

PATIENT DUMPING

What is the Emergency Medical Treatment and Active Labor Act?

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a federal statute which requires hospitals:

- To provide for an appropriate medical screening examination within the capability of the hospital's emergency department for any person who comes to the hospital's emergency department in order to determine whether an emergency medical condition exists.¹ The appropriateness of a screening examination is judged by whether it is performed equitably in comparison to other patients with similar symptoms, not by its proficiency in accurately diagnosing the patient's illness.²
- To provide stabilizing treatment to any person who comes to the hospital and has an emergency medical condition.³

What is an “emergency medical condition” under EMTALA?

The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical treatment could reasonably be expected to result in one of the following:⁴

- Placing the health of the individual (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman who is having contractions, an “emergency medical condition” means that:

- There is inadequate time to effect a safe transfer to another hospital before delivery, or
- Transfer may pose a threat to either the health or safety of the woman or the unborn child.

What does “stabilized” mean under the EMTALA?

The term “stabilized,” with respect to an emergency medical condition, means that no material deterioration of the condition is likely, within reasonable medical probability, to result

¹ 42 U.S.C. § 1395dd(a), 42 C.F.R. § 489.24(a).

² *Marshall v. East Carroll Parish Hosp. Serv. Dist.*, 134 F.3d 319 (5th Cir. 1998).

³ 42 U.S.C. § 1395dd(b), 42 C.F.R. § 489.24(a).

⁴ 42 U.S.C. § 1395dd(e)(1), 42 C.F.R. § 489(b).

from or occur during a transfer. In the case of a pregnant woman having contractions, “stabilized” means that the woman has delivered the baby and the placenta.⁵ The stabilization requirement is defined in regard to a possible transfer, and without reference to the patient’s long-term care within the hospital system.⁶

When may a hospital transfer a person with an emergency medical condition that has not been stabilized?

Under the EMTALA, a hospital may not transfer to another medical facility a person who has an emergency medical condition which has not been stabilized unless:⁷

- The person or the person’s legal representative, after being informed of the hospital’s obligations and the risks of transfer, in writing requests a transfer.
- A physician has signed a certification stating that, based on the information available at the time of the transfer, the medical benefits expected from appropriate medical treatment at another medical facility outweigh the increased risks to the person, or in the case of active labor, to the unborn child, from the transfer.
- If a physician is not physically present in the emergency department at the time the person is transferred, a qualified medical person, after consulting with a physician who determines that the benefits of transfer outweigh the risks, signs the required certification. The physician consulted must subsequently countersign the certification.

Any such transfer must be an appropriate transfer, meaning that:⁸

- The transferring hospital provides the medical treatment within its capacity which minimizes the risks to the patient’s health and, in an active labor case, the unborn child’s health.
- The receiving facility has available space and qualified personnel to treat the individual and has agreed to accept the transfer and provide appropriate medical treatment.
- The transferring hospital sends all medical records relating to the emergency medical condition, including records regarding the emergency medical condition, observations of signs and symptoms, preliminary diagnosis, treatment provided, test results, if any, and the informed written consent or certification for transfer, to the receiving facility.
- The transfer is effectuated by qualified personnel with the use of any necessary transportation equipment and medically appropriate life support measures.

⁵ 42 U.S.C. § 1395dd(e)(3)(B), 42 C.F.R. § 489.24 (b).

⁶ *Bryan v. Rectors & Visitors of the Univ. of Virginia*, 95 F.3d 349 (4th Cir. 1996).

⁷ 42 U.S.C. § 1395dd(c)(1)(A), 42 C.F.R. § 489.24(e)(1).

⁸ 42 U.S.C § 1395dd(c)(2), 42 C.F.R. § 489.24(e)(2).

Does EMTALA only apply to patients without health insurance?

No. EMTALA applies to “any individual” who presents to an emergency room regardless of whether the patient has health insurance or not.⁹

Does EMTALA create a national standard of care?

No. The aim of EMTALA is to address the problem of disparate treatment of insured and uninsured patients with emergency medical conditions. EMTALA does not create a federal medical malpractice statute, or recognize a separate cause of action for misdiagnosis or failure to recognize the extent of injury or illness and order additional diagnostic studies.¹⁰

Does EMTALA provide a private cause of action against an individual physician or a private clinic?

No. EMTALA provides a private cause of action only against hospitals for any individual who suffers personal harm as a result of the hospital violating EMTALA.¹¹ Courts which have addressed the issue have confirmed that EMTALA provides a cause of action against hospitals, not against physicians or private clinics.¹²

Does a physician have any individual liability under EMTALA?

Yes. Any physician who is responsible for the examination, treatment, or transfer of an individual with an emergency medical condition in a hospital and who negligently violates EMTALA’s provisions, or negligently signs a certification for transfer, or who negligently misrepresents an individual’s condition or other information is subject to a civil money penalty of up to \$50,000 for each violation.¹³ If the physician engages in gross and flagrant or repeat violations, the physician may be excluded from participation in the Medicare and Medicaid programs.¹⁴ In addition, a physician may be subject to malpractice liability if the physician’s conduct violates the applicable standard of care and proximately causes injury.

What is the potential liability of an on-call physician at a hospital who fails or refuses to appear within a reasonable amount of time after being notified of the need to see a patient with an emergency medical condition and the patient is transferred because the risk of being without the on-call physician’s services is greater than the risk of transfer?

A hospital on-call physician who fails or refuses to appear, within a reasonable amount of time, after being notified of the need to see a patient with an emergency medical condition, is subject to a civil money penalty of up to \$50,000 and, for gross and flagrant or repeated refusals,

⁹ 42 C.F.R. § 489.24(a)(1), *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037 (D.C. Cir. 1991).

¹⁰ *Guadalupe v. Agosto*, 299 F.3d 15 (1st Cir. 2002).

¹¹ 42 U.S.C. § 1395dd(d)(2)(A).

¹² *Brooks v. Maryland Gen. Hosp.*, 996 F.2d 708 (4th Cir. 1993), *Delaney v. Cade*, 986 F.2d 387 (10th Cir. 1993), *King v. Ahrens*, 16 F.3d 265 (8th Cir. 1994), *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872 (4th Cir. 1992).

¹³ 42 U.S.C. § 1395dd(d)(1)(B).

¹⁴ *Id.*

exclusion from participation in the Medicare and Medicaid programs.¹⁵ The physician authorizing the transfer is not subject to penalty.¹⁶

Must an on-call physician who is called to see a patient in the hospital emergency department assume the ongoing care of the patient after conducting an appropriate medical screening examination and providing any necessary stabilizing treatment?

Typically, no. A hospital on-call physician who is notified that his or her services are needed to screen and stabilize a patient in the emergency department must come in, screen, and stabilize the patient,¹⁷ but is not required to provide ongoing care to the patient after the patient has been screened and stabilized. If, however, the patient is admitted to the hospital, and the on-call physician is the one who admits the patient, or is designated as the patient's attending physician, or is asked to provide care and treatment to the patient in the hospital, then the on-call physician would have obligations with respect to the patient's ongoing care.

May a hospital on-call physician bill the patient or the patient's health plan for services the physician provides to screen and stabilize the patient in the emergency department even if the physician does not participate in the patient's health plan?

Yes. A nonparticipating hospital on-call physician may bill the patient or the patient's health plan for the services the physician provides in the emergency department to screen and stabilize the patient. Under Washington law, health plans are required to provide coverage for emergency services necessary to screen and stabilize a covered person even when those services are obtained from a nonparticipating hospital emergency department if a prudent layperson would reasonably have believed that an emergency medical condition existed and that use of a participating hospital emergency department would result in a delay that would worsen the emergency or if a provision of federal, state or local law required the use of a specific provider or facility.¹⁸

¹⁵ 42 U.S.C. § 1395dd(d)(1)(B).

¹⁶ 42 U.S.C. § 1395dd(d)(1)(C).

¹⁷ 42 U.S.C. § 1395dd(a), (d)(1)(B).

¹⁸ RCW 48.43.093.