

## Silver and Old: How EMTALA’s Outdated Appropriate Medical Screening Standard Impacts the Aging Population

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*Is it “theoretically or practically possible for a  
misdiagnosed condition to be properly stabilized”?*<sup>1</sup>

### ABSTRACT

With the U.S. elder population on the brink of booming, attention to the ramifications of legal standards that affect them is a must. In 2018, the Sixth Circuit split from its sister circuits and solidified an interpretation of the Emergency Medical Treatment and Labor Act’s (EMTALA) “appropriate medical screening” standard that will adversely affect aging individuals. Since older adults are the most likely demographic to use emergency care services, laws that impact emergency care will inevitably trickle down to this group of people. To protect already vulnerable older adults, EMTALA should be modified in such a way that (1) it eliminates interpretations such as the “improper motive” standard that the Sixth Circuit enforces and (2) gross deviation from the standard of care will constitute a “failure to provide appropriate medical screening”—and give rise to a cause of action under EMTALA.

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1. Jack E. Karns, *Hospital Screening Procedures and the Emergency Medical Treatment and Active Labor Act (EMTALA): Proof of “Improper Intent” Not Necessary in Failure to Stabilize Cases*, 9 WIDENER J. PUB. L. 355, 366 (2000).

## CONTENTS

ABSTRACT.....	863
INTRODUCTION .....	864
I. MAJORITY RULE FOR EMTALA’S APPROPRIATE MEDICAL SCREENING REQUIREMENT .....	866
II. THE SIXTH CIRCUIT’S “IMPROPER MOTIVE” STANDARD.....	869
III. THE IMPACT OF THE “IMPROPER MOTIVE” ON THE AGING POPULATION .....	872
<i>A. The Silver Context</i> .....	872
<i>B. Importance of Medical Screening     with Geriatric ED Patients</i> .....	873
IV. STATUTORY REVISION TO EMTALA’S APPROPRIATE MEDICAL SCREENING.....	876
<i>A. Issues with EMTALA’s Broad Language</i> .....	876
<i>B. Proposed Legislation for EMTALA’s     Appropriate Medical Screening</i> .....	877
CONCLUSION.....	880

## INTRODUCTION

You arrive at the emergency room. Your neck has been causing you problems and you have been experiencing dizziness, including “a spinning sensation, difficulty sleeping, nausea, vomiting, and a headache that worsen[s] with movement.”<sup>2</sup> You have been seeing a chiropractor for the last year and believe the visits led to your injuries.

It is finally your turn to see the ER doctor. Dr. Craig Reynolds treats you and notes that your symptoms include high blood pressure, elevated white blood cell count, the presence of red blood cells in urine, the presence of a fever, and dizziness with a worsening headache. You receive no further imaging, tests, or other diagnostic studies. Dr. Reynolds prescribes you medicine and tells you to “take it easy.” Then, you are discharged.

You learn later that your symptoms were consistent with vertebral dissection, which is known to result from excessive chiropractic manipulation of the neck. But Dr. Reynolds did not screen you for that

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2. *Elmhirst v. McLaren N. Mich. Hosp.*, No. 1:17-CV-00374, 2017 WL 4535714, at \*1 (W.D. Mich. July 19, 2017), *aff’d*, 726 F. App’x 439 (6th Cir. 2018), *cert. denied sub nom. Elmhirst v. McLaren N. Mich. Hosp.*, 139 S. Ct. 325 (2018).

condition. Since your discharge, your symptoms have worsened. You have a stroke, and you are back at the hospital four days later. This time, Dr. Roger Gietzen, a neurologist, treats you.

Dr. Gietzen tells you that you suffered from a stroke caused by vertebral dissection. Dr. Piyush Patel, an internist at the hospital, verifies this assessment and identifies the chiropractic manipulation as a potential underlying cause.<sup>3</sup>

You have no federal remedy—but you should.

Although Congress designed the Emergency Medical Treatment and Labor Act (EMTALA or the Act) to be a nondiscriminatory statute<sup>4</sup> for emergency treatment<sup>5</sup> rather than a federal medical malpractice statute,<sup>6</sup> individuals should be allowed to bring a suit under EMTALA if their ER screening is wildly deficient. Under EMTALA, hospitals have a duty to appropriately screen and stabilize patients that enter the emergency department—regardless of their ability to pay.<sup>7</sup> EMTALA establishes a private right of action under 42 U.S.C. § 1395dd(d)(2)(a).<sup>8</sup> Within a two-year statute of limitations,<sup>9</sup> an individual may bring a civil action against a Medicare-participating hospital (nearly 98% of hospitals fall into this category)<sup>10</sup> if he or she suffers as a direct result of that hospital.<sup>11</sup> While hospitals can be held liable under EMTALA under five general scenarios, this Comment will focus on one particular scenario: the failure to appropriately screen a patient for an emergency medical condition that is within the hospital's capabilities to treat.<sup>12</sup>

The standard for “appropriate medical screening” in the Sixth Circuit splits from the majority and moves in a harmful direction by requiring

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3. The introduction derives facts from *Elmhirst v. McLaren N. Mich. Hosp.*, 726 Fed. Appx. 439 (6th Cir. 2018).

4. Sai Balasubramanian, *Examining the Impacts of Current Malpractice Frameworks and EMTALA on Emergency Medicine*, 41 NOVA L. REV. 181, 201 (2017).

5. Hadley Hamilton & Samuel D. Hodge, Jr., et al., *A Look Behind the Closed Doors of the Emergency Room - A Medical/Legal Perspective*, 16 MICH. ST. U. J. MED. & L. 1, 3 (2011) (defining “emergency treatment” as “a medical specialty that focuses on the rapid assessment and diagnosis of acute illnesses and injuries followed by the stabilization and management of the patient”).

6. See Sara Rosenbaum, *The Enduring Role of the Emergency Medical Treatment and Active Labor Act*, 32 HEALTH AFF. 2075, 2078 (2013).

7. 42 U.S.C. § 1395dd(a) (2018); 42 U.S.C. § 1395dd(b) (2018).

8. 42 U.S.C. § 1395dd(d)(2) (2018).

9. *EMTALA Fact Sheet*, AM. COL. OF EMERGENCY PHYSICIANS, <https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/> [<https://perma.cc/FX4H-PQW9>].

10. Balasubramanian, *supra* note 3, at 201.

11. 42 U.S.C. § 1395dd(d)(2) (2018).

12. Michael J. Frank, *Tailoring EMTALA to Better Protect the Indigent: The Supreme Court Precludes One Method of Salvaging a Statute Gone Awry*, 3 DEPAUL J. HEALTH CARE L. 195, 203–04 (2000) (discussing other scenarios, including the failure to stabilize a patient before transferring, the failure to appropriately transfer a patient, refusal to accept a transferred patient, and delay of screening, stabilization, or transfer in order to inquire about a patient's ability to pay).

plaintiffs in an EMTALA claim to allege that a hospital acted with an “improper motive” in the failure to appropriately screen them.<sup>13</sup> Instead, the standard should move to include some component of negligence. Because of the rapidly aging population, elderly patients will be the largest demographic who will be affected by the laws and remedies governing the ER. Thus, to further protect the high volume of elderly patients who especially need appropriate care, grossly deficient medical screening should equate to the failure to screen under EMTALA and thus give rise to a cause of action.

This Comment contains four parts. First, this Comment will explain the majority rule regarding EMTALA’s “appropriate medical screening.” Second, it will address the Sixth Circuit’s split from other circuits, which is most recently demonstrated in *Elmhirst v. McLaren Northern Michigan*.<sup>14</sup> Third, it will illustrate the negative impact an “improper motive” standard would have on the aging population. Fourth, it will propose a statutory revision to EMTALA’s appropriate medical screening prong.

#### I. MAJORITY RULE FOR EMTALA’S APPROPRIATE MEDICAL SCREENING REQUIREMENT

Across federal courts, the majority rule for alleging inappropriate medical screening reflects EMTALA’s purpose of nondiscrimination: the requirement of uniform treatment.<sup>15</sup> More specifically, a plaintiff must allege (1) that he or she received a different examination than would have been offered to other patients presenting similar symptoms and (2) as a result of this disparate screening, the hospital failed to identify an emergency medical condition and he suffered harm as result.<sup>16</sup> 42 U.S.C. § 1395dd(a) delineates the screening requirement EMTALA imposes, which requires hospitals to provide “appropriate medical screening examination[s]” that are within the capability of the hospital’s emergency department to treat.<sup>17</sup>

Circuits have been opposed to implementing a motive requirement and have directly criticized the Sixth Circuit’s outlier interpretation and reasonings for the “improper motive” component. More specifically, the

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13. See generally *Elmhirst v. McLaren N. Mich. Hosp.*, 726 Fed. Appx. 439 (6th Cir. 2018).

14. *Id.*

15. *E.g.*, *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1138 (8th Cir. 1996).

16. See, e.g., *Sanders v. Legacy*, 676 F. App’x 709 (9th Cir. 2017); *Power v. Arlington Hosp. Ass’n*, 42 F.3d 851, 856 (4th Cir. 1994) (“[T]he plain language of [EMTALA] requires a hospital to develop a screening procedure designed to identify such critical conditions that exist in symptomatic patients and to apply that screening procedure uniformly to all patients with similar complaints.”) (quoting *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 879 (1992)).

17. 42 U.S.C. § 1395dd(a) (2018).

D.C. Circuit, First Circuit, Eighth Circuit, Tenth Circuit, and Fourth Circuit conflict with the Sixth Circuit.

The D.C. Circuit regards the motive for inappropriate screening as unimportant. In *Gatewood v. Washington Healthcare Corp.*, the court abided by the majority rule and evaluated whether the screening the plaintiff received was a departure from the treatment that a similarly situated patient would receive.<sup>18</sup> The court expressly stated that “any departure from standard screening procedures constitutes inappropriate screening” and further noted that “[t]he motive for such departure is not important.”<sup>19</sup>

Moreover, the First Circuit in *Correa v. Hospital San Francisco* reiterated the same idea. The court here laid out the majority rule that “[t]he essence of [EMTALA’s screening] requirement is that there be some screening procedure, and that it be administered even-handedly,”<sup>20</sup> and outwardly rejected any motive requirement by stating that “regardless of motive, a complete failure to attend a patient who presents a condition that practically everyone knows may indicate an immediate and acute threat to life can constitute a denial of an appropriate medical screening examination under section 1395dd(a).”<sup>21</sup>

A particularly direct critique of the Sixth Circuit’s “improper motive” is from the Eighth Circuit. In *Summers v. Baptist Medical Center Arkadelphia*, the Eighth Circuit stated, “[w]e cannot agree [with the Sixth Circuit] that . . . evidence of improper motivation is essential.”<sup>22</sup> Further, the court demonstrated that the statute does not require any type of motivation and concluded that the statute imposes a strict-liability standard—that is, the hospital is liable if it fails to provide appropriate medical screening, regardless of what the motivation was for the failure.<sup>23</sup> Thus, in the Eighth Circuit (like many others), a plaintiff need not demonstrate any level of intent on the part of the hospital; rather, the plaintiff must show only that the hospital failed to provide an appropriate medical screening examination in accordance with the majority uniform treatment rule.<sup>24</sup>

The Tenth Circuit also demonstrates distaste for the “improper motive” requirement and has firmly stated that no motive is attached to EMTALA liability.<sup>25</sup> In *Phillips v. Hillcrest Medical Center*, Phillips went

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18. *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991).

19. *Id.*

20. *Correa v. Hosp. S. F.*, 69 F.3d 1184, 1192 (1st Cir. 1995).

21. *Id.* at 1193.

22. *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1138 (8th Cir. 1996).

23. *Id.* at 1137–38.

24. *Id.* at 1143.

25. *See Phillips v. Hillcrest Med. Ctr.*, 244 F.3d 790, 798 (10th Cir. 2001).

to the ER and complained of severe chest pain and pneumonia-like symptoms.<sup>26</sup> After his examination, the physicians gave him two prescription medications and discharged him.<sup>27</sup> A few days later, his father brought him to a different ER.<sup>28</sup> The doctors at this ER confirmed that Phillips was suffering from bacterial endocarditis, and he died a few days later as a result of the infection.<sup>29</sup>

Although the court held that no EMTALA claim existed due to the lack of evidence that the ER deviated from EMTALA's uniform treatment requirement, the court stated, "This circuit, like many others, does not require any particular motive for EMTALA liability to attach[;] . . . EMTALA looks only at the participating hospital's actions, not motives."<sup>30</sup> Like the Eighth Circuit in *Summers*, the Tenth Circuit interprets EMTALA as imposing a strict-liability standard.<sup>31</sup>

Finally, the Fourth Circuit directly rejects the improper motive. In *Power v. Arlington Hospital Association*, a patient came into the ER because she was suffering from pain in her left hip, her lower left abdomen, and her back running down her leg; she also was experiencing shaking, difficulty walking, and severe chills.<sup>32</sup> Most importantly, she had a sizeable boil that was visible on her cheek.<sup>33</sup> The emergency nurses and physicians did not note the boil on their records during her first visit and merely prescribed her pain medication.<sup>34</sup> The only diagnostic test the doctors administered was a urine test before discharging her.<sup>35</sup> When she returned to the emergency room the next day, she was diagnosed with suffering from septic shock and was admitted into the intensive care unit.<sup>36</sup> She remained in the intensive care unit for four months and during that time she had been on life support, had both legs amputated, lost eyesight, and suffered severe and permanent lung damage.<sup>37</sup> According to a medical expert, if she had received appropriate medical screening (including a blood test) upon her first visit, then her infection would likely have been detected and properly treated.<sup>38</sup>

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26. *Id.* at 794.

27. *Id.* at 794–95.

28. *Id.* at 795.

29. *Id.*

30. *Id.* at 798.

31. *See id.*

32. *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 853 (4th Cir. 1994).

33. *Id.* at 854.

34. *Id.* at 854–55.

35. *Id.* at 855.

36. *Id.*

37. *Id.*

38. *Id.* at 855–56.

The Fourth Circuit held that a jury could conclude that the care given to Power deviated from that given to other similar patients.<sup>39</sup> Moreover, the *Power* court rejected Arlington Hospital Association's argument—which cites *Cleland v. Bronson Healthcare Group, Inc.* in the Sixth Circuit—that the plaintiff had to prove the existence of an improper motive on the part of the hospital in its failure to appropriately screen.<sup>40</sup> The court reasoned that (1) nothing in the statute itself requires an improper motive on the part of the hospital as a prerequisite to recovery; (2) the motive requirement is much too expansive; and (3) the issue with proving the existence of an improper motive.<sup>41</sup> Further, the court concluded that “having to prove the existence of an improper motive . . . would make a civil EMTALA claim virtually impossible,” naming this issue as “the most fundamental problem with the motive requirement.”<sup>42</sup>

## II. THE SIXTH CIRCUIT'S “IMPROPER MOTIVE” STANDARD

The story in the introduction is derived from the facts of *Elmhirst v. Northern Michigan*,<sup>43</sup> but the court in *Elmhirst* directly applied precedent. More specifically, the court relied entirely on *Cleland v. Bronson Health Care Group, Inc.*, which was decided in the early 1990s.<sup>44</sup>

In *Cleland*, the plaintiffs took their teenage son, who was complaining of cramps and vomiting, to the ER.<sup>45</sup> The doctors diagnosed him with influenza and discharged the teen four hours later.<sup>46</sup> However, the doctors' diagnosis was incorrect; the teen was suffering from intussusception, a condition that occurs when a part of the intestine telescopes within itself.<sup>47</sup> In less than twenty-four hours, he suffered from cardiac arrest and died.<sup>48</sup>

The court held that the plaintiffs failed to allege a claim under EMTALA regarding to the hospital's failure to appropriately screen.<sup>49</sup> The court reasoned that in addition to not alleging a departure screening,<sup>50</sup> they failed to allege a motive.<sup>51</sup> The court interpreted “appropriate”

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39. *Id.* at 856.

40. *Id.* at 857.

41. *Id.* at 857–58.

42. *Id.* at 858.

43. *Elmhirst v. McLaren N. Mich.*, 726 F. App'x 439 (6th Cir. 2018).

44. *Id.*; see *Cleland v. Bronson Health Care Grp., Inc.*, 917 F.2d 266 (6th Cir. 1990).

45. *Id.* at 268.

46. *Id.*

47. *Id.*

48. *Id.*

49. *Id.* at 269.

50. *Id.*

51. See *id.* at 272.

in § 1395dd(a) to “refer to the motives with which the hospital acts.”<sup>52</sup> Furthermore, the court in *Cleland* suggested that indigency, lack of insurance, race, sex, ethnic group, politics, occupation, education, personal prejudice, drunkenness, and spite are all possible improper motives resulting in the hospital’s liability under EMTALA.<sup>53</sup>

The Supreme Court overruled the “improper motive” standard for the stabilization duty in *Cleland* in *Roberts v. Galen of Virginia, Inc.*<sup>54</sup> In *Roberts*, the Supreme Court explicitly rejected its use because there was no such implication in the text of EMTALA.<sup>55</sup> The court found “no support for such a [motive] requirement in the text of the statute.”<sup>56</sup> The Supreme Court in this case also noted the “appropriate medical screening” circuit split:

The question of the correctness of the *Cleland* court’s reading of § 1395dd(a)’s “appropriate medical screening” requirement is not before us, and we express no opinion on it here. But there is no question that the text of § 1395dd(b) does not require an “appropriate” stabilization, nor can it reasonably be read to require an improper motive.

This fact is conceded by respondent, which notes in its brief that “the ‘motive’ test adopted by the court below . . . lacks support in any of the traditional sources of statutory construction.”<sup>57</sup>

When Elmhirst appealed the dismissal of her EMTALA claim, the appellate court applied the de novo standard of review.<sup>58</sup> The Sixth Circuit found that the district court properly dismissed her complaint for failing to allege an improper motive and directly applied *Cleland*.<sup>59</sup> But as mentioned in *Power*, the court creates an impossible burden of proof for a plaintiff to meet. Moreover, the court in *Elmhirst* justified its interpretation in an effort to distinguish a cause of action under EMTALA’s § 1395dd(a) from state-law medical malpractice claims.<sup>60</sup> Although the Supreme Court denied Elmhirst’s petition for certiorari,<sup>61</sup> a circuit split still exists—and *Elmhirst* pushes the interpretation of “appropriate” in the wrong direction.

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52. *Id.*

53. *Id.*

54. *Roberts v. Galen of Va., Inc.*, 525 U.S. 249, 250 (1999).

55. *Id.*

56. *Id.*

57. *Id.* at 253.

58. *Elmhirst v. McLaren N. Mich.*, 726 F. App’x 439, 441 (6th Cir. 2018), *cert. denied* 139 S. Ct. 325 (2018).

59. *Id.* at 440–41.

60. *Id.* at 442.

61. *Elmhirst v. McLaren N. Mich. Hosp.*, 139 S. Ct. 325 (2018).

The modernization of EMTALA can work to improve the quality of emergency care.<sup>62</sup> Outside commenters agree that an “improper motive” requirement should not be necessary for an EMTALA cause of action, and legislation revisions to make EMTALA more effective is the best route.<sup>63</sup> Jack Karns particularly showed disappointment in the Sixth Circuit’s decision to derive an “improper motive” retirement:

With all due respect to the Sixth Circuit, this is not the point of EMTALA. The Act is designed to protect patients who are critically injured by allowing hospitals to have screening and transfer decision procedures applied on a uniform basis. The scenario suggested by consideration of a proper or improper motive is not relevant in rendering an opinion for a case properly brought under EMTALA. The Sixth Circuit’s claim that the Cleland [sic] decision, if decided in any other manner, would effectively allow EMTALA to become a federal remedy for medical malpractice, is an overstatement because the statutory boundaries were clearly delineated in both the Act and by those who sponsored the legislation.<sup>64</sup>

Karns went on to make an incredible point: “Accordingly,” he states, “the court pointed out that EMTALA does not require doctors to conduct an appropriate medical screening in order to render a correct diagnosis, but rather that ‘they are charged with the duty [to] stabiliz[e] a patient’s condition as’ presented to them.”<sup>65</sup> He then closed his idea by saying, “This statement raises the rather interesting question as to whether it is theoretically or practically possible for a misdiagnosed condition to be properly stabilized.”<sup>66</sup>

The improper motive requirement is not a good one, and even courts within the Sixth Circuit do not uniformly agree with it. In *Burd v. Lebanon HMA*, the court criticized but followed the Sixth Circuit’s unique improper motive requirement and granted the defendant’s motion for summary judgment based on the plaintiff’s failure to provide evidence of such motive.<sup>67</sup>

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62. See generally Katharine Van Tassel, *Modernizing the Emergency Medical Treatment & Labor Act to Harmonize with the Affordable Care Act to Improve Equality, Quality and Cost of Emergency Care*, 15 HOUS. J. HEALTH L. & POL’Y 131 (2015).

63. See Judith L. Dobbertin, *Eliminating Patient Dumping: A Proposal for Model Legislation*, 28 VAL. U. L. REV. 291, 334–35 (1993). See generally Danielle Sapega, *Federal Code Blue: The Emergency Medical Treatment and Active Labor Act’s Prolonged Venture into Malpractice Law*, 29 TEMP. J. SCI. TECH. & ENVTL. L. 99 (2010).

64. Karns, *supra* note 1, at 365–66.

65. *Id.* at 366 (citing *Cleland v. Bronson Health Care Grp., Inc.*, 917 F.2d 266 (6th Cir. 1990)).

66. *Id.*

67. See *Burd v. Lebanon HMA, Inc.*, 756 F. Supp. 2d 896, 902–06 (M.D. Tenn. 2010).

### III. THE IMPACT OF THE “IMPROPER MOTIVE” ON THE AGING POPULATION

The federal standard for appropriate medical screening should not include a motive requirement. First, demographics are evolving; the emergency department (ED) in particular is rapidly graying.<sup>68</sup> Second, the medical screenings that older adults receive in an ED are extremely critical to their life expectancy and quality of life following a visit.<sup>69</sup> Ultimately, requiring an improper motive would negatively impact an already vulnerable population by creating unnecessary obstacles to remedies.

#### A. *The Silver Context*

The Silver Tsunami will inevitably flood emergency departments across the country with 10,000 baby boomers turning sixty-five years old each day.<sup>70</sup> The “Baby Boom” refers to births from 1946 to 1964 and has yet to show its full impact.<sup>71</sup> During this period, which was post-World War II, approximately seventy-five million Americans were born.<sup>72</sup> Moreover, the population of older adults is expected to increase: the percentage of Americans sixty-five years or older was 13% in 2010 and is projected to be more than 20% by 2030.<sup>73</sup>

Accordingly, “people ages sixty-five and older are the most likely to visit U.S. emergency departments”<sup>74</sup> and disproportionately use more emergency services than any other age group.<sup>75</sup> “Over 60 percent of hospital admissions for patients over the age of 65 come through the emergency department.”<sup>76</sup> However, some programs focus on improving

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68. See *As Baby Boomers Age, Projections Show an Increase in ED Visits and Subsequent Hospitalizations*, WEST HEALTH, <https://www.westhealth.org/resource/baby-boomers-age-projections-show-increase-ed-visits-subsequent-hospitalizations/> [https://perma.cc/EJ3T-NFWD].

69. See *infra* Section III(B).

70. Lisa Esposito, *What Is a Geriatric Emergency Department?*, U.S. NEWS (Sept. 28, 2018), <https://health.usnews.com/health-care/patient-advice/articles/2018-09-28/what-is-a-geriatric-emergency-department> [https://perma.cc/79MM-FCBJ].

71. Eric Berger, *The Graying of America: The Impact of Aging Baby Boomers on Emergency Departments*, 51 ANNALS EMERGENCY MED. 288, 288 (2008).

72. Sondra Williamson, *Serving an Aging Population in a Changing Health Care Landscape*, TEX. HOSP. ASS’N, May–June 2017, at 18.

73. JENNIFER M. ORTMAN, VICTORIA A. VELKOFF & HOWARD HOGAN, U.S. CENSUS BUREAU, AN AGING NATION: THE OLDER POPULATION IN THE UNITED STATES 2–3 (2014).

74. Esposito, *supra* note 70.

75. Mark McClelland & Jeanne M. Sorrell, *Enhancing Care of Older Adults in the Emergency Department: Old Problems and New Solutions*, 53 J. PSYCHOL. NURSING & MENTAL HEALTH SERVS. 18, 18–19 (2015).

76. Esposito, *supra* note 70.

ED care for older patients, which may help to reduce the chance of hospital admissions.<sup>77</sup>

Nonetheless, the emergency medicine system is at risk. The increasing volume of older patients will place a “huge demand on the entire health care system.”<sup>78</sup> According to Mr. Zia Agha, Chief Medical Officer at West Health Institute in San Diego, older adults in the ED must have *all* their needs thoroughly assessed, including medical and social problems.<sup>79</sup> “When the bulk of your patients are elderly, it’s just a lot more time consuming,” said Lynne Grief, who holds a Ph.D. in Nursing and directs Emergency Services at Sarasota Memorial Healthcare System in Sarasota, Florida.<sup>80</sup> “It’s definitely much more labor intensive.”<sup>81</sup>

Thus, tending to more elderly patients in emergency departments can mean less productivity for hospital staff; older individuals require more attention and their presenting symptoms are often not as straightforward compared to younger patients.<sup>82</sup> Overall, older patients usually need to have more diagnostic testing to attain effective answers.<sup>83</sup> In addition, communication in the ED can often be difficult due to the high prevalence of cognitive impairment of elderly patients.<sup>84</sup>

### *B. Importance of Medical Screening with Geriatric ED Patients*

Emergency Departments must adjust as baby boomers reach a geriatric status.<sup>85</sup> Older adults, unsurprisingly, are vulnerable patients, and approximately 25% of older adults discharged from the ED return to

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77. HIA Guest Blog, *Older Adult-Friendly Emergency Department Staff Help Reduce Hospital Admissions*, J. AM. GERIATRIC SOC’Y (Jan. 11, 2018), <http://www.healthinaging.org/blog/older-adult-friendly-emergency-department-staff-help-reduce-hospital-admissions/> [<https://perma.cc/V7FT-WSPN>].

78. Berger, *supra* note 71, at 289.

79. *Making Emergency Rooms Geriatric-Friendly*, STRAITS TIMES (Dec. 17, 2018), <https://www.straitstimes.com/lifestyle/making-emergency-rooms-geriatric-friendly> [<https://perma.cc/MGV6-GRH8>].

80. Berger, *supra* 71, at 289.

81. *Id.*

82. Tracy Hampton, *Experts Predict Visits by Baby Boomers Will Soon Strain Emergency Departments*, 299 J. AM. MED. ASS’N 2613, 2614 (2008). According to Dr. Bitondo Dyer, director of the Geriatric Medicine Division at the University of Texas Medical School in Houston, “Older people don’t present with diseases in the same ways that we’re taught in medical school.” *Id.* “For example, compared with their younger counterparts, older patients with pneumonia are less likely to have the typical hallmarks of fever and elevated white blood cell counts, and those with myocardial infarction are less likely to have chest pain.” *Id.*

83. *Id.*

84. *Id.*

85. *See generally* Joan Somes & Nancy Stephens Donatelli, *Retrofitting an Emergency Department to Make It Geriatric Friendly*, 43 J. EMERGENCY NURSING 472, 472–74 (2017).

hospitals within thirty days.<sup>86</sup> Moreover, older adults will be the most heavily impacted group of people under EMTALA as a matter of numbers.

For the geriatric population, the ED has a unique position in playing a role in improving care.<sup>87</sup> Essentially, the ED is an “ever-increasing access point for medical care,” and it is placed at a crossroads between inpatient and outpatient care.<sup>88</sup> The ED is essential. It “sets the stage” for subsequent care because it is the initial site of care for both inpatient and outpatient events.<sup>89</sup> Screening in the ED is critical; more accurate diagnoses can make the following care for older patients much more effective.<sup>90</sup>

The average ED geriatric patient stay is 20% longer than younger populations and uses 50% more lab and imaging services.<sup>91</sup> In addition, geriatric ED patients are 400% more likely to require social services, and geriatric patients frequently leave the ED dissatisfied.<sup>92</sup> “[O]ptimal outcomes are not consistently attained.”<sup>93</sup> These outcomes could be due to the possibility that the modern emergency care management model is not a fit for geriatric adults.<sup>94</sup> Overall, effective and reliable emergency medicine methods to improve post-ED geriatric outcomes face a number of challenges.<sup>95</sup>

Older adults should receive proper, “appropriate” screening, but the daily ED crowding makes effective screening difficult for all populations.<sup>96</sup> The most common priorities older ED patients raised were related to the accuracy and efficiency of the medical evaluation.<sup>97</sup> These priorities should be considered by those attempting to improve the emergency care of older adults.<sup>98</sup> Thus, the medical screening duty a hospital possesses is crucial as EDs are an important safety net and have a significant role in maintaining the health and safety of older adults.<sup>99</sup>

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86. Ula Hwang et al., *Transforming Emergency Care for Older Adults*, 32 HEALTH AFF. 2116, 2119 (2013).

87. Mark S. Rosenburg et al., Am. Coll. Emergency Physicians, *Geriatric Emergency Department Guidelines*, 63 ANNALS EMERGENCY MED. e7, e7 (2014).

88. *Id.*

89. *Id.*

90. *Id.*

91. *Id.*

92. *Id.*

93. *Id.*

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.* Among a sample of cognitively intact older ED patients.

98. See generally Katherine M. Hunold et al., *Priorities of Care Among Older Adults in the Emergency Department: A Cross-Sectional Study*, 23 ACAD. EMERGENCY MED. 362 (2016).

99. Christopher R. Carpenter et al., *High Yield Research Opportunities in Geriatric Emergency Medicine: Prehospital Care, Delirium, Adverse Drug Events, and Falls*, 66 A. J. GERONTOLOGY 775,

The Geriatric Task Force, which proposes guidelines for geriatric care, also finds screening to be specifically essential. In particular, when screening older adults, health care professionals must be especially cognizant of delirium.<sup>100</sup> “Delirium is an emergency medical condition that is associated with an increased risk of morbidity and mortality,” and patients who are discharged from the ED with delirium are nearly three times more likely to die within three months—compared to those whom emergency physicians identify with delirium.<sup>101</sup>

Approximately 1 in 10 older ED patients suffer from delirium.<sup>102</sup> However, emergency physicians recognize only a minority (16%–38%) as impaired.<sup>103</sup> Despite the continuing evidence supporting this finding, very little has changed.<sup>104</sup> “Older ED patients with delirium are still highly prevalent, poorly recognized, and frequently are discharged to home with inadequate planning and support.”<sup>105</sup>

In addition to screening for delirium, emergency department tools exist for screening older adults to determine if they are at risk for falls<sup>106</sup> or elder abuse<sup>107</sup>—all of which reinforce the importance of screening in the ED. Grossly inadequate screening should not be deemed as “appropriate” screening under EMTALA; it should count as the failure to screen. Further, plaintiffs should not have to prove a hospital’s improper motive because it has the same harmful effect as “patient dumping,” which is what Congress intended to prevent with EMTALA.<sup>108</sup>

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775 (2011) (“An ED visit by an older person often indicates heightened vulnerability to adverse outcomes (e.g., cognitive/functional decline, death).”).

100. Tamara G. Fong, Samir R. Tulebaev & Sharon K. Inouye, *Delirium in Elderly: Diagnosis, Prevention and Treatment*, NCBI (Mar. 29, 2011), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3065676/> [<https://perma.cc/EEV6-L4MA>] (“Delirium is a common clinical syndrome characterized by inattention and acute cognitive dysfunction.”).

101. Carpenter et al., *supra* note 99, at 777.

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.*

106. See generally Roberta A. Newton et al., *An Emergency Department Screen to Identify Older Adults At-Risk for Falls*, J. GERONTOLOGY & GERIATRIC RES. (Sept. 19, 2012), <https://www.omicsonline.org/open-access/an-emergency-department-screen-to-identify-older-adults-at-risk-for-falls-2167-7182.S1-002.php?aid=8953> [<https://perma.cc/2Y3Q-4ZCF>] (discussing fall statistics and relation to injury/death).

107. See Tony Rosen et al., *Recognizing and Managing Elder Abuse in the Emergency Department*, 49 EMERGENCY MED. 200, 200–07 (2017); see also *Elder Abuse and the Role of Emergency Medical Services EMS*, GERIPAL (Apr. 4, 2018), <https://www.geripal.org/2018/04/elder-abuse-and-EMS.html> [<https://perma.cc/3LB6-P2ED>].

108. “Patient dumping” is the practice of denying medical care due to a person’s status as being uninsured or lacking the ability to pay. See Tony Abraham, *Patient Dumping a Symptom of Health System Woes*, HEALTHCARE DIVE (Feb. 5, 2018), <https://www.healthcaredive.com/news/patient-dumping-symptom-of-health-system-woes/516018/> [<https://perma.cc/56B9-HZP3>].

#### IV. STATUTORY REVISION TO EMTALA'S APPROPRIATE MEDICAL SCREENING

The current EMTALA provision regarding “appropriate medical screening” has issues with its broad and ambiguous language.<sup>109</sup> The standard for “appropriate medical screening” should move toward including some component of negligence in defining the term “appropriate.” Ideally, a statutory revision would consider a grossly deficient medical screening “not appropriate” and be deemed a “failure to screen” under the EMTALA. In addition, this revision would expressly eliminate any need for a plaintiff to prove the defendant’s motive and focus on the defendant’s actions.

##### A. Issues with EMTALA’s Broad Language

Shortly after Congress passed EMTALA, some physicians predicted that its effectiveness would be crippled by its vague definitions of “emergency care” and “stabilization.”<sup>110</sup> While the physicians may have had other consequences in mind, they were right about one thing: the vagueness in the statute would create issues. However, courts have consistently been opposed to expanding EMTALA.<sup>111</sup> Nonetheless, EMTALA does not define the phrase “appropriate medical screening examination” beyond stating that its purpose is to identify the “emergency medical condition”<sup>112</sup> that has to be stabilized.<sup>113</sup> It does not define what it is and, maybe even more importantly, what it is not.

A recent commenter, Henna K. Pithia, expressed that the lack of a universally accepted definition for EMTALA’s “appropriate medical screening” is problematic because the way a court chooses to interpret it

109. See generally 42 U.S.C. § 1395dd(a) (2018).

110. *Id.*; see also Frank, *supra* note 12, at 232 (arguing that “EMTALA’s overbreadth may ultimately produce effects that are at odds with the goals that Congress hoped to attain in enacting this statute” and the “obvious problem is with the variety of judicial interpretations (most of which enjoy some plausibility) caused by the vagueness and overbreadth of the statute”); Mark J. Garwin, *Immunity in the Absence of Charity: EMTALA and the Eleventh Amendment*, 23 S. ILL. U. L.J. 1, 5–6 (1998) (“This variance in the courts’ rulings is a direct corollary of the failure of the statute’s language to accurately reflect the legislative intent behind its enactment.”).

111. Stephanie B. Livesay, *The New EMTALA Regulations: The Wrong Prescription for Emergency Department Congestion*, 3 APPALACHIAN J.L. 139, 155–156 (2004).

112. “Emergency medical condition” is defined as the following:

[M]anifesting 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) the placing of the health of the individual . . . in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part[.]

42 U.S.C. § 1395dd(e) (2011).

113. *Power v. Arlington Hosp. Ass’n*, 42 F.3d 851, 856 (4th Cir. 1994).

will determine whether or not an emergency medical condition exists.<sup>114</sup> She finds it critical that “these terms be defined more precisely and consistently.”<sup>115</sup>

State and federal courts are quite divided on how to apply EMTALA and “tug[] at the meaning of each provision.”<sup>116</sup> Although all the courts appear to agree that EMTALA does not create a federal medical malpractice claim, one court has described “an uneasy intersection between EMTALA and state law medical negligence claims.”<sup>117</sup>

Another commenter, George P. Smith (a professor of law at the Catholic University of America in Washington, D.C.<sup>118</sup>), has also expressed disagreement with EMTALA’s overly vague language<sup>119</sup>:

It has been suggested that EMTALA is ineffective because it has definitional flaws and enforcement shortcomings. Specifically, because the statute’s key words are either defined vaguely or not defined at all, courts juggle testimonies of medical experts and extract their own definitions. Oftentimes, the legislative history of EMTALA has been of value to judicial decisionmaking. . . . Judicial constructions of EMTALA’s language remain problematic because the courts must interpret the statute’s undefined terms and also apply those terms to a particular hospital’s practice.<sup>120</sup>

The overly broad language gives too much room for interpretation and ultimately can lead to harmful interpretations—such as requiring a plaintiff to allege an improper motive for the failure to appropriately screen in the emergency department.

### *B. Proposed Legislation for EMTALA’s Appropriate Medical Screening*

EMTALA should be looked at from a public health perspective in addition to case-by-case scenarios.<sup>121</sup> Public health looks at population health rather than just individual well-being.<sup>122</sup> “Appropriate medical

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114. Henna K. Pithia, *Patient Dumping: The Cobra That Never Struck*, 24 S. CAL. REV. L. & SOC. JUST. 109, 121–22 (2014).

115. *Id.* at 122.

116. Charlotte A. Hoffman, *EMTALA in the 21st Century: The Cornerstone of Care for Uninsured and Underinsured*, 47 NO. 11 DRI FOR DEF. 34 (2005) (quoting *Phillips v. Hillcrest Med. Ctr.*, 244 F.3d 790, 798 (10th Cir. 2001)).

117. *Id.*

118. George P. Smith, II, THE CATH. U. OF AM., <https://www.law.edu/about-us/faculty-and-staff/directory/expert-faculty/smith-george-p/index.html> [<https://perma.cc/PCS9-3UQX>].

119. George P. Smith, II, *The Elderly and Patient Dumping*, 73 FLA. B. J. 85, 86 (1999).

120. *Id.*

121. See generally Sara Rosenbaum & Brian Kamoie, *Finding a Way through the Hospital Door: The Role of EMTALA in Public Health Emergencies*, 31 J.L. MED. & ETHICS 590 (2003).

122. *What Is Public Health?*, CDC FOUND., <https://www.cdcfoundation.org/what-public-health> [<https://perma.cc/F6YL-BUQ5>].

screening” in EMTALA is just a piece of the puzzle; what EMTALA should be accomplishing for the public is the picture the puzzle creates. But the screening piece should be used to better protect the aging populations. James Bentley (a Senior Vice President of the American Hospital Association) writes, “[EMTALA] has a bias of caring [for] the individual over the community[.]”<sup>123</sup> Furthermore, Marlene Cimonis (a health policy and science journalist<sup>124</sup>) applies this same idea to the aging ED population:

[M]any emergency departments, while effective in dealing with acute problems, don’t always look at the big picture when it comes to older patients. This means comprehensive screening procedures to check all medications and health history, as well as conditions at home, with the aim of not having to admit them to the hospital.<sup>125</sup>

The vagueness in the statute hurts plaintiffs the most. The ambiguity in the phrase “appropriate medical screening examination” has created significant judicial confusion.<sup>126</sup> Even the court in *Cleland* declared the word “appropriate” to be “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.”<sup>127</sup> Interpreting “appropriate” to contain a motive on the part of the hospital creates a barrier which impedes on caring for older adults needs—which will eventually be the dominating population.<sup>128</sup>

If the “improper motive” expands, elderly patients will be significantly affected by the improper motive requirement as they are likely plaintiffs. However, EMTALA does not sufficiently protect elderly patients from being a victim of patient dumping.<sup>129</sup> Patient dumping and access to health care are already prominent issues for older adults since

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123. Rosenbaum & Kamoie, *supra* note 121, at 594 (quoting James Bentley, Senior Vice President, Am. Hosp. Ass’n, Remarks to the Second National Symposium on Medical & Public Health Response to Bioterrorism (Nov. 28, 2000)).

124. Marlene Cimonis, MUCK RUCK, <https://muckrack.com/marlene-cimonis> [<https://perma.cc/493G-XTU4>].

125. Marlene Cimonis, *ERs Can Be Loud, Hectic and Even Dangerous for the Elderly. Here’s How Hospitals Are Trying to Fix That*, WASH. POST (Dec. 8, 2018), [https://www.washingtonpost.com/national/health-science/ers-can-be-loud-hectic-and-even-dangerous-for-the-elderly-heres-how-hospitals-are-trying-to-fix-that/2018/12/07/9f242400-f362-11e8-80d0-f7e1948d55f4\\_story.html?noredirect=on&utm\\_term=.f9902318aab8](https://www.washingtonpost.com/national/health-science/ers-can-be-loud-hectic-and-even-dangerous-for-the-elderly-heres-how-hospitals-are-trying-to-fix-that/2018/12/07/9f242400-f362-11e8-80d0-f7e1948d55f4_story.html?noredirect=on&utm_term=.f9902318aab8) [<https://perma.cc/XP4D-NA55>].

126. Nathan S. Richards, *Judicial Resolution of EMTALA Screening Claims at Summary Judgment*, 87 N.Y.U. L. REV. 590, 603 (2012).

127. *Cleland v. Bronson Health Care Grp., Inc.*, 917 F.2d 266, 271 (6th Cir. 1990).

128. See Rosenbaum & Kamoie, *supra* note 121.

129. Smith, *supra* note 118, at 86.

they are not usually economically productive.<sup>130</sup> Generally, the elderly population is disproportionately impoverished as well as economically disadvantaged.<sup>131</sup> Thus, to better protect the elderly and to strengthen EMTALA's effectiveness—and to resolve the circuit split—Congress should clarify some of the statute's definitions.<sup>132</sup>

Some courts claim that EMTALA “is not a federal malpractice statute and it does not set a national emergency health care standard; claims of misdiagnosis or inadequate treatment are left to the state malpractice arena.”<sup>133</sup> Further, screening can satisfy EMTALA even if there is a misdiagnosis.<sup>134</sup> However, that does not mean there should be a near-impossible standard for plaintiffs to meet.

While some proposals for “appropriate screening” move toward eliminating overlap between medical malpractice and EMTALA screening,<sup>135</sup> this Comment proposes statutory language that would further overlap the two. Nevertheless, Beverly Cohen puts forward a worthy goal: “[T]o place control of enforcement back into the hands of the private individuals who were wronged in the first place.”<sup>136</sup> A statutory revision to § 1395dd(a) should expand the statute to include §§ 1395dd(a)(1) and 1395dd(a)(2) and read as follows:

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an *appropriate medical screening* examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.

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130. *Id.* at 87.

131. *Id.*

132. *Id.* at 86.

133. *E.g.*, *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996); *see also Del Carmen Guadalupe v. Negron Agosto*, 299 F.3d 15, 21 (1st Cir. 2002).

134. *See generally* Hemanth Gundavaram, *EMTALA: Screening Can Satisfy EMTALA, Despite Misdiagnosis*, 31 J.L. MED. & ETHICS 169, 170 (2003).

135. *See* Beverly Cohen, *Disentangling EMTALA from Medical Malpractice: Revising EMTALA's Screening Standard to Differentiate between Ordinary Negligence and Discriminatory Denials of Care*, 82 TUL. L. REV. 645, 683 (2007).

136. Lawrence Bluestone, *Straddling the Line of Medical Malpractice: Why There Should Be a Private Cause of Action against Physicians via EMTALA*, 28 CARDOZO L. REV. 2829, 2864 (2007).

- 1) “Appropriate” shall not be read to require an individual to prove an intent or any type of motivation on the part of the hospital. The standard shall be construed as a strict-liability provision.
- 2) A hospital’s gross deviation from the standard of care or grossly deficient screening shall be considered a failure to provide an appropriate medical screening.

This language eliminates the possibility of a court interpreting an improper motive from an “appropriate medical screening” and allows the patient the fair opportunity to bring a case under EMTALA when he or she has received grossly deficient medical screening. This interpretation is a higher standard than ordinary professional negligence,<sup>137</sup> yet provides a great protection for patients—and a greater protection for geriatric patients whose lives depend on effective screening.

The text of the appropriate screening requirement, like the “stabilization” requirement as the Supreme Court pointed out in *Roberts*, does not strongly implicate an improper motive.<sup>138</sup> Even under the majority standard, plaintiffs have difficulty achieving a case.<sup>139</sup> But the Sixth Circuit adds an extra barrier, which is unnecessary and even renders the private right of action useless to most injured plaintiffs.

#### CONCLUSION

The statutory revision provided in this Comment would better achieve Congress’s goal to prevent a type of “patient dumping.” While some commentators express concern of excessive litigation<sup>140</sup> or view the rationale for the improper motive requirement as “[o]ne way of limiting the potentially sweeping scope of the statute’s language[,] . . .”<sup>141</sup> effective patient dumping prevention is important. In the modern context, the Sixth Circuit’s interpretation makes inadequate and grossly deficient screening of an elderly person “appropriate,” forcing plaintiffs to prove a hospital’s improper motive in its failure to screen, a near-impossible standard to meet, has the same effect as kicking patients to the curb.<sup>142</sup>

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137. *E.g.*, *Hardy v. Marsh*, 170 S.W.3d 865 (Tex. App. 2005) (citations omitted) (“The standard of care for a doctor is what a reasonable and prudent doctor would have done under the same or similar circumstances. Identifying the standard of care is critical because ‘[w]hether a defendant breached his or her duty to a patient cannot be determined absent specific information about what the defendant should have done differently.’”).

138. *Roberts v. Galen of Va. Inc.*, 525 U.S. 250 (1999).

139. *See, e.g.*, *Jackson v. E. Bay Hosp.*, 246 F.3d 1248 (9th Cir. 2001).

140. Tristan Dollinger, *America’s Unraveling Safety Net: EMTALA’s Effect on Emergency Departments, Problems and Solutions*, 98 MARQ. L. REV. 1759, 1762 (2015).

141. *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996).

142. *See generally* *Elmhirst v. McLaren N. Mich.*, 726 F. App’x 439 (6th Cir. 2018).

Removing the obstacle of an improper motive for vulnerable plaintiffs and providing them with federal remedies for a grossly deficient screening does not suddenly transform EMTALA into a horrific federalized medical malpractice law. Rather, it protects the aging population, further encourages effective screening, and promotes nondiscrimination by stressing a truly “appropriate” medical screening standard for all patients.