking treatment for chest pains, breathing difficulties, anxiety, clamminess, and swollen feet. (Id. ¶ 22.) Kauffman's vital signs were the following: Temperature: 96.8, Pulse: 87, Respirations: 32, and Blood pressure: 132/88. (Id. ¶ 23.) "He was anxious, alert, oriented x3, and cooperative." (Id. ¶ 23.) His skin was warm and dry, and his lungs were clear. (Id. ¶ 24.)

At 5:45 a.m., Kauffman was seen by Defendant Dr. Franz, who ordered a BAT (Behavioral Avoidance Test) and a urine drug screen. (Id. ¶ 25.) At 6:00 a.m., Dr. Reeves, who is not a defendant, performed a multidiscplinary psychiatric assessment on Kauffman. (Id. ¶ 26.) His report indicated that Kauffman was brought to the emergency room by a female friend for complaints of "chest pain, high anxiety, hyperventilation, [and] sleeplessness." (Id. ¶ 27.) Dr. Reeves recommended that Kauffman set up an appointment with a psychiatrist and follow up with his primary care physician. (Id. ¶ 31.) No assessment of Kauffman's chest pain was ever performed. (Id. ¶ 33.) No electrocardiogram or blood work was ordered. (Id. ¶ 34.) No

[3] It appears that the Plaintiff made an error in dating the occurrence based on his own Motion in Opposition to Defendants' Motion for Judgment on the Pleadings, (Doc. No. 26), the Defendants' Answers, (Doc. Nos. 13, 14), the Motion. for Judgment on the Pleadings, (Doc. No. 23), and the Joinder Motions (Doc. Nos. 24, 25).

[4] Defendant Pottstown Hospital Company, LLC d/b/a and a/k/a Pottstown Memorial Medical Center. (Compl. ¶ 9.)

continuous cardiac monitoring was performed. (Id. ¶ 34.) No ongoing evaluation of his vital signs was conducted. (Id. ¶ 34.)

At 9:30 a.m., John Kauffman was given one mg. of a sedative, intramuscularly, after his urine drug screen came back negative. (Id. ¶¶ 38-39.) He was discharged at 9:35 a.m., and his vital signs upon discharge were the following: Pulse: 85, Respirations: 24, and Blood pressure: 140/106. (Id. ¶ 40.) His blood pressure was elevated, and he remained very anxious. (Id. ¶ 41.) No clinical impression was documented at the time of discharge. (Id. ¶ 44.)

Fewer than seven hours later, at approximately 4:00 p.m., Kauffman was found lying on his bed. (Id. ¶ 45.) He was blue in the face, and his heart was not beating. (Id. ¶ 45.) He was transported by an ambulance to Pottstown Memorial Medical Center with an admitting diagnosis of cardiac arrest. (Id. ¶ 46.) He was pronounced dead upon arrival. (Id. ¶ 47.) According to the autopsy, the cause of death was arteriosclerotic cardiovascular disease, hypertrophic cardiomyopathy, and pneumonitis. (Id. ¶ 48.)

Approximately one month later, on April 27, 2007, an addendum was added to Kauffman's chart, which documented his early morning visit to the hospital on March 23, 2007. The addendum read:

> Sent back to me to put Diagnosis on chart. Pt was signed out to me c[sic] [with] Dx [diagnosis] of Anxiety, Discharge instructions written by P. Franz and on chart. Waiting for urine to be obtained then D/C [discharged] per instructions. Anxiety is diagnosis at time.

(Id. ¶ 49.) Under "Clinical Impressions," the diagnoses of anxiety and hypertension were added. (Id. ¶ 50.)

The Plaintiff, the administrator of Kauffman's estate, alleges a violation of EMTALA by

all of the Defendants, under the heading "First Cause of Action Emergency Medical Treatment and Active Labor Act EMTALA Violation." (Id. ¶ 70.) All of the Defendants have answered the Complaint (Doc. Nos. 13, 14). Now, they move that the Court dismiss the EMTALA claims under Rule 12(c) of the Federal Rules of Civil Procedure.

STANDARD

The same legal standard that applies to motions filed under 12(b)(6) applies to motions filed under 12(c). See Patel v. Contemporary Classics of Beverly Hills, 259 F.3d 123, 126 (2d Cir. 2001) ("The standard for granting a Rule 12(c) motion for judgment on the pleadings is identical to that of a Rule 12(b)(6) motion for failure to state a claim."); Turbe v. Government of V.I., 938 F.2d 427, 428 (3d Cir. 1991) (applying 12(b)(6) standard to defendant's 12(c) motion). "Most of the authority on Rule 12(b)(6) applies to Rule 12(c)." 2 Moore's Federal Practice, § 12.38 (Matthew Bender 3d ed.). When reviewing the pleadings, "'[t]he facts presented [therein] and the inferences to be drawn therefrom [must be viewed] in the light most favorable to the nonmoving party.'" Rosenau v. Unifund Corp., 539 F.3d 218, 221 (3d Cir. 2008) (quoting Jablonski v. Pan Am. World Airways, Inc., 863 F.2d 289, 290-91 (3d Cir.1988)). Judgment will not be granted under Rule 12(c) unless "'the movant clearly establishes that no material issue of fact remains to be resolved and that he is entitled to judgment as a matter of law.'" Id.

ANALYSIS

Although EMTALA was enacted by Congress to address the problems associated with "patient dumping," the statute and case law applying the Act make clear that its protections flow to everyone, not just the indigent or uninsured.[5] See 42 U.S.C. § 1395dd; Gatewood v. Washington Healthcare Corp., 933 F.3d 1037, 1040-41 (D.C. Cir. 1991) (affirming the dismissal of plaintiff-widow's EMTALA claim on the rationale that allegations of mis-diagnosis are not actionable under EMTALA, while rejecting the district court's rationale that the Act's protections did not reach the deceased, who was insured). In order to recover under EMTALA, a plaintiff may proceed under a screening, stabilization, or stabilization/transfer theory. Here, the Plaintiff is proceeding under both a screening and a stabilization theory.

The Plaintiff has pleaded facts sufficient to show that Defendants Pottstown Memorial Medical Center and Pottstown Hospital Company, LLC, are subject to EMTALA's civil enforcement provisions. See 42 U.S.C. §§ 1395cc and 1395dd; (Compl. ¶¶ 14-16,18). However, the Plaintiff has not pleaded any facts to show that Defendants Franz and Spencer are subject to EMTALA, nor could he.[6] While EMTALA provides for both public and private enforcement of its provisions, the civil enforcement subsection limits private enforcement to claims against "participating hospitals." Compare 42 U.S.C. §1395dd(d)(1) (providing for civil money penalties against participating hospitals and physicians) with 42 U.S.C. §1395dd(d)(2) (providing

[5] The Third Circuit Court of Appeals has yet to rule on the scope of EMTALA liability; however, Torretti v. Paoli Hospital, Slip Copy, 2008 WL 268066 (E.D.Pa. Jan. 29, 2008) is currently pending at docket number 08-1525. Torretti involves a failure to stabilize claim. Summary judgment was granted in favor of the defendants.

[6] This issue was not addressed by any of the parties.

for civil enforcement against participating hospitals only); see also Eberhard v. City of Los Angeles, 62 F.3d 1253, 1256-57 (9th Cir. 1995) (rejecting plaintiff's theory of an implied private right of action against physicians under EMTALA, and stating that, "[o]ur holding today is consistent with every appellate court [e.g. the D.C., Fourth, Eighth, and Tenth Circuit Courts of Appeals] that has decided whether EMTALA allows a private right of action against physicians") (internal citations omitted); Davis v. Twp. of Paulsboro, 424 F. Supp. 2d 773, 779 (D.N.J. 2006) (dismissing EMTALA claims against individually named physicians and stating that "EMTALA only creates a private right of action against hospitals, not individual physicians"). Therefore, the EMTALA claims against Defendants Franz and Spencer, who are both physicians, must be dismissed and their Joinder Motions granted only in so far as they moved that the Court dismiss the EMTALA claims. (Doc. Nos. 24, 25.)

I. EMTALA - Screening

EMTALA requires a covered hospital "to 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," when "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." 42 U.S.C. § 1395dd(a). This subsection forms the basis of the EMTALA "screening" requirement. Although the statute does not define what an "appropriate medical screening examination" is, the caselaw is clear that the "essence of the requirement is that there be some screening procedure, and that it be administered even-handedly." Cruz-Queipo v. Hosp. Espanol Auxilio Mutuo de Puerto Rico, 417 F.2d 67, 70 (1st Cir. 2005) (quoting Correa v. Hosp. San Francisco, 69 F.3d 1184, 1189 (1st Cir. 1995)); see also

Nolen v. Boca Raton Cmty. Hosp. Inc., 373 F.3d 1151, 1155 (11th Cir. 2004) ("So long as the hospital gave to [plaintiff] the same quality screening that it would have given a similarly situated outpatient, there is no violation of EMTALA."); Marshall v. East Carroll Parish Hosp. Serv. Dist., 134 F.3d 319, 322 (5th Cir.1998) ("[A]n EMTALA 'appropriate medical screening examination' is not judged by its proficiency in accurately diagnosing the patient's illness, but rather by whether it was performed equitably in comparison to other patients with similar symptoms."); Vickers v. Nash Gen. Hosp. Inc., 78 F.3d 139, 143 (4th Cir. 1996) (EMTALA obligates hospitals to "'apply uniform screening procedures to all individuals coming to the emergency room.'") (quoting Matter of Baby K, 16 F.3d 590, 595 (4th Cir. 1994)); Davis, 424 F. Supp. 2d at 778-79 ("[T]he 'key requirement' of a hospital's duty under § 1359dd(a) 'is that a hospital apply its standard of screening uniformly to all emergency room patients, regardless of whether they are insured or can pay. The Act does not impose any duty on a hospital requiring that screening result in a correct diagnosis.'") (quoting Power v. Arlington Hosp. Ass'n., 42 F.3d 851, 856 (4th Cir. 1995)).

In support of his screening theory, the Plaintiff alleges, pertinently, that the Defendants:[7]

> Failed to conduct a full and complete medical screening examination . . . [t]reated Kauffman disparately from other similarly situated patients . . . [d]eparted from their standard medical screening examination of patients with complaints and symptoms similar to those of John Kauffman . . . [f]ailed to provide a level of screening examination reasonably calculated to identify critical conditions that may be afflicting symptomatic patients uniformly to all those who present with substantially similar conditions . . . [f]ailed to adhere to their own standard policies, procedures[,] protocols, care paths and/or critical pathways for patients entering the Emergency Department in similar medical circumstances . . . [and f]ailed to perform a medical screening examination within the capabilities of the [D]efendant hospitals' Emergency Department and ancillary

[7] References to "Defendants" hereinafter refer only to Defendants Pottstown Memorial Medical Center and Pottstown Hospital Company, LLC.

services.

(Compl. ¶ 70(a),(c)-(d),(f),(h),(i).) In other words, the Plaintiff alleges that the hospital somehow treated Kauffman differently from other patients with similar conditions or departed its standard procedures or both.

Accepting the Plaintiff's factual allegations as true and granting him all reasonable inferences therefrom, the Court concludes that the Plaintiff pleaded sufficient facts to state a claim under EMTALA's screening theory against Defendants Pottstown Memorial Medical Center and Pottstown Hospital Company, LLC**.**

II. EMTALA - Stabilization

The stabilization requirement of EMTALA arises from subsection (b) of the statute, which reads:

> If any individual . . . 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.

42 U.S.C. § 1395dd(b)(1). A plain reading of subsection (b) makes clear that liability on a stabilization theory turns on whether the hospital knew of a plaintiff's emergency medical condition. Indeed, there is ample case law to support the proposition that actual knowledge is a condition precedent to a stabilization claim.[8] See, e.g., Jackson v. East Bay Hosp., 246 F.3d 1248, 1256-57 (9th Cir. 2001) (adopting the "actual detection" rule and noting that it "comports

[8] Again, the Third Circuit has not yet ruled on the scope of EMTALA liability, though Torretti v. Paoli Hospital, Slip Copy, 2008 WL 268066 (E.D. Pa. Jan. 29, 2008), which involves a failure to stabilize claim, is currently pending before the Third Circuit, at docket number 08-1525.

with the law of five other circuits, which requires a showing of actual knowledge of the emergency medical condition by the hospital as a condition precedent to the stabilization requirement"); Marshall, 134 F.3d at 324-25 (summary judgment on behalf of defendants affirmed on stabilization claim where hospital had no knowledge of latent emergency medical condition).

Here, the Plaintiff alleges that either Kauffman or his friend who took Kauffman to the hospital told members of the hospital staff about Kauffman's chest pain. (Compl. ¶ 22.) Chest pain is considered to be an emergency medical condition under EMTALA.[9] Further, the Plaintiff alleges that Dr. Reeves' report reflects that Kauffman was brought to the emergency room for complaints about chest pain. (Id. ¶ 27.) Accepting as true Plaintiff's allegations and granting him all reasonable inferences therefrom, the Court concludes that the Plaintiff has pleaded sufficient facts to state a claim under EMTALA's stabilization theory against Defendants Pottstown Memorial Medical Center and Pottstown Hospital Company, LLC. See Cruz-Querpo, 417 F.3d at 71-72 (drawing an inference that hospital knew of chest pain complaints, based on the stage of proceedings and moving papers of the parties, and determining that the inference was sufficient to defeat a motion for summary judgment on a stabilization claim).

An appropriate Order follows.

[9] 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 – (i) placing the health of the individual . . . in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part." 42 U.S.C. § 1395dd(e)(1)(A).

IV. Conclusion

For the above-stated reasons, we will reverse the District Court's denial of Robertson's petition and remand for further proceedings consistent with this opinion. In particular, the District Court should order the Commonwealth authorities to free Robertson unless he is re-sentenced in the Pennsylvania courts for a single count of conspiracy within a period of time affixed by the District Court.[6]

Christopher TORRETTI; Honey Torretti, as parents & natural guardians of Christopher J. Torretti, a minor, and in their own right, Appellants

v.

MAIN LINE HOSPITALS, INC., d/b/a Paoli Memorial Hospital; Andrew Gerson, M.D.; Main Line Perinatal Associates; Mark Finnegan, M.D.; Patricia McConnell, M.D.; McConnell, Peden, Belden & Associates; Lankenau Hospital.

No. 08–1525.

United States Court of Appeals,
Third Circuit.

Argued Jan. 28, 2009.

Opinion filed Sept. 2, 2009.

Background: Parents of child who was born with brain damage brought action against hospital and physicians under the Emergency Medical Treatment and Active Labor Act (EMTALA). The United States District Court for the Eastern District of Pennsylvania, Juan R. Sanchez, J., 2008 WL 268066, granted hospital's motion for summary judgment, and parents appealed.

Holdings: The Court of Appeals, Ambro, Circuit Judge, held that:

(1) regulation providing that EMTALA did not apply to patients, including outpatients, was entitled to deference by Court of Appeals, and

(2) expectant mother did not present emergency medical condition when she arrived at hospital.

Affirmed.

Barbara R. Axelrod, Esquire, (Argued), James E. Beasley, Jr., Esquire, Dion G. Rassias, Esquire, The Beasley Firm, Philadelphia, PA, for Appellant.

Daniel F. Ryan, III, Esquire, O'Brien & Ryan, Plymouth Meeting, PA, Peter J. Hoffman, Esquire, (Argued), Eckert, Seamans, Cherin & Mellott, Philadelphia, PA, for Appellees.

Before SCIRICA, Chief Judge, AMBRO, and SMITH, Circuit Judges.

OPINION OF THE COURT

AMBRO, Circuit Judge.

This is our first opportunity to confront the Emergency Medical Treatment and Active Labor Act ("EMTALA" or the "Act"). 42 U.S.C. § 1395dd, *et seq.* Among other things, the Act forbids hospitals from refusing to treat individuals with emergency conditions, a practice often referred to as "patient dumping."

Appellants Christopher and Honey Torretti's son, Christopher, was born with severe brain damage after Mrs. Torretti's high-risk pregnancy went awry. On the morning of the birth, Mrs. Torretti went to her routine outpatient fetal monitoring ap-

pointment at a perinatal facility. The attending medical personnel at the facility directed her to her primary hospital for extended perinatal monitoring. She gave birth to Christopher shortly after arriving at the hospital. The Torrettis sued the hospitals and doctors involved under EMTALA, as well as state statutory and common-law claims. This appeal tests the boundaries of EMTALA, which is not a federal malpractice statute. Given these circumstances, relief for Christopher Torretti's traumatic brain injuries may be available in other forms, but is not provided under EMTALA. Thus, we affirm the District Court's grant of summary judgment.[1]

I. Background

This case, like most cases brought under EMTALA, is tragic. This was Mrs. Torretti's second pregnancy. Her first child was born healthy. Both pregnancies were high-risk because she is an insulin-dependent diabetic. Her primary obstetrician was Dr. Patricia McConnell, a member of the Peden Group, an obstetrics practice group based out of Lankenau Hospital ("Lankenau"). Lankenau is part of the Main Line Health system and located in Wynnewood, Pennsylvania.

Because of Mrs. Torretti's diabetic condition (which can present complications during a pregnancy), Dr. McConnell referred her to the Paoli Hospital Perinatal Testing Center ("Paoli"), located in Paoli, Pennsylvania, for monitoring throughout both pregnancies. Paoli is a center for fetal monitoring and consultation only, and is located in a medical building adjacent to Paoli Hospital. It is also owned by Main Line Health. The two hospitals are approximately twenty miles apart.

In Mrs. Torretti's third trimester, she began to have complications, primarily involving premature contractions. During this period, the Peden Group increased Mrs. Torretti's monitoring appointments at Paoli to twice per week from once per month. The Peden Group also monitored her as an outpatient at Lankenau on one occasion in mid-April 2005. Two weeks later, when she went to Paoli for routine monitoring on April 30, the Paoli medical staff detected that she was experiencing pre-term labor and directed her to Lankenau where she was hospitalized for three days. On that occasion, she drove herself from Paoli to Lankenau.

Near the end of Mrs. Torretti's pregnancy, in her 34th week, she had a routine monitoring appointment scheduled at Paoli on Monday, May 23. Two days before the appointment, she called Dr. McConnell twice. First, she complained of contractions. Dr. McConnell told her to put her feet up and relax. The second time Mrs. Torretti called, the contractions had lessened, but she explained that she was very uncomfortable because of her large size and had noticed a decrease in fetal movement. She asked about the possibility of receiving a therapeutic amniocentesis, a treatment to reduce her discomfort by removing some of the excess amniotic fluid. Dr. McConnell advised her to drink a glass of ice water to try and stir the baby; thereafter, for whatever reason, Mrs. Torretti detected increased movement. The doctor also told her that she could come to Lankenau if she preferred, but that nothing could be done until Monday. Mrs. Torretti chose not to go the hospital that weekend and did not believe that her condition was emergent.[2]

1. The District Court had subject matter jurisdiction over this EMTALA action pursuant to 42 U.S.C. § 1395dd, *et seq.,* and supplemental jurisdiction over the state claims pursuant to 28 U.S.C. § 1367. We have appellate jurisdiction under 28 U.S.C. § 1291.

2. *See* App. 97 (Question: "Did you feel your condition was emergent on the 21st?" Mrs. Torretti's answer: "No.").

On May 23, the Torrettis drove to Paoli for the appointment, which included a routine ultrasound and a fetal non-stress test.[3] When Mrs. Torretti arrived at Paoli, she was feeling general discomfort, primarily because of the strain on her back from the large size of her abdomen. She was not alarmed about her condition and did not feel that she was in an emergent state.[4] She told Dr. Andrew Gerson, a perinatologoist on Paoli's staff, about her conversation with Dr. McConnell over the weekend—that she was having a great deal of discomfort mainly due to her large size and had noticed a decrease in fetal movement, but that there was still some movement.

Dr. Gerson sat Mrs. Torretti in a chair and began the non-stress test. Over a 28–minute period, the test did not show expected fetal heart rate variability—normal accelerations and decelerations. Lack of variability in a non-stress test could be explained by a normal variant, such as a prolonged sleep cycle, or could be the sign of a problem. About the same time Mrs. Torretti began the non-stress test, her contractions returned. She indicated the "pain was so bad" that she was "grasping either the arm of the chair or both arms of the chair at once, and either almost grunting or to a degree yelling." The non-stress test indicated that she had 16 contractions in the 28 minutes of fetal monitoring—her contractions lasted approximately 50 to 70 seconds and were 1½ to 2½ minutes apart.

Dr. Gerson was aware of Mrs. Torretti's diabetic condition. He noted in her medical documents that her abdominal circumference was large—"off the charts." The fetus weighed approximately eleven pounds. Also, the ultrasound test indicated that she had excess amniotic fluid, but that the fetus "was moving its limbs and body."

Based on these preliminary test results and Mrs. Torretti's diabetic condition, Dr. Gerson terminated the non-stress test and sent her to Lankenau for longer-term monitoring of the baby.[5] In directing Mrs. Torretti to Lankenau, he also consulted with her regular doctor, Dr. McConnell, by telephone. Dr. Gerson testified that this plan appeared to be "perfectly safe" based on the "best information we had." He further testified that, even though she was having contractions, which had been commonplace throughout her third trimester, "delivery wasn't necessarily going to be imminent or need to be imminent and [ ] it was appropriate for her to go to Lankenau Hospital."[6] The nurse assisting Dr. Gerson commented to Mrs. Torretti that she believed Mrs. Torretti might deliver the baby sometime that day, but gave no indication of an emergency or imminency.

Mrs. Torretti testified that, while at Paoli, nothing in the statements or demeanor of anyone on Paoli's staff, including Dr. Gerson, indicated to her that her condition was emergent. For example, Mrs. Torretti stated that "[t]here was no

3. A non-stress test is a non-invasive test that measures fetal heart rate and contractions. Dr. Andrew Gerson, a perinatologist, explained that the test can last anywhere from 20 minutes to more than two hours, depending on the person.

4. *See* App. 101a (Question: "Did you feel your condition was emergent that day [at Paoli]?" Mrs. Torretti's answer: "No.").

5. Dr. Gerson stated that "one of the other concerns was [that Mrs. Torretti] be evaluated for her own sugar status and diabetes status, which, again, was one of the factors that made me realize that I thought she was going to [a] need more prolonged period of monitoring than what we could provide for her."

6. Dr. McConnell confirmed this view in testifying that Dr. Gerson told her that Mrs. Torretti would need prolonged monitoring, but that he did not anticipate a delivery that day.

[ ] urgency, though, as far as I was concerned. [The nurse] seemed pretty calm, and that's usually a pretty good indicator" because "I could usually read [the nurse] pretty well, I had known her since I had been pregnant with my first child." In addition, when Dr. Gerson discontinued the monitoring and sent her to Lankenau for prolonged monitoring, Mr. Torretti asked whether it was an emergency and if they should go in an ambulance. Dr. Gerson replied that it was not that urgent and that an ambulance was not necessary. Nonetheless, he requested that they go directly to Lankenau. En route to Lankenau, however, they stopped at their home. With the stop, the 20–mile trip took them approximately 45 minutes door-to-door.

As is customary, Dr. Gerson sent an explanatory letter to the Lankenau medical personnel along with the Torrettis. When Mrs. Torretti arrived, she had to wait approximately 15 to 20 minutes for a room. She stated that when she was first connected to the monitor, her condition seemed to be about the same as it had been at Paoli, but then "it worsened very quickly." Shortly thereafter, another doctor with the Peden Group checked on her. When he looked at the preliminary results, he exclaimed "oh shit!" The doctors immediately rushed Mrs. Torretti into surgery and she gave birth via caesarean section. The baby, Christopher Torretti, was born with severe brain damage.

Defendants moved for summary judgment on the EMTALA claim. The District Court ruled that the Torrettis did not offer sufficient evidence to raise a reasonable inference that defendants, specifically Dr. Gerson, knew Mrs. Torretti presented a medical emergency, and thus failed to sustain their burden under EMTALA. *Torretti v. Paoli Mem. Hosp.*, No. 06–3003, 2008 WL 268066, at *1 (E.D.Pa. Jan. 29, 2008). Accordingly, it granted the motion for summary judgment, dismissing the only federal claim. It also declined to exercise supplemental jurisdiction over the Torrettis' remaining state claims.

II. Standard of Review

When the District Court grants a motion for summary judgment, our review is plenary. *See Elsmere Park Club, L.P. v. Town of Elsmere*, 542 F.3d 412, 416 (3d Cir.2008) (citation omitted). Summary judgment is appropriate when no genuine issues of material fact exist and the moving party is entitled to judgment as a matter of law. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 322–23, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986). "We resolve all factual doubts and draw all reasonable inferences in favor of [ ] the nonmoving party." *See DL Res., Inc. v. FirstEnergy Solutions Corp.*, 506 F.3d 209, 216 (3d Cir.2007) (citation omitted). We may affirm or vacate the District Court's judgment on any grounds supported by the record. *Gorum v. Sessoms*, 561 F.3d 179, 184 (3d Cir.2009) (citation omitted).

III. EMTALA Background

EMTALA requires hospitals to give certain types of medical care to individuals presented for emergency treatment: (a) appropriate medical screening, (b) stabilization of known emergency medical conditions and labor, and (c) restrictions on transfer of unstabilized individuals to outside hospital facilities. 42 U.S.C. § 1395dd(a)-(c) [7]; *see Urban v. King*, 43

7. The statute states in pertinent part:
(a) Medical screening requirement
In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under 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 deter-

F.3d 523, 525 (10th Cir.1994) (stating that a hospital has two primary obligations under EMTALA: (1) if an individual arrives at an emergency room, the hospital must provide appropriate medical screening to determine whether an emergency medical condition exists; and (2) if the hospital determines an individual has an emergency medical condition that has not been stabilized, it may not transfer the patient unless certain conditions are met).

Congress enacted EMTALA in the mid–1980s based on concerns that, due to economic constraints, hospitals either were refusing to treat certain emergency room patients or transferring them to other institutions. *See* 68 F.R. 53,222, 53,223 (Sept. 9, 2003); *see also* H.R.Rep. No. 99–241, pt.3, at 27 (July 31, 1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 605 (indicating that Congress was "greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance"). As noted above, this practice is known as "patient dumping." *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 856 (4th Cir.1994). EMTALA requires hospitals to provide medical screening and stabilizing treatment to individuals seeking emergency care in a nondiscriminatory manner.[8] Although Congress was concerned that the indigent and uninsured tended to be the primary victims of patient dumping, EMTALA is not limited to these individuals. *See* 42 U.S.C. § 1395dd; *see also Roberts v. Galen of Virginia, Inc.*, 525 U.S. 249, 252, 119 S.Ct. 685, 142 L.Ed.2d 648 (1999) (holding that EMTALA does not require a plaintiff to show "that the hospital's inappropriate stabilization resulted from an improper motive such as one involving the indigency, race, or sex of the patient").

[1, 2] There is no general common-law duty for hospitals to accept and treat all individuals. Under EMTALA, however, any individual who suffers personal harm as a direct result of a hospital's violation of the statute may bring a private civil action for damages. 42 U.S.C. § 1395dd(d). While an EMTALA action usually will be brought in conjunction with a state statutory claim or common-law medical malpractice or negligence action arising out of the same events, it does not create a federal cause of action for malpractice. *See,*

mine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

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

(1) In general[:] If any individual ... 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.

....

(c) Restricting transfers until individual stabilized

(1) Rule[:] If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless .... [considerations not applicable to this case.]

8. Hospitals that voluntarily participate in the Medicare or Medicaid programs and have effective provider agreements must comply with EMTALA. *In re Univ. Med. Ctr.*, 973 F.2d 1065, 1083 (3d Cir.1992). When medical personnel working for a hospital violate EMTALA, that hospital is subject to liability for those violations "[b]ecause hospitals can act and know things only vicariously through individuals." *Burditt v. HHS*, 934 F.2d 1362, 1374 (5th Cir.1991) (internal citation omitted).

e.g., Summers v. Baptist Med. Ctr. Arkadelphia, 91 F.3d 1132, 1137 (8th Cir.1996); *Brooks v. Md. Gen. Hosp., Inc.*, 996 F.2d 708, 710, 713 (4th Cir.1993) (stating that EMTALA "does not create liability for malpractice based upon breach of national or community standard of care"). Liability is determined independently of whether any deficiencies in the screening or treatment provided by the hospital may be actionable as negligence or malpractice, see *Summers*, 91 F.3d at 1137, as the statute was aimed at disparate patient treatment.

IV. Outpatients Do Not Trigger EMTALA Coverage

[3] In analyzing an EMTALA claim, the Act does not stand alone. The Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) promulgated a Federal Regulation, 42 C.F.R. § 489.24(a)-(b),[9] and Final Rule, 68 F.R. 53,222 (Sept. 9, 2003),[10] clarifying the reach of EMTALA. *See* Brian Kamoie, *EMTALA: Dedicating an Emergency Department Near You*, 37 J. Health L. 41, at 55–56 (2004) (explaining that because of confusion in the interpretation and application of EMTALA, CMS set up a "Regulatory Reform Task Force" to recommend clarifications to the statute). Generally, we defer to a government agency's administrative interpretation of a statute unless it is contrary to clear congressional intent. *See Chevron USA, Inc. v. Natural Res. Defense Council, Inc.*, 467 U.S. 837, 843 & n. 9, n. 11, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984) (noting that when an agency with the power to construe a statute has provided a construction, we defer to that interpretation if it is "permissible"); *see also Mercy Home Health v. Leavitt*, 436 F.3d 370, 378 (3d Cir.2006) (explaining the *Chevron* deference test). "The court need not conclude that the agency construction was the only one it permissibly could have adopted to uphold the construction, or even the reading the court would have reached if the question initially had arisen in a judicial proceeding." *Chevron*, 467 U.S. at 843 n. 11, 104 S.Ct. 2778. Where Congress expressly delegates to an agency the power to construe a statute, we review the agency's interpretation under the "arbitrary and capricious" standard; where the delegation is implicit, the agency's interpretation must be "reasonable." *Id.* at 843–44, 104 S.Ct. 2778.

CMS has the congressional authority to promulgate rules and regulations interpreting and implementing Medicare-related statutes such as EMTALA. *See generally* 42 U.S.C. §§ 1302, 1395hh; 5 U.S.C. § 551, *et seq.* Among the 2003 clarifications, the Regulation and Final Rule address where and when EMTALA applies. CMS solicited public comments and took into account a range of objections to the proposed Regulation, providing a lengthy discussion responding to the comments and its reasons for its interpretation in the Final Rule. The Regulation was not raised by the parties or the District Court. Nevertheless, it is instructive to answer the question before us: whether Mrs. Torretti fits within EMTALA's scope—a patient antidumping statute. CMS has concluded that EMTALA does not apply to patients (and outpatients), which interpretation precludes the Torrettis' EMTALA claim in the first instance because Mrs. Torretti was an outpatient who came to Paoli for a scheduled appointment.

9. Titled "Special responsibilities of Medicare hospitals in emergency cases."

10. Titled "Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare–Participating Hospitals in Treating Individuals with Emergency Medical Conditions."

[4] Turning to the Regulation's interpretation of the statute, EMTALA's requirements are triggered when an "individual comes to the emergency department." [11] 42 C.F.R. § 489.24(a)(1).[12] To parse out this clause, an "individual" only "comes to the emergency department" if that person is not already a "patient." *See id.* § 489.24(b); *see also* 68 F.R. at 53,238 (explaining that because "outpatients" "are patients of the hospital already, we believe it is inappropriate that they be considered to have 'come to the hospital' for purposes of EMTALA"). The Regulation defines "patient" for our purposes as "[a]n individual who has begun to receive outpatient services as part of an encounter, as defined in § 410.2 of this chapter, other than an encounter that the hospi-

11. *Cf. Lopez–Soto v. Hawayek,* 175 F.3d 170, 173–76 (1st Cir.1999) (explaining that subsections (a) (screening) and (b) (stablilization) of EMTALA should be read in the disjunctive because (a) uses the term ''emergency department'' and (b) uses the term ''hospital,'' and concluding that transferring an infant born in the maternity ward with an emergent condition to another hospital with specialized care without stabilization would qualify as a claim under EMTALA). We note that this case came before CMS's 2003 clarifying Regulation and Final Rule. We do not attempt to speculate at how the First Circuit Court of Appeals would view this question in light of the revised Regulation, but in the Court's analysis it noted that the EMTALA ''provisions create distinct obligations and apply to different classes of individuals.'' *Id.* at 175. We also note that a ''labor and delivery department,'' where the baby in *Lopez–Soto* was born and transferred from, is considered to be a ''dedicated emergency department'' under the Regulation and Final Rule and thus falls under EMTALA, whereas Paoli's Perinatal Testing Center is for outpatient fetal monitoring and consulting only. *See* 68 F.R. at 53,229–30 (explaining that EMTALA coverage applies to ''labor and delivery departments'' because they ''provide care for emergency medical conditions on an urgent, nonappointment basis'').

As was the *Lopez–Soto* Court's focus, CMS pointed out that the nomenclature discrepancies in the statute have led to confusion and the uneven application of EMTALA. *See* 68 F.R. at 53,227–228; *see also* Kamoie, 37 J. Health L. at 46–47, 51–52. By focusing EMTALA obligations across methods of classification, such as by distinguishing between hospital patients and other individuals who come to the hospital, CMS attempted to clarify the statute. *See* 68 F.R. at 53,224 (''We proposed to clarify the extent to which EMTALA applies to inpatients and outpatients. We believe these clarifications will enhance understanding for hospitals as to what their obligations are under EMTALA, so that they more clearly understand to whom they are obligated under this provision of the statute, and whose care will be governed by the Medicare hospital [conditions of participation].'').

12. The pertinent part of subsection (a) of the Regulation states:

(a) Applicability of provisions of this section.
(1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) ''comes to the emergency department,'' as defined in paragraph (b) of this section, the hospital must—
(i) Provide 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 exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of § 482.55 of this chapter concerning emergency services personnel and direction; and
(ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section. 42 C.F.R. § 489.24(a).

tal is obligated by this section to provide." [13] 42 C.F.R. § 489.24(b).

CMS explains that EMTALA does not apply to outpatients, even if during an outpatient encounter "they are later found to have an emergency medical condition ... [and] are transported to the hospital's dedicated emergency department." 68 F.R. at 53,240 (pertinent section titled "Applicability of EMTALA: Individuals Present at an Area of the Hospital's Main Campus Other than the Dedicated Emergency Department" that corresponds with 42 C.F.R. § 489.24(b)); *see also id.* at 53,243, 53,247 ("[W]e are ... [a]dopting as final the proposed definition of patient ... to reflect the nonapplicability of EMTALA to an individual who has begun to receive outpatient services at an encounter at the hospital other than an encounter that the hospital is obligated by EMTALA to provide."). "These individuals are considered patients of the hospital and are protected by [Medicare's Conditions of Participation] and relevant State law," as well as "under general rules of ethics governing the medical profession." *Id.* at 53,238–40 [14]; *see also* Kamoie, 37 J. Health L. at 51–52.

The Torrettis argue that EMTALA is triggered because Mrs. Torretti came to Paoli for "what was, from the inception, a potential 'emergency medical condition' " because "EMTALA protects people who *present* 'for what may be an emergency medical condition.' " Appellants' Supp. Br. at 2 (quoting 68 F.R. 53,222) (emphasis added). This is not supported in the record. Mrs. Torretti came to Paoli for her scheduled bi-weekly appointment involving routine monitoring of her high-risk pregnancy and did not present as an emergency to the Paoli medical staff.[15] In fact, she testified that, because of her complications throughout her third trimester, she did not believe she was in an emergent state until *after* she began the monitoring at Lankenau and her condition quickly changed. Her other actions and testimony, as well as the testimony of her husband and the medical personnel, are consistent with this view.

13. ''Outpatient means a person who has not been admitted as an inpatient but who is registered on the hospital or CAH [critical access hospital] records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.'' 42 C.F.R. § 410.2.

14. The pertinent part of the CMS Final Rule states:

> EMTALA does not apply to any individual who, before the individual presents to the hospital for examination or treatment for an emergency medical condition, has begun to receive outpatient services as part of an encounter.... Such individuals would be included under this policy, regardless of whether or not they began the nonemergency encounter in order to keep a previously scheduled appointment or under orders of a physician or other medical practitioner.... [W]e believe it is inappropriate to consider such individuals, who are hospital outpatients who have protections under the [Medicare Conditions of Participation], to have ''come to the hospital'' for purposes of EMTALA as well, even if they subsequently experience an emergency medical condition.

15. We note, however, that EMTALA could be triggered in a circumstance where an individual comes to the hospital requesting treatment for an emergent condition, despite having a pre-scheduled appointment within the hospital for a related or unrelated reason. *See* 68 F.R. at 53,241; *id.* at 53,237 (''[I]f [an] individual [sent to a hospital for specific diagnostic tests] were to tell the hospital staff at the laboratory or radiology department that he or she needed emergency care, EMTALA would apply.''). As we discussed above, that is not the situation here and would require a different analysis. There is a narrow exception where an individual need not request emergency care, but Mrs. Torretti also does not fit under this exception, and we do not discuss it in more detail.

Contrary to the Torrettis' contention on appeal, Mrs. Torretti's statements to Dr. Gerson near the beginning of the appointment (describing her discomfort due to her large size and her conversations with Dr. McConnell over the weekend) do not amount to presenting an emergency. At any medical appointment, we would expect medical personnel attending to a patient to request pertinent medical information, and, in turn, expect that a patient share such information concerning the perceived state of her health, which is precisely what Mrs. Torretti did in this case. This type of routine patient-doctor dialogue does not transform a pre-scheduled medical appointment into an emergent situation triggering EMTALA.

The Torrettis also imply that, regardless of whether Mrs. Torretti was a "patient," because she had a high-risk pregnancy, each scheduled visit to Paoli during her pregnancy would qualify as a presentment of an emergency medical condition to trigger EMTALA coverage. Appellants' Supp. Br. at 3 ("Mrs. Torretti came to [Paoli] for what was, from the inception, a potential 'emergency medical condition.' As the fetus of a woman who has been an insulin-dependent diabetic since infancy, her baby was at serious risk of stillbirth or fetal death.") (citation omitted). This is an unreasonable interpretation of the Act that broadens its scope beyond Congress's intent. To illustrate this point, individuals in equivalent situations to Mrs. Torretti would be hospital outpatients who have routinely scheduled weekly or monthly appointments to receive dialysis or chemotherapy for treatment of kidney disease and cancer, respectively. We believe it is clear that Congress did not intend EMTALA to cover these individuals every time they come to the hospital for their appointments, even though they suffer from serious medical conditions that risk becoming emergent.

Given this context, we believe CMS's more restrictive interpretation on this issue is consistent with EMTALA, and is in accord with the Act's intent. Congress passed EMTALA to curb the problem of patient dumping by creating a statutory duty for hospitals to examine and treat individuals who come to them for emergency care. 42 U.S.C. § 1395dd. Accordingly, this interpretation is entitled to *Chevron* deference. *See Chevron,* 467 U.S. at 843, 104 S.Ct. 2778; *see also Village of Hoffman Estates v. Flipside, Hoffman Estates, Inc.,* 455 U.S. 489, 504, 102 S.Ct. 1186, 71 L.Ed.2d 362 (1982) (noting agency regulations interpreting a statute "will often suffice to clarify a standard with an otherwise uncertain scope").

One final note on this issue is that in supplemental briefing the Torrettis point to a Ninth Circuit Court case, *Arrington v. Wong,* 237 F.3d 1066, 1071–72 (9th Cir. 2001), and argue that CMS has taken an "expansive approach" to the phrase "comes to the emergency department," which triggers EMTALA. Appellants' Supp. Br. at 1. *Arrington* was issued prior to the 2003 Final Rule and revised Regulation that clarified the treatment of outpatients under the statute by revising the definition of "patient," which is the significant issue here. The "expansive approach" to which the *Arrington* court refers broadens the definition of the phrase "comes to the emergency department" to include other parts of the hospital, such as "hospital property-sidewalks," which is not determinative in this case. *See Arrington,* 237 F.3d at 1071–72 (addressing whether under EMTALA "hospitals must admit emergency patients who are being transported to the hospital in non-hospital owned ambulances," and noting that "[t]he [R]egulation answers this question"); *see also* 42 C.F.R. § 489.24(b) (explaining that if an individual is *not* a "patient," that individual "comes to the emergency department"

within the meaning of the statute under four circumstances).

In this circumstance, the Torrettis will have to pursue legal avenues other than EMTALA because the statute does not apply here. Moreover, claims of negligence or malpractice more accurately reflect the relief the Torrettis seek.

V. Summary Judgment

[5] Although we have concluded that Mrs. Torretti's circumstances are not those contemplated by EMTALA coverage, we would be remiss if we did not address the substance of the claim for future guidance. The Torrettis alleged a "stabilization" claim—that defendants violated EMTALA because they did not stabilize her emergency condition and inappropriately transferred her. Under this theory, EMTALA requires that Mrs. Torretti (1) had "an emergency medical condition; (2) the hospital actually knew of that condition; [and] (3) the patient was not stabilized before being transferred." *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 883 (4th Cir.1992). The District Court dismissed the claim on summary judgment because the Torrettis could not show that defendants had actual knowledge of an emergency medical condition. "The Act does not hold hospitals accountable for failing to stabilize conditions of which they are not aware, or even conditions of which they should have been aware." *Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139, 145 (4th Cir.1996) (citing *Baber*, 977 F.2d at 883) (indicating that "EMTALA would otherwise become coextensive with malpractice claims for negligent treatment").

As the District Court concluded, the requirement of actual knowledge is the key to this issue. We adopt this *mens rea* condition precedent, which conforms with all our sister circuit courts of appeals that have addressed this issue under EMTALA. *See, e.g., Vickers*, 78 F.3d at 141; *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir.1995); *Holcomb v. Monahan*, 30 F.3d 116, 117 (11th Cir. 1994); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C.Cir. 1991); *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (6th Cir. 1990); *see also* 42 U.S.C. § 1395dd(b)(1). When we discussed EMTALA at the outset, we indicated that it was not intended to create a federal malpractice statute or cover cases of hospital negligence. Thus, the actual knowledge element comports with Congress's intent in passing the Act.

The District Court concluded that the Torrettis' evidence was not sufficient to raise a disputed issue, and we agree with that conclusion. As we outlined above in the fact section, there is no evidence that any of the hospital staff at Paoli, and specifically Dr. Gerson, actually knew that Mrs. Torretti's condition was an emergency before directing her to Lankenau for further monitoring. The medical personnel at Paoli knew her pregnancy was high-risk because of her diabetic condition, which was indicated in her medical charts and the Paoli testing results from that day, and she had a recent history of treatment for pre-term labor and contractions similar to those exhibited at Paoli (and approximately three weeks prior to the May 23 appointment, medical personnel at Paoli sent her to *Lankenau* for further monitoring). She arrived for a routine appointment and did not present herself as an emergency patient, neither she nor Dr. McConnell believed her situation was emergent over the weekend preceding the Paoli appointment, she did not believe her condition was emergent until *after* she arrived at *Lankenau* and her condition changed quickly, Dr. Gerson did not indicate that he believed her condition was emergent (*e.g.*, before Mrs. Torretti left Paoli, he expressly stated to the contrary when asked about transporting her to

Lankenau in an ambulance and when he spoke to Dr. McConnell about further monitoring at Lankenau), none of the other hospital staff indicated her condition was emergent (*e.g.*, Mrs. Torretti's testimony conveys that the nurse at Paoli commented that Mrs. Torretti might deliver the baby sometime that day, but did not suggest it was imminent or the situation was an emergency), and the Torrettis' expert report is unreliable to the extent that it opines on the element of actual knowledge.[16] One of the Torrettis' experts, Dr. Steven A. Klein, a fetal medicine specialist, stated in his undated first report that Dr. Gerson "should have urgently sent her to the nearest OB facility (Paoli Hospital)" and "not to do so was below the standard of care." These statements opine only on malpractice or negligence and not the actual knowledge standard under EMTALA. Dr. Klein added in his second report, attached to the opposition to summary judgment, that he believed Dr. Gerson knew Mrs. Torretti's condition was emergent. He based this opinion on several facts contained in his two reports about Mrs. Torretti's condition while at Paoli. One of those facts—that "[M]rs. Torretti complained of NO fetal movements for 2 days"—is not supported in the record. Mrs. Torretti testified that she complained of reduced, not absent, fetal movements over the weekend prior to the Paoli appointment, and was able to stir the baby when she called Dr. McConnell the second time. Dr. McConnell testified to this as well, and Mrs. Torretti's medical report from Paoli indicates the same. Thus, regardless how we view the ability of medical experts to opine on the element of actual knowledge of another, we need not answer that question because here Dr. Klein's reports are not sufficient to create a disputed issue of material fact.

* * * * * *

In this context, we affirm the District Court's grant of summary judgment.

16. Mrs. Torretti's testimony that, near the end of her ultrasound, she heard Dr. Gerson state that ''it had a score of two,'' is not enough to raise a disputed issue of material fact. She believed the number referred to her biophysical profile score, though she did not state any reasons for this belief. That profile measures the health of the baby using both an ultrasound and a non-stress test. The corresponding score ranges from 0, which is very problematic, to 10, which is the best score.

Dr. Gerson testified that he was not able to conduct a formal biophysical profile, but that the ultrasound showed

> both gross body movements and limb movements, as well as [excess] fluid around the baby[, which] allowed me to come to the conclusion that the baby had a biophysical profile score of 6, which is a profile score that allows one to draw a conclusion that delivery wasn't necessarily going to be imminent or need to be imminent and that it was appropriate for her to go to Lankenau.

This number is corroborated in Mrs. Torretti's medical report, which states that the biophysical profile score is 6. It is also consistent with Dr. Gerson's actions in sending Mrs. Torretti to Lankenau for further monitoring. Moreover, the letter Dr. Gerson sent to Lankenau indicated that, based on her ultrasound, ''the placenta was found in the Posterior position and noted to be grade 2.'' This information is consistent with the statement Mrs. Torretti overheard Dr. Gerson make during the ultrasound. As the District Court concluded, Mrs. Torretti's speculation alone, without more, is insufficient to survive summary judgment.

PATRICIA SMITH, ADMINISTRATRIX OF THE ESTATE OF MARTHA E. SMITH, DECEASED, AND PATRICIA SMITH; MARY J. SCOTT, Appellants,
v.
ALBERT EINSTEIN MEDICAL CENTER; BETH DUFFY; DR. ROBERT WEISBERG; DR. STEVEN LEWIS; DR. JERRY COHEN; PATRICIA MAISANO, R.N. OF IKOR, INC.; DR. KEVIN HAILS; DR. ROBERT W. SOLIT; ATTORNEY PATRICIA Q. IMBESI; ATTORNEY ANNE MAXWELL; ROBERT STUMP; DR. MICHAEL MILLENSON; DR. MOSHE CHASKY; DR. ROGER KYLE; SAINT AGNES CONTINUING CARE CENTER; SUSAN MAZZACANO, R.N.; RICHARD K. HELLER, R.N.; FOX CHASE CANCER CENTER; VITAS HEALTHCARE CORPORATION ATLANTIC.

No. 09-3463.

United States Court of Appeals, Third Circuit.

Submitted Pursuant to Third Circuit LAR 34.1 April 27, 2010.
Filed: April 28, 2010.

Before: SMITH, FISHER AND GARTH, Circuit Judges.

NOT PRECEDENTIAL

OPINION

PER CURIAM.

Patricia Smith and Mary Scott, proceeding pro se, appeal an order of the United States District Court for the Eastern District of Pennsylvania dismissing their amended complaint. We will affirm the District Court's order.

Smith and Scott filed a complaint against nineteen defendants claiming violations of the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd ("EMTALA"), constitutional violations, medical malpractice, and fraud in connection with the medical care their mother, Martha Smith, received before her death.[1] The District Court granted the defendants' motions to dismiss the complaint for lack of subject matter jurisdiction and for failure to state a claim upon which relief could be granted without prejudice to their filing an amended complaint.

Smith and Scott ("Smith's daughters") filed an amended complaint. As recognized by the District Court, the facts supporting their claims are difficult to decipher. Smith's daughters allege that Albert Einstein Medical Center and Drs. Weisberg, Lewis, Cohen, and Solit failed to properly assess and treat Martha Smith's renal failure and other ailments. They further allege that Albert Einstein Medical Center, through attorney Patricia Imbesi, secured the appointment of a

guardian for their mother in December 2006 in the Philadelphia Court of Common Pleas in violation of Martha Smith's and their constitutional rights. Smith's daughters state that they unsuccessfully filed an action in federal court seeking Martha Smith's transfer from Albert Einstein Medical Center.

Smith's daughters further aver that on January 11, 2007, Martha Smith had a biopsy, which was authorized by court-appointed guardian Patricia Maisano, but not Martha Smith. On January 22, 2007, they learned that hemodialysis was not provided to Martha Smith, allegedly causing seizures, unconsciousness, congestive heart failure, a coma, and death. On January 31, 2007, Martha Smith received an oncology evaluation by Fox Chase Cancer Center doctors Michael Millenson and Roger Kyle.

Smith's daughters further state that on February 5, 2007, Albert Einstein Medical Center transferred Martha Smith in a non-responsive state to Saint Agnes Continuing Care Center for hospice care. They aver that Smith's court-appointed attorney, Anne Maxwell, did not have prior knowledge of the transfer. They claim that Saint Agnes Continuing Care Center, Vitas Healthcare Corporation, and nurses Susan Mazzacano and Richard Heller also failed to provide medical treatment. Martha Smith died on February 12, 2007.

The defendants moved to dismiss the amended complaint pursuant to Federal Rule of Civil Procedure 12(b)(6). The District Court granted the motions to dismiss Smith's daughter's constitutional and federal claims, holding that they had not alleged the requisite state action for a claim under 42 U.S.C. § 1983 or the elements of a claim under EMTALA. The District Court declined to exercise supplemental jurisdiction over the state law claims and ruled that any further amendments to the amended complaint appeared futile or inequitable. This appeal followed.[2]

We have jurisdiction pursuant to 28 U.S.C. § 1291. Our review of an order granting a motion to dismiss under Rule 12(b)(6) is plenary. Nami v. Fauver, 82 F.3d 63, 65 (3d Cir. 1996).

The District Court did not err in dismissing Smith's daughters' constitutional claims, which relate to the legal proceedings in which a guardian was appointed for Martha Smith. Smith's daughters allege that Patricia Imbesi, attorney for Albert Einstein Medical Center, filed a fraudulent petition and that the state court judge appointed an "illegal" guardian without appointing counsel to represent Smith. The District Court correctly presumed that Smith's daughters brought their constitutional claims pursuant to 42 U.S.C. § 1983 and concluded that the facts did not suggest that Imbesi acted under color of state law. See Groman v. Township of Manalapan, 47 F.3d 628, 638 (3d Cir. 1995) (stating there is no liability under § 1983 for those not acting under color of state law).[3]

The District Court also correctly held that Smith's daughters failed to state a claim under EMTALA, which was enacted to address concerns that, for economic reasons, hospitals were refusing to treat certain emergency room patients or transferring them to other places. Torretti v. Main Line Hosp., Inc., 580 F.3d 168, 173 (3d Cir. 2009). EMTALA requires hospitals to give certain types of medical care to individuals presented for emergency treatment, including appropriate medical screening and stabilization of known emergency medical conditions and labor, and restricts transfer of unstabilized individuals to outside hospital facilities. Id. at 172.[4]

In Torretti, we explained that, under the applicable regulation, EMTALA's requirements are triggered when an "individual comes to the emergency department" and that an individual only does so if that person is not already a "patient." Id. at 175 (citing 42 C.F.R. § 489.24(a),(b)). The plaintiff in Torretti was an outpatient and we held that EMTALA was not implicated. Id. at 174-75.

As noted by the District Court, the amended complaint in this case does not allege that Martha Smith presented herself for emergency treatment. To the contrary, it can be inferred from the amended complaint that Martha Smith was a patient at Albert Einstein Medical Center who was transferred to Saint Agnes Continuing Care Center for hospice care. Because Smith was a patient, EMTALA does not apply. See 42 C.F.R. § 489.24(b) (defining "patient" to include inpatients and outpatients); Torretti, 580 F.3d at 174-75.[5]

Having stated no federal claim, the District Court did not abuse its discretion in declining to exercise supplemental jurisdiction over any state law claims. See 28 U.S.C. § 1367(c)(3).

Accordingly, we will affirm the District Court's order.

[1] The named defendants are Albert Einstein Medical Center, Beth Duffy, Dr. Robert Weisberg, Dr. Steven Lewis, Dr. Jerry Cohen, Dr. Kevin Hails, Dr. Robert Solit, lawyers Patricia Imbesi and Anne Maxwell, Patricia Maisano, Robert Stump, Fox Chase Cancer Center, Dr. Michael Millenson, Dr. Moshe Chasky, Dr. Roger Kyle, St. Agnes Continuing Care Center, VITAS Healthcare Corporation Atlantic, Susan Mazzacano, and Richard Heller.

[2] Albert Einstein Medical Center argues on appeal, as it argued in District Court, that the District Court lacked federal subject matter jurisdiction. We agree with the District Court that it had jurisdiction based on the claimed violations of EMTALA, a federal statute. See 28 U.S.C. § 1331.

[3] The District Court also noted that the state court judge was not a named defendant. If named as a defendant, the judge would be immune from suit under § 1983 for money damages arising from her judicial acts. Gallas v. Supreme Court of Pennsylvania, 211 F.3d 760, 768 (3d Cir. 2000).

[4] Hospitals that voluntarily participate in the Medicare or Medicaid programs and have effective provider agreements must comply with EMTALA. Id. at 173 n.8. Smith's daughters do not allege that the defendants are "participating hospitals" against which a cause of action may be brought.

See 42 U.S.C. § 1395dd(d)(2)(A). Like the District Court, we will assume the defendant hospitals must comply with EMTALA.

[5] We further stated in Torretti that, in order to state a claim under EMTALA based on a failure to stabilize an emergency medical condition and an improper transfer, EMTALA requires an "emergency medical condition," that the hospital actually knew of the condition, and that the patient was not stabilized before being transferred. Id. at 178. Although Smith's daughters complain that Martha Smith's transfer to Saint Agnes Continuing Care Center violated EMTALA, as recognized by the District Court, they do not aver that Smith had an "emergency medical condition" as defined by statute or that Albert Einstein Medical Center knew of such a condition.

934 F.2d 1362, 60 USLW 2075, 33 Soc.Sec.Rep.Serv. 566, Med & Med GD (CCH) P 39,476
(Cite as: 934 F.2d 1362)

United States Court of Appeals,
Fifth Circuit.
Michael L. BURDITT, M.D., Petitioner,
v.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Respondent.
No. 90-4611.

July 9, 1991.

Physician appealed civil penalty determination of Executive Appeals Board of Department of Health and Human Services for violation of Emergency Medical Treatment and Active Labor Act (EMTALA). The Court of Appeals, Reavley, Circuit Judge, held that: (1) physician's conduct in failing to weigh medical risks and benefits before ordering transfer of severely hypertensive woman in active labor violated Act; (2) evidence supported imposition of $20,000 fine; and (3) assessment of fine did not effect public taking of physician's services without just compensation in contravention of Fifth Amendment.

Affirmed and enforced.

West Headnotes

fice of Gen. Counsel, Inspector Gen. Div., and Michael J. Astrue, Gen. Counsel, David V. Foster, Sp. Asst., USDHH, Washington, D.C., for respondent.

Mike Driscoll, County Atty., Dori A. Wind, Asst. County Atty., Houston, Tex., for amicus curiae Harris County Hosp. Dist.

Ann Torregrossa, Chester, Pa., G. Gordon Bonneyman, Legal Service of Middle Tenn., Nashville, Tenn., for amici curiae Pa. Consumer Subcommittee, et al.

Ronald Ellis, Julius Levonne, Chambers, Marianne Lado, NAACP Legal Defense and Ed. Fund, Inc., and Alison Wetherfield, Martha F. Davis, NOW Legal Defense and Ed. Fund, New York City, for amici curiae NAACP Legal Def. and Ed. Fund, et al.

David C. Vladeck, Public Citizen Litigation Group, Washington, D.C., for amici curiae Congressman Henry Waxman, et al.

James L. Feldesman, Jacqueline C. Leifer, Roger A. Schwartz, Feldesman, Tucker, Leifer, Fidell & Bank, Washington, D.C., for amici curiae Assoc. of Maternal and Child Health Programs and Nat. Assoc. of Comm. Health Centers.

Brenda Willett, East Tex. Legal Services, Nacogdoches, Tex., for amici curiae Doris Spencer, Lendy Gooch, et al.

Michael T. Isbell, Evan Wolfson, New York City, and Ruth Eisenberg, Washington, D.C., for amici curiae Lamda Legal Def., etc.

***1366** Petition for Review of an Order of the United States Department of Health and Human Services.

Before REAVLEY, HIGGINBOTHAM and DUHÉ, Circuit Judges.

REAVLEY, Circuit Judge:

Hospitals that execute Medicare provider agreements with the federal government pursuant to 42 U.S.C. § 1395cc must treat all human beings who enter their emergency departments in accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd.[FN1] Hospitals and responsible physicians found to have violated EMTALA's requirements are subject to civil money penalties. The present appeal is from the order of an executive appeals board of the Department of Health and Human Services (DHHS) assessing a $20,000 fine against Dr. Michael L. Burditt. He contends on appeal that: 1) the government misconstrued EMTALA; 2) findings of fact establishing his violative conduct are not supported by substantial record evidence; and 3) EMTALA unconstitutionally takes the services of physicians without just compensation. We affirm and enforce.

FN1. Unless otherwise noted, all references in this opinion to EMTALA are to the statute as it existed on December 5, 1986. *See* 42 U.S.C. § 1395dd (Supp. IV 1987).

I. BACKGROUND

A. FACTS

Mrs. Rosa Rivera arrived in the emergency room of DeTar Hospital in Victoria, Texas at approximately 4:00 p.m. on December 5, 1986.[FN2] At or near term with her sixth child, she was experiencing one-minute, moderate contractions every three minutes and her membranes had ruptured. Two obstetrical nurses, Tammy Kotsur and Donna Keining, examined her and found indicia of labor and dangerously high blood pressure. Because Rivera had received no prenatal care, and had neither a regular doctor nor means of payment, Kotsur telephoned Burditt, who was next on DeTar's rotating call-list of physicians responsible for such “unaligned” obstetrics patients. Upon hearing Rivera's history and condition, Burditt told Kotsur that he “didn't want

to take care of this lady" and asked her to prepare Rivera for transfer to John Sealy Hospital in Galveston, Texas, 170 miles away. Burditt agreed to call back in five to ten minutes.

> FN2. Unless otherwise noted, all times cited in this opinion are *post meridian* on December 5, 1986.

Kotsur and Keining told the nursing supervisor, Jean Herman, and DeTar's Administrator, Charles Sexton, of their belief that it would be unsafe to transfer Rivera. When Burditt called back, Keining told him that, according to Sexton's understanding of hospital regulations and federal law, Burditt would have to examine Rivera and personally arrange for John Sealy to receive her before he could legally transfer her. Keining asked Burditt for permission to start an intravenous push of magnesium sulfate as a precaution against convulsive seizures. Burditt told Keining to begin administering this medication only if Rivera could be transported by ambulance. He said that otherwise, Keining was not to administer intravenous treatment because Rivera would have to go to John Sealy by private car.

Burditt arrived at approximately 4:50 to examine Rivera. He confirmed her blood pressure to be the highest he had ever seen, 210/130, and he assumed that she had been hypertensive throughout her pregnancy. As the experienced head of DeTar's obstetrics and gynecology department, Burditt knew that there was a strong possibility that Rivera's hypertension would precipitate complications which might kill both Rivera and her baby. He also knew that the infants of hypertensive mothers are at higher-than-normal risk of intrauterine growth retardation. He estimated that Rivera's baby was six pounds-less than normal weight-and arranged her transfer to John Sealy, a perinatal facility better equipped than DeTar to care for underweight infants. Burditt obtained telephonic acceptance of Rivera from a Dr. ***1367** Downing at John Sealy, and, per Downing's request, instructed Keining to administer magnesium sulfate intravenously and have Rivera transported by ambulance.

At approximately 5:00, Herman showed Burditt DeTar's guidelines regarding EMTALA, but he refused to read them. Burditt told Herman that Rivera represented more risk than he was willing to accept from a malpractice standpoint. Herman explained that Rivera could not be transferred unless Burditt signed a DeTar form entitled "Physician's Certificate Authorizing Transfer." Burditt asked for "that dang piece of paper" and signed his name under the following:

I have examined the patient, _____, and have determined that, based upon the information available to me at this time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the patient's medical condition from effecting [the] transfer. The basis for my conclusion is as follows: _____

Burditt listed no basis for his conclusion and remarked to Herman that "until DeTar Hospital pays my malpractice insurance, I will pick and choose those patients that I want to treat."

Burditt then went to care for another unaligned patient, Sylvia Ramirez, while the nurses arranged Rivera's transfer. They found another obstetrical nurse, Anita Nichols, to accompany Rivera to John Sealy. Burditt returned to the nurses' station and stayed there from 5:30 to 6:18. He never again examined Rivera or asked about her medical condition, though he inquired several times about the status of her transfer. Burditt delivered the Ramirez baby at 6:22. Afterward, Nichols told him the results of her examination of Rivera and informed him that the ambulance had arrived. Based exclusively on Nichols' statements, Burditt concluded that Rivera's condition had not changed since his examination two hours before. Burditt did not reexamine Rivera though he saw her being wheeled to the ambulance. He did not order any medication or life support equipment for Rivera during her transfer.

Nichols delivered Rivera's healthy baby in the ambulance approximately 40 miles into the 170-mile

trip to John Sealy. She directed the driver to nearby Ganado Hospital to get a drug called pitocin to staunch Rivera's bleeding. While there, Nichols telephoned Burditt, who ordered her to continue to John Sealy despite the birth. Instead, per Rivera's wishes, Nichols returned Rivera to DeTar, where Burditt refused to see her because she failed to proceed to John Sealy in accordance with his instructions. Burditt directed that Rivera be discharged if she was stable and not bleeding excessively. A DeTar official pressed Burditt to allow Dr. Shirley Pigott to examine Rivera. Rivera stayed at DeTar under Pigott's care for three days and left in good health.

B. PROCEDURAL HISTORY

In mid-1988, the Inspector General of the United States Department of Health and Human Services (DHHS) demanded a $25,000 civil penalty from Burditt for violating EMTALA. After hearing the arguments of counsel and the testimony of eleven witnesses, an administrative law judge (ALJ) found that Burditt knowingly violated EMTALA in several ways but that mitigating circumstances warranted a reduction in the fine assessed against him to $20,000. Burditt appealed the ALJ's fact findings and legal conclusions to the Departmental Appeals Board (DAB) established by appellee Dr. Louis Sullivan, DHHS Secretary. After briefing and oral argument, DAB issued its "Final Decision" upholding the $20,000 civil penalty against Burditt. DAB sustained most of the ALJ's fact findings and legal conclusions, reversed four findings concerning mitigating circumstances and active labor, and modified three other findings. Burditt appeals DAB's Final Decision.

II. DISCUSSION

We have jurisdiction to review DAB's Final Decision under 42 U.S.C.A. § 1320a-7a(e) (West Supp.1991). We will ***1368** uphold DAB's fact findings if they are "supported by substantial evidence on the record considered as a whole." *Id.* And a "court of appeals can only invalidate an administrator's interpretation [of a statute imposing a civil monetary penalty] if that interpretation is unreasonable." *Griffon v. United States Dep't of Health & Human Services,* 802 F.2d 146, 148 (5th Cir.1986).

A. EMTALA VIOLATIONS

DeTar had executed a Medicare provider agreement pursuant to 42 U.S.C. § 1395cc and was obligated to treat Rivera in accordance with EMTALA.

1. Screening

Because Rivera presented herself to DeTar's emergency department and a request was made on her behalf for care, EMTALA required DeTar to

> 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 or to determine if the individual is in active labor....

42 U.S.C. § 1395dd(a) (Supp. IV 1987) (emphasis added), *amended by* 42 U.S.C.A. § 1395dd(a) (West Supp.1991). The parties agree that DeTar appropriately screened Rivera and discovered that she had an "emergency medical condition"-severe hypertension-within the meaning of 42 U.S.C. § 1395dd(e)(1).[FN3]

> FN3. EMTALA defines "emergency medical condition" 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-
> >
> > (A) placing the patient's health in serious jeopardy,

> (B) serious impairment to bodily functions, or
>
> (C) serious dysfunction of any bodily organ or part.
>
> 42 U.S.C. § 1395dd(e)(1) (Supp. IV 1987), *amended by* 42 U.S.C.A. § 1395dd (West Supp.1991).

2. Emergency Medical Condition and Active Labor

[1] Patients diagnosed with an "emergency medical condition" or "active labor" must either be treated or be transferred in accordance with EMTALA. Burditt claims that Rivera received all of the care that she was due under EMTALA because he stabilized her hypertension sufficiently for transfer and she was not in active labor when she left DeTar for John Sealy.

a. Unstable Emergency Medical Condition

Rivera's blood pressure was 210/130 at 4:00 and 5:00. This was the last reading known to Burditt before he facilitated her transfer. Nurses also measured her blood pressure as 173/105 at 5:30, 178/103 at 5:45, 186/107 at 6:00, and 190/110 at 6:50. Experts testified that Rivera's hypertension put her at high risk of suffering serious complications, including seizures, heart failure, kidney dysfunction, tubular necrosis, stroke, intracranial bleeding, placental abruption, and fetal hypoxia. This is substantial, if not conclusive evidence that Rivera entered and exited DeTar with an emergency medical condition.

Burditt argues that he fulfilled EMTALA's requirements with respect to Rivera's hypertension by "stabilizing" it, or

> provid[ing] such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from [a] transfer....

42 U.S.C. § 1395dd(e)(4)(A) (Supp. IV 1987), *amended by* 42 U.S.C.A. § 1395dd(e)(3)(A) (West Supp.1991). He claims that the magnesium sulfate that he ordered for Rivera has an antihypertensive effect that complements its primary anticonvulsive purpose.

Development of any of the possible complications could have killed or seriously injured Rivera, her baby, or both, and thus would constitute a "material deterioration" under 42 U.S.C. § 1395dd(e)(4)(A). Any deterioration would "result" from transfer in that Rivera would have received better ***1369** care for any complication at DeTar than in the ambulance. Thus, Burditt could not have stabilized Rivera unless he provided treatment that medical experts agree would prevent the threatening and severe consequences of Rivera's hypertension while she was in transit. DAB could properly disregard Burditt's testimony and accept that of all other testifying experts in holding that Burditt provided no such treatment, and thus did not stabilize Rivera's emergency medical condition.[FN4]

> FN4. Curiously, DAB and the parties expend considerable effort addressing whether Burditt erred by not administering the drug apresoline to Rivera to lower her blood pressure before transport. This argument could not decide whether Rivera had an emergency medical condition and whether Burditt stabilized it.

b. Active Labor

EMTALA defines "active labor" as labor [FN5] at a time when

> FN5. All agree that labor begins with the onset of uterine contractions; Rivera began experiencing contractions before Burditt examined her at 4:50. Congress explicitly recognized this definition of "labor" in revising EMTALA. *See* 42 U.S.C.A. § 1395dd(e)(1)(B) (West Supp.1991).

(B) there is inadequate time to effect safe transfer to another hospital prior to delivery, or

(C) a transfer may pose a threat [to] the health and safety of the patient or the unborn child.

42 U.S.C. § 1395dd(e)(2)(B)-(C) (Supp. IV 1987), *amended by* 42 U.S.C.A. § 1395dd(e)(1)(B) (West Supp.1991). This statutory definition renders irrelevant any medical definition of active labor. DAB affirmed the ALJ's finding that Rivera had begun active labor by the time Burditt authorized her transfer.

Though ambiguous, the foregoing section's attempt to categorize women in labor indicates that Congress intended to extend EMTALA's treatment and transfer protections to only a subset of all women in labor. Consistent with the congressional objective of facilitating the efficiency of our nation's health care system, we interpret the provision to rationally select groups most needful of EMTALA's treatment and transfer protections.

[2] Read literally, clause B confers active labor status on any woman who delivers her baby in transit. But this interpretation enshrines the use of hindsight as a legal standard and in so doing, protects an irrationally selected group of women. We think that clause B allows hospitals to transfer at will women in uncomplicated labor who, within reasonable medical probability, will arrive at another hospital before they deliver their babies. A hospital that transfers a woman in labor when the timing call mandated by clause B is close risks a battle of experts regarding anticipated delivery time, distance, and safe transport speed.

[3] Burditt challenges the ALJ's finding that, at approximately 5:00, there was inadequate time to safely transfer Rivera to John Sealy before she delivered her baby. Dr. Warren Crosby testified that, based on Burditt's own examination results,[FN6] Rivera would, more likely than not, deliver within three hours after Burditt spoke with Downing at John Sealy. This expert testimony constitutes substantial record evidence to sustain the ALJ's finding.[FN7] Burditt does not challenge DAB's conclusion that the ambulance trip from ***1370** DeTar to John Sealy takes approximately three hours. We therefore hold that DAB properly concluded that Rivera was in active labor under 42 U.S.C. § 1395dd(e)(2)(B).

FN6. Burditt's 4:50 examination revealed that Rivera had carried several pregnancies to term and that she had ruptured membranes, contractions beginning at 7:00 a.m. and becoming regular before 4:00, a cervix dilated to 3 centimeters, and a smaller-than-usual fetus.

FN7. Burditt argues that because no harm befell Rivera, the record evidence is equivocal as to whether there was inadequate time to effect a safe transfer to John Sealy. Given the emphasis of 42 U.S.C. § 1395dd(e)(2)(C) (Supp. IV 1987), *amended by* 42 U.S.C.A. § 1395dd(e)(1)(B)(ii) (West Supp.1991) on "the health and safety of the patient [and] the unborn child," we think that the word "safe" in 42 U.S.C. § 1395dd(e)(2)(B) (Supp. IV 1987), *amended by* 42 U.S.C.A. § 1395dd(e)(1)(B)(i) (West Supp.1991) describes only the type of transfer a doctor is to consider in estimating transfer time. For example, Burditt would not have been entitled to estimate that Rivera's ambulance could travel 100 miles in an hour. Whether harm actually befalls a woman in transit is irrelevant to her active labor status.

[4] The ALJ also found that Rivera was in active labor under clause C at the time Burditt examined her. There is always some risk of a vehicular accident in transit, so transfer always "may" pose a threat to the health and safety of the patient or fetus. But, as previously explained, Congress did not intend to accord active labor status to all women in labor, so we must discern what group Congress sought to protect with clause C. We have pre-

viously explained that Congress accords EMTALA's "treat or transfer" protection to those with conditions that would *seriously* impair the patient's health absent immediate medical care and those who will, within reasonable medical probability, deliver babies before safe transfer can be effected.

[5] We must "give effect, if possible, to every word Congress used." *Reiter v. Sonotone Corp.*, 442 U.S. 330, 339, 99 S.Ct. 2326, 2331, 60 L.Ed.2d 931 (1979). We can give required effect to clause C only by according active labor status to a group that would not necessarily qualify for EMTALA's "treat or transfer" protection under the definitions of emergency medical condition and active labor previously discussed.

We believe that Congress intended clause C to extend EMTALA's "treat or transfer" protection to women in labor who have any complication with their pregnancies regardless of delivery imminency. Because better medical care is available in a hospital than in an ambulance, whether a transfer "may pose a threat" under 42 U.S.C. § 1395dd(e)(2)(C) depends on whether the woman in labor has any medical condition that could interfere with the normal, natural delivery of her healthy child. Under the statutory language, a woman in labor is entitled to EMTALA's treatment and transfer protections upon a showing of possible threat; it does not require proof of a reasonable medical probability that any threat will come to fruition. *Cf.* 42 U.S.C. § 1395dd(e)(4)(A) (Supp. IV 1987), *amended by* 42 U.S.C.A. § 1395dd(e)(3)(A) (West Supp.1991) (defining stabilization in terms of "reasonable medical probability"). For women to gain EMTALA's "treat or transfer" protection under 42 U.S.C. § 1395dd(e)(2)(C), Congress rationally required less of a showing of probability and severity of harm for women in labor than the general population under its definition of emergency medical condition.

[6] The record overwhelmingly confirms that Rivera's hypertension could have interfered with a normal delivery, and she was thus in active labor under 42 U.S.C. § 1395dd(e)(2)(C).

3. Treat or Transfer

Upon discovery of active labor or an emergency medical condition, EMTALA usually requires hospitals to treat the discovered condition.[FN8] Under certain circumstances, however, EMTALA allows hospitals to transfer patients instead of treating them. 42 U.S.C. § 1395dd(b)(1)(B). Because Burditt transferred Rivera without stabilizing her, whether he violated EMTALA depends on whether the manner in which he accomplished the transfer complies with the requirements of 42 U.S.C. § 1395dd(c).

FN8. But Congress only mandates treatment "within the staff and facilities available at the hospital." 42 U.S.C. § 1395dd(b)(1) (Supp. IV 1987), *amended by* 42 U.S.C.A. § 1395dd(b)(1)(A) (West Supp.1991); *see also* H.R. REP. NO. 241, 99th Cong., 1st Sess., pt. 1, at 27, *reprinted in*, 1986 U.S. CODE CONG. & ADMIN. NEWS 42, 579, 605 (hospitals must provide treatment "within their competence"). One may prove that a hospital has violated this standard by presenting evidence that something other than the present or projected medical needs of its patients determined the treatment provided. *See Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (6th Cir.1990) (no unreasonable screening claim under EMTALA in absence of evidence that non-medical considerations affected execution of screening examination).

a. Certification

A hospital may not legally transfer someone who has an emergency medical condition which has not been stabilized or who is ***1371** in active labor unless the patient requests a transfer or

a physician ... has *signed* a *certification* that, *based upon* the reasonable risks and benefits to the patient, and *based upon* the information available at the time, the medical *benefits* reasonably expected from the provision of appropriate medical treatment at another medical facility *outweigh* the increased *risks* to the individual's medical condition from effecting the transfer....

42 U.S.C. § 1395dd(c)(1)(A)(ii) (Supp. IV 1987) (emphasis added), *amended by* 42 U.S.C.A. § 1395dd(c)(1)(A)(ii)-(iii) (West Supp.1991).

[7] A hospital may violate this provision in four ways. First, before transfer, the hospital might fail to secure the required signature from the appropriate medical personnel on a certification form. But the statute requires more than a signature; it requires a signed *certification.* Thus, the hospital also violates the statute if the signer has not actually deliberated and weighed the medical risks and the medical benefits of transfer before executing the certification.[FN9] Likewise, the hospital fails to make the certification required by 42 U.S.C. § 1395dd(c)(1)(A)(ii) if the signer makes an improper consideration a significant factor in the certification decision.[FN10] Finally, a hospital violates the statute if the signer actually concludes in the weighing process that the medical risks outweigh the medical benefits of transfer, yet signs a certification that the opposite is true.[FN11]

FN9. In revising EMTALA, Congress has expressly provided that medical personnel must make a *determination* regarding medical risks and benefits, not just sign a paper stating as much. *See* 42 U.S.C.A. § 1395dd(c)(1)(A)(iii) (West Supp.1991).

FN10. Burditt characterizes his wish to avoid a malpractice suit by Rivera as a medical reason for transferring her. We agree that a physician's belief that others are more competent to perform a required procedure is a medical reason for transfer. But if the physician instead believes that the patient is likely to sue whomever provides treatment, and transfers to avoid suit, then the reason for the transfer is financial and nonmedical. We do not reach the question of which belief Burditt held when he stated that "until DeTar pays my malpractice insurance, I will pick and choose those patients that I want to treat," because we do not understand DAB to have formally held that Burditt violated EMTALA by considering impermissible factors in weighing risks and benefits.

> While we appreciate the predicament of physicians, they may not obligate themselves to hospitals receiving federal funds without accepting EMTALA's obligations.

FN11. Evidence that a signer was aware of certain medical risks and medical benefits before making a certification decision when that person claims not to have considered those risks and benefits may be used to prove this fourth class of violation under 42 U.S.C. § 1395dd(c)(1)(A)(ii).

Whether a reasonable physician would have considered different medical factors than those considered by the signer, or would have weighted factors differently in reaching a certification decision, need not be considered in determining whether a hospital has violated 42 U.S.C. § 1395dd(c)(1)(A)(ii). The signer need not be correct in making a certification decision; the statute only requires a signed statement attesting to an actual assessment and weighing of the medical risks and benefits of transfer.

[8] We find abundant record evidence to support DAB's finding that

Burditt signed the "Physician's Certificate Authorizing Transfer" certifying that the risks of the transfer were outweighed by the benefits without actually engaging in any meaningful weighing of the

risks and benefits....

Burditt himself testified that he was completely ignorant of EMTALA's requirements and did not believe that EMTALA governed his actions. He testified: "I didn't know what I was doing, but I signed her [certification] so I could send her." In his brief to this court, he explains that he signed Rivera's certification "because [Nurse] Herman insisted." The ALJ properly disregarded Burditt's self-serving, after-the-fact justification for transferring Rivera-that DeTar lacked facilities to care for Rivera's underweight infant. The record shows that upon hearing of Rivera's condition over the telephone, Burditt made an immediate and unwavering decision to ***1372** transfer her without weighing the medical risks and benefits of transfer. Because he signed her transfer certification as a mere formality, it lacks legal effect as a certification.

Every reasonable adult, let alone physician, understands that labor evolves to delivery, that high blood pressure is dangerous, and that the desirability of transferring a patient with these conditions could well change over a two-hour period. Burditt's indifference to Rivera's condition for the two hours after he conducted his single examination demonstrates not that he unreasonably weighed the medical risks and benefits of transfer, but that he never made such a judgment. DAB's statement that Burditt certified "under circumstances where no reasonable [obstetrician] would have certified" means only that the facts of this case show certification to be so unacceptable that it is unlikely that Burditt actually made the required certification.

Thus, we affirm DAB's finding that Burditt violated EMTALA by transferring Rivera without complying with the certification requirement of 42 U.S.C. § 1395dd(c)(1)(A)(ii).

b. Transfer Appropriateness

[9] Besides certifying the medical need for transferring patients protected by EMTALA, hospitals must appropriately transfer these people. 42 U.S.C. § 1395dd(c)(1)(B). The statutory definition of appropriate transfer requires, *inter alia*, that

> the transfer [be] effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer....

42 U.S.C. § 1395dd(c)(2)(C) (Supp. IV 1987), *amended by* 42 U.S.C.A. § 1395dd(c)(2)(D) (West Supp.1991). The relative standard of EMTALA's screening and treatment requirements is conspicuously missing from this provision. *Compare* 42 U.S.C. §§ 1395dd(a), 1395dd(b)(1)(A) *with* 42 U.S.C. § 1395dd(c)(2)(C). Because Congress obviously was aware of the option of requiring only relatively qualified personnel and transportation equipment, we understand 42 U.S.C. § 1395dd(c)(2)(C) to require personnel and transportation equipment that a reasonable physician would consider appropriate to safely transport the patient in question.

As previously explained, 42 U.S.C. § 1395dd(c)(1)(A)(ii) does not require a physician to correctly ascertain all risks and benefits associated with transfer. For this reason, we think that Congress inserted "as required" in 42 U.S.C. § 1395dd(c)(2)(C) to limit the scope of the requirement of qualified personnel and equipment to those conditions known to the transferring physician.

[10] DAB correctly rejected Burditt's argument that he effected Rivera's transfer through qualified personnel and equipment by sending her to John Sealy in an ambulance that met state licensing requirements. *See* Tex. Dep't of Health, 25 TEX.ADMIN. CODE § 157.67 (West August 4, 1988) (Basic Life Support Vehicle Requirements for a Permit). The standards set by § 157.67 ensure that medical transport vehicles are adequately prepared to perform their primary function of taking people from the scene of an illness or injury to a hospital for diagnosis and treatment. EMTALA prevents patient dumping by limiting transfers of people with emer-

gency medical conditions or in active labor to those that are medically necessary and effected with qualified personnel and equipment. Section 157.67 ensures safe transfer when it is required while EMTALA limits when transfer is allowed. The purposes of these two laws do not coincide; fulfillment of one's requirements does not necessarily satisfy those of the other.

Burditt would limit the requirement of "qualified ... transportation equipment" to the transport vehicle itself, excluding all other equipment necessary to ensure safe transfer of the patient. But 42 U.S.C. § 1395dd(c)(2)(C) includes "necessary and medically appropriate life support measures" within its definition of qualified transportation equipment. Also, EMTALA's legislative history indicates that Congress***1373** intended "transfer [to] be made by proper personnel using equipment that meets health and safety standards." H.R. REP. NO. 241, 99th Cong., 1st Sess., pt. 1, at 27, *reprinted in,* 1986 U.S. CODE CONG. & ADMIN.NEWS 579, 605. We thus read "transportation equipment" to include all physical objects reasonably medically necessary for safe patient transfer.

We now consider whether DAB correctly applied 42 U.S.C. § 1395dd(c)(2)(C). The record indicates that the obstetrical nurse and two emergency medical technicians who accompanied Rivera in transit were qualified to deliver Rivera's baby in the absence of complications. But it is undisputed that they were unqualified to perform a cesarean section or treat the other complications from Rivera's hypertension that could have developed.

The ALJ could properly credit expert testimony to the effect that only a physician could have fulfilled the "qualified personnel" requirement of 42 U.S.C. § 1395dd(c)(2)(C) in this case. Likewise, expert testimony substantially supports the ALJ's finding that because he did not order a fetal heart monitor for Rivera's ambulance, Burditt failed to effect the transfer through qualified transportation equipment.

We have not found similar record support for the ALJ's statement that qualified equipment for Rivera's ambulance also included the drug pitocin and a blanket for the newborn. But, as experts, Drs. Mark D. Akin and Robert T. Greene, Jr. testified that hypertensive women face increased risk of placental abruption, and without a fetal heart monitor in the ambulance, it would be almost impossible to perceive this condition during transport. This is sufficient evidence from which the ALJ could properly conclude thata reasonable physician would have included a fetal heart monitor as *equipment* to ensure Rivera's safe transfer.

We therefore affirm the ALJ's finding that Burditt violated the appropriate-transfer requirement of 42 U.S.C. § 1395dd(c)(1)(B).

4. Improper Motive

[11] Burditt asks this court to invent a requirement found nowhere in the statute that an improper, or nonmedical, motive for transfer must be proved as an element of all EMTALA transfer violations. As written, EMTALA prevents patient dumping without such a requirement. *See* H.R.REP. NO. 241, 99th Cong., 1st Sess., pt. 1, at 27, *reprinted in,* 1986 U.S.CODE CONG. & ADMIN.NEWS 579, 605 (Congress sought to prevent patient dumping with EMTALA). We refuse to alter the statutory scheme. *Cf. Cleland,* 917 F.2d at 269-70 (refusing to find that EMTALA covers only the indigent and uninsured absent explicit statutory limitation).

B. CIVIL MONEY PENALTY

DAB affirmed the ALJ's decision to fine Burditt $20,000 under 42 U.S.C. § 1395dd(d)(2) (Supp. IV 1987), *amended by* 42 U.S.C.A. § 1395dd(d)(1)(B)-(C) (West Supp.1991), which provides that

a participating hospital that knowingly violates a requirement of this section and the responsible physician in the hospital with respect to such a violation are each subject ... to a civil money penalty of

not more than $25,000 for each such violation.

Burditt proffers several reasons why he should not be fined under this statute; we reject them all.

1. Responsible Physician

[12] The "responsible physician" subject to EMTALA's civil penalties is defined as one who

(A) is employed by, or under contract with, the participating hospital, and

(B) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred.

42 U.S.C. § 1395dd(d)(2) (Supp. IV 1987), *amended by* 42 U.S.C.A. § 1395dd(d)(1)(B)-(C) (West Supp.1991).

Burditt asserts that under controlling Texas law, he is not "under contract" with ***1374** DeTar. But "[i]n the absence of a plain indication to the contrary, ... it is to be assumed when Congress enacts a statute that it does not intend to make its application dependent on state law." *Dickerson v. New Banner Inst., Inc.*, 460 U.S. 103, 119, 103 S.Ct. 986, 995, 74 L.Ed.2d 845 (1983), quoting *NLRB v. Natural Gas Utility Dist.*, 402 U.S. 600, 603, 91 S.Ct. 1746, 1748, 29 L.Ed.2d 206 (1971). Burditt offers nothing in EMTALA's language, purpose, or legislative history to indicate that Congress intended state law to determine when a physician is under contract with a hospital. We recognize no reason for conditioning the applicability of EMTALA's civil penalty provision on the vagaries of the several state laws. Equivalent violative actions by physicians should be deterred with equivalent fines. *See Clearfield Trust Co. v. United States*, 318 U.S. 363, 367, 63 S.Ct. 573, 575, 87 L.Ed. 838 (1943). DAB correctly held that federal law controls the issue of whether a physician is "under contract" with a hospital for purposes of 42 U.S.C. § 1395dd(d)(2).

[13][14] We also agree with DAB that a physician is "under contract" with a hospital when, pursuant to their mutual agreement, the physician examines and treats or transfers people who are covered by EMTALA, regardless of whether the agreement refers to EMTALA. In his 1974 application to DeTar for staff privileges, Burditt agreed to be bound by DeTar's bylaws. Pursuant to those bylaws, Kotsur took Burditt's name from DeTar's call-list of physicians responsible for unaligned obstetrical patients. Burditt falls squarely within EMTALA's definition of a responsible physician.

2. DeTar's EMTALA Violation

[15] Under 42 U.S.C. § 1395dd(d)(2), responsible physicians may be fined only "with respect to" a hospital's knowing EMTALA violation. Burditt complains that DeTar was not joined as a party to the proceedings against him. But unless the Inspector General seeks a civil penalty against it, the hospital need not be party to a proceeding against a physician. Adjudication of hospital liability in such a proceeding is merely an element in the case against the physician and is not binding on the hospital.

[16] DAB correctly held that hospital physicians who treat patients in fulfillment of their contractual responsibilities are the hospital's agents for purposes of such treatment. Because hospitals can act and know things only vicariously through individuals, *see United States v. A & P Trucking Co.*, 358 U.S. 121, 125, 79 S.Ct. 203, 206, 3 L.Ed.2d 165 (1958), any EMTALA violation by such a physician is also a violation by the hospital. Thus, record evidence of Burditt's knowing EMTALA violation is evidence of DeTar's knowing violation.

3. Requisite Mental State

[17] A responsible physician may be fined only if that person "knowingly violated [an EMTALA] requirement." 42 U.S.C. § 1395dd(d)(2) (Supp. IV 1987), *amended by* 42 U.S.C.A. §

1395dd(d)(1)(B)-(C) (West Supp.1991). By making the object of the knowing violation EMTALA's *requirements* as opposed to EMTALA itself, Congress predicated liability on a physician's violative action or inaction undertaken with knowledge of *facts* such that the action or inaction constitutes a violation. Liability attaches regardless of the physician's understanding of the statute.

The ALJ interpreted the word "knowingly" in conformance with the False Claims Act, 31 U.S.C.A. § 3729(b) (West Supp.1991), and held that it encompasses actual knowledge, deliberate ignorance, and reckless disregard of operative facts. All agree that actual knowledge and deliberate ignorance of operative facts can form the basis of a knowing violation, but Burditt challenges the ALJ's determination that action taken while recklessly disregarding such facts is also sufficient. We presently decline to decide whether liability under EMTALA may be predicated on a physician's reckless disregard of operative facts.

DAB found that, in at least one manner, Burditt violated EMTALA because he actually knew all facts necessary to establish the violation. Thus, the ALJ's legal interpretation***1375** of "knowingly" was unnecessary to this case's outcome. Moreover, Congress has since amended EMTALA to allow the federal government to fine physicians who negligently violate EMTALA's requirements. 42 U.S.C.A. § 1395dd(d)(1)(B) (West Supp.1991). Thus, it is not clear that the mental-state question posed by Burditt will ever need to be answered by a court.

By examining Rivera, Burditt gained actual knowledge of her hypertension and labor, which DAB correctly labeled an emergency medical condition and active labor. Burditt stipulated that he arranged for and ordered Rivera's transfer. We have previously affirmed DAB's finding that Burditt did not engage in the weighing process that we hold to be required by 42 U.S.C. § 1395dd(c)(1)(A)(ii). Because the requisite weighing process is a mental exercise, it must be true that Burditt actually knew that he did not weigh the medical risks and benefits to Rivera from the transfer in deciding to transfer her. In this way, Burditt knowingly violated EMTALA's requirements by transferring Rivera while aware of the facts that made his transfer a violation.

Burditt argues that he cannot be fined under EMTALA because he transferred Rivera in a good-faith effort to protect her underweight infant. But nothing in EMTALA admits the existence of a good-faith exception.

We affirm DAB's conclusion that Burditt knowingly violated an EMTALA requirement.

4. Aggravating and Mitigating Circumstances

[18] DAB's final $20,000 penalty assessment against Burditt comports with EMTALA's limit of $25,000 per knowing violation and our verification of at least one knowing violation. *See* 42 U.S.C. § 1395dd(d)(2) (Supp. IV 1987), *amended by* 42 U.S.C.A. § 1395dd(d)(1)(B)-(C) (West Supp.1991). EMTALA provides no standard for deciding civil sanction amounts, but it includes its provisions as "grounds for imposition of a civil money penalty under section 1320a-7a(a) of [title 42]." *Id.* And 42 C.F.R. § 1003 implements 42 U.S.C.A. § 1320a-7a(a) (West Supp.1991). 42 C.F.R. § 1003.100(a). Thus, we agree with DAB that while parts of 42 C.F.R. § 1003 are plainly inapplicable to EMTALA actions, the ALJ could properly determine Burditt's fine amount using 42 C.F.R. § 1003.106(b)(5), which states:

circumstances of an aggravating or mitigating nature should be taken into account if, in the interests of justice, they require either a reduction of the penalty ... or an increase in order to assure the achievement of the purposes of this part.

Congress intended EMTALA's civil sanctions largely to deter violations. H.R. REP. NO. 241, 99th Cong., 1st Sess., pt. 3, at 7, *reprinted in*, 1986 U.S. CODE CONG. & ADMIN.NEWS 726, 729.

Although 42 C.F.R. § 1003.106(b)(5) does not express the most determinate of standards, the Supreme Court teaches that
where Congress has entrusted an administrative agency with the responsibility of ... achieving the statutory policy "the relation of remedy to policy is peculiarly a matter for administrative competence."

Butz v. Glover Livestock Commission Co., 411 U.S. 182, 185, 93 S.Ct. 1455, 1458, 36 L.Ed.2d 142 (1973) quoting *American Power & Light Co. v. SEC*, 329 U.S. 90, 112, 67 S.Ct. 133, 146, 91 L.Ed. 103 (1946). We will affirm DAB's determination of the penalty amount unless, based on the totality of the record, its decision constitutes an abuse of discretion. *Butz*, 411 U.S. at 188, 93 S.Ct. at 1459.

As aggravating circumstances, the ALJ found that Burditt: 1) did not examine Rivera after his initial examination; 2) did not attempt to consult another doctor; 3) did not read the copy of the law given to him by Herman; and 4) did not treat Rivera upon her return to DeTar. As mitigating circumstances, the ALJ found that: 1) Rivera had received no prenatal care; 2) DeTar had no medical records of Rivera's health history; and 3) Burditt has instituted corrective measures to prevent future illegal transfers from DeTar.

We agree with DAB that substantial record evidence establishes the existence of ***1376** all of the circumstances found to be aggravating or mitigating. We also agree that the ALJ properly characterized four of Burditt's acts as aggravating circumstances because they demonstrate flagrant disregard for the anti-dumping principles that Congress enshrined in EMTALA. Similarly, we think that DAB correctly held that a patient's lack of prenatal care or medical records cannot operate as a mitigating circumstance without undermining EMTALA's primary, though not exclusive, purpose of protecting the indigent. *See Johnson v. American Airlines, Inc.*, 745 F.2d 988, 992 (5th Cir.1984) (court's objective in statutory interpretation "is to ascertain congressional intent and give effect to legislative will"), *cert. denied*, 472 U.S. 1027, 105 S.Ct. 3500, 87 L.Ed.2d 631 (1985).

We find no error in DAB's conclusion as to the amount of Burditt's sanction.

C. EMTALA'S CONSTITUTIONALITY

[19] As his final attempt to escape DAB's assessment, Burditt claims that EMTALA effects a public taking of his services without just compensation in contravention of the Constitution's Fifth Amendment.

Assuming *arguendo* that professional services constitute property protected by the Takings Clause,[FN12] Burditt has not shown that EMTALA effects a taking. EMTALA imposes no responsibilities directly on physicians; it unambiguously requires *hospitals* to examine and stabilize, treat, or appropriately transfer all who arrive requesting treatment. Its provision for sanctions against physicians who knowingly violate its requirements is merely an enforcement mechanism that does not alter its explicit assignment of duties.

> FN12. *But see White v. United States Pipe & Foundry Co.*, 646 F.2d 203, 205 n. 3 (5th Cir. Unit B 1981) (attorney services not protected property under Fifth Amendment's Takings Clause).

Governmental regulation that affects a group's property interests "does not constitute a taking of property where the regulated group is not required to participate in the regulated industry." *Whitney v. Heckler*, 780 F.2d 963, 972 (11th Cir.) (temporary freeze of Medicare payments is no taking because physicians are not required to treat Medicare patients), *cert. denied*, 479 U.S. 813, 107 S.Ct. 65, 93 L.Ed.2d 23 (1986); *accord Minnesota Ass'n of Health Care Facilities, Inc. v. Minnesota Dep't of Public Welfare*, 742 F.2d 442, 446 (8th Cir.1984) (state law limiting fees that nursing homes voluntarily participating in Medicaid may charge non-Medicaid patients effects no taking "[d]espite the strong financial inducement to participate in Medi-

caid"), *cert. denied*, 469 U.S. 1215, 105 S.Ct. 1191, 84 L.Ed.2d 337 (1985).

Two levels of voluntariness undermine Burditt's taking assertion. Only hospitals that voluntarily participate in the federal government's Medicare program must comply with EMTALA. *See* 42 U.S.C. § 1395cc(a)(1)(I) (West Supp.1991) (hospitals eligible to receive Medicare payments if they agree, *inter alia*, to comply with EMTALA). Hospitals must consider the cost of complying with EMTALA's requirements in deciding whether to continue to participate in the Medicare program.

Second, Burditt is free to negotiate with DeTar or another hospital regarding his responsibility to facilitate a hospital's compliance with EMTALA. Thus, physicians only voluntarily accept responsibilities under EMTALA if they consider it in their best interest to do so. Accordingly, Burditt's claim under the Takings Clause is without merit.

III. CONCLUSION

The determination of the Secretary through his Departmental Appeals Board is AFFIRMED and ENFORCED.

C.A.5,1991.
Burditt v. U.S. Dept. of Health and Human Services
934 F.2d 1362, 60 USLW 2075, 33 Soc.Sec.Rep.Serv. 566, Med & Med GD (CCH) P 39,476

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Office of the Inspector General
US Department of Health & Human Services
Civil Monetary Penalties and Affirmative Exclusions

The Office of Inspector General (OIG) has the authority to seek civil monetary penalties (CMPs), assessments, and exclusion against an individual or entity based on a wide variety of prohibited conduct. In each CMP case resolved through a settlement agreement, the settling party has contested the OIG's allegations and denied any liability. No CMP judgment or finding of liability has been made against the settling party.

OIG Enforcement Cases Relating to EMTALA

The cases listed below represent recently-closed cases initiated by the OIG's Office of Counsel to the Inspector General. To view additional cases, visit
https://oig.hhs.gov/fraud/enforcement/cmp/cmp-ae.asp

04-02-2018 - North Carolina Hospital Settles Case Involving Patient Dumping Allegations

On April 2, 2018, Southeastern Regional Medical Center (SRMC), Lumberton, North Carolina, entered into a $200,000 settlement agreement with OIG. The settlement resolves allegations that, based on OIG's investigation, SRMC violated the Emergency Medical Treatment and Labor Act (EMTALA) when it failed to provide an appropriate medical screening exam, stabilizing treatment, and/or an appropriate transfer for four individuals.

Specifically, in the following two instances, SRMC failed to provide an appropriate medical screening examination and/or stabilizing treatment. The first patient, a 71-year-old male who had been living independently, presented to SRMC's Emergency Department (ED) on January 21, 2016, complaining of leg pain, weakness, inability to walk, and a drastic change in behavior and functioning. His daughter reported that he was occasionally disoriented, but that he had just made a trip to visit her and was in good health. The ED physician ordered labs and IV fluids. After about ten hours, the patient was discharged with a diagnosis of dehydration and weakness. Less than six hours later, the patient returned to the ED with similar symptoms and complaints. This time, another ED physician diagnosed the patient with a traumatic subdural hemorrhage and transferred the patient for brain surgery. At the receiving hospital, the patient remained in critical condition for two weeks with diagnoses of acute respiratory failure, possible stroke, and seizures. The patient passed away the following week. The second patient, a 49-year-old male, presented to SRMC's ED on August 27, 2015, with lethargy and overdose of multiple medications. The patient said he was depressed and expressed suicidal ideations. The ED physician ordered blood and urine tests, an EKG, and a head CT, and noted the patient had a history of depression and chronic back pain. The patient was placed on suicide precaution watch, but no psychiatric evaluation was ordered. The patient was discharged about 4.5 hours later with diagnoses of polypharmacy and asthenia with discharge instructions for near-syncope and weakness. Four days later, the patient died due to a self-inflicted gunshot wound to the head.

In two additional instances, SRMC failed to meet its EMTALA obligations when it failed to re-evaluate the patient at the time of transfer to determine whether: (1) the benefits to each patient continued to outweigh the risks, (2) the previous arrangements for appropriate personnel and transportation equipment were appropriate given the patient's deterioration, and (3) additional medical treatment was needed to minimize the risks to the individual's health, and in the case of a woman in labor, the health of the unborn child. The third patient, a 44-year-old female, presented to SRMC's ED on February 28, 2014 at 3:38 p.m. for evaluation of an altered mental status when she was found unresponsive with an empty bottle of butalbital beside her. A CT scan revealed an extensive acute subarachnoid hemorrhage with possible artery aneurysm bleed. At 9:30 p.m., the ED physician certified that the medical benefits of neurosurgery at a hospital over 122 miles away outweighed the risks of transfer. However, the patient was not transferred until 2:16 a.m. the following day, when her condition had significantly deteriorated. The fourth patient, a 26-year-old who was 28 weeks pregnant, presented to the ED on March 13, 2014 with a complaint of ruptured membranes and lower back discomfort. The ED physician examined the patient at 11:15 a.m. and determined that her unborn child required tertiary services not available at SRMC and certified that the medical benefits of delivery at a hospital over 80 miles away outweighed the risks of transfer. However, the patient was not transferred until 1:00 p.m. Between the time of the ED physician's certification and the patient's transfer, the patient continued to have contractions. Senior Counsel Sandra Sands and Associate Counsel Matthew J. Westbrook represented OIG.

06-23-2017 - South Carolina Hospital Settles Case Involving Patient Dumping Allegations

On June 23, 2017, AnMed Health (AnMed), in Anderson, South Carolina, entered into a $1,295,000 settlement agreement with OIG. The settlement agreement resolves allegations that, in 36 incidents investigated by OIG, AnMed violated the Emergency Medical Treatment and Labor Act (EMTALA). In these incidents, individuals presented to AnMed's Emergency Department (ED) with unstable psychiatric emergency medical conditions. Instead of being examined and treated by an on-call psychiatrist, and despite empty beds in its psychiatric unit to which the patients could have been admitted for stabilizing treatment, the patients were involuntarily committed and kept in AnMed's ED for between 6 and 38 days each. The following is an example of one such incident. A patient presented to AnMed's ED via law enforcement with psychosis and homicidal ideation and was involuntarily committed. The patient did not receive psychiatric examination or treatment by available AnMed psychiatrists and was not admitted to the psychiatric unit for stabilizing treatment. Instead, the patient was kept in the ED for 38 days and at one point was seen by a psychiatrist from another facility that was familiar with her condition. The psychiatrist prescribed a variety of medications for agitation. The patient eventually was discharged home. Senior Counsel Sandra Sands represented OIG.

05-12-2017 - Georgia Hospital Settles Case Involving Patient Dumping Allegation

On May 12, 2017, Monroe County Hospital (MCH) in Forsyth, Georgia, entered into a $25,000 settlement agreement with OIG. The settlement agreement resolves allegation that MCH violated the Emergency Medical Treatment and Labor Act when it failed to provide an appropriate medical screening examination and stabilizing treatment for a woman who presented to MCH's Emergency Department (ED) complaining she was 36 weeks pregnant and her water had broken. The patient told a nurse that she wanted to see her physician in Macon, Georgia. Without providing a medical screening examination, ED staff decided that the patient could go see her physician in Macon. The patient was then escorted to her car and told to call 911. Emergency medical services arrived and found the patient in her car. She was brought to another hospital where she delivered her child within an hour of arriving. Under EMTALA, a small hospital can be fined up to $25,000 per violation. Associate Counsel Srishti Sheffner represented OIG.