

MEMORANDUM

To: Justice Polly Esther, U.S. Supreme Court Justice
From: Scott Malott, Student Law Clerk
Date: August 30, 2010
Re: In re Estate of Frank Forever v. Last Stop General Hospital and Ray Sunshine M.D., jointly and severally

QUESTIONS PRESENTED

I. The Emergency Medical Treatment and Active Labor Act ("EMTALA" or "the Act") mandates that hospitals provide appropriate medical screening as well as stabilization of emergency conditions for hospital patients.¹

A. Does a hospital's obligation under the EMTALA to stabilize a patient's emergency medical condition continue after the patient is admitted to the hospital?

B. What social policies are at stake in this appeal, and how should the Court respond?

BRIEF ANSWERS

I. A. Probably not. The circuit courts are split on the issue, but the holding that a majority of circuits chose and the holding most congruent with congressional intent is that a hospital's obligation under the act ends, in most cases, when a patient is admitted to the hospital.

B. Social policy exists on both sides, but the stronger argument is in favor of holding hospitals responsible for behavior that looks like patient dumping. It is important that hospitals provide the same screening and treatment for indigent or uninsured patients as they do for those whose coverage is not in question, even if it drives up health care costs for everybody. The Court should respond by affirming the grant of summary disposition in favor of Dr. Ray Sunshine and by reversing and remanding the grant of summary disposition in favor of the hospital.

STATEMENT OF FACTS

On March 29, 2005, Mr. Frank Forever was in a bad car accident. Paramedics arrived on the scene and transported Mr. Forever to the emergency room at Last Stop General Hospital where he was provided a medical screening exam. Mr. Forever was admitted to the hospital under the care of Dr. Ray Sunshine, an internist and physician employee of the hospital.

When he was admitted, Mr. Forever was complaining of headache, neck pain, difficulty breathing, and pain in his left leg. The corresponding admitting diagnosis was a suspected fractured left leg, suspected fractured ribs, severe headaches, and a possible head injury. X-ray exams confirmed the fractured leg and ribs, and the leg and ribs were casted and wrapped

¹ 42 U.S.C. § 1395dd (2010).

respectively. Even after the doctor prescribed a variety of pain medications, Mr. Forever continued to complain of neck pain and severe headaches.

In response to Dr. Sunshine's order for a neurological consultation, Dr. Hector Healer, a neurologist, examined Mr. Forever and recommended a CT scan or MRI to rule out a possible cerebral hemorrhage. Mr. Forever underwent a CT scan on April 1 that showed no hemorrhage, but, even though he could breathe better and had no neck pain, Mr. Forever continued to experience frequent headaches through April 2.

Dr. Healer examined Mr. Forever again and put a note in his file that he "discussed performing [an] MRI with Dr. Sunshine as it is more accurate and precise than a CT scan." Dr. Sunshine acknowledged on April 3 that Mr. Forever was still complaining of headaches, and another note in the file indicated that Mr. Forever's insurance company was contacted regarding approval for performing the MRI. However, instead of an MRI, the next note in Mr. Forever's file said that he was being prepped for discharge and that his headaches had improved and become less frequent and severe.

On April 4, just five days after his accident and admittance to the hospital, Mr. Forever was released from the hospital and sent home with his family. Mr. Forever's discharge diagnosis included concussion and possible head injury. Once home, Mr. Forever began to experience another severe headache, and, as he sat down for dinner with his family for the first time in nearly a week, Mr. Forever collapsed and fell out of his chair unconscious. He was rushed to the hospital, but he died shortly thereafter. Experts that examined Mr. Forever's records post mortem determined that the hemorrhage was several days old and most likely would have been discovered with an MRI.

Frieda Forever, Frank's wife, filed a two-count complaint in the United States District Court for the Western District of Swinny. Her first count was dismissed on a legal technicality, and she was left with only her second, which was based on EMTALA. The District Court granted defendant's motion to dismiss because Mr. Forever had been admitted to the hospital. The United States Court of Appeals for the Thirteenth Circuit upheld the dismissal, and this appeal remains.

DISCUSSION

I. The Emergency Medical Treatment and Active Labor Act ("EMTALA") mandates that hospitals provide appropriate medical screening as well as stabilization of emergency conditions for hospital patients.

A. Does a hospital's obligation under the EMTALA to stabilize a patient's emergency medical condition continue after the patient is admitted to the hospital?

B. What social policies are at stake in this appeal, and how should the Court respond?

Frieda Forever wants to hold Last Stop General Hospital and Dr. Ray Sunshine liable for her husband's death based on EMTALA. Courts have interpreted the Act differently, but the

majority of them hold that a hospital's duty to stabilize ends once the hospital admits the patient. All circuits agree that EMTALA was enacted to prevent "patient dumping" by hospitals and not to be a federal medical malpractice statute. While there are public policy issues regarding discharging unstable patients, the biggest concern is providing a remedy for patients who have been inappropriately discharged. The real question is when does EMTALA end and state malpractice statutes begin, and unless some evidence of purposefully admitting the patient to avoid liability under the Act exists, the answer is once the patient is admitted.

This memo will analyze holdings from various circuits and compare them with the facts of our case. First, it will analyze those that hold that the duty ends at admittance and then those that hold otherwise. The public policy involved will be discussed throughout as the individual courts discuss it. Finally, the article will conclude that the Court should affirm the grant of summary disposition in favor of Dr. Ray Sunshine and reverse and remand the grant in favor of the hospital. The Court should clarify that the hospital could still be liable under the Act if any evidence exists indicating that Mr. Forever's admittance was motivated by the hospital's desire to avoid EMTALA liability.

The Act requires hospitals with emergency rooms to provide any individual who asks for treatment with "an appropriate medical screening examination . . . to determine whether or not an emergency medical condition . . . exists."² The Act goes on to define an "emergency medical condition" as a medical condition whose symptoms are so bad that if medical attention is not provided immediately, then the following results could be expected: "(i) placing the health of the individual . . . in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part . . ."³ Once the hospital determines that a person has an emergency medical condition, the Act requires that the hospital provide "for such further medical examination and such treatment as may be required to stabilize the medical condition . . ."⁴ In addition, the Act forbids transferring a patient (including sending him home) until his emergency medical condition is stabilized unless one of the very specific exceptions (none of which apply here) are met.⁵ Finally, the Act defines "stabilize" as "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility . . ."⁶ The Act does not specify any temporal limitation on its provisions, nor does it define reasonable probability.

Last Stop General Hospital's motive for its decision to send Mr. Forever home should not be subject scrutiny. In *Roberts v. Galen of Virginia, Inc.*, the patient in question was run over by a truck and rushed to Humana Hospital – University of Louisville in Louisville, Kentucky, a hospital owned by respondent.⁷ She was severely injured, and she remained in a volatile state for the approximately six weeks she stayed at Humana.⁸ After that time, respondents arranged for

² § 1395dd(a).

³ § 1395dd(e)(1)(A).

⁴ § 1395dd(b)(1)(A).

⁵ § 1395dd(c)(1).

⁶ § 1395dd(e)(3)(A).

⁷ 525 U.S. 249, 251 (1999).

⁸ *Id.*

the patient's transfer to Crestview Health Care Facility in Indiana where, upon her arrival, her condition became much worse.⁹ Finally, the patient was transferred to Midwest Medical Center, also in Indiana, where she remained for many months and incurred substantial medical expenses due to her deterioration.¹⁰ The patient applied for financial assistance under Indiana's Medicaid program, but she was denied for failing to satisfy the program's residency requirement.¹¹ The patient's guardian, filed suit claiming that Humana violated § 1395dd(b) because it failed to stabilize Ms. Johnson before transferring her.¹² The United States District Court for the Western District of Kentucky granted summary judgment in favor of the hospital because Ms. Roberts did not show that the hospital had acted with an improper motive, and the United States Court of Appeals for the Sixth Circuit affirmed.

The United States Supreme Court held that "there is no question that the text of § 1395dd(b) does not require an 'appropriate' stabilization, nor can it reasonably be read to require an improper motive."¹³ The Court reasoned that "[t]he Court of Appeals' holding – that proof of improper motive was necessary for recovery under § 1395dd(b)'s stabilization requirement – extended earlier Circuit precedent deciding that the 'appropriate medical screening' duty under § 1395dd(a) also required proof of an improper motive."¹⁴ Therefore, since § 1395dd(b) does not contain any language that efforts to stabilize or decisions to discharge a patient must be "appropriate," the Court held that Plaintiffs did not have to show that the hospital had an improper motive.¹⁵ While the Court did not issue an opinion as to the correctness of the Sixth Circuit's holding that § 1395dd(a)'s "appropriate medical screening" requirement commands proper motive, it did note that it is in conflict with the laws of other Circuits, which do not.¹⁶

In the case before this Court, Mr. Forever was only in the hospital for six days rather than the six weeks that Humana treated Ms. Johnson. The *Roberts* decision makes clear that Mrs. Forever will not have to show that the hospital had an improper motive in declaring Mr. Forever stable or releasing him to his family, as that is not required by the statute. It remains unclear, though, how long after a patient's arrival at the hospital the provisions of § 1395dd(b) apply. That question will be the focus of the rest of this analysis.

In *Bryan v. Rectors and Visitors of the University of Virginia*, the patient died after the hospital decided that she should receive no more life-saving measures and entered a "do not resuscitate" order.¹⁷ On February 5, 1993, another hospital transferred the patient to the University of Virginia Medical Center, and when she arrived she was experiencing emergency respiratory distress.¹⁸ After treating her condition for twelve days, the hospital decided through

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.* at 251-52.

¹³ *Id.* at 253.

¹⁴ *Id.* at 252.

¹⁵ *Id.* at 252-53.

¹⁶ *Id.* at 253, n.1.

¹⁷ 95 F.3d 349, 350 (4th Cir. 1996).

¹⁸ *Id.*

its internal procedures that it should not make any further effort to keep the patient alive.¹⁹ The hospital entered its "do not resuscitate" order on February 17, 1993, and eight days later, on February 25, 1993, the patient experienced a life-threatening episode that the hospital left untreated, and she died.²⁰ The United States District Court for the Eastern District of Virginia dismissed the case for failure to state a claim because it believed that the EMTALA "imposed no obligations on a hospital once the hospital has admitted the patient."²¹

The United States Court of Appeals for the Fourth Circuit held that the Act only requires that hospitals provide "limited stabilizing treatment to" emergency patients.²² The Court reasoned that "EMTALA is a limited "anti-dumping" statute, not a federal malpractice statute. . . . Its 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."²³ The Court decided this way based on both case law and the congressional record.²⁴ Based on its investigation, the Court held that

the stabilization requirement was intended to regulate the hospital's care of the patient only in the immediate aftermath of the act of admitting her for emergency treatment and while it considered whether it would undertake longer-term full treatment or instead transfer the patient to a hospital that could and would undertake that treatment. It cannot plausibly be interpreted to regulate medical and ethical decisions outside that narrow context.²⁵

Finally, the Court decided that, based on its interpretation of the law, dismissal for failure to state a claim was proper because there was no allegation that the hospital violated the act any time before Ms. Robertson had been there for twelve days.²⁶ Like the plaintiff in *Bryan*, Mr. Forever was a patient at the hospital for several days before the hospital decided that no more treatment was necessary.

In *Bryant v. Adventist Health System/West*, a 17-year old disabled boy died after two hospitals attempted to help him, and he had surgery at one.²⁷ The boy had a history of pneumonia, bronchitis, and asthma, and he was admitted to the hospital after he had been suffering from a fever for four days and had been coughing up blood.²⁸ The first doctor, Dr. Rosenthal, examined the boy and administered his chest x-ray, but he failed to detect a lung abscess and diagnosed the boy with only pneumonia and asthma.²⁹ Requesting that he come

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id.* at 351.

²² *Id.* at 352.

²³ *Id.* at 351 (citing *Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139, 142-43 (4th Cir. 1996); *Brooks v. Maryland Gen. Hosp., Inc.*, 996 F.2d 708, 710 (4th Cir.1993)).

²⁴ *Id.* at 351-52.

²⁵ *Id.* at 352.

²⁶ *Id.* at 353.

²⁷ 289 F.3d 1162, 1164 (9th Cir. 2002).

²⁸ *Id.*

²⁹ *Id.*

back the next day for further diagnosis and treatment, the hospital released the boy home, but the next day, the hospital called and asked him to return immediately because another doctor recognized the lung abscess.³⁰ The boy was admitted, started deteriorating, was transferred to another hospital where he had surgery, and he died suddenly and unexpectedly after being released to go home.³¹ The boy's heirs filed suit against the first hospital alleging several claims, including violation of EMTALA.³² The District Court dismissed the EMTALA claims against the hospital, and this appeal followed.³³

The United States Court of Appeals for the Ninth Circuit held that EMTALA's stabilization requirement only applied after the hospital detected an emergency medical condition, it ceased to apply once a patient was admitted to a hospital, and that even though Plaintiff's expert said Dr. Rosenthal should have detected the lung abscess, "the expert's opinion may be relevant to a malpractice claim under state law, [but] it is not relevant to the EMTALA claim."³⁴ The plaintiff conceded that the hospital staff performed an appropriate medical screening, so the only accused violation was of the stabilization requirement.³⁵ The Court reasoned that the hospital could not be held liable for failing to stabilize a condition that it never knew existed, and that the question of whether it *should* have known the condition existed was one for a state-law malpractice claim, not EMTALA.³⁶ The court did note, however, that where the concern is that the hospital purposely fails to discover an emergency condition in order to avoid the Act's stabilization requirement, "a hospital may be found liable under EMTALA's screening provision if the screening examination 'is so cursory that it is not "designed to identify acute and severe symptoms that alert the physician of the need for immediate medical attention to prevent serious bodily injury.'"³⁷ Finally, supporting its holding that "the stabilization requirement normally ends when a patient is admitted for inpatient care,"³⁸ the Court reasoned that the term stabilization "is defined only in connection with the transfer of an emergency room patient."³⁹ It said that "Congress enacted EMTALA 'to create a new cause of action, generally unavailable under state tort law, for what amounts to failure to treat' and not to "duplicate preexisting legal protections."⁴⁰ Its final support was that "[a]fter an individual is admitted for inpatient care, state tort law provides a remedy for negligent care. If EMTALA liability extended to inpatient care, EMTALA would be 'convert[ed] ... into a federal malpractice statute, something it was never intended to be."⁴¹

³⁰ *Id.*

³¹ *Id.*

³² *Id.*

³³ *Id.* at 1165.

³⁴ *Id.* at 1166.

³⁵ *Id.* at 1165-66.

³⁶ *Id.* at 1166 (citing *Baker v. Adventist Health, Inc.*, 260 F.3d 987, 993-94 (9th Cir. 2001); *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995)).

³⁷ *Id.* n.3 (quoting *Jackson v. E. Bay Hosp.*, 246 F.3d 1248, 1256 (9th Cir. 2001) (quoting *Eberhardt*, 62 F.3d at 1257)).

³⁸ *Id.* at 1167.

³⁹ *Id.*

⁴⁰ *Id.* at 1168-69 (quoting *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991)).

⁴¹ *Id.* at 1169 (quoting *Hussain v. Kaiser Found. Health Plan*, 914 F. Supp. 1331, 1335 (E.D. Va. 1996)).

It its consideration, the Court did recognize but disagree with the United States Court of Appeals for the Sixth Circuit's discussion of the matter in *Thornton v. Southwest Detroit Hospital*, which is discussed below.⁴² The *Thornton* Court was faced with the case of a stroke patient who was admitted to the hospital for ten days, released, then her condition deteriorated.⁴³ "The Sixth Circuit explained that, 'once a patient is found to suffer from an emergency medical condition in the emergency room, she cannot be discharged until the condition is stabilized, regardless of whether the patient stays in the emergency room.'"⁴⁴ The Fourth Circuit responded with the following comment:

We agree with the Sixth Circuit that a hospital cannot escape liability under EMTALA by ostensibly "admitting" a patient, with no intention of treating the patient, and then discharging or transferring the patient without having met the stabilization requirement. In general, however, a hospital admits a patient to provide inpatient care. We will not assume that hospitals use the admission process as a subterfuge to circumvent the stabilization requirement of EMTALA. If a patient demonstrates in a particular case that inpatient admission was a ruse to avoid EMTALA's requirements, then liability under EMTALA may attach. But this is not such a case.⁴⁵

So, in *Bryant*, the Ninth Circuit only addressed the stabilization requirement, and it said that the requirement was met once a patient was admitted to the hospital. In our case, that would mean that the hospital met all of EMTALA's requirements through its treatment of Mr. Forever in the emergency room. Once it screened him, realized he had an emergency condition, and chose to admit him rather than transfer him, the Fourth Circuit would hold that the hospital's liability under EMTALA was over. The only exception would be if any evidence existed that the hospital only admitted him to avoid liability or if the screening was so cursory as to not be designed to identify his hemorrhage. Also, based on the *Bryant* Court's language, whether or not the hospital should have known of Mr. Forever's hemorrhage "may be relevant to a malpractice claim under state law, [but] it is not relevant to the EMTALA claim."

The United States Court of Appeals for the Eleventh Circuit relied purely on the language of the Act to determine that "the triggering mechanism for stabilization treatment under EMTALA is transfer."⁴⁶ In *Harry v. Marchant*, a patient was brought to the emergency room where treatment was requested on her behalf.⁴⁷ Her initial diagnosis was "pneumonia rule out sepsis," and even though the emergency room physician wanted to admit her to the Intensive Care Unit ("ICU"), the hospital did not admit her until after her primary care physician examined her later in the day.⁴⁸ Shortly after being admitted to the ICU, the patient lapsed into respiratory and cardiac failure and died.⁴⁹ In affirming the District Court's dismissal of the plaintiff's

⁴² *Id.* at 1168 (citing *Thornton v. Sw. Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990)).

⁴³ *Id.* (citing *Thornton*, 895 F.2d 1131).

⁴⁴ *Id.* (quoting *Thornton*, 895 F.2d at 1134).

⁴⁵ *Id.* at 1169.

⁴⁶ *Harry v. Marchant*, 291 F.3d 767, 772 (11th Cir. 2002).

⁴⁷ *Id.* at 768.

⁴⁸ *Id.*

⁴⁹ *Id.*

EMTALA claims, the Eleventh Circuit agreed with its brother circuits that EMTALA is meant solely to prevent patient dumping, not to be a federal malpractice statute.⁵⁰ To execute its statutory analysis, the Court simply took the Act's definition of "stabilize" and inserted it into the portion that talked about the stabilization requirement.⁵¹ The Court decided that the stabilization requirement should require the hospital provide the following:

. . . (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required [to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result or occur during the transfer of the individual from a facility], or . . .⁵²

So, using that language, the Court held that it was clear that if a patient was not transferred, then the Act's stabilization requirement was not triggered.⁵³ In our case, Mr. Forever was transferred; he was released to his family, so outside of agreeing with the other courts' holdings that EMTALA was meant solely to prevent patient dumping, *Harry* did not apply.

In *Lima-Rivera v. UHS of Puerto Rico, Inc.*, the United States District Court for the District of Puerto Rico took a slightly different view of the requirements to state a claim under EMTALA.⁵⁴ That Court held that a prima facie EMTALA case included the following elements:

. . . (3) the hospital either (a) did not afford the patient an appropriate screening in order to determine if she had an emergency medical condition, or (b) bade farewell to the patient (whether by turning her away, discharging her, or improvidently transferring her) without first stabilizing the emergency medical condition.⁵⁵

In order to be discharged, a patient must first be admitted, so by stating the elements this way, the Court has impliedly included all hospital patients. In fact, the Court adopted the specific language of *Lopez-Soto v. Hawayek* to do just that. It said, "Congress's preoccupation with patient dumping is served, not undermined, by forbidding the dumping of *any* hospital patient with a known, unstabilized, emergency condition."⁵⁶ Finally, the *Lima-Rivera* Court confirmed its opinion in the face of an interpretative legislative ruling that stated that EMTALA ceased to apply when a patient is admitted as an inpatient.⁵⁷ The Court flatly stated that it disagreed and that "[i]nterpretive rules 'do not have the force and effect of law and are not accorded that weight in the adjudicatory process.'"⁵⁸

⁵⁰ *Id.* at 770.

⁵¹ *Id.* at 770-71.

⁵² *Id.* at 771 (quoting 42 U.S.C. § 1395dd(b)(1)).

⁵³ *Id.*

⁵⁴ 476 F. Supp. 2d 92, 98 (D.P.R. 2007)

⁵⁵ *Id.* (citing *Correa v. Hosp. San Francisco*, 69 F.3d 1184, 1190 (1st Cir. 1995)) (emphasis added).

⁵⁶ *Id.* at 97 (quoting *Lopez-Soto v. Hawayek*, 175 F.3d 170, 177 (1st Cir. 1999)) (emphasis in original).

⁵⁷ *Id.* at 97 (discussing 42 C.F.R. § 489.24(d)(2)(i)).

⁵⁸ *Id.* at 97-98 (quoting *Shalala v. Guernsey Mem'l Hosp.*, 514 U.S. 87, 99 (1995) (citing *Chrysler Corp. v. Brown*, 441 U.S. 281, 302 n. 31(1979))).

In *Thornton v. Southwest Detroit Hospital*, a stroke victim was admitted to the hospital, and she spent ten days in the hospital's ICU and another 11 days in regular inpatient care.⁵⁹ At that point, the doctor planned on releasing her to the Detroit Rehabilitation Institute, but the patient was not accepted there because the patient's insurance did not cover rehabilitation treatment, so the doctor released her to her sister's care instead.⁶⁰ The patient's condition deteriorated rapidly, then the Rehabilitation Institute admitted her.⁶¹ The United States Court of Appeals for the Sixth Circuit upheld the district court's grant of summary disposition in this case because the patient's condition did in fact stabilize before she was discharged.⁶² Before coming to its conclusion, however, the Court expressed that EMTALA's requirements continue after admittance to the hospital by stating, "Although emergency care often occurs, and almost invariably begins, in an emergency room, emergency care does not always stop when a patient is wheeled from the emergency room into the main hospital. . . . Emergency care must be given until the patient's emergency medical condition is stabilized."⁶³

In its recent holding in *Moses v. Providence Hospital and Medical Center*, the Sixth Circuit reiterated its language from *Thornton*, but it also added an important part: EMTALA claims cannot be brought against individual physicians.⁶⁴ The Court reasoned that because Congress included individual physicians in the governmental enforcement provision of the act but chose to exclude them in the civil enforcement provision it was clear from the statute that private causes of action could not include the physicians.⁶⁵ The Court also relied on the decisions of several other circuits that supported its holding.⁶⁶

When all of the above decisions are taken together, a clear split in opinion develops. Mr. Forever was admitted to the hospital and cared for over a period of six days. He was not fully stable when he was released, but the hospital had performed testing and provided him medication. The question is whether the hospital should remain liable under EMTALA even after state malpractice statutes take over to provide an avenue for relief.

In *Morgan v. North Miss. Med. Ctr., Inc.*, the United States District Court for the Southern District of Alabama surveyed several courts' case laws and decided that the Ninth Circuit's determination that EMTALA liability ended when a patient was admitted to the hospital unless there was some evidence the admittance was a subterfuge to avoid EMTALA liability was most correct.⁶⁷ The Court reasoned that the Fourth Circuit's approach in *Bryan* was

⁵⁹ 895 F.2d 1131, 1132 (6th Cir. 1990).

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.* at 1135.

⁶³ *Id.*

⁶⁴ 561 F.3d 573, 587 (6th Cir. 2009).

⁶⁵ *Id.*

⁶⁶ *Id.* (citing *Baber v. Hosp. Corp. of America*, 977 F.2d 872, 877-78 (4th Cir. 1992); *King v. Ahrens*, 16 F.3d 265, 271 (8th Cir. 1994); *Eberhardt v. City of L.A.*, 62 F.3d 1253, 1256-57 (9th Cir. 1995); *Delaney v. Cade*, 986 F.2d 387, 393-94 (10th Cir. 1993); *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1040 n.1 (D.C. Cir. 1991) (*dicta*)).

⁶⁷ 403 F. Supp. 2d 1115, 1129-30.

too limiting, and it provided hospitals with an easy out – simply admit the patient then release him.⁶⁸ The Court also discussed the Sixth Circuit’s approach and found that it was much too broad because “it would allow for an open-ended, uncabined duration of the stabilization requirement with no logical limiting principle,” which could allow the duty to infringe “on regulatory territory patrolled by state malpractice law”⁶⁹ The Court settled on the Ninth Circuit’s interpretation because it placed an appropriate limit on the law, but it also addressed any fears that hospitals would admit patients just to avoid potential liability.⁷⁰ The Court also discussed the same interpretative ruling that *Lima-Rivera* rebuffed, and believes its holding is consistent with the ruling because the ruling only ends EMTALA liability when a hospital “admits [an] individual as an inpatient *in good faith* in order to stabilize the emergency medical condition”⁷¹

CONCLUSION

When Congress enacted EMTALA, it was trying to end the practice of “patient dumping,” or the transferring of indigent and uninsured patients to other hospitals. There is a consensus among the circuits that EMTALA was not meant to be a malpractice statute, nor should it supersede state malpractice laws. In addition, the 2003 interpretive ruling specifically states that EMTALA liability should end when a patient is admitted. The Court should adopt the language from the Ninth Circuit and the *Morgan* case and hold that Last Stop General Hospital’s duty under EMTALA ended once the hospital admitted Mr. Forever unless evidence exists showing that the hospital only admitted him to avoid that duty. The Court should uphold the dismissal in favor of Dr. Ray Sunshine because EMTALA does not allow for private causes of action against individual doctors. The Court should reverse and remand the dismissal in favor of the hospital because there needs to be further investigation into any evidence that the hospital admitted Mr. Forever as a ruse to avoid EMTALA liability. In other words, the Court should hold that a hospital’s obligation to stabilize a patient under EMTALA continues after the patient is admitted if the hospital admitted the patient specifically to avoid its EMTALA obligation, so it does not end at admittance as a matter of law.

Public policy arguments will be well served by this decision as well because hospitals will still be required to provide emergency treatment and stabilization to all patients, so the indigent and uninsured cannot be turned away. Once the hospital admits the patient, any decisions on the patient’s care, transfer, or discharge will be covered under state malpractice laws. Hospital liability under EMTALA will not be indefinite as the Sixth Circuit would have it, but it also will not be as limited as the Fourth Circuit desires. Unless Ms. Forever can show on remand that the hospital’s motive in admitting her husband was improper, she will not have relief under EMTALA. Her relief should have come through the state malpractice claim that was previously dismissed.

⁶⁸ *Id.* at 1128 (discussing *Bryan*, 95 F.3d at 352).

⁶⁹ *Id.* at 1129 (discussing *Thornton*, 895 F.2d at 1134-35).

⁷⁰ *Id.* at 1129-30.

⁷¹ *Id.* at 1129 n.14 (quoting 42 C.F.R. § 489.24(d)(2)(i)) (emphasis in original).