

## PATIENT DUMPING: IMPLICATIONS FOR THE ELDERLY

George P. Smith, II

*Before 1986, the common law provided that doctors and hospitals had no duty to admit or treat persons who sought their care except in limited circumstances. Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA) to curb this so-called patient-dumping problem. EMTALA provides that Medicare-participating hospitals must treat all patients who arrive in emergency conditions.*

*Professor Smith first discusses the patient-dumping problem and how EMTALA has provoked many hospitals to curtail their emergency facilities to avoid treating indigent and uninsured patients. He discusses the specifics of EMTALA's main statutory provision, § 1395, and then focuses on EMTALA's particular impact on indigent elderly persons who have neither insurance nor Medicare. The author explains how EMTALA may indirectly encourage hospitals to dump elderly patients who do not have Medicare. Next, Professor Smith argues that EMTALA's definitional flaws and weak enforcement mechanisms make it an ineffective statute and suggests several ways of strengthening its effectiveness. Last, the author examines society's ethical obligations to treat its elderly citizens and suggests that doctors have an affirmative obligation to treat indigent elderly patients as a condition to their licensure.*

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## I. Introduction

Although patients in “right to refuse medical treatment” cases have trouble terminating their medical care, many persons have trouble *obtaining* medical care in the first place because they are refused admission to hospitals. This problem is called “patient dumping.”<sup>1</sup> Examples of patient dumping include: a man with severe burns over ninety-five percent of his body who was refused admittance to over forty burn-center hospitals despite pleas from the man’s personal physician;<sup>2</sup> a man with a knife wedged into his spine;<sup>3</sup> and a woman entering labor with what the doctor who refused her care described as the highest blood pressure he had ever seen.<sup>4</sup> The common thread in patient-dumping situations is that these patients either do not have medical insurance or are otherwise unattractive to the hospitals.<sup>5</sup>

Also known as “demarketing of services” or “management of patient mix,”<sup>6</sup> patient dumping refers to the hospital practice of transferring or refusing to treat persons who are indigent, uninsured, or otherwise undesirable to admit.<sup>7</sup> Patient dumping has origins in the common-law no-duty rule.<sup>8</sup> The no-duty rule provides that hospitals have no duty to admit and treat all patients who seek care and, in some cases, have no duty even to specify reasons for rejecting patients.<sup>9</sup> Hospitals often “dump” patients who arrive at hospital wards either without any health insurance or with only Medicaid insur-

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1. See Daniel N. Rosenstein, *Emergency Stabilization for a Wounded COBRA*, 9 ISSUES L. & MED. 255 (1993); Karen I. Treiger, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. REV. 1186 (1986).

2. See Art Harris, *Burn Victim Refused by 40 Hospitals*, WASH. POST, May 12, 1982, at A1.

3. See George J. Annas, *Your Money or Your Life: "Dumping" Uninsured Patients from Hospital Emergency Wards*, 76 AM. J. PUB. HEALTH 74, 74 (1986).

4. See *Burditt v. United States Dep't of Health & Human Servs.*, 934 F.2d 1362, 1366 (5th Cir. 1991).

5. See Treiger, *supra* note 1, at 1187. See generally MICHAEL MACDONALD ET AL., HEALTH CARE LAW: A PRACTICAL GUIDE § 20.01[2] (1985 & Supp. 1997). Patient dumping is not limited to patients without medical insurance. Impoverished persons disproportionately rely on emergency rooms for all of their medical needs and thus face an increased risk of being denied health care. See generally George C. Benjamin et al., *Medicaid, Managed Care and Emergency Care*, 22 ANNALS EMERGENCY MED. 1746 (1993).

6. Rosenstein, *supra* note 1, at 256.

7. See *id.*

8. See Treiger, *supra* note 1, at 1191.

9. See *id.*; see also *Birmingham Baptist Hosp. v. Crews*, 157 So. 224, 225 (Ala. 1934) (stating that a private hospital need not specify reasons for refusing to treat a patient).

ance—a program which doctors know provides low reimbursement payments to physicians themselves. The economic pressures placed upon hospitals over the past decade increased the frequency of patient dumping in cases falling under the no-duty rule.<sup>10</sup> The common-law no-duty rule and hospitals' ability to refuse medical treatment have been limited by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986<sup>11</sup> and the Emergency Medical Treatment and Active Labor Act (EMTALA),<sup>12</sup> an amendment to COBRA.

This essay first discusses patient dumping before and after COBRA and EMTALA were enacted. It then surveys the threat that patient dumping poses to the elderly and analyzes the judicial treatment of a patient-dumping scenario under EMTALA. The essay also discusses the interaction of Medicare and patient dumping, and theorizes how Medicare may exacerbate patient dumping. It then proceeds to evaluate the strengths and weaknesses of EMTALA, examines the legal enforcement of EMTALA's antidumping rules, and considers effective state and local policies regarding patient dumping. Finally, this essay structures working principles and justifies an ethical basis for the proposition that care for the elderly should be a high priority, if not a mandate, for health-care providers. This essay concludes that the elderly will be secure from the indignity of patient dumping only when society and the health-care industry acknowledge the inherent value of the elderly as an important segment of contemporary American life.

## II. EMTALA: Patient Dumping and the Federal Response

Before COBRA and EMTALA limited a hospital's right to refuse medical treatment to patients, the common law's no-duty rule was bound only by four exceptions: (1) once a hospital provides medical care, it must do so nonnegligently; (2) once a person gains "patient" status, the caregiver must aid and protect that patient; (3) where a person relies upon a caregiver's custom of providing emergency care, a duty to provide that care exists; and (4) true "emergency" cases obviate the no-duty rule.<sup>13</sup> Although commentators have asserted that the

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10. See *Hines v. Adair County Pub. Hosp.*, 827 F. Supp. 426, 428 (1993).

11. Pub. L. No. 99-272, 100 Stat. 82 (codified as amended at 42 U.S.C. § 1395dd (1994)).

12. 42 U.S.C. § 1395dd (1994).

13. See Andrew Jay McClurg, *Your Money or Your Life: Interpreting the Federal Act Against Patient Dumping*, 24 WAKE FOREST L. REV. 173, 184-85 (1989) (citing the

no-duty rule was applied narrowly,<sup>14</sup> its application was apparently widespread enough to provoke Congress to pass EMTALA.<sup>15</sup> Before EMTALA, experts estimated that hospitals dumped up to 250,000 patients a year.<sup>16</sup>

Congress recognized the public need to reduce the incidence of patient dumping when it enacted COBRA and EMTALA's antidumping provisions.<sup>17</sup> Section 1395 of EMTALA provides in pertinent part: "If a patient at a hospital has an emergency medical condition which has not been stabilized . . . the hospital may not transfer the patient unless—the transfer is an appropriate transfer to that facility."<sup>18</sup> EMTALA applies to hospitals that receive federal funds from the Medicare and Medicaid programs, and provides for civil monetary fines against participating hospitals and physicians who violate EMTALA.<sup>19</sup>

Hospitals and physicians will violate § 1395 either "by failing to detect the nature of the emergency condition through inadequate screening procedures, [or after detecting the emergency nature of the patient's condition,] by failing to stabilize the condition before releasing the plaintiff."<sup>20</sup> However, a threshold requirement needed to protect a patient under EMTALA is that he or she must arrive at a hospital's emergency room in an emergency condition.<sup>21</sup> In sum, to plead a § 1395 claim, a patient must prove: (1) that he or she arrived at a defendant hospital's emergency room in an emergency condition and (2) either that the hospital failed to adequately screen the patient to determine an emergency condition or that the hospital discharged or transferred the patient before his or her emergency condition had passed.<sup>22</sup>

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seminal no-duty rule case of *Birmingham Baptist Hosp. v. Crews*, 157 So. 224 (Ala. 1934), in which a hospital was protected by the no-duty rule where a two-year-old child with diphtheria was administered antitoxin, oxygen, and a throat swab, but later died after was released).

14. See *id.* at 184.

15. See *Hines*, 827 F. Supp. at 428.

16. See David A. Ansell & Robert L. Schiff, *Patient Dumping: Status, Implications and Policy Recommendations*, 257 JAMA 1500, 1500 (1987).

17. See *Rosenstein*, *supra* note 1, at 256.

18. 42 U.S.C. § 1395(c)(1)(B) (1994).

19. See *Abercrombie v. Osteopathic Hosp. Founders Ass'n*, 950 F.2d 676, 680 (10th Cir. 1991).

20. *DeBerry v. Sherman Hosp. Ass'n*, 741 F. Supp. 1302, 1305 (N.D. Ill. 1990).

21. See *id.* at 1305.

22. See *id.*



EMTALA's powers are broad. EMTALA requires all hospitals that execute Medicare provider agreements with the federal government to treat "all human beings who enter their emergency departments" in accordance with the Act's provisions.<sup>23</sup> The Act is alleged to have such a "landslide potential" that its reach in the area of health law has been compared to the pervasive Racketeering Influenced and Corrupt Organization statute in the area of business fraud and corporate law.<sup>24</sup>

As observed, EMTALA requires Medicare-participating hospitals to provide their services without charge to all persons who seek emergency medical treatment and to women who are in active labor. The hospital must do so even where the person seeking admission is not enrolled in Medicare.<sup>25</sup> Linking EMTALA to Medicare reimbursement requirements totally eliminates any federal obligation to compensate hospitals for their costs arising from their obligations under EMTALA which would have otherwise existed.<sup>26</sup> Furthermore, the financial obligations imposed under EMTALA are conditional and only apply to hospitals with emergency departments.<sup>27</sup> Consequently, in order to escape the financial rigidity of this provision, more than seven hundred hospitals have decreased their emergency facilities—including critical-care trauma units—since EMTALA's passage.<sup>28</sup> Hospitals have curtailed their emergency services because severe overcrowding overwhelmed their facilities.<sup>29</sup> By limiting the acquisition and use of expensive resuscitative equipment, the number of physicians in emergency medicine, and the availability of beds in emergency hospital units, hospitals can control, if not limit, EMTALA mandates.<sup>30</sup>

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23. *Burditt v. United States Dep't of Health & Human Servs.*, 934 F.2d 1362, 1366 (5th Cir. 1994).

24. See Gary Taylor, *Cracking Down on Patient Dumping*, NAT'L L.J., June 6, 1988, at 2.

25. See 42 U.S.C. § 1395dd(a), (b)(1), (e)(1)(A) (1994); RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? 9 (1997). See generally American College of Emergency Physicians, *Policy Statement: Definition of Emergency Service*, 23 ANNALS EMERGENCY MED. 1397 (1994).

26. See EPSTEIN, *supra* note 25, at 91.

27. See *id.* at 95.

28. See *id.* at 97.

29. See *id.*

30. See *id.* at 97-98; see also Anna-Katrina S. Christakis, *Emergency Room Gatekeeping: A New Twist on Patient Dumping*, 1997 WIS. L. REV. 295.

### III. The Judicial Treatment of § 1395 Violations

For those physicians and hospitals that violate EMTALA, the Act has profound implications. One example of EMTALA's judicial application is *Burditt v. United States Department of Health & Human Services*.<sup>31</sup> In the *Burditt* case, the DeTar Hospital emergency room in Victoria, Texas, refused medical treatment to Rosa Rivera, who was at or near term with her sixth child.<sup>32</sup> Although two obstetrical nurses concluded that Ms. Rivera was in labor and had "dangerously high" blood pressure,<sup>33</sup> the attending physician, Dr. Michael L. Burditt, stated that "he didn't want to take care of this lady,"<sup>34</sup> and directed attending nurses to transfer Ms. Rivera to a public hospital 170 miles away.<sup>35</sup> As an experienced obstetrician who was head of his department, Dr. Burditt knew that Ms. Rivera's hypertension could cause life-threatening complications to both Ms. Rivera and her baby.<sup>36</sup> In addition, two obstetrical nurses warned both their head nurse and the hospital administrator that transferring Ms. Rivera in her situation would violate federal law.<sup>37</sup> Nonetheless, Dr. Burditt authorized the transfer.<sup>38</sup>

At the time of the incident, Dr. Burditt allegedly stated, "[U]ntil DeTar Hospital pays my malpractice insurance, I will pick and choose those patients that I want to treat."<sup>39</sup> Dr. Burditt never reevaluated Ms. Rivera and failed to order any medication or life support for Ms. Rivera's 170-mile trip to the closest public hospital, John Sealy Hospital.<sup>40</sup> Forty miles into the trip to John Sealy, Ms. Rivera gave birth.<sup>41</sup>

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31. 934 F.2d 1362 (5th Cir. 1991).

32. *See id.* at 1366.

33. *See id.* (Ms. Rivera's blood pressure was 210/130).

34. *Id.*

35. *See id.* at 1366-67.

36. *See id.* at 1366.

37. *See id.*

38. *See id.* at 1367.

39. *Id.* *See generally* Donna B. Jones, *The Devil or the Sea: Transfer Regs Create a Dilemma*, 85 TEX. MED. 70 (1989) (stating that due process, as mandated in Medicare's quality review procedures, lies at the heart of the *Burditt* case).

The medical industry has created outstanding projections and has helped create a system (of enforcement) that is totally ineffectual doing what it was commissioned to do . . . . [T]he due process argument is used over and over again by physicians who want to try and repudiate a particular measure and we tend to sit back and say, "well, gosh, everyone deserves due process . . . ."

Virginia Ellis & Robert Steinbrook, *Doctors Lobby Uses Clout to Block Agency Reforms*, L.A. TIMES, May 14, 1990, at A1 (quoting Assemblywoman Jacky Speier).

40. *See Burditt*, 934 F.2d at 1367.

41. *See id.*

The attending nurse ordered the ambulance driver to a nearby private hospital so that the nurse could obtain a blood coagulant for Ms. Rivera. The nurse then called DeTar and Dr. Burditt to forewarn them Ms. Rivera would have to return to DeTar.<sup>42</sup> Fortunately, Ms. Rivera was placed under the care of another doctor at DeTar, and she returned to good health in three days.<sup>43</sup>

After a complaint was filed against Dr. Burditt, the Inspector General of the Department of Health and Human Services (DHHS) fined Dr. Burditt \$25,000 for violating EMTALA.<sup>44</sup> An Administrative Law Judge (ALJ) heard arguments on the issue and agreed that Dr. Burditt violated EMTALA, but reduced the fine to \$20,000. DHHS Secretary Dr. Louis Sullivan upheld this penalty.<sup>45</sup> On appeal, the Court of Appeals for the Fifth Circuit upheld the ALJ's findings against Dr. Burditt.<sup>46</sup> The court of appeals agreed with the ALJ that Ms. Rivera entered DeTar in an emergency medical condition and that Dr. Burditt failed to stabilize her condition before he ordered her transfer to John Sealy.<sup>47</sup>

The *Burditt* case focused on the issue of a hospital's ability to "treat or transfer" patients in accordance with EMTALA. The court stated that under EMTALA, a qualified hospital must either treat patients who enter its emergency ward or, as in the *Burditt* situation, transfer them to another facility.<sup>48</sup> *Burditt* held that before transferring a patient, a physician should perform a balancing test and sign a certification stating (1) that he or she has weighed the benefits of transferring the patient to another facility against the risks involved in the transfer and (2) that the physician concludes that the benefits to the patient do outweigh the risks.<sup>49</sup> The court stated that a hospital will violate EMTALA's transfer provision, § 1395dd(c)(1)(A), by: (1)

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42. See *id.*

43. See *id.*

44. See *id.*

45. See *id.*

46. See *id.*

47. See *id.* at 1369. Ms. Rivera was not only in an emergency medical condition, but also pregnant and in "active labor." See *id.* at 1370.

48. See *id.* at 1370-71; see also 42 U.S.C. § 1395dd(c)(1)(A)(ii-iii) (1994).

49. See *Burditt*, 934 F.2d at 1371 & n.9 ("In revising EMTALA, Congress has expressly provided that medical personnel must make a determination regarding medical risks and utilities, [and not merely] sign a paper stating such"); see also *id.* at 1371 n.11 ("Evidence that a signer was aware of certain medical risks and medical benefits before making a certification decision when that person claims not to have considered those risks and benefits may be used to prove . . . violation under 42 U.S.C. § 1395dd(c)(1)(A)(ii)").

failing to secure signatures required for transfer; (2) failing to deliberate on the risks and benefits of a transfer; (3) improperly considering significant factors during a certification decision; or (4) making an errant transfer decision after performing the transfer balancing test.<sup>50</sup> Because Dr. Burditt admitted that he “didn’t know what he was doing” when he signed Ms. Rivera’s transfer, the court found that Dr. Burditt failed to deliberate adequately on the risks of her transfer and thus violated § 1395.<sup>51</sup>

After discussing the appropriate decision-making procedures for patient transfers, *Burditt* also addressed how an appropriate transfer under EMTALA must be performed. Dr. Burditt asserted that transporting Ms. Rivera in a licensed state ambulance constituted an appropriate and safe transfer under EMTALA.<sup>52</sup> The court disagreed and stated that § 1395dd(c)(2)(C) requires that the transfer vehicle not only be a “qualified transport vehicle,” but also must contain the equipment and personnel necessary to safely transfer the particular patient.<sup>53</sup> The court found that the personnel for Ms. Rivera’s transfer were unqualified to perform foreseeable medical treatment;<sup>54</sup> thus, the hospital transfer violated the Act.

The *Burditt* court concluded that under EMTALA’s plain language, patient-dumping violations do not require any finding of improper motive. EMTALA intends to penalize hospitals and physicians that transfer patients unsafely, regardless of whether the patient is dumped for an improper motive, such as an economic rea-

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50. *See id.* at 1371.

51. *Id.* (Dr. Burditt was “completely ignorant of EMTALA’s [transfer] requirements” and testified, “I didn’t know what I was doing but I signed her [certification] so I could send her”); *see also id.* at 1371 n.10 (the court would not reach the issue of whether a transfer of a patient to another hospital, as a means of avoiding risky procedures, and ultimately a malpractice lawsuit, was prohibited by EMTALA).

52. *See id.* at 1372.

53. *See id.* at 1372-73 (The court read “‘transportation equipment’ under the act to include all physical objects reasonably medically necessary for safe patient transfer.”).

54. *See id.* at 1372. “The ALJ could properly credit expert testimony to the effect that only a physician could have fulfilled the ‘qualified personnel’ requirements” in this case because the obstetrical nurses could not have performed a caesarean section or adequately treated the complications arising from Rivera’s hypertension that may have arisen during the transfer. *Id.*

son.<sup>55</sup> Therefore, EMTALA protects not only indigent or uninsured persons, but any person who is in an emergency condition.<sup>56</sup>

#### IV. Section 1395's Weaknesses and the Implications for the Elderly

Despite the availability of Medicare, the elderly are not immune from problems of patient dumping. Medicare and private insurance may not entirely cover an elderly individual's medical expenses. Approximately 400,000 elderly Americans have no health insurance.<sup>57</sup> Some health-care providers are leery of treating patients who may be unable to fully pay their fees and may be tempted to dump these patients.<sup>58</sup> This threat is particularly significant to elderly patients because Medicare is estimated to pay only one-half of an elderly person's medical expenses.<sup>59</sup> Therefore, despite the availability of Medicare, patient dumping still poses a legitimate threat to elderly Americans. EMTALA and similar state statutes may be the only protection available to elderly individuals who face the problem of patient dumping.

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55. See *id.* at 1373; *Cleland v. Bronson Health Care Group*, 917 F.2d 266, 269-70 (6th Cir. 1990) (The court interpreted EMTALA to extend its benefits and rights "to any individual who arrives at [a qualified] hospital." The court also stated that its interpretation of the act would lead to a much broader interpretation than Congress may have intended, but the result was one permitted by the plain language of the statute.); see also *Stevison v. Enid Health Sys., Inc.*, 920 F.2d 710 (10th Cir. 1990). But see *Thorton v. Southwest Hosp.*, 895 F.2d 1131, 1132 (6th Cir. 1990) (stating in dicta that the Act requires hospitals to give emergency aid to indigent patients).

56. See *Burditt*, 934 F.2d at 1373.

57. See *Census Bureau Finds 14.7 Percent Without Health Insurance in 1992*, Health Care Pol'y Rep. (BNA) No. 31, at D-45 (Oct. 11, 1993) [hereinafter *Census*] (In 1992, 1.2% of the elderly were not covered.); see also *Uninsured Figure Exceeds 38 Million, Small Firms Lead Decline*, Health Care Pol'y Rep. (BNA) No. 41, at D-29 (Dec. 20, 1993) [hereinafter *Uninsured*] (stating that 38.5 million Americans were uninsured in 1992 and that the total number of uninsured increases to 38.9 million Americans).

58. See *Health Care Providers, Senior Citizens Groups Warn of Effect of More Medicare Cuts*, Health Care Pol'y Rep. (BNA) No. 15, at D-5 (June 14, 1993) [hereinafter *Health Care Providers*].

59. See *Census*, *supra* note 57, at D-45.

## V. Does Medicare Exacerbate the Patient-Dumping Problem?

Ninety-six percent of elderly Americans are covered by the federal Medicare program.<sup>60</sup> One question that the availability of Medicare poses to the elderly and to society as a whole is whether Medicare indirectly encourages physicians and hospitals to dump patients. This issue is better understood after an explanation of the basic rules of the Medicare program.

The Medicare program has two parts: Part A includes inpatient services other than physician services, and Part B includes outpatient and ambulatory services.<sup>61</sup> Part A provides for federal reimbursement of hospital services provided per patient discharge<sup>62</sup> according to a formula that determines the regionally weighed cost for each procedure that is performed.<sup>63</sup> This is a Discharge Related Group (DRG) scheme which is subject to yearly congressional budget caps.<sup>64</sup> Part B has a fee-for-service scheme,<sup>65</sup> which reimburses doctors for nearly any service they perform.<sup>66</sup> Congress limited Part B's fee-for-service provisions with value-scaled service reimbursements<sup>67</sup> and fee caps.<sup>68</sup> Nonetheless, Part B reimburses doctors for virtually all normally performed physician services, including diagnosis, therapy, surgery, home, office, and institutional telephone calls, and consultation services.<sup>69</sup>

The Medicare DRG mechanism aims to maintain complete care and yet stem rising costs by discouraging hospitals from overtreating

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60. *See id.*

61. *See* MACDONALD ET AL., *supra* note 5, § 7.03[2][a].

62. *See id.* § 7.03[3][a][i][E] ("The DRG amount is payable only if there is a discharge . . . . Generally, a patient is considered discharged, which entitles a hospital to a full DRG payment, when the patient is formally released from the hospital (transfer to another hospital [is not] recognized as a discharge), dies in the hospital, or is transferred to another hospital or unit that is excluded from the [Medicare] system.").

63. *See id.* § 7.03[3][a][i][D]. Although this essay posits the question of whether Medicare's DRG system provides a perverse incentive to hospitals to limit the treatment of uninsured patients (and in particular, uninsured chronically ill elderly patients), it does not deny that DRG's have been an effective cost control mechanism for the Medicare program.

64. *See id.* § 7.03[3][a][i][F].

65. *See* Mr. Stark's Race Backward, N.Y. TIMES, Mar. 10, 1994, at A24.

66. *See* Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9331, 100 Stat. 1874, 2018; *see also* MACDONALD ET AL., *supra* note 5, § 7.03[4][b][iii].

67. *See* MACDONALD ET AL., *supra* note 5, § 7.03[4][b][iii].

68. *See id.* § 7.03[3][a][i][A].

69. *See* 42 C.F.R. § 410.20 (1997).

patients.<sup>70</sup> Although at first glance Medicare's Part A or inpatient services appears to be premised on notions of a welfare state, Medicare actually has the effect of excluding from hospital care many persons not covered by Medicare. Because Medicare reimburses hospitals according to the number of complete-care discharges each hospital performs, Medicare-participating hospitals may allocate space to Medicare patients who provide a certain basis for payment. Persons who are covered neither by Medicare nor private insurance may be unable to pay for all hospital services and thus pose financial risks to hospitals. Hospitals are assured payment from Medicare patients. Thus, Part A of the Medicare program arguably encourages hospitals to dump patients without Medicare. At the very least, a hospital has a federally created incentive not to treat those without Medicare coverage.

Part B of the Medicare program poses a similar health-care dilemma to the uninsured. Physicians have an incentive to favor treating patients covered by Medicare over patients who are either uninsured or have private insurance. A doctor is certain to recover fees from the federal government but not certain to receive payment from the uninsured or those privately insured persons whose insurance does not cover certain medical expenses. Part B's relative value scale<sup>71</sup> and overall volume limits annually fix the amount of funding for reimbursement.<sup>72</sup> This mechanism usually results in Medicare paying eighty percent of a physician's fee.<sup>73</sup> However, a physician need not accept Medicare's reimbursement amount and, instead, may

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70. See James E. Bryan, *View from the Hill*, 31 AM. FAM. PHYSICIAN 353, 354 (1985).

71. See Omnibus Reconciliation Act of 1989, Pub. L. No. 101-239, § 6102(a), 103 Stat. 2106, 2169 (1989) (codified at 42 U.S.C. § 1395w-4 (1994)); MACDONALD ET AL., *supra* note 5, § 7.03[4][b][ii]. The relative value scale establishes fees according to:

(1) the "relative value" of the service; (2) a "conversion factor" for the year; and (3) a "geographic adjustment factor" for the service for the fee schedule area. The relative value of a physician's service consists of three components: (1) the "work component;" (2) the "practice-expense component;" and (3) the "malpractice component" . . . . The "conversion factor" for each year is the mechanism whereby the Secretary updates the fee for different categories of services from year to year. . . . The "geographic adjustment factor" reflects the relative costs of the various components of the relative scale for the different fee schedule areas.

*Id.* § 7.03[4][b][iii][A] (footnote omitted).

72. See MACDONALD ET AL., *supra* note 5, § 7.03[4][b][iii][A].

73. See *id.* § 7.03[4][b][i].

bill the patient directly for his or her entire fee and leave the patient to seek Medicare reimbursement for the remainder.<sup>74</sup>

Like Part A, Medicare Part B also encourages physicians, who desire some guarantee of payment, to favor the treatment of elderly patients with Medicare over those without Medicare. Thus, Medicare may contribute to the patient dumping threat facing the 400,000 uninsured elderly Americans. In the future, patient dumping may threaten more elderly persons because Medicare benefits may be reduced by a "graying" federal budget and corresponding cuts in the Medicare program.<sup>75</sup>

## VI. Why Punishment for § 1395 Violations Rarely Occurs: EMTALA's Statutory and Administrative Shortcomings

EMTALA should serve to prevent hospitals' dumping of uninsured and underinsured persons who enter emergency wards of hospitals. Despite EMTALA's provisions, patient dumping continues, and judicial enforcement of EMTALA appears to be waning. Only nine percent of the hospitals cited by the Health Care Financing Administration (HCFA) for violating EMTALA were punished.<sup>76</sup> Between 1986 and 1992, HCFA investigated 268 hospitals for 302 EMTALA violations, but only fined seventeen of these hospitals.<sup>77</sup>

Some commentators have argued that EMTALA is ineffective because it has definitional flaws and enforcement shortcomings.<sup>78</sup> They assert that because the statute's key words are either vaguely defined or not defined at all, courts juggle testimonies of medical experts and extract their own definitions.<sup>79</sup> However, courts have looked to EMTALA's legislative history for help in defining its terms and usually

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74. See *id.* § 7.04[b][ii].

75. See Ronald Bayer & Daniel Callahan, *Medicare Reform: Social and Ethical Perspectives*, 10 J. HEALTH POLITICS, POL'Y & L. 533, 534 (1986); *Health Care Providers*, *supra* note 58 (stating that pivotal members of Congress are proposing Medicare cutbacks of up to \$35 billion over the next five years).

76. See Howard Libit, *Most Hospitals Not Punished for Ousting Patients Who Can't Pay*, L.A. TIMES, May 20, 1993, at A16 (proposing that "the Government is basically telling the hospitals that over 90% of the time, if we catch you, you're not going to be fined").

77. See *Crack Down on Patient Dumping*, CHICAGO SUN-TIMES, May 31, 1993, at 15.

78. See Rosenstein, *supra* note 1, at 278 n.146. See generally Normand F. Pizza, *Patient Transfers—COBRA as Amended*, HEALTH LAW., Summer 1992, at 1.

79. See Rosenstein, *supra* note 1, at 278-89.



broaden EMTALA's reach.<sup>80</sup> Judicial constructions of EMTALA's language are still problematic because courts must interpret the statute's undefined terms and also apply those terms to a particular hospital's practice. For example, in *Baber v. Hospital Corporation of America*,<sup>81</sup> the Fourth Circuit Court of Appeals had to interpret and apply the undefined term "appropriate medical screening examination" to determine whether the hospital violated EMTALA's § 1395dd(e)(1)(A).<sup>82</sup>

In the *Baber* case, Brenda Baber slipped and hit her head on the edge of a table during a brain seizure that occurred while she was waiting to obtain psychiatric care at Raleigh General Hospital's (RGH) emergency room.<sup>83</sup> The injury occurred at about midnight.<sup>84</sup> Although the attending physicians at RGH sutured Ms. Baber's scalp, they continued to focus their attentions on Ms. Baber's psychiatric condition.<sup>85</sup> The doctors at RGH did not perform any examination of Ms. Baber's head injury and postponed analysis until after her transfer to Beckley Appalachian Regional Hospital (BARH), a hospital with a psychiatric ward.<sup>86</sup> Ms. Baber was transferred to BARH and received a CT scan which revealed both a serious head injury and a need to transfer her back to RGH's neurological unit. However, before Ms. Baber could be transferred back to RGH, she died due to an intracerebrovascular rupture caused by her fall.<sup>87</sup>

The Fourth Circuit found that RGH and its physicians did not violate EMTALA because Ms. Baber's transfer to BARH was consistent with the hospital's screening procedures and these procedures were consistent with EMTALA's "medically appropriate screening" requirement.<sup>88</sup> The court stated that because Congress left the term "medically appropriate screening" undefined, it would scrutinize the phrase on a case-by-case basis but not create an a priori definition or reasonableness standard for interpreting the phrase.<sup>89</sup>

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80. See *id.* at 278.

81. 977 F.2d 872 (4th Cir. 1992).

82. See *id.* at 878-85.

83. See *id.* at 875.

84. See *id.*

85. See *id.* at 876.

86. See *id.*

87. See *id.*

88. See *id.* at 879.

89. See *id.* at 878 n.7. The *Baber* court stated, "Some commentators have criticized defining 'appropriate' in terms of the hospital's medical screening standard because hospitals could theoretically avoid liability by providing very cursory and substandard screening to all patients, which might enable the doctor to ignore an emergency medical condition." *Id.* (citations omitted).

The *Baber* case illustrates how EMTALA's statutory faults have hampered its effectiveness. Other courts have criticized EMTALA for being plagued by "weasel words."<sup>90</sup> EMTALA fails to define or only vaguely defines other key statutory terms such as "emergency medical condition,"<sup>91</sup> "to stabilize,"<sup>92</sup> and "reasonable transfers."<sup>93</sup> Thus, these terms become Achilles' heels for EMTALA. EMTALA's flexible statutory language may be the reason why only nine percent of hospitals that HCFA cites for EMTALA violations actually receive punishment.<sup>94</sup>

EMTALA's protections do not sufficiently reassure those uninsured elderly patients who seek hospital care that they will be protected against patient dumping. Although elderly persons who have neither Medicare nor private insurance may have an increased risk of dumping, elderly persons may also be denied adequate emergency medical treatment for other reasons.<sup>95</sup> For example, some unethical physicians discriminate against persons with diseases such as AIDS;<sup>96</sup> and other physicians favor treating patients with simple ailments over patients with complex ailments to reduce their risks of malpractice.<sup>97</sup>

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90. See Rosenstein, *supra* note 1, at 278-79 (stating that the lack of a precise definition of "emergency medical condition" has been one of the main weaknesses of COBRA; the statute interprets the term "emergency medical condition" with more descriptive terms). Section 1395dd(e)(1)(A) states: "[A] medical condition manifesting itself by acute symptoms of sufficient severity . . . such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual . . . in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part." 42 U.S.C. § 1395dd(e)(1)(A) (1994); see also *Cleland v. Bronson Health Care Group*, 917 F.2d 226, 271 (6th Cir. 1990).

91. 42 U.S.C. § 1395dd(e)(1)(A) (1994); see Rosenstein, *supra* note 1, at 280.

92. 42 U.S.C. § 1395dd(c)(1)(A); see Rosenstein, *supra* note 1, at 280.

93. See *Cleland*, 917 F.2d at 271 (stating that Congress was wrong to term the standard for proper screening "appropriate screening"). The *Cleland* court stated, "'appropriate' is one of the most wonderful weasel words in the dictionary and a great aid to the resolution of disputed issues in the drafting of legislation. Who, after all, can be found to stand up for 'inappropriate' treatment or actions of any sort." *Id.*

94. See *Libit*, *supra* note 76, at A16.

95. See *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991); *Delany v. Cade*, 756 F. Supp. 1476, 1485-86 (D. Kan. 1991).

96. See Rebecca Perl, *Law Doesn't Stop Hospitals from Dumping Patients; Practice of Turning Away the Poor and Sick Costs Lives*, ATLANTA J. & CONST., Sept. 29, 1991, at A1 (stating that "doctors simply don't want the hassle of treating a complicated case that they can send elsewhere. Other causes [of patient dumping] include discrimination and the desire to avoid certain illness, such as AIDS").

97. See *Burditt v. United States Dep't of Health & Human Servs.*, 934 F.2d 1362, 1366 (5th Cir. 1991); see also Perl, *supra* note 96, at A1 (stating that COBRA was put in place to thwart doctors picking over high-risk patients).

Congress created EMTALA to curb the number of patients dumped by hospitals and physicians, but, unfortunately, Congress provided EMTALA with a faulty enforcement mechanism.<sup>98</sup> To compound EMTALA's inherent weaknesses, the DHHS rarely enforces EMTALA's provisions against hospitals and physicians.<sup>99</sup> One of EMTALA's most powerful provisions included the DHHS's ability to suspend or terminate the Medicare contract of a hospital found to dump patients.<sup>100</sup> Unfortunately, Congress revoked this power<sup>101</sup> when it realized that suspending a hospital's Medicare contract would disproportionately harm those persons who solely depend on Medicare.<sup>102</sup> Congress did leave intact the DHHS's authority to fine (\$50,000 per incident) physicians who knowingly violate EMTALA and hospitals who negligently violate EMTALA.<sup>103</sup> However, some commentators have suggested that hospitals faced with EMTALA fines continue to dump indigent patients because the DHHS fines are often less than the costs of the medical care they refuse to give.<sup>104</sup>

## VII. Strengthening EMTALA

To strengthen EMTALA's effectiveness, Congress must clarify its definitions and broaden its enforcement mechanisms. The DHHS must also improve its enforcement. Congress should model EMTALA after state and local antidumping programs. For example, in California, a state law penalizes hospitals that receive dumped patients but which fail to report the dumping hospitals.<sup>105</sup> Congress could improve EMTALA enforcement by setting up a similar "failure to report dumping hospitals" penalty for hospitals that accept the dumped patients. Congress should also require hospitals to follow the practice of a Texas public hospital that requires other hospitals to telephone and secure the acceptance of any patient they wish to transfer to the public

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98. See 42 U.S.C. § 1395dd(d) (1994).

99. See Treiger, *supra* note 1, at 1209.

100. See 42 U.S.C. § 1395dd(d)(1).

101. See Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4008, 4207, 104 Stat. 1388-30, 1388-44, 1388-117.

102. See Treiger, *supra* note 1, at 1217 (stating that the punitive measures would mean that the Medicare patients would be denied access to the suspended hospital).

103. See 42 U.S.C. § 1395dd(d)(1); Rosenstein, *supra* note 1, at 267.

104. See Rosenstein, *supra* note 1, at 288 n.208.

105. See *id.* at 289 n.214.

hospital.<sup>106</sup> The hospital monitors the transfers by recording all incoming telephone calls.<sup>107</sup> This hospital's practice has reduced the number of unstable patient transfers and deaths related to patient transfers.<sup>108</sup>

Crucial to the whole issue of EMTALA coverage is whether hospitals should retain both admitting and exclusion powers or relinquish the prerogative to an inept and insensitive federal bureaucracy.<sup>109</sup> Linked inextricably to this concern is the ultimate question of whether EMTALA will, over time, "increase the number of lives saved, or more properly, raise them to a level that justifies the public expenditures."<sup>110</sup>

### VIII. Ethical Obligations to Treat the Elderly

In a society where the elderly are more susceptible to illness and disability than any other age group,<sup>111</sup> the elderly "ought to command special attention in matters pertaining to health care."<sup>112</sup> Clearly, access to hospitals and health care resources is an important concern to the elderly.<sup>113</sup> Many elderly persons have Medicare, or private insurance, or both; but many others have neither. Like society as a whole, the elderly population is composed of persons having various income levels, interests, and needs.<sup>114</sup> Even if society's ethical consensus advocated unlimited access to health care, health-care providers would still be unlikely to provide health care to persons unable to pay for it.<sup>115</sup> Patient dumping and access to health care remain prominent is-

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106. See Elizabeth Hudson, *Texas Leads Fight to Halt "Patient Dumping" by Private Hospitals*, WASH. POST, Mar. 20, 1988, at A4.

107. See *id.*

108. See *id.*

109. See EPSTEIN, *supra* note 25, at 104-05.

110. *Id.*

111. See Arthur Caplan, *Ethical Issues and the Care of the Elderly*, in IMPROVING THE HEALTH OF OLDER PEOPLE: A WORLD VIEW 675, 675 (Robert Kane et al. eds., 1990).

112. *Id.* at 679.

113. See generally Stephen Crystal, *Health Economics, Old-Age Politics, and the Catastrophic Medicare Debate*, in HEALTH CARE OF THE AGED: NEEDS, POLICIES, AND SERVICES 21, 27 (Abraham Monk ed., 1990); see also Benjamin et al., *supra* note 5, at 1746-48; George P. Smith, II, *Our Hearts Were Once Young and Gay: Health Care Rationing and the Elderly*, 8 U. FLA. J.L. & PUB. POL'Y 1, 9-10 (1996).

114. See GEORGE P. SMITH, II, *LEGAL AND HEALTHCARE ETHICS FOR THE ELDERLY* ch. 1 (1996).

115. See generally Catherine K. Cassel, *Health Care for the Elderly: Meeting the Challenges*, in *LEGAL AND ETHICAL ASPECTS OF HEALTH CARE FOR THE ELDERLY* 3, 5 (Marshall B. Kapp et al. eds., 1985).

sues for the elderly because elderly persons are typically not economically productive.<sup>116</sup> The elderly population is disproportionately impoverished and economically disadvantaged.<sup>117</sup>

Some physicians and patients have adopted a consumerist image of the doctor as an independent contractor who sells his knowledge and skill to patients who demand care.<sup>118</sup> This contractual model of medical care<sup>119</sup> overlooks the moral and ethical considerations inherent in an emergency patient-physician situation and belittles the idea that a doctor should make "a correct technological (medical) choice consonant with a patient's needs and desires."<sup>120</sup> In addition, for-profit hospitals face an inelastic demand for services,<sup>121</sup> which ultimately contributes to their being unresponsive to altruistic social winds.

Americans should be particularly offended by hospitals' dumping elderly patients because the elderly are characterized as recruited to poverty after relatively decent working lives.<sup>122</sup> An elderly person's "social worth" and corresponding health-care resource allocation should not be determined by his or her ability to be a rational consumer<sup>123</sup> who has saved money to purchase healthful elderly

116. See Caplan, *supra* note 111, at 668-73.

117. See *id.* at 675.

118. See Daniel A. Moros et al., *Chronic Illness and the Physician-Patient Relationship: A Response to the Hasting's Centers "Ethical Challenges of Chronic Illness?"*, 16 J. MED. & PHIL. 161, 170 (1991). See generally Edmund D. Pellegrino, *Rationing Health Care: The Ethics of Medical Gatekeeping*, 2 J. CONTEMP. HEALTH L. & POL'Y 23, 28 (1986).

119. See Bruce Jennings et al., *Ethical Challenges of Chronic Illness*, HASTINGS CTR. REP., Feb.-Mar. 1988, at 51, 58. The "contractual model" is described as a scenario in which "the patient is a rational, self-interested subject who, threatened by illness, enters into a contractual agreement with a physician (or other health care provider) and temporarily submits himself to medical authority in order to combat the illness." *Id.*

120. Moros et al., *supra* note 118, at 170 (citations omitted). The "contractual model" of medical care, as applied in the dumping context means that doctors who avoid entering "contracts" with patients would not be obliged to render care to patients unable to purchase their services. See *id.*

121. See generally DAVE LINDROFF, *MARKETPLACE MEDICINE: THE RISE OF THE FOR-PROFIT HOSPITAL CHAINS* chs. 1, 2, 5 & 8 (1992).

122. See Bayer & Callahan, *supra* note 75, at 536 (citing Daniel Callahan, *What Do Children Owe Elderly Parents?*, 15 HASTINGS CTR. REP., Apr. 1985, at 32, 32-37 (arguing that an elderly person's value to society is established by that person's contribution to society throughout his or her healthy years)); see also Caplan, *supra* note 111, at 668.

123. See Caplan, *supra* note 111, at 668 ("Inspired by the work of Philosopher John Rawls, many scholars argue that each one of us, were we ignorant of our station in life and our medical needs, would adopt a strategy of investing our health care dollars so as to maximize our chances of reaching old age . . . [and]

years. Health care should instead be allocated by considering the fairness<sup>124</sup> to the persons who need health care the most—sick and indigent elderly persons.

One “ideal-theory”<sup>125</sup> ethic to apply to the patient-dumping dilemma would be to adapt philosopher John Rawls’s “justice as fairness” theory to health care. Although applying this theory to health care may lead to varied results, health-care allocations for the elderly made from Rawls’s “original position” allocates more to the indigent elders at low or no cost because indigent elderly persons are found to have higher incidences of illness and health problems.<sup>126</sup> More affluent elderly persons, who can pay for medical care but who still have age-related illnesses such as chronic disease and disability,<sup>127</sup> would assume a greater financial burden for their health-care costs. Admittedly, the current federal health-care budget may reflect this model. Yet, to assure medical care for all elderly persons, especially the 400,000 elderly persons not covered by Medicare, society must devote more than money to health-care allocation and the patient-dumping syndrome. Contrary to the pleas of major health-care providers, providers have a greater obligation to contribute to uninsured individuals’ health care than normal taxpayers.<sup>128</sup> American health-care policy must reflect a commitment to the fair and humane treatment of indigent elderly persons who require emergency medical care.

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would want to live in a society that gave priority to the health care need of those in early or mid-life.”). This essay argues that, contrary to Caplan’s interpretation of the “justice as fairness” approach to health care, because health-care needs are usually most urgent later in life, Rawls’s concept of “original position” would allocate the largest part of a society’s health-care resources to those most needy during life’s later stations.

124. See Frank I. Michelman, *Constitutional Welfare Rights and a Theory of Justice*, in READING RAWLS: CRITICAL STUDIES ON RAWLS’S “A THEORY OF JUSTICE” 319, 320 (Norman Daniels ed., 1974) (stating that an “ideal theory” is the “selection, defense, and working out of principles of justice for and in the supposed context of a society”).

125. See *id.*

126. See Cassel, *supra* note 115, at 6.

127. See LINDROFF, *supra* note 121, at 196 (stating that a “certificate of need” permit filled out by Humana Hospital Corporation states that due to public policy and Humana’s taxpayer status, Humana hospitals “do not have the responsibility to provide care for the indigent except in emergencies and where [federal] reimbursement . . . is provided”).

128. See generally Caplan, *supra* note 111, at 677.

## IX. Conclusion

Society should follow a "fairness" ethic which respects the wisdom,<sup>129</sup> self-respect,<sup>130</sup> and achievement of elderly persons when it allows health-care providers to operate and profit in any community.<sup>131</sup> Respect for the dignity and autonomy of elderly patients, as well as the motive to help indigent elderly patients, must replace the profit motive held by both hospitals and doctors as the lodestar for American health-care delivery. In order to reach this goal, society should restrict medical licenses to health-care providers who will care for indigent elderly persons as a condition of doing business with the rest of society. Only then might the incidence of dumping elderly patients be significantly diminished.

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129. See JOHN RAWLS, A THEORY OF JUSTICE 440 (1971).

We may define self-respect . . . as having two aspects. First of all, . . . it includes a person's sense of his own value, his secure conviction that his good, his plan of life, is worth carrying out. And second, self-respect implies a confidence in one's ability, so far as it is within one's power to fulfill one's intentions. When we feel that our plans are of little value, we cannot pursue them with pleasure or take delight in their execution . . . . It is clear then why self-respect is a primary good.

*Id.* See generally Michelman, *supra* note 124, at 340 (stating that Rawls's notion of self-respect is "a moral entitlement . . . capable of implying some conception of a minimum insurance-rights package").

130. See SMITH, *supra* note 114, ch. 1.

131. See *id.* at chs. 2, 12.