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INDIGENT ACCESS TO EMERGENCY MEDICAL CARE: THE POOR BLEED RED, BUT THE HOSPITALS WANT GREEN

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INDIGENT ACCESS TO EMERGENCY CARE: THE POOR BLEED RED, BUT THE HOSPITALS WANT GREEN

I. INTRODUCTION

The sudden and urgent need to acquire emergency medical care is a painful and traumatic experience. For an increasingly large segment of the population in the United States, however, the physical pain and mental anguish of a medical emergency may be transcended by the fear that access to care will be denied or limited for economic reasons. For example, a man with a knife wedged against his spine was transferred from an emergency room because he did not have insurance or a one-thousand dollar cash advance. Similarly, a mother seeking emergency care for her infant suffering from spinal meningitis was turned away from the hospital because she lacked insurance or the fifty-four dollar emergency room fee. Also, when neurosurgeons in a private hospital refused to attend to an indigent man suffering from serious head injuries the patient lapsed into a coma prior to transfer to a public facility and died without regaining consciousness. Commonly referred to as patient dumping, the denial of medical service to a patient or the transfer of patients from one hospital capable of providing care to another for economic reasons is a social and legal problem that confronts our society today.

The patient dumping problem is the product of a unique combination of past and present day factors. In retrospect, it is clear

2. Id. at 1186 (citing Annas, Your Money or Your Life: "Dumping" Uninsured Patients from Hospital Emergency Wards, 76 AM. J. PUB. HEALTH 74, 74 (1986)).
3. Id.
4. Note, Cobra's Fangs, supra note 1, at 1186 (citing Himmelstein, Woolhandler, Harly, Bader, Silber, Backer & Jones, Patient Transfers: Medical Practice as Social Triage, 74 AM. J. PUB. HEALTH 494, 495 (1984)).
6. See Note, Cobra's Fangs, supra note 1, at 1186-87. Most evidence points to the conclusion that the flow of inter-hospital transfers for economic reasons is from for-profit facilities to public, non-profit facilities. Id.
7. Id. at 1189-96.
that the common law "no duty to treat" rule\(^8\) and the doctrine of charitable immunity\(^9\) were significant factors that operated to form the foundation of the problem. Present day factors that add to the growth and severity of patient dumping include increases in the number of unemployed or otherwise medically indigent persons;\(^10\) increased Medicaid and Medicare budget cuts in recent years;\(^11\) the dramatic, spiraling costs of health care;\(^12\) a fundamental shift in the health care industry from nonprofit to for-profit;\(^13\) and the general ineffectiveness of both federal and state programs designed to improve access to health care for the medically indigent.\(^14\)

Section I of this Note will discuss the foundation of patient dumping - the common law "no duty to treat" rule and the shield of charitable immunity. Section II will discuss state judicial attempts at circumventing the harsh results of strict interpretation and application of the common law. Section III will discuss state legislative attempts to curb patient dumping; and Section IV will discuss the federal government's past and present attempts to curb patient dumping and increase access to health care.

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10. Note, Cobra's Fangs, supra note 1, at 1193. For instance, the number of people under the age of 65 who had no health insurance increased from 29 million in 1979 to 35 million in 1984. Id. (citing Dowell, Hill-Burton: The Unfulfilled Promise, 12 J. HEALTH POL. POL'Y & L. 153 (1987)). "When those with inadequate insurance coverage are added to the number of uninsured, the total number of Americans in danger of being dumped exceeds 50 million." Id. at 1193, n.55 (citing Dowd, U.S. Health Care Faulted in Senate, N.Y. Times, Jan. 13, 1987, at A1, col. 3).
11. McClurg, supra note 8, at 180.
12. See generally Note, Cobra's Fangs, supra note 1, at 1192-93. Illustrative of the general rise in the cost of health care are Medicaid statistics which show a coverage rate of 40% in 1980, versus a Medicaid coverage rate of 70% in 1965. Id. at 1194.
13. See generally id. at 1193; "Private, for-profit hospitals have prospered in the competitive era," with one large corporation earning over $297 million during 1984. McClurg, supra note 8, at 181 (citing Kraft, Hospitals for Profit: What Price Care, L.A. Times, Mar. 31, 1985, at 1, col. 4). Contrasting this profit margin with the $7.4 billion in uncompensated health care spent in 1985 illustrates the obvious burden being placed on public, not for profit institutions. McClurg, supra note 8, at 182.
14. See generally Note, Cobra's Fangs, supra note 1, at 1193; Ansell & Schiff, supra note 5, at 1500; McClurg, supra note 8, at 182-83.
II. THE COMMON LAW AND PATIENT DUMPING

The common law imposes no legal duty upon either hospitals or physicians to treat patients seeking medical care. Consequently, prior to the middle of the twentieth century the medical community had virtually no legal incentive to render treatment to those who were unable to pay. The sole exception to the harsh results which flowed from application of the common law "no duty to treat" rule revolved around the fundamental distinction between misfeasance and nonfeasance. Nonfeasance, or the refusal to provide treatment, could never lead to liability. Misfeasance, or active misconduct after initiation of treatment that contributed to the injuries of the plaintiff, could potentially lead to negligence liability for either hospital or doctor. The misfeasance exception to the "no duty to treat" rule was applied strictly by courts. Illustrative of this is Birmingham Hospital v. Crews, where the plaintiff brought his daughter, suffering from diphtheria, to the emergency room of the defendant hospital. The emergency room staff administered some medical care, but refused to admit the child or continue treatment, because they feared contagion. The child died soon thereafter, and a negligence claim based on misfeasance was brought. Applying the misfeasance rule strictly, the court denied recovery and created a distinction between emergency care and in-patient care. The court held that "treatment in an emergency" and "full hospital service" were fundamentally different in terms of duty owed, and liability for misfeasance could attach only in the case of active misconduct during full

15. Rothenberg, supra note 9, at 25.
16. Id.
17. Id.; see also McClurg, supra note 8, at 183; W. Keeton, D. Dobbs, R. Keeton & D. Owens, The Law Of Torts 56, 373-75 (1984). "Generally, there is no duty to assist one in peril where the actor has not created the risk." Id.
18. Rothenberg, supra note 9, at 25.
19. Id.
20. See generally McClurg, supra note 8, at 182-85.
22. Id. at 399, 157 So. at 224.
23. Id. at 400, 157 So. at 225 (it is only fair to note that the emergency room staff in this case, in refusing to admit the child, was following standard hospital procedure).
24. Id., 157 So. at 225.
25. Id. at 398, 157 So. at 224.
hospital service.\textsuperscript{26} Strict interpretation of the "no duty to treat" rule and its own implicit exception, as seen in the previous case, created a significant barrier to effective prosecution of hospitals and physicians by plaintiffs who were denied or received limited medical assistance.\textsuperscript{27} The "no duty to treat" rule was not, however, a hospital's only means of escaping liability for nonfeasance or even misfeasance.

Early hospitals in the United States operated as charitable institutions,\textsuperscript{28} financially dependant to a large degree on philanthropic donations.\textsuperscript{29} As a result, courts were hesitant to pierce the veil of protection provided by the "no duty to treat" rule without simultaneously dismantling the firmly entrenched shield of charitable immunity.\textsuperscript{30} Until the middle of the twentieth century, the doctrine of charitable immunity was viable, widely accepted, and routinely applied, as evidenced by its adoption in more than forty states.\textsuperscript{31} Application of the shield of charitable immunity can be seen in *McDonald v. Massachusetts General Hospital*.\textsuperscript{32} Relying on *Holliday v. St. Leonard's*,\textsuperscript{33} recovery to a plaintiff whose leg was found to have been negligently set by a hospital employee was denied.\textsuperscript{34} The denial was based solely on the shield of charitable immunity, which states that hospitals relying on charitable donations cannot be required to use those funds for the payment of tort liabilities.

\textsuperscript{26} *Id.* at 400, 157 So. at 225.

\textsuperscript{27} See Rothenberg, *supra* note 9, at 25.


\textsuperscript{29} *Id.*

\textsuperscript{30} Rothenberg, *supra* note 9, at 26-29. "Charitable immunity is an exception to the general rule that one is liable for one's own negligence . . . ." *Id.* at 27 (emphasis in original).

\textsuperscript{31} *Id.* (citing Note, *The Quality of Mercy: "Charitable Torts" and Their Continuing Immunity*, 100 HARV. L. REV. 1382, 1384 (1987)).

\textsuperscript{32} 120 Mass. 432 (1876).


\textsuperscript{34} *McDonald*, 120 Mass. at 432.
The doctrine, while widely accepted, was also widely criticized. The doctrine came under staunch attack, and by the late 1960's most state courts had abrogated the doctrine through decision and state legislatures had done the same by statute.

III. STATE COURT ATTEMPTS TO COMBAT PATIENT DUMPING

As detailed above, the "no duty to treat" rule, combined in some cases with the shield of charitable immunity, created formidable if not impregnable barriers to plaintiffs seeking recovery based on hospital or physician negligence. Generally dissatisfied with the results that followed strict application of the "no duty to treat" rule, state courts began to apply judicially created theories designed to mitigate the harshness of the common law in an attempt to render "justice." While case law details these judicial attempts at mitigation, it should be noted that state courts did not simply disregard the common law; they consciously made attempts to circumvent it. Judicial creativity was the key ingredient in this mitigation process, because of the continued acceptance and recognition of the validity of the "no duty to treat" rule.

Following the dismantling of the shield of charitable immunity, early efforts at striking a balance between strict application of the "no duty to treat" rule and judicial recognition of "justice" focused on a hospital's duty to act non-negligently after undertaking the care or treatment of a patient. Misfeasance, as found in section 323 of the Restatement (Second) of Torts, provides that, "one who undertakes, either gratuitously or for consideration, to render services to another, is subject to liability for harm resulting from a failure to exercise reasonable care in their performance."

35. Id. at 436 (citing Holliday v. St. Leonards, 142 Eng. Rep. 769 (1861)).
36. Rothenberg, supra note 9, at 28.
37. Id.
39. See generally Rothenberg, supra note 9, at 32.
40. See generally Note, Cobra's Fangs, supra note 1, at 1196-97.
41. McClurg, supra note 8, at 185.
42. Restatement (Second) of Torts § 323 (1965).
care, if such failure either increases the risk of harm or harm is suffered because the other relied upon the undertaking.”43 Always recognized as a potential source for finding physician or hospital liability,44 the application of the misfeasance rule was expanded to a significantly more liberal level of interpretation during the early 1960’s.45

Application of this heightened level of misfeasance liability is best illustrated by O’Neill v. Montefiore Hospital.46 In O’Neill, the decedent, experiencing a heart attack, went to the defendant hospital’s emergency room.47 Decedent was refused treatment because the hospital did not participate in his insurance plan.48 Prior to leaving the hospital however, an emergency room nurse phoned the decedent’s doctor in an attempt to make alternate arrangements for care.49 Expressing clear dissatisfaction with the "no duty to treat" rule, the court sidestepped the issue of a hospital’s duty, or lack thereof, and focused on the misfeasance exception to the common law.50 Examining the emergency room nurse’s action, the appellate division reversed the dismissal of plaintiff’s action and held that plaintiff’s proof was prima facie sufficient to permit a jury to make the reasonable inference that the nurse’s phone call constituted an attempt to administer medical treatment.51

Although a significant step away from strict interpretation and application of the "no duty" rule, the O’Neill alternative theory is plagued by interpretation and application problems. Issues that must be resolved prior to use by counsel are: when does a hospital begin to render aid, how much does a hospital have to do before being held to have administered care, and which hospital personnel, ranging from doctors to orderlies, must be involved to trigger liability.52 To date, these issues remain unanswered.

43. Id.
44. See supra notes 17-27 and accompanying text.
47. Id. at 134, 202 N.Y.S.2d at 438.
49. Id., 202 N.Y.S.2d at 438.
52. See generally Rothenberg, supra note 9, at 38.
Wilmington General Hospital v. Manlove\textsuperscript{53} involves another judicially created theory. The parents of a child stricken with what was later diagnosed as bronchial pneumonia brought a wrongful death action against Wilmington General, alleging that the hospital was negligent in its failure to provide emergency care.\textsuperscript{54} The hospital denied any such liability and stated that the nurse who refused to admit the patient was properly following hospital procedure.\textsuperscript{55} "Procedure" stated that in the event that a patient is under the care of another physician, the hospital will not treat such patient.\textsuperscript{56} The Delaware Superior Court, dissatisfied with the harsh result that would follow strict application of the "no duty to treat" rule and precedent, fashioned an exception.\textsuperscript{57} The "quasi-public institution" exception to the common law was based on state statutory benefits received by the Delaware hospital.\textsuperscript{58} These benefits included tax exemptions, public funding and corporate charters.\textsuperscript{59} In return for these benefits, all hospitals, including private institutions, would have been required by the court, "at all times to render reasonably needed aid in those instances where an emergency involving death or serious bodily impairment might reasonably be said to exist."\textsuperscript{60} On appeal, the Delaware Supreme Court rejected the "quasi-public institution" exception,\textsuperscript{61} but affirmed the order denying the defendant hospital's motion for summary judgment by creating its own alternate theory.\textsuperscript{62}

The Delaware Supreme Court began its analysis of \textit{Manlove} by reiterating the common law rule that a private hospital does not owe the public a duty to treat every patient appearing at the emergency room.\textsuperscript{63} Further, the appellate court made very clear that the receipt of public funds or exemptions from state taxation does not create a duty to treat

\textsuperscript{54} \textit{Id.} at 17, 174 A.2d at 136.
\textsuperscript{55} \textit{Id.} at 17-18, 174 A.2d at 136-37.
\textsuperscript{56} \textit{Id.} at 18, 174 A.2d at 137.
\textsuperscript{58} \textit{Id.} at 343, 169 A.2d at 21.
\textsuperscript{59} \textit{Id.} at 343, 169 A.2d at 21.
\textsuperscript{60} \textit{Id.} at 345, 169 A.2d at 22.
\textsuperscript{61} \textit{Id.} at 343, 169 A.2d at 21.
\textsuperscript{63} \textit{Id.} at 19, 174 A.2d at 137.
where one previously did not exist. Unable to find adequate legal support to uphold the "quasi-public institution" theory, yet still dissatisfied with the result that would result from strict application of the "no duty to treat" rule, the state supreme court developed a reliance based theory to justify holding the hospital liable. The court found that if a patient relies on a well established hospital custom of rendering aid in similar emergency situations, subsequent denial of treatment will have the same practical effect as that of the hospital denying treatment in the face of a legal duty. Because the plaintiff in Manlove had relied, ultimately to his detriment, on what the court interpreted as a carefully cultivated reputation developed by the defendant hospital of rendering aid in similar situations, the hospital may be held liable and the case was remanded for further proceedings. The theory constructed by the appellate court in Manlove is clearly derived from the reliance theory as it appears in section 323 of the Restatement (Second) of Torts.

One who undertakes, gratuitously or for consideration, to render service to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if the harm is suffered because of the other's reliance upon the undertaking.

In order to be held liable under the Manlove theory, it is necessary that: "(1) The hospital maintain an emergency room; (2) an 'unmistakable emergency' exists; (3) a well-established custom to render care in such circumstances be found; and (4) the injured party relied on that custom." A closer look at the test implicit in the

64. Id. at 19, 174 A.2d at 137.
65. Id. at 25, 174 A.2d at 140. See also Enfield and Sklar, Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem, 13 A.J.L.MED. 561, 568-69 (1988).
66. Manlove, 54 Del. at 25, 174 A.2d at 140.
67. Id. at 27, 174 A.2d at 141. See also Rothenberg, supra note 10, at 36.
68. Rothenberg, supra note 9, at 36.
69. RESTATEMENT (SECOND) OF TORTS, § 323.
70. Rothenberg, supra note 9, at 36 (emphasis in original)(citations omitted).
Manlove theory reveals the application pitfalls in all but the first prong.\textsuperscript{71} As to what constitutes an "unnecessary emergency," no definition and no working criteria can be found in Manlove.\textsuperscript{72} Further, the level of proof necessary to establish whether the hospital is perceived by the community as a reliable source of emergency care is also unclear and undefined.\textsuperscript{73} Finally, proving that a plaintiff actually relied on this custom falls prey to the difficulties described above as well as countless other proof problems.\textsuperscript{74} While problems of application hamper this judicial attempt at circumventing the common law, the Manlove holding is significant in that it marked the "first time that a court went beyond the constraints of both the traditional tort misfeasance-nonfeasance theories and the requirement of a hospital-patient relationship to find a new basis of liability."\textsuperscript{75}

Continued attempts at developing a workable alternative to the common law "no duty to treat" rule led the Arizona Supreme Court to take another step toward establishing a legal duty for hospitals to provide care. In Guerrero v. Copper Queen Hospital,\textsuperscript{76} the Manlove theory of detrimental reliance was rejected, and a new theory, similar to the "quasi-public institution" theory espoused by the lower court in Manlove, was established.\textsuperscript{77}

The plaintiffs in Guerrero were denied treatment at the defendant hospital and were forced to travel to another hospital,\textsuperscript{78} prolonging both suffering and recovery.\textsuperscript{79} The plaintiff's allegations of detrimental reliance were based heavily on the Manlove theory,\textsuperscript{80} while the hospital sought a reaffirmation of the "no duty to treat" rule.\textsuperscript{81} Dissatisfied with both rationales, the Arizona court held that "[t]he character of private hospitals in Arizona has been changed by statute and regulations" and that

\begin{itemize}
\item \textsuperscript{71} Id.
\item \textsuperscript{72} Id.
\item \textsuperscript{73} Id. at 36-37.
\item \textsuperscript{74} Id.
\item \textsuperscript{75} Id. at 36.
\item \textsuperscript{76} 112 Ariz. 104, 537 P.2d 1329 (1975).
\item \textsuperscript{77} Id. at 107, 537 P.2d at 1332. See also Rothenberg, supra note 9, at 50-51.
\item \textsuperscript{79} Id. at 611, 529 P.2d at 1205.
\item \textsuperscript{80} Guerrero, 112 Ariz. at 104, 537 P.2d at 1330.
\item \textsuperscript{81} Id. at 105-06, 537 P.2d at 1330-31.
\end{itemize}
Arizona public policy now required a general hospital to maintain facilities for the provision of emergency care, care that may not be denied absent cause. The Arizona theory was based on the presence of state regulatory, licensing, and operating standards. The court made clear that the rationale for imposing a duty to render emergency care was a logical judicial extension of the legislature's pervasive regulation of hospitals. The loophole present in the Guerrero holding, that a hospital could legally deny treatment "with cause," was effectively limited in a later case, Thompson v. Sun City Community Hospital.

In Thompson, the court set out the only three defenses available to a hospital charged with failure to render emergency care: (1) that "the hospital is not obligated (or capable) under its state license to provide the necessary emergency care, (2) there is a valid medical cause to refuse emergency care, [and] (3) there is no true emergency requiring care and thus no emergency care which is medically indicated." The Arizona theory is more workable on an ad hoc basis than either Manlove theory, as evidenced by its successful application in numerous cases. The impact of this approach on patient dumping cases outside Arizona, however, has been negligible. The most common explanation for the limited impact of the Arizona theory is that "[i]t required courts to make the leap from statutes and regulations designating standards for hospital licensing - to a duty treat any and all persons in need of emergency care, based on broad public policy concerns." Theories developed by state courts designed to circumvent the "no duty to treat" rule were generally plagued by application problems. The unclear reasoning and lack of definitions of key terms led to unsuccessful use of these alternate theories both within the particular jurisdictions

82. Id. at 106, 537 P.2d at 1331.
83. Id. at 106, 537 P.2d at 1331.
84. Id. at 106, 537 P.2d at 1331.
86. Rothenberg, supra note 9, at 52.
87. Thompson, 141 Ariz. at 603, 688 P.2d at 611 (emphasis added).
89. Rothenberg, supra note 9, at 53 ("[t]he reason is not completely clear, but may be due to the fact that Guerrero depended on Arizona statutory policy with little precedential value elsewhere").
90. Id. at 53 ("[m]orally, the connection is desirable, but legally, it required the creation of a private cause of action implied from state licensing statutes."). Id.
involved and outside those jurisdictions. While the application and definition problems are generally viewed as primarily responsible for the negligible impact of these mitigation attempts, it is apparent that many state courts presume that rectifying the patient dumping problem by creating a legal duty to treat is a legislative task, beyond the parameters of judicial power.91

IV. STATE LEGISLATIVE ATTEMPTS TO COMBATTING PATIENT DUMPING

In spite of state judicial attempts to alleviate the harsh results of patient dumping created in large part by the aforementioned "no duty to treat" rule, the number of patients denied access to emergency medial care for economic reasons continus to increase. In 1987, experts estimated that over a quarter of a million patients were transferred for purely economic reasons.92 These increases have spawned several studies in recent years. One such study concluded that in a poll of transferred patients, 97% either lacked insurance or were Medicaid/Medicare subscribers.93 A similar study of hospital transfers found that 95% of the trauma patients transferred during a two year period had no insurance coverage,94 and a third such study found that 63% of persons transferred lacked adequate health insurance.95

Despite these statistics, representatives of the private health care sector contend that transfers for economic reasons occur only in isolated areas and on a limited scale.96 The general public, due primarily to lack

91. See generally Note, Cobra's Fangs, supra note 1, at 1197; Rothenberg, supra note 9, at 53.


93. See Note, Cobra Fang's, supra note 1, at 1189-90 (quoting Schiff, Ansell, Schlosser, Idris, Morrison & Whitman, Transfers to a Public Hospital - A Prospective Study of 467 Patients, 314 NEW ENG. J. MED. 552, 556 (1986)).

94. See McClurg, supra note 8, at 177 (citing Reed, Cawley & Anderson, Special Report: The Effect of a Public Hospital's Transfer Policy on Patient Care, 315 NEW ENG. J. MED. 1428, 1431 (1986)).

95. Id. (citing Himmelstein, Woolhandler, Harnly, Bader, Silber, Backer & Jones, Patient Transfers: Medical Practice as Social Triage, 74 AM. J. PUB. HEALTH 494, 495 (1984)).

96. Ansell & Schiff, supra note 5, at 1500 (these representatives "contend that case reports of patient dumping are anecdotal and represent rare isolated incidents.").
of information, is similarly misdirected in its understanding of the magnitude of the patient dumping problem. Nevertheless, despite general ignorance of the severity of this problem, over one-half of the states have presently enacted statutes designed to ensure indigent access to emergency medical care and to reduce the number of patients transferred for economic reasons.  

Nevertheless, few of these statutes are adequately written so as to fulfill their objectives. This is best understood by comparing two general categories of patient dumping legislation illustrated by the California and New York statutes. California's statute exemplifies the "cutting edge" of state patient dumping legislation, while New York's is representative of those that fail to achieve what is intended.

Effective January 12, 1988, California Health and Safety Code section 1317 represents an example of the most comprehensive state legislation aimed at patient dumping to date. The statute prescribes indigent access to emergency medical care, addresses patient dumping, and sets up a scheme for the reimbursement of uncompensated care. In California, any hospital with an emergency room is required to provide screening and treatment if necessary "to relieve or eliminate the emergency medical condition." Hospitals may not inquire about the patient's insurance coverage or ability to pay prior to the provision of proper treatment. Furthermore, they cannot inquire into the patient's "race, citizenship, ethnicity, religion, national origin, age, sex, preexisting medical condition or physical or mental

97. See generally Dowell, Indigent Access to Hospital Emergency Room Service, 18 CLEARINGHOUSE REV. 483, 493-99 (1984)(state-by-state summary of emergency care legislation and/or case law); McClurg, supra note 8, at 190 (state statutory remedies for patients unlawfully dumped).
100. Compare CAL. HEALTH & SAFETY CODE § 1317-1317.2(a) def. of emergency med. condition with lack of definition in N.Y. PUB. HEALTH LAW § 2805-b.
101. See CAL. HEALTH & SAFETY CODE § 1317 (a), (d)(a) "Emergency services and care shall be provided to any person requesting the services or care, or for whom services or care is requested, for any health facility . . . that maintains . . . an emergency department to provide emergency services to the public when the health facility has appropriate facilities and qualified personnel." Id.
102. See id. at § 1317(a)-(d).
103. See generally id. at § 1797.98(a).
104. Id. at § 1317.1(a)
105. Id. at § 1317(d).
handicap." The statute makes clear that these restrictions and regulations apply to both physicians and hospitals.\footnote{107}

In the event that the hospital denies treatment, the hospital must give written and oral notice to the patient or patient's family.\footnote{108} The notice must include a clear statement of the patient's right to receive emergency care.\footnote{109} Furthermore, notice including a similar statement of patient's rights must be posted in all emergency rooms.\footnote{110} However, a hospital may still deny treatment if reasonable care was used in determining either that the patient was not suffering an emergency or that the hospital was not equipped to treat the problem at hand.\footnote{111} Strict procedures must be followed by hospitals making or receiving transfers, and detailed records of these transfers must be kept on file with the state.\footnote{112} In the event that a hospital properly decides to transfer a patient, they must make arrangements for the receiving hospital to provide proper care.\footnote{113}

Most significantly, the California statute erects a system of inner checks and balances to safeguard implementation of regulations. Hospital personnel who learn of violations must report them to the California Department of Health Services.\footnote{114} Local emergency service agents may also refer violations to the district attorney for prosecution.\footnote{115} In conjunction with these safeguards, a detailed scheme of civil fines (applicable to both hospitals and physicians), damages, injunctive relief, and attorneys fees for patients and hospitals wronged by violations is available.\footnote{116} And finally, the California statute details a system designed to allocate certain percentages of funds taken from traffic fines in order to compensate doctors and hospitals who provide care to the indigent.\footnote{117}

\footnote{106. Id. at § 1317(b).}
\footnote{107. See generally id. at § 1317.6(c). See also supra, note 103.}
\footnote{108. Id. at § 1317.3(d).}
\footnote{109. Id.}
\footnote{110. Id.}
\footnote{111. Id. at § 1317(c).}
\footnote{112. See §§ 1317.2-4.}
\footnote{113. Id. at § 1317.2(a)-(c).}
\footnote{114. Id. at § 1317.4.}
\footnote{115. Id. at § 1317.5(a)-(b).}
\footnote{116. Id. at § 1317.6.}
\footnote{117. Id. at § 1797.98(a).}
While the New York statute is not nearly as innovative as the California law, it is typical of state legislative attempts nationwide. New York Public Health Law section 2805-b(1) provides that "[e]very general hospital shall admit any person who is in need of immediate hospitalization . . . and shall not before admission question the patient . . . concerning insurance, credit, or payment of charges." Further, "[n]o general hospital shall transfer any patient to another hospital or health care facility on the grounds that the patient is unable to pay or guarantee payment for services rendered." Similarly, general hospitals that maintain facilities providing out-patient emergency care must provide care to any person who requires it.

On its face, the New York statute is similar to the California legislation. However, any similarity ends there, for the New York statute is grossly inadequate in many areas; definitions of vital terms are either completely non-existent or imprecise. Further, the New York statute lacks notice requirements, a crucial element in patient dumping legislation, because most people are unaware of their rights to medical care. Similarly, and in contrast to the California statute, New York does not provide adequate penalty provisions. The maximum fine for hospitals found to have transferred patients in contravention of the statute is one thousand dollars. Large private corporate hospital organizations will not be deterred by such an insignificant fine. Finally, the New York statute does not provide a civil damage remedy or a private right of action for those harmed by physicians or hospitals.

119. See generally McClurg, supra note 8, at 190-97 ("[these] statutes may supplement or largely supplant the common law principles discussed above").
121. Id.
122. Id.
123. Id. at §§ 2805-b(1) to (5).
124. For instance, the operative term "emergency" is not defined in the New York statute. Compare id. at § 2805 with CA. HEALTH & SAFETY CODE §§ 1317.2, 1317.3, 1317.4 (West Supp. 1988).
125. Compare N.Y. PUB. HEALTH LAW § 2805-b with CA. HEALTH & SAFETY CODE § 1317.3 (d); see also Ansell & Schiff, supra note 5, at 1501.
126. Compare NEW YORK PUB. HEALTH LAW § 2805-b(2)(b) with CA. HEALTH & SAFETY CODE § 1317.4 (proceedings to impose fine) and § 1317.6 (penalties).
127. See NEW YORK PUB. HEALTH LAW § 2805-b(2)(b).
128. Compare NEW YORK PUB. HEALTH LAW § 2805-b(2)(b) with CA. HEALTH & SAFETY CODE § 1317.6(j).
V. FEDERAL ATTEMPTS TO CURB PATIENT DUMPING

A. The Hill-Burton Act

During the first few years of the twentieth century, doctors began treating patients in newly constructed hospitals rather than in their homes. Funding for these hospitals came primarily from philanthropic organizations. Physician and hospital fees were generally paid in full by the patient following treatment. During the Depression, the infrastructure of the typical hospital began to crumble. Large donations from the wealthy all but vanished, as did cash payment for treatment. Unable to cope with the financial pressures, many hospitals were forced to close their doors. By the end of World War II, the United States was faced with a crisis - severe shortages of hospital beds combined with a health care delivery system underdeveloped as a result of a decade of economic depression.

With passage of the Hospital Survey and Construction Act of 1946, generally referred to as the Hill-Burton Act, the face of the hospital system in the United States changed. The federal government began its entry into what had previously been a wholly private industry. Generally, the Hill-Burton Act provided federal funds for the construction

129. See Waldman, supra note 28, at 1223 (quoting HEALTH POLITICS AND POLICY 78 (Litman & Robbins eds., 1984)). Advances in anesthesia and anti-infection procedures were two primary factors in the rise of in-hospital care. Id. at 1223 n.30.
130. Id. at 1223.
131. Id. It should be noted that during the first several decades of the twentieth century, sophisticated health insurance plans were virtually non-existent. However, due in large part to a burgeoning pre-Depression economy, many people were financially able to pay for medical services without such assistance. Id.
132. Id. at 1223-24 (due in large part to the crumbling Depression era economy, philanthropic donations were drastically reduced; patients were no longer able to pay for medical services, and over 800 hospitals, unable to offset costs between 1928 and 1938, were closed (citing Note, The Hill-Burton Act 1946-1980: Asynchrony in the Delivery of Health Care to the Poor, 39 M.D.L. REV. 316, 318-19 (1979))).
133. Id.
134. Id.
135. Id. at 1224.
137. Senators Hill and Burton were largely responsible for the introduction of the legislation in 1945, hence the common name. Waldman, supra note 28 at 1224.
and modernization of existing public and private nonprofit health care facilities. Combined with a sharp increase in private investment, more than five billion dollars in grants, loans, and loan guarantees placed the hospital and health care delivery industry back on its feet.

In the context of patient dumping and indigent access to emergency medical care, the most important feature of the Hill-Burton Act was the contingency placed on eligibility to receive funds. Approval of an application, available only to public or nonprofit hospitals, was contingent upon receipt of the facility's assurances to provide an appropriate level of uncompensated care.

The Act required hospitals receiving funds to make their emergency services available for a period of twenty years to all persons residing in the area of the facility. While not part of the original intent of its drafters, by the time the Act was passed the community service obligation was strongly supported.

In retrospect, the Hill-Burton Act has been only a partial success. It revived a troubled industry, but has had an extremely limited impact on the assurance of emergency medical care to the indigent. There are several reasons that can be highlighted to illustrate why the Act has failed in this respect. First, the operative term "emergency" is not defined anywhere in the Act. Second, the Department of Health and Human Services (HHS), which is responsible for monitoring the Act's implementation, has deferred this function to state agencies designed to

138. Id. at 1227 (citing Wing, The Community Service Obligation of Hill-Burton Health Facilities, 23 B.C.L. REV. 577, 577-78, n.6 (1984)). Specifically, the Hill-Burton Act is responsible for over 40% of today's existing acute care hospital beds. Id.

139. Id.

140. Id. "The four criteria for eligibility (for federal funds) were: (1) the facility's financial status, (2) the nature of the services provided by the facility, (3) the area's need for free and below cost care and (4) the facility's cooperation with other facilities to provide charity care." Id. (citing Rose, Federal Regulation of Services to the Poor Under the Hill-Burton Act: Realities and Pitfalls, 70 N.W.U.L. REV. 168, 189 (1975).

141. Id.

142. 42 U.S.C. § 291c(e)(1)-(2).

143. See Waldman, supra note 28, at 1228-29. Both John Muir Mem. Hosp., Inc. v. Davis, 726 F.2d 1443, 1446 (9th Cir. 1984) and Wyoming Hosp. Assoc. v. Harris, 727 F.2d 936, 941 (10th Cir. 1984) have affirmed that the community care obligations imposed on fund recipients were clearly supported during passage of Hill-Burton.

144. See 42 U.S.C. §§ 291 to 291o-1. The result of this failure is that hospitals are free to set their own standards for what constitutes an emergency. By interpreting the term strictly, hospitals can effectively reduce the number of patients they are under a duty to treat. See also Note, Cobra's Fangs, supra note 1, at 1199.
regulate fund disbursement and compliance with the community care obligations. However, HHS has failed to supply those agencies with guidelines under which to operate. The result is that prior to 1970, no state actively monitored hospital compliance, allowing health care facilities to completely disregard their obligations. Lastly, the Hill-Burton Act does not provide a private right of action for compensatory or punitive damages for plaintiffs alleging that hospitals have failed to provide care as outlined by the Act. Evidence of the gross failure to comply with community care obligations in return for federal aid is staggering, especially in light of the fact that almost half of the acute care hospital beds in this nation are products of Hill-Burton funds.

In 1985, HHS proposed two sets of regulations which could have the effect of further reducing or eliminating community care obligations owed by hospitals receiving Hill-Burton funds. To date, both sets of regulations have become effective, and while the new provisions do not encompass a great number of hospitals, they do add to the number of hospitals increasingly unwilling to bear the burden of uncompensated care.

The first set of regulations, commonly referred to as the March regulations, are a reflection of the changes approved by Congress in the Deficit Reduction Act of 1984. "Upon the transfer of ownership or upon leasing to an entity ineligible to receive Hill-Burton funds, a hospital owing Hill-Burton obligations must inform HHS of the change in management." Following this notification to HHS, three options

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145. See 42 U.S.C. §§ 291c, 2911-291m; Waldman, supra note 28, at 1227.
146. Note, Cobra's Fangs, supra note 1, at 1198.
147. Id. at 1199-1200. The failure of HHS to erect a monitoring system at either the state or federal level has been a major factor in the Act's partial failure. However, in 1979, HHS did promulgate some regulation directed at states - they had little or no effect in the past decade. Id.
148. Id.; see also 42 U.S.C. § 291c(e)(1).
149. See supra note 140 and accompanying text.
151. Waldman, supra note 28, at 1233.
152. Id.; see also 42 C.F.R. § 124.704.
153. 42 C.F.R. § 124.704(a)(2) provides in pertinent part:
   (i) A facility "ceases to be" a facility for which a grant could have been made under
arise: (1) either the government may receive the value of the facility's cost of modernization or construction at the time of the transfer multiplied by the ratio of the federal subsidy to the project cost itself or, (2) the new owner may apply for a waiver of the community care obligation and then set up a trust to fund, for a limited time, care to the indigent, or (3) a complete waiver may be requested if there is strong evidence that another facility in the immediate geographical area is better suited to provide the care. The lump sum payment system inherent in the March regulations is a perfect accompaniment to the profit maximization rationale of most for-profit hospital corporations. Once the lump sum is paid (option 1) or runs out (option 2) all obligations under Hill-Burton are complete. Critics argue that there are no assurances that hospitals will continue to provide uncompensated care after the lump sum is paid or runs out.

The second set, the September regulations, provide that a facility which receives at least ten percent of its operating funds from state or local government may qualify as a public facility. Thereafter, the newly created public facility is exempt from keeping records of the uncompensated care it administers. Over 53% of all Hill-Burton hospitals would qualify for this exemption. Again, it is argued that under this regulation, hospitals will no longer be compelled to provide

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the statute pursuant to which the grant was awarded when it is not longer operated as such a facility; and

(ii) A facility "ceases to be a public or non-profit facility "when an entry that is not a public or other non-profit corporation or association assumes management responsibilities with respect to the facility which, in the Secretary's judgment, are so pervasive as to constitute operation of the facility.

154. See Waldman, supra note 28, at 1233-34.
155. See generally id. at 1235.
156. Id.
157. Id.
158. 42 C.F.R. § 124.513(b)(3)(i) (10% funding figure is exclusive of all compensation received as reimbursements for Medicare and Medicaid recipients).
159. Id. A hospital may also demonstrate that they have provided twice the amount of uncompensated care over the last three years to receive the record-keeping exemption. Id.
160. Waldman, supra note 28, at 1236.
care to the needy.161 Furthermore, absent records which detail the amount of uncompensated care delivered by a given facility, it will become impossible to monitor compliance.162

Experts conclude that both sets of regulations subvert the legislative intent of the statute.163 The practical effect of the regulations is that hospitals are eligible to receive vast sums of federal money in return for promises of uncompensated care that go largely ignored and completely unenforced. Further, the regulations support the premise that hospitals can negotiate with HHS when receiving funds - negotiations designed to increase profits, inevitably at the expense of the medically indigent.164

B. COBRA

In 1985 Congress passed section 9121 of the Consolidated Omnibus Budget Reconciliation Act.165 The clear and overriding intent of a bi-partisan coalition of congressional supporters in enacting this legislation was to halt the ever-increasing trend of hospitals denying emergency medical services to patients because of their inability to pay.166 Section 9121, commonly referred to as COBRA, creates a statutory duty for hospitals to provide stabilizing treatment to any person with an emergency medical condition.167 To achieve this end, COBRA places strict limits and regulations on the transfer of patients from one hospital capable of providing care to another based on economic considerations.168 COBRA’s anti-dumping provisions represent the most comprehensive federal attempt to date at ensuring access to stabilizing emergency medical care for those who cannot afford it.

COBRA requires that all hospitals that participate in the Medicare program and operate an emergency department must provide a medical

161. Id.
162. See generally id. at 1236-40.
163. Id. at 1237.
164. See generally id. at 1238.
166. See McClurg, supra note 8, at 197-99.
167. Id.; see also Rothenberg, supra note 9, at 60.
168. See generally Rothenberg, supra note 9, at 61.
examination to any person requesting one. The examination, defined in accordance with the title of the Act, is designed to determine whether a patient is suffering from an "emergency medical condition" or is in "active labor." Under the Act, an emergency medical condition is defined as one that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunctions of any bodily organ or part.

Active labor is defined as

[the] time at which delivery is imminent; there is inadequate time to effect safe transfer to another hospital prior to delivery; or a transfer may pose a threat to the health and safety of the patient or the unborn child.

If a patient meets the criteria as outlined in the definitional sections of the Act, the hospital must provide stabilizing treatment or transfer in accordance with appropriate procedures and safeguards. Following the initial mandatory medical screening, a doctor may determine that the benefit the patient will receive if transferred to another facility will


The law protects all persons who come to an emergency room, whether or not such persons are eligible for Medicare benefits. All persons who show up at the emergency door must be treated alike, whether or not they are insured. This duty is not conditioned on any guarantee of government reimbursement. (citation omitted) (emphasis in original).

170. The title is Examination and Treatment for Emergency Medical Conditions and Women in Labor.

172. Id. at § 1395dd(e)(1).
173. Id. § 1395dd(e)(2).
174. Id. at § 1395dd(e)(2).
outweigh the risk involved in the transfer.\textsuperscript{175} This may occur if one hospital is not properly equipped to deal with the particular medical emergency at hand.\textsuperscript{176} Should this situation arise, the transferring doctor must certify this conclusion in writing.\textsuperscript{177} While at first blush this transfer provision may appear to provide hospitals and doctors with another loophole through which indigent access can continue to be hindered, it was designed to protect patient interests by allowing hospitals to evaluate emergency situations considering not only COBRA liability but also the best interests of the patient.\textsuperscript{178} Without this provision, which in no manner whatsoever reduces a hospital’s duty to provide stabilizing care, facilities lacking proper equipment or personnel to treat a specific emergency would nevertheless be forced to administer treatment in order to avoid liability, regardless of the adequacy of the treatment.\textsuperscript{179}

The provisions of the Act which regulate the transfer of indigent patients suffering from emergency medical conditions or active labor prior to stabilization impose upon hospitals and doctors far-reaching duties. Included among the strict procedures for transfers under COBRA are regulations designed to monitor not only the transferring facility, but the receiving facility.\textsuperscript{180} First, the receiving facility must agree to accept and treat the patient, a condition based in part on the availability of beds and necessary qualified personnel.\textsuperscript{181} When a transfer is effectuated, the transferring facility is under a duty to provide the receiving hospital with all medical records concerning the transferred patient.\textsuperscript{182} Further, the transfer must be carried out with medically necessary personnel and

\textsuperscript{175} Id. § at 1395dd(c)(1)(A)(ii). It should be noted that COBRA covers all patient movements, not merely the traditional inter-hospital transfer. Id. at § 1395dd(c)(5). Inter-hospital movements of patients that are not in accordance with the Act may be considered dumping. Id. Further, delays in rendering treatment may also be considered dumping. Id. at § 1395dd(b)(1).

\textsuperscript{176} Id. at § 1395dd(c)(2).

\textsuperscript{177} Id.; see also Rothenberg, supra note 9, at 61 n.299.

\textsuperscript{178} See Enfield & Sklar, supra note 65, at 582.

\textsuperscript{179} See id.

\textsuperscript{180} 42 U.S.C. § 1395dd(c)(2). It should be noted that hospitals may transfer a patient without risking liability when the patient or her representatives request a transfer. Id. at § 1395dd(c)(1).

\textsuperscript{181} Id. at § 1395dd(c)(2).

\textsuperscript{182} Id.
equipment, to ensure the patient's safety during the actual transfer. 183

The Act contains both enforcement and remedy provisions for instances where obligations and duties are either not fully met or completely disregarded. 184 The Department of Health and Human Services (HHS), specifically the HHS Secretary, are designated monitoring agents. 185 Some commentators believe that HHS' role ideally should be to implement the Act and to measure compliance, investigating violations and issuing sanctions where warranted. 186 A precursor to HHS' investigation is a medical facility's knowing, willing, or negligent failure to meet the statutory requirements of COBRA. 187

In the event the Secretary's investigation uncovers a violation, both hospital and physician are potentially subject to sanctions. 188 Specifically, a hospital found to have violated the Act is subject to suspension or termination of its Medicare contract. 189 Further, civil penalties of up to $25,000 per violation can be levied against hospitals and responsible physicians who knowingly violate the Act. 190

Perhaps the most significant aspect of COBRA, from an enforcement perspective, is the provision which allows an individual who has suffered harm as a result of a violation of the Act to pursue a private cause of action to recover "those damages available for personal injury under the law of the state in which the hospital is located." 191 And finally, COBRA's remedial provisions extend to medical facilities that have suffered financial loss as a direct result of another hospital's unlawful transfer of patients. 192

In the face of these thorough and far-reaching remedial

183. Id. In the event that a hospital has properly determined that a transfer is warranted pursuant to the strict restrictions, and the patient refuses to agree to such transfer, the hospital is deemed to have administered stabilizing treatment and thereafter relieved of COBRA liability. See Enfield & Sklar, supra note 65, at 583.
184. See generally Note, Cobra's Fangs, supra note 1, at 1217-21.
186. Note, Cobra's Fangs, supra note 1, at 1219.
187. Id. at § 1395dd(d)(1).
188. Id. at § 1395dd(d)(2).
189. Id. at § 1395dd(d)(1).
190. Id. The term "responsible physician" encompasses all physicians employed or under contract with the hospital in question. Id. at § 1395dd(d)(2).
191. Id. at § 1395dd(d)(3)(A).
192. Id. at § 1395dd(d)(3)(B). By showing that an improper transfer occurred, any hospital that receives such a transfer can obtain damages or appropriate equitable relief under the laws of the state in which the hospital is located. Id. § 1395dd(d)(3)(B).
provisions, HHS enforcement of COBRA has been lax. As a direct result, the importance of utilizing the private right of action created by COBRA increases dramatically. Without the benefit of Supreme Court precedent, several federal district courts have begun to fashion a framework within which a plaintiff under COBRA must operate. Each case that will be discussed below involves the foundation of COBRA claims, jurisdiction, pleadings, and damages.

1. Jurisdiction. — Section 1395dd(d)(3)(A) provides that a plaintiff who has suffered harm as a direct result of a violation of the Act may recover damages in a civil action against the health care facility. However, the Act does not state in which forum, state or federal, a plaintiff may bring this private action. Nevertheless, a firm body of case law has developed, supporting early contentions that federal jurisdiction is available to plaintiffs.

*Bryant v. Riddle Memorial Hospital* was the first case in which a federal court determined that COBRA provided for a private cause of action in federal court. Through an extensive examination of the legislative history pertinent to this issue, the Bryant court determined that it was indeed the intent of Congress to allow a private COBRA action to be brought in federal court. Focusing on committee reports, the court observed that the Ways and Means Committee stated the following: "Any persons or entity adversely and directly affected by a participating hospital's violation of these requirements may bring an action, in an appropriate state or Federal district court, for damages to the person arising from the violation." The Bryant court’s initial determination that federal courts may hear private COBRA claims has been routinely

193. See McClurg, supra note 8, at 200. "Despite estimates of 250,000 dumped patients per year, as of January 1, 1988, the Department of Health and Human Services (HHS) had imposed monetary penalties against only two hospitals and never had suspended a hospital from Medicare participation." Id. (citations omitted).

194. See generally Rothenberg, supra note 9, at 67-69.

195. See infra notes 196-223 and accompanying text.


198. See infra notes 201-207 and accompanying text.


200. Id. at 493.

201. Id. at 492-93 (citations omitted).

202. Id. at 492 (citations omitted).
followed in subsequent cases. In particular, *Sorrells v. Babcock*\textsuperscript{203} not only followed the *Bryant* rationale, but went further and held that federal courts could exercise ancillary jurisdiction over a plaintiff's pending state law claims for medical malpractice, reasoning that both claims arose out of a common nucleus of facts.\textsuperscript{204} The consensus thus far is that federal district courts are available to plaintiffs seeking to assert a private cause of action under COBRA.\textsuperscript{205}

2. **Pleadings.** — Because COBRA plaintiffs generally tread where no plaintiff has previously been, pleading a violation of the statutory duties proscribed by the Act can be troublesome. Motions to dismiss for failure to state a claim are a common defense tactic.\textsuperscript{206} Several cases can be analyzed to detail the necessary elements each cause of action must allege in order for a COBRA plaintiff to avoid dismissal.\textsuperscript{207}

In *Deberry v. Sherman*,\textsuperscript{208} the plaintiff alleged that the defendant hospital discharged her child prior to stabilization, thereby violating COBRA.\textsuperscript{209} The hospital moved to dismiss for failure to state a claim upon which relief could be granted.\textsuperscript{210} Specifically, the hospital asserted that the plaintiff's COBRA cause of action was nothing more than a state malpractice claim of misdiagnosis.\textsuperscript{211} The court, after examining the facts and setting forth the applicable law on stating a claim, established a framework within which COBRA plaintiffs should operate so as to effectively state a cause of action.\textsuperscript{212}

\textsuperscript{203} 733 F. Supp 1189 (N.D. Ill. 1990).
\textsuperscript{204} Id. at 1191-92.
\textsuperscript{208} 741 F. Supp. 1302 (N.D. Ill. 1990).
\textsuperscript{209} Id. at 1303. Plaintiff took her daughter to defendant emergency room "with a fever, rash, stiff neck with her head tilted to the left, and dispositional aberrations including irritability and lethargy." Although the plaintiff's daughter was tested, two days later the daughter had worsened and was eventually diagnosed as suffering from spinal meningitis which caused deafness. Id:
\textsuperscript{210} Id.
\textsuperscript{211} Id.
\textsuperscript{212} Id. at 1303-05.
We conclude that the would-be COBRA plaintiff must allege that he (1) went to the defendant's emergency room (2) with an emergency medical condition, and that the hospital either (3) did not adequately screen him to determine whether he had such a condition, or (4) discharged or transferred him before the emergency condition had been stabilized.213

As long as "the basic facts have been alleged . . . this is sufficient for purposes of Rule 8(a)."214

When pleading a COBRA violation, plaintiffs and their attorneys must take care to analyze the facts of the alleged misconduct to be certain that the circumstances do not allege a cause of action based on state medical malpractice law.215 A clear majority of the federal courts that have had the opportunity to examine pleadings which intentionally or unintentionally cloak malpractice claims in the form of COBRA violations have refused to exercise jurisdiction.216 Further, COBRA plaintiffs must, at some point, assert that the alleged misconduct was the result of a denial of medical services based on a lack of insurance or money.217 The rationale behind each of these pleading requirements is similar, and is based on judicial interpretation of the legislative intent behind COBRA.218

First, as a general rule, misdiagnosis and resultant harm do not, standing alone, constitute a violation of COBRA.219 For instance, in Stewart v. Myrick,220 the plaintiff alleged a violation of COBRA revolving around the failure of the defendant emergency room physician to diagnose what later turned out to be heart disease with unstable angina pectoris, an emergency medical condition.221 By examining the

213. Id. at 1305.

214. Id. (citing F.R. Civ. P. 8(a)).


218. See supra notes 167-70.

219. See, e.g., Stewart, 731 F. Supp. at 434-36. Rather, the misdiagnosis is challengeable under traditional medical malpractice precepts, in state court.


221. Id. at 434.
legislative history of the Act, the Stewart court concluded that Congress intended to create a cause of action under COBRA based on denials of medical care for economic reasons. Because it was uncontroverted that Stewart was never denied treatment or discharged due to a lack of insurance, the case represented a traditional claim for malpractice, not dumping. Citing a similar case, Evin v. University Heights Hospital, with approval, the Stewart court stated:

The plaintiff's interpretation reaches beyond the purpose of the statute, which is specifically directed toward preventing prospective patients from being turned away for economic reasons. Underlying plaintiff's reading of the Act is her implicit complaint that she was misdiagnosed. . . . This complaint, rather than focusing on the "dumping" problem, begins by attacking the doctors provisional diagnosis. Claims regarding diagnosis . . . lie in the area of medical malpractice . . .

Clearly, federal courts are reluctant to extend COBRA beyond what they have determined are its legislatively designed parameters. To avoid this litigation pitfall, plaintiffs should exercise care in their pleadings, resisting the desire to tie misdiagnosis in with the anti-dumping proscriptions of COBRA.

3. Damages. - As stated previously, the damage provisions of COBRA, which relate specifically to private causes of action asserted by individual plaintiffs, do not preempt state law. It is clear from the reported cases that federal courts are interpreting and applying this part of the Act strictly, limiting damages recoverable to those available under state law.

222. Id. at 434-36.
223. Id. at 434.
224. Id. at 436.
228. See, e.g., Reid v. Indianapolis Osteopathic Medical Hospital, Inc., 709 F. Supp. 853 (S.D. Ind. 1989); Maziarka v. St. Elizabeth Hospital, No. 88 Civ. 6658 (N.D. Ill. Feb. 15, 1989). On its face, this failure to preempt state law may seem harmless, but this changes when it is understood that traditionally, state laws have not
In *Reid v. Indianapolis Osteopathic Medical Hospital, Inc.*, the district court was faced with interpreting COBRA in light of state laws that had the effect of capping damages available under malpractice statutes. The court found that the intent behind COBRA's remedial provisions was to defer to these limitations, which had the effect of reducing the amount of damages awarded. Similarly, in *Maziarka v. St. Elizabeth Hospital*, the court held that the unavailability of a punitive damage award under state medical malpractice law carried over to the adjudication of COBRA remedies, and effectively denied punitive damages to COBRA plaintiffs in that jurisdiction.

Plaintiffs and their attorneys should remain aware of the potential for lower recoveries than may have been anticipated. Further, attorneys must be versed in the applicable state medical malpractice laws of the particular jurisdiction in order to best serve the interests of their clients.

VI. CONCLUSION

The United States is a nation of unrivaled strength, wealth, and opportunity. It is therefore both puzzling and disturbing to realize the magnitude of the problem of patient dumping in America. It is unconscionable that large segments of the population are either completely denied access to emergency medical care or left to suffer in overburdened facilities, which, for purely economic reasons, are saturated with patients. While it is quite clear that patient dumping developed concurrently with the modern health care delivery system, it is not at all clear why this was permitted to occur. But, the reality is that, each year, hundreds of thousands of people are denied access to emergency medical care for economic reasons. This nation needs to find a manageable and effective means of stopping this unfortunate trend.

The most recent federal attempt to curb patient dumping, as well

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been cognizant of the damages suffered by the denial of access to emergency medical care. The result of these combined factors is that punitive damages may not be recoverable, or caps may be placed on damage awards.

230. *Id.*
231. *Id.* at 855.
233. *Id.*
234. *See supra* notes 11-15 and accompanying text.
as several state attempts,\textsuperscript{235} provide the modern foundation from which this nation can begin to achieve emergency medical care for all. The statutory duty to provide such care created in COBRA and similar state equivalents, forces both hospitals and physicians to administer emergency care to any individual in need, regardless of his or her ability to pay.\textsuperscript{236} However, the fundamental change that has taken place in the hospital industry, from non-profit to for-profit, sharply conflicts, at all levels, with these newly created statutory duties. The modern health care delivery system is increasingly a slave to the demand for profits, a quest that inevitably detracts from the provision of uncompensated care to those who are ill and unable to pay for medical services.

It is of vital importance that COBRA and the state statutory schemes dealing with patient dumping act in concert with, and not in conflict with, other state and federal laws. Consequently, valid attempts should be made to rectify the imprecisions in COBRA language. "Medical Screening" must be defined so that hospitals and physicians are not presented with potential loopholes. Further, the limits inherent in state law damage provisions available to plaintiffs suing under COBRA should be removed, so that hospitals and physicians who have ignored their duty to provide care can be sanctioned appropriately. Finally, a combined federal, state, and general public effort is of paramount importance in combatting patient dumping, due in large part to the decades of hostile precedent as well as the general ignorance surrounding the social horror of large segments of our population being unable to receive necessary emergency medical care due to their economic status.

\textit{Christopher J. Field}

\textsuperscript{235} McClurg, \textit{supra} note 8, at 182.
\textsuperscript{236} Ansell \& Schiff, \textit{supra} note 5, at 1501.