EMTALA:
AVOIDING CHAPTER 74 - DOES YOUR CASE FIT?

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CHAPTER 22
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I. INTRODUCTION

As we know, medical malpractice attorneys evaluating their potential malpractice cases generally review the relevant standard of care, potential clinical violations and whether there may be some causal relationship to a bad outcome. With the right answers, they file their Chapter 74 claims in Texas state courts. What may be overlooked is a potential cause of action under federal law, the Emergency Medicine Treatment and Active Labor Act (“EMTALA”). This paper examines a patient’s private right of action under EMTALA and the possible advantages bringing a claim under this federal statute versus Chapter 74.

II. BACKGROUND OF EMTALA

EMTALA is a federal law that was enacted in 1986 to prevent “patient dumping”—i.e., the practice of refusing to treat patients who are unable to pay. 42 U.S.C. §1395dd(a)-(c); Marshall v. E. Carroll Parish Hosp. Serv. Dist., 134 F.3d 319, 322 (5th Cir. 1998). Several studies in the mid-1980s demonstrated that large numbers of uninsured patients seeking emergency treatment were transferred to public hospitals, oftentimes when they were unstable and in serious condition. Karen I. Treiger, Note, Preventing Patient Dumping: Sharpening the COBRA’s Fangs, 61 N.Y.U. L. REV. 1186, 1189-91 (1986). Through EMTALA, Congress sought to prevent patient dumping by requiring any hospital that had an emergency department and that participated in the Medicare program to “treat any patient in an emergency condition, regardless of the patient’s ability to pay.” Id. at 1188. Congress had no trouble getting hospitals’ attention, as penalties under the Act were potentially severe. An offending hospital faced not only civil monetary penalties (originally $25,000 per violation, now $50,000), but also civil actions by a patient and other medical facilities that suffered a financial loss due to the violation. 42 U.S.C. §1395dd(d)(2) and (3) (1987 version). More significantly, if the hospital “knowingly and willfully, or negligently” violated the Act, it could lose its funding from Medicare—a potential disaster for hospitals. 42 U.S.C. § 1395dd(d)(1) (1987 version).

III. EMTALA CLAIMS

To prevent patient-dumping, the statute creates a private cause of action for individuals who are allegedly harmed either by a participating hospital’s failure to (1) provide them with an “appropriate medical screening” to determine if an emergency medical condition exists or (2) “stabilize” them before transfer or discharge if a statutorily-defined emergency medical condition has been detected. 42 U.S.C. § 1395dd(a)-(c).

A. Medical Screening Requirement

The medical screening requirement arises when a patient presents to a “hospital emergency department” and requests (or someone requests for her) an “examination or treatment for a medical condition.” 42 U.S.C. § 1395dd(a). In such a situation, “the hospital must provide for an appropriate medical screening examination . . . to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.” Id. The Fifth Circuit has explained that an “appropriate medical screening examination” is not judged by its proficiency in accurately diagnosing the patient’s illness, but rather by whether it was performed equitably in comparison to other patients with similar symptoms.” Marshall v. East Carroll Parish Hosp., 134 F.3d 319, 322 (5th Cir. 1998).

If the hospital determines an “emergency medical condition” exists, it must provide treatment necessary to stabilize the patient, or it must transfer her as subsection (c) of the Act mandates. 42 U.S.C. § 1395dd(b)(1). The Act’s definition of “an emergency medical condition” is critical. Subsection (e)(1) defines “emergency medical condition” as:

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in –

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions –

(i) there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.


Importantly, this language regarding “emergency medical care” was adopted almost in its entirety by the Texas medical malpractice statute at Chapter 74 of the
Civil Practice and Remedies Code. “Emergency medical care” is now defined specifically by section 74.001(a)(7) as follows:

[B]ona fide emergency services provided after the sudden onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The term does not include medical care or treatment that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient or that is unrelated to the original medical emergency.

TEX. CIV. PRAC. & REM. CODE §74.001(a)(7).

This definition parallels the definition of “emergency medical condition” in §1395dd(e)(1) of EMTALA. However, the last sentence of the definition is new language. It clarifies that emergency medical care does not include care that occurs after the patient is stabilized or that is unrelated to the original medical emergency.

Another important EMTALA provision is subsection (h). It precludes a hospital from delaying “provision of an appropriate medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) of this section in order to inquire about the individual’s method of payment or insurance status.” 42 U.S.C. § 1395dd(h). This goes to the heart of EMTALA: a patient’s ability to pay is totally irrelevant as to whether she is entitled to emergency care.

B. Stabilization Requirement

The term “stabilize” means “to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. . . .” 42 U.S.C. § 1395dd(e)(3)(A). If the hospital determines that no such condition exists, it may transfer the patient and need not comply with the Act’s “transfer rule.” 42 U.S.C. § 1395dd(c)(1)-(2).

The Act provides a hospital with two “outs” regarding the stabilization requirement. First, the hospital satisfies subsection (b)(1) if it offers an examination and stabilizing treatment to a patient with an emergency medical condition, but she refuses the treatment. 42 U.S.C. § 1395dd(b)(2). The hospital also discharges its stabilization duties if it offers to transfer the patient in accordance with the “transfer rule” and she refuses to consent to the transfer. 42 U.S.C. § 1395dd(b)(3). In both situations, the hospital must inform the patient of the “risks and benefits” of the treatment or transfer, and it must “take all reasonable steps to secure the individual’s (or person’s) written informed consent to refuse” the same. 42 U.S.C. § 1395dd(b)(2)-(3).

As one might imagine, the Act applies to the overwhelming majority of hospitals in the country. This is because most hospitals not only have emergency departments — most also participate in the Medicare program. However, it is important to note that the Act does not apply to all hospitals. Obviously, if a hospital does not have an emergency department, it is not subject to the medical screening requirement. In addition, an entity which is not a “hospital” is not subject to EMTALA.

III. EMTALA AND CHAPTER 74

When analyzing the interplay between EMTALA and state law, it is paramount to remember that EMTALA is NOT a federal medical malpractice statute. Subsection (f) clarifies that the Act is not meant to supplant state law: “The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.” 42 U.S.C. § 1395dd(f). This is plainly a nod to the Supremacy Clause. A state statute presents an actual conflict with federal law when compliance with both federal and state laws is an impossibility or where state law is an obstacle to the “execution of the full purposes and objectives of Congress.” Hyundai Motor Co. v. Alvarado, 974 S.W.2d 1, 4 (Tex. 1998). An example of a preempted state statute presented in In re Baby “K”, 16 F.3d 590, 597 (4th Cir. 1994), where the court found that a Virginia statute directly conflicted with EMTALA, because it exempted physicians from rendering care that they consider medically or ethically inappropriate.

IV. WHY EMTALA?

Potential plaintiffs can bring claims under either the state or federal statute, or both. If your cause of action meets the requirements of the federal statute, it might be beneficial to file your claim under EMTALA instead of Chapter 74. And because Chapter 74 Emergency Room claims require a different standard of proof, there are several factors for counsel must weigh before filing their claim.

A. No Tolling Provision

Like Chapter 74, EMTALA also provides a two year statute of limitations for claims based on claim
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under the Act. 42 U.S.C. § 1395dd(d)(2)(C). An EMTALA action accrues from the date of violation, and the Act contains no tolling provision. Id. If you choose to bring both a state and EMTALA claim, it is important to realize that several courts have held that state tolling provisions are preempted by and do not toll the limitations period for EMTALA claims. See e.g. Saltares v. Hosp. San Pablo Inc., 371 F. Supp. 2d 28, 35 (D.P.R. 2005). For example, state statutes that toll the running of the limitations period until after discovery have been held not to apply to EMTALA claims. Id. at 35.

If you choose to bring a claim solely under EMTALA, be sure to understand the time limitations you may face to guarantee you will not be faced with a statutory bar.

B. No 120 day Reports

As we all know, one of the most burdensome and litigated requirements of Chapter 74 is the 120 day expert report requirement. Texas courts have held that if a party brings both an EMTALA claim and a health care liability claim under Chapter 74 in state court, then an expert report must be served under §74.351. See Tenet Hospitals Ltd. V. Boata, 304 S.W.3d 528 (Tex. App.–El Paso 2009, pet. denied). In contrast, a majority of the Texas federal courts have held that the expert report requirement of 74.351 does not apply in federal courts. See Mason v. United States, 486 F.Supp.2d 621, 625 (W.D. Tex. 2007) (holding that “in light of the recent change in law and the persuasive reasons provided by every district court in Texas to consider this issue, the Court holds that §74.351 does not apply in federal court”).

In sum, an EMTALA claim in federal court requires no 120 day expert report; a significant departure from a Chapter 74 claim and potential hurdle.

C. Damages

EMTALA provides that a person bringing an EMTALA cause of action may obtain "those damages available for personal injury under the law of the State in which the hospital is located." 42 USC § 1395dd(d)(2)(A). Included are compensatory damages and punitive damages, but only if punitive damages are allowed under the law of the state where the hospital sits. Taylor v. Dallas Co. Hosp. Dist., 976 F.Supp. 437 (N.D. Tex. 1996).

Although there is no direct Texas case law on the issue, the majority rule is that state damage caps on medical malpractice claims are applied to EMTALA recoveries. See, e.g., Power v. Arlington Hosp. Ass’n, 42 F.3d 851, 861-63 (4th Cir. 1994); Barris v. County of Los Angeles, 83 Cal.Rptr.2d 145 (1999). However, it is worth noting that several courts have held that state medical malpractice damage caps do not apply to EMTALA claims, because EMTALA claims are not within the class of claims covered by such statutory schemes. See e.g. Brooks v. Maryland Gen’l Hosp., Inc., 996 F.2d 708 (4th Cir. 1993); Jackson v. East Bay Hosp., 980 F.Supp. 1341, 1347 (N.D. Ca. 1997). Courts reason that because statutory malpractice caps only apply to claims arising from the negligence of the health care provider, and EMTALA requires no showing of negligence, such statutory caps do not apply to EMTALA claims.

Chapter 74’s limit on non-economic damages does not capture punitive damages (See TEX. CIV. PRAC. & REM. CODE 41.001(12)), though a party is nonetheless limited in their punitive damages recovery unless they can “bust” the punitive damages cap. TEX. CIV. PRAC. & REM. CODE 41.008. However, the limit in punitive damages and the wrongful death cap limits of Chapter 74 may not apply to EMTALA recoveries. Therefore, EMTALA must be considered because of the potentially larger recoveries available.

D. Federal Court Advantages

Finally, bringing an EMTALA claim gets you into federal court, which may carry advantages over state court, depending on your perspective. While federal judges are generally more receptive to summary judgment and dispositive motions, higher damages ceilings, no need for 120 day reports and stricter schedules may bear in favor of a federal venue.

V. CONCLUSION

EMTALA, the federal “anti-dumping” statute, may be an overlooked federal alternative that can provide a plaintiff and their counsel with a broader range of opportunities and increased chances of recovery over traditional Chapter 74 medical malpractice claims. EMTALA requires no expert report within 120 days of service, provides for a potentially larger damages award, and provides a federal backdrop before potentially more favorable judges.

When evaluating your potential claims, be sure to consider EMTALA and the potential advantages it provides over Chapter 74, especially in the context of the emergency room.