No. 92-421

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

RICHMOND MEMORIAL HOSPITAL,

Petitioners,

v.

TAJA SMITH, an infant who sues by and through her next friend and mother, Connie Elizabeth Smith, and CONNIE ELIZABETH SMITH, individually,

Respondents.

On Petition for Writ of Certiorari to the Supreme Court of Virginia

MOTION FOR LEAVE TO FILE AND BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONER

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MOTION FOR LEAVE TO FILE BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

The American Hospital Association ("AHA") respectfully moves the Court for leave to file a brief *amicus curiae* in support of the Petitioner Richmond Memorial Hospital.

The American Hospital Association has an interest in this case because the scope of coverage of the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, affects the AHA's approximately 5400 hospital members,

many of whom are Medicare providers. EMTALA requires Medicare hospitals to fulfill certain obligations to individuals with emergency conditions. The Virginia Supreme Court has interpreted this federal act in a manner that broadly expands its scope of coverage to include all admitted patients at a hospital who develop emergency conditions. As a principal spokesman for American hospitals, the AHA can provide the Court with information relevant to the effect of the *Richmond Mem.* decision upon hospital operations nationwide.

Undersigned counsel for AHA has attempted to obtain consent to the filing of this brief pursuant to Supreme Court Rule 37.2. Counsel for Petitioners has given such consent but counsel for Respondents has indicated that Respondents will not consent.

WHEREFORE, AHA moves that this Court allow the filing of the "Brief of Amicus Curiae American Hospital Association In Support of Petitioner Richmond Memorial Hospital," which is submitted herein with the requisite number of printed copies.

Respectfully submitted,

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October 5, 1992

QUESTION PRESENTED

The first issue raised by the Petition and upon which the American Hospital Association submits this Brief Amicus Curiae is:

Whether the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd, imposed on Medicare hospitals to screen, and if appropriate, stabilize or transfer a patient coming to the emergency department also apply to such patient after stabilization or to a hospital patient not admitted through the emergency department?

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

Cases

TABLE OF AUTHORITIES – Continued

Federal Statutes and Regulations

TABLE OF AUTHORITIES – Continued

State Statutes

Legislative History

TABLE OF AUTHORITIES – Continued

Miscellaneous

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BRIEF OF THE AMERICAN HOSPITAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONER

INTEREST OF THE AMICUS CURIAE

The American Hospital Association ("AHA") is the primary national membership organization for hospitals in this country. It has approximately 5400 member hospitals and other health care organizations. AHA's principal objective is to promote high-quality health care and health services for all, through leadership and assistance to hospitals and health care organizations in meeting the health care needs of their communities.

Virtually all AHA acute care hospitals provide emergency room services and are participants in the federal Medicare program. As participants in the program, they are subject to EMTALA.[1] As the front line providers of emergency medical care, they are directly and significantly affected by its requirements. Under the Virginia Supreme Court's decision, *Smith v. Richmond Mem. Hosp.*, 243 Va. 445, 416 S.E.2d 689 (1992), EMTALA may now affect all patient transfers and discharges.[2]

AHA and its members are committed to assuring that individuals with emergency conditions[3] have access to emergency medical care through hospital emergency departments. An

[1]This Brief uses the term EMTALA to refer to the obligations imposed upon Medicare hospitals by 42 U.S.C. § 1395dd (1988). Other courts, including the court below, use the term COBRA because EMTALA was adopted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985. As COBRA contains many unrelated provisions, use of the term EMTALA helps to focus on the specific legislation relating to Medicare hospital emergency departments' responses to individuals with emergency conditions. Unless indicated otherwise, citations to EMTALA refer to the statute as it existed in 1988, the date of the events in the underlying action.

[2]As defined in EMTALA, a "transfer" includes a discharge. 42 U.S.C. § 1395dd(e)(5). All transfers of patients with unstabilized emergency conditions must follow the subsection (c) protocols. *Id.* § 1395dd(b).

[3]For purposes of this Brief, the term "emergency condition" means both "emergency medical condition" and "active labor," as those terms were defined in 1988. In 1988 EMTALA referred to "emergency medical condition" and "active labor" in separate definitional sections. 42 U.S.C. § 1395dd(e)(1 & 2) (1988). Congress later amended EMTALA to merge the terms into one definitional concept "emergency medical condition" that incorporates the 1988 subsection (e)(1) definition of emergency medical condition and a modified version of the 1988 subsection (e)(2) definition of active labor. 42 U.S.C. § 1395dd(e)(1)(A & B)(1988 & Supp. I 1989).

emergency department's refusal to provide emergency treatment to a person with an emergency condition is a matter of serious concern and is dealt with severely under EMTALA. A hospital can be fined, lose the right to payment for treating Medicare beneficiaries, and be sued in a civil damages action. 42 U.S.C. § 1395dd(d). The federal investigative process is swift and public. *See* Notice of Proposed Rulemaking, 53 Fed. Reg. 22,513, 22,518 (June 16, 1988) (expressing federal enforcement agency's intent to follow the fast-track termination process). It has been and continues to be of concern to AHA and its members that a statute with such serious implications be administered clearly, fairly, and faithfully to the intent of Congress.

In the absence of interpretive federal regulations, on behalf of its member hospitals, AHA sought the views of the Health Care Financing Administration ("HCFA") of the Department of Health and Human Services, the federal agency charged with enforcement of EMTALA. With the benefit of HCFA's views, AHA prepared a briefing to its members on the requirements of EMTALA. The Virginia Supreme Court's conclusion that the EMTALA transfer protocols apply to the inpatient[4] setting regardless of contact with the emergency department is inconsistent with both AHA's understanding of the reach of the statute and the interpretation HCFA follows in enforcing the statute. As a result, AHA members who followed the federal agency's interpretation of EMTALA may now face different legal liabilities from private actions and from administrative enforcement of the act. Consequently, the Virginia Supreme Court's decision undercuts fair and uniform enforcement of EMTALA. Further, AHA member hospitals now face new risks

[4]For purpose of the discussion in this Brief, the term "inpatient" refers to a patient admitted for a hospital stay and treatment upon the order of an admitting physician. In contrast, there are countless patient visits to a hospital's emergency department and for outpatient services which do not result in an admission. These patients would not be considered "inpatients."

of liability for treatment settings and decisions never addressed by Congress in enacting EMTALA. With litigation proceeding across the country in state and federal courts, the risk of inconsistent and contrary imposition of liability on AHA member hospitals increases as a result of the Virginia Supreme Court ruling.

SUMMARY OF ARGUMENT

This Court should grant the petition and determine that the EMTALA requirements for Medicare hospitals to screen, and if appropriate, stabilize or transfer apply only to a patient that presents to the emergency department in an emergency condition. The Court should reverse the holding below that an inpatient not admitted to a Medicare hospital through the emergency department may seek EMTALA damages. In addition, this Court should affirm Congress's intent that EMTALA obligations terminate once a Medicare hospital stabilizes an emergency condition.

Only this Court can authoritatively resolve the proper scope of this federal statute. The Virginia court's overbroad interpretation of EMTALA directly conflicts with the federal enforcement agency's interpretation and has spawned further confusion among the courts applying the statute. If left unresolved, this conflict will prolong the uncertainty faced by Medicare hospitals that have followed federal agency guidance but now may have broader liability in private damage actions. Neither a plain reading of the statute, nor its legislative history support the conclusion of the *Richmond Mem.* court. EMTALA should be interpreted to impose a series of related requirements linked to the presentment of a person with an emergency condition at a Medicare hospital emergency department.

Determining when the Act's obligations begin and end will ensure that EMTALA fulfills its purpose without excessive intrusion into traditional state law responsibilities for and

regulation of the delivery of medical care. The *Richmond Mem.* decision threatens to dislocate the traditional treatment relationships among inpatients, their admitting physicians, and hospitals. This Court should provide guidance at this time to restrain legal interpretations of EMTALA that would convert its provisions into a federal malpractice statute, bypassing state efforts to reform tort law.

ARGUMENT IN SUPPORT OF GRANTING THE WRIT

I. TO ELIMINATE FURTHER INCONSISTENT APPLICATION OF FEDERAL REQUIREMENTS FOR HOSPITAL EMERGENCY DEPARTMENTS THIS COURT SHOULD REVIEW THE VIRGINIA SUPREME COURT'S DECISION.

EMTALA is an important federal statute, intended to assure that individuals with emergency medical conditions have access to emergency medical treatment at hospital emergency departments. The decision of the Virginia Supreme Court may make every hospital patient's medical stabilization, transfer or discharge subject to EMTALA. The Virginia court's interpretation of EMTALA raises solely a federal question. The potential impact of the Virginia court's decision makes it imperative that this Court intervene now and construe EMTALA's scope and application.

This Court also should accept the Petition to resolve a conflict between the Virginia court's interpretation of EMTALA and the interpretation applied by HCFA. HCFA has consistently interpreted the requirements of EMTALA to apply to the emergency department of a hospital. *See* Notice of Proposed Rulemaking, 53 Fed. Reg. at 22,518-19 (June 16, 1988) (discussing application of the screening, stabilization and transfer requirements in the context of a person presenting for emergency services). HCFA has repeatedly confirmed its position that EMTALA applies to the emergency department and has made clear that its application ends at the point the individual is

stabilized. Pet. Br. App. H-4 to H-5 (1990)(responding to AHA inquiry at App. G-8 to G-9); App. E-6, E-14 to E-15 (1992)(HCFA instructions to State Agencies regarding enforcement of EMTALA). Hospitals which have relied on HCFA's interpretation are now placed at risk of additional liability under *Richmond Mem.* The effect of the decision is to create parallel but inconsistent requirements for hospital compliance with EMTALA under the private action and administrative enforcement provisions.

Imposing liability in a private action where there has been no patient contact with the emergency department also is inconsistent with the holdings of other jurisdictions. In reviewing the Act, several courts have indicated that the plaintiff must allege presentment to the emergency department. *E.g., Johnson v. University of Chicago Hosp.*, 774 F. Supp. 510, 513 (N.D. Ill. 1991)(EMTALA claim dismissed because plaintiff did not come to emergency room of hospital); *Daniels v. Wills Eye Hosp.*, No. CIV. A. 91-2309, 1992 WL 103009 (E.D. Pa. May 7, 1992)(all EMTALA claims dismissed because plaintiff could not allege that he presented to an emergency department of hospital). *See Teufel v. United States*, No. 89-1272-K, 1992 WL 160908, *4-*5 (D. Kan. Jun. 15, 1992)(rejecting *Richmond Mem.* in context of long-term psychiatric treatment); *Deberry v. Sherman Hosp. Ass'n*, 741 F. Supp. 1302, 1305 (N.D. Ill. 1990)(essential element of § 1395dd(b) claim is that plaintiff presented to emergency department of hospital). *But see Helton v. Phelps*, 794 F. Supp. 332, 333 (E.D. Mo. 1992); *Loss v. Song*, No. 89C 6952, 1990 WL 159612 (N.D. Ill. Oct. 16, 1990)(child born after mother came to emergency room entitled to bring EMTALA claim).

Acceptance of the Petition would reduce inconsistency and confusion among the courts on other issues of EMTALA

interpretation.[5] A decision by this Court on the scope and application of EMTALA would bring clarity to the threshold issue in all cases -- when does EMTALA afford a private right of action. Uniform application would be assisted if this Court accepted the Petition and determined whether EMTALA's requirements only afford persons with emergency conditions access to emergency departments for emergency medical treatment.

Until reviewed by this Court, *Richmond Mem.* will control private actions in Virginia state courts and will be used as persuasive authority in other state and federal courts. It has already been cited with approval in one case holding that a cause of action for EMTALA can arise without presentation at the emergency room, *Helton v. Phelps*, 794 F. Supp. at 333, and in several others negating application of provisions of state medical malpractice acts[6] deemed to conflict with EMTALA. *HCA Health Servs. v. Gregory*, 596 N.E.2d 974 (Ind. App. 1992), *Power v. Arlington Hosp.*, No. CIV. A. 92-0005-A, ___ F. Supp.

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[5]Litigation of key aspects of EMTALA has resulted in a variety of conflicting, inconsistent, and thus confusing interpretations. Some courts require a demonstration that the hospital's action was influenced by the indigence or economic circumstances of the individual, *see, e.g., Evitt v. University Heights Hosp.*, 727 F.Supp. 495 (S.D. Ind. 1989), *Di Gicomo v. St. Joseph's Hosp.*, 582 N.Y.S. 2d 887 (App. Div. 1992); others do not, *see, e.g., Brooker v. Desert Hosp. Corp.*, 947 F.2d 412 (9th Cir. 1991), *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037 (D.C. Cir. 1991), *Collins v. DePaul Hosp.*, 963 F.2d 303 (10th Cir. 1992). One has considered treatment as an inpatient to satisfy a hospital's obligation, *Collins v. DePaul Hosp.*, 963 F.2d at 308, another has required more, *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131, 1134 (6th Cir. 1990).

[6] One federal district court has reached the opposite conclusion. *Brooks v. Maryland Gen. Hosp. Inc.*, Civ. A. No. HAR-91-2819, 1992 WL 142690 (D. Md. 1992) (applying Maryland malpractice act requirements to EMTALA claim).

___, 1992 WL 210588, at *5 (E.D. Va. Aug. 28, 1992). Resolution of the threshold issue by this Court would conserve judicial and health care resources that would otherwise be expended in litigation in state and federal courts, and would assure uniformity in the interpretation of the respective rights and obligations under EMTALA for patients, hospitals, and physicians throughout the country.

II. THE VIRGINIA SUPREME COURT DECISION IMPROPERLY EXPANDS THE LIMITED FEDERAL OBLIGATION OF MEDICARE HOSPITALS TO PROVIDE EMERGENCY DEPARTMENT ACCESS.

EMTALA created a limited obligation requiring Medicare hospitals to respond to any individual seeking treatment at a hospital emergency department. To comply with EMTALA, the emergency department must screen the individual and determine if the individual has an emergency condition. 42 U.S.C. § 1395dd(a). If an emergency condition exists, the hospital must either stabilize the person's condition or[7] transfer the person using EMTALA procedures. 42 U.S.C. § 1395dd(b)(1)(A & B) & (c). Notwithstanding these limited statutory requirements, the *Richmond Mem.* court held that a hospital could be liable under EMTALA for civil damages to an inpatient who had not presented to the hospital emergency department. 243 Va. at 454-55, 416 S.E.2d at 694.

[7]Some courts have misread EMTALA to create an obligation to stabilize before transfer. *Deberry v. Sherman Hosp. Ass'n*, 741 F. Supp. 1302, 1305 (N.D. Ill. 1990) (to state an EMTALA claim, would-be plaintiff may allege that hospital transferred him before stabilizing the emergency condition). Yet the statutory requirement clearly is disjunctive: "[T]he hospital must provide *either* (A)[stabilization] *or* (B)[transfer pursuant to the provisions of subsection 1395dd(c)]. 42 U.S.C. § 1395dd(b)(1) (emphasis added).

On its face, EMTALA establishes a unitary set of requirements through subsections (a), (b), and (c), which are cumulative in nature. 42 U.S.C. § 1395dd(a-c). In marked contrast to the statute's terms, the Virginia Supreme Court held that "each subsection [of EMTALA] describes distinct patient circumstances requiring different treatment protocols." 243 Va. at 451, 416 S.E.2d at 692. The *Richmond Mem.* court found "nothing in [EMTALA] which limits application of these subsections [b and c] solely to a patient who initially arrives at an emergency room and who has not been stabilized." *Id.* at 452, 416 S.E.2d at 692. The court acknowledged, however, that "the legislative history of [EMTALA] indicates Congressional concern with denial of treatment and inappropriate transfers of indigent *persons who come to the emergency rooms*," *id.* at 454, 416 S.E.2d at 693-94 (emphasis added). Yet the court held that "the plain language Congress chose does not limit the Act to those circumstances." *Id.* at 454, 416 S.E.2d at 694.

Consequently, *Richmond Mem.* imposes on all hospitals in Virginia increased requirements and liability under a federal statute for patient care unrelated to emergency department screening and stabilization. Neither EMTALA's text nor its legislative history support the *Richmond Mem.* holding. As further demonstrated below, this Court should review the Virginia Supreme Court's ruling to assure consistent and appropriate application of the rights and remedies created by Congress to assure access to emergency care.

Congress created EMTALA as a specific remedy for a significant but discrete problem: the refusal by some hospital emergency rooms to assist indigent individuals with emergency conditions. "[EMTALA] addresses an issue which has gained much public attention over the last year. . . . [T]he inappropriate transfer of a number of seriously ill patients *from the emergency rooms of private hospitals to public hospitals*." 131 Cong. Rec. 28568 (Oct. 23, 1985) (Sen. Durenberger) (emphasis added). Many states did not require hospitals to respond to requests for

emergency assistance. *See, e.g., Walling v. Allstate Ins. Co.*, 183 Mich. App. 731, 735, 455 N.W.2d 736, 738 (1990) (describing traditional common law rule). Congress concluded that in a number of states there was no statutory, regulatory, or common law requirement to treat patients coming to a hospital emergency department. "Some states have laws which ensure that no emergency patient is denied emergency care because of inability to pay. But, 28 states have no such law." 131 Cong. Rec. 28569 (Oct. 23, 1985) (Sen. Kennedy). Both the hospital and the doctor in such states were free to decline treatment, even in admittedly emergent circumstances such as trauma or active labor.

To close this perceived gap in state law, Congress crafted EMTALA subsections (a) and (b)

> to require[ ] hospital emergency departments to medically screen and stabilize any patient seeking medical attention from the emergency department.

131 Cong. Rec. 29829 (Oct. 31, 1985) (remarks of Congressman Stark). Thus, EMTALA compels Medicare hospital emergency departments to conduct an appropriate medical screening of all individuals seeking emergency care to determine if an emergency condition exists. If an emergency condition is identified, the hospital must then treat the patient to stabilize the condition or transfer the patient. Transfer in such cases must comport with the protocols set forth in subsection (c). By these cumulative provisions all persons have access to initially responsive treatment for emergency conditions.

EMTALA, however, plainly does not govern treatment of inpatients already afforded access to a hospital. After admission to a hospital, patients do not need the EMTALA guarantees of access to screening and stabilization because they have a common law remedy if such treatment is negligent. *See Stuart Cir. Hosp. Corp. v. Curry*, 173 Va. 136, 147-52, 3 S.E.2d 153, 157-59 (1939). Only one type of patient needs and has EMTALA

protection: a person who presented to the emergency department with an emergency condition. *Thornton v. Southwest Detroit Hosp. Corp.*, 895 F.2d at 1134. Moreover, once the hospital stabilizes an emergency condition, the hospital has met its EMTALA duties. *Id.*; *Brooker v. Desert Hosp. Corp.*, 947 F.2d at 415; *Delaney v. Cade*, 756 F. Supp. 1476, 1485-87 (D. Kan. 1991). Thereafter, other regulatory and common law duties may apply; but, the "gap" perceived by Congress is closed when the emergency condition has been screened in the emergency department and the person stabilized or transferred, if appropriate.

A. The Plain Language Of EMTALA Creates A Cumulative Requirement For Emergency Department Screening, Stabilization Or Transfer.

Plainly read, the provisions of section 1395dd mandating access to emergency care are not severable. Subsection (a) creates the duty to determine by medical screening whether any patient coming to the emergency department requires treatment for an emergency condition. Then, and only if such emergency condition is found, subsection (b) creates a duty to "treat" by stabilizing or transferring the patient in accordance with EMTALA directives. If the hospital intends to transfer, under subsection (c) it must get an appropriate consent from the patient or document the emergency physician's "certification" of the medical necessity for transfer and consent of the receiving hospital.

The Virginia Supreme Court ignored the statutory context of these interrelated and interdependent provisions of EMTALA. It allowed plaintiff Smith to pursue her claims that Richmond Memorial Hospital failed to stabilize her condition as required by subsection (b) and, alternatively, failed to transfer her in accordance with the transfer protocols of subsection (c). Yet, the provisions of § 1395dd are triggered when an individual seeking care appears at the emergency department. The department then "must provide for . . . an appropriate medical screening . . . to

determine" if an emergency condition exists. 42 U.S.C. § 1395dd(a). Plaintiff Smith apparently was admitted to Richmond Memorial Hospital by her regular obstetrician and, therefore, she did not allege that she had received a screening from Richmond Memorial Hospital's emergency department.[8] The hospital's subsection (b) obligation to stabilize or transfer plaintiff Smith would arise only if an emergency department subsection (a) screening was sought and disclosed an emergency condition.

Contrary to the Virginia opinion, subsection (b) does not independently compel the hospital to make a determination; it merely describes what the hospital must do *if* a determination has been made, *i.e.*, stabilize or transfer.[9] Unlike subsection (a), subsection (b) does not require the hospital to arrive at a determination.

The Virginia Supreme Court does not explain why the stabilization requirement would exist independently of the screening determination. Moreover, if subsection (b) were read

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[8] In addition, Ms. Smith's claim fails because she conceded that, after her admission on July 18, 1988, Richmond Memorial Hospital "treated and stabilized her." Pet. Br. at 7-8 (citing Tr. 44 of Trial Court's Hearing on the Demurrer).

[9] The change from "emergency department" in subsection (a) to "hospital" in subsection (b) is the sole basis for the *Richmond Mem.* interpretation that subsections (a), (b) and (c) describe "distinct patient circumstances requiring different treatment protocols." 243 Va. at 451, 416 S.E.2d at 692. A more plausible reading would be that the change in terms expressed Congress's intent that the emergency department may need to use other hospital departments and resources to screen, stabilize or transfer patients coming to the emergency department. This reading is supported by later amendments compelling the hospital to use all of its resources that are reasonably available to respond to an emergency condition. *E.g.*, Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6211(a), 103 Stat. 2106, 2245 (1989), amending 42 U.S.C. § 1395dd(a).

in isolation to create "a different treatment protocol," as *Richmond Mem.* holds, 243 Va. at 451, 416 S.E.2d at 692, its requirements would not be limited to Medicare hospitals, nor even to hospitals with emergency departments. Finally, because subsection (b) does not independently impose any duty to conduct a medical screening, under the Virginia court's analysis a hospital simply could refuse to make a determination and avoid liability under EMTALA entirely.

Clearly, such results would be contrary to the express language of the Act read as a whole. And courts must read a statute as a whole in a manner that gives effect to the intent of the legislature. *Richards v. United States*, 369 U.S. 1, 11 (1962) (quoting *Mastro Plastics Corp. v. NLRB*, 350 U.S. 270, 285 (1956) (quoting *United States v. Boisdoré's Heirs*, 50 U.S. (8 How.) 113, 122 (1850))). Only by reading the plain language of subsections (a), (b)(1), and (c) as related and cumulative requirements does EMTALA mandate that Medicare hospital emergency departments afford appropriate medical screening and treatment.

B. The Legislative History Confirms That Congress Intended To Impose EMTALA Requirements Only To The Extent Necessary To Ensure Access To Hospital Emergency Departments For Emergency Treatment.

The legislative history of EMTALA confirms that Congress intended to assure all persons coming to an emergency department an appropriate medical screening and, if necessary, stabilization or transfer. The contemporaneous Ways & Means Committee Report, H. Rep. No. 241, 99th Cong., 1st Sess., pt. 1, at 4 ("H. Rep., pt. 1") (July 31, 1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 582, irrefutably establishes the intent in its explanation of subsection (b):

> Necessary Stabilizing Treatment.-- Within their capacities, hospital *emergency departments* must provide appropriate treatment *to stabilize* patients who have emergency medical

> conditions and to provide treatment for patients in active labor, *or provide for appropriate transfers*.

131 Cong. Rec. 29825 (Oct. 31, 1985) (emphasis added)[10]. This early language clearly establishes that the Committee always intended that subsection (b) would be a continuation of the EMTALA requirement that begins with the emergency department screening. Subsection (b) was not intended to impose an independent obligation for the hospital to constantly determine if an emergency condition existed for every patient admitted to the hospital. (Yet, this is the effect of the Virginia opinion.) Rather subsection (b) complements the screening provision by assuring that emergency conditions identified by the screening are treated through stabilization or a transfer in accordance with the subsection (c) protocols.

Legislative history also establishes that EMTALA's requirements are directed to the hospital emergency department. The Judiciary Committee's comments on the proposed EMTALA provisions presuppose that the screening and the stabilization or transfer obligation imposed by the bill applied *only* to hospitals with emergency medical departments.

> [S]ome hospitals, particularly those located in rural or poor areas, may decide to close their emergency rooms entirely rather than risk the [bill's proposed] civil fines, damage awards, and as to physicians, criminal penalties that might ensue.

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[10]Section 1395dd first appeared as § 124(b) in H.R. 3128, 99th Cong., 1st Sess. (1985), with its accompanying H. Rep. No. 241, pt. 1, at 3-4, 27-28, 131-134, from the House Ways and Means Committee. In the various bills pending during 1985-86, as in the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82, 164 (Apr. 7, 1986), the EMTALA § 1395dd provisions appear under § 1867, referring to its enumeration in the Social Security Act.

H. Rep. 241, 99th Cong., 1st Sess., pt. 3, at 6 (Sept. 11, 1985), *reprinted in* 1986 U.S.C.C.A.N. 726, 728.[11] Yet, by focusing on subsection (b) in isolation the Virginia opinion would extend EMTALA to all hospitals.

The Senate history also reveals the narrow focus of the legislation upon emergency treatment. "The bill does not create an obligation of any hospital to treat any patient *except in an emergency situation* and does not interfere with the practice of medicine." S. Rep. No. 146, 99th Cong., 1st Sess. 454 (Oct. 2, 1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 413 (emphasis added). The Senators stated on the floor that the provisions regulated emergency room treatment.

> [EMTALA] would enable the Secretary of Health and Human Services to terminate a hospital from the Medicare program that has inappropriately transferred or "dumped" a patient *from* its emergency room.

131 Cong. Rec. 28569 (Oct. 23, 1985) (Sen. Heinz) (emphasis added). No Senator suggested that the bill would regulate

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[11]The comments during the House debate also indicate an understanding that the proposed EMTALA requirements would apply only to the emergency room operations of hospitals. The Ways and Means Committee had placed in the Record its "Detailed Description of H.R. 3128" with "a more detailed description of the Medicare and public assistance provisions [Title I]". 131 Cong. Rec. 29822, 29823, 29824 (Oct. 31, 1985). This "more detailed description" repeated the explanation from the Ways and Means Committee Report, H. Rep. No. 241, pt. 1, that subsection (b) applied only to hospital emergency departments. *Compare* 131 Cong. Rec. 29825 (Oct. 31, 1985) *with* H. Rep. No. 241, pt. 1, at 4, *reprinted at* 1986 U.S.C.C.A.N. at 582, *supra* p. 13-14. The text of subsection (b) in the October 31, 1985 version of H.R. 3128 as adopted on the House floor the same day exactly matches the text of § 1395dd(b)(1) as adopted in the final version on March 1986. 131 Cong. Rec. 29846 (Oct. 31, 1985).

stabilization or transfer of patients unrelated to emergency department care.

Taken as a whole, the legislative history and the statutory text confirm that EMTALA imposes a specific continuous and cumulative obligation. Patients who do not arrive through the emergency department, or who have been stabilized after emergency department screening, simply are not within the zone of patient interests protected by EMTALA. In contradiction to the overwhelmingly consistent legislative intent, however, the *Richmond Mem.* court has held that a patient who was admitted to a hospital by her physicians, and apparently not as result of seeking treatment in the emergency department, may pursue EMTALA damages. Faced with this Virginia Supreme Court ruling, all of Virginia's hospitals, and the hospitals of any other state that adopts this ruling, must struggle to understand and apply EMTALA's requirements in virtually every hospital treatment setting.

III. THE VIRGINIA SUPREME COURT DECISION WILL SIGNIFICANTLY AND ADVERSELY AFFECT HOSPITALS.

A. The Virginia Court's Interpretation of EMTALA Disrupts Traditional Clinical Relationships And Responsibilities.

If applied to the inpatient setting, EMTALA will reach hundreds of thousands of treatment decisions made in the course of the routine operation of hospitals in transferring or discharging patients. During 1990, over 31 million individuals were admitted to community hospitals. American Hosp. Ass'n, *AHA Hospital Statistics* 20 (1991-92 ed.). The Virginia court's decision potentially imposes EMTALA requirements on all transfers or discharges relating to those patients.

Construing EMTALA as applicable to inpatient settings results in consequences unintended by Congress. The overlap between its provisions and already existing clinical and legal relationships will create unnecessary confusion regarding legal liability and treatment obligations. In contrast to the emergency department, where individuals arrive unaccompanied by a physician or without any personal physician, admission as an inpatient and their course of treatment is under the care and supervision of a physician who has privileges to admit and treat at the hospital. *See* Joint Comm'n on Accreditation of Hosps., *Accreditation Manual for Hospitals* 59 (1992) (Medical Staff Std. 2.16.5). Treatment decisions, including transfer and discharge, are the responsibility of this attending physician. An essential obligation of a hospital under the EMTALA transfer provision is to assure that a physician is involved in a decision to transfer. *See* 42 U.S.C. § 1395dd(c)(1)(A)(ii). For an inpatient, such a decision to transfer could only be made with the treating physician's authorization.

Applying EMTALA to the inpatient setting also would insert the federal government into the role of evaluating medical judgment and treatment decisions. A challenge to the transfer of an inpatient under EMTALA necessarily would include a review of the treating physician's judgment. The practice of medicine and the operation of hospitals, however, are adequately regulated under existing state agencies and accrediting organizations. *See, e.g.*, Cal. Health & Safety Code §§ 1250-1339.67, Cal. Bus. & Prof. Code §§ 2000-2504 (West 1990 & Supp. 1992); Ill. Rev. Stat. ch. 111 ½, ¶¶ 142-57, Ill. Rev. Stat. ch. 111, ¶¶ 4400-1 to -63 (1991); N.Y. Pub. Health Law §§ 2800-2813, N.Y. Educ. Law §§ 6520-6531 (McKinney 1985 & Supp. 1992). There is an existing body of state law establishing the respective rights and responsibilities in the patient/physician and patient/hospital relationships. Federal law has traditionally deferred to the states on such matters of health and public welfare. *Hillsborough County, Florida v. Automated Medical Labs., Inc.*, 471 U.S. 707(1985).

Superimposing EMTALA on the inpatient setting also would potentially subject disputes over inpatient transfer and discharge decisions to the federal administrative enforcement process. A HCFA investigation can be initiated on the basis of any complaint that a person's rights under EMTALA have been violated. Yet the Medicare Act is not intended to affect the practice of medicine or authorize its regulation. Section 1801 of the Medicare Act, 42 U.S.C. § 1395 (1988). The Report of the Senate Committee on Labor and Human Resources Report confirms that EMTALA was not intended to be an exception to this established principle of the Medicare Act. S. Rep. No. 146, 99th Cong., 1st Sess. 454 (1985), *reprinted in* 1986 U.S.C.C.A.N. at 413, *supra* p.15. Through its ongoing involvement with the Medicare program, Congress is familiar with the operations of hospitals and the routine relationship between inpatients and their physicians. Congress would not have made inpatient transfer disputes subject to HCFA investigations without leaving some legislative history of its intent to do so.

B. The Virginia Court's Decision Undermines State Tort Reform.

The Virginia Supreme Court's decision may also serve to frustrate accomplishment of state tort reform initiatives. *Richmond Mem.* has determined that the Virginia Malpractice Act's 90 day notice requirements, Va. Code Ann. § 8.01-581.2(A) (1992), do not apply to EMTALA claims. 243 Va. at 455-57, 416 S.E.2d at 694-95. Over the past 20 years virtually all states have enacted some tort reform measures. General Accounting Office, *Medical Malpractice: A Framework for Action* 8 (May, 1987). Reforms included statutory caps on noneconomic damages, prior notice requirements, shortened statutes of limitations, and prescreening panels. State tort reform efforts reflect the balance struck by state legislatures to deter and compensate for negligent acts in the delivery of health care while minimizing the adverse effects of broad-ranging malpractice liability upon the delivery of health care services. By applying

EMTALA to the transfer or discharge of inpatients, *Richmond Mem.* has extended the scope of issues subject to a private action to include the judgment of a treating physician in transferring or discharging his or her patient, thus blurring the distinction between EMTALA claims and negligence claims. By refusing to apply the state malpractice notice requirement, *Richmond Mem.* has isolated these federal challenges from the procedures that would otherwise apply. *Richmond Mem.* sets the stage for the use of EMTALA to litigate issues that clearly are intended to be the subject of a negligence action where state tort reform requirements would apply.

Applying EMTALA to the inpatient setting confuses the clinical and legal relationships of patients, their physicians, and hospitals. Nothing in the statutory text, the legislative history of the Act, or the *Richmond Mem.* analysis supports deviation from the longstanding principles and practices governing the treatment of inpatients.

CONCLUSION

The Virginia Supreme Court's disjointed reading of EMTALA should not remain a precedent further sowing seeds of confusion about the proper application of EMTALA. Congress adopted this law to fill a gap in existing state laws which often failed to assure access to emergency care. EMTALA is an important federal response to this discrete national problem; its clear terms and manifest intent should not be subject to disparate and conflicting interpretation by state courts.

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