No. 92-2195

IN THE

United States Court of Appeals for the Fourth Circuit

SUSAN M. POWER,

Plaintiff-Appellee,

v.

ARLINGTON HOSPITAL ASSOCIATION,

Defendant-Appellant.

BRIEF AMICUS CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF DEFENDANT-APPELLANT ARLINGTON HOSPITAL ASSOCIATION

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EM + ALA : duty to screen

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BRIEF AMICUS CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF DEFENDANT-APPELLANT ARLINGTON HOSPITAL ASSOCIATION

INTEREST OF THE AMICUS

Virtually all American Hospital Association ("AHA") acute care hospitals provide emergency room services and are participants in the federal Medicare program. Because they participate in the program, they are subject to the Emergency Medical Treatment Active Labor Act ("EMTALA" or "the Act"), 42 U.S.C. § 1395dd (1988 & Supp. II 1990). As the front line providers of emergency medical care, they are directly and significantly affected by its requirements. AHA and its members are committed to assuring that individuals with emergency conditions have access to emergency medical care through hospital emergency departments. An emergency department's refusal to provide an appropriate medical screening to a person who seeks an examination 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). 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.

ISSUES ON REVIEW[1/]

Among the issues arising in the case on appeal, this brief addresses two questions related to the proper interpretation of EMTALA:

Issue 1

What are the elements of proof necessary to establish a violation of the EMTALA requirement that a hospital provide for an appropriate medical screening examination to determine whether an emergency medical condition exists?

Issue 2

What constitutes the proper jury instructions for a determination of fact where all elements of an EMTALA violation are pled and supported by some evidence?

1/ Amicus concurs with the Appellant's statement of subject matter and appellate jurisdiction, Fed. R. App. P. 28(a)(2), and the Appellant's statement of applicable standard of review. 4th Cir. R. 28(c).

STATUTORY HISTORY, CONGRESSIONAL INTENT, AND JUDICIAL INTERPRETATION OF EMTALA

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. Many states did not require hospitals to respond to requests for emergency assistance. 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 examine or treat patients coming to an emergency department.[2/] 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 1395dd(a) and (b). EMTALA compels the emergency departments of Medicare participating hospitals to provide for an appropriate medical screening of all individuals seeking emergency care to determine if an emergency condition exists. 42 U.S.C. § 1395dd(a). If an emergency condition is identified, the hospital must then treat the patient in an attempt to stabilize the condition or transfer the patient. Id. § 1395dd(b). Transfer of a person with an emergency condition must comport with the

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2/ "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 (1985)(Sen. Kennedy).

statutory requirements in § 1395dd(c). By these cumulative provisions all persons can obtain an initial evaluation of their condition, and treatment if an emergency condition exists.

In interpreting EMTALA, this Court has carefully outlined the scope of EMTALA in light of the congressional purpose. In Baber v. Hospital Corp. of Amer., 977 F.2d 872 (4th Cir. 1992), this Court recognized that "EMTALA is no substitute for state law medical malpractice actions." Id. at 880. For it was "not designed to provide a federal remedy for misdiagnosis or general malpractice." Brooks v. Maryland Gen. Hosp., Inc., ___ F.2d ___, ___, No. 92-1852, 1993 WL 214696, at *1 (4th Cir. June 21, 1993). EMTALA "does not create liability for malpractice based on a breach of national or community standard of care; at the core, it aims at disparate treatment." Brooks, 1993 WL 214696, at *4. Like this Court in Baber and Brooks, other courts have recognized that EMTALA is not a federal malpractice statute. Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 272 (6th Cir. 1990)("the terms of the statute . . . precludes resort to a malpractice or other objective standard . . . ."); Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1041 (D.C. Cir. 1991)(the Act does not "creat[e] a sweeping federal cause of action with respect to what are traditional state-based claims of negligence or malpractice.").

In addition, "[EMTALA] does not guarantee that the emergency personnel will correctly diagnose a patient's condition as a result of this screening." Baber, 977 F.2d at 879 (footnote omitted); accord Brooks, 1993 WL 214696 at *2. The function of the medical

screening examination required by § 1395dd(a) is to ensure that a hospital "develop a screening procedure designed to identify such critical conditions that exist in symptomatic patients and to apply that screening procedure uniformly to all patients with similar complaints." Baber, 977 F.2d 879 (footnote omitted). When a hospital by policy and practice provides for a system of organizing and coordinating its response to any presenting patient, the hospital has complied with EMTALA, 42 U.S.C. § 1395dd(a).

STATEMENT OF THE CASE

To prevail on an EMTALA claim, a plaintiff must prove a violation of a requirement of the Act imposed on a Medicare participating hospital. In this case, plaintiff Susan Power alleged essentially two violations of EMTALA: failure to provide for an appropriate medical screening upon her initial visit to Arlington Hospital ("Hospital"), and failure to stabilize her condition prior to an improper transfer. The Hospital moved for summary judgment on both claims, which the court denied. The evidence at trial did not convince either the jury or the district court judge on the second issue. The basis for the jury verdict now on appeal, therefore, is the count alleging that Arlington Hospital failed to meet the EMTALA requirement that it "provide for an appropriate medical screening examination . . . ." 42 U.S.C. § 1395dd(a) (emphasis added). The jury awarded Ms. Power $ 5,000,000 on her claim. The Hospital filed a motion for judgment as a matter of law, a motion for a new trial, and a motion for

remittitur. The court denied all three motions. The Hospital brought this appeal from the judgment entered on the verdict and from the denial of the post-trial motions.

STATEMENT OF FACTS PERTINENT TO AMICUS ISSUES[3/]

Susan Power presented to the emergency room of Arlington Hospital on February 24, 1993 at 5:45 a.m. complaining of pain in her hip. Ms. Power contends that she had an infected boil clearly visible on her face and that she had experienced chills. Upon arrival, Nurse Barbara Goldy helped Ms. Power from the car and took her, by wheelchair, directly to the examining room. The Hospital did not require Ms. Power to pass through its customary triage or registration process. Nurse Christine Stadher took her vital signs and recorded a preliminary nursing assessment. Nurse Goldy performed a dipstick urinalysis test shortly after Ms. Power's arrival. Neither the boil nor the chills was noted in the Hospital record.

Dr. Mitchell Heiman began his examination of Ms. Power at 6:00 a.m., within 15 minutes of her arrival, and ordered an X-ray. While the X-ray was being taken, Dr. Heiman's shift ended, so he discussed the case with Dr. Benedict Semmes, who assumed responsibility for Ms. Power's care. Dr. Semmes further examined Ms. Power after her return from X-ray around 7:00 a.m. At that

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[3/] The Appellant's Brief contains a full recitation of the facts. The following synopsis focuses on facts especially relevant to the issues addressed in this Amicus Brief.

time he reviewed her X-ray with her and discussed the nature of the pain she was feeling. He decided that she could be discharged home with instructions to return to the Hospital if the pain got worse or did not improve. He gave her medication for pain and a mild antibiotic in case she had a urinary tract infection. Dr. Semmes also gave Ms. Power the name of an orthopaedic surgeon. In addition he ordered a urinalysis, but the results did not arrive prior to her discharge and departure by car. During the course of her emergency department visit, the Hospital became aware that Ms. Power was an unemployed, British subject without medical insurance.

Unbeknownst to the Hospital, Ms. Power had a sepsis condition, which meant that her body was unsuccessfully attempting to fight a general infection. It is undisputed that the Hospital did not identify her emergency medical condition on the 24th. After discharge from the emergency department, her condition worsened. In accordance with Dr. Semmes's instructions, she returned the next day to the Hospital's emergency department. At that time, the Hospital diagnosed her condition as septic shock and admitted Ms. Power as an inpatient for treatment. The severity of Ms. Power's condition eventually resulted in a bilateral amputation of the legs below the knees and a loss of sight in one eye. After treating Ms. Power for more than four months, the Hospital arranged for her transfer to a hospital in Britain.

SUMMARY OF ARGUMENT

AHA seeks the development of a correct and consistent interpretation of EMTALA in accordance with the congressional intent. It appears that some plaintiffs have misread EMTALA and are attempting to turn the Act into an alternative to a traditional medical malpractice action. Yet this Court has joined other Circuit Courts in rejecting the theory that EMTALA claims can be adjudicated under malpractice standards. The case on appeal demonstrates the importance of distinguishing between an EMTALA claim and a malpractice claim.

There is a bright line distinction between violations of EMTALA requirements and claims for medical malpractice. The issue under EMTALA is whether a hospital provided for appropriate access to emergency care; the issue in medical malpractice is whether the quality of care provided conformed to prevailing standards of care. Thus, proof of deviations from the standards of care by physicians or other medical professionals would not establish a violation of EMTALA's requirements.

Plaintiff prevailed on only one claim of an EMTALA violation: that the Hospital did not provide for an appropriate medical screening examination. Yet the evidence adduced at trial established that the Hospital had procedures in place that provided for and that she received an appropriate medical screening examination. The EMTALA issue never should have been submitted to the jury. Moreover, the incorrect jury instructions allowed the jury to decide that a violation of EMTALA occurred if the quality

of medical practice did not meet normative standards of professional care and judgment -- the test for medical malpractice. The jury instructions should have focussed on whether the Hospital provided for access by all patients to a medical screening examination.

ARGUMENT

I. ARLINGTON HOSPITAL PROVIDED FOR AN APPROPRIATE MEDICAL SCREENING EXAMINATION WITHIN THE CAPABILITY OF ITS EMERGENCY DEPARTMENT AND ANCILLARY SERVICES.

EMTALA imposes on a hospital the duty to provide all persons seeking emergency medical assistance with access to a screening examination and further emergency treatment or appropriate transfer, if the hospital concludes that an emergency condition exists. Thus, to meet the requirement of § 1395dd(a), the hospital must have procedures to ensure that every person seeking emergency assistance gets an appropriate medical screening examination. Congress sought to create a specific duty to respond to patients with emergency conditions because it had determined that no such "duty to treat" existed at common law in many states.[4/] Brooks, 1993 WL 214696, at *1. Under the common law, admitted patients who actually received treatment but whose treatment was allegedly incorrect had recourse through state malpractice law. In imposing the EMTALA requirements that Medicare participating hospitals respond to persons seeking emergency assistance, Congress did not

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4/ See supra n. 2.

affect or disturb the role of state malpractice law in resolving questions concerning the quality of the treatment received. Therefore, courts should not allow EMTALA to become the means of adjudicating the quality of the care provided. If the Hospital provided for a screening by qualified medical personnel who were required to avail themselves of all ancillary services and resources of the Hospital as they determined appropriate in their professional judgment, the Hospital met the screening requirement of EMTALA.

Careful attention to the language of EMTALA explains what a hospital must do. "[T]he hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department . . . ." 42 U.S.C. § 1395dd(a). "Provide for" connotes that the hospital should take steps necessary to ensure the provision of the services.[5/] The Act does not require that the hospital itself provide the screening. Indeed, typically a hospital would not do so; in virtually every jurisdiction, only the medical professional person, not the institution, actually makes the medical decisions related to a medical screening examination. The Act also does not require a "medically appropriate" screening examination; that would be determined by reference to prevailing professional standards of care. Rather, it requires there to be an "appropriate medical" screening examination. The appropriateness of the screening is

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[5/] The same "provide for" language is employed in § 1395dd(b).

determined by the hospital's satisfaction of the requirements of EMTALA. "[A] hospital emergency room may develop one general procedure for screening all patients[;] it may also tailor its screening procedure to the patient's complaints or exhibited symptoms." Baber, 977 F.2d at 879 n. 6. Either form of procedure or screening system establishes the appropriate medical screening examination required of a hospital by EMTALA.

Plaintiffs can prevail on an EMTALA claim in several ways. For example, they can prove that a hospital refused to provide any screening. They can show that the Hospital delayed the screening while it determined their insurance status. 42 U.S.C. § 1395dd(h). They can demonstrate that a hospital's procedures to provide for an appropriate medical screening were a sham. They can prove that the hospital segregated nonpaying patients and, in fact, had disparate procedures for patients who are uninsured, have AIDS, are nonresidents, or other characteristics that would form the basis for illegal discrimination. They can try to establish that a hospital routinely tolerated deviations from its procedures for screening such that they constituted no procedures at all. But none of these possible avenues for recovery were available in the case on appeal because Ms. Power offered no facts to show any of these types of violations. Arlington Hospital had a general procedure for screening patients, and it employed that system in examining Ms. Power.

In acknowledging she received a screening on February 24th, plaintiff could not and did not allege that the Hospital violated

the Act by failing to provide a screening at all. Rather, her only claim for recovery depended on an allegation that the Hospital did not provide for an appropriate medical screening examination on the 24th.[6/]

A review of the facts demonstrates that, as a matter of law, the Hospital provided for an appropriate medical screening examination as required by EMTALA. The Hospital had a general system to respond to all requests for assistance by persons coming to its emergency department which it afforded Ms. Power. This system included assuring the availability of services of qualified medical personnel to respond to patient requests for assistance, including qualified emergency physicians.[7/] When she arrived in obvious distress, Ms. Power was taken directly to an examining room and her vital signs recorded. Indeed, the Hospital's screening system permitted her to bypass the regular registration and triage process for ambulatory persons -- a doctor saw her within 15 minutes of her arrival and began her medical examination. The emergency department called upon ancillary services to obtain

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[6/] The February 25, 1993 emergency department screening examination could not form a basis for a lack of adequate screening claim. On the 25th, the Hospital diagnosed her emergency condition and admitted her for stabilizing treatment. Thus, the Hospital met the requirements of § 1395dd(a) and (b) on that day.

[7/] Although the Hospital afforded trained emergency physician coverage in the emergency department, EMTALA does not require that a physician personally respond to all requests for medical emergency treatment. Other medical personnel can respond to emergency medical conditions as that term is defined in EMTALA. See 42 U.S.C. § 1395dd(c)(1)(A)(iii)("qualified medical person" not a physician).

laboratory and X-ray services for her. Further examination occurred. The records reflect that a determination was made that no emergency condition existed. As the final step, the doctor encouraged her to return to the Hospital if necessary. If mistakes were made in discharging Ms. Power on February 24, those mistakes are not evidence that the Hospital failed to provide for an appropriate medical screening. "[EMTALA] does not guarantee that the emergency personnel will correctly diagnose a patient's condition as a result of this screening." Baber, 977 F.2d at 879.

The plaintiff did not dispute that there was an established practice at the Hospital for medical screening examination in the emergency department. Indeed, during cross-examination, plaintiff's counsel elicited this testimony from Dr. Benedict Semmes describing the Hospital's system for appropriate medical screening examination:

> MR. CAUSEY: [W]hat standards did [the doctors] typically follow to perform a medical screening exam for a patient that would come into an emergency room like Susan did that morning? . . . .
>
> DR. SEMMES: You would take a history, perform a physical exam, have a differential diagnosis in your mind, order appropriate diagnostic tests, develop a treatment plan, determine a need whether to admit or discharge the patient, and implement the plan.

JA 347, 350. Dr. Semmes described what the Hospital required of doctors in administering a screening exam to patients.[8/] Although plaintiff's counsel dwelt at length on Dr. Semmes' alleged incorrect treatment, to prevail under EMTALA a plaintiff would have to show that any deviations from the Hospital's screening process were known to and tolerated by the Hospital. No such allegation or evidence is found in the trial record.[9/]

In this EMTALA claim, the dispositive fact is that the Hospital had a procedure that it required emergency department doctors to follow for all patients. This procedure applied to every patient who arrived for a screening examination of an emergency condition. The Hospital did not change or vary its screening protocol with the socioeconomic status or other characteristics that would form the basis for unlawful discrimination. The existence of these procedures constituted full compliance by the Hospital with the EMTALA requirement that it provide for an appropriate medical screening examination.

Reduced to essentials, Power's claim was this: the doctors failed to note her boil, they failed to note her statements of pain

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[8/] Dr. Semmes admitted that he did not always follow the procedures in treating Ms. Power, JA 355, but such testimony is not evidence that the Hospital failed to provide for an appropriate screening or tolerated such departures from procedure.

[9/] The Hospital system was not "so low that it amounted to no 'appropriate medical screening [examination].'" Baber, 977 F.2d at 879 n. 7 (emphasis original)(noting possibility of "sham" screening without deciding whether such an allegation states and EMTALA claim). Ms. Power did not present evidence to demonstrate a "sham" screening examination claim.

location, one doctor failed to review her history before examining her, she was discharged before her urinalysis test results were done, and a complete blood count should have been done. The plaintiff's evidence was directed to prove that the doctors did not meet the medical standard of care for treatment of a person in her condition. None of this evidence, however, singly or in combination, proves that the Hospital failed to provide for an appropriate medical screening examination. Rather, the facts establish that the Hospital provided for an appropriate medical screening examination, and Ms. Power was afforded one on February 24, 1990.

In light of plaintiff's misunderstanding of the statutory requirements of EMTALA, it is not surprising that she offered expert testimony concerning the medical standard of care applicable to treatment of her symptoms. JA 476-78. Yet all of Dr. Colson's testimony was irrelevant for he could not address the one issue central to the case: did Arlington Hospital have procedures to provide for appropriate screening examinations? Baber, 977 F.2d at 882 (proffered plaintiff's expert did not create an EMTALA issue because expert did not testify as to the defendant hospital's standard screening examination procedure). In fact Dr. Colson admitted that he had no direct knowledge of the Hospital's procedures.[10/] JA 517-18. The only effect of his testimony was

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10/ There were several reasons why Dr. Colson lacked knowledge. He had not worked at the Hospital. JA 454. He had not reviewed any documents describing its procedures. JA 483. Yet it is the individual hospital's specific procedures that must (continued...)

to invite exactly the wrong kind of analysis by the jury: a focus on whether the doctors met the medical standard of care.

After the verdict, the district court judge acknowledged that the claim based upon inappropriate transfer should not have been submitted to the jury. JA 917. The evidentiary proof of this separate EMTALA claim simply magnified the problem of using a malpractice standard of care to adjudicate EMTALA issues. Trial of this claim exposed the jury to a series of witnesses who repeatedly addressed the nature and severity of Ms. Power's condition up to and through the transfer. All of this evidence was couched in terms of medical standards of care. In addition it would tend to bias the jury in determining the nature of any injury proximately caused by any other EMTALA violation.

No reasonable juror could find that Arlington Hospital violated EMTALA. Ms. Power failed to offer any evidence that would show that the Hospital failed to provide for an appropriate medical screening. In light of her failure of proof, the trial court should have granted the Hospital's motion for judgment as a matter of law after trial.

10/ (...continued)
be examined in determining whether the hospital violated EMTALA. Baber, 977 F.2d at 880-81.

II. THE JURY INSTRUCTIONS DID NOT SET FORTH THE ESSENTIAL ELEMENTS OF THE EMTALA CLAIM.

A. Proper Jury Instructions For An EMTALA Claim Focus On The Specific EMTALA Obligations Without Reference To A Negligence Standard Of Care.

"[T]he goal of 'an appropriate medical screening examination' is to determine whether a patient with acute or severe symptoms has a life threatening or serious medical condition." Baber, 977 F.2d at 879. Jury instructions for an EMTALA claim must examine whether a hospital created procedures to try to meet that goal and whether they applied those procedures uniformly to all those seeking care. The instructions in this case did not direct the jury to a proper examination of EMTALA issues; instead, they misdirected the jury into a traditional, negligence-based malpractice test.

Proper jury instructions would present three questions:

a.) Did a hospital have a system to provide for a medical screening exam?

b.) Was this system appropriate to determine (i.e., capable of establishing) if a emergency medical condition exists?[11/]

c.) Was the system afforded to the plaintiff?[12/]

11/ This test addresses those plaintiffs claiming that a hospital had only a sham system.

12/ This instruction would address the claim of a plaintiff who actually was refused a screening exam.

If the jury answers yes to all three questions, then no EMTALA violation exists.[13] When a plaintiff alleges that the system was disparately applied, however, a fourth question should be posed:

> d.) did the hospital provide the system to the plaintiff in a disparate manner based on ability to pay,[14] socioeconomic status, disease condition (e.g., AIDS), or other improper consideration?

As Baber noted, "appropriateness" is determined by reference to whether the system is properly "designed to identify" when the patient has a critical condition suggesting the presence of an emergency medical condition. 977 F.2d at 879. Thus, determining the "appropriateness" of the medical screening examination does not focus on the specific clinical judgment reached, rather it looks at the design of a hospital's examination system overall. When a court focuses on the medical care provided in a specific exam to decide "appropriateness," it has incorrectly substituted a malpractice test for the proper EMTALA inquiry.

Although Ms. Power alleged that the Hospital knew she had no insurance, there was no evidence introduced that the screening system applied to her on February 24 was any different than the screening system that the Hospital applied to all other patients.

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[13] If the jury answered no to any one of the questions, it would then have to decide the issue of proximate causation.

[14] This instruction addresses claims that the screening was delayed while the hospital determined the patient's insurance coverage.

Therefore, her claim did not raise the fourth question.[15/] Based on the evidence at trial, no juror could conclude other than that the Hospital clearly had a system; the system was properly designed to detect an emergency condition; and the Hospital applied the system in Ms. Power's case. Thus, Ms. Power cannot recover as a matter of law.

Lacking evidence that would allow recovery under the proper tests, Ms. Power's case reverted to malpractice standards as a proxy for determining "appropriateness." Her allegations that the physicians violated the standard of care became the test of an EMTALA violation for an "inappropriate" screening exam. Her theory misdirected the trial court into allowing proof of malpractice to establish EMTALA violations.

> [T]he claim may also be established through proof of a failure to adhere to the Hospital's standard protocols, or, absent such standard protocols, proof of a failure to meet the standard of care to which the Hospital adheres.

[15/] Plaintiff proceeded below on a theory that demonstrating a doctor's deviation from the medical standard of care constituted proof of an EMTALA violation. As Part I explained, the test for determining a violation of the EMTALA requirements is not based upon medical standards of care but rather upon whether a hospital established and applied a screening system uniformly. Nor does the evidence establish that Arlington Hospital provided its standard screening system to Ms. Power in a different manner than it provided the system to other patients, so there is no disparate treatment claim in this case. As there is no disparate treatment claim, this case does not require the Court to resolve an issue the Baber court, 979 F.2d at 880 n. 6, did not decide: whether to require proof of motive in a disparate treatment case. Compare Cleland, 917 F.2d at 272 (dicta)("'[A]ppropriate' must more correctly be interpreted to refer to the motives with which the hospital acts."), with Gatewood, 933 F.2d at 1041 (dicta)("The motive for such departure is not important to this analysis, which applies whenever and for whatever reason a patient is denied the same level of care provided others . . . .").

> In the latter instance, the line between malpractice and a violation of EMTALA blurs somewhat.

Power v. Arlington Hosp. Ass'n, 800 F. Supp. 1384, 1387 n. 6 (E.D. Va. 1992)(emphasis added)(denial of summary judgment). The lower court's "blurred line" view was rejected by this Court in Baber:

> The critical element of an EMTALA cause of action is not the adequacy of the screening examination but whether the screening examination that was performed deviated from the hospital's evaluation procedures that would have been performed on any patient in a similar condition.

977 F.2d at 881 (emphasis added). Using malpractice standards as a proxy for determining EMTALA violations confuses two separate forms of liability. Malpractice focuses on a negligence standard; EMTALA is not a negligence claim, it is a statutory liability claim in which violation of the statute establishes liability.[16/] Because the statute explicitly defines the standard to meet, negligence standards cannot be substituted.

16/ The negligence/statutory liability distinction can become even further confused when a court refers to EMTALA as a "strict liability" cause of action. This is an incorrect use of the term strict liability. Statutory liability applies when a violation of the statute and resulting injury will result in liability. Instead of relying on negligence principles, the statute defines the duty imposed. By contrast, strict liability does not require any proof of violation of a duty, whether imposed by statute or arising from a common law standard of care. 3 Fowler V. Harper et al., The Law of Torts § 17.5 n. 1 (2d ed. 1986)(contrasting statutory liability with strict liability). Engaging in the activity (such as dynamite blasting) creates liability for resulting injury without any examination of whether the activity was performed with care.

B. The Instructions Incorrectly Applied The Malpractice Standard To The EMTALA Claim.

The jury instructions concerning the inappropriate screening claim, JA 865-69, reflected the court's misapplication of a malpractice standard to an EMTALA claim.

> [T]he term "appropriate medical screening" under the statute means that the hospital must accord all persons the same level of treatment routinely and typically provided patients in similar medical circumstances regardless of whether the individual is insured or financially able to pay for the medical services rendered.
>
> In essence, the law requires hospitals to follow the standard screening procedures in providing care to all individuals who request emergency medical services from the hospital's Emergency Department.

Instructions, JA 866-67 (emphasis added).

The trial court's "level of treatment" language incorrectly allowed the jury to apply a malpractice test in determining whether the Hospital deviated from the requirements of EMTALA concerning an appropriate screening. Immediately after the invocation of the malpractice standard, the court switched to a proper EMTALA standard: "the standard screening procedures." By juxtaposing a standard of care instruction (e.g., "level of treatment"), which is clearly inappropriate, and a "standard procedure" requirement, the court's instructions were not only internally inconsistent but also an incorrect statement of the law.

The problem with the instruction is particularly acute considering the court's allowance of Dr. Colson's testimony, which was replete with reference to a broader, regional medical standard

of practice. Coupled with the Instructions' invocation of treatment standards, the effect of Dr. Colson's testimony was to profoundly mislead the jury away from the proper EMTALA factors. The court left the jury rudderless -- permitting them to exercise unbridled discretion in choosing a standard of care to apply. This lack of proper direction requires reversal.

C. Proper EMTALA Instructions Should Inform The Jury That Adverse Patient Outcome Does Not Prove A Violation Of EMTALA Requirements.

Aside from avoiding the confusion of malpractice with EMTALA, proper EMTALA jury instructions should help the jury understand that an adverse outcome to the patient does not constitute proof of an inappropriate screening. EMTALA "does not guarantee that the emergency personnel will correctly diagnose a patient's condition as a result of the screening." Baber, 977 F.2d at 879. See also Gatewood, 933 F.2d at 1041; Cleland, 917 F.2d at 271. The fact that a patient's condition did not improve[17/] is not relevant to the question of whether the EMTALA requirements were violated. At most, evidence of a patient's deterioration is relevant only to a determination of whether the EMTALA violation proximately caused the lack of patient improvement and the extent of any damages.

17/ The deterioration of a patient's condition is irrelevant to a determination of whether an EMTALA requirement was violated. In fact, a patient whose condition improves can bring an EMTALA claim seeking injunctive relief to halt such practices as delaying screening exams to determine insurance coverage. See 42 U.S.C. § 1395dd(d)(2)(A)(allowing equitable relief); § 1395dd(h)(forbidding hospital to delay screening exam for reasons of determining extent of patient's insurance coverage).

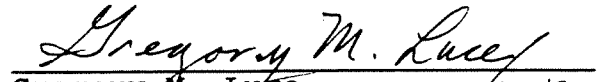
Because the risk of the jury misusing the evidence of adverse patient outcome to establish a violation of the EMTALA requirements is quite high, the trial court should always instruct the jury that the patient's adverse outcome is not proof that a hospital failed to provide for an appropriate screening.

CONCLUSION

This Court should reverse the denial of Arlington Hospital's request for judgment as a matter of law: the plaintiff failed to prove the essential elements of an EMTALA violation. Even if the Hospital were not entitled to judgment as a matter of law, it should receive a new trial on the EMTALA claim because the jury instructions misdirected the jury to apply a malpractice standard to determine a hospital's liability under EMTALA.

Respectfully submitted,

AMERICAN HOSPITAL ASSOCIATION



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19 July 1993

CERTIFICATE OF SERVICE

I hereby certify that I caused two copies of the foregoing Brief Amicus Curiae of the American Hospital Association in Support of Appellant Arlington Hospital Association to be served, via postage-prepaid, first-class mail, this 19th of July 1993 on all counsel of record listed below.

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STATUTORY ADDENDUM

§ 1395dd. Examination and treatment for emergency medical conditions and women in labor

(a) Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

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

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

(2) Refusal to consent to treatment

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer

A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) of this section and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized

(1) Rule

If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless—

(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that [1] based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer

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 (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement

(1) Civil money penalties

(A) 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. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a-7a(a) of this title.

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who—

(i) signs a certification under subsection (c)(1)(A) of this section that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is is [2] gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a-7a of this title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320a-7a(a) of this title.

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1395cc(a)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement

(A) Personal harm

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

(B) Financial loss to other medical facility

Any medical facility that suffers a financial loss 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 financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions

No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with peer review organizations

In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1), the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of subchapter XI of this chapter) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review.

(e) Definitions

In this section:

(1) The term "emergency medical condition" means—

(A) 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 (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

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

(B) with respect to a pregnant women [3] who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means hospital that has entered into a provider agreement under section 1395cc of this title.

(3)(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) The term "hospital" includes a rural primary care hospital (as defined in section 1395x(mm)(1) of this title).

(f) Preemption

The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination

A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) 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.

(h) No delay in examination or treatment

A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) of this section in order to inquire about the individual's method of payment or insurance status.

(i) Whistleblower protections

A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) of this section or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

(As amended Dec. 19, 1989, Pub. L. 101-239, title VI, §§ 6003(g)(3)(D)(xiv), 6211(a)-(h), 103 Stat. 2154, 2245-2248; Nov. 5, 1990, Pub. L. 101-508, title IV, §§ 4008(b)(1)-(3)(A), 4027[4207](a)(1)(A), (2), (3), (k)(3), 104 Stat. 1388-44, 1388-117, 1388-124.)