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## HOW COVID-19 PUT THE SPOTLIGHT ON THE EMTALA

*Ikra Kafayat\**

### ABSTRACT

There was a time when those that were unable to afford medical care risked being denied treatment in emergency situations. Before Congress passed Emergency Medical Treatment & Labor Act (EMTALA), patients were being transferred to different hospitals, without being screened, because they did not have insurance and could not afford the treatment. Hospitals are no longer allowed to transport patients without properly screening and stabilizing them. Patients can bring a suit against a hospital if they believe the hospital violated EMTALA, however, in certain circuits the patient will need to prove that hospital had an “improper motive” for failing to properly screen them. When the Coronavirus pandemic took over the world, hospitals requested temporary waivers so that they can transport patients to off-campus testing sites. Hospitals were allowed to set up stations, away from the hospital, to treat patients with COVID. After reviewing both sides, this Note argues that patients should not have to prove such a huge burden like the motive of the hospital. Although, EMTALA was created so that patients are not turned away due to their financial situations, a lot of work still needs to be done to ensure that all patients are treated equally regardless of their race and socioeconomic status.

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## I. INTRODUCTION

Picture this: while riding your bicycle, you unexpectedly fall off and hurt your arm. You are in a lot of pain and wonder if your arm is broken, so you rush to the hospital's emergency room to get it checked out. After waiting for a long time, a nurse finally approaches you. Before asking what brought you to the emergency room, she asks if you have insurance. You respond that you do not have insurance. She asks if you can pay for the treatment out of pocket. You say that you cannot because you do not have a job and lack the financial means to do so. The nurse then informs you that she cannot examine or treat you due to your inability to pay for the treatment. You are then advised to go to a different hospital, preferably a public hospital, that may treat you despite your inability to pay for treatment. Sounds wrong and unfair, right? And yet, this hypothetical was a common reality prior to the enactment of the Emergency Medical Treatment & Labor Act ("EMTALA").

In 1986, Congress enacted the EMTALA to ensure that everyone had access to medical care in emergency situations, regardless of their financial situation.<sup>1</sup> This Act prevented hospitals from transporting uninsured patients to public hospitals without properly screening them and ascertaining that they were stable enough to be transferred.<sup>2</sup> A hospital is allowed to transfer a patient upon the patient's request or "if a hospital is unable to stabilize a patient within its capacity."<sup>3</sup> Hospitals that provide emergency services and accept patients with Medicare are obligated to provide a medical screening examination ("MSE") to determine whether the patient has a qualifying emergency condition.<sup>4</sup>

Hospitals face consequences for violating the EMTALA. For example, a patient may sue the hospital if the EMTALA procedures are violated. In the Sixth Circuit, patients need to prove that the hospital had an "improper motive" for failing to properly screen them.<sup>5</sup>

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<sup>1</sup> *Emergency Medical Treatment & Labor Act (EMTALA)*, CTR. FOR MEDICARE AND MEDICAID SERV. (Mar. 4, 2021), <https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA>.

<sup>2</sup> Mike Lipscomb, *What is EMTALA?*, APOLLOMD (Feb. 17, 2017), <https://apolloomd.com/blog/what-is-emtala>.

<sup>3</sup> *Emergency Medical Treatment & Labor Act (EMTALA)*, *supra* note 1.

<sup>4</sup> *Id.*

<sup>5</sup> *See generally* *Elmhirst v. McLaren N. Mich.*, 726 F. App'x 439, 440 (6th Cir. 2018); *Correa v. Hosp. S.F.*, 69 F.3d 1184, 1194 n.9 (1st Cir. 1995).

However, the First, Fourth, Eighth, Tenth, and District of Columbia Circuits split from the Sixth Circuit and held that the plaintiff does not need to prove the motive of the hospital.<sup>6</sup>

In 2020, this fast-paced world had to hit the brakes as the Coronavirus (“COVID-19”) pandemic took over.<sup>7</sup> The world stood still, confused, as the virus multiplied at an unimaginable rate and no one knew how or why it was spreading so quickly.<sup>8</sup> In many parts of the world, the virus continues to spread at alarming rates.<sup>9</sup> Hospitals did not have time to prepare for this virus.<sup>10</sup> They were flooded with patients of all ages, displaying similar symptoms.<sup>11</sup> Hospital employees were working around the clock trying to save lives and, at the same time, trying to make sure that they did not contract the virus themselves.<sup>12</sup> As the virus continues to spread internationally, new mutations, called variants, of the original virus continue to emerge at alarming rates.<sup>13</sup> As of March 2022, the following variants have been detected: alpha, gamma, beta, mu, delta, and omicron.<sup>14</sup> Especially noteworthy are the delta and omicron variants which have been characterized as more contagious than the other variants.<sup>15</sup>

The COVID-19 pandemic affected almost every aspect of the health care system, especially the emergency medicine system.<sup>16</sup> Hospitals, organizations, administrators, and insurers needed to alter models and procedures to make sure that they were providing quality

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<sup>6</sup> *Elmhirst*, 726 F. App’x 439 at 443.

<sup>7</sup> *A Pandemic Atlas: How COVID-19 Took Over the World in 2020*, ASSOCIATED PRESS (Dec. 16, 2020), <https://apnews.com/article/pandemics-brazil-israel-india-coronavirus-pandemic-c1ba685119fd12108dd6d89f2fb89702>.

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

<sup>10</sup> Victor Porcelli, *New York City Public Hospitals Were Unprepared for Major Crisis, Costing Lives During Covid Outbreak, Review Finds*, GOTHAM GAZETTE (July 25, 2020), <https://www.gothamgazette.com/city/9605-new-york-city-public-hospitals-were-unprepared-for-major-crisis-costing-lives-covid-outbreak>.

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

<sup>13</sup> Daniel C. DeSimone, *What’s the Concern About the New Covid-19 Variants? Are They More Contagious?*, MAYO CLINIC (Dec. 30, 2021), <https://www.mayoclinic.org/diseases-conditions/coronavirus/expert-answers/covid-variant/faq-20505779>.

<sup>14</sup> *Id.*

<sup>15</sup> *Id.*

<sup>16</sup> Heather L. Brown, *Emergency Care EMTALA Alterations During the COVID-19 Pandemic in the United States*, J. EMERGENCY NURSING (Nov. 30, 2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7704064>.

service to patients during the pandemic as well as making sure their staff was safe.<sup>17</sup> Deviation from the standard practice became necessary to provide care to the patients.<sup>18</sup> The EMTALA is just one example of a statute that was amended to reflect the pandemic and to assure that all patients were treated equally.<sup>19</sup> Two major provisions of the EMTALA were altered due to COVID-19.<sup>20</sup> First, hospitals were now allowed to transfer patients who were not yet medically stabilized and redirect individuals to a different location for the MSE.<sup>21</sup> Second, Centers for Medicare & Medicaid Services (“CMS”) waived the requirements for patients to be treated only by qualified medical personnel, now allowing physician assistants and nurse practitioners to fall under the qualified medical person category.<sup>22</sup>

Plaintiffs suing hospitals under the EMTALA should not have the burden of proving that the hospital had an “improper motive.” This Note begins by analyzing the EMTALA and how the circuit courts interpret certain parts of the statute differently. Part II of this Note discusses the legislative history and the purpose of the EMTALA. Part III further analyzes the EMTALA by recognizing the new workflows and processes implemented by hospitals in light of the pandemic and the problems the hospitals had to deal with during the pandemic. Part IV is divided into two parts and analyzes cases on both sides of the circuit split and the reasons for the differences. Finally, Part V concludes this Note by arguing why the plaintiff should not have the burden to prove improper motive and why Congress should repeal the amendments to the EMTALA.

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<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> *ACEP COVID-19 Field Guide*, AM. COLL. EMERGENCY PHYSICIANS (Mar. 30, 2020), <https://www.acep.org/corona/covid-19-field-guide/regulations-and-liability/emtala>.

<sup>20</sup> Brown, *supra* note 16.

<sup>21</sup> *Id.*

<sup>22</sup> *Id.*

## II. WHAT IS THE EMTALA AND WHY WAS THE EMTALA CREATED?

First and foremost, the EMTALA is not a federal medical malpractice statute.<sup>23</sup> It does not replace state law.<sup>24</sup> The EMTALA is not a substitute for state law malpractice actions, and was not intended to guarantee or provide a federal remedy for misdiagnosis or medical negligence.<sup>25</sup> The EMTALA was enacted as a legislative response to patient dumping.<sup>26</sup> Patient dumping refers to situations when hospitals refuse to treat or transfer indigent prospective patients because of their inability to pay for emergency medical treatment.<sup>27</sup> Studies analyzing patient dumping reported that the main reason hospitals transferred patients was because they lacked insurance.<sup>28</sup> Dr. Arthur Kellermann, an Assistant Professor and Chief for the Division of Emergency at the University of Tennessee, and Dr. Bela Hackman, a Senior Fellow at the Department of Cardiology for the University of Tennessee, conducted a study in 1985 and found that eight-nine percent of the 164 cases that were recorded listed the transfer reason as “no money” or “no insurance.”<sup>29</sup> A second study conducted by researchers in Chicago in 1986, reported that eighty-seven percent of transferring hospitals only did so because the transferred patients did not have insurance.<sup>30</sup> This study defined patient dumping as “the denial of or limitation in the provision of medical services to a patient for economic reasons and the referral of that patient elsewhere.”<sup>31</sup> Lastly, the third study, conducted in 1997 at Harvard Medical School, found that sixty-three percent of the 458 patients transferred to the

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<sup>23</sup> James Weston, *What in the World is EMTALA?: An Introduction to the Emergency Medical Treatment and Active Labor Act*, PRIMERUS, <https://www.primerus.com/business-law-news/what-in-the-world-is-emtala-an-introduction-to-the-emergency-medical-treatment-and-active-labor-act.html> (last visited Mar. 26, 2021).

<sup>24</sup> *Id.*

<sup>25</sup> *Power v. Arlington Hosp. Ass’n*, 42 F.3d 851, 856 (4th Cir. 1994).

<sup>26</sup> Sara Rosenbaum, *The Enduring Role of The Emergency Medical Treatment and Active Labor Act*, HEALTH AFF. (Dec. 2013), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.0660>.

<sup>27</sup> *Id.*

<sup>28</sup> *Arrington v. Wong*, 237 F.3d 1066, 1074 n.10 (9th Cir. 2001).

<sup>29</sup> Karen I. Treiger, *Preventing Patient Dumping: Sharpening the COBRA’s Fangs*, 61 N.Y.U.L. REV. 1186, 1190–91 (1986).

<sup>30</sup> *Id.*

<sup>31</sup> *Id.*

emergency department of Highland General Hospital in Oakland lacked insurance.<sup>32</sup> There was no evidence that patients requested the transfer or that they were being transferred because the transferring hospital did not have enough beds.<sup>33</sup>

The EMTALA was enacted to protect patients so that in an emergency all patients are treated, regardless of their ability to pay, in a Medicare-participating hospital.<sup>34</sup> If the hospital is unable to treat them, then the patients have to be properly screened and transferred to another hospital.<sup>35</sup> Patient dumping became a great concern in the 1980s because the number of uninsured Americans grew rapidly.<sup>36</sup> Patient dumping also increased during that time due to the reformation of the Medicare payment system.<sup>37</sup> More specifically, the Medicare payment system was reformed in 1983 and it “eliminated the ability of hospitals to pass on to the government the costs of caring for indigent patients.”<sup>38</sup> Congress decided that enacting the EMTALA was necessary because “twenty-eight States had no” laws that would “ensure that no emergency patient is denied emergency care because of inability to pay.”<sup>39</sup> The need for legislation grew because of an increase in complaints from patients, their families, and health care providers about hospitals refusing to treat certain people or transferring unstable patients.<sup>40</sup> The EMTALA protects everyone; in addition to patients who are unable to pay for their treatment, the EMTALA also protects patients who are covered by Medicare and Medicaid, as well as those who are uninsured.<sup>41</sup> The protection covers children and adults, citizens and non-citizens who seek care at the emergency department.<sup>42</sup> The EMTALA also protects employees who report

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<sup>32</sup> *Id.*

<sup>33</sup> David U. Himmelstein et al., *Patient Transfers: Medical Practice as Social Triage*, 74 AM. J. PUB. HEALTH 494, 495 (1984).

<sup>34</sup> *Emergency Medical Treatment & Labor Act (EMTALA)*, *supra* note 1.

<sup>35</sup> *Id.*

<sup>36</sup> Brief of Respondent at 11, *Roberts v. Galen Va., Inc.*, 525 U.S. 249 (1999) (No. 97-53).

<sup>37</sup> *Id.*

<sup>38</sup> *Id.*

<sup>39</sup> *Harry v. Marchant*, 291 F.3d 767, 773 (11th Cir. 2002).

<sup>40</sup> Michael Thornsberry, *EMTALA Education: A Way to Mitigate Risk*, AM. ASS'N FOR PHYSICIAN LEADERSHIP (Jan. 28, 2019), <https://www.physicianleaders.org/news/emtala-education-way-mitigate-risk>.

<sup>41</sup> *Arrington*, 237 F.3d at 1069-70.

<sup>42</sup> Thornsberry, *supra* note 40.

violations of the EMTALA from retaliation.<sup>43</sup> Specifically, a hospital is not allowed to penalize or take adverse action against any physician who does not transfer an emergency patient who has not been stabilized or any hospital employee who reports the EMTALA violation.<sup>44</sup> The EMTALA provides:

In the case of a hospital that has a hospital emergency department, if any individual...comes to the emergency department...for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department . . . to determine whether or not an emergency medical condition...exists.<sup>45</sup>

Hospitals are only required to provide screening to the extent necessary to determine whether an emergency condition exists and if such condition does exist, then the hospital must satisfy the EMTALA's stabilization and treatment requirements.<sup>46</sup> The EMTALA is triggered when a person goes to a hospital due to an emergency.<sup>47</sup> The Act defines what constitutes emergency medical condition.<sup>48</sup> An emergency medical condition is defined as:

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in--  
 (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,  
 (ii) serious impairment to bodily functions, or  
 (iii) serious dysfunction of any bodily organ or part; or  
 (B) with respect to a pregnant woman who is having contractions--  
 (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

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<sup>43</sup> 42 U.S.C. § 1395dd(e)(1) (2020).

<sup>44</sup> *Id.*

<sup>45</sup> *Id.*

<sup>46</sup> *Id.*

<sup>47</sup> Lipscomb, *supra* note 2.

<sup>48</sup> 42 U.S.C. § 1395dd(e)(1)(A) (2020).

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.<sup>49</sup>

This definition requires that the hospital must treat anyone who is in a condition that could cause harm to the patient if the condition is not treated.<sup>50</sup> The hospital cannot delay treatment to inquire about the patient's ability to pay.<sup>51</sup>

Ignoring this Act can result in severe penalties that are also specified in the statute.<sup>52</sup> A hospital that negligently violates this statute can be penalized up to \$50,000.<sup>53</sup> If a hospital has fewer than 100 beds in total, it can be penalized up to \$25,000 for each violation.<sup>54</sup> Along with fines, other penalties include termination of the hospital or physician's Medicare provider agreement.<sup>55</sup> A patient can file a personal injury lawsuit in civil court against the hospital under a "private cause of action."<sup>56</sup> The Act states that "[a]ny individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of the [EMTALA]" may bring a personal injury claim to obtain damages that are available as well as appropriate equitable relief against the hospital under the law of the state in which the hospital is located.<sup>57</sup> If a receiving facility suffered financial loss as a result of another hospital's violation of the EMTALA, it can bring suit against the violating hospital to recover damages.<sup>58</sup> According to the Act, two private rights of action can be taken against the hospitals, but not against the physicians themselves.<sup>59</sup> The Act further states that "[a]ny medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of the [EMTALA]" may bring a civil action for similar damages and appropriate equitable relief.<sup>60</sup> Under the EMTALA, a hospital's obligations end when (a) a patient is admitted to the hospital; (b) a patient is appropriately

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<sup>49</sup> *Id.*

<sup>50</sup> *Id.*

<sup>51</sup> Lipscomb, *supra* note 2.

<sup>52</sup> 42 U.S.C. § 1395dd(e)(1) (2020).

<sup>53</sup> *Id.*

<sup>54</sup> *Id.*

<sup>55</sup> *Id.*

<sup>56</sup> *Id.*

<sup>57</sup> 42 U.S.C. § 1395dd(d)(2)(A) (2020).

<sup>58</sup> *ACEP COVID-19 Field Guide*, *supra* note 19.

<sup>59</sup> Brief for the U.S. as Amici Curiae Supporting Petitioner at 2, *Roberts v. Galen Va., Inc.*, 525 U.S. 249 (1998) (No. 97-53).

<sup>60</sup> *Id.*

transferred; or (c) a patient refuses treatment after being informed of the risks.<sup>61</sup>

### III. HOW COVID-19 ALTERED THE EMTALA

COVID-19 changed how we navigate the world.<sup>62</sup> On March 11, 2020, the COVID-19 epidemic became a pandemic because of how quickly it spread all over the world.<sup>63</sup> Restrictions were put into place to control the spread of this deadly virus.<sup>64</sup> Offices were closed, and people found themselves working from home.<sup>65</sup> Restrictions were put on interacting with people from other households.<sup>66</sup> Gyms, movie theaters, schools, and places of worship were temporarily closed.<sup>67</sup> Many people lost their jobs because it was not possible for them to work from home, thus causing the unemployment rate to skyrocket.<sup>68</sup> Working from home caused emotional exhaustion and people felt isolated from their colleagues.<sup>69</sup> At first, some reported feeling more content because they did not have to deal with the workplace stress on a daily basis but that was not the case for many.<sup>70</sup> After working from home for over a year, many are facing another issue: burnout.<sup>71</sup> For some, the work-home life has been blurred because now they do not have an option of not bringing work home.<sup>72</sup> It has become harder to separate the work and home life when Zoom meetings are being held at the dining room table or work is being done out of the bedroom. This is causing people to become both mentally and physically exhausted.<sup>73</sup> Females reported higher levels of work exhaustion

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<sup>61</sup> Lipscomb, *supra* note 2.

<sup>62</sup> Maria Cohut, *Global Impact of the COVID-19 Pandemic: 1 Year On*, MED. NEWS TODAY (Mar. 12, 2021), <https://www.medicalnewstoday.com/articles/global-impact-of-the-covid-19-pandemic-1-year-on>.

<sup>63</sup> *Id.*

<sup>64</sup> *Id.*

<sup>65</sup> *Id.*

<sup>66</sup> *Id.*

<sup>67</sup> *Id.*

<sup>68</sup> *Id.*

<sup>69</sup> *Id.*

<sup>70</sup> *Id.*

<sup>71</sup> Beth Howard, *When Work-From-Home Burnout Doesn't Let Up*, AARP (May 17, 2021), <https://www.aarp.org/health/conditions-treatments/info-2021/work-from-home-burnout-stress.html>.

<sup>72</sup> *Id.*

<sup>73</sup> *Id.*

because they also had to take on most of the household responsibilities.<sup>74</sup> Small businesses took a major hit as well and some even had to close their doors for good.<sup>75</sup> Many lives were lost as a result of this pandemic; along with grieving the loss of loved ones, people also had to deal with depression, isolation, and other mental health issues.<sup>76</sup> The fear of contracting the virus increased the level of anxiety in people across the globe.<sup>77</sup> Inability to attend important milestones for loved ones has been difficult for people to cope with and only added to their anxiety.<sup>78</sup>

As more information about the novel coronavirus came to light, hospitals were trying to determine how to treat as many patients as possible while at the same time trying to protect their employees and other patients from COVID-19.<sup>79</sup> Hospitals “diverted resources from routine inpatient critical care and outpatient clinics” to meet the demand of the pandemic.<sup>80</sup> The hospitals were so overwhelmed with the number of COVID-19 patients that they received every day that they had to “defer ‘non-urgent’ visits, evaluations, diagnostics, surgeries and therapeutics.”<sup>81</sup>

Under the existing EMTALA rules, redirecting patients to offsite locations with minimal contact was difficult.<sup>82</sup> Hospitals began requesting temporary emergency waivers of their EMTALA

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<sup>74</sup> Cohut, *supra* note 62.

<sup>75</sup> *Id.*

<sup>76</sup> *Id.*

<sup>77</sup> *Id.*

<sup>78</sup> *Id.*

<sup>79</sup> Porcelli, *supra* note 10.

<sup>80</sup> Hummy Song et al., *How Hospitals Can Meet the Needs of Non-Covid Patients During the Pandemic*, HARV. BUS. REV. (July 14, 2020), <https://hbr.org/2020/07/how-hospitals-can-meet-the-needs-of-non-covid-patients-during-the-pandemic>.

<sup>81</sup> *Id.* Hospitals across the country canceled procedures that were deemed not urgent due to the overwhelming number of COVID patients being admitted into hospitals. *Id.* Hospitals canceled non-urgent surgeries such as joint replacements and weight loss operations. Liz Kowalczyk, *Hospitals cancel hundreds of non-urgent procedures, surgeries, and medical appointments*, BOSTON GLOBE (Mar. 17, 2020), <https://www.bostonglobe.com/2020/03/17/metro/hospitals-cancel-hundreds-non-urgent-procedures-surgeries-medical-appointments>.

<sup>82</sup> *Health Care Advisory: Hospital EMTALA Obligations Under Recent COVID-19 Waivers*, ALSTON & BIRD (Apr. 1, 2020), <https://www.alston.com/en/insights/publications/2020/04/hospital-emtala-obligations>.

obligations to facilitate off-campus drive-through testing sites.<sup>83</sup> CMS has the authority to grant these waivers and it began doing so once the President announced the COVID-19 public health emergency.<sup>84</sup> Due to a large number of waiver requests, on March 30, 2020, CMS issued a memorandum reiterating the requirements of the EMTALA for all hospitals nationwide.<sup>85</sup> Although CMS did not make any changes to the requirements, “it interpreted the requirements as they relate to the novel COVID-19 virus.”<sup>86</sup> For example, a hospital is not allowed to refuse screening to a patient with COVID-19 or a patient who may have COVID-19.<sup>87</sup> However, this new guidance “announced a blanket waiver for all hospitals nationwide of enforcement of section 1867(a) of the Act” regarding the medical screening examination requirement, allowing hospitals “to screen patients at a location offsite from the hospital’s campus to prevent the spread of COVID-19.”<sup>88</sup>

Prior to this blanket waiver, hospitals were allowed to be part of offsite screening locations, but they could not redirect patients who came to their emergency room or the hospital to the offsite locations.<sup>89</sup> If the patients were seeking only a COVID-19 test, and no other screening, the guidance allowed hospitals to direct those patients to offsite locations that were testing sites and patient screening centers for potential COVID-19 patients.<sup>90</sup>

With this waiver, the MSE requirements are more flexible.<sup>91</sup> The screening does not need to constitute a full MSE by a qualified medical person.<sup>92</sup> If a patient goes to a hospital without a medical emergency and requests only a COVID-19 test, then the patient can receive just the test at the hospital and does not need to go through a full MSE.<sup>93</sup> A qualified person, who can recognize those who need immediate treatment, should still redirect patients so that those with a

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<sup>83</sup> *Id.*

<sup>84</sup> *Id.*

<sup>85</sup> Alan H. Einhorn et al., *COVID-19: CMS Issues EMTALA Guidance*, NAT’L L. REV. (Mar. 17, 2020), <https://www.natlawreview.com/article/covid-19-cms-issues-emtala-guidance>.

<sup>86</sup> *Id.*

<sup>87</sup> *Id.*

<sup>88</sup> *Health Care Advisory: Hospital EMTALA Obligations Under Recent COVID-19 Waivers*, *supra* note 82.

<sup>89</sup> *Id.*

<sup>90</sup> *Id.*

<sup>91</sup> *Id.*

<sup>92</sup> *Id.*

<sup>93</sup> *Id.*

medical condition receive stabilizing treatment instead of being sent to an offsite screening location.<sup>94</sup> Non-clinical staff may be stationed at non-emergency entrances around the hospital to redirect people to other locations.<sup>95</sup> Additionally, hospitals are permitted to encourage prospective patients to visit the offsite locations for COVID-19 screening, instead of going to hospitals, which were frequently overwhelmed.<sup>96</sup> Under the CMS guidance, the offsite locations should not be held out to the public as a place that provides care of emergency medical conditions.<sup>97</sup>

The CMS guidance allows hospitals to use telehealth to screen patients for COVID-19; however, the EMTALA obligations are not triggered if the patient is not physically in the hospital.<sup>98</sup> A qualified medical person must be the one conducting the MSE via telehealth and the exam can be conducted either on campus or at an offsite location.<sup>99</sup> If both the patient and the qualified medical person are using an electronic two-way technology in different areas of the same hospital, then the qualified medical person is not using telehealth services under Medicare.<sup>100</sup> Because these services would not constitute a telehealth visit, they should be billed as an in-person visit and are therefore subject to the EMTALA regulations.<sup>101</sup>

Although CMS created guidance for the hospitals because of COVID-19, some things remain unchanged.<sup>102</sup> A hospital is still in violation of the EMTALA if it refuses to screen someone who presents to the emergency department with suspected or confirmed COVID-19.<sup>103</sup> Hospitals without intensive care unit capabilities are still required to conduct an MSE on individuals with suspected or

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<sup>94</sup> *Id.*

<sup>95</sup> *Id.*

<sup>96</sup> *Id.*

<sup>97</sup> *Id.*

<sup>98</sup> *Id.*

<sup>99</sup> *Id.*

<sup>100</sup> Sandra M. DiVarco & Cathy Ren, *CMS Issues FAQs on EMTALA Requirements for Hospitals*, NAT'L L. REV. (May 3, 2020), <https://www.natlawreview.com/article/cms-issues-faqs-emtala-requirements-hospitals>.

<sup>101</sup> *Id.*

<sup>102</sup> Danielle Gordet & Robert Slavkin, *Some Things Never Change: EMTALA in the Time of COVID-19*, AKERMAN (Apr. 14, 2020), <https://www.akerman.com/en/perspectives/hrx-some-things-never-change-emtala-in-the-time-of-covid-19.html>.

<sup>103</sup> *Id.*

confirmed COVID-19 cases and they have to initiate stabilizing treatment.<sup>104</sup> Additionally, a hospital cannot decline to perform an MSE on someone who presents to the emergency department possibly with COVID-19, even if the hospital does not have enough personal protective equipment at the facility.<sup>105</sup> Lastly, if a person who meets the screening criteria for COVID-19 wants to leave the hospital against medical advice, the hospital is obligated to obtain the person's written informed refusal.<sup>106</sup> The hospital should also contact state and local public health authorities to determine if any other steps are required.<sup>107</sup>

#### IV. BOTH SIDES OF THE SPLIT

The EMTALA is triggered as soon as a patient enters the emergency department of the hospital.<sup>108</sup> "Emergency department" is a very broad term that includes the hospital's parking lots, sidewalks, and adjacent medical buildings.<sup>109</sup> Patients who are part of an outpatient encounter, meaning they do not need to be admitted to the hospital, are exempt from the EMTALA regulations.<sup>110</sup> Outpatient physician offices are typically exempt from the EMTALA because they do not have the resources to stabilize critically ill patients and therefore are not required to perform an MSE or stabilization treatment of a critically ill patient before that patient is transferred to an emergency department.<sup>111</sup> When a person arrives at the hospital via an ambulance, the hospital is subject to the EMTALA once the individual is brought onto hospital property.<sup>112</sup> However, under the EMTALA a hospital can close its emergency department "if it genuinely no longer has the capacity to screen and treat individuals."<sup>113</sup> Even if a hospital has such a "closure," "the hospital is always obligated by the

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<sup>104</sup> *Id.*

<sup>105</sup> *Id.*

<sup>106</sup> *Id.*

<sup>107</sup> *Id.*

<sup>108</sup> *Health Care Advisory: Hospital EMTALA Obligations Under Recent COVID-19 Waivers*, *supra* note 82.

<sup>109</sup> AL LULLA & BRIDGETTE SVANCAREK, EMS USA EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (StatPearls Publ'g LLC 2021).

<sup>110</sup> *Id.*

<sup>111</sup> *Id.*

<sup>112</sup> Jeffery Herman, *EMTALA in the Age of Coronavirus: CMS Releases New Guidance*, GREENSFELDER (Mar. 17, 2020), <https://www.greensfelder.com/health-care-today-blog/emtala-in-the-age-of-coronavirus-cms>.

<sup>113</sup> *Id.*

EMTALA to act within its capabilities to provide screening and any necessary stabilization treatment or transfer an individual who comes to the hospital for examination or treatment for an emergency medical condition.”<sup>114</sup>

The CMS guidelines state that several factors will be considered if a complaint is received regarding the EMTALA violations during COVID-19.<sup>115</sup> Such factors include but are not limited to “the CDC guidance at the time of the alleged violation, the capabilities of the referring hospital, and capabilities of the recipient hospital and its capacity at the time of the request.”<sup>116</sup> To state a claim, a plaintiff must allege that she went to the emergency room of a Medicare-provider hospital seeking treatment, and the hospital either failed to screen her in the same way as it would screen other patients, or that the hospital discharged or transferred her before her medical condition was stabilized.<sup>117</sup>

#### A. The Sixth Circuit’s Approach regarding “Improper Motive”

Under the EMTALA, a hospital can be sued if it failed to evaluate or stabilize a medical condition that causes harm to a patient.<sup>118</sup> In certain circumstances, the EMTALA may serve as a basis for a lawsuit against an individual physician.<sup>119</sup> One of the main issues that the Sixth Circuit needs to address is motive and whether the hospital’s failure to provide proper screening was due to an “improper motive.”<sup>120</sup> The Sixth Circuit upheld its ruling in *Cleland v. Bronson Health Care Group, Inc.*<sup>121</sup> that a plaintiff alleging a screen-based violation of the EMTALA must prove that the hospital had an improper motive for failing to appropriately screen the plaintiff.<sup>122</sup>

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<sup>114</sup> *Id.*

<sup>115</sup> *Id.*

<sup>116</sup> *Id.*

<sup>117</sup> Reynolds v. Me. Gen. Health, 218 F.3d 78, 83 (1st Cir. 2000).

<sup>118</sup> Thomas Robenalt, *Failure to Provide Emergency Room Examination May Be Medical Malpractice*, ROBENALT L. (Dec. 27, 2019), <https://www.lawyersthatfightforyou.com/medical-malpractice/2019/12/27/failure-to-provide-emergency-room-examination-may-be-medical-malpractice>.

<sup>119</sup> *Id.*

<sup>120</sup> *Elmhirst*, 726 F. App’x at 439.

<sup>121</sup> 917 F.2d 266, 268 (6th Cir. 1990).

<sup>122</sup> *Id.*

The “improper motive” standard was established in *Cleland*.<sup>123</sup> In that case, the plaintiffs sued the hospital alleging that it misdiagnosed and prematurely discharged their 15-year-old son.<sup>124</sup> The plaintiffs brought their son to the hospital because he was vomiting and complaining of cramps.<sup>125</sup> After examining him, the doctors diagnosed the son with influenza and discharged him.<sup>126</sup> He suffered a cardiac arrest and died less than twenty-four hours later.<sup>127</sup> The district court dismissed the complaint under Rule 12(b)(6) of the Federal Rules of Civil Procedure (“FRCP”).<sup>128</sup> The United States District Court the Western District of Michigan interpreted the EMTALA as applying only to indigent and uninsured patients.<sup>129</sup> Although the Sixth Circuit Court of Appeals affirmed the lower court’s decision, it disagreed with the district court’s interpretation of the EMTALA’s applicability.<sup>130</sup> The Court of Appeals held that “the statute applies to any and all patients.”<sup>131</sup> It interpreted the phrase “appropriate medical screening” to mean “a screening that the hospital offers to all paying patients.”<sup>132</sup> It also clarified the phrase “emergency medical condition” to mean “a condition within the actual knowledge of the doctors on duty or those doctors that would have been provided to any paying patient.”<sup>133</sup> The Court of Appeals held that the plaintiffs did not allege that the statutory duties were breached and therefore affirmed the decision of the district court.<sup>134</sup> Additionally, the court held that the term “appropriate” refers to the actions of the hospital and if the hospital acts in the same manner for all patients, regardless of how the patient pays, then the screening that is provided is considered to be “appropriate” within the meaning of the statute.<sup>135</sup> This case was

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<sup>123</sup> *Id.*

<sup>124</sup> *Id.*

<sup>125</sup> *Id.*

<sup>126</sup> *Id.*

<sup>127</sup> *Id.*

<sup>128</sup> *Id.* FRCP Rule 12(b) pertains to pretrial motions and this rule specifically deals with motions to dismiss for failure to state a claim upon which relief can be granted. FED. R. CIV. P. 12(b)(6).

<sup>129</sup> *Cleland*, 917 F.2d at 268.

<sup>130</sup> *Id.*

<sup>131</sup> *Id.*

<sup>132</sup> *Id.*

<sup>133</sup> *Id.* at 269.

<sup>134</sup> *Id.* at 272.

<sup>135</sup> *Id.*

the first to set forth the test for improper motive.<sup>136</sup> Several other circuits have since rejected *Cleland's* “improper motive requirement.”<sup>137</sup>

The Sixth Circuit’s improper motive requirement imposes an additional burden on plaintiffs that other circuits do not mandate. In one such case, plaintiff Elmhirst sued the hospital that treated her, alleging that the hospital neglected to screen her for a vertebral dissection even though she displayed symptoms of the condition when she first arrived at the hospital.<sup>138</sup> She was prescribed medication and then discharged, after being examined by a doctor.<sup>139</sup> Her symptoms worsened, and she returned to the hospital four days later.<sup>140</sup> She was examined by a different doctor who determined that she had suffered a stroke that was caused by vertebral dissection.<sup>141</sup> She filed a complaint alleging the hospital “failed to provide her with an appropriate medical screening and failed to stabilize her medical condition before discharging her,” violating the EMTALA.<sup>142</sup> She further alleged that “the undetected condition cause[d] her to suffer a stroke, leaving her permanently disabled.”<sup>143</sup> The hospital responded by filing a motion to dismiss under FRCP 12(b)(6).<sup>144</sup> The district court granted the defendant hospital’s motion and dismissed both of plaintiff’s claims because the complaint did not plead any facts showing that the hospital had an “improper motive” when it failed to provide appropriate medical screening.<sup>145</sup>

Plaintiff’s first claim was a screening claim based on *Cleland's* improper-motive requirement and, on appeal, the plaintiff argued that the court should eliminate the “improper motive” requirement because it was rejected by the Tenth, Fourth, First, Eighth, and D.C. Circuits.<sup>146</sup> However, the Sixth Circuit Court of Appeals affirmed the lower

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<sup>136</sup> *Elmhirst*, 726 F. App’x at 443.

<sup>137</sup> *Id.* (explaining that the Tenth, Fourth, First, and Eighth Circuits, and the United States Court of Appeals for the District of Columbia Circuit have also rejected *Cleland's* “improper motive requirement.”).

<sup>138</sup> *Id.*

<sup>139</sup> *Id.* at 441.

<sup>140</sup> *Id.*

<sup>141</sup> *Id.*

<sup>142</sup> *Id.*

<sup>143</sup> *Id.*

<sup>144</sup> *Id.*

<sup>145</sup> *Id.*

<sup>146</sup> *Id.* at 441.

court's decision.<sup>147</sup> The court held that the decision in *Cleland* is binding.<sup>148</sup> *Cleland* imposed the burden on plaintiffs to demonstrate that the hospital acted with an "improper motive" when it failed to provide an appropriate medical screening.<sup>149</sup> On appeal, the plaintiff argued that the court should reconsider *Cleland*.<sup>150</sup> Ultimately, the court held that the complaint did not offer sufficient factual support to successfully allege that the hospital acted with "improper motive."<sup>151</sup> Because she failed to dispute these allegations, she waived any argument regarding the hospital's motive.<sup>152</sup> The court held that it was obligated to apply *Cleland* because it was the law in the Sixth Circuit.<sup>153</sup>

Plaintiff's second claim was a stabilizing claim where the plaintiff alleged that the hospital failed to properly treat her emergency medical condition before discharging her.<sup>154</sup> The court held that the EMTALA provides that if a hospital detects a patient's emergency medical condition, then it has a duty to provide the necessary treatment.<sup>155</sup> However, if it does not detect such a condition, then the hospital cannot be liable under the EMTALA for failure to stabilize a condition it did not detect.<sup>156</sup> In her complaint, the plaintiff did not allege that the hospital discharged her after discovering her condition, but that "the Hospital wrongfully failed to detect her emergency medical condition."<sup>157</sup> She alleged that she had symptoms for a condition known as vertebral dissection and because the hospital neglected to properly screen her, it did not detect that condition and instead discharged her.<sup>158</sup> Therefore, the court affirmed the district court's decision and held that the district court did not err in dismissing her stabilization claim.<sup>159</sup> If this case was in a circuit that does not require the "improper motive" standard, the plaintiff would not need

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<sup>147</sup> *Id.*

<sup>148</sup> *Id.*

<sup>149</sup> *Id.* at 442.

<sup>150</sup> *Id.*

<sup>151</sup> *Id.* at 443.

<sup>152</sup> *Id.*

<sup>153</sup> *Id.* at 444.

<sup>154</sup> *Id.*

<sup>155</sup> *Id.*

<sup>156</sup> *Id.*

<sup>157</sup> *Id.* at 445.

<sup>158</sup> *Id.* at 440.

<sup>159</sup> *Id.* at 445.

to prove that the hospital intentionally acted in a way that was unfair to the patient.

In *Roberts v. Galen of Va.*,<sup>160</sup> the patient, after spending six weeks at the hospital, was transferred to a nursing facility which transferred back to a medical center after her health had deteriorated.<sup>161</sup> The plaintiff brought a personal injury suit under the EMTALA against the hospital, alleging that it had failed to properly screen and stabilize her before transferring her to the nursing facility.<sup>162</sup> The trial court ruled in favor of the hospital and held that the “plaintiff failed to prove that the hospital acted with an ‘improper motive’ when it failed to stabilize her.”<sup>163</sup>

The Sixth Circuit stated that the district court in *Roberts* properly interpreted the *Cleland* holding which required that a “plaintiff prove a hospital acted with an improper motive in order to recover under the EMTALA.”<sup>164</sup> The Sixth Circuit noted that the United States Court of Appeals for the Fourth Circuit stated “the EMTALA is not a substitute for state law malpractice actions, and was not intended to guarantee proper diagnosis or to provide a federal remedy for misdiagnosis or medical negligence.”<sup>165</sup> The court also rejected plaintiff’s position that to succeed on the EMTALA claim, she can prove that Humana Hospital-University of Louisville, in Louisville, Kentucky (Humana) deviated from its normal treatment of patients and that this deviation is what distinguishes the EMTALA claim from a negligence claim.<sup>166</sup> The court did not adopt this position because, in a defense to a claim brought under the EMTALA, the hospital would need to prove that it breached a standard of care to the patient “or that it breached the applicable standard of care with respect to all similarly situated patients.”<sup>167</sup> Ultimately, the court is asking the hospital to prove that it has committed medical negligence or

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<sup>160</sup> 525 U.S. 249 (1999).

<sup>161</sup> *U.S. Supreme Court Addresses Emergency Medical Treatment and Labor Act*, FINDLAW (Mar. 28, 2006), <https://corporate.findlaw.com/law-library/u-s-supreme-court-addresses-emergency-medical-treatment-and.html>.

<sup>162</sup> *Id.*

<sup>163</sup> *Id.*

<sup>164</sup> *Roberts v. Galen of Va.*, 111 F.3d 405, 409 (6th Cir. 1997).

<sup>165</sup> *Id.* See also *Power*, 42 F.3d at 857; *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996).

<sup>166</sup> *Roberts*, 525 U.S. at 119.

<sup>167</sup> *Id.*

malpractice.<sup>168</sup> The Sixth Circuit declined to adopt such an approach in *Cleland* so that hospitals were not put in an unjustifiable position.<sup>169</sup> That is why *Cleland* imposed the burden on showing improper motive on the plaintiff.<sup>170</sup> In *Cleland*, the court explained that the plaintiff is not only limited to a showing of an “improper motive involving indigency or lack of insurance, but the plaintiff can also show other improper reasons such as race, sex, politics, occupation, education, personal prejudice; that is, anything except medical negligence.”<sup>171</sup> The Sixth Circuit held that “to interpret *Cleland* in any other manner would effectively reduce the EMTALA to nothing more than a federal remedy for medical malpractice.”<sup>172</sup> Although the Sixth Circuit affirmed the lower court’s decision, it was ultimately reversed by the Supreme Court.<sup>173</sup>

The Supreme Court held that “the EMTALA plaintiff does not need to prove that a hospital had an ‘improper motive’ in order to prevail in a personal injury suit brought under the EMTALA for the hospital’s failure to stabilize a patient before transfer.”<sup>174</sup> The Court reasoned that the Act’s legislative history confirms that Congress chose to address the patient dumping problem through “imposition of a substantive standard of medical care, not a prohibition against acting with an improper motive.”<sup>175</sup> None of the committee reports and statements in floor debates described the hospital’s obligation in objective terms and the reports did not suggest that proof of a violation depended on proof of improper motive under the EMTALA.<sup>176</sup> Also, the Secretary of Health and Human Services (HHS) has taken the position that “improper motive is not an element of a violation of the EMTALA.”<sup>177</sup> In light of the Secretary’s enforcement responsibilities under the EMTALA, that “position is entitled to deference and, because it is reasonable, should be conclusive.”<sup>178</sup>

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<sup>168</sup> *Id.*

<sup>169</sup> *Id.*

<sup>170</sup> *Id.*

<sup>171</sup> *Id.*

<sup>172</sup> *Roberts*, 111 F.3d at 410.

<sup>173</sup> *U.S. Supreme Court Addresses Emergency Medical Treatment and Labor Act*, *supra* note 161.

<sup>174</sup> *Id.*

<sup>175</sup> Brief for the U.S., *supra* note 59, at 10.

<sup>176</sup> *Id.*

<sup>177</sup> *Id.*

<sup>178</sup> *Id.*

Every other circuit court that has addressed the issue of “improper motive” has concluded that the Sixth Circuit erred in holding that “‘improper motive’ is an element even in an ‘appropriate medical screening examination’ case.”<sup>179</sup> Although *Roberts* did not rule on the motive requirement when assessing violations of a hospital’s statutory screening duty,<sup>180</sup> other circuits have rejected the motive requirement and noted that nothing in the EMTALA’s text suggests such a limitation.<sup>181</sup> However, a circuit split still exists because the Sixth Circuit held that the term “‘appropriate’ must more correctly be interpreted to refer to the motives with which the hospital acts.”<sup>182</sup> If a hospital treats a paying and a nonpaying patient in the same exact way, then according to the statute, the medical screening that is provided would be considered “‘appropriate.’”<sup>183</sup>

42 U.S.C. § 1395dd subsection (a) of the EMTALA requires hospitals to provide appropriate MSE within their capacity when determining if an emergency medical condition exists for any person who goes to the hospital requesting treatment.<sup>184</sup> The statute does not make any reference to the hospital’s motive, let alone any requirement that a plaintiff bringing a lawsuit against a hospital under the EMTALA has to prove that the hospital had an improper motive for failing to provide the appropriate MSE pursuant to the statute.<sup>185</sup> Only the Sixth Circuit imposes this additional burden of proving the hospital’s motive on the plaintiff.<sup>186</sup>

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<sup>179</sup> *Id.*

<sup>180</sup> 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 the EMTALA’s screening requirement, but it did note that in interpreting the EMTALA to mandate such a test the Sixth Circuit is in conflict with several other circuits.”).

<sup>181</sup> See *Summers*, 91 F.3d at 1138 (“[T]he statute contains no such requirement.”).

<sup>182</sup> *Cleland*, 917 F.2d at 272.

<sup>183</sup> *Id.*

<sup>184</sup> 42 U.S.C. § 1395dd(a) (2020).

<sup>185</sup> *Power*, 42 F.3d at 857.

<sup>186</sup> *Elmhirst*, 726 F. App’x at 439.

## B. The Other Circuits' Approaches Regarding "Improper Motive"

In *Power v. Arlington Hospital Ass'n*,<sup>187</sup> the Fourth Circuit reasoned that, due to the lack of an "improper motive" requirement in the statute, plaintiffs suing under the EMTALA should not be required to prove that the hospital had an improper motive.<sup>188</sup> The Fourth Circuit rejected the improper motive standard because "there is nothing in the statute itself that requires proof of indigence, inability to pay, or any other improper motive on the part of a hospital as a prerequisite to recovery."<sup>189</sup> In *Cleland*, the Sixth Circuit's interpretation of subsection (a) of the EMTALA was that the additional pleading requirement would distinguish the EMTALA cause of action under federal law from a medical malpractice cause of action under state law.<sup>190</sup> The court explained that liability under subsection (a) of the EMTALA may arise when a hospital's emergency department fails to provide adequate medical screening, as the standard is "typically exhibited during medical screenings, for any reason other than the informed medical judgment of the physician or other hospital employee who administered the screening."<sup>191</sup> The court listed a few different improper motivations that can cause someone to administer care that falls below the hospital's standard of care while providing a medical screening, such as race, gender, and inability to pay.<sup>192</sup> The Sixth Circuit's basis behind its interpretation of subsection (a) of the EMTALA was that the additional pleading requirement differentiates a cause of action under the EMTALA, a federal law, from medical malpractice causes of action, which fall under state law.<sup>193</sup>

However, this reasoning is different from that of the Fourth Circuit which, along with the First, Eighth, Tenth, and D.C. Circuits, states that proof of an "improper motive" for failing to provide the plaintiff with appropriate screening is not necessary to bring a cause of action against a hospital for a violation under the EMTALA.<sup>194</sup> The Fourth Circuit reasoned that requiring plaintiffs to prove the

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<sup>187</sup> *Power*, 42 F.3d at 857.

<sup>188</sup> *Id.* at 851.

<sup>189</sup> *Id.*

<sup>190</sup> *Cleland*, 917 F.2d at 272.

<sup>191</sup> *Id.*

<sup>192</sup> *Id.*

<sup>193</sup> *Id.*

<sup>194</sup> *Power*, 42 F.3d at 857.

motivations of a hospital employee or physician is far too great of a burden to impose.<sup>195</sup> The difficulty of meeting such a high burden would preclude legal recovery in most cases.<sup>196</sup> Asking plaintiffs to prove motive is like asking them to prove what someone is thinking or the reasoning behind someone's actions, which is virtually impossible.<sup>197</sup>

In *Summers v. Baptist Med. Ctr. Arkadelphia*,<sup>198</sup> the Eighth Circuit stated that imposing the "improper motive" standard on plaintiffs seeking recovery under the EMTALA would limit the scope of the statute's language.<sup>199</sup> The court reasoned that the statute is, as the plaintiff in *Summers* argued, a strict-liability provision and that "if a hospital fails to provide appropriate MSE, it is liable, no matter what the motivation was for this failure."<sup>200</sup> In *Gatewood v. Wash. Healthcare Corp.*,<sup>201</sup> the D.C. Circuit Court of Appeals similarly held that any departure from its standard screening procedure violates the EMTALA and that "motive for such departure is not important to this analysis."<sup>202</sup>

## V. CONCLUSION

The statutory language of the EMTALA does not suggest that proof of improper motive is required to establish that a hospital has failed "within the staff and facilities available," to provide "such further medical examination and such treatment as may be required to stabilize the [patient's] medical condition."<sup>203</sup> The language of the statute makes the duties of a hospital very clear.<sup>204</sup> The hospital must provide sufficient treatment "to stabilize the medical condition," without regard to the hospital's motive.<sup>205</sup> The EMTALA requires a hospital to assure that a patient's condition is unlikely to deteriorate during a transfer and that the emergency medical condition refers to a

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<sup>195</sup> *Id.* at 858.

<sup>196</sup> *Id.*

<sup>197</sup> *Id.*

<sup>198</sup> *Summers*, 91 F.3d at 1137.

<sup>199</sup> *Id.* at 1132.

<sup>200</sup> *Id.* at 1138.

<sup>201</sup> 933 F.2d 1037, 1041 (1991).

<sup>202</sup> *Id.*

<sup>203</sup> Brief for the U.S., *supra* note 59, at 9.

<sup>204</sup> *Id.*

<sup>205</sup> *Id.*

condition that “could reasonably be expected to result in serious jeopardy” to the patient's health.<sup>206</sup> This supports the conclusion that “the EMTALA imposes an objective standard of care, and neither could be read to impose a further requirement that the hospital act with an improper subjective motive.”<sup>207</sup> The Sixth Circuit relies on the definition of the word “appropriate” when determining motive and every standard definition makes it clear that “the word refers to the type of action, not the motive with which it is undertaken.”<sup>208</sup> Also, the EMTALA’s provisions regarding sanctions explicitly state that “various sanctions may apply to a hospital that ‘negligently’ violates the Act.”<sup>209</sup> These provisions would be futile if “violations of the EMTALA necessarily involve conduct that is more culpable than mere negligence because it was committed with an improper motive.”<sup>210</sup>

The Secretary of HHS administers monetary fines to those that violate the EMTALA and “because the Secretary has an important role in the administration of the EMTALA, her interpretation of the EMTALA is entitled to deference.”<sup>211</sup> The Secretary has concluded that “proof of an improper motive is not an essential element” that needs to be proven.<sup>212</sup> The Sixth Circuit is the only circuit that “requires a claimant under the EMTALA [to] prove that the offending hospital acted with an improper motive.”<sup>213</sup> The Sixth Circuit has interpreted the statute so narrowly that it is almost impossible for a plaintiff in its jurisdiction to prevail in a cause of action under the EMTALA.<sup>214</sup> Other circuits do not impose the improper motive requirement because they recognize that a court cannot require an element where the statute makes no such provision.<sup>215</sup> For example, the Fourth Circuit asserts that according to subsection (a) of the EMTALA, the standard of care is determined by the capabilities of the

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<sup>206</sup> *Id.*

<sup>207</sup> *Id.*

<sup>208</sup> *Id.* at 11.

<sup>209</sup> *Id.*

<sup>210</sup> *Id.*

<sup>211</sup> *Id.*

<sup>212</sup> *Id.*

<sup>213</sup> Brief of Petitioner at 28, *Roberts v. Galen of Virginia, Inc.*, 525 U.S. 249 (1998) (No. 97-53).

<sup>214</sup> *Id.*

<sup>215</sup> *Id.*

hospital staff and the services that are available at the emergency department of that specific hospital.<sup>216</sup>

Effective enforcement of the EMTALA is essential to assure that all patients are treated equally. COVID-19 came as a surprise to most and no one knows how long it will stay. Nor does anyone know what its lasting effects will be. The memorandum issued by CMS regarding the requirements of the EMTALA was necessary because the hospitals were overwhelmed with patients and were quickly running out of space.<sup>217</sup> Hospitals had to ensure patients who came to the emergency room were treated and, at the same time, needed to protect their staff from the virus. Allowing hospitals to use telehealth services and test patients for COVID-19 at an offsite location permitted them to use their limited resources for critical patients.<sup>218</sup> It is important for hospitals to remember that the EMTALA remains in effect even though the CMS guidelines loosened some of the requirements and that the EMTALA obligations are not triggered if the patient is not physically present in the hospital.

Hospitals, offsite urgent care facilities, and physicians need to be aware of their obligations under the EMTALA and must take affirmative steps to comply with the statute's requirements.<sup>219</sup> There are several steps that can be taken to ensure compliance with the EMTALA such as "providing the EMTALA training to relevant personnel, ensuring that all patients are screened by qualified personnel, and avoiding any delays in screening while assessing a patient's ability to pay."<sup>220</sup> It is also important for the hospital to "chart all patient screenings thoroughly, and providing treatment at a level consistent with the capabilities of the facility and its staff."<sup>221</sup>

If the Sixth Circuit had adopted a test used by any of the other circuits rather than the "improper motive" test, then the outcome would

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<sup>216</sup> *Power*, 42 F.3d at 858.

<sup>217</sup> See *Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implications Related to Coronavirus Disease 2019 (COVID-19)*, CTR. FOR MEDICAID & MEDICARE SERVS. (Mar. 30, 2020), <https://www.cms.gov/files/document/qso-20-15-hospital-cah-emtala-revised.pdf>.

<sup>218</sup> *Id.*

<sup>219</sup> Ryan J. King, *Reducing Risk Under the Emergency Medical Treatment and Active Labor Act (EMTALA)*, BURNS WHITE ATT'YS L. (Mar. 12, 2021), <https://burnswhite.com/reducing-risk-under-the-emergency-medical-treatment-and-active-labor-act-emtala>.

<sup>220</sup> *Id.*

<sup>221</sup> *Id.*

have been different. If the Sixth Circuit followed the Fourth Circuit's reasonableness standard, then the hospital would have the opportunity to show that the patient was treated the same as all other patients or that a certain procedure was not given because the physician believed it was not reasonable or necessary under the circumstances. This would allow the hospital to prove that there were no "improper motives" involved in the care of the patient.

Consider this hypothetical: an African American male visits the emergency room with breathing issues. He is seen by a nurse who, after administering a few tests, does not think he needs to be admitted to the hospital. All the signs point to bronchitis. She gives him medication that would help him and then discharges him. Two days later, he returns to the hospital's emergency room with the same issue but before he is seen by a nurse, he collapses and dies in the hospital. If his family decides to sue the hospital in the Sixth Circuit, they will need to prove that the nurse who saw him when he first visited the hospital had an "improper motive." One way the family can prove that is by alleging that the nurse treated him differently because of his race or gender. However, if this case was in the Fourth Circuit, or any of the other circuits that rejected the "improper motive" standard, then the hospital will need to prove that it did not suspect any other medical issue besides bronchitis and that it would have treated everyone who came to the hospital, presenting the same issues, the same way.

Although the EMTALA was created to prevent hospital patient dumping, it appears that the federal law is not living up to its purpose. In 2015, researchers from Yale University analyzed about 215,028 emergency department visits to 160 hospitals for pneumonia, asthma and chronic obstructive pulmonary disease.<sup>222</sup> They found that after being stabilized, uninsured patients or those covered by Medicaid were more likely to be transferred to another hospital than a patient who was covered by private insurance.<sup>223</sup> The researchers also noticed that uninsured patients were more likely to be discharged from the emergency department.<sup>224</sup> After adjusting for factors, such as a patient's age, sex, income and health conditions, in an effort to eliminate bias in the results, they found that "more than three decades

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<sup>222</sup> Gaby Galvin, *'Patient Dumping' Still a Problem Despite Law*, U.S. NEWS (Apr. 1, 2019), <https://www.usnews.com/news/health-news/articles/2019-04-01/patient-dumping-still-a-problem-despite-federal-law>.

<sup>223</sup> *Id.*

<sup>224</sup> *Id.*

later after the EMTALA took effect, lower-income patients still face unequal treatment in emergency care settings.”<sup>225</sup>

The requirement that patients who bring lawsuits against hospitals must prove that the hospital had an “improper motive” is nearly impossible to achieve. Requiring patients to prove the motivations of a hospital employee or a physician is too high burden. This high standard would preclude legal recovery in most cases. As long as uninsured patients continue to utilize emergency departments for their medical care, it is important for courts to provide them with adequate protections through the EMTALA.

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<sup>225</sup> *Id.*