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EMTALA'S OFT-OVERLOOKED "REVERSE DUMPING" PROVISION AND THE IMPLICATIONS FOR TRANSFEREE HOSPITAL LIABILITY FOLLOWING *ST. ANTHONY HOSPITAL*¹

I. INTRODUCTION

A man, in great distress, arrives at the emergency room of a small medical clinic with the assistance of a woman. He is having difficulty standing on his own and appears visibly disoriented. Charge Nurse Lu, noticing the man's condition, rushes over to check on him. He is clearly confused and is unable to answer the nurse's questions. The woman informs Nurse Lu that she witnessed him swerve and fall off of his motorcycle on a road a few miles away. Realizing that he may be seriously injured and, in an act of kindness, the woman offered to take the injured man to the hospital. She informs Nurse Lu that the injured man's coherence has been dropping steadily since the accident.

Nurse Lu immediately suspects a subdural hematoma.² Knowing that the situation is critical and the man's life may hang in the balance, she immediately requests a computed tomography, or CT, scan.³ The results of the scan confirm her suspicions.

Nurse Lu, realizing the clinic is not equipped to handle the delicate neurosurgery that the patient requires, informs the attending emergency room physician, Dr. Claremore, of the situation. Dr. Claremore immediately calls the nearest full-service hospital that she knows has the necessary equipment and specialized staff necessary to treat the patient. She is eventually connected to Dr. Young, the attending neurologist at the hospital. After listening to an explanation of the patient's situation, Dr.

1. 309 F.3d 680 (10th Cir. 2002).

2. See THE MERCK MANUAL OF MEDICAL INFORMATION 1452 (Robert Berkow et al. eds., 1997). The manual offers the following definition:

In a subdural hematoma, blood collects beneath the dura mater [the outermost layer of the brain], usually in association with a significant injury to brain tissue. Drowsiness to the point of unconsciousness, loss of sensation or strength, and abnormal movements including seizures usually develop rapidly, although symptoms occasionally develop more gradually when the injury is mild.

Id.

3. *Id.* at 312. A CT scan is defined as follows: "Computed tomography (CT) is a computer-enhanced scanning technique for analyzing x-ray pictures. A computer generates two-dimensional, high-resolution images that resemble anatomic slices of the brain. . . ." *Id.*

Young refuses to accept the transfer of the injured man and abruptly ends the phone conversation, telling Dr. Claremore that the patient is her problem. Dr. Claremore then secures a helicopter transfer of the patient to a major teaching hospital in the state capitol.

The preceding hypothetical⁴ was intended as an illustration of the issues that arise among hospitals and other medical treatment facilities in the pursuit of patient care. Just as in this hypothetical case, complex and competing concerns surround the decision to treat a patient often arise in the context of life-threatening injuries.⁵

Congress responded to these concerns with a particular statute that was included in the Comprehensive Omnibus Budget Reconciliation Act of 1985 (“COBRA”),⁶ namely, the Emergency Medical Treatment and Active Labor Act (“EMTALA”).⁷ EMTALA is also known as the “patient dumping” statute.⁸ This statute fundamentally alters the obligations of hospitals toward patients.⁹ A particular provision of the statute addresses the obligations of hospitals who receive a request of transfer from another medical facility.¹⁰ This provision is commonly referred to as the “reverse dumping” provision of EMTALA,¹¹ presumably in response to the overall statute’s colloquial moniker.

In 2002, the Tenth Circuit Court of Appeals, in the case of *St. Anthony Hospital v. U.S. Department of Health and Human Services*,¹² focused on a transferee hospital’s¹³ liability under the reverse dumping provision of

4. This hypothetical was loosely adapted from the facts of *St. Anthony Hospital v. U.S. Dept. of Health and Human Services*, 309 F.3d 680 (10th Cir. 2002), which is the focus of this Note.

5. See J.B. Orenstein, *A State of Emergency*, WASH. POST, Apr. 22, 2001, at B1 (discussing how hospital emergency rooms are becoming more crowded and the practice of diversion, where ambulances are being re-routed to less busy hospitals).

6. Pub. L. No. 99-272, 100 Stat. 82 (1986).

7. 42 U.S.C. § 1395dd (2000).

8. See Melissa K. Stull, Annotation, *Construction and Application of Emergency Medical Treatment and Active Labor Act (42 U.S.C.S. § 1395dd)*, 104 A.L.R. FED. 166, 175 (1991). “‘Patient dumping’ . . . refers to the practice of a hospital that, despite being capable of providing the needed medical care, transfers a patient to another institution or refuses to treat a patient because the patient is unable to pay.” *Id.*

9. 42 U.S.C. § 1395dd. There are three main obligations imposed on hospitals under EMTALA. The first is that hospitals must provide all emergency patients with a medical screening examination. *Id.* § 1395dd(a). Second, if there is an emergency condition, the hospital must stabilize the patient or transfer the patient to another hospital. *Id.* § 1395dd(b). Third, EMTALA imposes requirements on certain hospitals to accept transfers of patients. *Id.* § 1395dd(c)(2), (g). These obligations will be discussed in more detail in Part II, *infra*.

10. 42 U.S.C. § 1395dd(g).

11. Connell Foley LLP, *Health Care and Medical Practice Update—December 2002*, at <http://www.cfg-lawfirm.com/opinions/health-med-update-0212.html> (last visited Jan. 16, 2005).

12. 309 F.3d 680 (10th Cir. 2002).

13. For the duration of this Note, the term “transferee hospital” refers to a medical facility which

EMTALA.¹⁴ This case serves as an important examination of this provision, in light of the scarcity of case law addressing this issue, and will serve as the focus of this Note.

Part II of this Note will focus on the history of the EMTALA statute, addressing the motivations behind the enactment of EMTALA.¹⁵ Part II will also examine the body of case law that has helped to define the major terms of the statute¹⁶ and will discuss the background of the *St. Anthony Hospital* opinion.¹⁷ Next, Part III will analyze the Tenth Circuit's interpretation of the reverse dumping provision and consider its potential impact on medical care.¹⁸ Finally, Part IV will include proposals for legislative reform to address the issues raised by the *St. Anthony Hospital* decision.¹⁹

II. HISTORY

A. Background on EMTALA

To understand the motivation for a statute like EMTALA, a discussion of the historical context of the physician-patient relationship is appropriate. Under traditional common law principles, hospitals did not have a duty to treat and could refuse treatment of any particular patient.²⁰ The law initially attempted to deal with this issue by imposing a duty upon physicians in limited circumstances, as well as imposing duties on hospitals.²¹

EMTALA was enacted out of concern that state law was inadequate to ensure that indigent patients who were in need of emergency medical

receives a request for a patient transfer from another facility.

14. *St. Anthony Hosp.*, 309 F.3d 680.

15. *See infra* Part II.A.

16. *See infra* Part II.B.

17. *See infra* Part II.C.

18. *See infra* Part III.

19. *See infra* Part IV.

20. Stull, *supra* note 8, at 175; *see also* Hurley v. Eddingfield, 59 N.E. 1058, 1058 (Ind. 1901) ("In obtaining the state's license (permission) to practice medicine, the state does not require, and the licensee does not engage, that he will practice at all or on other terms than he may choose to accept.").

21. *See* Oliver v. Brock, 342 So.2d 1, 3-5 (Ala. 1976) (imposing a duty to treat on doctors once the treatment relationship had been established to the satisfaction of the court); *Wilmington General Hosp. v. Manlove*, 174 A.2d 135, 140 (Del. 1961) (indicating that the court would have held the hospital liable for refusing treatment if the patient had suffered from an "unmistakable emergency" and had acted on reliance of a "well-established custom of the hospital to render aid"); *Hand v. Tavera*, 864 S.W.2d 678, 680 (Tex. App. 1993) (holding that a doctor-patient relationship was established because the patient was a subscriber of the health maintenance organization (HMO) which employed the physician).

treatment received such care.²² The concern arose because of the practice of some hospitals which were refusing treatment to patients who either did not have insurance or did not have the ability to pay for the services.²³ Numerous medical studies indicated that federal intervention was necessary to cure an epidemic of patient dumping.²⁴

22. See generally MARK A. HALL ET AL., *HEALTH CARE LAW AND ETHICS* 123 (6th ed. 2003). See *supra* note 8 (defining “patient dumping”).

23. Stull, *supra* note 8, at 175. “[W]e cannot stand idly by and watch those Americans who lack the resources to be shunted away from immediate and appropriate emergency care whenever and wherever it is needed.” Andrew Jay McClurg, *Your Money or Your Life: Interpreting the Federal Act Against Patient Dumping*, 24 WAKE FOREST L. REV. 173, 199 n.110 (1989) (quoting 131 CONG. REC. S13,904 (daily ed. Oct. 23, 1985)); see also Karen I. Trieger, Note, *Preventing Patient Dumping: Sharpening the COBRA’s Fangs*, 61 N.Y.U. L. REV. 1186, 1193–94 (1986). The author describes two factors that arguably contributed to the increase in patient dumping:

The first factor contributing to the patient dumping problem is an increase in the number of uninsured people in the United States. The number of people under sixty-five without health insurance increased from twenty-nine million in 1979 to thirty-five million in 1984. This dramatic increase is due, in part, to federal and state reductions in the Medicaid program. Over one million people were cut from the Medicaid program between 1981 and 1985. Because of these federal cuts, Medicaid covered less than forty percent of the poor in this nation in 1984—compared to seventy percent when the program began in 1965. These Medicaid reductions coincide with a marked increase in patient dumping.

Second, widespread cost containment efforts by the federal government have contributed to the patient dumping problem. In 1983, Congress altered the way in which the government finances Medicare. Under the old, cost-based system, Medicare reimbursed hospitals according to the reasonable costs they incurred in providing medical care to Medicare beneficiaries. In contrast, under the new prospective payment system, when a patient enters the hospital, she is diagnosed and is classified under one of the 468 diagnosis related groups (DRGs), and the hospital is paid a predetermined sum for her care. If the hospital can care for the patient for less than the fixed sum, it may keep the surplus as profits. If, however, the cost of the care exceeds the fixed payment, the hospital must absorb the additional cost. The purpose of the new system is to encourage efficiency by providing economic incentives to spend less.

Id. at 1193–94 (citations omitted).

24. See David U. Himmelstein et al., *Patient Transfers: Medical Practice as Social Triage*, 74 AM. J. PUB. HEALTH 494 (1984). In this study, the researchers analyzed 458 patient transfers to a major public hospital from fourteen other private hospitals in the area occurring in a six-month period. *Id.* at 494. The results of the study yielded some intriguing statistics: 289 of the transferred patients did not have any medical insurance at the time of transfer; each of the private hospitals with an emergency room in the area was responsible for at least eleven patient transfers; and four of the private hospitals accounted for fifty-five percent of all transfers. *Id.* at 495. The researchers concluded that “the transfer of patients from private to public hospital emergency rooms is common, involves primarily uninsured or government insured patients, disproportionately affects minority group members, and sometimes places patients in jeopardy.” *Id.* at 496. The researchers also commented on potential motivations for the transfers:

The apparent absence of medical indications for transfer, together with our finding that in 11 charts physicians indicated that the patient was transferred because of inability to pay, suggests that in some cases transfers were motivated by the financial interests of private hospitals and physicians. The transfer of uninsured patients shifts non-reimbursable services to the public hospital.

Id.; see also Schiff et al., *Transfers to a Public Hospital*, 314 NEW ENG. J. MED. 552 (1986). This

When EMTALA was introduced under COBRA, it made hospitals liable to the federal government for improper refusals to treat, as well as improper transfers.²⁵ The Act's enforcement was limited to hospitals which participate in the federal Medicare program.²⁶ Congress imposed certain duties on hospitals receiving patients who were in need of emergency care.²⁷ By imposing these duties, the statute attempted to define numerous terms used to clarify what is required of the hospital in any given situation.²⁸

B. Case Law Defining Key EMTALA Terms

The first requirement imposed upon hospitals is to conduct an "appropriate" medical screening of every emergency patient.²⁹ Although it

study occurred in the Chicago area and involved transfers to Cook County Hospital from forty-two surrounding hospitals. *Id.* at 553. These researchers also concluded that patient transfers were predominantly motivated by economic concerns:

The great majority of the patients (87 percent) were transferred because of lack of insurance. . . . The predominance of transfers made because the patient lacked insurance supports the contention that the increase in the number of transfers to Cook County Hospital and other public hospitals since 1980 has been attributable to economic reasons.

Id. at 555.

25. 42 U.S.C. § 1395dd(d). "A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than \$50,000 (or not more than \$25,000 in the case of a hospital with less than 100 beds) for each such violation." *Id.* § 1395dd(d)(1)(A). A private cause of action also exists under this section of the statute: "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. . . ." *Id.* § 1395dd(d)(2)(A).

26. *Id.* § 1395dd(e). The statute defines a "participating hospital" as one "that has entered into a provider agreement under section 1395cc of this title." *Id.* § 1395dd(e)(2). Section 1395cc addresses agreements with service providers. 42 U.S.C. § 1395cc. Section 1395b-3(a) concerns health insurance benefits for the elderly. *See* 42 U.S.C. § 1395b-3(a). "The Secretary of Health and Human Services shall establish a health insurance advisory service program . . . to assist medicare-eligible individuals with the receipt of services under the medicare and medicaid programs and other health insurance programs." *Id.* In essence, a "participating hospital," as defined in the statute, refers to a hospital participating in a Medicare/Medicaid provider agreement. 42 U.S.C. §§ 1395dd(e)(2), 1395cc, 1395b-3(a).

27. *See supra* note 9 (describing the duties of hospitals under EMTALA).

28. 42 U.S.C. § 1395dd(e). Despite Congress's attempts to define the terms used in EMTALA, the statute has been criticized for being vague. *See* Lowell C. Brown & Shirley J. Paine, *Patient Dumping by Specialized Care Facilities: Compliance Efforts Riddled with Uncertainties*, 9 NO. 6 HEALTHSPAN 3, 3 (1992); Michael J. Frank, *Tailoring EMTALA to Better Protect the Indigent: The Supreme Court Precludes One Method of Salvaging a Statute Gone Awry*, 3 DEPAUL J. HEALTH CARE L. 195, 195 (2000); Elizabeth A. Larson, Note, *Did Congress Intend to Give Patients the Right to Demand and Receive Inappropriate Medical Treatments?: EMTALA Reexamined in Light of Baby K*, 1995 WIS. L. REV. 1425, 1427.

29. 42 U.S.C. § 1395dd(a). "[I]f any individual . . . comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination. . . ." *Id.*

explicitly requires such a screening, the statute fails to define what qualifies as “appropriate.”³⁰ The First Circuit addressed this issue in *Correa v. Hospital San Francisco*.³¹ In this case, the relatives of the deceased patient filed suit against the hospital that had refused treatment for the patient, who eventually died.³² The plaintiffs claimed inappropriate screening, alleging that the hospital staff ignored the patient’s serious condition when refusing immediate medical attention.³³

The court found the hospital to be in violation of EMTALA, holding that the duty to provide appropriate screening is fulfilled if the hospital “provides for a screening examination 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.”³⁴ The court dismissed the arguments of the defendant hospital that contended it had complied with the requirements of EMTALA.³⁵

30. *Id.* § 1395dd(e).

31. 69 F.3d 1184, 1192–93 (1st Cir. 1995).

32. *Id.* at 1188–89. The deceased, Ms. Gonzalez, was a sixty-five year old woman complaining of dizziness, nausea, and chest pain. The plaintiffs were Ms. Gonzalez’s three children and four grandchildren. *Id.* at 1189. The plaintiffs alleged two violations of EMTALA, including a claim of inappropriate screening. *Id.*

33. *Id.* at 1188–89. Although there is conflicting evidence as to what the receptionist at the hospital was told, it is undisputed that Ms. Gonzalez was given a number, specifically number forty-seven, and was told to wait. *Id.* at 1188. After waiting for over an hour, the hospital was only tending to patient number twenty-four. *Id.* at 1189. Ms. Gonzalez waited an additional forty-five to seventy-five minutes before she was driven to another medical facility. *Id.*

Ms. Gonzalez was driven to the office of another physician, Dr. Rojas. *Id.* Ms. Gonzalez’s condition deteriorated rapidly and despite Dr. Rojas’ efforts to resuscitate her, he was unable to do so. *Id.* Ms. Gonzalez died as Dr. Rojas attempted to secure her transfer to another facility. *Id.* Her death was attributed to hypovolemic shock. *Id.*

34. *Id.* at 1192.

35. *Id.* at 1191–94. The defendant initially argued that it did not have any obligation to screen Ms. Gonzalez because she did not have an emergency condition. *Id.* at 1192. The court dismissed this contention as “doubly flawed.” *Id.* The court noted that EMTALA requires participating hospitals to screen all patients in their emergency rooms regardless of “whether or not they are in the throes of a medical emergency when they arrive.” *Id.* The court also noted that the record did not indicate conclusively that the decedent was not suffering from an emergency condition at the time she arrived at the hospital. *Id.*

The hospital next argued that it gave Ms. Gonzalez the same appropriate screening that it provided to all of its patients. *Id.* The court, in response to the defendant’s contention that it had performed what it felt was an appropriate screening, articulated a benchmark standard for courts to use in evaluating such a screening. *Id.* at 1192; *see also supra* note 34 and accompanying text.

Finally, the hospital argued that it did not deny Ms. Gonzalez a screening or treatment. 69 F.3d at 1193. In support of this contention, the hospital argued that Ms. Gonzalez was given a number and would have been treated had she waited. *Id.* The court rejected this argument on the grounds that the evidence in the record was consistent with the conclusion that the hospital deliberately denied Ms. Gonzalez a screening. *Id.* In addition, the court emphasized the defendant’s inaction: “[A] complete failure to attend a patient who presents a condition that practically everyone knows may indicate an

In a case decided approximately three years prior to *Correa*, the Fourth Circuit, in *Baber v. Hospital Corp. of America*,³⁶ considered the related question of what standard of care to impose on EMTALA's screening requirement.³⁷ In *Baber*, the plaintiff argued that an appropriate medical screening must satisfy a national standard of care, *i.e.*, what any emergency room in the country would do in a similar situation.³⁸ The court rejected the plaintiff's contention, and instead adopted an individual hospital standard of care based on what was customary at that particular hospital.³⁹

In addition to an appropriate medical screening, EMTALA requires that the patient be stabilized when an emergency condition exists.⁴⁰ According to the statute, "to stabilize" means "provid[ing] such medical treatment of the condition as may be necessary to assure, within

immediate and acute threat to life can constitute a denial of an appropriate medical screening examination. . . ." *Id.*

36. 977 F.2d 872 (4th Cir. 1992).

37. The patient, Baber, entered the hospital and was "nauseated, agitated, and thought she might be pregnant." *Id.* at 875. The attending physician, Dr. Kline, "examined her central nervous system, lungs, cardiovascular system, and abdomen." *Id.* Dr. Kline then proceeded to give Baber several drugs in an attempt to control Baber's agitation. *Id.* Baber later convulsed and fell, lacerating her scalp. *Id.* After reexamining Baber, Dr. Kline concluded that her anxiety, restlessness and disorientation were caused by "her pre-existing psychiatric problems of psychosis with paranoia and alcohol withdrawal." *Id.* After consulting with Baber's psychiatrist, both physicians agreed that she needed further psychiatric treatment. *Id.* at 876. They agreed that Baber should be transported to another facility that had a psychiatric ward, as the current hospital did not. *Id.* Dr. Kline concluded that Baber did not have a serious head injury and was fit to be transferred safely. *Id.* After the transfer, Baber suffered a grand mal seizure. *Id.* A CT scan revealed that she had a fractured skull as well as a subdural hematoma. *Id.* See generally *supra* notes 2-3 (defining subdural hematoma and CT scan, respectively). Baber was immediately transferred back to the original hospital which had a neurosurgeon available. *Baber*, 977 F.2d at 876. She later died from a ruptured blood vessel in her brain. *Id.*

38. *Baber*, 977 F.2d at 878.

39. *Id.* at 878, 880. "We conclude instead that EMTALA only requires hospitals to apply their standard screening procedure for identification of an emergency medical condition uniformly to all patients . . ." *Id.* at 878. The court looked to the statutory language concluding that "[t]he statutory language clearly indicates that EMTALA does not impose on hospitals a national standard of care in screening patients," and "[h]ad Congress intended to require hospitals to provide a screening examination which comported with generally accepted medical standards, it could have clearly specified a national standard." *Id.* at 879-80. The court also indicated that other jurisdictions have addressed this issue and have reached a similar conclusion. *Id.* at 880. "[T]he D.C. Circuit held that a hospital provides an appropriate medical screening if it 'conforms in its treatment of a particular patient to its standard screening procedures.'" *Id.* (citing *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991)).

40. 42 U.S.C. § 1395dd(b)(1)(A). "If any individual . . . comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must 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 . . ." *Id.* EMTALA allows transfers of individuals once they are stabilized, and, in certain circumstances, prior to stabilization. 42 U.S.C. § 1395dd(b)(1)(B), (c). See *infra* note 60.

reasonable medical probability, that no material deterioration of the condition is likely.”⁴¹

In *Summers v. Baptist Medical Center Arkadelphia*,⁴² the Eighth Circuit addressed the issue of stabilization.⁴³ The plaintiff in *Summers* argued that the hospital did not properly stabilize his condition.⁴⁴ The court dismissed the claim, holding that the duty to stabilize only arises when the treating hospital determines that an “emergency medical condition”⁴⁵ exists.⁴⁶ The court added that the treating hospital must have actual knowledge of the “emergency medical condition” before any liability under EMTALA will attach.⁴⁷

In *Brooker v. Desert Hospital Corp.*,⁴⁸ the Ninth Circuit addressed the related question of whether a treating hospital has the duty under EMTALA to completely treat the patient’s condition as part of stabilization.⁴⁹ The plaintiff in *Brooker* asserted that the defendant hospital failed to provide stabilizing treatment and improperly transferred her in an unstable condition.⁵⁰ After looking at the language of the statute, the court

41. 42 U.S.C. § 1395dd(e)(3)(A).

42. 91 F.3d 1132 (8th Cir. 1996).

43. *Id.* at 1140.

44. *Id.* The plaintiff, Summers, arrived at Baptist’s emergency room in an ambulance after falling out of a tree while deer hunting. *Id.* at 1135. He was complaining of chest and back pain. *Id.* The emergency room physician, suspecting muscle spasms, ordered four spinal x-rays. *Id.* The x-rays did not reveal anything unusual, so the patient was given pain reliever injections and discharged. *Id.* Later, it was determined that Summers had suffered a broken vertebra, sternum, and rib. *Id.* at 1135–36.

45. See 42 U.S.C. § 1395dd(e)(1)(A). The statute defines an 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 (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.

Id.

46. *Summers*, 91 F.3d at 1140. The court concluded that “[t]his claim must fail because, under the express wording of the statute, this [stabilization] portion of EMTALA applies only if ‘the hospital determines that the individual has an emergency medical condition’” *Id.* The court explained further: “Here, the hospital believed Summers was suffering from muscle spasms, not an emergency medical condition. The duty to stabilize therefore never arose. A hospital must have had actual knowledge of the individual’s unstabilized emergency medical condition if a claim under § 1395dd(c) is to succeed.” *Id.*

47. *Id.* The court pointed out that the failure of the hospital to discover the patient’s true injuries may be indicative of medical negligence but it does not constitute an EMTALA violation. *Id.* at 1138. Accord *Vickers v. Nash*, 78 F.3d 139 (4th Cir. 1996) (holding that misdiagnosis is a matter of state malpractice law and not actionable under EMTALA).

48. 947 F.2d 412 (9th Cir. 1991).

49. *Id.* at 415.

50. *Id.* The plaintiff Brooker was admitted to the defendant, Desert Hospital’s, emergency room with complaints of chest pain. *Id.* at 413. The patient was diagnosed as having a heart attack and was admitted to the hospital. *Id.* A coronary angiography revealed severe blockages in two of the patient’s arteries. *Id.* The treating physician, Dr. Rao, recommended that Brooker undergo bypass surgery due to

held that EMTALA does not impose a duty to "alleviate completely [plaintiff's] emergency condition."⁵¹ The court cited the findings of the district court in support of its holding.⁵²

In *Cleland v. Bronson Health Care Group, Inc.*,⁵³ the Sixth Circuit considered the issue of whether a hospital is considered to have satisfied the stabilization requirement of EMTALA if the patient dies soon after discharge.⁵⁴ The plaintiffs, parents of the deceased, alleged that their son's condition could not have met the requirements for stabilization before discharge in light of the outcome.⁵⁵ The court rejected this argument holding that the hospital fulfilled its duty to stabilize the patient under EMTALA.⁵⁶

The *Cleland* court concluded that nothing in the record indicated that the patient was not stabilized.⁵⁷ In addition, the court, after examining the

the severity of the blockages in her arteries. *Id.* Brooker experienced complications on the night before the scheduled procedure so Dr. Rao administered emergency assistance by inserting a balloon pump into the patient. *Id.* The next day Dr. Rao learned that the hospital's cardiac surgeon would not be available to perform the surgery for a few days. *Id.* Dr. Rao wished to perform the surgery as quickly as possible so he asked for and received Brooker's consent to transfer her to another facility where the surgery could be performed sooner. *Id.* at 413–14. The plaintiff claimed that the transfer caused her to suffer a heart attack. *Id.* at 414.

51. *Id.* at 415. "The Act [EMTALA] did not require the hospital to perform angioplasty or bypass surgery within a specified time period. Rather the Act [EMTALA] required the hospital to provide Brooker with appropriate medical screening and stabilizing treatment and to refrain from transferring her unless she was 'stabilized.'" *Id.*

52. *Id.* "The court found 'nothing in the record to indicate that it was likely that the transfer would have any effect upon the plaintiff's condition.'" *Id.* The Ninth Circuit also discussed the treating physician's progress notes indicating that the patient was "clinically stable." *Id.* The court went on to conclude that "[t]he [district] court did not err in concluding that no material deterioration in Brooker's condition was likely within reasonable medical probability." *Id.*

53. 917 F.2d 266 (6th Cir. 1990).

54. *Id.* The patient had initially come to the emergency room complaining of abdominal cramps and experiencing vomiting. *Id.* at 268–69. The patient was diagnosed as suffering from gastroenteritis and hypoglycemia. *Id.* at 269. The patient was returned to the hospital that same night in cardiopulmonary arrest. *Id.*

55. *Id.* The patient died within twenty-four hours of being discharged. *Id.*

56. *Id.* The court reasoned:

[I]n hindsight, any stability was quite short-run. The patient died. However, neither the normal meaning of stabilization, nor any of the attendant legislative history or apparatus, indicates that Congress intended to provide a guarantee of the result of emergency room treatment and discharge. In the hospital's opinion, the patient was stable, and they would have believed that a patient with any differing characteristics would have been stable. We therefore hold that within the meaning of the Act [EMTALA] the hospital did its duty to stabilize young Cleland. . . .

Id. at 271.

57. *Id.* at 269. The court observed that the patient was "not in acute distress, neither the doctors nor the patient or his parents made the slightest indication that the condition was worsening in any way, or that it presented any risk that might become life-threatening, or that it would worsen markedly by the next day." *Id.* at 271.

normal meaning of stabilization and the legislative history of the statute, concluded that nothing “indicates that Congress intended to provide a guarantee of the result of emergency room treatment and discharge.”⁵⁸ In essence, the court indicated that a good faith attempt at stabilization, in which the hospital is reasonably certain that the patient’s condition is stable, would probably withstand a charge of improper stabilization.⁵⁹

In addition to appropriate screenings and stabilization, EMTALA also contains a section addressing what constitutes an appropriate transfer.⁶⁰ A particular subsection of the provision requires “qualified transfer equipment” and “qualified personnel” for effecting the transfer.⁶¹ The Fifth Circuit, in *Burditt v. U.S. Department of Health and Human Services*,⁶² helped to define these terms.

In *Burditt*, the physician appellant argued that he effected an appropriate transfer by sending the patient in an ambulance meeting state licensing requirements.⁶³ The court construed the physician’s argument as limiting the “qualified transfer equipment” requirement to the transport vehicle itself.⁶⁴ The court disagreed, concluding that “qualified transfer equipment” included “all physical objects reasonably medically necessary for safe patient transfer.”⁶⁵

58. *Id.*

59. *See id.*

60. 42 U.S.C. § 1395dd(c)(2). The provision reads as follows:

An appropriate transfer to a medical facility is a transfer (A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual’s health and, in the case of a woman in labor, the health of the unborn child; (B) in which the receiving facility—(i) has available space and qualified personnel for the treatment of the individual, and (ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment; (C) in which the transferring hospital sends to the receiving facility all medical records . . . related to the emergency condition for which the individual has presented, available at the time of transfer . . . ; (D) in which the transfer is effected through qualified personnel and transportation equipment. . . .

Id.

61. *Id.* § 1395dd(c)(2)(D); *see also supra* note 60.

62. 934 F.2d 1362, 1372–73 (5th Cir. 1991). The patient, Rosa Rivera, arrived at the emergency room of DeTar Hospital experiencing contractions. *Id.* at 1366. Rivera had received no prenatal care so the obstetrical nurses called Dr. Michael Burditt, the on-call physician responsible for such patients. *Id.* Dr. Burditt examined the patient and found that she had severely high blood pressure, which could result in the death of Rivera and her child. *Id.* Dr. Burditt decided to transfer Rivera by ambulance to another hospital located 170 miles away because he was not willing to accept the risk of treating Rivera. *Id.* at 1366–67. The nurses arranged for Rivera’s transfer to the other facility, finding an obstetrical nurse to accompany her. *Id.* at 1367. Rivera gave birth in the ambulance during the trip to the transferee hospital. *Id.*

63. *Id.* at 1372–73.

64. *Id.* at 1372.

65. *Id.* at 1373. The court pointed out that Dr. Burditt did not order a fetal heart monitor for Rivera’s ambulance which, through expert testimony, could reasonably be considered to be “qualified

The *Burditt* court then considered the requirement of "qualified personnel," finding that the medical staff who accompanied the patient in this case, two emergency medical technicians and an obstetrical nurse, satisfied the qualified personnel requirement, *absent any medical complications*.⁶⁶ The court went on to state that, in the circumstances of this case, in which the patient may have required a cesarean section, it is possible that only a physician would have satisfied the "qualified personnel" requirement.⁶⁷ The Fifth Circuit's reasoning indicates that in order to satisfy the qualified personnel requirement, the personnel must be qualified to treat any *reasonably foreseeable complication* in the transfer of the patient.⁶⁸

C. St. Anthony Hospital v. U.S. Department of Health and Human Services

Aside from the provisions previously discussed, EMTALA also includes a nondiscrimination provision,⁶⁹ otherwise known as the reverse dumping provision. This provision imposes a duty on receiving, or transferee, hospitals to accept an appropriate transfer.⁷⁰ In addition to establishing the duty to accept these transfers, the provision contains two caveats: (1) the receiving hospital must have "specialized capabilities or facilities;" and (2) must have the "capacity" to treat the patient.⁷¹ The statute offers little in terms of clarification as to what is meant by these

transfer equipment." *Id.* "[E]xpert testimony substantially supports the ALJ's [administrative law judge'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." *Id.* The court added the following regarding the expert testimony:

[The experts] 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 that a reasonable physician would have included a fetal heart monitor as *equipment* to ensure Rivera's safe transfer.

Id. (emphasis in original).

66. *Id.* The court commented that "[t]he 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." *Id.* The court explained further: "[I]t is undisputed that they were unqualified to perform a cesarean section or treat the other complications from Rivera's hypertension that could have developed." *Id.*

67. *Id.*

68. *See supra* notes 66–67 and accompanying text.

69. 42 U.S.C. § 1395dd(g).

70. *Id.* The statute reads: "A participating hospital that has specialized capabilities or facilities . . . shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual." *Id.*

71. *Id.* *See supra* note 70.

two terms.⁷² In *St. Anthony Hospital v. U.S. Department of Health and Human Services*, the Tenth Circuit attempted to shed some light on this issue.⁷³

St. Anthony Hospital arose out of an appeal of a decision of the Departmental Appeals Board (“DAB”) of the Department of Health and Human Services (“DHHS”).⁷⁴ In May 1998, the Office of the Inspector General (“OIG”)⁷⁵ initiated an action against St. Anthony for refusing to accept an appropriate transfer in violation of section 1867(g) of the Social Security Act, which mirrors the EMTALA statute.⁷⁶

On April 8, 1995, R.M.,⁷⁷ the patient, was involved in an automobile accident.⁷⁸ He was taken to the emergency room at Shawnee Regional Hospital located approximately thirty-five miles outside of Oklahoma City,⁷⁹ where he was diagnosed with a neurological injury approximately two hours later.⁸⁰ The attending physician in the emergency room, Dr. Kent Thomas, arranged for the patient’s transfer to University Hospital in Oklahoma City.⁸¹ Due to complications arising during the attempted trip to University Hospital, the patient had to be returned to Shawnee Regional

72. 42 U.S.C. § 1395dd.

73. *St. Anthony Hosp. v. U.S. Dep’t of Health and Human Servs.*, 309 F.3d 680 (10th Cir. 2002).

74. *Id.* at 686. “The *Departmental Appeals Board* provides prompt, fair, and impartial dispute resolution services to parties in many different kinds of disputes involving components of the Department of Health and Human Services.” United States Department of Health and Human Services, Departmental Appeals Board, at <http://www.hhs.gov/dab> (last visited Nov. 14, 2004).

75. The Office of the Inspector General (“OIG”) is the investigative arm of the Department of Health and Human Services. The OIG’s mission statement is as follows:

The mission of the Office of Inspector General . . . is to protect the integrity of Department of Health and Human Services (HHS) programs, as well as the health and welfare of the beneficiaries of those programs. The OIG has a responsibility to report both to the [HHS] Secretary and to the Congress program and management problems and recommendations to correct them. The OIG’s duties are carried out through a nationwide network of audits, investigations, inspections and other mission-related functions performed by OIG components.

United States Department of Health and Human Services, Office of Inspector General, *OIG Mission*, at <http://oig.hhs.gov/organization/OIGmission.html> (last visited Nov. 14, 2004).

76. *The Inspector Gen. v. St. Anthony Hosp.* (Oct. 5, 1999), at <http://www.hhs.gov/dab/decisions/or620.htm>. Section 1867(g) of the Social Security Act is codified as 42 U.S.C. § 1395dd(g), EMTALA’s reverse dumping provision. *See supra* notes 69–70 and accompanying text.

77. *St. Anthony Hosp.*, 309 F.3d at 687 n.1. The court referred to the patient, a sixty-five year old male, by his initials. *Id.*

78. *Id.* at 687.

79. *Id.* Shawnee is a small local hospital that “lacked the ability to perform many complex medical procedures.” *Id.* *See also* *The Inspector Gen. v. St. Anthony Hosp.* (Oct. 5, 1999), at <http://www.hhs.gov/dab/decisions/cr620.htm>.

80. *St. Anthony Hosp.*, 309 F.3d at 687.

81. *Id.*

Hospital.⁸² The patient had been misdiagnosed and was in a very grave condition.⁸³

Dr. Spengler, Dr. Thomas's replacement, began treatment to stabilize R.M.'s condition and made alternate arrangements for the patient's more expeditious transfer.⁸⁴ As a result of the change in diagnosis from a broken back to an injured abdominal aorta, University Hospital was no longer able to accept the transfer.⁸⁵

Shawnee Regional Hospital then contacted the emergency room at St. Anthony, a large hospital in Oklahoma City.⁸⁶ Shawnee's request for a transfer of R.M. was refused by St. Anthony.⁸⁷ Dr. Spengler eventually made arrangements to transfer R.M. by Medi-Flight to another hospital in Oklahoma City.⁸⁸

Following the events of this day, a peer review organization reviewed Shawnee Regional Hospital's conduct to determine whether it had complied with its duties under EMTALA.⁸⁹ The peer review organization determined that Shawnee had complied with its duties given its limited

82. *Id.* The patient had actually suffered an injury to his abdominal aorta, which is "the principal vessel carrying blood to the lower part of his body." *Id.*

83. *Id.* Dr. Carl Spengler, Dr. Thomas' replacement and a third year medical resident, examined R.M.:

R.M. was extremely cyanotic . . . from his . . . [navel] down throughout his lower extremities.

R.M. had no sensation to touch from his umbilicus [navel] down. R.M.'s skin below the umbilicus was cold, whereas it had normal appearance and temperature above the umbilicus.

R.M. was complaining of back pain. He had no pulse in his femoral arteries in his legs or feet.

Id.

84. *Id.* at 688. Dr. Spengler arranged for Medi-Flight helicopter transportation of R.M. to University Hospital because it would be faster and because the helicopter personnel are better trained than the ambulance personnel. *Id.*

85. *Id.* Dr. Spengler called University Hospital to inform the hospital's attending emergency room physician that R.M.'s diagnosis had changed. *Id.* Dr. Spengler was informed that University Hospital already had two emergency surgeries pending and, therefore, would not be able to receive R.M. *Id.*

86. *Id.* Dr. Spengler spoke with Dr. Billy Buffington at St. Anthony and attempted to arrange a transfer. *Id.* Dr. Buffington consulted with Dr. Scott Lucas, St. Anthony's on-call thoracic and vascular surgeon. *Id.*

87. *Id.* Dr. Lucas at St. Anthony informed Dr. Spengler that he "was not interested in taking R.M.'s case." *Id.* In addition, "[h]e told Dr. Spengler that the case was University Hospital's problem." *Id.* (citation omitted).

88. *Id.* (citation omitted).

89. *Id.* at 688-89. See 42 U.S.C. § 1395dd(d)(3).

In considering allegations of violations of the requirements of this section in imposing . . . [liability] the Secretary shall request the appropriate utilization and quality control peer review organization . . . to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings.

Id.

capabilities.⁹⁰ In addition, the peer review organization found that the risks involved in R.M.'s transfer were outweighed by the benefits.⁹¹

After the peer review organization released its findings, the OIG determined that St. Anthony failed to accept an appropriate transfer. St. Anthony moved to dismiss on the basis that the agency's decision was premature.⁹² An administrative law judge found that St. Anthony met the criteria under EMTALA imposing a duty to accept the transfer of R.M.⁹³ St. Anthony appealed the administrative law judge's decision to the DAB.⁹⁴ After an unfavorable decision by the DAB, St. Anthony then appealed the decision to the Tenth Circuit Court of Appeals on both procedural and substantive grounds.⁹⁵

90. *St. Anthony Hosp.*, 309 F.3d at 689. The peer review organization's findings were quoted in the court's opinion:

According to the on call surgery list, [Shawnee physician] Dr. Howard was credentialed to perform vascular surgery and the repair of an "occluded" aorta . . . [A]ccording to subsequent documentation received from Shawnee Regional legal representatives, Dr. Howard had not performed abdominal vascular surgery in at least one year, therefore he did not feel capable of performing such surgery. As a practical matter, . . . [Shawnee Regional Hospital] did not have the capacity to provide further stabilizing treatment in the form of vascular surgery.

Id. (citation omitted).

91. *Id.*

92. *Id.* St. Anthony argued that the action by the OIG was "premature" and moved to dismiss the Inspector General's action on the grounds that it had not been allowed an opportunity for "review by an appropriate peer review organization." *Id.* The motion was denied by the administrative law judge. *Id.*; see also 42 U.S.C. § 1395dd(d)(3).

93. *St. Anthony Hosp.*, 309 F.3d at 689. See *The Inspector Gen. v. St. Anthony Hosp.* (Oct. 5, 1999), at <http://www.hhs.gov/dab/decisions/cr620.htm>. The administrative law judge determined that St. Anthony had the specialized capabilities in order to care for the patient:

[St. Anthony] had available to it on the evening of April 8, 1995 everything that was necessary to provide the requisite care to R.M. Dr. Lucas is a specialist who is adept at performing the delicate emergency vascular surgery that R.M. required. Respondent [St. Anthony] had the surgical suites, the staff, the facilities, and the equipment on hand to do the necessary surgery.

Id. In addition, the administrative law judge found that St. Anthony had the capacity to treat the patient: "[St. Anthony] had on hand or available to it the qualified staff, including Dr. Lucas, necessary to provide vascular surgery to R.M. None of Respondent's [St. Anthony's] operating rooms were in use on that evening." *Id.*; see also *supra* notes 69–71 and accompanying text.

94. *St. Anthony Hosp.*, 309 F.3d at 690. The DAB affirmed the civil monetary penalty of the administrative law judge but increased the penalty. *Id.*; see also *St. Anthony Hosp. v. The Inspector Gen.* (June 5, 2000), at <http://www.hhs.gov/dab/decisions/dab1728.html>.

95. *St. Anthony Hosp.*, 309 F.3d at 690–94. The procedural issues included St. Anthony's claim that DHHS failed to satisfy EMTALA's requirements by denying St. Anthony's request for peer review. *Id.* at 689–90, 694; see also *supra* note 89. These procedural issues are outside of the scope of this Note and will not be discussed further.

The standard of review of the DAB's decision by the Tenth Circuit was as follows:

When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter, for the court, as well as the agency, must give effect to the unambiguously expressed

St. Anthony's substantive challenges included an opposition to the DAB's finding that St. Anthony had the specialized capability and capacity to treat the patient.⁹⁶ These two factors impose a duty upon a transferee hospital to accept an appropriate transfer under EMTALA's nondiscrimination provision.⁹⁷ St. Anthony argued that there was insufficient evidence of its fulfillment of these requisite factors.⁹⁸ Addressing St. Anthony's specialized capability, the court disagreed with the hospital's argument and concluded that there was ample evidence to satisfy this factor.⁹⁹ In support of this conclusion, the court listed certain facts substantially supported by the record: St. Anthony had nineteen unoccupied surgical suites on the night of Shawnee Regional Hospital's requested transfer; St. Anthony had the necessary equipment on hand to perform the required surgery; St. Anthony had numerous physicians on call for various emergencies, including neurology, general surgery, and thoracic surgery; and St. Anthony had a specialist on hand who was skilled in the particular type of surgery that Shawnee's transfer patient required.¹⁰⁰ The Tenth Circuit indicated that these conditions were indicative of a hospital having "specialized capability" as required by the EMTALA statute.¹⁰¹

St. Anthony also contested the administrative law judge's finding that it had the capacity to treat Shawnee Regional Hospital's patient.¹⁰² The court agreed with the DAB, finding that St. Anthony did indeed have the requisite capacity.¹⁰³ In accepting the conclusion of the administrative law

intent of Congress. If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

St. Anthony Hosp., 309 F.3d at 691 (quoting *Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842–43 (1984)).

96. *St. Anthony Hosp.*, 309 F.3d at 694. St. Anthony also challenged the following DAB findings: (1) the patient's condition was unstable at the time of transfer request; (2) "Shawnee Regional Hospital would have been able to effect a transfer to St. Anthony through qualified personnel and medical equipment had St. Anthony accepted the transfer; [(3)] Shawnee requested to transfer the patient to St. Anthony." *Id.* St. Anthony also claimed that it had never refused to accept the patient. *Id.*

97. 42 U.S.C. § 1395dd(g). *See supra* notes 69–72 and accompanying text.

98. *St. Anthony Hosp.*, 309 F.3d at 701.

99. *Id.*

100. *Id.*

101. *Id.*; *see also supra* note 93. The administrative law judge indicated that specialized care may include any care that requires the services of specialists and facilities that are not within the reach of smaller hospitals that offer a lower level of care. *St. Anthony Hosp.*, 309 F.3d at 701 (citation omitted).

102. *St. Anthony Hosp.*, 309 F.3d at 702.

103. *Id.*

judge, the Tenth Circuit endorsed the following subfactors as being indicative of the capacity to treat: St. Anthony had the ability to accommodate the requested examination or treatment; St. Anthony had qualified staff available to treat the patient; St. Anthony had the necessary beds to accommodate the patient; and St. Anthony had the necessary equipment available to treat the patient.¹⁰⁴

In addition to its challenges regarding the specialized capability and capacity factors, St. Anthony also challenged the transfer itself as being inappropriate under EMTALA.¹⁰⁵ St. Anthony argued that one of the requirements of an appropriate transfer—namely the agreement to accept the transfer and to provide appropriate medical treatment—was not met because St. Anthony had refused to accept Shawnee Regional Hospital's transfer request, thereby negating the appropriateness of the transfer.¹⁰⁶ The court agreed with the administrative law judge in dismissing this claim because it led to an "absurd result."¹⁰⁷

III. ANALYSIS

The Tenth Circuit's consideration of EMTALA's nondiscrimination provision in *St. Anthony Hospital* provides a judicial interpretation of the reverse dumping provision. Prior to *St. Anthony Hospital* and the related administrative agency decisions, little guidance existed concerning the applicability of the reverse dumping provision to hospitals receiving transfers.

The court, in addressing St. Anthony's challenges, added some clarity to the terms "specialized capability" and "capacity" as used in the reverse dumping provision of the EMTALA statute.¹⁰⁸ Under the Tenth Circuit's interpretation of these terms, it is clear that there is significant overlap

104. *Id.* (citation omitted).

105. *Id.* See *supra* notes 60–61 and accompanying text.

106. *St. Anthony Hosp.*, 309 F.3d at 700.

107. *Id.* See *supra* note 93. The administrative law judge similarly dismissed St. Anthony's identical argument in that court. "Congress did not intend to say that an 'appropriate transfer' . . . could be present only where that hospital has agreed to accept the transfer. If Congress had done so § 1867(g) [EMTALA's nondiscrimination provision] would be meaningless." *The Inspector Gen. v. St. Anthony Hosp.* (Oct. 5, 1999), at <http://www.hhs.gov/dab/decisions/cr620.htm>. The judge conceded that "a transfer may be inappropriate where a hospital 'dumps' a patient on another hospital without that hospital's consent." *Id.*

108. See *supra* notes 96–104 and accompanying text; see also 42 U.S.C. § 1395dd(g). It is interesting to note that the Tenth Circuit appears to have borrowed the definition of "capacity" promulgated by DHHS, 42 C.F.R. § 489.24(b) (2002).

between the subfactors that define specialized capability and capacity to treat.¹⁰⁹

The distinguishing element appears to be that specialized capability is more specifically related to the particulars of the potential transfer, *i.e.*, the required treatment and the patient's status.¹¹⁰ On the other hand, capacity refers to a more general availability of resources.¹¹¹ For example, if a patient requires a coronary artery bypass graft ("CABG"),¹¹² the transferee hospital's availability of operating rooms and surgical staff would contribute to the capacity to treat the patient, whereas, having an on call cardio-thoracic surgeon particularly skilled in CABG procedures, as opposed to angioplasty,¹¹³ would be indicative of the transferee hospital's specialized capability.

After *St. Anthony Hospital*, transferee hospitals have a clearer understanding of when they will be required to accept transfers. They have a modicum of discretionary authority based on their capacity and specialized capability to treat patients.¹¹⁴ The duties of a transferee hospital somewhat resemble the common law no-duty-to-treat rule in limited circumstances.¹¹⁵

The Tenth Circuit's adopted definition of specialized capability raises some implications for large modern hospitals.¹¹⁶ Under that definition, the availability of a trained vascular surgeon as well as more modern operating facilities are critical to the conclusion that a hospital has the specialized capability required by EMTALA's reverse dumping

109. See *supra* notes 100, 104 and accompanying text. The court characterized the two factors as "closely related term[s]." *St. Anthony Hosp.*, 309 F.3d at 701.

110. See *supra* note 100 and accompanying text.

111. See *supra* note 104 and accompanying text.

112. A coronary artery bypass graft ("CABG") is more commonly referred to as bypass surgery. See generally THE MERCK MANUAL OF MEDICAL INFORMATION, *supra* note 2, at 134. The CABG procedure is described as follows: "Bypass surgery consists of grafting veins or arteries from the aorta . . . to the coronary artery, thus skipping over (bypassing) the obstructed area." *Id.* at 135.

113. *Id.* Angioplasty is a procedure in which a wire is inserted into a large peripheral artery and threaded through the arterial system until it reaches the occluded artery. *Id.* A catheter with a balloon attached to the tip is threaded into the occluded region. *Id.* The balloon is then inflated momentarily in an effort to reduce the occlusion blocking the flow of blood through the artery. *Id.* The inflated balloon then compresses the obstruction allowing blood to flow. *Id.*

114. 42 U.S.C. § 1395dd(g). A transferee hospital can evaluate its specialized capability or capacity before a transfer must be accepted. See *supra* notes 108–11 and accompanying text. In contrast, the original hospital must screen all emergency patients who arrive at its emergency room under EMTALA's medical screening requirement. See 42 U.S.C. § 1395dd(a).

115. See *supra* notes 20–21 and accompanying text. University Hospital, originally contacted by Shawnee Regional regarding the transfer of the patient, R.M., properly refused to accept transfer on account of a lack of capacity. *St. Anthony Hosp.*, 309 F.3d at 688.

116. See *supra* notes 100–01 and accompanying text (discussing the court's definition of specialized capability).

provision.¹¹⁷ Therefore, any hospital within reasonable transporting distance that employs specialists and utilizes advanced equipment may be liable to accept transfers from various local smaller hospitals unless it can affirmatively prove that it does not have the specialized capability to treat the patient.¹¹⁸

Under the Tenth Circuit's holding, a large, modern teaching hospital will likely not succeed in arguing that it lacks the specialized capability to treat almost any emergency condition that arises.¹¹⁹ In addition, under the court's broad definition of capacity, a large hospital would have an uphill battle to establish a lack of capacity.¹²⁰

The court's holding, if followed by other circuits, could lead to the unfortunate result of discouraging large teaching hospitals from moving into medically under-served areas. Under EMTALA's treatment scheme, hospitals that provide stabilizing treatment, either as the original hospital or the transferee hospital, are not compensated for the costs incurred in treating an indigent patient who is not insured.¹²¹ Imagine a scenario in which one large hospital is expected to carry the burden and expense of providing stabilizing treatment to numerous patients suffering from emergency conditions who are being transferred from many local area clinics incapable of providing the necessary treatment that the patient requires.¹²²

A technologically-advanced hospital may think twice before constructing a facility in a non-urban area. Under the Tenth Circuit's interpretation of EMTALA's reverse dumping provision, such a medical facility could be inundated with a deluge of patients and have absolutely no recourse to recover its expenses. If a modern, full-service hospital is

117. *St. Anthony Hosp.*, 309 F.3d at 701–02.

118. *See supra* notes 116–17 and accompanying text.

119. *See supra* note 110 and accompanying text.

120. *See supra* note 104 and accompanying text.

121. *See* American College of Emergency Physicians, *Fact Sheets: EMTALA*, at <http://www.acep.org/1,393,0.html> (last visited Nov. 14, 2004) (“EMTALA places great responsibility on hospitals and emergency physicians to provide a health care safety net and shoulder the financial burden of providing EMTALA-related medical care.”).

122. *See* Schiff et al., *supra* note 24, at 556. The Schiff study provided some economic data regarding the costs incurred by Cook County Hospital in the treatment of transferred patients: “84 percent of the \$3.35 million charged to the transferred patients, or \$2.81 million, was nonreimbursable. Thus, we estimate that in 1983 the nonreimbursable costs to Cook County Hospital of providing care to transferred patients was \$24.1 million, or 12 percent of the total 1983 operating budget.” *Id.* This data represents total costs incurred by the transferee hospital in the treatment of transferred patients and not just the costs of a medical screening which is all that the EMTALA statute requires. While the aggregate numbers might be different, the message is the same: patient transfers have a significant economic impact on receiving hospitals.

deterred from moving into under-served areas, it could affect the potential level of health care available to residents in those communities.

An argument could be made that a large hospital can absolve itself of any obligation to comply with EMTALA by refusing Medicare and Medicaid patients.¹²³ While this might be a viable option for certain boutique clinics¹²⁴ that cater to the wealthy, most hospitals are financially dependent on federal and state government subsidization of Medicare and Medicaid patient care.¹²⁵

Aside from this issue, the Tenth Circuit correctly dismissed St. Anthony's claim that it could not be liable for refusing to accept the transfer because the transfer was not appropriate.¹²⁶ Under St. Anthony's argument, a transferee hospital could never be held liable for refusing a transfer to which it did not agree.¹²⁷ As the court correctly determined, this would lead to an "absurd result"¹²⁸ and completely abrogate the effect of the reverse dumping provision.¹²⁹ Although the statute, on its face,

123. EMTALA liability is limited to hospitals that participate in Medicare and Medicaid provider agreements. See 42 U.S.C. §§ 1395dd(e)(2), 1395cc. See *supra* note 26 and accompanying text.

124. Specialized boutique clinics can forgo emergency departments in addition to refusing Medicare patients. See Peter Neurath, *Congress Slams Brakes on Boutique Hospitals*, PUGET SOUND BUS. J. (Jan. 16, 2004), available at <http://www.bizjournals.com/seattle/stories/2004/01/19/newscolumn2.html>.

125. See The Century Foundation, Medicare Watch, *Medicare: Nuts and Bolts*, at <http://www.medicarewatch.org/Basics/NutsandBolts.asp> (last visited Nov. 14, 2004). Medicare statistics from 1999 indicate that Medicare "spent \$128.8 billion on Part A benefits and \$80.7 billion on Part B benefits." *Id.* Part A covers "inpatient hospital services, nursing facility care following a hospital stay, some home health services, and hospice care." *Id.* Part B "helps pay for the cost of physician services, outpatient hospital services, and medical equipment and supplies." *Id.*; see also The Century Foundation, Medicare Watch, *What is Wrong with Medicare*, at <http://www.medicarewatch.org/Basics/WhatsWrong.asp> (last visited Nov. 14, 2004). Medicare expenditures are making up an increasing portion of the federal budget. Medicare Watch offers the following observations:

By 2030, Medicare will be responsible for covering 22 percent of the population, compared to 14 percent today, and the program's share of the federal budget is projected to increase proportionately. As a share of gross domestic product, Medicare is expected to climb from 2.4 percent in 1998 to 5.8 percent in 2030.

Id. With the addition of Medicaid payments, these government payments for the elderly and the poor make up a substantial pool of money that is available to hospitals which accept these patients. *Id.*

126. See *supra* notes 105–07 and accompanying text.

127. *St. Anthony Hosp.*, 309 F.3d at 700.

128. See *supra* note 107 and accompanying text.

129. See *supra* note 107 and accompanying text; see also *St. Anthony Hosp. v. The Inspector Gen.* (June 5, 2000), at <http://www.hhs.gov/dab/decisions/dab1728.html>. The DAB's opinion offered some additional insight on this issue:

We conclude that the ALJ did not err in determining that section 1867(c)(2)(B)(ii) [42 U.S.C. § 1395dd(c)(2)(B)(ii)] was inapplicable. The Act's definition of an "appropriate transfer" is not found in the general definition section of EMTALA. Rather, it appears in the context of the requirements that govern a hospital's actions when it transfers an unstabilized

contains a contradiction, under the rules of statutory construction, if the plain meaning of a statute would lead to an absurd result, courts should look beyond the words to the purpose of the provision.¹³⁰

Clearly, Congress's purpose in enacting the EMTALA statute was not to impose a duty on transferee hospitals and then hand these hospitals the power to defy this mandate with a simple "No." As the administrative law

patient. Thus, the criteria in section 1867(c)(2) [1395dd(c)(2)] provide guidance as to the meaning of "appropriate transfer" in this case only to the extent that they can be harmonized with section 1867(g) [1395dd(g)]. Recognizing that applying section 1867(c)(2)(B)(ii) [1395dd(c)(2)(B)(ii)] in the context of an alleged reverse-dumping case would eviscerate section 1867(g) [1395dd(g)], the ALJ properly determined that the subsection should not be applied here.

Id.

130. The Supreme Court articulated the applicable rule as follows:

There is, of course, no more persuasive evidence of the purpose of a statute than the words by which the legislature undertook to give expression to its wishes. Often these words are sufficient in and of themselves to determine the purpose of the legislation. In such cases we have followed their plain meaning. When that meaning has led to absurd or futile results, however, this Court has looked beyond the words to the purpose of the act. Frequently, however, even when the plain meaning did not produce absurd results but merely an unreasonable one "plainly at variance with the policy of the legislation as a whole" this Court has followed that purpose, rather than the literal words. When aid to construction of the meaning of words, as used in the statute, is available, there certainly can be no "rule of law" which forbids its use, however clear the words may appear on "superficial examination." The interpretation of the meaning of statutes, as applied to justiciable controversies, is exclusively a judicial function. This duty requires one body of public servants, the judges, to construe the meaning of what another body, the legislators, has said. Obviously there is danger that the courts' conclusion as to legislative purpose will be unconsciously influenced by the judges' own views or by factors not considered by the enacting body. A lively appreciation of the danger is the best assurance of escape from its threat but hardly justifies an acceptance of a literal interpretation dogma which withholds from the courts available information for reaching a correct conclusion. Emphasis should be laid, too, upon the necessity for appraisal of the purposes as a whole of Congress in analyzing the meaning of clauses or sections of general acts. A few words of general connotation appearing in the text of statutes should not be given a wide meaning, contrary to a settled policy, "excepting as a different purpose is plainly shown."

United States v. Am. Trucking Ass'ns, 310 U.S. 534, 543-44 (1940) (citations omitted).

It is clear from the purpose of the statute that the interpretation of the reverse dumping provision advanced by St. Anthony would frustrate congressional intent. *See* Triege, *supra* note 23, at 1207 n.140 (1986) (citing H.R. REP. NO. 99-241, pt. 1, at 27 (1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 605). The House of Representatives report contained the following observations:

The [House Committee on Ways and Means] is 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. The Committee is most concerned that medically unstable patients are not being treated appropriately. There have been reports of situations where treatment was simply not provided. In numerous other instances, patients in an unstable condition have been transferred improperly, sometimes without the consent of the receiving hospital.

Id.; *see also supra* note 23 (stating that a transferee hospital's ability to refuse transfer of patients would severely undermine the general concerns of Congress in enacting the EMTALA statute).

judge concluded in the prior proceeding, Congress in drafting the statute to say that the transferee hospital must accept the transfer was most likely attempting to deter the transfer of patients to transferee hospitals without providing notice of the transfer.¹³¹

IV. PROPOSAL

In light of the Tenth Circuit's recent elaboration of EMTALA's reverse dumping provision in *St. Anthony Hospital*, most modern, research-oriented hospitals within the court's jurisdiction will be required to accept transfers of patients from smaller, lesser-equipped medical facilities. The goal of the reverse dumping provision, and the Tenth Circuit's loose interpretation of the requisite factors imposing a duty on transferee hospitals, is obvious, and certainly laudable. The goal is to insure a minimum level of care for patients suffering from emergency conditions regardless of their ability to pay and whether or not they have insurance.¹³² The reverse dumping provision exists to provide a safety net for patients who seek emergency care but have the misfortune of arriving at the doors of a facility incapable of providing the requisite care.¹³³

Considering the aforementioned implications of the *St. Anthony Hospital* decision,¹³⁴ a balance must be struck between Congress's concerns for public welfare and the economic realities of modern day health care.¹³⁵ Overhead costs are high; between supplies, systems

131. See *supra* note 107.

132. See *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1039 (D.C. Cir. 1991).

The Emergency Act was passed in 1986 amid growing concern over the availability of emergency health care services to the poor and uninsured. The statute was designed principally to address the problem of "patient dumping," whereby hospital emergency rooms deny uninsured patients the same treatment provided paying patients, either by refusing care outright or by transferring uninsured patients to other facilities.

Id.

133. See *supra* notes 69–71 and accompanying text.

134. See *supra* Part III.

135. See generally AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS (2003 ed.). In 2001, the total expenses of large hospitals having over 500 patient beds registered with the association was \$105,085,709,086. *Id.* at 27. 249 hospitals fell into this category. *Id.* at 26. This breaks down to expenses of \$422,030,960 per facility. The expenses for the smallest facilities in the survey, those having between six and twenty-four beds, totaled \$1,613,936,534. *Id.* at 13. A total number of 281 facilities fell into this category. *Id.* at 12. Thus, the average expenses for a small facility was approximately \$5,743,546. The average per hospital expenses for the other categories of the survey are as follows: 25–49 beds: \$12,425,261; 50–99 beds: \$22,458,818; 100–199 beds: \$54,483,084; 200–299 beds: \$108,525,238; 300–399 beds: \$169,618,501; 400–499 beds: \$247,756,417. See *id.* at 12–25. These numbers reflect what, intuitively, would be expected: larger facilities have greater expenses than smaller facilities. (Note: these per hospital expenses were calculated by dividing the number of facilities by the total expenses for each category of facilities).

maintenance,¹³⁶ and personnel, a modern facility of the type targeted by the reverse dumping provision must generate a substantial amount of revenue just to break even.¹³⁷

One potential reform would be to allow transferee hospitals the option of refusing a transfer if there are other comparable facilities available to accept the patient. Under this scenario, a particular transferee hospital would not be saddled with the responsibility for taking on a potentially indigent patient just because it is at the top of an attending physician's speed dial list at a small local clinic. Under this scheme, the transferee hospital would be exempt from accepting the patient if the transferring hospital could make alternate arrangements within a reasonable amount of time.¹³⁸

This proposal would be particularly effective in major metropolitan areas where there are a number of large research hospitals available for patient transfer under the reverse dumping provision. As it stands, the statute places every major facility at the mercy of smaller surrounding facilities to decide which transferee hospital they will select to receive their patient.¹³⁹ Under this proposal, if a particular qualified hospital is called on to receive a patient transfer, and is given the opportunity to refuse the transfer, it can defray some of the patient traffic directed towards it without incurring liability under the EMTALA statute.¹⁴⁰ It should be reiterated that a particular transferee hospital's ability to refuse to accept a patient transfer is contingent upon the transferring hospital's ability to obtain a transfer agreement at another hospital within a reasonable amount of time.¹⁴¹

136. Systems maintenance is an arbitrary term that this Note uses to refer to costs involving the operation and maintenance of all of the equipment hospitals use in the treatment of patients as well as the costs of utilities.

137. *See supra* note 135. Because larger hospitals have expanded facilities that make them attractive as transfer destinations, they may be particularly vulnerable to the economic repercussions of providing emergency care to the indigent. This care adds to a hospital's expenses without adding any off-setting revenue, creating an adverse effect on a hospital's bottom line.

138. It would be up to the courts to determine what constitutes a reasonable period of time. Traditional contract law notions of reasonable time would most likely apply.

139. 42 U.S.C. § 1395dd(g). The language of EMTALA's reverse dumping provision provides no escape valve for hospitals that satisfy the requirements of specialized capability and capacity. *Id.* *See also supra* note 70.

140. Normally under EMTALA's reverse dumping provision, liability would be imposed for refusing to accept a transfer of the patient. 42 U.S.C. § 1395dd(d), (g); *see also supra* notes 69–71 and accompanying text. The option to refuse transfer would, in essence, provide transferee hospitals with the ability to suspend the strict duties imposed on them under EMTALA as long as the transferring hospital is able to secure the transfer of the patient elsewhere. *See also infra* note 141 and accompanying text.

141. An argument could be made that grave consequences could arise if all major hospitals in an

An alternative measure that would be particularly effective in areas with only one major medical facility is cost-sharing. A single modern medical facility surrounded by smaller facilities would be particularly susceptible to patient transfers. Under the cost-sharing plan, a transferring hospital has to bear some of the costs associated with the treatment of indigent patients who are transferred. Therefore, the large hospital would not have to absorb the costs alone.¹⁴²

Under this proposal, the concerns a large hospital might have with moving into an under-served area would be alleviated by the knowledge that it will receive assistance in paying for the costs associated with the care of transferred patients.¹⁴³ In addition, requiring smaller hospitals to share in the treatment costs might create incentives for these facilities to expand their own capabilities because it may be more cost-effective than cost-sharing with larger hospitals.

V. CONCLUSION

St. Anthony Hospital represents a decision by a federal circuit court specifically addressing the reverse dumping provision of EMTALA. The Tenth Circuit's opinion added some clarification to the arguably nebulous terms of "specialized capabilities" and "capacity" used by Congress.¹⁴⁴ In

area refuse to accept the transfer. It is unlikely that this will occur because each large hospital in the area will most likely accept some transfer requests in the interest of maintaining good business relations among the larger facilities and in the hope that the others will act in kind in the future. In any event, if the transferring hospital is unable to secure a transfer with any facility in the area, it would be free to call on any of the large hospitals, which will then face liability under EMTALA if they refuse.

142. Underlying this proposal is the fundamental assumption that the original hospital should be financially responsible, to a certain degree, for the care of the indigent patient. The cost-sharing plan proposed in this Note endeavors to guard against the scenario of numerous smaller facilities sending multiple patients to one large facility without sharing in the cost. Smaller clinics are generally more geographically dispersed and it is likely that they will receive patients from their immediate surrounding areas. On the other hand, larger hospitals tend to be both of lesser number and more centrally located in a geographic area. These hospitals face the unique possibility of receiving transfer requests from numerous facilities and, if they are expected to absorb the full cost of treatment, bear a disproportionate share of the financial burden.

143. Some might argue that allowing a large hospital to share the cost of treatment of an indigent patient with a smaller hospital might encourage price gouging. In other words, a large transferee hospital which receives a patient transfer from a smaller hospital might be tempted to inflate the charges in the interest of fleecing the smaller facility. This Note's cost-sharing proposal envisions a series of contractual relationships between the smaller hospitals and the larger hospitals to guard against this potentiality. The federal government could ensure compliance by making Medicare payments contingent upon the existence of valid contracts, as it does for compliance with EMTALA in general. *See supra* note 26 and accompanying text. Under this proposal, smaller hospitals are still entitled to traditional contractual remedies in the event of egregious abuse of the system by large hospitals.

144. *See supra* notes 96–104 and accompanying text.

doing so, the court cast a wide net by borrowing from the definitional language of the DHHS and adopting a very loose definition of both terms.¹⁴⁵

As a result of the court's holding, hospitals, particularly large, modern research hospitals, need to be keenly aware of the reverse dumping provision and its implications for liability. In addition, Congress should consider the potential ramifications of one of the highest courts in the federal judiciary construing the statutory language so broadly. Granted that the potential consequences discussed in this Note are speculative and time will be the ultimate measure of the effects of the Tenth Circuit's opinion, courts in other circuits should consider these possibilities and the potential effects on the public welfare if this issue should arise within their jurisdictions.

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145. *See supra* notes 116–20 and accompanying text.

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