Medical Malpractice or Patient Dumping: New Hampshire's Experience with EMTALA

By:

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I. Introduction

Over thirty years ago, Congress enacted the Emergency Medical Treatment and Active Labor Act ("EMTALA") in response to highly publicized incidents where hospitals were caught refusing service to indigent patients and even removing them from their premises and "dumping" them in areas with a large homeless population. EMTALA was intended to close a perceived loophole in state law civil liability which generally did not apply to claims alleging a failure to treat. Although EMTALA was not meant to displace state malpractice liability, but rather to supplement it, there has been some confusion about its reach. Two cases from New Hampshire illustrate the distinction between a proper EMTALA claim and a claim subject only to state malpractice law.

II. Background

In the 1980s, Congress grew concerned with "the increasing number of reports that hospital emergency rooms [were] refusing to accept or treat patients with emergency conditions if the patient [did] not have medical insurance."[1] To combat this practice of "patient dumping," Congress enacted EMTALA as a part of the Consolidated Omnibus Reconciliation Act ("COBRA") in 1986.[2] EMTALA created a new cause of action that was "generally unavailable under state tort law, for what amounts to failure to treat."[3] Congress simultaneously amended the Social Security Act, conditioning hospitals' continued participation in the Medicare Program on their acceptance of the new duties imposed by EMTALA.[4]

III. Application of EMTALA

To establish a cause of action for damages under EMTALA, Congress requires plaintiffs to show three things: (1) the hospital is a participating hospital, covered by EMTALA, that operates an emergency department;[5] (2) the plaintiff arrived at the facility seeking treatment; and (3) the hospital either (a) did not afford the patient an appropriate screening in order to determine if she had an emergency medical condition, or (b) released the patient without first stabilizing the emergency medical condition.[6]

A. Appropriate Screening

Under subsection (a) of EMTALA, participating hospitals are required to afford an appropriate medical screening that is within the hospital's capabilities to all persons who come to their emergency room seeking medical assistance.[7] This provision "obligates hospitals to screen only those individuals who present themselves at the emergency department."[8]

Of note, a plaintiff need not show that he or she suffered from an emergency medical condition at the time he or she arrived to the hospital's emergency department to establish an appropriate screening claim.[9] Instead, EMTALA requires participating hospitals to appropriately screen every patient that enters their emergency rooms "whether or not they are in the throes of a medical emergency when they arrive."[10] A participating hospital's failure to appropriately screen "by itself is sufficient to ground liability" so long as the other elements of the inappropriate screening claim are satisfied.[11]

Although EMTALA does not define "appropriate medical screening" courts have found that a participating hospital is required to provide an examination that is "reasonably calculated to identify critical medical conditions that may be afflicting symptomatic patients and provides that level of screening uniformly to all those who present substantially similar complaints."[12] Put simply, EMTALA requires "that there be some screening procedure, and that it be administered even-handedly."[13]

In determining whether a hospital provided uniform screening, courts consider "[w]hether a hospital's existing screening protocol was followed in a circumstance where triggering symptoms were identified by hospital emergency room staff…"[14] When a hospital establishes policies for screening examinations, it "defines which procedures are within its capabilities" and "set[s] the parameters for an appropriate screening."[15] Accordingly, a hospital violates EMTALA's screening requirement when it fails to provide its own standard screening examination to all similarly situated patients.[16]

Importantly, courts have refused to interpret EMTALA as a "substitute for state law medical malpractice actions."[17] Indeed, "every court that has considered EMTALA has disclaimed any notion that it creates a general federal cause of action for medical malpractice in emergency rooms."[18] EMTALA does not guarantee all patients a proper diagnosis or even that they receive adequate care.[19] Therefore, a faulty screening, "as opposed to disparate screening or refusing to screen at all, does not contravene the statute."[20] The Fourth Circuit emphasized that:

> EMTALA is implicated only when individuals who are *perceived* to have the same medical condition receive disparate treatment; it is not implicated whenever individuals who turn out *in fact* to have had the same condition receive disparate treatment. The Act would

> otherwise become indistinguishable from state malpractice law. As a result, when an exercise in medical judgment produces a given diagnosis, the decision to prescribe a treatment responding to the diagnosis cannot form the basis of an EMTALA claim of inappropriate screening…In fact, not only does treatment based on diagnostic medical judgment not violate the Act, it is precisely what EMTALA hoped to achieve—handling of patients according to an assessment of their medical needs, without regard to extraneous considerations such as their ability to pay.[21]

Thus, A hospital's failure to follow its standard screening procedures where no identifiable triggering symptoms were presented does not rise to an EMTALA violation.[22] Similarly, a hospital is not liable under EMTALA if it follows its standard screening procedures and identifiable triggering symptoms were presented but the patient is misdiagnosed.[23]

As the Eighth Circuit succinctly held, "instances of 'dumping,' or improper screening of patients for a discriminatory reason, or failure to screen at all, or screening a patient differently from other patients perceived to have the same condition, all are actionable under EMTALA. But instances of negligence in the screening or diagnostic process, or of mere faulty screening, are not."[24]

B. Duty to Stabilize

Under subsections (b) and (c), if any individual presents to a participating hospital and the hospital determines that an emergency condition exists, the hospital must render the services that are necessary to stabilize the patient's condition, unless transferring the patient to another facility is medically indicated and can be accomplished with relative safety.[25] Unlike subsection (a), a participating hospital's duties are not limited to those patients that present to the emergency department for evaluation.[26]

The First Circuit has explained that a hospital's duty to stabilize under EMTALA:

> does not impose a standard of care prescribing how physicians must treat a critical patient's condition while he remains in the hospital, but merely prescribes a precondition the hospital must satisfy before it may undertake to transfer the patient. Thus, a hospital cannot violate the duty to stabilize unless it transfers a patient as that procedure is defined in EMTALA. [27]

Moreover, hospitals are not liable under EMTALA for failing to stabilize unknown conditions or those conditions which it negligently failed to diagnose.[28] In order to violate EMTALA's stabilization provision, a hospital

must have actual knowledge of the medical condition and nevertheless fail to do anything to stabilize.[29] If the hospital has actual knowledge of the emergency medical condition, it must then provide "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 for transfer of the individual to another medical facility."[30] EMTALA defines "to stabilize" as providing the medical treatment that "may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual…"[31]

C. Proof of Indigence or Improper Motive Not Required

Although EMTALA was enacted to stop the practice of patient dumping of poor or uninsured patients, "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." [32] In other words, to succeed on an EMTALA claim, a plaintiff need not prove that he or she was turned away or provided disparate treatment because of his or her indigence or inability to pay. In fact, EMTALA does not require the plaintiff to prove any improper motive on the part of the hospital. [33] By its terms, EMTALA's screening provision applies to "any individual" who comes to the hospital's emergency room and its stabilization provision applies to "any individual" that comes to the hospital.[34] Thus, while EMTALA undoubtedly covers those patients that are "dumped" for monetary reasons, "[t]he question is not whether a plaintiff has insurance, or whether he was refused screening because of lack of insurance, but, rather, whether he was afforded an 'appropriate' medical screening examination."[35]

IV. New Hampshire Cases

In *Foord v. Capital Region Health Care Corp.,* [36] a recent decision issued by our federal district court, the court distinguished EMTALA's stabilization claim from ordinary medical negligence claims. In *Foord*, the patient presented to Concord Hospital's Emergency Department with neurological symptoms and underwent a number of tests and consultations before she was incorrectly diagnosed and discharged.[37] At the time of discharge, the patient was asymptomatic, ambulatory, and stable. The patient died days later from a subarachnoid hemorrhage.[38] The patient's husband sued Concord Hospital, among others, for medical malpractice and EMTALA violations and Concord Hospital moved for summary judgment on the EMTALA claims. The plaintiff argued that his wife's hemorrhage was an emergency medical condition that Concord Hospital failed to stabilize before discharging her. [39] The court rejected the plaintiff's "tautological" argument because "under that reasoning,

any medical malpractice case in which the doctors failed to correctly diagnose an emergency condition and thereafter released the patient would trigger EMTALA" and this did not "reflect the legal requirements under EMTALA."[40] In granting Concord Hospital's motion, the court found that because Concord Hospital did not diagnose a subarachnoid hemorrhage, its conduct was reasonable in light of its diagnosis.[41] The court's holding permitted the plaintiff to refile the estate's medical malpractice claims in state court.

On the other hand, in *Carlisle v. Frisbie Mem'l Hosp.*,[42] our supreme court addressed a situation in which EMTALA's stabilization provisions were found to have been violated. In *Carlisle*, the plaintiff presented to Frisbie's emergency room after becoming intoxicated and increasingly suicidal.[43] An emergency physician offered the plaintiff counseling from a local guidance center and although the plaintiff declined, she expressed a willingness to be seen by any other counselor or psychologist.[44] Instead, the emergency physician called the police and the plaintiff was arrested and taken to the Strafford County Jail, where she remained for fourteen hours without medical treatment.[45] The plaintiff sued Frisbie, alleging, among other things, that it failed to stabilize her in violation of EMTALA and the jury awarded a verdict for the plaintiff. Frisbie appealed the judgment and the trial court's denial of its motion for directed verdict, arguing, in part, that the plaintiff did not present sufficient evidence for the jury to conclude that Frisbie failed to stabilize the plaintiff.[46]

In upholding the trial court's denial of Frisbie's motion for directed verdict, the court first considered whether the evidence could support a finding that the plaintiff suffered from an emergency medical condition when she presented to Frisbie.[47] The plaintiff presented expert testimony that intoxicated and suicidal patients are regularly found in emergency rooms and such patients require close monitoring because they pose a risk to themselves.[48] The plaintiff also presented expert testimony that emergency physicians monitor drunk patients to watch for signs of alcohol withdrawal.[49] Moreover, a defense expert testified that there was concern for the patient's safety. The court found this evidence to be sufficient to support a finding that the plaintiff had an emergency medical condition when she presented to Frisbie.[50]

The court next examined whether the plaintiff was properly stabilized before her transfer to the Strafford jail, noting that "a psychiatric patient is stable for purpose of discharge under EMTALA 'when he/she is no longer considered to be a threat to him/herself or others.'"[51] The court found that the evidence supporting the patient's failure to stabilize claim included:

- Frisbie's defense expert testimony that the plaintiff needed stabilization for her suicidal thoughts and intoxication and that she was unstable, which was a threat to her life.
- The plaintiff's medical records indicating that the plaintiff was unstable.
- The plaintiff's testimony that the only thing the emergency physician did prior to calling the police was briefly examine her and offer counseling from the local guidance center.[52]

In light of this evidence, the court declined to overturn the trial court's denial of Frisbie's motion for directed verdict.[53]

V. Conclusion

As the foregoing New Hampshire cases show, it is easy to blur the lines between medical malpractice claims and EMTALA claims because oftentimes, a hospital's standard screening protocols also represent the applicable standard of care in a malpractice case. However, these claims are distinct and EMTALA ultimately fills a narrow gap by providing a civil remedy where state law does not.

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[1] H.R. Rep. No. 241(I), 99th Cong., 1st Sess. 27 (1986), reprinted in 1986 U.S.C.C.A.N. 42, 605.
[2] *See Marshall v. East Carroll Parish Hosp.*, 134 F.3d 319, 322 (5th Cir. 1998) (stating EMTALA was enacted to prevent patient dumping, the "practice of refusing to treat patients who are unable to pay"); *Summers v. Baptist Medical Ctr. Arkadelphia*, 91 F.3d 1132, 1136 (8th Cir. 1996) (acknowledging purpose of EMTALA was to address the narrow problem of dumping uninsured, underinsured, or indigent patients); *Correa v. Hosp. San Francisco*, 69 F.3d 1184, 1189 (1st Cir. 1995) (noting Congress's intent in passing EMTALA); *Vickers v. Nash Gen. Hosp.*, 78 F.3d 139, 142 (4th Cir. 1996) (reiterating purpose of EMTALA was to address patient dumping); *Baber v. Hospital Corp. of America*, 977 F.2d 872, 884 (4th Cir. 1992) (explaining EMTALA was intended to "Send a clear signal to the hospital community…that all Americans, regardless of wealth or status, should know that a hospital will provide what serice it can when are truly in physical distress"); *Gatewood v. Washington Healthcare Corp.*, 33 F.2d 1037, 1039 (D.C. Cir. 1991) (explaining EMTALA was passed "amid growing concern over the availability of emergency health care services to the poor and uninsured" and was "designed principally to address the problem of "patient dumping"); *Foord v. Capital Region Health Care Corp.*, No. 17-cv-596-AJ, 2020 U.S. Dist. LEXIS 16620 at *7 (D. N.H. Jan. 27, 2020) (noting EMTALA was the congressional response to hospital emergency rooms refusing to treat patients without insurance); *Nichols v. Estabrook*, 741 F. Supp. 325, 329 (D. N.H. 1989) (stating that the "section of COBRA relevant to this case, the Emergency Medical Treatment and Active Labor Act, was enacted to combat the growing problem of "patient dumping").
[3] *Gatewood v. Washington Healthcare Corp.*, 33 F.2d 1037, 1041 (D.C. Cir. 1991).
[4] *See Correa v. Hosp. San Francisco*, 69 F.3d 1184, 1189 (1sr Cir. 1995).
[5] Generally-speaking, a hospital is subject to EMTALA if it participates in the federal Medicare program. *See Carlisle v. Frisbie Mem'l Hosp.*, 152 N.H. 762, 767 (2005). It may seem obvious that the defendant hospital in an EMTALA violation claim is a participating hospital given the widespread participation of hospitals in the federal Medicare program. However, the plaintiff is still required to prove that the hospital is, in fact, subject to EMTALA. In *Carlisle,* the defendant hospital appealed the trial court's denial of a motion for directed verdict, arguing, in part, that the plaintiff failed to establish that Frisbie Memorial Hospital was a participating hospital. This argument was ultimately rejected by our supreme court because this issue was not raised at

trial. Nevertheless, it is important to remember to establish each element of the EMTALA claim, regardless of how obvious it may seem. *See id.*
[6] *See* 42 U.S.C. §1395dd; *Foord v. Capital Region Health Care Corp.*, No. 17-cv-596-AJ, 2020 U.S. Dist. LEXIS 16620 (D. N.H. Jan. 27, 2020).
[7] *See* 42 U.S.C. §1395dd(a). 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 title [42 USCS §§ 1395 et seq.]) 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.

Id.
[8] *Lopez-Soto v. Hawayek*, 175 F.3d 170, 173 (1st Cir. 1999) (emphasizing that a hospital's duty under subsection (a) only applies to those patients that present to the emergency department); *Baber v. Hospital Corp. of America*, 977 F.2d 872, 884 (4th Cir. 1992) (finding that a "hospital's duty to provide an appropriate medical screening arises only if the patient seeks treatment from the emergency department").
[9] *See Correa v. Hosp. San Francisco*, 69 F.3d at 1192 n. 5 (rejecting other courts' interpretation that a plaintiff must show that he or she had a medical emergency on arrival to ER as an ingredient of an inappropriate screening claim).
[10] *Id.*
[11] *Id.* at 1190.
[12] *Correa v. Hosp. San Francisco*, 69 F.3d 1184, 1190 (1st Cir. 1995).
[13] *Id.*; *see also Baber v. Hospital Corp. of America*, 977 F.2d at 879 (holding that the plain language of EMTALA requires hospitals to develop screening procedures and apply the procedure uniformly).
[14] *Foord v. Capital Region Health Care Corp.*, No. 17-cv-596-AJ, 2020 U.S. Dist. LEXIS 16620 at *9 (citing *Cruz-Vazquez v. Mennonite Gen. Hosp., Inc.,* 717 F.3d 63, 68-69 (1st Cir. 2013) (quoting *Correa v. Hosp. San Francisco*, 69 F.3d 1184, 1190 (1st Cir. 1995)).
[15] *Cruz-Quiepo v. Hosp. Espanol Auxilio Mutuo de P.R.,* 417 F.3d 67, 70 (1st Cir. 2005); *Correa v. Hosp. San Francisco*, 69 F.3d at 1193; *Repp v. Andarko Mun. Hosp.*, 43 F. 3d at 521; *Gatewood v. Washington Healthcare Corp.*, 33 F.2d at 1041 (explaining "what constitutes an 'appropriate' screening is properly determined not by reference to particular outcomes, but instead by reference to a hospital's standard screening procedures").
[16] *See Battle v. Memorial Hosp.*, 228 F.3d 554, 558 (5th Cir. 2000) (finding "evidence that a hospital did not follow its own screening procedures can support a finding of EMTALA liability for disparate treatment"); *Repp v. Andarko Mun. Hosp.*, 43 F. 3d at 521 (concluding that "a hospital violates section 1395dd(a) when it does not follow its own standard procedures"); *Gatewood v. Washington Healthcare Corp.*, 33 F.2d at 1041 (explaining "a hospital fulfills the 'appropriate medical screening" requirement when it conforms in its treatment of a particular patient to its standard screening procedures. By the same token, any departure from standard screening procedures constitutes inappropriate screening in violation of the Emergency Act").
[17] *Power v. Arlington Hosp. Ass'n.*, 42 F.3d 851, 856 (4th Cir. 1994); *see also Reynolds v. MaineGeneral Health*, 218 F.3d 78, 83 (1st Cir. 2000) (emphasizing that "EMTALA is a limited 'anti-dumping' statute, not a federal malpractice statute").
[18] *Summers v. Baptist Medical Ctr. Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996).
[19] *See Baber v. Hospital Corp. of America*, 977 F.2d 872, 880 (4th Cir. 1992).
[20] *Correa v. Hosp. San Francisco*, 69 F.3d 1184, 1192-93 (1st Cir. 1995).
[21] *Vickers v. Nash Gen. Hosp.*, 78 F.3d 139, 142 (4th Cir. 1996).
[22] *See id.*
[23] *See Reynolds v. MaineGeneral Health*, 218 F.3d 78, 83 (1st Cir. 2000); *Marshall v. East Carroll Parish Hosp. Serv. Dist.*, 134 F.3d 319, 323 (5th Cir. 1998)(clarifying that "a treating

physician's failure to appreciate the extent of the patient's injury or illness, as well as a subsequent failure to order an additional diagnostic procedure, may constitute negligence or malpractice but cannot support an EMTALA claim for inappropriate screening").

[24] *Summers v. Baptist Medical Ctr. Arkadelphia*, 91 F.3d 1132, 1139 (8th Cir. 1996).

[25] *See* 42 U.S.C. §1395dd(b) and (c). Subsection (b) provides, in part:

> **(1)** In general. If any individual (whether or not eligible for benefits under this title [42 USCS §§ 1395 et seq.]) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—
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> > **(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).

Id. Subsection (c) provides, in part:

> **(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)), the hospital may not transfer the individual unless—
>
> > **(A)**
> >
> > > **(i)** the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,
> > >
> > > **(ii)** a physician (within the meaning of section 1861(r)(1) [42 USCS § 1395x(r)(1)]) has signed a certification that[,] based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or
> > >
> > > **(iii)** if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1861(r)(1) [42 USCS § 1395x(r)(1)]), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and
> >
> > **(B)** the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

Id.

[26] *See Lopez-Soto v. Hawayek*, 175 F.3d 170, 175 (1st Cir. 1999) (explaining that subsection (b)" obligates hospitals to stabilize individuals (wherever in the hospital they may be) when emergency medical conditions are detected").

[27] *Alvarez-Torres v. Ryder Mem. Hosp. Inc.*, 582 F.3d 47, 51-52 (1st Cir. 2009) (citing *Fraticelli-Torres v. Hosp. Hermanos*, 300 Fed. Appx. 1, 4 (1st Cir. 2008)).

[28] *See Kenyon v. Hosp. San Antonio, Inc.*, 951 F. supp. 2d 255 (D.P.R. 2013); *Vickers v. Nash Gen. Hosp.*, 78 F.3d 139, 142 (4th Cir. 1996).
[29] *See Vickers v. Nash Gen. Hosp.*, 78 F.3d 139, 145 (4th Cir. 1996).
[30] 42 U.S.C. §1395dd(b)(1)(A).
[31] 42 U.S.C. §1395dd(e)(3)(A).
[32] *Correa v. Hosp. San Francisco*, 69 F.3d 1184, 1193-94 (1sr Cir. 1995); *Power v. Arlington Hosp. Ass'n.*, 42 F.3d 851, 857 (4th Cir. 1994) (noting that "there is nothing in the statute itself that requires proof of indigence, inability to pay, or any other improper motive on the part of a hospital as a prerequisite to recovery"); *Collins v. DePaul Hosp.*, 968 F.2d 303 (10th Cir. 1992) (explaining "the fact that Congress, or some of its members, viewed COBRA as a so-called "anti-dumping" bill, i.e., a bill designed to prohibit hospitals from dumping poor or uninsured patients in need of emergency care, does not subtract from tis use of the broad term "any individual").
[33] *See Correa v. Hosp. San Francisco*, 69 F.3d at 1194 (finding EMTALA does not impose a motive requirement and explaining that "regardless of motive, a complete failure to attend a patient who presents a condition that practically everyone knows may indicate an immediate and acute threat to life can constitute a denial of an appropriate medical screening examination under section 1395dd(a)"); *Power v. Arlington Hosp. Ass'n.*, 42 F.3d at 858 (finding that "proving improper motive on the part of the hospital…would make a civil EMTALA claim virtually impossible"); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037 (D.C. Cir. 1991) (noting that the motive for the hospital's departure from its screening protocols is not relevant to the analysis).
[34] 42 U.S.C. §1395dd(a) & (b).
[35] *Summers v. Baptist Medical Ctr. Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996).
[36] No. 17-cv-596-AJ, 2020 U.S. Dist. LEXIS 16620 at (D. N.H. Jan. 27, 2020).
[37] *See id.* at 5-8.
[38] *See id.*
[39] *Foord v. Capital Region Health Care Corp.*, No. 17-cv-596-AJ, 2020 U.S. Dist. LEXIS 16620 at *16 (D. N.H. Jan. 27, 2020).
[40] *Id.*
[41] *Id.*
[42] 152 N.H. 762 (2005).
[43] *See id.* at 764.
[44] *See id.*
[45] *See id.* at 765.
[46] *Carlisle v. Frisbie Mem'l Hosp.*, 152 N.H. at 767.
[47] *See id.* at 768.
[48] *See id.*
[49] *See id.* at 769.
[50] *Id.*
[51] *Carlisle v. Frisbie Mem'l Hosp.*, 152 N.H. at 769 (citing *Thomas v. Christ Hosp. and Medical Center*, 328 F.3d 890, 893 (7th Cir. 2003).
[52] *Id.*
[53] *Id.*