

JUDICIAL RESOLUTION OF EMTALA SCREENING CLAIMS AT SUMMARY JUDGMENT

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The Emergency Medical Treatment and Active Labor Act (EMTALA) is a federal statute that requires hospitals to screen and, if necessary, treat and stabilize every individual who comes to the emergency department. To comply with EMTALA, a hospital's screening must be performed uniformly for patients with similar symptoms. Courts have undermined the statute's effectiveness, however, by routinely granting summary judgment to defendant hospitals charged with EMTALA screening violations. The ease with which hospitals prevail at the summary judgment stage fails to remedy and deter disparities in care. Moreover, it discourages emergency departments from using written protocols. The implementation of written guidelines for emergency-department care can significantly improve EMTALA's effectiveness by making violations more easily ascertainable, encouraging hospitals to self-regulate, and substantially improving hospital care. This Note argues for a greater evidentiary burden on hospitals that would require a hospital, before it can be granted summary judgment, to elucidate explicitly the elements of its uniform screening procedure and demonstrate affirmatively that this procedure was employed during the plaintiff's emergency room examination.

INTRODUCTION

In 1986, Congress recognized that the United States faced a serious health care crisis. Hospitals, confronted with high expenses and an inability to spread costs adequately, were engaging in “patient dumping,” a practice by which certain patients—typically uninsured and minority individuals—receive inferior medical care or are denied treatment altogether.¹ In response, Congress passed the Emergency

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¹ See *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1039 (D.C. Cir. 1991) (explaining that hospitals “patient dump[]” when “emergency rooms deny uninsured patients the same treatment provided paying patients,” and noting that “[r]eports of patient dumping rose in the 1980s, as hospitals, generally unencumbered by any state law duty to treat, faced new cost containment pressures combined with growing numbers of uninsured and underinsured patients”).

Medical Treatment and Active Labor Act (EMTALA or the Act).² EMTALA imposes affirmative duties on hospitals to screen and, if necessary, treat and stabilize every individual who comes to the emergency department.³ In passing the Act, Congress hoped to ensure that hospitals would provide equal treatment regardless of race, ethnicity, or ability to pay.⁴

Twenty-five years later, however, EMTALA has failed to achieve its stated goal. Reports of patient dumping continue,⁵ and some commentators suspect that the practice has increased in the past two decades.⁶ Recent studies in academic medical journals have found sig-

² 42 U.S.C. § 1395dd (2006). The Emergency Medical Treatment and Active Labor Act (EMTALA) was passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, 100 Stat. 82. Experts and popular opinion agree that reducing the prevalence of patient dumping is an important social goal. See Barry R. Furrow, *An Overview and Analysis of the Impact of the Emergency Medical Treatment and Active Labor Act*, 16 J. LEGAL MED. 325, 327 (1995) (“Studies have confirmed that delivery of emergency care as soon as possible reduces death rates substantially.”); Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155, 156 n.3 (2004) (citing sources showing that a large majority of Americans believe people who require medical care should be able to receive it regardless of income); see also Lawrence Bluestone, Note, *Straddling the Line of Medical Malpractice: Why There Should Be a Private Cause of Action Against Physicians via EMTALA*, 28 CARDOZO L. REV. 2829, 2839 (2007) (“[B]ecause of the egregious nature of [patient dumping], any incidence seems too much.”).

³ See 42 U.S.C. § 1395dd(a) (requiring hospitals to provide appropriate screening examinations and ancillary services to individuals coming to the emergency department). Congress imposed its mandate on hospitals receiving federal Medicare funds. As a practical matter, this includes virtually all hospitals. As a constitutional matter, it allows Congress to rely on its broad authority under the Spending Clause. Medical care provided pursuant to these duties is not reimbursed; EMTALA was a political solution that allowed Congress to address inequities in emergency care without increasing federal spending.

⁴ See 131 CONG. REC. 28,569 (1985) (statement of Sen. Kennedy) (“[O]ver the last few years, disturbing reports have surfaced about individuals who have been denied emergency services at hospitals . . . because they lacked health insurance or funds to pay cash at the door. In some cases, racial discrimination may have been involved.”); *id.* at 28,568 (statement of Sen. Durenberger) (“The purpose of this amendment is to send a clear signal to the hospital community . . . that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress.”); *id.* at 28,569 (statement of Sen. Dole) (“We must put an end to certain unsafe practices . . . whereby a hospital, for purely financial reasons, refuses to initially treat or stabilize an individual with a true medical emergency.”).

⁵ See U.S. GOV'T ACCOUNTABILITY OFFICE, EMERGENCY CARE: EMTALA IMPLEMENTATION AND ENFORCEMENT ISSUES 3 (2001) [hereinafter GAO REPORT] (“Violations of EMTALA continue to occur, underscoring the need for effective education and enforcement.”); Michael J. Frank, *Tailoring EMTALA To Better Protect the Indigent: The Supreme Court Precludes One Method of Salvaging a Statute Gone Awry*, 3 DEPAUL J. HEALTH CARE L. 195, 198 (2000) (“[P]atient dumping continues.”); Bluestone, *supra* note 2, at 2865–66 (“Patient dumping continues to happen in busy hospital emergency rooms, with dramatic and unsavory results to patients, normally minorities and normally poor.”).

⁶ See Thomas A. Gionis et al., *The Intentional Tort of Patient Dumping: A New State Cause of Action To Address the Shortcomings of the Federal Emergency Medical Treatment*

nificant disparities in care based on insurance status⁷ and similar inequities have been reported on the basis of patient identity, such as race and gender.⁸ And although the 2010 Patient Protection and Affordable Care Act reaffirmed EMTALA by noting that “[n]othing in this Act shall be construed to relieve any health care provider from providing emergency services as required by . . . law, including . . . EMTALA,”⁹ it did nothing to improve upon continuing practices of patient dumping.

Much of EMTALA’s ineffectiveness derives from the routine dismissal, through summary judgment, of private claims under the act. The problem is especially acute in suits alleging violations of EMTALA’s screening requirement. EMTALA requires hospitals to provide an “appropriate medical screening examination” to “any individual” who “comes to the emergency department.”¹⁰ Courts are in agreement that medical screening examinations are “appropriate” under EMTALA if they are provided uniformly.¹¹ Plaintiffs, however, have had considerable difficulty convincing courts that hospitals provided disparate treatment. Claims of EMTALA screening violations often hinge on the competing testimonies of doctor and patient, and judges typically defer to the physician’s judgment. Indeed, hospitals regularly prevail on summary judgment solely on the basis of physician affidavits asserting that the plaintiff received a standard screening.¹² Thus, EMTALA litigation has remedied only the most

and *Active Labor Act (EMTALA)*, 52 AM. U. L. REV. 173, 176–77, 195, 236–38 (2002) (“[C]areful analysis of all available data sources indicates that patient dumping is on the rise.”).

⁷ See, e.g., Heather Rosen et al., *Downwardly Mobile: The Accidental Cost of Being Uninsured*, 144 ARCHIVES SURGERY 1006, 1006, 1010 (2009) (summarizing academic literature showing that “[u]ninsured patients currently face health-related disparities in screening, hospital admission, treatment, and outcomes,” and conducting a study finding that, “even after admission to a hospital, trauma patients can have worse outcomes based on insurance status”); Anbesaw Wolde Selassie et al., *The Influence of Insurance, Race, and Gender on Emergency Department Disposition*, 10 ACAD. EMERGENCY MED. 1260, 1266 (2003) (performing multivariate logistic regression on emergency-department data and finding that, “after controlling for a patient’s clinical condition . . . , patients who were uninsured were consistently less likely to be admitted, regardless of the severity of the injury”).

⁸ See *infra* notes 167–70 and accompanying text (citing studies finding disparities in medical treatment and physician decisions based on race, gender, indigence, and AIDS status).

⁹ Patient Protection and Affordable Care Act, 42 U.S.C. § 18023(d) (2006).

¹⁰ 42 U.S.C. § 1395dd(a).

¹¹ See *infra* notes 77–78 and accompanying text (noting judicial consensus that a medical screening is “appropriate” under EMTALA if it is the same as emergency department examinations provided to similar patients).

¹² See BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY STOLTZFUS JOST & ROBERT L. SCHWARTZ, *HEALTH LAW: CASES, MATERIALS AND*

blatant cases of patient dumping and has left subtler violations unaddressed.

When courts routinely grant summary judgment to defendant hospitals on EMTALA screening claims merely on the basis of physician affidavits, it discourages the implementation of written guidelines for emergency-room care. Some of the few instances in which hospitals did *not* win on summary judgment were, in fact, cases in which the plaintiff learned of an explicit protocol that was not followed.¹³

Judicial resolution of EMTALA claims should not discourage the use of detailed procedures for directing the tests physicians implement during screening, as these written standards can produce substantial benefits to patients. First and foremost, explicit screening guidelines improve EMTALA's effectiveness by making clear when individuals are not treated uniformly. This, in turn, helps deter subtle, but nonetheless damaging, instances of patient dumping. Moreover, as divergence from standard treatment becomes more obvious and more easily penalized, hospitals may be motivated to self-regulate. Internal compliance mechanisms will not only help achieve EMTALA's goals, but will also significantly lessen the need for expensive litigation. Additionally, recent literature indicates that the use of checklists in medical care can significantly improve patient outcomes.¹⁴ Written protocols for emergency department screenings may produce similar improvements in care.

Frequent use of summary judgment by certain courts has, to some extent, undermined EMTALA. But summary judgment can help to solve the Act's shortcomings if it is used with greater restraint. Courts should curtail the granting of summary judgment to a hospital that cannot show that its screening matched its written guidelines for emergency-room care.

PROBLEMS 619 (6th ed. 2008) ("The great majority of EMTALA claims are resolved through summary judgment, possibly reflecting judicial concerns that the Act is too broad."); *see also infra* note 101 and accompanying text (noting that defendant hospitals in EMTALA suits frequently prevail at summary judgment).

¹³ *See infra* note 178 and accompanying text (citing examples).

¹⁴ *See infra* Part IV.C (discussing the medical benefits of standardized protocols in greater detail). *See generally* ATUL GAWANDE, *THE CHECKLIST MANIFESTO: HOW TO GET THINGS RIGHT* (2009) (explaining how checklists and written guidelines in medical care can significantly improve patient outcomes); MICHAEL L. MILLENSON, *DEMANDING MEDICAL EXCELLENCE: DOCTORS AND ACCOUNTABILITY IN THE INFORMATION AGE* (1997) (discussing surprisingly large divergences in care both between and within hospitals, and arguing that implementation of quality measurement and written protocols of best practices could help to reduce inconsistencies); PETER PRONOVOST & ERIC VOHR, *SAFE PATIENTS, SMART HOSPITALS: HOW ONE DOCTOR'S CHECKLIST CAN HELP US CHANGE HEALTH CARE FROM THE INSIDE OUT* (2010) (explaining how checklists and written guidelines in medical care can significantly improve patient outcomes).

Part I of this Note documents the need to improve EMTALA's effectiveness and explains why private enforcement is imperative to its success. Part II explains EMTALA's basic structure and highlights the judicial reaction to its ambiguous "appropriate medical screening" language. Part III provides examples of courts deferring to physician judgment and using summary judgment to dismiss claims that deserve greater scrutiny. Part IV elaborates on the problems judicial enforcement of EMTALA has created and proposes a solution.

I

THE NEED FOR EFFECTIVE PRIVATE ENFORCEMENT OF EMTALA

Congress passed EMTALA in response to numerous reports of patient dumping from across the country. In addition to an abundance of disturbing anecdotal accounts,¹⁵ a number of studies showed frequent inferior treatment of uninsured persons.¹⁶ Although estimates vary, one report suggests that, before the passage of EMTALA, 250,000 patients each year were denied necessary medical care because they were unable to pay.¹⁷

Commentators have suggested a number of explanations for the increase in reported patient dumping that prompted EMTALA's enactment.¹⁸ Most theories focus on rising hospital costs¹⁹ and commonly note that uninsured patients "place[] a strain on the ability of

¹⁵ See H.R. REP. NO. 100-531 (1987) (providing dramatic anecdotal accounts); see also Karen I. Treiger, Note, *Preventing Patient Dumping: Sharpening the Cobra's Fangs*, 61 N.Y.U. L. REV. 1186, 1186 (1986) (discussing various examples of patient dumping). *But cf.* David A. Hyman, *Lies, Damned Lies, and Narrative*, 73 IND. L.J. 797 (1998) (criticizing the use of anecdotal stories of patient dumping).

¹⁶ See Treiger, *supra* note 15, at 1187 n.15 (noting a Cook County study that concluded that "[i]n recent years there have been increases in the number of interhospital transfers of patients to public general hospitals across the United States"). Treiger also references another study conducted by the Harvard Medical School, "which found that the lives of 33 out of 458 patients who were transferred to Highland's emergency room in the first six months of 1981 were gravely endangered because they were transferred before they were stabilized." *Id.* Additionally, she describes a study performed at Harbor General Hospital in Los Angeles that "found that dumping compromised the care of a significant percentage of 50 patients transferred to Harbor General's emergency room." *Id.* *But cf.* Hyman, *supra* note 15, at 843 ("[C]loser examination reveals some significant difficulties with the empirical studies.").

¹⁷ See David A. Ansell & Robert L. Schiff, *Patient Dumping: Status, Implications, and Policy Recommendations*, 257 JAMA 1500, 1500 (1987) ("Extrapolating from data in available studies, we estimate that 250,000 patients in need of emergency care annually are transferred for economic reasons."). *But see* Hyman, *supra* note 15, at 863 ("The claim that 250,000 patients a year are dumped is impressive, but is based on generalizing from a skewed sample . . .").

¹⁸ See Demetrios G. Metropoulos, Note, *Son of Cobra: The Evolution of a Federal Malpractice Law*, 45 STAN. L. REV. 263, 266 (1992), for a discussion of the "pressures" that

hospitals to provide uncompensated care while remaining solvent.”²⁰ Changes to Medicare and Medicaid limiting reimbursement rates exacerbated these financial pressures.²¹ The factors that contributed to the rise of patient dumping remain problems today, as does the economic incentive for hospitals to refuse to treat the indigent and uninsured;²² “[p]atient dumping is a dangerous but

“forced hospitals to forego their traditional role as providers of free emergency care. As a result, private hospitals began to turn away or transfer indigent patients.”

¹⁹ See *Smith v. Richmond Mem'l Hosp.*, 416 S.E.2d 689, 691 (Va. 1992) (“While private hospitals traditionally did treat people in emergency situations, they generally were not fully compensated . . . for treatment of indigent patients. With growing competition among hospitals, shifting this cost to paying patients became more difficult. As the hospitals’ economic losses increased, the instances of patient dumping also increased.”); Frank, *supra* note 5, at 197 (“As health care costs spiraled heavenward, some hospitals could no longer afford this practice, and refused to treat even emergency patients absent proof of ability to pay.”).

²⁰ Dana E. Schaffner, Note, *EMTALA: All Bark and No Bite*, 2005 U. ILL. L. REV. 1021, 1025.

²¹ See 131 CONG. REC. 28,570 (1985) (statement of Sen. Proxmire) (discussing a “new prospective payment system for Medicare” and noting that the “same incentives for more efficient patient care management can all too easily become incentives for underservice”); Beverly Cohen, *Disentangling EMTALA from Medical Malpractice: Revising EMTALA’s Screening Standard To Differentiate Between Ordinary Negligence and Discriminatory Denials of Care*, 82 TUL. L. REV. 645, 653–54 (2007) (“[T]here were large cutbacks in health care spending by governmental programs. . . . Medicare . . . converted its hospital payments from payments for each service rendered and each day of inpatient care to ‘case-based’ rates [These rates] rewarded hospitals for being more efficient in treating patients, causing hospitals to monitor services more carefully . . . and to more strictly limit the length of inpatient stays.”); see also Robert Reinhold, *Treating an Outbreak of Patient Dumping in Texas*, N.Y. TIMES, May 25, 1986, <http://www.nytimes.com/1986/05/25/weekinreview/treating-an-outbreak-of-patient-dumping-in-texas.html> (explaining that “[p]rospective payment, the new system of reimbursing hospitals under Medicare, the Federal medical insurance for the elderly, the rapid growth of investor-owned hospitals, and tighter cost controls by private medical insurers have all combined to make hospital care more competitive,” and concluding that “[t]here is little margin left for hospitals to pay for care of the indigent”).

²² The incentive to avoid providing care to patients unable to pay is particularly visible when hospitals choose to deport illegal immigrants requiring long-term or otherwise expensive care. See Deborah Sontag, *Deported, by U.S. Hospitals: Immigrants, Spurned on Rehabilitation, Are Forced Out*, N.Y. TIMES, Aug. 3, 2008, at 1, available at <http://www.nytimes.com/2008/08/03/us/03deport.html>. Sontag describes how a Florida hospital, which had spent \$1.5 million caring for a severely injured and mentally disabled illegal immigrant, chartered a plane and transferred the patient to a community hospital in his native Guatemala. She explains that this is but one example of “a little-known but apparently widespread practice” that “some advocates for immigrants see . . . as a kind of international patient dumping.” *Id.*; see also Deborah Sontag, *Jury Rules for Hospital that Deported Patient*, N.Y. TIMES, July 28, 2009, at A10, available at <http://www.nytimes.com/2009/07/28/us/28deport.html> (reporting that a Florida jury found the hospital not liable for its actions because it “did not act unreasonably” in repatriating the “severely brain-injured Guatemalan patient against the will of his guardian”); see generally Kristie-Anne Padrón, Note, *Deported Before Dawn: Bridging Policy and Funding Gaps To Discourage Hospitals from Privately Repatriating Immigrant Patients*, 20 B.U. PUB. INT. L.J. 105, 108 (2010)

predictable accompaniment to the market-driven health care system”²³

The social costs of patient dumping are immense. Not only are victims confronted with a heightened risk of death or injury, but the practice also “negatively affect[s] the hospitals receiving the ‘dumped’ patients.”²⁴ The most blatant and notorious instances of patient dumping involve complete refusals to treat. But a hospital can also dump a patient it examines if the individual’s screening was less thorough than what the hospital typically provides; just as much harm can result from a cursory examination that fails to identify an emergent condition as from an overt denial of care. Furthermore, patient dumping is not limited to the poor; “there have . . . been reports of patient dumping linked to other non-medical factors, such as the patient’s race, ethnicity, sexual orientation, or contraction of a socially unacceptable disease.”²⁵ Nor does it necessarily involve acts of intentional discrimination: Unconscious biases can produce significant disparities in the quality and thoroughness of emergency department screenings.²⁶ Given hospital incentives and the costs the practice imposes on society, it is imperative that courts and legislatures attach considerable penalties to patient dumping to ensure deterrence.²⁷

Although EMTALA was not the first or only approach to fighting the problem of patient dumping, it is the only one with the capacity to prevent it effectively. Congress’s prior attempt at creating legislation designed to ensure equal access to emergency care—the Hill-Burton Act²⁸—was a failure. Hill-Burton lacked “adequate

(examining “the problems generated by private repatriation, its legal implications, and possible alternatives to repatriation”).

²³ Gionis et al., *supra* note 6, at 307; *see also* 131 CONG. REC. 28,568 (statement of Sen. Durenberger) (“[T]here are indications that this practice [of patient dumping] could escalate. . . . [W]e are seeing change in the health-care marketplace which may even encourage this practice.”).

²⁴ Danielle Sapega, Comment, *Federal Code Blue: The Emergency Medical Treatment and Active Labor Act’s Prolonged Venture into Malpractice Law*, 29 TEMP. J. SCI. TECH. & ENVTL. L. 96, 105 (2010) (“One study based in Chicago revealed that the emergency transfers in 1983 to the Cook County Public Hospital cost the hospital approximately \$24.1 million in uncompensated care.”).

²⁵ Bluestone, *supra* note 2, at 2833; *see also* *Burditt v. U.S. Dep’t of Health & Human Servs.*, 934 F.2d 1362, 1367 (5th Cir. 1991) (stating that a physician transferred a woman because she “represented more risk than he was willing to accept from a malpractice standpoint”); *infra* notes 167–70 and accompanying text (discussing disparities in medical care based on race, gender, socioeconomic class, and AIDS status).

²⁶ *See infra* note 171 (discussing research on unconscious discrimination).

²⁷ *See* Treiger, *supra* note 15, at 1200 (“[W]ithout fear of punishment, hospitals feel free to disregard their obligations.”).

²⁸ Hospital Survey and Construction Act, ch. 958, 60 Stat. 1040 (1946) (codified as amended at 42 U.S.C. §§ 291–291m (2006)).

provisions detailing punitive measures if hospitals refused to comply, which created a lag in hospital compliance.”²⁹ Even though Hill-Burton required hospitals receiving federal construction funds to serve the poor, it did not explicitly authorize an individual cause of action if care was denied.

Tort law is similarly ineffective; hospitals have historically had no common law duty to treat.³⁰ Several state courts have created new tort duties to fill this gap, but these novel theories of liability provide only limited remedies, as they are commonly premised on reliance and abandonment.³¹ Even where a state tort claim might be actionable, EMTALA can be a superior tool for achieving appropriate compensation and deterrence.³² Additionally, although some states responded to the problem by enacting statutes, these laws were generally

²⁹ Sapega, *supra* note 24, at 104–05; *see also* Karen H. Rothenberg, *Who Cares?: The Evolution of the Legal Duty To Provide Emergency Care*, 26 HOUS. L. REV. 21, 59 (1989) (“[T]he Hill-Burton Act has not proved to be an effective enforcement tool for establishing a duty to provide emergency care.”). *See generally* Michael A. Dowell, *Hill-Burton: The Unfulfilled Promise*, 12 J. HEALTH POL. POL’Y & L. 153, 154 (1987) (lamenting that “the Hill-Burton Act, unenforced and largely ignored . . . remains an illusory assurance of indigent patient access to hospital care,” and explaining that “[w]idespread facility non-compliance and ineffective enforcement . . . have frustrated the purpose of the act throughout its existence”).

³⁰ *See, e.g.*, *Smith v. Richmond Mem’l Hosp.*, 416 S.E.2d 689, 691 (Va. 1992) (“Under the common law, private hospitals have no duty to accept or to provide treatment for patients.”); *see also* *Torretti v. Main Line Hosps., Inc.*, 580 F.3d 168, 173 (3d Cir. 2009) (“There is no general common-law duty for hospitals to accept and treat all individuals.”); *Hardy v. N.Y.C. Health & Hosp. Corp.*, 164 F.3d 789, 792–93 (2d Cir. 1999) (“EMTALA was enacted to fill a lacuna in traditional state tort law by imposing on hospitals a legal duty (that the common law did not recognize) to provide emergency care to all.”); *Root v. Liberty Emergency Physicians, Inc.*, 68 F. Supp. 2d 1086, 1091 (W.D. Mo. 1999) (“EMTALA has been described as a ‘gap-filler’ for state malpractice law, giving patients who would otherwise have no claim in state court a forum to redress their injuries.”), *aff’d*, 209 F.3d 1068 (8th Cir. 2000); *Guerrero v. Copper Queen Hosp.*, 537 P.2d 1329, 1330 (Ariz. 1975) (“[A]s a general rule, a private hospital is under no obligation to accept any individual who applies as a patient.”). The cases of *Campbell v. Mincey*, 413 F. Supp. 16 (N.D. Miss. 1975), and *Childs v. Weis*, 440 S.W.2d 104 (Tex. Civ. App. 1969), are powerful examples of state law inadequately preventing hospital patient dumping.

³¹ *See generally* BARRY R. FURROW ET AL., *HEALTH LAW* 524 (2d ed. 2000) (summarizing the “common law theories” through which “several states . . . have held hospitals liable for failure to provide emergency care,” but noting that “[t]he basis for the duty to provide emergency care . . . may result in differences in the scope of the duty”).

³² *See* Alicia K. Dowdy et al., *The Anatomy of EMTALA: A Litigator’s Guide*, 27 ST. MARY’S L.J. 463, 469 (1996) (noting that although “hospitals are ordinarily not liable for the physicians’ conduct or alleged medical malpractice,” they are under EMTALA); *Metropoulos, supra* note 18, at 284–86 (describing the advantage to plaintiffs of suing under EMTALA rather than pursuing only tort claims).

ineffective.³³ The majority of states did not institute even these meager stopgaps.³⁴

Effective enforcement of EMTALA is therefore essential to the assurance of equalized emergency care.³⁵ Courts have understood that Congress passed the statute with the inadequacies of state law in mind.³⁶ The Act contains both private and public enforcement mechanisms: A patient can recover personal injury damages from a hospital that violates EMTALA,³⁷ and the Centers for Medicare and Medicaid Services (CMS) and the Office of Inspector General (OIG) in the Department of Health and Human Services may enforce EMTALA against offending hospitals.³⁸

Public enforcement by CMS and OIG, however, is unlikely to deter patient dumping fully. The Act itself caps fines at \$50,000 for large hospitals and \$25,000 for facilities with fewer than one hundred

³³ See Dowell, *supra* note 29, at 154–55 (noting that, despite laws in over twenty states restricting “the denial of emergency care due to a patient’s inability to pay,” commentators asserted that “more and more patients are unable to obtain necessary hospital care”); Rothenberg, *supra* note 29, at 56–57 (“[M]ost state laws have limited enforcement potential.”); see also 131 CONG. REC. 28,569 (1985) (statement of Sen. Kennedy) (“[E]ven in the 22 states which already have emergency medical care statutes on the books, enforcement of those laws has been poor. Many of the abuses have occurred in States which already have laws on the books.”).

³⁴ See 131 CONG. REC. 28,569 (statement of Sen. Kennedy) (“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. Federal legislation in this area is long overdue.”).

³⁵ See Wendy W. Bera, Comment, *Preventing “Patient-Dumping”: The Supreme Court Turns Away the Sixth Circuit’s Interpretation of EMTALA*, 36 HOUS. L. REV. 615, 623 (1999) (“[W]ithout . . . EMTALA, . . . [i]f [hospitals] provided substandard emergency treatment . . . patient[s] would likely have extremely limited remedies in some jurisdictions.”).

³⁶ See *Bryan v. Rectors & Visitors of the Univ. of Va.*, 95 F.3d 349, 351 (4th Cir. 1996) (“[EMTALA’s] core purpose is to get patients into the system who might otherwise go untreated and be left without a remedy because traditional medical malpractice law affords no claim for failure to treat.”).

³⁷ See 42 U.S.C. § 1395dd(d)(2)(A) (2006) (stating that “[a]ny individual who suffers personal harm as a direct result of a participating hospital’s violation of a requirement of this section” may obtain damages “in a civil action against the participating hospital”). However, there is no private cause of action under EMTALA against individual doctors. See *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1256–57 (9th Cir. 1995) (holding that “EMTALA does not allow private suits against physicians,” and noting that every other appellate court that has considered the issue has agreed).

³⁸ See Lauren A. Dame, *The Emergency Medical Treatment and Active Labor Act: The Anomalous Right to Health Care*, 8 HEALTH MATRIX 3, 11–13 (1998) (explaining that the Department of Health and Human Services “is responsible for enforcing EMTALA” and that this “duty is divided between two of its agencies,” the Office of Inspector General, and the Centers for Medicare and Medicaid Services). Dame actually refers to the “Health Care Financing Administration,” *id.*, which was renamed the Centers for Medicare and Medicaid Services (CMS) in 2001. See Press Release, U.S. Dep’t of Health and Human Servs., *The New Centers for Medicare & Medicaid Services (CMS)* (June 14, 2001), available at <http://archive.hhs.gov/news/press/2001pres/20010614a.html>.

beds.³⁹ In contrast, private civil suits have the potential to impose substantially greater penalties.⁴⁰ And although CMS has the capacity to revoke Medicare privileges from hospitals found to have violated the Act,⁴¹ this has, in practice, been an empty threat.⁴² The effectiveness of public enforcement is also subject to budgetary considerations⁴³ and agency discretion.⁴⁴ OIG rarely reaches the statutory cap on penalties; “the majority of hospital fines were \$25,000 or less.”⁴⁵ Commentators have criticized a perceived paucity of government enforcement of EMTALA.⁴⁶ CMS and OIG appear to have been

³⁹ See 42 U.S.C. § 1395dd(d)(1)(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.”).

⁴⁰ See, e.g., *Power v. Alexandria Physicians Grp., Ltd.*, 887 F. Supp. 845, 846 (E.D. Va. 1995) (“[T]he patient . . . won a \$1 million judgment against a hospital for . . . violation of the federal Emergency Medical Treatment and Active Labor Act.”), *aff’d*, 91 F.3d 132 (4th Cir. 1996). The *Power* verdict, in fact, might have been significantly larger in another state; the damages were capped at \$1 million per Virginia law. See *id.* (holding that the plaintiff, having already reached the cap in her EMTALA suit, could not “recover any damages for the same injuries in a second malpractice action”).

⁴¹ See GAO REPORT, *supra* note 5, at 3 (“CMS . . . has authority to terminate the Medicare provider agreement of a hospital that has violated EMTALA.”).

⁴² See *St. Anthony Hosp. v. U.S. Dep’t of Health & Human Servs.*, 309 F.3d 680, 693 (10th Cir. 2002) (“Although a hospital’s violation of EMTALA’s provisions theoretically can result in the termination of that hospital’s provider agreement, . . . termination generally does not occur in practice so long as the hospital takes corrective action.”). A 2008 presentation by three experts on EMTALA, including a senior attorney at the Office of Inspector General (OIG) and a regional administrator for CMS, reported that, “[s]ince inception of EMTALA,” only thirteen hospitals “have been terminated from Medicare.” Mark A. Guza et al., *Presentation at the Hospitals and Health Systems Institute: EMTALA Patterns of Enforcement Unintended Consequences 3* (Feb. 14, 2008). That constitutes approximately 0.2% of the nearly 6000 hospitals in the United States, and it accounts for over two decades of EMTALA enforcement. See *Fast Facts on US Hospitals*, AM. HOSP. ASS’N, <http://www.aha.org/research/rc/stat-studies/fast-facts.shtml> (last visited Mar. 22, 2012) (reporting 5754 registered hospitals). Many terminated hospitals, moreover, “were later recertified.” GAO REPORT, *supra* note 5, at 20.

⁴³ See, e.g., GAO REPORT, *supra* note 5, at 24 (explaining the increased number of EMTALA cases settled by OIG between 1997 and 1998 as, “[a]ccording to the OIG,” a result of “additional OIG staffing that resulted in the elimination of a backlog of cases”); *cf.* U.S. DEP’T OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GEN., PATIENT DUMPING AFTER COBRA, at ii (1988) (“Resolution of dumping complaints is time consuming.”).

⁴⁴ See GAO REPORT, *supra* note 5, at 17 (“[T]he OIG . . . has assessed fines in less than half of the violation cases forwarded by CMS.”).

⁴⁵ *Id.* at 4.

⁴⁶ See *Dame*, *supra* note 38, at 26. (“[The government] rarely penalizes hospitals that violate [EMTALA] as long as they agree to come into compliance; it rarely imposes civil monetary fines, and when it does, the amounts are often low; it enforces the act inconsistently across the country; and it took years to issue final regulations implementing the law.”); Gionis et al., *supra* note 6, at 178–79 (“[I]t has been reported that government enforcement has ‘tragically failed’ to control patient dumping.”); Vivian L. Regehr, Comment, *Please Resuscitate! How Financial Solutions May Breathe Life into EMTALA*,

more active in their enforcement efforts in the past decade, but this increase has been slight,⁴⁷ and the imposition of punishment remains rare.⁴⁸ Additionally, although the public enforcement mechanism is complaint-driven,⁴⁹ the statute lacks an incentive mechanism for individuals to report occurrences of patient dumping; civil penalties are paid exclusively to the government.⁵⁰ Thus, EMTALA's ability to deter hospital misconduct relies in large part on private suits.⁵¹

II

STRUCTURE AND INTERPRETATIONS OF EMTALA

A. *The Statute*

EMTALA requires a hospital to provide medical screenings and stabilizing treatment for patients with emergency medical conditions and those in childbirth. EMTALA does not necessarily cover all United States hospitals, but because the Act's obligations apply to any hospital that is a Medicare provider, as a practical matter, it reaches nearly all emergency departments.⁵²

EMTALA provides:

30 U. LA VERNE L. REV. 180, 188–89 (2008) (“The Office of the Inspector General has been heavily criticized for being ineffective in monitoring and enforcing EMTALA violations. . . . [T]here is general consensus among the commentators that hospitals are not being held adequately accountable.”).

⁴⁷ Compare GAO REPORT, *supra* note 5, at 18 (showing, in 1999, 215 violations confirmed by CMS), and *id.* at 24 (“From 1995 to 1997, the OIG settled an average of about 16 cases per year and collected about \$997,000 in fines in total. From 1998 to 2000, it settled an average of 55 cases per year and collected about \$4.7 million fines.”), with Guza et al., *supra* note 42, at 4 (showing an average of about 258 violations per year from 2004 to 2006 found by CMS), and *id.* at 14 (reporting an average of 22 cases settled by OIG per year between 2002 and 2006, for an average of about \$588,700 per year).

⁴⁸ See *St. Anthony Hosp. v. U.S. Dep’t of Health & Human Servs.*, 309 F.3d 680, 693 (10th Cir. 2002) (“Civil monetary penalties are rare. . . . More than half of the cases reviewed by the OIG are closed without the assessment of any penalty. Many are dropped following PRO [peer review organization] review of the allegations brought against a hospital.”); Bluestone, *supra* note 2, at 2842 (“Civil monetary penalties are, in the words of OIG, ‘relatively uncommon.’” (quoting DEP’T OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GEN., THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT: THE ENFORCEMENT PROCESS 8 (2001))).

⁴⁹ See GAO REPORT, *supra* note 5, at 17 (“Enforcement of EMTALA is a complaint-driven process; CMS investigates a hospital only when it receives information about an alleged EMTALA violation.”).

⁵⁰ See Bluestone, *supra* note 2, at 2856 (“The statute provides for civil monetary penalties to be paid to the government. This lack of personal recovery would seem to create a disincentive for reporting and pursuing EMTALA claims even in cases of obvious harm.”).

⁵¹ See *Phillips v. Hillcrest Med. Ctr.*, 244 F.3d 790, 796 (10th Cir. 2001) (“To ensure compliance with [EMTALA], Congress created a private cause of action.”).

⁵² See FURROW ET AL., *supra* note 31, at 523 (“Because the federal Emergency Medical Treatment and Labor Act applies to any hospital that is a Medicare provider, it reaches nearly every hospital that operates an emergency department.”).

[I]f any individual . . . comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination . . . including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition . . . exists.⁵³

This requirement is in place only to the extent that the hospital “has a[n] . . . emergency department” and the medical screening is “within the capability of the hospital's emergency department.”⁵⁴ CMS, in its State Operations Manual, explains that a “medical screening examination” under EMTALA is the process necessary to determine whether an individual has an emergency medical condition.⁵⁵ “Depending on the individual's presenting signs and symptoms,” an appropriate screening “can involve a wide spectrum of actions, ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures.”⁵⁶

EMTALA also requires that:

If any individual . . . comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either . . . for such further medical examination and such treatment as may be required to stabilize the medical condition or for transfer of the individual to another medical facility.⁵⁷

The statute also severely restricts a hospital's ability to transfer non-stabilized individuals.⁵⁸

⁵³ 42 U.S.C. § 1395dd(a) (2006). An “emergency medical condition” is defined in the Act as:

a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in 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, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Id. § 1395dd(e)(1).

⁵⁴ *Id.* § 1395dd(a).

⁵⁵ CTRS. FOR MEDICARE & MEDICAID SERVS., STATE OPERATIONS MANUAL 36–37 (2010), available at https://www.cms.gov/manuals/Downloads/som107ap_v_emerg.pdf.

⁵⁶ *Id.* (explaining that a medical screening examination “is not an isolated event” and listing “lumbar punctures, clinical laboratory tests, [and] CT scans” as examples of “ancillary studies and procedures” that might be part of a medical screening examination).

⁵⁷ *Id.* § 1395dd(b).

⁵⁸ *Id.* § 1395dd(c). This general prohibition is, however, subject to some exceptions. The hospital may make a transfer if “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 if “the individual . . . requests transfer to another medical facility.” *Id.*

B. *The Judicial Response to EMTALA's Ambiguities*

EMTALA's broad and undefined language has frustrated courts.⁵⁹ Ambiguity in the phrase "appropriate medical screening examination," in particular, initially created significant judicial confusion.⁶⁰ EMTALA does not delineate what constitutes an "appropriate" exam,⁶¹ and one court, interpreting EMTALA, declared the word "appropriate" to be "one of the most wonderful weasel words in the dictionary, and a great aid to the resolution of disputed issues in the drafting of legislation."⁶²

The simplest and perhaps most intuitive understanding of the phrase "appropriate medical screening" is that the Act requires a procedure that satisfies an objective standard of care.⁶³ Courts have staunchly opposed such a result, however, declaring that the Act cannot be used to form a federal malpractice claim.⁶⁴ In support of the argument for a more limited meaning of "appropriate," courts have noted that EMTALA's caveat specifying that the hospital provide a screening "within [its] capabilit[ies]"⁶⁵ suggests that a more subjective standard should be applied.⁶⁶ Thus, the structure of the Act "precludes resort to a malpractice or other objective standard of care."⁶⁷ Similarly, courts are quick to note that EMTALA does not preempt

⁵⁹ See *Dollard v. Allen*, 260 F. Supp. 2d 1127, 1131 n.3 (D. Wyo. 2003) ("Since EMTALA's enactment . . . , courts have struggled with the interpretation of the Act. It is safe to assume that § 1395dd has not made its way into any textbooks on statutory construction as a model of Congress's ability to draft a plain and unambiguous statute.").

⁶⁰ See *FURROW ET AL.*, *supra* note 31, at 517 ("[T]he indeterminacy of the requirement of an appropriate medical screening examination has vexed plaintiffs claiming under the Act.").

⁶¹ See *Frank*, *supra* note 5, at 205 ("[M]any commentators have noted that the law provides little guidance regarding what constitutes a screening exam.").

⁶² *Cleland v. Bronson Health Care Grp., Inc.*, 917 F.2d 266, 271 (6th Cir. 1990).

⁶³ See *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1136 (8th Cir. 1996) (en banc) (speculating that "perhaps the most natural [meaning]" of "the word 'appropriate' . . . would be that medical screening examinations must be correct, properly done, if not perfect, at least not negligent"); *FURROW ET AL.*, *supra* note 31, at 517 ("An instinctive interpretation of the standard of appropriateness in relation to medical services is that those services should meet the standards of the profession.").

⁶⁴ See, e.g., *Collins v. DePaul Hosp.*, 963 F.2d 303, 308 (10th Cir. 1992) (upholding the dismissal of a § 1395dd(a) claim on summary judgment and noting that "[i]f there was any medical malpractice along the way, [the plaintiff] had the right to institute a medical malpractice action in state court").

⁶⁵ 42 U.S.C. § 1395dd(a) (2006).

⁶⁶ See, e.g., *Cleland*, 917 F.2d at 272 ("[T]he terms of the statute, specifically referring to a medical screening exam by a hospital 'within its capabilities' precludes resort to a malpractice or other objective standard of care as the meaning of the term 'appropriate.'" (quoting § 1395dd(a))).

⁶⁷ *Id.*

state laws⁶⁸ and that principles of federalism compel a narrow scope for the Act.⁶⁹ Lastly, the legislative history suggests that Congress's intent was not to create a federal malpractice statute.⁷⁰

The vast majority of courts hold that a plaintiff need not allege improper motive in order to prove an EMTALA screening violation. An early reading of the statute by the Sixth Circuit in *Cleland v. Bronson Health Care Group* required the plaintiff to show that the physician or hospital acted out of animus.⁷¹ A similar interpretation by the Sixth Circuit, which required improper motive for EMTALA's stabilization requirement, was reversed by the Supreme Court in *Roberts v. Galen of Virginia, Inc.*⁷² Although *Roberts* did not rule on the acceptability of a motive when assessing violations of a hospital's statutory screening duty,⁷³ other circuits have explicitly rejected any requirement of ill motive,⁷⁴ noting that nothing in EMTALA's text suggests such a constraint.⁷⁵

⁶⁸ See, e.g., *Baker v. Adventist Health, Inc.*, 260 F.3d 987, 993 (9th Cir. 2001) (explaining that EMTALA was not intended to serve as a federal malpractice statute, because it "expressly contains a non-preemption provision for state remedies").

⁶⁹ See *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996) (en banc) ("[I]n construing statutes that are less than explicit, the courts will not assume a purpose to create a vast new realm of federal law, creating a federal remedy for injuries that state tort law already addresses.").

⁷⁰ See *Harry v. Marchant*, 291 F.3d 767, 773 (11th Cir. 2002) ("The legislative history of EMTALA makes clear the statute was not intended to be a federal malpractice statute . . .").

⁷¹ *Cleland*, 917 F.2d at 272 ("[A]ppropriate must . . . be interpreted to refer to the motives with which the hospital acts.").

⁷² See *Roberts v. Galen of Va., Inc.*, 525 U.S. 249 (1999), *rev'g* 111 F.3d 405 (6th Cir. 1997). To date, *Roberts* is the only case in which the Supreme Court directly addressed EMTALA.

⁷³ See David E. Mitchell, *EMTALA's Stabilization Requirement Does Not Require Proof of Improper Motive: Roberts v. Galen of Virginia*, 38 DUQ. L. REV. 163, 167 (1999) (explaining that, in *Roberts*, the Supreme Court "did not rule on the correctness of the Sixth Circuit's requirement of proof of an improper motive in relation to EMTALA's screening requirement, but it did note that in interpreting EMTALA to mandate such a test the Sixth Circuit is in conflict with several other circuits").

⁷⁴ See *Correa v. Hosp. S.F.*, 69 F.3d 1184, 1193-94 (1st Cir. 1995) ("Every court of appeals that has considered this issue has concluded that a desire to shirk the burden of uncompensated care is not a necessary element of a cause of action under EMTALA."). Despite the unanimity among other circuits in rejecting any obligation to demonstrate ill motive in order to prove an EMTALA screening claim, the Sixth Circuit maintains this requirement. See *Estate of Lacko v. Mercy Hosp., Cadillac*, No. 11-12361, 2011 WL 5301775, at *4 (E.D. Mich. Nov. 3, 2011) ("In the Sixth Circuit, whether a hospital administered an 'appropriate' screening refers not only to the hospital's standards, but also to the motives with which a hospital acts." (quoting *Cleland*, 917 F.2d at 272)).

⁷⁵ See *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1138 (8th Cir. 1996) (en banc) ("[T]he statute contains no such requirement.").

Although litigants have frequently debated what comprises the duty to screen,⁷⁶ courts have generally come to an agreement⁷⁷ that the phrase “appropriate medical screening” requires only that a hospital provide *uniformity* in its emergency department examinations.⁷⁸ To establish that a hospital violated EMTALA, the plaintiff “must show that the hospital treated him differently from other patients with similar symptoms.”⁷⁹ This is a plausible and reasonable reading of “appropriate.” In theory it should meet EMTALA’s goals. But in practice it has not.

The articulation of a uniformity standard does not, on its own, disentangle claims of physician negligence from patient dumping. Unless a hospital consistently provides substandard care, any instance of negligence in an emergency department screening must, almost by definition, constitute nonuniform treatment.⁸⁰ In order to thoroughly distinguish EMTALA claims from theories of tort law, courts commonly focus on process rather than outcome when assessing uniformity.⁸¹ Judges refuse to accept negligence in the performance of an

⁷⁶ See Diane S. Mackey, *The Emergency Medical Treatment and Active Labor Act: An Act Undergoing Judicial Development*, 19 U. ARK. LITTLE ROCK L.J. 465, 476 (1997) (“Much of the litigation to date has focused on just what constitutes an ‘appropriate’ examination.”).

⁷⁷ See *Correa*, 69 F.3d at 1192 (“[T]he courts have achieved a consensus on a method of assessing the appropriateness of a medical examination in the EMTALA context.”).

⁷⁸ See, e.g., *Jackson v. E. Bay Hosp.*, 246 F.3d 1248, 1256 (9th Cir. 2001) (“We hold that a hospital satisfies EMTALA’s ‘appropriate medical screening’ requirement if it provides a patient with an examination comparable to the one offered to other patients presenting similar symptoms”); *Phillips v. Hillcrest Med. Ctr.*, 244 F.3d 790, 797 (10th Cir. 2001) (“EMTALA’s requirement of an ‘appropriate screening examination’ undeniably requires [a hospital] to ‘apply uniform screening procedures to all individuals coming to the emergency room.’ . . . [A] hospital’s obligation under EMTALA is measured by whether it treats every patient perceived to have the same medical condition in the same manner.” (quoting *Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139, 143 (4th Cir. 1996))); *Battle v. Mem’l Hosp.*, 228 F.3d 544, 557 (5th Cir. 2000) (“[An EMTALA plaintiff] must show that the hospital treated him differently from other patients with similar symptoms.”); *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 881 (4th Cir. 1992) (“[W]e hold that a hospital satisfies the requirements of § 1395dd(a) if its standard screening procedure is applied uniformly to all patients in similar medical circumstances.”); *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991) (“[A] hospital fulfills the ‘appropriate medical screening’ requirement when it conforms in its treatment of a particular patient to its standard screening procedures.”).

⁷⁹ *Battle*, 228 F.3d at 557.

⁸⁰ See *Summers*, 91 F.3d at 1138 (“It would almost always be possible to characterize negligence in the screening process as non-uniform treatment, because any hospital’s screening process will presumably include a non-negligent response to symptoms or complaints”).

⁸¹ See *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991) (“[W]hat constitutes an ‘appropriate’ screening is properly determined not by reference to particular outcomes, but instead by reference to a hospital’s standard screening procedures.”); see also *Bode v. Parkview Health Sys., Inc.*, No. 1:07-CV-324, 2009 WL 790199, at

otherwise uniform screening examination as sufficient evidence of disparate treatment to preclude disposing of the claim on summary judgment.

EMTALA requires consistency in the provision of screening examination tests and procedures to similarly situated individuals, but it does not guarantee that those tests and procedures will be error-free. Courts have had difficulty, however, distinguishing between a mistake in the execution of a standard screening and a disparity in the type and scope of a screening. The latter violates EMTALA but nevertheless may be attributable to negligence. This problem arises because, in much EMTALA litigation, it is factually ambiguous what exactly constituted the hospital's uniform protocol and whether the hospital adhered to it. Courts, wary of extending the statute's reach into the realm of malpractice litigation, frequently dismiss EMTALA claims involving such factual ambiguity at summary judgment, sometimes explicitly deferring to the affidavits of the defendant hospital. This is often an aggressive and arguably inappropriate use of summary judgment. The next Part addresses the use of this procedural device and how courts misapply it.

III

JUDICIAL USE OF SUMMARY JUDGMENT TO DISPOSE OF EMTALA SCREENING CLAIMS

A. *Modern Summary Judgment Use and Efficiency Concerns*

In federal courts, where EMTALA cases are typically litigated,⁸² summary judgment is governed by Rule 56 of the Federal Rules of Civil Procedure. Rule 56 states that “[t]he court shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law.”⁸³ Summary judgment prevents parties from proceeding to trial when they would be unable to win;⁸⁴ it is intended to preclude

*8 (N.D. Ind. Mar. 23, 2009) (explaining that “[t]he quality of the screening is not what is being questioned, what is being questioned is if there is uniformity in the screenings,” and noting that “a good screening will not stop a violation of EMTALA from occurring, if a patient with similar symptoms got a better screening then EMTALA has been violated because there has been a lack of uniformity”).

⁸² See Dowdy et al., *supra* note 32, at 467 (“[T]he majority of reported suits brought under EMTALA have been maintained in federal court” (footnote omitted)).

⁸³ FED. R. CIV. P. 56(a).

⁸⁴ See Gonzalez v. Torres, 915 F. Supp. 511, 515 (D.P.R. 1996) (describing summary judgment as a “device [that] allows courts and litigants to avoid full-blown trials in unwinnable cases, thus conserving the parties’ time and money and permitting courts to husband scarce judicial resources” (citing McCarthy v. Nw. Airlines, 56 F.3d 313, 314–15 (1st Cir. 1995))); Martin B. Louis, *Federal Summary Judgment Doctrine: A Critical Analysis*, 83

unnecessary and wasteful adjudication.⁸⁵ The Supreme Court has explained that, in order to “survive the defendant’s motion,” the plaintiff “need only present evidence from which a jury might return a verdict in his favor.”⁸⁶

While the standard for ruling on a summary judgment motion under Rule 56 has not changed, in the past two decades courts have been increasingly receptive to using the procedure.⁸⁷ This evolution in practice stems from judicial re-characterizations of the motion in the Supreme Court’s 1986 “trilogy” of summary judgment cases: *Celotex Corp. v. Catrett*,⁸⁸ *Anderson v. Liberty Lobby, Inc.*,⁸⁹ and *Matsushita Electric Industrial Co. v. Zenith Radio Corp.*⁹⁰ The clogged federal dockets of many courts, moreover, have increased openness to the use of the procedural tool, which is seen as a means of increasing judicial efficiency.⁹¹

Although intended to improve efficiency by resolving claims quickly, summary judgment might not necessarily reduce litigation costs in the aggregate.⁹² Some scholars note that the resources

YALE L.J. 745, 745 (1974) (writing that summary judgment is frequently used “to identify claimants who lack evidence sufficient to reach the jury and who will therefore probably suffer a directed verdict or its equivalent at trial”).

⁸⁵ See, e.g., *Goodman v. Mead Johnson & Co.*, 534 F.2d 566, 573 (3d Cir. 1976) (“The purpose of the rule is to eliminate a trial in cases where it is unnecessary and would only cause delay and expense.”); see also *Quinn v. Syracuse Model Neighborhood Corp.*, 613 F.2d 438, 445 (2d Cir. 1980) (explaining that summary judgment can be a “useful device for unmasking frivolous claims and putting a swift end to meritless litigation”).

⁸⁶ *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248, 257 (1986) (“[S]ummary judgment will not lie if the dispute about a material fact is ‘genuine,’ that is, if the evidence is such that a reasonable jury could return a verdict for the nonmoving party.”).

⁸⁷ See 11 JAMES WM. MOORE ET AL., MOORE’S FEDERAL PRACTICE §§ 56.50, 56.51 (3d ed. 2011) (discussing the “‘modern’ expanded approach to summary judgment ushered in by the Supreme Court’s 1986 trilogy”).

⁸⁸ 477 U.S. 317 (1986).

⁸⁹ 477 U.S. 242 (1986).

⁹⁰ 475 U.S. 574 (1986); see Milton I. Shadur, *From the Bench: Trials or Tribulations (Rule 56 Style)?*, LITIG., Winter 2003, at 5, 5 (“[T]he far more favorable climate for the granting of summary judgments that was created by the Supreme Court’s 1986 trilogy of Rule 56 cases—[*Celotex*, *Anderson*, and *Matsushita*]—has worked a systemic sea change.”).

⁹¹ See Edward Brunet, *The Use and Misuse of Expert Testimony in Summary Judgment*, 22 U.C. DAVIS L. REV. 93, 94 (1988) (“Today’s courts, facing more complex cases and an increasing caseload, are simply more receptive to docket clearing devices such as summary judgment.”).

⁹² See Elizabeth M. Schneider, *The Dangers of Summary Judgment: Gender and Federal Civil Litigation*, 59 RUTGERS L. REV. 705, 776 (2007) (“[E]fficiency goals are clearly not met by the new practice of summary judgment—more time may be spent on the processes of summary judgment than might be spent on trial.”); see also Arthur R. Miller, *The Pretrial Rush to Judgment: Are the “Litigation Explosion,” “Liability Crisis,” and Efficiency Cliché Eroding Our Day in Court and Jury Trial Commitments?*, 78 N.Y.U. L. REV. 982, 1062 (2003) (explaining that the tendency to equate summary judgment with

litigants spend on unsuccessful motions may be greater than the savings associated with swift resolution of cases via summary judgment.⁹³ An overuse of summary judgment in EMTALA cases might be an example of the procedure exacerbating systemic inefficiencies.⁹⁴ The ease with which defendant hospitals obtain summary judgment in EMTALA screening cases may encourage them to refrain from adopting written protocols that could reduce future expenses, both to litigants and to courts.

*B. Summary Judgment Use in EMTALA Screening Cases:
Deference to Physician Judgment*

Some types of cases are far more amenable to the proper usage of summary judgment than others. In particular, where facts are less likely to be in dispute—such as contract claims relying on written documents—summary judgment is typically more suitable. On the other hand, many of the factual disputes that arise under EMTALA claims—competing testimonies, for example—are less appropriate for judicial consideration at the summary judgment stage.⁹⁵

In *Markman v. Westview Instruments*, the Supreme Court maintained that “credibility determinations . . . are the jury’s forte.”⁹⁶ In *Anderson*, the Court likewise made explicit that its holding did not alter the established roles of judge and jury: “Credibility determinations, the weighing of the evidence, and the drawing of legitimate inferences from the facts are jury functions, not those of a judge, whether he is ruling on a motion for summary judgment or for a

directed verdict in modern litigation may “oblige counsel to increase the time and expense devoted to discovery”).

⁹³ See D. Theodore Rave, Note, *Questioning the Efficiency of Summary Judgment*, 81 N.Y.U. L. REV. 875, 876 (2006) (“While it seems intuitive that avoiding costly trials would save money, that savings is only realized when summary judgment is granted. Modern summary judgment, however, is a frequently used motion that is costly to oppose and, if not granted often enough, may be a net drain on society.”); see also Jeffrey W. Stempel, *A Distorted Mirror: The Supreme Court’s Shimmering View of Summary Judgment, Directed Verdict, and the Adjudication Process*, 49 OHIO ST. L.J. 95, 171–72 (1988) (arguing that “suggestions that more widespread use and granting of summary judgment will lead to faster, less expensive adjudication (irrespective of the accuracy of outcome) overlook several considerations militating against such anticipated benefits”).

⁹⁴ Additionally, the increase in grants of summary judgment for defendants is particularly acute in disputes involving race, class, or gender. See Schneider, *supra* note 92, at 714–15 (“[J]udicial decision making in gender cases illustrates the way in which current summary judgment practice permits subtle bias to go unchecked . . .”).

⁹⁵ See RICHARD L. MARCUS ET AL., CIVIL PROCEDURE: A MODERN APPROACH 464 (5th ed. 2009) (“Summary judgment problems become more difficult when issues of motive and intent are presented.”).

⁹⁶ 517 U.S. 370, 389 (1996).

directed verdict.”⁹⁷ Even though the plaintiff must show some factual support for his or her claim,⁹⁸ the judge ordinarily may not choose between competing affidavits or testimonies, regardless of whether or not the judge finds one to be more believable,⁹⁹ unless, as was the case in *Matsushita*, one side’s argument is wholly implausible.¹⁰⁰

As demonstrated in the remainder of this Section, claims arising under EMTALA often come down to competing testimonies and therefore should be resolved infrequently using summary judgment. Yet courts regularly use summary judgment in claims brought under EMTALA,¹⁰¹ on occasion explicitly and inappropriately deferring to the assertions of the defendant hospital and its physicians.

The Fifth Circuit Court of Appeals in *Marshall v. East Carroll Parish Hospital Service District*,¹⁰² for example, affirmed the district court’s grant of summary judgment for the defendant hospital despite the presence of competing affidavits as to the uniformity of the screening procedure. The plaintiff in *Marshall*, fifteen-year-old Nydia Marshall, was brought to the defendant hospital’s emergency room because “she ‘wouldn’t move’ while at school.”¹⁰³ At the emergency room, she “was unable to verbally communicate.”¹⁰⁴ Marshall was examined by Dr. Horowitz, who “had several medical tests performed

⁹⁷ *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986).

⁹⁸ See *Ayala-Gerena v. Bristol Myers-Squibb Co.*, 95 F.3d 86, 95 (1st Cir. 1996) (“[E]ven in cases where elusive concepts such as motive or intent are at issue, summary judgment may be appropriate if the nonmoving party rests merely upon conclusory allegations, improbable inferences, and unsupported speculation.” (quoting *Goldman v. First Nat’l Bank of Bos.*, 985 F.2d 1113, 1116 (1st Cir. 1993)) (internal quotation marks omitted)).

⁹⁹ See, e.g., *Bates v. Design of the Times, Inc.*, 622 N.W.2d 684, 687 (Neb. 2001) (“If [the witness’s] testimony is to be believed, then the trier of fact could find for [plaintiff]. Whether [the witness] is to be believed or not is a question for the trier of fact and cannot be decided on summary judgment.”); see also *Rule v. Brine, Inc.*, 85 F.3d 1002, 1011 (2d Cir. 1996) (“The function of the district court in considering the motion for summary judgment is not to resolve disputed issues of fact but only to determine whether there is a genuine issue to be tried.”).

¹⁰⁰ See *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986) (concluding that, where a litigant’s “claim is one that simply makes no economic sense,” the litigant “must come forward with more persuasive evidence to support their claim than would otherwise be necessary” to prevail at summary judgment); see also SAMUEL ISSACHAROFF, *CIVIL PROCEDURE* 59–60 (3d ed. 2012) (discussing *Matsushita*).

¹⁰¹ See 62 AM. JUR. *Trials* 119, § 44 (1997) (“[D]efendants in EMTALA actions frequently move for summary judgment”); Michael J. Staab, *Is There a Private Cause of Action Under COBRA for Misdiagnosis?*, 28 J. HEALTH & HOSP. L. 1, 2 (1995) (“[I]t has proven extremely difficult for the patient to avoid having a summary judgment granted on behalf of the hospital.”); see also *supra* note 12 and accompanying text (noting that the majority of EMTALA cases are decided at summary judgment).

¹⁰² 134 F.3d 319 (5th Cir. 1998).

¹⁰³ *Id.* at 321.

¹⁰⁴ *Id.*

on her,” decided she had a respiratory infection, and discharged her.¹⁰⁵ Later that same day, her “symptoms continued to worsen, and she was taken to . . . a different hospital, where she was diagnosed as suffering from a cerebrovascular accident consistent with a left middle cerebral artery infarction.”¹⁰⁶

In response to Marshall’s claim that Dr. Horowitz failed to administer an appropriate medical screening examination, the hospital moved for summary judgment, submitting on its behalf the testimony of Dr. Horowitz and the nurse who had diagnosed Marshall.¹⁰⁷ Not surprisingly, the affidavit of Dr. Horowitz asserted that “Nydia Marshall was given an appropriate medical screening examination that would have been performed on any other patient.”¹⁰⁸ In opposition to the hospital’s motion, Marshall submitted a sworn affidavit from Nurse Middlebrooks, “a licensed practical nurse, who had been on duty at the Hospital emergency room when Nydia Marshall was treated.”¹⁰⁹ Nurse Middlebrooks stated that:

[S]he witnessed a disagreement between Nurse Arrington and Dr. Horowitz over whether Marshall should be admitted or transferred to another hospital, rather than discharged, and that, during her 14-year employment at the Hospital, she had seen several other patients with symptoms similar to Nydia Marshall’s, who had all been admitted for observation and further testing and treatment.¹¹⁰

Despite explicitly noting that summary judgment is proper only when “there is no genuine issue as to any material fact,” and that “inferences . . . are viewed in the light most favorable to the non-movant,” the Fifth Circuit granted summary judgment to the defendant hospital.¹¹¹ The court unequivocally explained that it valued the affidavit of Dr. Horowitz over that of Nurse Middlebrooks, claiming that the latter’s statements were “conclusory” and “unsupported.”¹¹² The court also questioned Nurse Middlebrooks’s expertise, writing that, “[c]onsidering that Middlebrooks is a licensed practical nurse, not a doctor, we question whether she is competent to compare the symptoms and treatment of Nydia Marshall to other patients.”¹¹³ In *Marshall*, competing affidavits created contested issues of fact as to

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ See *id.* at 324 (noting that the hospital, “as part of its evidence in support of summary judgment,” submitted the “affidavits of Dr. Horowitz and Nurse Green”).

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.* at 321, 325.

¹¹² *Id.* at 324.

¹¹³ *Id.*

what constituted the hospital's standard screening procedure for patients with Marshall's symptoms, and whether the physician followed this protocol. This was an open question material to the ruling on whether or not Marshall's treatment was uniform. In this case, then, the grant of summary judgment was improper, especially since the court reached its conclusion by making a credibility determination.

The decision of the Eighth Circuit in *Summers v. Baptist Medical Center Arkadelphia*¹¹⁴ likewise presents what appears to be a troubling misuse of summary judgment to dispose of a claim for inappropriate screening under EMTALA. The district court granted the defendant hospital's motion for summary judgment. The court of appeals at first reversed this ruling,¹¹⁵ but after a rehearing en banc, the Eighth Circuit affirmed the lower court's decision.¹¹⁶

Summers was brought to the defendant hospital's emergency room after a deer-hunting accident, in which he "fell out of a tree stand."¹¹⁷ Summers claimed to have told the physician that his chest and back hurt and that he was "hearing this popping noise every time [he] breathed."¹¹⁸ The physician asserted, however, that "Summers did not complain of pain in the front part of his chest," and the doctor remarked that he "did not remember the patient's saying he could hear popping-type sounds."¹¹⁹ As a result, "[n]o x-rays of the chest were taken," and "Summers was told that he was suffering from muscle spasms."¹²⁰ Summers "asked to be admitted to the hospital," but "[h]e was told no."¹²¹ Two days later, and still in considerable pain, Summers went to a different hospital, where, among other tests, a chest x-ray and CT scan were done, which "revealed a fresh break of the seventh thoracic vertebra . . . [and] a broken sternum and a broken seventh rib."¹²² Summers was placed into intensive care.¹²³

The defendant hospital "agree[d] that patients complaining of pain in the front of their chest, or of snapping or popping noises when

¹¹⁴ 91 F.3d 1132 (8th Cir. 1996) (en banc).

¹¹⁵ *Summers v. Baptist Med. Ctr. Arkadelphia*, 69 F.3d 902, 903 (8th Cir. 1995) (en banc).

¹¹⁶ See 91 F.3d at 1140 ("[W]e believe the District Court acted correctly in granting the defendant's motion for summary judgment on Mr. Summers's claims under EMTALA. The judgment of the District Court is therefore Affirmed.")

¹¹⁷ *Id.* at 1135.

¹¹⁸ *Id.*

¹¹⁹ *Id.*

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² *Id.* at 1135–36.

¹²³ *Id.* at 1136.

breathing, would normally be given a chest x-ray.”¹²⁴ The *Summers* majority, however, claimed that “the physician, we must assume through inadvertence or inattention, did not perceive Summers to have cracking or popping noises in his chest, or pain in the front of his chest,” and that “[t]his is why no chest x-rays were taken.”¹²⁵ Yet, as Judge Heaney pointed out in his dissenting opinion in *Summers*, the court overstepped the boundaries of summary judgment in reaching this arguably factual conclusion. Judge Heaney argued that the majority’s “assumption” that the physician failed to perform necessary tests through inadvertence

usurps the role of the jury and makes the factual findings necessary to dismiss Summers’ claim as one of mere negligence. It was for the jury, not the district court or this court, to determine the relative credibility of the parties and what occurred in the emergency room that day.¹²⁶

Marshall and *Summers* are both important and influential opinions and among the most frequently cited EMTALA cases;¹²⁷ numerous other courts have followed their reasoning.¹²⁸ Some have, moreover, been similarly aggressive in their use of summary judgment

¹²⁴ *Id.*

¹²⁵ *Id.* at 1139 (emphasis added).

¹²⁶ *Id.* at 1141 (Heaney, J., dissenting).

¹²⁷ According to a Westlaw search run on January 27, 2012, the most cited opinions discussing the merits of civil suits under EMTALA are: *Baber v. Hospital Corp. of America*, 977 F.2d 872 (4th Cir. 1992) (383 citing cases); *Correa v. Hospital San Francisco*, 69 F.3d 1184 (1st Cir. 1995) (232 citing cases); *Marshall v. East Carroll Parish Hospital Service District*, 134 F.3d 319 (5th Cir. 1998) (183 citing cases); *Hardy v. New York City Health & Hospital Corp.*, 164 F.3d 789 (2d Cir. 1999) (169 citing cases); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037 (D.C. Cir. 1991) (160 citing cases); *Bryant v. Adventist Health System*, 289 F.3d 1162 (9th Cir. 2002) (150 citing cases); *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990) (144 citing cases); *Thornton v. Southwest Detroit Hospital*, 895 F.2d 1131 (6th Cir. 1990) (118 citing cases); *Eberhardt v. City of Los Angeles*, 62 F.3d 1253 (9th Cir. 1995) (101 citing cases); *Vickers v. Nash General Hospital, Inc.*, 78 F.3d 139 (4th Cir. 1996) (99 citing cases); *Summers v. Baptist Medical Center Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996) (en banc) (98 citing cases); *Power v. Arlington Hospital Ass’n*, 42 F.3d 851 (4th Cir. 1994) (95 citing cases); *Harry v. Marchant*, 291 F.3d 767 (11th Cir. 2002) (76 citing cases); *Bryan v. Rectors & Visitors of the University of Virginia*, 95 F.3d 349 (4th Cir. 1996) (67 citing cases); *Roberts v. Galen of Virginia, Inc.*, 525 U.S. 249 (1999) (65 citing cases); *Repp v. Anadarko Municipal Hospital*, 43 F.3d 519 (10th Cir. 1994) (64 citing cases); *Battle v. Memorial Hospital*, 228 F.3d 544 (5th Cir. 2000) (54 citing cases); *In re Baby K*, 16 F.3d 590 (4th Cir. 1994) (43 citing cases).

¹²⁸ For example, the district court in *Guzman v. Memorial Hermann Hospital System*, 637 F. Supp. 2d 464 (S.D. Tex. 2009), *aff’d*, 409 F. App’x 769 (5th Cir. 2011), followed the logic of *Summers* explicitly in granting summary judgment for the defendant hospital on the plaintiff’s screening claim, writing that “[t]he facts of this case are similar to those in *Summers*.” *Id.* at 486. The use of summary judgment by the court in *Guzman* was likewise aggressive, as it similarly relied on deference to the physician’s perceived diagnosis: The results for an important screening test were not read before the patient was discharged because the doctor did not think waiting was necessary. *See id.* at 482–88.

and deference to the assertions of the defendant hospital and its treating physicians. In *Magruder v. Jasper County Hospital*,¹²⁹ for example, the court granted the defendant's motion for summary judgment on the plaintiff's disparate screening claim despite hospital records that allegedly showed instances of other patients with similar symptoms receiving more extensive screenings.¹³⁰ The court, persuaded by affidavits submitted by the hospital,¹³¹ held that there was insufficient evidence to show disparate screening.¹³² In *Cruz-Vazquez v. Mennonite General Hospital*,¹³³ the court initially denied the defendant hospital's motion for summary judgment, because the treating physician had failed to conduct certain tests and examinations that were mandated by the hospital's own explicit protocol.¹³⁴ Only a month later, however, the court vacated its prior opinion and instead granted the defendant hospital's motion for summary judgment.¹³⁵ The court excused the treating physician's failure to perform tests that

¹²⁹ 243 F. Supp. 2d 886 (N.D. Ind. 2003).

¹³⁰ The plaintiffs in *Magruder* "reference[d] four particular instances" that were asserted to reveal disparities in care for "similar patients presenting with similar conditions." *Id.* at 893. The plaintiffs similarly attempted to show nonuniformity by arguing that the patient's "condition was labeled as 'Non-urgent' with a diagnosis of 'swelling,' while other patients presenting to the emergency department . . . with a diagnosis of 'swelling' were labeled as 'Urgent.' They claim that from 2000 to 2001 there were 25 such cases and therefore, this is a disparity in treatment." *Id.*

¹³¹ The hospital provided the affidavit of its vice president of nursing to assert that "the medical screening provided to Jacob Magruder on May 8, 2001, comported with the established Hospital policies and procedures and was comparable to that offered to similar patients." *Id.* The physician who performed the screening also submitted an affidavit making this declaration. *See id.* ("Dr. Ahler also testified that his medical examination of Jacob Magruder was . . . the same type of physical examination and medical treatment that he would provide to any other similar patient with similar complaints or symptoms."). The hospital also tried to discredit the evidence provided by the plaintiff, arguing that the four other patients referenced by the Magruders were distinguishable and that not enough information could be gleaned from labels of urgent and non-urgent. *See id.* at 894 (noting the hospital's argument that "of the four patients referenced to by the Magruders only two were infants, both of whom presented with complaints and symptoms completely different from Jacob Magruder," and also noting the hospital's contention that "the information contained in the log is insufficient to establish that any patient presented with a condition similar to Jacob Magruder").

¹³² *See id.* (holding that "[i]t has not been established that [the hospital] applied its standard screening process differently to Jacob Magruder than to other similar patients with similar conditions").

¹³³ No. 08-1236 (JP), 2011 WL 3607669 (D.P.R. Aug. 15, 2011).

¹³⁴ *Id.* at *7 (observing that defendant hospital had in place a Third Trimester Bleeding protocol that "explicitly stated that third trimester bleeding 'must be differentiated from bloody show by speculum exam'" and "certain laboratory studies must [also] be performed," but "no such exam was performed" on the patient and the required studies were not conducted).

¹³⁵ *Cruz-Vazquez v. Mennonite Gen. Hosp., Inc.*, No. 08-1236 (JAF/JP), 2011 WL 4381888 (D.P.R. Sept. 20, 2011).

were “required” by the hospital’s protocol because the doctor “made a medical judgment not to perform [the] additional tests.”¹³⁶ And in *Bryant v. John D. Archbold Memorial Hospital*,¹³⁷ the Eleventh Circuit needed only two sentences to affirm the lower court’s grant of summary judgment to the defendant hospital,¹³⁸ despite facts presented on appeal that seemed to indicate genuine contested issues in the plaintiff’s screening claim. The treating physician admitted that, for the symptoms presented, he would normally have examined the patient’s abdomen, and the plaintiff asserted that his abdomen was not checked during the screening.¹³⁹ Yet the court held that the routine of one physician at the hospital was not representative of a general screening policy,¹⁴⁰ and the hospital submitted affidavits averring that an appropriate screening was performed.¹⁴¹

¹³⁶ *Id.* at *2–3. The *Cruz-Vazquez* court explained that the physician’s “decision not to conduct additional tests had nothing to do with [the patient’s] ability to pay but rather with [the physician’s] assessment of [the patient’s] medical condition.” *Id.* at *3. This rationalization, however, appears to disregard the holdings of the vast majority of courts, including the First Circuit, that a plaintiff suing under EMTALA need not prove improper intent. *See supra* notes 71–72 and accompanying text (noting that only the Sixth Circuit requires a showing of ill motive). The failure to adhere to the hospital’s written protocol was compelling evidence of a disparate screening, and yet the court discerned that the treating physician’s “medical judgment” removed any issue of genuine fact. The court suggested that it was motivated to grant summary judgment aggressively (and arguably improperly) by its frustration with the frequency by which EMTALA is used to bring malpractice claims into federal court. *See Cruz-Vazquez*, 2011 WL 4381888, at *3 (“[T]oo often, this Court has seen plaintiffs use EMTALA to bring their medical malpractice claims to federal court . . .”).

¹³⁷ 202 F. App’x 410 (11th Cir. 2006).

¹³⁸ The court’s reasoning was limited:

After a thorough review of the briefs and the record on appeal, we find no error in the grant of summary judgment to Defendants. The district court appropriately analyzed the EMTALA statute and the record evidence and properly determined that no dispute exists as to an issue of material fact.

Id. at 411.

¹³⁹ *See Bryant v. John D. Archbold Mem’l Hosp.*, No. 6:05-CV-11, 2006 WL 1517074, at *3 (M.D. Ga. May 23, 2006) (“Plaintiff . . . argues that because Defendant Crowley stated that he always conducts a physical examination of the abdomen when a patient has been involved in a motor vehicle accident, that his failure to conduct a physical exam of Plaintiff’s abdomen would establish Defendant Hospital’s liability under the EMTALA.”), *aff’d*, 202 F. App’x 410.

¹⁴⁰ The *Bryant* court reasoned that “it is the hospital’s standard practices, rather than the individual practices of the physicians employed there, that are relevant in determining EMTALA liability.” *Id.* at *4. The court concluded, therefore, that “showing that an individual physician either chose not to or forgot to conduct a physical exam of a specific area, which he or she normally performs, is not enough to establish the hospital’s liability under the EMTALA.” *Id.*

¹⁴¹ The hospital’s summary judgment brief quoted the statements of Dr. Mel Hartsfield, the facility’s vice president of medical affairs. Dr. Hartsfield, “after reviewing the medical records of Mrs. Bryant’s Emergency Department visit on September 25, 2004,” testified that “the screening and treatment of Mrs. Bryant by Dr. Crowley and other Archbold staff

Although the judicial sentiments in *Marshall* and *Summers* are the norm, some courts have exhibited greater skepticism toward a hospital's or physician's assertion of uniform care. A prominent example is *Power v. Arlington Hospital Ass'n*.¹⁴² Although the doctor in *Power* "testified unequivocally that he would not have treated any other patient with the same complaints and vital signs any differently than he treated Power,"¹⁴³ the court did not defer to this contention. Rather, it acknowledged that the plaintiff had presented sufficient evidence in showing that the physician failed to follow "usual procedure" by not recording Power's medical history or the results of an x-ray on her chart and by discharging Power before the results from her urinalysis had returned.¹⁴⁴

Nonetheless, the influence of *Power* is questionable. Just two years after the Fourth Circuit decided *Power*, it issued an opinion in *Vickers v. Nash General Hospital, Inc.*¹⁴⁵ that contradicts the reasoning of *Power*.¹⁴⁶ *Vickers* came to the hospital with a severe head injury. It was alleged that those arriving at the emergency room in *Vickers's* condition normally received testing for intracranial injury, whereas he received only staple sutures and was discharged.¹⁴⁷ Nonetheless, the court dismissed *Vickers's* claim, stating that "Dr. Hughes treated *Vickers* for what he 'perceived to be' *Vickers's* medical condition," and that, "[i]n his medical judgment . . . the laceration did not warrant testing for intracranial injury."¹⁴⁸ The *Vickers* court concluded that "EMTALA is implicated only when individuals who are *perceived* to have the same medical condition receive disparate

who participated in Mrs. Bryant's care is consistent with Archbold Emergency Department's standard screening procedures for patients presenting with Mrs. Bryant's clinical picture." Brief in Support of Defendants' Motion for Summary Judgment at 10, *Bryant*, 2006 WL 1517074 (No. 6:05-CV-11). The hospital's brief also repeated the statements of the plaintiff's treating nurse and physician: "Nurse Connell and Dr. Crowley also testified that the medical assessments, screenings, diagnostic tests and treatment given to Bryant were the same as provided to all patients presenting to the Emergency Department with a similar history, symptoms and complaints." *Id.*

¹⁴² 42 F.3d 851 (4th Cir. 1994). Although *Power* was an appeal from a jury verdict against the defendant hospital, the court's finding that the facts were sufficient to establish an inappropriate screening is important.

¹⁴³ *Id.* at 855.

¹⁴⁴ *Id.*

¹⁴⁵ 78 F.3d 139 (4th Cir. 1996).

¹⁴⁶ The primary difference relates to the high deference granted to the physician's assessment by the *Vickers* court. See *infra* note 158 and accompanying text.

¹⁴⁷ 78 F.3d at 141-43. *Vickers* died 4 days later. *Id.*

¹⁴⁸ *Id.* at 144.

treatment.”¹⁴⁹ The majority in *Summers* explicitly stated that they found the rationale of *Vickers* more persuasive than that of *Power*.¹⁵⁰

IV

AN ELABORATION ON THE PROBLEM, AND A SOLUTION

A. *An Elaboration on the Problem*

Marshall and *Summers* exemplify forceful judicial application of summary judgment against claims alleging EMTALA screening violations. The dissenting opinion in *Summers* conjectured that the motivation for “[t]he majority’s inappropriate resolution of this appeal from a grant of summary judgment is . . . its fear of giving EMTALA too ‘expansive’ an interpretation such that it would apply in situations traditionally covered only by state malpractice law.”¹⁵¹ The appellate courts in these cases have set a precedent for an aggressive use of summary judgment. The result is surely a reduction in the deterrent effect of EMTALA. But it may also extend the use of summary judgment in other contexts, perhaps realizing some of the fears of those scholars who have criticized an excessive use of the procedural tool.¹⁵²

The *Marshall* and *Summers* opinions also highlight a key flaw in the way courts have applied EMTALA’s screening requirement. Courts have developed a uniform reaction to claims that appear to allege misdiagnoses. The response is to cite language explaining that the Act was not intended to cover state tort law claims and contend therefore that “EMTALA . . . does not guarantee that the emergency personnel will correctly diagnose a patient’s condition as a result of

¹⁴⁹ *Id.* The court in *Vickers* also contended that the intracranial testing was part of a treatment plan and therefore subsequent to the question of whether the screening was appropriate. *Id.* (“[I]f disparate treatments based on disparate diagnoses sufficed to raise a claim under EMTALA, every allegation of misdiagnosis could automatically be recast as a claim under the Act.”). This argument is flawed. If a procedure—such as the intracranial testing in *Vickers*—is not intended to treat in any way, but is instead designed to diagnose the scope of the injury or disease, then it must be classified as part of a hospital’s screening. Stating otherwise reduces screenings to mere cursory observations and mischaracterizes thermometers as instruments that cure. See *supra* notes 55–56 and accompanying text (explaining that a medical screening examination “is not an isolated event” and can involve numerous diagnostic tests and procedures).

¹⁵⁰ See *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1139 n.4 (8th Cir. 1996) (en banc) (“In fairness to the plaintiff, we observe that *Power* . . . comes close, on its facts, to supporting his position. We find the reasoning of the Fourth Circuit’s later opinion in *Vickers* . . . more persuasive.” (citations omitted)).

¹⁵¹ *Id.* at 1142 (Heaney, J., dissenting).

¹⁵² See *supra* Part III.A (discussing the proper use of summary judgment and providing examples of courts arguably employing the procedural mechanism inappropriately in EMTALA cases).

this screening.”¹⁵³ This assertion, however, is inappropriately broad as it fails to elucidate the interplay of EMTALA and tort law with sufficient clarity. In particular, it implies that these two bases of hospital liability are completely distinct, when, in fact, there is properly a substantive overlap.

There are two different sources of misdiagnosis. The first source is carelessness in the administration of tests during a screening or in interpreting the results of these tests. The second source is neglect that results in certain typically administered tests not being done at all. A misdiagnosis that stems from the first source might form the basis of a malpractice action, but it likely will not violate EMTALA; in such cases, the hospital has followed its uniform screening procedure but has made a mistake while doing so.¹⁵⁴ The second source of misdiagnosis, however, is a violation of EMTALA because the hospital, by failing to perform certain tests that are part of its standard protocol, has plainly performed a nonuniform screening.¹⁵⁵ This disparate care might also violate tort law.¹⁵⁶ The distinction between these

¹⁵³ *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 879 (4th Cir. 1992).

¹⁵⁴ The exceptional circumstance where the first form of misdiagnosis could nonetheless constitute a violation of EMTALA is if the mistake in performing the test or reading its results could be shown to have been *intentional*. It is reasonable, in instances of the first form of misdiagnosis, to require that plaintiffs indicate that the failure to perform or interpret tests correctly was due to animus. The court cannot know for sure why the doctor made a mistake, but if he or she took the time (and spent the hospital’s resources) to perform each and every procedure other patients receive, it is a reasonably safe assumption that any mistake was due to reasons—exhaustion, for example—that are safely left to tort law to resolve.

¹⁵⁵ Unlike with the first form of misdiagnosis, *see supra* note 154, the second potential cause of misdiagnosis deserves far more judicial skepticism and scrutiny. In this scenario, a doctor forgets or declines to perform certain tests on an individual that the hospital would typically perform on other patients with similar problems. Here, the hospital has directly benefited monetarily from the negligence, and courts should be suspicious that the mistake was—either consciously or subconsciously—an intentional denial of treatment. The hospital’s benefit is not just from an avoidance of the time and cost of running additional procedures, although such expenses are surely significant in their own right. In providing a less than thorough exam, the hospital lessens the likelihood that an emergency medical condition may be found, thus diminishing the probability that it will be saddled with the burden of stabilizing the patient. *See* Judith L. Dobberty, *Eliminating Patient Dumping: A Proposal for Model Legislation*, 28 VAL. U. L. REV. 291, 315 (1993) (discussing “a loophole in EMTALA: because hospitals can shield themselves from liability by falsely diagnosing a condition as non-emergency, the hospital’s duty to stabilize does not arise until an emergency condition has been established”); *cf.* *Bryant v. Adventist Health Sys.*, 289 F.3d 1162, 1166 (9th Cir. 2002) (“[W]e have held that a hospital has a duty to stabilize only those emergency medical conditions that its staff detects. . . . Every circuit to address this issue is in accord.”).

¹⁵⁶ Whether it violates tort law depends on what constitutes the standard of care in the particular case. *See* Barry R. Furrow, *The Patient Injury Epidemic: Medical Malpractice Litigation as a Curative Tool*, 4 DREXEL L. REV. 41, 84–85 (2011) (“Customary practice is

two sources of misdiagnosis is cogently articulated by the *Power* court.¹⁵⁷

Many courts fail to distinguish between these two forms of misdiagnosis because they frame the issue incorrectly. Rather than asking whether another individual would have received the same screening, the question is reformulated. Instead, the inquiry is based not on objective indicia of the patient's condition but on the medical condition that the specific treating physician perceived the person to have and the procedures that the doctor determined were necessary. The *Vickers* court gave great deference to the "medical judgment" of the defendant doctor.¹⁵⁸ And judicial deference to physician perception is illustrated by the court in *Summers*, which focused on the subjective knowledge of the physician and accepted his assertion that he did not hear popping noises or the plaintiff's complaints of chest pain.¹⁵⁹ Although not all courts have followed the logic of *Vickers* and *Summers*,¹⁶⁰ many have exhibited similar deference to physicians' thoughts.¹⁶¹

the normal benchmark for evaluating . . . negligence. Medical practice, however, often lacks clear standards, with several approaches often viewed as acceptable . . .").

¹⁵⁷ See *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 859 (4th Cir. 1994) (discussing the difference between inaccurate readings of certain tests and failing to conduct tests at all, in terms of the interplay of tort law and EMTALA).

¹⁵⁸ *Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139, 144 (4th Cir. 1996). Although *Vickers* was decided at the motion to dismiss stage, rather than at summary judgment, the reasoning in its opinion could apply at either juncture. The dissent in *Vickers* disputed the dismissal of the claim under the limited standard of Federal Rules of Civil Procedure 12(b)(6). More importantly, the dissent assigned a motive to the court's stretched use of Rule 12(b)(6), which makes for an interesting analogy to an overly aggressive use of summary judgment. *Id.* at 146 (Ervin, J., dissenting) ("The majority's real problem is not with what *Vickers* alleged, but with the statutory language, which allows an EMTALA violation to be proven even when the failure to screen or stabilize is not shown to have been based on an economic motive.").

¹⁵⁹ See *supra* notes 114–26 and accompanying text (discussing *Summers*).

¹⁶⁰ See, e.g., *Cruz-Queipo v. Hosp. Español Auxilio Mutuo de P.R.*, 417 F.3d 67, 68 (1st Cir. 2005) ("Notes from the screening examination do not indicate that Cruz complained of chest pain. For purposes of summary judgment, however, we must credit Cruz's assertion that he did, in fact, report such pain, and, drawing all reasonable inferences in Cruz's favor, we must assume that the emergency room doctors were aware of the chest pain."); *Kauffman v. Franz*, No. 07-CV-5043, 2009 WL 3157333, at *2–3 (E.D. Pa. Sept. 25, 2009) (denying defendant hospital's summary judgment motion where there was "conflicting evidence regarding [the treating physician's] perception of [the patient's] condition"); see also *Kauffman v. Franz*, No. 07-CV-5043, 2010 WL 1257958, at *3 (E.D. Pa. Mar. 26, 2010) (denying the defendant hospital's motion for reconsideration and explaining that to "dispose of the EMTALA claim at summary judgment" would require "weigh[ing] the documentary evidence of [the patient's] complaint of chest pain against [the physician's] testimony, and choos[ing] to credit [the physician]. The Court cannot perform this function without invading the province of the factfinder").

¹⁶¹ See, e.g., *Guzman v. Mem'l Hermann Hosp. Sys.*, 637 F. Supp. 2d 464, 483, 487 (S.D. Tex. 2009) (discussing "the rule from *Vickers* and *Summers* that the doctor's actual

An assessment of uniformity in screening examinations that defers to the perception and judgment of an individual physician in determining what constituted the hospital's standard protocol will inexorably excuse disparate care. Commentators have noted substantial discrepancies in physician decisions both between and within hospitals.¹⁶² Without standardized instruction of some sort from a hospital, it is highly unlikely that screenings performed by different physicians could possibly be uniform.¹⁶³

diagnosis is taken as a given in an EMTALA case”), *aff'd*, 409 F. App'x 769 (5th Cir. 2011); *see also* *Gerber v. Nw. Hosp. Ctr., Inc.*, 943 F. Supp. 571 (D. Md. 1996). The plaintiff in *Gerber* arrived at the hospital complaining of considerable pain. During her screening she made repeated references to suicide, and “[t]he friend that accompanied Gerber to the hospital also advised Dr. Neustadt that she had discussed suicide earlier.” *Id.* at 574. Yet, “while on many prior occasions (in treating other patients) Dr. Neustadt called in one of any number of readily available mental health care professionals to screen patients who had come to Northwest’s emergency room with psychiatric complaints, he failed to provide her with such services.” *Id.* at 574–75. Citing *Vickers*, the court dismissed the screening claim. The court reasoned that disparate treatment is measured only as to perceived conditions and symptoms. *See id.* at 577 (“Gerber does not allege that the treatment she *in fact* received differed from that received by individuals *perceived* to have the same condition. . . . ‘EMTALA is implicated only when individuals who are perceived to have the same medical condition receive disparate treatment.’” (quoting *Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139, 144 (4th Cir. 1996))).

¹⁶² *See, e.g.*, MILLENSON, *supra* note 14, at 4 (“In the absence of reliable information, physicians’ decisions fluctuate wildly.”). Millenson cites numerous examples of this throughout his book. *See id.* (“[W]hen family practitioners in Washington State were queried about treating a simple urinary tract infection in women, eighty-two physicians came up with an extraordinary 137 different strategies.”); *id.* at 15–18 (discussing enormous inconsistencies in the treatment of pneumonia patients at eight hospitals in Maine, noting that the researchers in the study “looked in vain for any consistent pattern,” and concluding that “[t]he results in this one small state showed just how deceptive the surface similarities of American medicine can be”); *id.* (noting similar disparities in methods of treating heart attack victims and remarking that one “possible explanation for the variation” was that “[t]he differences could result from physicians’ ‘practice styles’ or ‘preferences,’ the polite terms the medical community uses to describe treatment that varies because doctors vary”); *id.* at 30 (noting dissimilarity among physicians deciding whether or not to remove a child’s tonsils).

¹⁶³ *See id.* at 112 (noting the experience of one hospital, which, when it attempted to “write a protocol spelling out every detail of treatment” for acute respiratory distress syndrome, encountered substantial problems with physician variance: “A treatment regimen that appeared on the surface to be orderly and scientific quickly dissolved into a series of individual ‘rules of thumb’ used by each physician”); M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 YALE J. HEALTH POL’Y L. & ETHICS 95, 100 (2001) (“Most medical decisions do not rest firmly on empirical evidence. There are typically multiple diagnostic and therapeutic options, and wide variations in the incidence of many common medical and surgical procedures have been documented within small geographic areas and between individual practitioners.”). Studies suggest, moreover, that many doctors at large hospitals are unaware of EMTALA and its requirements. *See, e.g.*, Joseph Zibulewsky, *Medical Staff Knowledge of EMTALA at a Large, Tertiary-Care Hospital*, 21 AM. J. EMERGENCY MED. 8, 12 (2003) (surveying the “staff of a large, private teaching hospital,” and finding that “the majority of the medical staff, including a significant number of physicians who take call regularly for the ED, have no knowledge of

Limiting the category of acts that constitute EMTALA violations to instances of disparate treatment based on perceived condition is also problematic because it is logically linked to motive and intent. EMTALA's plain text, however, precludes any such inquiry. A violation is contingent solely on whether or not an individual was screened uniformly. The doctor's perception is relevant only where there is a factual dispute as to what constituted the individual's symptoms and complaints; the doctor's opinion may then assist the jury in deciding whether to believe the plaintiff's assertions. Using physician perception to otherwise bar liability inappropriately narrows the scope of physician activity covered by EMTALA. Although courts assert that animus is not a necessary element of an EMTALA violation, plaintiffs nonetheless may need to demonstrate bias in order to survive summary judgment.¹⁶⁴ This puts a tremendous burden on plaintiffs, as proving intent is notoriously difficult.¹⁶⁵

Deference to physician perception, moreover, results in underdeterrence of more subtle forms of patient dumping.¹⁶⁶ Studies have found, for example, that there are significant racial disparities in

EMTALA" and "those who are familiar with the law have a limited breadth of knowledge about it").

¹⁶⁴ See *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1142 (8th Cir. 1996) (en banc) (Heaney, J., dissenting) ("The majority gives lip service to following the literal language of the statute by not requiring proof of bias on the part of the hospital. Yet its strained definition of 'appropriate,' . . . effectively limits the statute's application to only those cases that involve bias or discrimination."). Judge Heaney added that he saw "no way for a plaintiff to prove non-uniform or disparate treatment without evidence of the hospital's bias against a particular group to which he belongs." *Id.*; see also *FURROW ET AL.*, *supra* note 31, at 518 ("[B]ecause some courts have adopted a deferential stance toward the judgment of the treating physician, plaintiff may need to focus on proving motive . . . even if the jurisdiction does not require proof of improper motive . . ." (footnotes omitted)).

¹⁶⁵ Numerous courts and commentators have noted the challenge of showing intent. See, e.g., *United States v. Matthews*, 431 F.3d 1296, 1314 (11th Cir. 2005) (commenting on "the uniquely difficult task of proving intent in conspiracy cases").

¹⁶⁶ See *Pettyjohn v. Mission-St. Joseph's Health Sys., Inc.*, No. 1:99CV171-C, 2000 WL 33311929, at *4 (W.D.N.C. Nov. 22, 2000) (expressing concern "that deferring to subjective findings can allow room for corporate mischief" but noting that the binding precedents of *Baber* and *Vickers* "essentially create a situation where EMTALA can only be implicated where a 'whistle-blower' at a hospital reveals the hospital's improper motive or where the emergency condition is so patent, i.e., a heart attack or gunshot wound, that even laypersons would see the need for stabilizing treatment"), *aff'd*, 21 F. App'x 193 (4th Cir. 2001); cf. *Necia B. Hobbes*, *Out of the Frying Pan into the Fire: Heightened Discrimination & Reduced Legal Safeguards When Pandemic Strikes*, 72 U. PITT. L. REV. 779, 796 (2011) (noting that, because the EMTALA statute does not require proof of intentional discrimination, it has the potential to "prevent[] both inadvertent discrimination and discrimination which is purposeful but difficult to prove," and it can thereby protect "minority individuals . . . from being turned away based on discrimination that is subconscious, institutional, or even discrimination that is intentional but cannot be proven").

treatment decisions by doctors.¹⁶⁷ Other analyses have reported similar inequalities on the basis of gender,¹⁶⁸ indigence,¹⁶⁹ and AIDS status.¹⁷⁰ Many scholars contend that discrimination in modern society frequently occurs unconsciously.¹⁷¹ If a plaintiff presents evidence that

¹⁶⁷ See, e.g., Kevin A. Schulman et al., *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. MED. 618, 623–25 (1999) (describing significant differences in doctor reactions to Black and White individuals reporting identical symptoms); see also Janice C. Blanchard et al., *Racial and Ethnic Disparities in Health: An Emergency Medicine Perspective*, 10 ACAD. EMERGENCY MED. 1289, 1289–93 (2003) (reviewing “existing research on disparities in the area of emergency medicine,” noting, for example, that “[r]ecent data showed that nonwhites with acute cardiac ischemia were two times more likely to be sent home from the ED, and nonwhites with myocardial infarctions were over four times more likely to be missed,” and contending that “[r]acial bias is an important factor that must be considered in explaining disparities”); Jordan J. Cohen, *Disparities in Health Care: An Overview*, 10 ACAD. EMERGENCY MED. 1155, 1156 (2003) (stating that the “evidence is incontrovertible” that “biases and stereotypes affect patient care”); Arnold M. Epstein & John Z. Ayanian, *Racial Disparities in Medical Care*, 344 NEW ENG. J. MED. 1471, 1471–72 (2001) (explaining that “[m]any studies have shown that black Americans are less likely than whites to receive a wide range of medical services, including potentially life-saving surgical procedures,” and suggesting, as one contributing factor, that “both white and black physicians may have subtle biases that are based on other social factors and that influence their judgments about patients’ suitability for procedures”); Diana J. Burgess et al., *Why Do Providers Contribute to Disparities and What Can Be Done About It?*, MEDSCAPE NEWS, Dec. 7, 2004, available at <http://www.medscape.com/viewarticle/494312> (collecting research on social cognition and provider decision making, and explaining that, although “[c]linicians are generally expected, and expect themselves, to view each patient objectively and impartially, . . . these expectations are highly unrealistic. Providers, like all humans, are likely to unconsciously apply stereotypes when making sense of patients”); Kurt Samson, *Researchers Find Racial Disparities in Care for Epilepsy at Hospitals*, NEUROLOGY TODAY, Jan. 6, 2011, at 1 (reporting a finding that “blacks and Hispanics were less likely to receive neuroimaging or to be admitted to the hospital when seen in their tertiary care emergency department (ED) for an epileptic seizure”). Burgess et al. emphasize that “features of the health care setting that decrease cognitive capacity, such as fatigue, overload, and time pressure” exacerbate problems of “stereotyping and bias.” Burgess et al., *supra*.

¹⁶⁸ See Schulman et al., *supra* note 167 (finding similar disparities in physician decisions based on gender).

¹⁶⁹ See, e.g., RAYMOND S. DUFF & AUGUST B. HOLLINGSHEAD, *SICKNESS AND SOCIETY* 84–85, 117–18 (1968) (reporting disparate treatment of patients on the basis of socioeconomic status by physicians, nurses, and hospital administrators); Selassie et al., *supra* note 7, at 1266 (finding that the uninsured were less likely to be admitted to a hospital, even after controlling for the patient’s clinical condition).

¹⁷⁰ See, e.g., Scott Burreis, *Dental Discrimination Against the HIV-Infected: Empirical Data, Law and Public Policy*, 13 YALE J. ON REG. 1, 35 (1996) (reporting discrimination against HIV-positive patients in the provision of dental care); see also *Howe v. Hull*, 874 F. Supp. 779, 786 (N.D. Ohio 1994) (denying a defendant hospital’s summary judgment motion in an EMTALA case against a hospital that allegedly “did not wish to treat an AIDS patient”).

¹⁷¹ See, e.g., Anthony G. Greenwald & Linda Hamilton Krieger, *Implicit Bias: Scientific Foundations*, 94 CAL. L. REV. 945, 946, 961, 966–67 (2006) (explaining that “the science of implicit cognition suggests that actors do not always have conscious, intentional control over the processes of social perception, impression formation, and judgment that motivate

another patient with the same symptoms and complaints would have received a different screening, it should be irrelevant that the physician misperceived the plaintiff's condition.

Courts have interpreted EMTALA to require equality in screening processes and have held that the statute may be violated regardless of intent. The Act has the potential, therefore, to remedy and deter all inequities of care, including those that are rooted in unconscious biases. The current handling of EMTALA claims, however, fails to ensure equality between patients in the tests and procedures received during screenings. For courts to ascertain whether similarly situated individuals received the same tests or, more specifically, to distinguish one instance of misdiagnosis from another, it must be plain what tests are standard for a hospital's screening examination in response to certain symptoms or medical problems. The simplest solution to this evidentiary problem is to have hospitals prepare written standards so that deviations from the norm are obvious.¹⁷² Courts have, however, been too quick to defer to the medical judgment of physicians, preventing a meticulous inquiry into whether the plaintiff received all of the tests his or her condition warranted. This may, as in the *Marshall* decision, constitute an inappropriate use of summary judgment. To make matters worse, it also discourages hospitals from maintaining written guidelines on emergency-department protocol, increasing the opacity of what constitutes uniform care and making the detection of EMTALA violations more difficult.¹⁷³

their actions," asserting that "evidence that implicit attitudes produce discriminatory behavior is already substantial and will continue to accumulate," and concluding that "a substantial and actively accumulating body of research evidence establishes that implicit race bias is pervasive"). For a general overview of legal scholarship dealing with unconscious discrimination, see Symposium, *Unconscious Discrimination Twenty Years Later: Application and Evolution*, 40 CONN. L. REV. 927 (2008).

¹⁷² Some doctors, in fact, have proposed increased reliance on written guidelines as a strategy for reducing disparities in emergency-department care. See Lynne D. Richardson et al., *Racial and Ethnic Disparities in the Clinical Practice of Emergency Medicine*, 10 ACAD. EMERGENCY MED. 1184, 1187 (2003) ("It has been suggested that increased reliance upon evidence-based protocols might decrease clinical disparities by decreasing uncertainty and minimizing individual physician discretion."). Legal academics have made similar suggestions. See, e.g., Bloche, *supra* note 163, at 117–18 (recommending reduced discretion and greater use of rules-based protocols as a method of reducing race-based disparities in medical care); Dania Palanker, Note, *Enslaved by Pain: How the U.S. Public Health System Adds to Disparities in Pain Treatment for African Americans*, 15 GEO. J. ON POVERTY L. & POL'Y 847, 874 (2008) (proposing the implementation of "[s]tandardized pain assessment and pain treatment guidelines" in order to "reduce the amount that unconscious bias impacts physician treatment decisions").

¹⁷³ Questions of physician perception, however, may also occur even where the requirements of a screening based on specific symptoms are perfectly clear. A dispute may occur when there is a question as to what the symptoms *were*. The doctor may claim the patient complained of only one ailment, while the patient contends she told the physician of an

Given judicial willingness to defer to physician perceptions when ruling on summary judgment motions, many hospitals may rightly decide against the promulgation of written guidelines for the tests and procedures administered in emergency-department screenings;¹⁷⁴ the maintenance of an unwritten policy likely reduces the hospital's potential EMTALA liability. If a patient alleges that his or her screening should have involved, for example, an x-ray, the court will place upon the patient the difficult burden of showing that the hospital's screening was nonuniform.¹⁷⁵ The hospital can simply submit

additional ailment. *Summers*, discussed *supra* notes 114–26 and accompanying text, is a prominent example of this situation as it involved a disagreement between physician and patient over whether the physician heard the patient's complaints of chest pain. Contrary to common practice, with sufficient evidentiary support this should routinely constitute a genuine issue of material fact reserved for jury determination. But this factual scenario is, nonetheless, an exception to the general contention of this Note that the use of written standards will make claims easily and properly resolvable at the summary judgment stage. In cases of disputed presentation of symptoms, even if an explicit screening protocol exists, summary judgment is likely inappropriate.

¹⁷⁴ Although some hospitals have written guidelines for the processing of emergency-department patients, such as standardized triage instructions or requirements for nurse monitoring, a survey of EMTALA opinions indicates that few hospitals have detailed protocols that guide physicians during screenings. *See, e.g., Reynolds v. MaineGeneral Health*, 218 F.3d 78, 83–84 (1st Cir. 2000) (discussing a basic policy that required the taking of “complete [medical] history”); *Cunningham v. Fredonia Reg'l Hosp.*, No. 95-3350, 1996 WL 584917, at *2 (10th Cir. Oct. 11, 1996) (involving a policy that determined whether a nurse or a physician would screen a patient depending on the severity of the patient's chest pain); *Bode v. Parkview Health Sys., Inc.*, No. 1:07-CV-324, 2009 WL 790199, at *2, *4 (N.D. Ind. Mar. 23, 2009) (noting that the hospital had a written nursing policy requiring that “nurses . . . take each patient's blood pressure,” but making clear, in its affidavits, that “[i]t is within the medical judgment of the physician who performs the Medical Screening Examination to determine what history, examination and testing is needed in order to determine whether the patient has an Emergency Medical Condition”); *Fuentes Ortiz v. Mennonite Gen. Hosp.*, 106 F. Supp. 2d 327, 331 (D.P.R. 2000) (noting that, in response to an interrogatory question asking “whether on May 21st, 1998 you had established any policies or procedures for screening patients coming to your emergency room who display or complain of symptoms such as the ones described by plaintiff in his complaint,” the hospital administrator stated: “Patient is first screened in Triage . . . Relative to the specific condition of the patient, no protocol exists, other than the applicable standard of care.”); *see also Timothy H. Bosler & Patrick M. Davis, Is EMTALA a Defanged Cobra?*, 51 J. Mo. B. 165, 169 (1995) (“[M]any hospitals do not provide an established protocol for screening procedures related to even common serious medical conditions . . . Based on our personal experience, many hospitals provide emergency room service through contract physicians and provide little, if any, written screening standards or protocols for the guidance of the individual employees or independent contractors to determine how they will screen a given patient presentation.”).

¹⁷⁵ *See Spillman v. Sw. La. Hosp. Ass'n*, No. 2:05 CV 450, 2007 WL 1068489, at *3 (W.D. La. Apr. 4, 2007) (“[The plaintiff's] attorney suggested that to prove anything other than a deviation from the standard of care . . . is virtually impossible. Though the court agrees that it is difficult to obtain such evidence, it is not impossible.”); *FURROW ET AL., supra* note 31, at 518 (“[I]f . . . the hospital has not developed written guidelines or clearly established practices or has developed only the most barebones policies, plaintiff will have to reach for other evidence of the hospital's departure from its norm.”). The judicial requirement that

an affidavit asserting that its standards were met, move for summary judgment, and feel confident that the plaintiff will be unable to meet the high evidentiary hurdle that courts typically require in such situations.¹⁷⁶ Moreover, even if the plaintiff can show that, given his or her symptoms, the hospital's standard demanded an x-ray,¹⁷⁷ the physician can respond that he or she perceived the plaintiff's condition differently, such that an x-ray was not warranted. This, too, has often been enough to defeat a plaintiff's claim on summary judgment. Conversely, some of the few instances of plaintiffs prevailing at summary judgment on an EMTALA screening claim involved instances of hospitals not following some sort of written protocol.¹⁷⁸ Thus, a

plaintiffs show that the screening or treatment they received was markedly different from what other patients would receive, if they were in the plaintiff's position, puts litigants asserting EMTALA violations in a difficult position. Proving such a counter-factual may be nearly impossible without hard evidence as to what constitutes the hospital's standard procedures. See Bloche, *supra* note 163, at 110–11 (lamenting that “[t]he cursory evaluation and transfer or discharge of members of disadvantaged minority groups . . . is . . . rendered more likely to occur with impunity” because EMTALA plaintiffs face a steep evidentiary hurdle in proving disparate care, especially since a hospital's physicians are unlikely to testify against one another).

¹⁷⁶ The following is typical litigant practice for defendant hospitals:

An emergency room physician or other staff member will usually provide an affidavit in support of the defendant's motion for summary judgment on a screening claim. It will essentially consist of statements that the affiant is familiar with the defendant's standard screening procedures, and that those procedures were followed in the plaintiff's case.

62 AM. JUR. *Trials*, *supra* note 101. For further examples of defendant affidavits asserting uniformity in care, see *supra* notes 131 and 141.

¹⁷⁷ Even where plaintiffs have mustered some evidence to support their disparate screening claim, some courts have nonetheless ruled against them on summary judgment. In *Marshall*, for example, the plaintiff lost at summary judgment despite having the good fortune of finding someone who worked at the defendant hospital who was willing to testify on the plaintiff's behalf. See *supra* notes 102–13 and accompanying text (summarizing *Marshall*). And *Magruder* is one of the few cases where a plaintiff was able to present evidence from past medical records of alleged non-uniformity in screening, but the court still chose to grant the hospital summary judgment. See *supra* notes 129–32 and accompanying text (discussing *Magruder*). The plaintiffs in *Battle v. Memorial Hospital* were creative in trying to compare the patient's screening with a screening the same patient received at the hospital sixteen hours later, but the court rejected this as insufficient to show disparate treatment. See 228 F.3d 544, 557 (5th Cir. 2000) (deciding that “[t]he decision that a patient who had a normal lumbar puncture approximately sixteen hours earlier in the same hospital does not require a repeat of that procedure, while arguably an error in medical judgment, does not constitute disparate treatment under EMTALA”). Similarly, a treating physician's statement that he always performs a certain test that he failed to administer to the plaintiff was insufficient in *Bryant v. John D. Archbold Memorial Hospital*. See *supra* notes 137–41 and accompanying text (describing *Bryant*).

¹⁷⁸ See, e.g., *Battle v. Mem'l Hosp.*, 228 F.3d at 558 (overruling the trial court's grant of judgment as a matter of law against the plaintiff's screening claim where the defendant hospital's written emergency department “Nursing Care Standards” stated that “[i]nfants and elderly are usually hospitalized if no definitive source for fever/infection is determined,” and a “rational jury may have concluded . . . that the source of [the plaintiff's]

hospital can significantly reduce its potential EMTALA liability by choosing not to have explicit and clear guidelines for emergency department screenings. At least one law firm website has advised hospitals that express physician requirements “can only cause problems in the event of [EMTALA] litigation.”¹⁷⁹

By granting hospitals summary judgment despite a lack of concrete evidence as to whether a given screening was uniform, courts have incentivized to obscure standard treatment procedures.¹⁸⁰ In effect, courts have encouraged practices that make it harder to discern when violations of EMTALA have occurred,¹⁸¹ increasing the extent to which EMTALA claims appear to blend into tort law.¹⁸² This, in turn, undermines private enforcement of EMTALA because it makes it difficult for the plaintiff to demonstrate, and for the court to verify, that treatment was nonuniform.

fever and infection was not determined at the time he was released” (first alteration in original)); *Abney v. Univ. Med. Ctr. of S. Nev.*, No. 2:09-cv-02418-RLH-PAL, 2011 WL 468349, at *7 (D. Nev. Feb. 4, 2011) (denying the defendant hospital’s motion for summary judgment where the hospital violated its written policy that the Triage Nurse be notified of any individual seeking treatment); *Macamaux v. Day Kimball Hosp.*, No. 3:09-CV-164 JCH, 2011 WL 4352007, at *2, *6 (D. Conn. Sept. 16, 2011) (denying the defendant hospital’s motion for summary judgment where the hospital had a policy stating that the radiology department “must” take x-rays that reveal portions of the spine, and it failed to redo the plaintiff’s faulty x-rays); *Bode*, 2009 WL 790199, at *7–10 (denying the defendant hospital’s motion for summary judgment where the hospital violated its written policy requiring nurses to measure blood pressure during the initial assessment and take vital signs every two hours). *Bode* is particularly interesting because the court refused to excuse the hospital’s deviation from written policy despite the contention of the treating physicians that “they had all of the information they needed . . . to complete an appropriate medical screening.” *Id.* at *8. The case illustrates that, where a hospital fails to adhere to an explicit policy, courts might not be as willing to defer to the exculpatory assertions of the hospital and its physicians. *But see supra* notes 133–36 and accompanying text (citing an example of a court justifying failure to follow a hospital’s written protocol by deferring to the treating physician’s medical judgment).

¹⁷⁹ See *Garan Lucow Miller P.C., Summers v Baptist Medical Center, EMTALA.COM*, <http://www.emtala.com/summers.htm> (last visited Mar. 22, 2012) (discussing methods of compliance under EMTALA and recommending that hospitals “refrain from imposing requirements of treatment, stabilization, consultation, or any other step which is properly regarded as a matter of medical judgment and discretion. Such policies can only cause problems in the event of litigation . . .”).

¹⁸⁰ For an example of a case involving a hospital with a barebones screening procedure, see *Hutchinson v. Greater Southeast Community Hospital*, 793 F. Supp. 6, 8 (D.D.C. 1992), which states that the hospital had no “policies, protocols, or procedures specifying any required content of an emergency screening exam, or describing what comprises an adequate or inadequate screening exam.”

¹⁸¹ See *Frank, supra* note 5, at 208 (“[T]he lack of a written policy makes it more difficult to prove that a hospital failed to adhere to that protocol.”).

¹⁸² See *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1141 (8th Cir. 1996) (en banc) (Heaney, J., dissenting) (“The more a hospital’s established procedures are unwritten and loosely-defined—or essentially equivalent to ‘due care’—the more an EMTALA cause of action may overlap with a state medical malpractice claim.”).

Explicit guidelines have the potential not only to improve EMTALA's effectiveness, but also the medical care hospitals provide. Although courts have held that EMTALA does not require a hospital to develop an explicit guideline for emergency-department screenings,¹⁸³ judicial resolution of EMTALA claims should at least not deter the use of written screening standards. The following Section demonstrates that a judicious and proper use of summary judgment could reduce the disincentives to adopting explicit guidelines.

B. A Solution

Courts should grant summary judgment for defendant hospitals that affirmatively and explicitly demonstrate compliance with their own internal processes. Ideally, EMTALA jurisprudence should incentivize proper procedures, rather than focus on patient outcomes. This Section lays out a precise and workable summary judgment standard that, if followed, would better achieve EMTALA's goals.

In order to prevail on summary judgment, a defendant hospital should have the burden of proving with substantial specificity what constituted its standardized procedure for patients with the plaintiff's symptoms and characteristics.¹⁸⁴ A hospital would not satisfy this burden by the common practice of submitting an affidavit with the conclusory contention that the plaintiff was provided the same screening as any other patient.¹⁸⁵ Even if a hospital properly establishes what its exact uniform protocol is, it should not be granted summary judgment if the plaintiff can produce evidence suggesting any of the following: (1) that the standard practice was not applied to the patient; (2) that the proffered protocol is not, in fact, the hospital's actual procedure; or (3) that the hospital knew of patient symptoms

¹⁸³ See, e.g., *id.* at 1140 (“[T]he hospital did have a screening procedure, even if unwritten in part, and the statute makes no additional requirement. It says nothing about written procedures.”); *Guzman v. Mem'l Hermann Hosp. Sys.*, 637 F. Supp. 2d 464, 492 (S.D. Tex. 2009) (“EMTALA does not require hospitals to impose detailed or symptom-specific screening-exam protocols or procedures on its physicians.”), *aff'd*, 409 F. App'x 769 (5th Cir. 2011). Regulations require emergency service “policies and procedures,” but do not necessitate that they be written or detailed. See 42 C.F.R. § 482.55 (2007) (outlining the standards of practice for emergency care providers). Some commentators have suggested, however, that EMTALA should require hospitals to adopt written screening protocols. See *Bosler & Davis*, *supra* note 174, at 169 (“To require a hospital to adopt standardized treatment protocols is not unreasonable or unrealistic.”).

¹⁸⁴ This, not surprisingly, would be a direct break with established EMTALA jurisprudence. See, e.g., *Marshall v. E. Carroll Parish Hosp. Serv. Dist.*, 134 F.3d 319, 324 (5th Cir. 1998) (“[A] hospital is not required to show that it had a uniform screening procedure.”).

¹⁸⁵ See, e.g., *supra* notes 131, 141 & 176 (providing examples of hospitals prevailing at summary judgment on the basis of physician, nurse, and administrator affidavits averring that standard protocols were followed and that the plaintiff received a uniform examination).

that required the use of a different protocol than the one the hospital administered during the patient's screening.¹⁸⁶

If a hospital chooses not to maintain written procedures, it may be difficult (although possible) for it to satisfy its initial burden of establishing what comprised its uniform screening procedure for certain situations. The same is true for a hospital that has a written guideline that lacks any detailed instruction. Even if the hospital or a physician claims to have followed standard procedures, where a plaintiff supplies some contradictory evidence, the court should be exceedingly hesitant to grant summary judgment in the absence of a properly detailed written procedure. In such a scenario, a credibility determination as to the hospital's or doctor's assertions is needed. Essentially, a trial is required; vigorous cross-examination can help the fact-finder identify just what constituted uniform care and assess whether or not the hospital's standard was met.¹⁸⁷

Conversely, where a hospital has a written protocol dictating standard emergency-department procedure for specific conditions, a court should frequently grant summary judgment if the hospital

¹⁸⁶ The first argument is unlikely to pose a significant evidentiary burden; discovery of the patient's record or testimony of treating doctors and nurses would probably suffice. It is also the most likely contention that a plaintiff with an EMTALA screening claim would make. The third argument is more complicated. It typically involves a disagreement between the patient's purported assertions about his condition and the perceptions of the treating physician regarding the patient's condition. This is a classic he-said-she-said situation that juries resolve frequently through credibility determinations based on the cumulative weight of the evidence presented; in such an instance, summary judgment is improper. The second argument is the most difficult to successfully demonstrate. It is theoretically possible, for example, that a hospital might have guidelines it uses for one set of patients and different guidelines it uses for another set. This would be a blatant EMTALA violation, but would be difficult for a private litigant to prove without something akin to testimony from a whistle-blower within the hospital.

¹⁸⁷ A recent opinion denying a defendant hospital's summary judgment motion in an EMTALA screening case appears to take an approach similar to that advocated by this Note. See *Hale v. Ne. Vt. Reg'l Hosp., Inc.*, No. 1:08-cv-82-jgm, 2011 WL 4625974, at *4-5 (D. Vt. Sept. 30, 2011). In *Hale*, the plaintiff asserted that the defendant hospital provided a disparate screening when the hospital failed to perform a lumbar puncture in response to a complaint of head pain. See *id.* at *5. The *Hale* court noted that "[o]n two prior occasions," when the patient had gone to the defendant hospital's emergency room complaining of head pain, a lumbar puncture was performed. *Id.* The hospital had no written policy and did not "cite any evidence explaining its lumbar puncture policy." *Id.* Rather than defer to the defendant hospital's conclusory insistence that the screening was appropriate, the court concluded that, since the hospital had failed to elucidate its standard practice, there was "a material issue of fact as to whether this is a case of misdiagnosis based upon an appropriate screening examination or a case of failure to provide an appropriate screening examination." *Id.*; cf. *supra* note 177 (discussing *Battle v. Mem'l Hosp.*, 228 F.3d 544, 557 (5th Cir. 2000), which rejected the plaintiff's assertion that a hospital's failure to perform a lumbar puncture, when the hospital had done so on the patient's prior visit sixteen hours earlier, was sufficient evidence of a nonuniform screening to survive summary judgment).

identifies that it followed its own guidelines. The explicit instruction eliminates any genuine issues of fact as to what constituted the hospital's standard treatment in the given situation. And where there is a written protocol that fails to match the procedures a physician administered in screening the plaintiff, it will be readily apparent that the hospital is liable.¹⁸⁸

Hospitals may respond to this approach by choosing, on their own initiative, to adopt written emergency-room checklists. At the very least, hospitals will no longer be discouraged from employing explicit guidelines by the risk of EMTALA liability. Faced with the prospect of courts adjudicating EMTALA screening claims based on this standard, a rational hospital will recognize that adopting a written protocol for emergency-department treatment will significantly lower its expected litigation costs without producing a marked increase in liability risk.¹⁸⁹

This can be illustrated by comparing potential outcomes with and without written standards. In those scenarios where the physician followed standard procedure, the hospital will benefit from having a written procedure: When its protocol is written, the hospital will easily demonstrate what constituted its uniform practice, and it will likely prevail via summary judgment at little expense.¹⁹⁰ However, when it has only an unwritten protocol, the hospital will have greater difficulty meeting its initial burden of establishing what constituted its uniform screening, and will therefore find it costlier and more difficult to win at summary judgment.

¹⁸⁸ The only exception would be for departures from a written policy that are *de minimis*. Courts have properly concluded that minor deviations from emergency-department protocols that do not impair the standard quality and thoroughness of the screening should be excused. *See Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519, 523 (10th Cir. 1994) (“Mere *de minimis* variations from the hospital’s standard procedures do not amount to a violation of hospital policy. To hold otherwise would impose liabilities on hospitals for purely formalistic deviations when the policy had been effectively followed.”).

¹⁸⁹ This can be contrasted with the decision a hospital faces under the current judicial handling of EMTALA claims: Adopting a written procedure does not likely lower expected litigation costs, while it does markedly increase the risk of liability. *See supra* notes 174–82 and accompanying text (explaining that an aggressive use of summary judgment to dismiss EMTALA screening claims might discourage hospitals from implementing written screening protocols).

¹⁹⁰ An example of a hospital following its own written policy that resulted in an easy dismissal of an EMTALA case at summary judgment is *Baker v. Adventist Health, Inc.*, 260 F.3d 987 (9th Cir. 2001). In *Baker*, the defendant hospital had “a written policy requiring the emergency department to request a mental health evaluation from [a specified county mental health department] if the medical screening turns up evidence of a ‘psychiatric disturbance’ or symptoms of substance abuse.” *Id.* at 991. The treating physicians acted in “accordance with [this written] hospital policy,” and the court had little trouble concluding that summary judgment was appropriate. *Id.*

And in those scenarios where the physician failed to follow standard procedure, under the proposed burden-shifting standard, the hospital's written protocol is unlikely to increase its expected litigation costs or liabilities. A hospital without a written guideline might avoid liability in such a situation. But in order to prevail in court, the hospital would have to fabricate a detailed standard that fit the screening the plaintiff received, which would open the institution to a substantial risk of prospective liability.¹⁹¹ And even after asserting that its procedure was correctly followed, since the hospital lacked a clear-cut, written protocol, it would have a significant chance of not prevailing at summary judgment if the plaintiff could muster any sort of evidence creating a genuine dispute as to a material fact.¹⁹²

Hospitals could worry that some aspects of effective diagnostic medicine necessitate physician discretion and that, in these instances, independent medical judgment should not be restricted by explicit protocols.¹⁹³ This concern, however, likely applies to only a minority of diagnostic scenarios.¹⁹⁴ Advances in medical science and modern technology have made much of emergency department medicine

¹⁹¹ Under the Federal Rules of Evidence, testimony by a physician or hospital administrator in one trial may be introduced as substantive evidence against the hospital in a subsequent trial. The statement would be admissible as an opposing party statement. See FED. R. EVID. 801(d)(2) (stating the admission by party-opponent exception to hearsay).

¹⁹² Moreover, where a patient's screening is nonuniform, hospitals with written guidelines may actually suffer lower jury awards on average. These facilities will obviously have violated EMTALA, and the only issues at trial might be causation and damages. The facts surrounding the purported inequality of the screening—circumstances that likely cast the hospital in an unfavorable light—may be irrelevant to the resolution of these questions and hence not presented to the jury. Scholars have commented on this in situations of jury bifurcation and trifurcation. See, e.g., D. Alan Rudlin & Christopher R. Graham, *Toxic Torts: A Primer*, 17 NAT. RESOURCES & ENV'T 210, 257 (2003) ("The division of liability from damages is particularly beneficial to defendants as the approach sometimes insulates them from prejudice when the jury considers the introduction of injury evidence.").

¹⁹³ See *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 858 (4th Cir. 1994) (recognizing "the importance of medical judgment in treatment decisions"). But cf. MILLENSON, *supra* note 14, at 136–37 (explaining that, although "[s]ome good guidelines are implemented with a rigidity that threatens innovation[,] . . . the alternative to care that is guided by the evidence is care that relies on each doctor's memory").

¹⁹⁴ In a recent article, Professor Ronen Avraham makes a fascinating and novel proposal for immunizing doctors from medical malpractice lawsuits if they comply with evidence-based medical guidelines. These guidelines would be written by private firms, which would be incentivized to produce high-quality protocols by the threat of negligence liability. See Ronen Avraham *Private Regulation*, 34 HARV. J.L. & PUB. POL'Y 543, 549–50, 552 (2011). In suggesting this scheme, Professor Avraham responds to the same critique of guidelines that is addressed here: "Good medicine requires discretion." *Id.* at 615–19. Professor Avraham similarly contends that this criticism may be "overstated" because, in part, "doctoring is far from pure art" and "[s]ome doctoring, perhaps most doctoring, can be reduced to guidelines." *Id.* at 616. He notes that "clinical practice guidelines are pervasive, directing physicians in areas as disparate as treating ulcers, heart failure, and smoking addiction." *Id.*

standardizable.¹⁹⁵ Where medical care can be reduced to clear rules, recent literature suggests that the use of written guidelines and reduced physician discretion will improve rather than diminish quality of care.¹⁹⁶ If a hospital nonetheless believes medical discretion is a vital component of certain types of diagnoses, it may expressly provide for such physician choice in its guidelines.¹⁹⁷ In doing so, however, it would forego the judicial deference provided to precise protocols. In order to prevail at summary judgment it would instead need to establish clearly the issues its doctors uniformly consider in such instances, thereby demonstrating that the physician's decision was consistent with standard hospital practice.¹⁹⁸

C. *Benefits of Written Screening Guidelines*

The use of detailed, written screening guidelines in hospital emergency departments considerably improves EMTALA's effectiveness in deterring even subtle instances of patient dumping. When a plaintiff sues a hospital that has no written standard, proving disparate treatment is exceedingly difficult. Courts are thus often faced with competing assertions of what constituted the hospital's standard practice and whether it was followed, with both sides' contentions unsupported by clear proof. Given judicial concerns about EMTALA's scope, in these situations it is unsurprising that courts often defer to the judgment of the hospital's physician and dismiss the plaintiff's claim under summary judgment. Written guidelines, however, resolve this evidentiary dilemma, as they provide courts with clear proof of disparate care to rely upon when denying a hospital's motion for summary judgment.¹⁹⁹ Subtle instances of patient dumping are, in such cases, revealed and appropriately punished.

¹⁹⁵ See *infra* notes 222–25 and accompanying text (discussing the development of best practice decision trees and computer products that assist physician diagnoses); see also Barry R. Furrow, *The Patient Injury Epidemic: Medical Malpractice Litigation as a Curative Tool*, 4 DREXEL L. REV. 41, 88 (2011) (“Guidelines can surmount the cookbook medicine objection of inflexibility by being individualized, using medical record information and computer processing speed.”).

¹⁹⁶ See *infra* Part IV.C (discussing the benefits of checklist procedures).

¹⁹⁷ If it does not, and a physician fails to adhere to a written protocol, the hospital should be liable under EMTALA, regardless of whether the doctor did so in his or her best medical judgment. Hence this Note agrees with the approach taken by the *Bode* court, see *supra* note 178, and not that of the *Cruz-Vazquez* court, see *supra* note 136.

¹⁹⁸ Cf. Avraham, *supra* note 194, at 553, 618–19 (2011) (explaining that, under his proposal, a doctor is free to decline to use or follow a guideline, but that by doing so the doctor would be unable to assert the “private regulatory compliance defense”).

¹⁹⁹ See, e.g., *supra* note 178 and accompanying text (providing examples of a hospital violating a written procedure and having its motion for summary judgment denied).

With standards clearly assigned to visible markers of liability, and with hospitals more likely to adopt written protocols, EMTALA may even become self-enforced by the litigants.²⁰⁰ That is, if clearly stated standards for care become more readily accessible to the parties, violations will be increasingly apparent.²⁰¹ And to the extent courts more uniformly apply a judicial standard to these infringements, parties will be able to accurately assess, *ex ante*, the likely costs involved. If hospitals become more attuned to what constitutes a violation and the likelihood of punishment, they will ensure that physicians follow screening protocols uniformly to avoid potential liability.²⁰² And when the statute's screening duty is not met, litigants with a better understanding of the expected liabilities will act quickly to settle their claims. These lower litigation costs will be a boon to all hospitals, patients, and courts.²⁰³

The increased adoption of written emergency-department guidelines for care may also produce a valuable side effect: improved care for all patients. In two new books, one by Peter Pronovost and Eric Vohr²⁰⁴ and the other by Atul Gawande,²⁰⁵ the authors demonstrate that the increased use of checklists by doctors and nurses leads to substantially improved patient outcomes. The premise is simple:

²⁰⁰ Recent literature in the field of labor and employment law suggests the benefits of self-regulation. See CYNTHIA ESTLUND, *REGOVERNING THE WORKPLACE: FROM SELF-REGULATION TO CO-REGULATION* 17 (2010) ("Effective self-regulatory processes can introduce flexibility and responsiveness into the regulatory regime and reduce the costs and contentiousness associated with litigation while promoting the internalization of public law norms into the regulated organization itself.").

²⁰¹ This is an important element of a self-regulatory regime. That is, courts must be "counted on to distinguish effective from ineffective systems of self-regulation." *Id.*

²⁰² A key part of a self-regulation model is encouragement through relief from some of the burdens of the regulatory framework. See *id.* ("[S]elf regulation is not mandated but is encouraged and rewarded, most tangibly by the promise of relief from some aspect of the background enforcement regime."). Such "relief" will be provided to hospitals by the potential to cheaply dispose of EMTALA suits where written screening policies were followed properly. See *supra* note 190 and accompanying text (explaining that hospitals that adhere to explicit screening protocols should be able to easily prevail in EMTALA litigation via summary judgment, and providing an example).

²⁰³ Self-regulation of EMTALA by hospitals can help ensure that the goals of EMTALA will be implemented by the primary actors that are capable of enforcing the statute in the cheapest manner:

The shift toward self-regulation is based in large part on the recognition that those who are best situated to detect, report, and avoid organizational misconduct are the insiders employed by the organization. Systems that activate the monitoring potential of insiders can improve corporate compliance far beyond what ordinary law enforcement can do.

ESTLUND, *supra* note 200, at 17.

²⁰⁴ PRONOVOST & VOHR, *supra* note 14.

²⁰⁵ GAWANDE, *supra* note 14.

“Checklists . . . help prevent experienced people from making errors due to flawed memory and attention”²⁰⁶

Pronovost’s first checklist was a basic guideline for preventing line infections²⁰⁷ that included only five simple steps.²⁰⁸ “These steps [were] no-brainers; they have been known and taught for years.”²⁰⁹ The results of Pronovost’s simple checklist were “dramatic . . . [T]he ten-day line-infection rate went from eleven per cent to zero.”²¹⁰ The checklist improved patient outcomes and reduced hospital expenses.²¹¹

Checklists in other hospitals, and for other procedures, have had comparable success.²¹² When similar checklists were used at hospitals in Michigan, “[w]ithin the first three months . . . the infection rate in Michigan’s I.C.U.s decreased by sixty-six per cent,” saving “more than fifteen hundred lives.”²¹³ And when a nineteen-point checklist for surgical care was circulated in the spring of 2008, “the results were startling . . . [A]ll eight hospitals saw the rate of major postsurgical complications drop by 36 percent . . . [and] deaths fell by 47 percent.”²¹⁴

²⁰⁶ *Cutting Down on Errors: Ticking Off*, THE ECONOMIST, Jan. 14 2010, <http://www.economist.com/node/15268786>; see also MILLENSON, *supra* note 14, at 66 (“[T]he belief that ‘good’ doctors don’t make errors flies in the face of decades of research into why humans dealing with complex systems of any sort make mistakes.”).

²⁰⁷ Pronovost notes that he was alarmed by the number of people dying each year from “bloodstream infections” and decided to make “a checklist that standardizes what clinicians do before catheterization.” Claudia Dreifus, *A Conversation with Dr. Peter J. Pronovost*, N.Y. TIMES, Mar. 9, 2010, at D2 (internal quotation marks omitted), available at <http://www.nytimes.com/2010/03/09/science/09conv.html>.

²⁰⁸ See Atul Gawande, *Annals of Medicine: The Checklist*, THE NEW YORKER, Dec. 10, 2007, at 86, 91 available at http://www.newyorker.com/reporting/2007/12/10/071210fa_fact_gawande?currentPage=all (listing the five physician steps: “(1) wash their hands with soap, (2) clean the patient’s skin with chlorhexidine antiseptic, (3) put sterile drapes over the entire patient, (4) wear a sterile mask, hat, gown, and gloves, and (5) put a sterile dressing over the catheter site once the line is in”).

²⁰⁹ *Id.* (“[I]t seemed silly to make a checklist just for them.”).

²¹⁰ *Id.*

²¹¹ *Id.* (“They calculated that, in this one hospital, the checklist had prevented forty-three infections and eight deaths, and saved two million dollars in costs.”).

²¹² Pronovost and his colleagues made checklists for other tasks and were able to duplicate the original success. “One aimed to insure that nurses observe patients for pain at least once every four hours and provide timely pain medication. This reduced the likelihood of a patient’s experiencing untreated pain from forty-one per cent to three per cent.” *Id.* They also “tested a checklist for patients on mechanical ventilation The proportion of patients who didn’t receive the recommended care dropped from seventy per cent to four per cent” *Id.*

²¹³ *Id.* at 94.

²¹⁴ Robin Marantz Henig, *A Hospital How-To Guide That Mother Would Love*, N.Y. TIMES, Dec. 24, 2009, at C12, available at <http://www.nytimes.com/2009/12/24/books/24book.html?pagewanted=all>.

The checklists were successful, posits Pronovost, for two main reasons: “First, they helped with memory recall, especially with mundane matters that are easily overlooked in patients undergoing more drastic events. . . . A second effect was to make explicit the minimum, expected steps in complex processes.”²¹⁵ The checklists not only clarified the level of care required,²¹⁶ but they also helped to improve the consistency of medical treatment.²¹⁷

One obvious argument against the use of written protocols in emergency-department examinations²¹⁸ is that the sheer number of potential injuries or illnesses a person could have makes the standardization of care in any given instance exceedingly difficult.²¹⁹ Although this concern underscores some of the difficulties hospitals may initially encounter in designing effective guidelines,²²⁰ it does not detract from the immense long-term benefits of improved patient outcomes once this initial hurdle is overcome.²²¹ Medical science has already developed prescribed practices and algorithms for a variety of scenarios; for many of these, the creation of a protocol may require little more than choosing the approaches a hospital wishes to include in its uniform

²¹⁵ Gawande, *supra* note 208, at 91–92.

²¹⁶ *See id.* at 92 (“Checklists established a higher standard of baseline performance.”).

²¹⁷ *See id.* at 91 (“[S]imply having the doctors and nurses in the I.C.U. make their own checklists for what they thought should be done each day improved the consistency of care to the point that, within a few weeks, the average length of patient stay in intensive care dropped by half.”).

²¹⁸ Another criticism may be that standardized guidelines will lead to overtesting. To the extent that an increase in the use of diagnostic procedures occurs, however, it will be commensurate with the degree to which patients were previously not receiving the same thoroughness of screening as other individuals. In other words, uniform protocols do nothing more than assure equality in testing. If the hospital chooses to structure its screenings so that many tests are regularly conducted, and if, as this Note contends, some patients do not receive the tests they should, then guidelines will increase the amount of testing. But the ultimate choice for how much testing is done lies solely with the hospital in the creation of its policy.

²¹⁹ As Danielle Sapega notes:

Emergency rooms typically see patients with a wide spectrum of conditions, from life threatening heart attacks to the common cold. Illnesses can be very unpredictable in their clinical presentation and behavior making it extremely difficult to tell when a patient’s symptoms are a warning of true danger or are representative of a routine condition that would allow discharge from the emergency room with referral to a primary care physician.

Sapega, *supra* note 24, at 101.

²²⁰ *See* MILLENSON, *supra* note 14, at 18 (“Discovering ‘what works best’ in medicine, however, is slow and difficult work. The answers are not intuitively obvious, and the search is not very glamorous.”).

²²¹ *See id.* at 29 (explaining that efforts to standardize best practice via written protocols are “not theoretical,” and noting that some hospitals have “already made them and shown they can be effective in saving lives. The changes are not complicated. All that is required to reap their benefits is an investment of time and money . . .”).

screenings.²²² And advances in computer technology are facilitating instantaneous physician access to extensive guidelines.²²³ More importantly, the complexity of medical diagnosis assures that the institution of checklists will provide significant benefits.²²⁴ If a simple five-step checklist can substantially improve care, then surely guidelines covering diagnosis would prove invaluable.²²⁵ Greater intricacy only heightens the likelihood of lapses and thus augments the potential gain standard protocols can provide.²²⁶

Guidelines that help practitioners avoid mistakes in diagnoses can lead to substantial improvements in patient outcomes.²²⁷ Gawande begins his book discussing a simple oversight during an emergency-department assessment that nearly cost a man his life.²²⁸ And Pronovost writes that “[m]isdiagnosis is one of the relatively

²²² See JEROME GROOPMAN, *HOW DOCTORS THINK* 5–6 (2007) (discussing the prevalence of “preset algorithms and practice guidelines in the form of decision trees” in medical education); Bosler & Davis, *supra* note 174, at 169 (“Many such screening procedures are already in published form and merely would need to be adopted by hospital emergency departments.”).

²²³ One exciting new product is Isabel, which is “a web-based, Diagnosis Checklist System” that “provides a practical and dynamic diagnosis checklist.” *About Isabel*, ISABEL: THE DIAGNOSIS CHECKLIST, <http://www.isabelhealthcare.com/home/ourmission> (last visited Mar. 22, 2012); ISABEL: THE DIAGNOSIS CHECKLIST, <http://www.isabelhealthcare.com/home/default> (last visited Mar. 22, 2012) (“Isabel . . . [is] a diagnosis decision support application that assists physicians with getting the diagnosis right the first time. . . . [T]he Isabel tool uses the patient’s demographics and clinical features to produce a list of possible diagnoses—including time-sensitive ‘Don’t Miss Diagnoses.’”); see also MILLENSON, *supra* note 14, at 84–87 (discussing the efforts of a hospital to program a computer with “clinical knowledge . . . [in order] to correctly interpret the meaning of each patient’s biological signs and symptoms”).

²²⁴ See Atul Gawande, *A Lifesaving Checklist*, N.Y. TIMES, Dec. 30, 2007, <http://www.nytimes.com/2007/12/30/opinion/30gawande.html> (noting that hospital professionals “are struggling . . . to provide increasingly complex care in the absence of effective systemization”).

²²⁵ Cf. GAWANDE, *supra* note 14, at 4–7 (recalling an incident discussing a patient complication in which he failed to consider a possibility that is “mentioned in every textbook”).

²²⁶ Gawande argues that the historic problem of “ignorance” in medicine has been overcome by a rising problem with “ineptitude.” *Id.* at 8. He explains that “[w]e have accumulated stupendous know-how. . . . Nonetheless, that know-how is often unmanageable.” *Id.* at 13. Gawande stresses that the reason for “[a]voidable failures” is that “the volume and complexity of what we know has exceeded our individual ability Knowledge has both saved us and burdened us.” *Id.* In response, he urges hospitals to “build[] on experience and take[] advantage of the knowledge people have but . . . also make[] up for inevitable human inadequacies [through the use of] a checklist.” *Id.*

²²⁷ See PRONOVOST & VOHR, *supra* note 14, at 230–31 (“Our best estimates suggest that misdiagnosis [of pancreatic cancer] kills at least forty thousand to eighty thousand people every year (although this is likely a gross underestimation).”).

²²⁸ See GAWANDE, *supra* note 14, at 1–3 (discussing a stabbing victim who was incorrectly considered noncritical because, although “everyone involved got almost every step right[,] . . . no one remembered to ask the patient or the emergency medical technicians what the weapon was”).

unexplored areas of potential patient harm and one of the most devastating in terms of cost, death, and injury. Diagnostic errors are more than three times more likely to result in serious disability than drug errors.”²²⁹ Although Pronovost used his checklists primarily in intensive care units, Gawande notes that checklists can produce potential gains throughout the field of medicine, including screening and diagnosis.²³⁰

CONCLUSION

The frequent inability of plaintiffs suing under EMTALA to survive summary judgment has substantially curtailed the Act’s capacity to remedy and deter disparities in emergency-department screenings. At summary judgment, many federal courts, often without a detailed explanation of what constituted the hospital’s uniform practice, are highly deferential to the assertions, judgments, and perceptions of treating physicians. To the extent that this practice constitutes a “weighing of the evidence,”²³¹ it amounts to an aggressive, if not improper, use of summary judgment. And it puts a tremendous evidentiary burden on EMTALA plaintiffs that precludes meaningful private enforcement of the Act.

The implementation of written standards for hospital emergency-department screenings will resolve this problem and improve EMTALA’s effectiveness because it will make standard practice unambiguous and discrepancies in screenings more easily ascertainable. This may also encourage hospitals to self-regulate, increasing the likelihood that EMTALA violations are remedied efficiently. Moreover, recent literature strongly suggests that the use of written screening protocols in emergency departments will also improve hospital care. Checklists for emergency-room screening would benefit not only the uninsured, the indigent, and the minorities that EMTALA was enacted to protect, but also every other patient who enters an emergency room.

Despite the benefits that could therefore accompany the use of explicit protocols for emergency-room screenings, hospitals are

²²⁹ PRONOVOST & VOHR, *supra* note 14, at 231. Pronovost goes on to explain that “physicians often rely too heavily on their own limited knowledge regarding a particular illness. . . . This is due in part to ego and autonomy, but also to the lack of any effective system for sharing and distributing . . . knowledge.” *Id.*

²³⁰ See Gawande, *supra* note 208, at 94 (“[T]here are hundreds, perhaps thousands, of things doctors do that are at least as dangerous and prone to human failure as putting central lines into I.C.U. patients. It’s true of cardiac care, stroke treatment, H.I.V. treatment, and surgery of all kinds. It’s also true of diagnosis . . .”).

²³¹ *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986).

discouraged from adopting such standards when courts routinely dispose of EMTALA screening claims through an aggressive use of summary judgment. If hospitals are able to defeat claims of nonuniform treatment at summary judgment solely on the basis of physician affidavits, they are incentivized to refrain from adopting a written screening standard. The written standard would rarely be needed for the hospital to succeed at summary judgment on an EMTALA claim, and it might be used against the hospital in litigation. On the other hand, if courts impose a greater evidentiary burden on hospitals before granting them summary judgment, explicit screening protocols would have the potential to more frequently aid hospitals in winning EMTALA lawsuits. Modifying the judicial treatment of screening claims at summary judgment can thereby remove disincentives to the use of written screening standards. This will better deter subtle instances of patient dumping, increase EMTALA's effectiveness as a regulatory scheme, and facilitate the adoption of hospital emergency-department practices that are likely to improve medical care for all.