Santa Clara Law Review

Volume 31 | Number 3 Article 5

1-1-1991

Taking Aim at Hospital Dumping of Emergency Department Patients: The Cobra Strikes Back

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TAKING AIM AT HOSPITAL "DUMPING" OF EMERGENCY DEPARTMENT PATIENTS: THE COBRA STRIKES BACK

I. INTRODUCTION

Imagine, if you will, a seriously injured accident victim lying in a hospital emergency room bleeding profusely. While for many of us this scene conjures up images of kindly health care professionals in white lab coats working frantically to treat the unfortunate victim, for millions of Americans the harsh reality is that they will not receive adequate treatment, nor any at all. The fact is that in private hospitals, those who can pay or can guarantee payment by a third party payor will receive care while those thirty-five million Americans[1] who do not have health insurance will, in all likelihood, receive a cursory examination only to be "shipped off" to a county hospital.[2] The concept just described is known politely as "patient transfer." In not so polite conversation the same concept is known

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1. *See* Dallek & Waxman, *"Patient Dumping:" A Crisis in Emergency Medical Care for the Indigent*, 19 CLEARINGHOUSE REV. 1413, 1413 (1986) (citing U.S. BUREAU OF THE CENSUS, CURRENT POPULATION SURVEY (1984)).

2. A review of the studies detailing the incidence of patient transfers, and the type of individual most likely to be transferred, reveals that the majority of transferred patients lacks health insurance.

> A study at Highland General Hospital in Oakland, California, found that of 458 patients transferred to the emergency department from other hospitals, 63% had no insurance, 21% had Medicaid, 13% had Medicare, and only 3% had private insurance. This study also presented evidence that a disproportionately large number of transferred patients were minorities. A study of 1021 patients transferred from other hospitals to the emergency department of Parkland Memorial Hospital in Dallas found that 77% of the transferred patients lacked third-party coverage. A study from Cook County Hospital in Chicago of 467 patients transferred to the emergency department from other hospitals found that the transferred patients were predominantly black or Hispanic (89%), were largely unemployed (81%), and were usually transferred because they lacked adequate health insurance (87%).

Ansell & Schiff, *Patient Dumping; Status, Implications, and Policy Recommendations*, 257 J. A.M.A 1500, 1500 (1987) (citations omitted).

as "dumping."[3] In essence, dumping is the refusal of a hospital to care for an emergency patient based on that patient's supposed inability to pay for treatment.[4] By transferring an indigent or uninsured person, the private hospital can shift the cost burden of caring for the individual to a public hospital. Widespread dumping, therefore, has had a tremendous negative economic impact on public sector hospitals.[5] In addition

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3. The cases are replete with examples of patient dumping by private hospitals. *See, e.g.*, Thompson v. St. Anne's Hosp., 716 F. Supp. 8 (N.D. Ill. 1989) (private hospital transferred an unstabilized, indigent, pregnant woman who was experiencing labor pains and vaginal bleeding to a county hospital); DeBerry v. Sherman Hosp. Ass'n, 741 F. Supp. 1302 (N.D. Ill. 1990) (patient sought treatment at defendant hospital's emergency department. The patient was treated but released before the condition was stabilized. Two days later when the patient finally was admitted to the hospital it was determined that the patient was suffering from spinal meningitis). In one particularly egregious case, an indigent, teenage, pregnant woman, in labor, was refused admission at the defendant hospital after examination. The physician who examined her directed her to a hospital approximately 200 miles away, and when queried about transportation to said facility instructed the woman to make the journey in her boyfriend's 1976 Ford Pinto. The good doctor additionally advised that she not speed. *See* Owens v. Nacogdoches County Hosp. Dist., 741 F. Supp. 1269 (E.D. Tex. 1990). In addition to the aforementioned cases, numerous newspaper articles illustrate widespread dumping of indigent patients by private hospitals' emergency departments. *See, e.g.*, Gollner, *Doctor "Dumped" Indigent Patient, State Panel Told*, L.A. Times, Mar. 29, 1990, at B3, col. 1 (Valley ed.); Gewertz, *Lawsuit Blames Hospitals for Indigent Man's Death*, L.A. Times, Mar. 30, 1990, at B3, col. 1 (San Diego County ed.); Blum, Cox, Lavelle, *Doctor Fined for Dumping Patient in Labor*, NAT'L L.J., Aug. 14, 1989, at 6.

4. "Patient dumping is the refusal of hospitals, usually private hospitals, to treat patients in need of emergency care (many of them women in labor) because of their inability to pay. Instead of receiving treatment the indigent, uninsured patient is turned away or shuffled across town to the nearest public hospital; the latter practice is euphemistically referred to as an 'economic transfer.'" McClurg, *Your Money or Your Life: Interpreting the Federal Act Against Patient Dumping*, 24 WAKE FOREST L. REV. 173, 174 (1989) [hereinafter *Your Money or Your Life*]. Dumping has also been defined as "the denial of or limitation in the provision of medical services to a patient for economic reasons and the referral of that patient elsewhere." Ansell & Schiff, *supra* note 2, at 1500. It has also been defined as "the denial of emergency medical services or the premature transfer of one patient from one hospital to another because that person cannot guarantee payment. Hospital administrators euphemistically have called this practice 'demarketing of services' and 'transfers of patients for economic reasons.'" Enfield & Sklar, *Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem*, 13 AM. J.L. & MED. 561, 562 n.1 (citing Friedman, *The "Dumping" Dilemma: The Poor Are Always With Some of Us*, HOSP., Sept. 1, 1982, at 51). Dumping has also been referred to as "economic triage." *Id.*

5. Drs. Ansell and Schiff have demonstrated and documented the economic impact on public hospitals as a result of private hospitals refusal to treat indigent patients. Ansell and Schiff report that:

to the economic costs of patient transfer, there are the medical costs to be considered. The medical consequences of dumping are serious and even fatal. Studies done at Highland General Hospital in Oakland, California, Parkland Memorial Hospital in Dallas, Texas, and Cook County Hospital in Chicago, Illinois, have found that 32% of transferred patients' medical conditions were jeopardized by transfer (Highland Study), 24% of those patients transferred were not in a stabilized condition at the time of the transfer (Cook County Study), and 22% of the dumped patients' medical conditions were serious enough to merit admission to the intensive care unit (Cook County Study).[6] Other medical costs of dumping include delay in receiving necessary medical treatment and a higher mortality rate for those persons dumped.[7]

This comment will address the federal antidumping legislation—as embodied in 42 U.S.C. § 1395dd ("COBRA")—as well as the California antidumping provisions. The purpose of this comment is to compare and contrast the California and the federal antidumping legislation with emphasis on the definitional differences in these provisions relating to an "emergency," a "stable patient" and a "transfer." Other areas to be discussed include when a patient transfer is acceptable and appropriate, and the liability of hospitals and doctors for the improper transfer of a patient. Finally, this comment will address some of the unresolved aspects of antidumping legislation such as an "implicit transfer" or "constructive dumping" in which a hospital does not transfer a patient from its emer-

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> In Chicago, transfers to its emergency department of patients from other hospitals who required medical and surgical care cost Cook County Hospital an estimated $24.1 million in 1983 in uncompensated care. If the patients transferred to Cook County Hospital are representative of the patients transferred to public hospitals nationwide, the cost to public hospitals in the United States just of transferred patients requiring medical and surgical care would be $1.04 billion annually. This constitutes a direct shift of costs from the private health sector to financially troubled public hospitals. This $1.04 billion estimate of costs would be substantially higher if patients requiring pediatric, obstetric-gynecologic, and psychiatric care were included.

Ansell & Schiff, *supra* note 2, at 1500 (citations omitted).

6. *See generally* Ansell & Schiff, *supra* note 2.

7. *See* Ansell & Schiff, *supra* note 2, at 1500 (citations omitted) ("In Chicago, transferred patients requiring medical (i.e. nonsurgical) care had more than twice the mortality rate of patients directly admitted to Cook County Hospital").

gency room but instead "shuts down" to an ambulance carrying the injured party from the scene of an accident and reroutes the ambulance—a practice known as "diversion"—to another hospital. The author will suggest various statutory enactments that would deal with the aforementioned unresolved aspects of federal and state antidumping legislation.

II. BACKGROUND

A. *Reasons for Dumping*

In these days of ever-increasing medical costs,[8] private hospitals have been forced to become more competitive and cost efficient.[9] As the costs of providing quality health care services skyrocketed during the past decade or so, hospitals responded by undertaking actions which, although lessening the hospitals' costs, can also result in violations of federal antitrust[10] and antidumping laws. In order to reduce costs and expenses, avoid the duplication of facilities, and promote efficiency, hospitals have resorted to merging with other hospitals,[11] acquiring other hospitals,[12] and establishing exclusive contracts with physicians for such medical services as anesthe-

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8. To illustrate the recent increases in the cost of medical care consider the following figures:

> Medicaid, the joint state and federal program designed to provide care to certain groups of the poor, spent over $23 billion in 1980, compared with $6.3 billion in 1972. The cost of a day in the hospital has increased over 1000 percent since 1950. Health care costs have increased from 7.8 percent of the Gross National Product (GNP) in 1978 to 10.8 percent of the GNP in 1983.

Enfield & Sklar, *supra* note 4, at 563 (citing Perkins, *The Effects of Health Care Cost Containment on the Poor: An Overview*, 19 CLEARINGHOUSE REV. 831 (1985)). National health care costs in the last twenty years have increased from $50 billion annually to $500 billion annually. *See Your Money or Your Life*, *supra* note 4, at 181 (citing *Can You Afford to Get Sick?*, NEWSWEEK, Jan. 30, 1989, at 46).

9. Note, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. REV. 1186, 1195 (1986) [hereinafter *Preventing Patient Dumping*].

10. Federal antitrust law consists of the Sherman Act (15 U.S.C. §§ 1-7 (1990)), the Clayton Act (15 U.S.C. §§ 18-27 (1990)), and the Federal Trade Commission Act (15 U.S.C. §§ 45-58 (1990)).

11. *See, e.g.*, United States v. Carillion Health Sys., 707 F. Supp. 840 (W.D. Va. 1989), *aff'd without opinion*, 892 F.2d 1042 (4th Cir. 1989); United States v. Rockford Memorial Corp., 898 F.2d 1278 (7th Cir. 1990), *cert. denied*, 111 S. Ct. 1295 (1990).

12. *See, e.g.*, Hospital Corp. of Am. v. FTC, 807 F.2d 1381 (7th Cir. 1986).

sia and radiology.[13] These cost-cutting measures, although often subjecting the hospital to increased antitrust scrutiny by the Federal Trade Commission (FTC) and the Department of Justice, are to be applauded as valiant attempts by the health care industry to control spiralling health care costs. However, an unfortunate result of economic competitiveness in the health care industry, and hospital efforts to contain costs, is increased dumping of uninsured and underinsured persons.

The idea of hospitals as economically competitive entities is a phenomenon of recent vintage. Historically, hospitals were seen as "noncompetitive entities."[14] In the past, the structure of the health care industry was thought to be noncompetitive because "the demand for health care was independent of the price of services . . . [and] the activities of normal consumers."[15] In the past, because the demand for health care was inelastic[16] (or independent of the cost of the health care services required) the health care industry was viewed as noncompetitive.[17] Recently, however, courts have recognized the competitiveness in the hospital industry based on a realistic look at how the industry actually operates, and have abandoned the traditional view of hospitals as noncompetitive entities.[18] Be-

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13. *See, e.g.*, Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2 (1984).

14. Note, *Defining the Relevant Market in Health Care Antitrust Litigation: Hospital Mergers*, 75 KY. L.J. 175, 177 (1986) [hereinafter Note, *Defining the Relevant Market*].

15. *Id.* at 177 (footnote omitted).

16. "An inelastic demand is said to exist when a one percent increase in price causes a less than one percent decrease in the quantity demanded. In general, a consumer's demand is inelastic when it is not very sensitive to price changes in either direction." Schramm & Renn, *Hospital Mergers, Market Concentration and the Herfindahl-Hirschman Index*, 33 EMORY L.J. 869, 883 n.34 (citation omitted).

17. *See* Note, *Defining the Relevant Market*, *supra* note 14, at 177-78.

18. As noted, one result of this abandonment of the view of hospitals as noncompetitive entities is increased antitrust scrutiny and enforcement in the health care industry. While the scope of this comment is not broad enough to accommodate an exhaustive review of the antitrust implications of the new "competitiveness" among hospital, suffice it to say that presently "health care industries are just as constrained by the antitrust laws as are other industries." Proger, *Antitrust Developments Affecting the Health Care Sector*, 57 ANTITRUST L.J. 315, 317 (1988). In fact, "[b]y rough count, five times as many health antitrust actions have been brought since . . . 1975 than during the previous 85 years of Sherman Act history." Note, *Defining the Relevant Market*, *supra* note 14, at 178 n.16 (citing Halper, *The Health Care Industry and the Antitrust Laws: Collision Course?*, 49 ANTITRUST L.J. 17, 17 (1980)). Moreover, it is clear that the courts will continue to

cause of changes in the structure of hospital reimbursement and payment systems, and "consumer pressure to reduce the escalating cost[s] of health care,"[19] hospitals have been forced to become more cost efficient, and, as a result, competition in the industry has increased. In this climate of increasing economic competitiveness, and cost awareness, providing health care for those unable to pay is not only impractical, but also "bad business."[20] Thus now, more so than ever, hospitals are likely to dump uninsured patients.[21] In fact, "[a]nnually an estimated 250,000 patients in need of emergency care are transferred for economic reasons."[22] A myriad of reasons have been postulated to explain these large numbers of dumped patients. Among the most common are an increase in the number of uninsured Americans and federal cost containment programs.

1. *An Increase in the Number of Uninsured Americans*

From 1979 to 1984, the number of uninsured Americans under the age of sixty-five increased from 29 million to 35 million[23] due to dramatic reductions in Medicaid and Medicare,[24] as well as employer-sponsored traditional insurance plans. Accordingly, the number of poor covered by Medicaid in 1984 was less than 40%, whereas in 1965 the number of

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treat the health care industry the same as other industries in applying the antitrust laws. *See, e.g.*, Patrick v. Burgett, 486 U.S. 94 (1988); Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2 (1984); Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982); United States v. Rockford Memorial Corp., 898 F.2d 1278 (7th Cir. 1990), *cert. denied*, 111 S. Ct. 1295 (1990); United States v. Carillion Health Sys., 707 F. Supp. 840 (W.D. Va. 1989), *aff'd without opinion*, 892 F.2d 1042 (4th Cir. 1989); and Hospital Corp. of Am. v. FTC, 807 F.2d 1381 (7th Cir. 1986).

19. Note, *Hospital Antitrust: The Merging Hospital and the Resulting Exposure to Antitrust Merger and Monopolization Laws*, 24 WASHBURN L.J. 300, 303 n.23 (1984).

20. *Preventing Patient Dumping*, *supra* note 9, at 1195.

21. *Preventing Patient Dumping*, *supra* note 9, at 1193.

22. Waxman, *Protecting Emergency Room Patients: The Dumping Must Stop*, 24 TRIAL 58 (1988) [hereinafter *Protecting Emergency Room Patients*] (citing Ansell & Schiff, *supra* note 2, at 1500).

23. "This dramatic increase is due, in part, to federal and state reductions in the Medicaid program. Over one million people were cut from the Medicaid program from 1981 to 1985." *Preventing Patient Dumping*, *supra* note 9, at 1193-94 (citing Dowell, *Hill-Burton: The Unfulfilled Promise*, 12 J. HEALTH POL. POL'Y & L. 153, 153 n.1 (1987)).

24. *Preventing Patient Dumping*, *supra* note 9, at 1193.

poor covered was equal to 70%.[25] This dramatic decrease in Medicaid coverage has left millions of poor Americans without any medical insurance whatsoever. In fact, between the years 1981 and 1985 over one million people were dropped from the Medicaid program.[26] Medicaid now insures less than half the Americans who live below the federal poverty line.[27] Furthermore, "[i]n some states, Medicaid coverage has deteriorated so badly that a family of four with an annual income of more than $4,248 is no longer eligible for benefits."[28]

In addition to Medicare and Medicaid cutbacks, American corporations and employers have scaled back on health care expenditures for employees. This has been done by simply denying health care coverage completely to certain employees and by limiting coverage to Health Maintenance Organizations (HMO's)[29] or Preferred Provider Organizations (PPO's).[30]

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25. *Preventing Patient Dumping, supra* note 9, at 1194 (citing Reinhold, *Treating An Outbreak of Patient Dumping in Texas,* N.Y. Times, May 25, 1986, § 4, at 4, col. 3.)

26. *See Your Money or Your Life, supra* note 4, at 180.

27. *See Your Money or Your Life, supra* note 4, at 180.

28. *Your Money or Your Life, supra* note 4, at 180 (citing *Can You Afford to Get Sick?,* NEWSWEEK, Jan. 30, 1989, at 46).

29. Health Maintenance Organizations (HMO's) are a kind of prepaid medical insurance plan in which the HMO's assume a contractual obligation to assure the delivery of health services to enrollees who pay a fixed premium. In so-called 'open panel' HMO's, physicians are reimbursed on a fee-for-service basis, but the total fees are limited by the amount of payments by subscribers. This plan alters the incentive structure found in conventional insurance plans. In a conventional plan, both the patient and the physician have an incentive to overconsume health care services, the patient because he does not bear the full cost of the services and the provider because his income rises as the patient's consumption rises. In an HMO plan, the patient has an even greater incentive to overconsume because there are no deductibles or co-insurance features. The provider, however, has an incentive to underprovide, because once the premiums are paid, additional services serve only to increase costs. The result is that HMO's offer a lower-cost option to those willing to accept fewer services in return. *Your Money or Your Life, supra* note 4, at 181 n.45 (citations omitted).

30. Under a PPO arrangement, the hospital or insurance company will pay the expenses of patients who use particular health care providers, chosen by the hospital or insurance company, in exchange for a fixed monthly fee. Under the plan, if the health care consumer utilizes the services of a health care provider who is not a "preferred provider" the consumer is forced to pay all, or part of, the cost of the services. The intent of a PPO is to induce consumers to seek health care services from the preferred providers. The effect of this arrangement is that the preferred providers will receive more business, and thus in exchange for the increase in business the preferred providers will agree to reduce their fees for the services. Thus the PPO can pass along the savings to health care consum-

As one commentator has noted:

> In 1984, traditional company insurance plans covered 96% of American workers, allowing them to choose their source of care and to get reimbursed for the costs. Today, only 28% of workers are able to participate in such plans; the rest have been forced to accept Health Maintenance Organizations or Preferred Provider Organizations that restrict coverage or limit which doctors they can see.[31]

Consequently, private hospitals are unable to seek reimbursement for emergency care tendered to these uninsured persons and have increasingly resorted to patient dumping.[32]

2. *Federal Cost Containment Programs*

As cost containment programs of the federal government have increased, so has the problem of patient dumping. Beginning in 1983, the way in which Medicare was financed was changed by Congress from a system reimbursing hospitals for the "reasonable costs they incurred in providing medical care to Medicare beneficiaries"[33] to a "prospective payment system."[34] Under this prospective payment system, the federal government pays hospitals a fixed, predetermined sum for the care provided to the Medicare patient based upon a classification of the patient's treatment under "Diagnosis Related Groups (DRGs)."[35]

Thus, under this fixed payment system of Medicare reimbursement, "[i]f the hospital can care for the patient for less than the fixed sum, it may keep the surplus as profits. If, however, the cost of care exceeds the fixed payment, the hospital must absorb the additional cost."[36] It was hoped that this new system of Medicare reimbursement would create greater hospi-

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ers who are part of the plan. *See* Ball Memorial Hosp., Inc., v. Mutual Hosp. Ins., Inc., 784 F.2d 1325, 1330 (7th Cir. 1986); *See also* Note, *Ball Memorial Hospital: Section 2 Sherman Act Analysis in the Alternative Health Care Delivery Market,* 14 AM. J.L. & MED. 249, 250-51 (1988). For a more complete discussion of Preferred Provider Organizations, see Comment, *Preferred Provider Organizations: Can Doctors Do the Price-Fixing?,* 37 OKLA. L. REV. 733 (1984).

31. *Your Money or Your Life, supra* note 4, at 181 (footnotes omitted).
32. *See Preventing Patient Dumping, supra* note 9, at 1194.
33. *Preventing Patient Dumping, supra* note 9, at 1194.
34. *Preventing Patient Dumping, supra* note 9, at 1194.
35. *See* 42 Fed. Reg. 34, 728 (1984) (codified at 42 C.F.R. 405).
36. *Preventing Patient Dumping, supra* note 9, at 1194.

tal efficiency, and less waste of resources, by essentially rewarding the efficient hospital, which could keep the surplus, and punishing the inefficient hospital, which would be forced to absorb the loss. Although the merits of this sort of economic incentive are open to debate, one thing is perfectly clear: As hospitals became increasingly risk adverse with regard to absorbing the cost of Medicare patients, dumping increased. The "incentive" created by the arguably ill-conceived DRG system was to treat fewer Medicare patients. Consequently, as the administrators and policy makers of many hospitals came to regard "charity care as an inefficient giveaway,"[37] patient dumping increased.[38]

In short, due to the changes in the Medicare reimbursement system, consumer pressures to reduce the increasing costs of medical treatment, and competition from low cost alternatives to traditional in-hospital health care services (i.e. free-standing urgent care centers which compete directly with hospital emergency departments) hospitals have been forced, in the words of one commentator, "to enter the arena of strategic planning."[39] A hospital's "strategic plan" generally boils down to the hospital concentrating on ways to control its costs and expenses, and strategies to maintain, or expand, its market

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37. *Preventing Patient Dumping, supra* note 9, at 1194.

38. In the medical literature regarding patient dumping, or economic transfer, of the uninsured and underinsured, commentators have remarked that "[m]oral and ethical guidelines to protect patients are being increasingly ignored by hospitals given strong incentives to transfer the uninsured. At many private hospitals' emergency departments, pressure is placed on physicians to refrain from admitting uninsured patients." Ansell & Schiff, *supra* note 2, at 1501 (citing Bernard, *Patient Dumping: A Resident's First-Hand View*, 34 NEW PHYSICIAN 23 (1985); Anderson, Cawley, & Andrulis, *The Evolution of A Public Hospital Transfer Policy*, 2 METROPOLITAN HOSP. 1 (1985)). In addition, "[a] patient's condition might even be misrepresented in efforts to transfer them to a public hospital." *Id.* (citing Anderson, Crawley, & Andrulis, *The Evolution of A Public Hospital Transfer Policy*, 2 METROPOLITAN HOSP. 1 (1985)). For discussion of a study of patient transfers to Highland General Hospital in Oakland, California, see Himmelstein, Woolhandler, Harnly, Bader, Silber, Backer and Jones, *Patient Transfers: Medical Practice as Social Triage*, 74 AM. J. OF PUB. HEALTH, 494 (1984).

39. Note, *Hospital Antitrust: The Merging Hospital and the Resulting Exposure to Antitrust Merger and Monopolization Laws*, 24 WASHBURN L.J. 300, 301-02 (1984). "Strategic planning includes 'the systematic generation and analysis of information on environmental trends, market needs, demands, competition and performance.'" *Id.* at 302 n.15 (quoting Gregory & Klegon, *The Value of Strategic Marketing to the Hospital*, HEALTH CARE FIN. MGMT., Dec. 1983, at 16).

base.[40] Furthermore, as part of the "strategic plan," hospitals diversify to combat the "competition created by regulat[ory] and economic pressures."[41] If hospitals fail to diversify, and fail to become more cost efficient, "many inefficient hospitals may become insolvent."[42] Another tragic result of "strategic planning" is increased dumping of indigent emergency department patients. This increase in patient dumping, brought on by an increase in the number of uninsured Americans and the DRG system, created the need for legislative action to combat the phenomenon. Thus, the United States Congress and many state legislatures responded with antidumping legislation.[43] In the next section of this comment an analysis of federal and California anti-dumping legislation will be undertaken.

B. *Legislative Attempts to Curb Patient Dumping*

1. *The Federal Response to Patient Dumping: COBRA*

In 1985, the United States Congress enacted legislation designed to protect emergency room patients from improper and inappropriate transfers.[44] The federal antidumping legislation is contained in section 9121 of the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as "COBRA."[45] This legislation is intended to apply to emergen-

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40. *See id.* at 302.

41. *Id.* "Diversification may take the form of expansion, consolidation, acquisitions, and joint ventures." *Id.* (footnote omitted).

42. *Id.* (footnote omitted).

43. In addition to federal and state legislation prohibiting or limiting patient transfers based on economic considerations, ethical guidelines exist which counsel against patient dumping. For example, "[t]he Joint Commission on Accreditation of Hospitals states that 'individuals shall be accorded impartial access to treatment or accommodations that are available or medically indicated, regardless of race, creed, sex, national origin, or sources of payment for care.'" Ansell & Schiff, *supra* note 2, at 1502 (quoting Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals, at ix (1984)). Additionally, "[t]he emergency care guidelines of the American College of Emergency Physicians states that 'emergency care should be provided to all patients without regard to their ability to pay.'" Ansell & Schiff, *supra* note 2, at 1502 (quoting American College of Emergency Physicians, *Emergency Care Guidelines (Position Paper)*, 11 ANN. EMERG. MED. 222, 222-26 (1982)).

44. "The purpose of the Anti-Dumping Act is to end the national scandal, as Senator Durenberger described it, of 'rejecting indigent patients in life threatening situations for economic reasons alone.'" Owens v. Nacogdoches County Hosp. Dist., 741 F. Supp. 1269, 1281 (E.D. Tex. 1990) (quoting 131 CONG. REC. S13903 (daily ed. Oct. 23, 1985)).

45. Pub. L. No. 99-272, § 1921, 100 Stat. 82, 164-67 (codified as amended at

cy medical conditions and women in the final stages of childbirth.[46]

In essence, COBRA requires participating Medicare hospitals, which staff an emergency room, to examine all individuals, regardless of whether that person is eligible for Medicare benefits, to determine if a medical emergency exists.[47] If a medical emergency does exist, the hospital is required to stabilize the emergency condition.[48] Under COBRA, a hospital is not necessarily prohibited from transferring an emergency department patient, but rather is required to restrict the transfer until the individual's condition has been stabilized.[49] Furthermore, COBRA states that a transfer of a stabilized emergency department patient may not be made unless the individual or the individual's guardian requests the transfer,[50] or a

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42 U.S.C. § 1395dd (1988).

COBRA is not the first federal legislative response to the problem of dumping of uninsured patients by private hospitals. Rather, Congress' first attempt to force private hospitals to treat uninsured emergency department patients is found in the Hill-Burton Act, 42 U.S.C. § 291 (1988). The Hill-Burton Act, enacted in 1946, was not primarily concerned with the problem of patient dumping, but instead was enacted to provide federal money to aid states in the construction of new hospitals and the modernization of older facilities. *See Preventing Patient Dumping, supra* note 9, at 1198. In return for this federal assistance, the Hill-Burton Act required participating hospitals to "provide, for a twenty year period, a reasonable volume of free or below-cost care to any person unable to pay." *Preventing Patient Dumping, supra* note 9, at 1198 (footnote omitted). However, the Hill-Burton Act, because of lack of enforcement by the Department of Health and Human Services and deficiencies in the statute's penalty and definition sections, was ineffective in checking the flow of uninsured or indigent patients transferred from private hospitals' emergency departments. In response to the failure of Hill-Burton, Congress in 1986 enacted the antidumping provisions of COBRA. For a more detailed analysis of the Hill-Burton Act and its failure to protect the uninsured emergency department patient, see Dowell, *Hill-Burton: The Unfulfilled Promise,* 12 J. HEALTH POL. POL'Y & L. 153 (1987); *Preventing Patient Dumping, supra* note 9, at 1198-1201.

46. *See* 42 U.S.C. § 1395dd (1988).

47. *See id.* § 1395dd(a) ("In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for . . . [Medicare benefits]) 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 . . . to determine whether or not an emergency medical condition . . . exists.").

48. *Id.* § 1395dd(b)(1)(A) ("If any individual . . . comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide . . . for such further medical examination and such treatment as may be required to stabilize the medical condition . . . .").

49. *See id.* § 1395dd(c).

50.

If an individual at a hospital has an emergency medical condition

physician determines that "the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual . . . from effecting the transfer."[51]

COBRA further states that an appropriate transfer is one in which the receiving medical facility "has available space and qualified personnel for the treatment of the individual,"[52] and "has agreed to accept transfer of the individual and to provide appropriate medical treatment."[53] Moreover, COBRA requires that the transferring hospital provide the receiving hospital with all of the transferred patient's medical records.[54] COBRA also requires that the patient transfer be effectuated by qualified medical personnel employing medically appropriate standards of transfer.[55]

a. *Enforcement of Federal Antidumping Legislation*

Enforcement of the federal antidumping legislation is implemented in three ways: (1) through a suspension or revoca-

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which has not been stabilized . . . the hospital may not transfer the individual unless—

(A)(i) the individual (or a legally responsible individual acting on the patient's behalf) after being informed of the hospital's obligations under this section and of the risks of transfer, in writing requests transfer to another medical facility.

Id. § 1395dd(c)(1)(A)(i).

51. *Id.* § 1395dd(c)(1)(A)(ii).

52. *Id.* § 1395dd(c)(2)(B)(i).

53. *Id.* § 1395dd(c)(2)(B)(ii).

54.

An appropriate transfer to a medical facility is a transfer—

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the condition for which the individual was presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) . . . and the name and address of any on-call physician . . . who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment.

Id. § 1395dd(c)(2)(C).

55. "An appropriate transfer to a medical facility is a transfer—

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer . . . ." *Id.* § 1395dd(c)(2)(D).

tion of a hospital's Medicare provider agreement;[56] (2) through civil monetary penalties of up to $50,000 imposed on offending hospitals or doctors;[57] and (3) by allowing private individuals who suffer harm due to an improper transfer to bring a civil suit against an offending hospital.[58]

1) *Revocation or Suspension of a Hospital's Medicare Provider Agreement*

As previously noted, COBRA does not apply to all hospitals, but rather only to hospitals that have emergency departments and are participants in the Medicare reimbursement program.[59] However, since "[n]inety-eight percent of the hospitals in this country participate in the Medicare program"[60] COBRA in essence, if not on its face, applies to all hospitals which staff emergency departments.

Thus, a very effective enforcement tool of COBRA is the revocation or termination of a hospital's Medicare provider agreement,[61] or a suspension thereof,[62] for any hospital that

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56. *See id.* § 1395dd(d)(1).

57. *See id.* § 1395dd(d)(2).

58. *See id.* § 1395dd(d)(3).

> Also note that COBRA provides that
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> [a]ny medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of [COBRA] . . . may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the state in which the hospital is located, and such equitable relief as is appropriate.

Id. § 1395dd(d)(3)(B).

59. *Id.* § 1395dd(a)(1).

60. *Your Money or Your Life, supra* note 4, at 199, n.112 (citing Health Care Financing Admin., Bureau of Management and Strategy, HCFA Statistics 13 (1986)). As of 1986, the year of COBRA's adoption, there were 6,941 hospitals in the United States registered with the American Hospital Association. *See Preventing Patient Dumping, supra* note 9, at 1188 n.19 (citing American Hosp. Ass'n, Hospital Statistics vii (1986)). Of these 6,941 hospitals, 6,710 participate in the federally funded Medicare reimbursement scheme. *Id.* at 1188 n.19 (citing Health Care Financing Admin., Bureau of Management & Strategy, HCFA Statistics 13 (1986)). Thus, 6,710 out of 6,941 or 98% of American Hospitals participate in the Medicare program.

61. *See id.* § 1395dd(d)(1)(A) (1988). ("If a hospital knowingly and willfully, or negligently, fails to meet the requirements of [COBRA] . . . such hospital is subject to . . . termination of its [Medicare] provider agreement . . . .").

62. *See id.* § 1395dd(d)(1)(B) ("If a hospital knowingly and willfully, or negligently, fails to meet the requirements of [COBRA] . . . such hospital is subject to . . . , at the option of the Secretary [of the Department of Health and Human

violates the COBRA requirements. Furthermore, a hospital is subject to termination or suspension of its Medicare provider agreement for all "knowing, willful or negligent" violations of COBRA.[63]

Although the revocation or suspension of a hospital's Medicare provider agreement is an effective method of enforcing COBRA, its draconian approach can be likened somewhat to "throwing out the baby with the bath water" for two reasons. First, since "approximately forty percent of [a] participating hospital['s] revenues come from the Medicare Program,"[64] cutting off a hospital's Medicare funding could drive some hospitals out of business and into bankruptcy. Although this would eliminate the problem of dumping, it could also have the effect of depriving single-hospital rural communities of any health care. While the author has not found a single case of a hospital having its Medicare funding revoked due to patient dumping,[65] COBRA clearly states that this is a possibility, no matter how remote.[66] Because of this very real possibility, the author would propose an amendment to the enforcement provisions of COBRA limiting this remedy to repeated, willful and knowing violations of the Act. As the legislation now stands, a single act of negligence on the part of a hospital could result

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Services], suspension of such [Medicare provider] agreement for such period of time as the Secretary determines to be appropriate, upon reasonable notice to the hospital and to the public.").

63. *Id.* § 1395dd(d)(1).

COBRA also provides that a physician upon whom a civil monetary penalty is imposed may also be subject to having his or her Medicare participation terminated or suspended. A discussion of this possibility will be undertaken in a discussion of physicians' liability to civil monetary penalties.

64. *Preventing Patient Dumping, supra* note 9, at 1217 (citing Vladeck, *Medical Hospital Payment by Diagnosis-Related Groups,* 100 ANNALS OF INTERNAL MED. 576, 576 (1984)).

65. "Federal enforcement of COBRA has been lax. Despite estimates of 250,000 dumped patients per year, as of January 1, 1988, the Department of Health & Human Services (HHS) had imposed monetary penalties against only two hospitals and never had suspended a hospital from Medicare participation." *Your Money or Your Life, supra* note 4, at 200.

66. Research revealed only one incidence of a hospital threatened with revocation of its Medicare reimbursement as a result of noncompliance with COBRA's antidumping provisions. This hospital was Brookside Hospital located in San Pablo, California. *See* Enfield & Sklar, *supra* note 4, at 590 n.141 (1988) (citing N.Y. Times, Apr. 1, 1987, at A17, col. 1.). However, the hospital never lost its Medicare funding as the Health Care Financing Administration never carried out its threat. *Id.* at 590 n.141 (citing MOD. HEALTHCARE, Apr. 24, 1987, at 24.).

in a revocation of its Medicare funding.

A second problem with the provision for revocation or suspension of a hospital's Medicare funding is that "it would also mean that Medicare patients [would be] denied access to that hospital."[67] Congressional intent in enacting COBRA's antidumping provisions was to insure that indigent patients would receive proper emergency care.[68] However, this intent could be thwarted entirely if a hospital has its Medicare funding revoked, thus depriving Medicare patients of medical treatment.

2) *Civil Monetary Penalties*

a) *Hospital*

Further enforcement of COBRA's antidumping regulations is effected through the imposition of civil fines of up to $50,000 for each violation by a participating Medicare hospital.[69] However, these fines will be levied only against hospitals that "knowingly" violate COBRA's requirements.[70] This enforcement tool is better suited to achieving the congressional intent of preventing patient dumping while providing medical care for the indigent than revocation or suspension of a Medicare provider agreement. As previously illustrated, revocation of the Medicare provider agreement could drive a hospital out of business. While a civil penalty of $50,000 on a hospital could have a harsh economic effect, it is seriously doubted that it could wreak as much havoc as a deprivation of up to forty percent of a hospital's revenues.[71]

Notwithstanding the greater damage to a hospital caused by a revocation of its Medicare provider agreement, this means

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67. *Preventing Patient Dumping, supra* note 9, at 1217 (footnote omitted).

68. "The purpose of the Anti-Dumping Act is to end the national scandal, as Senator Durenberger described it, of 'rejecting indigent patients in life threatening situations for economic reasons alone.'" Owens v. Nacogdoches County Hosp. Dist., 741 F. Supp. 1269, 1281 (E.D. Tex. 1990) (quoting 131 CONG. REC. at S13903 (daily ed. Oct. 23, 1985)).

69. *See* 42 U.S.C. § 1395dd(d)(2)(A) (1988).

70. "A participating hospital that *knowingly* violates a requirement [of COBRA] . . . is subject to a civil monetary penalty of not more than $50,000 for each violation." *Id.* (emphasis added).

71. "Approximately forty percent of a participating hospital's revenues come from the Medicare Program." *Preventing Patient Dumping, supra* note 9, at 1217 (citation omitted).

of enforcement is permitted upon a lesser standard of liability than that for imposition of civil monetary penalties. As incredible as it may seem, a hospital can theoretically lose its Medicare provider agreement (and thus in all likelihood a large share of its revenues) merely on the negligent failure to meet COBRA's requirements, whereas the imposition of a civil monetary fine cannot occur unless a hospital commits a "knowing" violation of COBRA.[72] This makes absolutely no sense whatsoever, and it seems reasonable that Congress consider amending COBRA so that civil monetary fines could be levied for negligence[73] (as a way of further attaining hospital compliance with the regulations) and, more importantly, making the revocation or suspension of Medicare funding dependent on knowing or willful repeated violations.[74]

b) *Physicians*

Civil monetary penalties of up to $50,000 can also be imposed upon a physician knowingly responsible for the hospital's violation of COBRA's antidumping provisions.[75]

COBRA further provides that an on-call physician who fails or refuses to come to the hospital to treat an uninsured emergency department patient shall be liable for a civil monetary fine of up to $50,000. However, if the emergency department physician transfers the patient because of the on-call physician's refusal to treat the uninsured patient, the transferring physician shall not be liable.[76]

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72. *See* 42 U.S.C. § 1395dd(d)(2)(A) (1988).

73. The author's proposed amendment to COBRA, lessening the standard for imposition of a civil monetary fine against an offending hospital to a negligence standard, can be found in the proposal section of this comment.

74. For an argument that regulations should be promulgated clarifying and enumerating proper circumstances for the termination or suspension of a hospital's Medicare funding, see *Preventing Patient Dumping*, *supra* note 9, at 1217.

75. *See* 42 U.S.C. § 1395dd(d)(2)(B) (1988) ("[A]ny physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual and who knowingly violates a requirement of this section . . . is subject to a civil monetary penalty of not more than $50,000 for each such violation . . . .").

76. *See id.* § 1395dd(d)(2)(C) ("If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians . . . and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician

The imposition of a civil monetary penalty on a physician who violates the provisions of COBRA now rests upon a finding that the physician *knowingly* violated the Act. This standard should be lowered to negligence to ensure greater compliance with COBRA.

3) *Civil Enforcement*

As a further means of compelling compliance by hospitals with the Federal Emergency Medical Treatment and Active Labor Act, COBRA provides:

> Any individual who suffers personal harm as a direct result of a participating hospital's violation of [COBRA] . . . may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the state in which the hospital is located, and such equitable relief as is appropriate.[77]

COBRA does not, however, create a right of private action against the physician who violates the statute, but in the opinion of the author, it should. California law does provide for civil suits against doctors.[78] It should also be noted that in one of the first cases alleging COBRA violations in which an opinion was recorded, *Bryant* v. *Riddle Memorial Hospital*,[79] the court determined that COBRA provides for a "Federal cause of action."[80] Thus, a person who suffered harm as a result of a violation of COBRA could bring suit in either a federal court under federal subject matter jurisdiction or in a state court.

COBRA also provides:

> Any medical facility that suffers a financial loss as a direct

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determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a [civil monetary] penalty . . . . However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.").

77. *Id.* § 1395dd(d)(3)(A).

78. *See* CAL. HEALTH & SAFETY CODE § 1317.6(f) (West Supp. 1989).

79. 689 F. Supp. 490 (E.D. Penn. 1988).

80. *Id.* at 493. *Accord*, Thornton v. Southwest Detroit Hosp., 895 F.2d 1131 (6th Cir. 1990); Stewart v. Myrick, 731 F. Supp. 433 (D. Kan. 1990); Reid v. Indianapolis Osteopathic Medical Hosp., 709 F. Supp. 853, 854 n.1 (S.D. Ind. 1989); Sorrells v. Babcock, 733 F. Supp. 1189 (N.D. Ill. 1990); Owens v. Nacogdoches County Hosp. Dist., 741 F. Supp. 1269, 1273 (E.D. Tex. 1990); Thompson v. St. Anne's Hosp., 716 F. Supp. 8 (N.D. Ill. 1989).

> result of a participating hospital's violation of [COBRA] . . . may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the state in which the hospital is located, and such equitable relief as is appropriate.[81]

This provision of the federal antidumping law is very important because one study of dumping that occurred before the enactment of COBRA found that generally the public hospital receiving the transferred patient was only partly compensated for the patient's care by the private, transferring hospital.[82] This study found that the hospital charges for care that were documented in 240 of 243 cases transferred to the public hospital by private hospitals for economic reasons, the costs were in excess of $380,000.[83] Of this $380,000 in medical expenses, the public hospital recovered less than $60,000.[84] Thus, in this study alone, private hospitals shifted the economic burden of caring for indigent patients to the public hospital in the amount of $320,000 of uncompensated medical care.[85] Perhaps the most interesting aspect of the COBRA provisions for civil actions by individuals and medical facilities harmed by a

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81. 42 U.S.C. § 1395dd(d)(3)(C) (1988).

82. *See* Kellermann & Hackman, *Emergency Department Patient "Dumping:" An Analysis of Interhospital Transfers to the Regional Medical Center at Memphis, Tennessee,* 78 AM. J. OF PUB. HEALTH 1287 (1988).

83. *See id.* at 1289.

84. *See id.* The following chart demonstrates the cost of the uncompensated care provided to persons transferred to the public hospital's emergency department:

Payor	N	%	Charges	Total Collections*	Uncomp. Care
Medicare	9	3.8	81,456	49,832	31,624
Medicaid	49	20.4	17,192	5,711	11,481
Private Ins.	15	6.3	28,602	2,261	26,341
Self-pay	167	69.5	254,523	1,868	252,655
Total	240	100.0	381,773	59,672	322,101

* Receipts 6 months following Emergency Department visit and/or subsequent hospitalization.

Source: Kellermann & Hackman, *supra* note 82, at 1290, TABLE 2.

85. *See id.* Interestingly enough, at one point during this study, due to hospital overcrowding as a result of accepting so many dumped patients, the public hospital was forced to transfer out 12 patients to area private hospitals. The recipient private hospitals in this situation "required promise of payment from 3rd party payors or the [public hospital] before accepting any of these patients in transfer." *Id.* at 1289.

hospital's violation of the statute is the fact that COBRA does not state upon what basis the hospital's liability is assessed. In the words of one commentator, the level of liability required by the COBRA provision "creat[ing] the private right of actions against hospitals appear[s] to be strict liability."[86] Because the statute fails to state the grounds upon which liability will be assessed, "recovery . . . requires proof only of a violation, causation, and damages."[87] The statute by its very terms does not state upon what basis liability will be imposed in civil enforcement actions. Although, as a general principle, courts will not interpret statutes as imposing strict liability unless there is a clear legislative purpose to do so,[88] two recent federal courts in interpreting COBRA's civil enforcement provisions have found that the standard upon which liability is to be based is strict liability.[89] Although neither federal court engaged in any substantial discussion regarding a finding of a clear legislative purpose to impose strict liability in civil enforcement actions brought under COBRA, ostensibly the legislative purpose of deterring patient dumping and compensating victims was enough to convince these courts that the liability basis for civil enforcement actions was strict liability.

b. *The California Response to Patient Dumping*

The California legislation concerning a hospital's obligation to provide emergency care and a hospital's obligation not to transfer emergency room patients unless certain specified criteria are met is one of the most extensive of such statutes enacted by any state. California law requires a hospital to provide emergency care to anyone requesting such care for "any

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86. *Your Money or Your Life, supra* note 4, at 207.

87. *Your Money or Your Life, supra* note 4, at 207.

Although a complete discussion of the impact of a strict liability cause of action is beyond the scope of this paper, for a further treatment of the subject (as well as negligence per se with regard to civil causes of action for COBRA violations), see *Your Money or Your Life, supra* note 4, at 207-14. *See also* Reid v. Indianapolis Osteopathic Medical Hosp., 709 F. Supp. 853 (S.D. Ind. 1989).

88. *See Your Money or Your Life, supra* note 4, at 207 (citing W. KEETON, D. DOBBS, R. KEETON, & D. OWEN, PROSSER & KEETON ON THE LAW OF TORTS, 228 (5th ed. 1984)).

89. *See* Stevison v. Enid Health Sys., Inc., 920 F.2d 710, 1990 U.S. App. (LEXIS 20865) (10th Cir. 1990) ("We construe this statute as imposing a strict liability standard . . . ."); *Reid*, 709 F. Supp. at 855 ("[T]he federal antidumping statute was based on a strict liability standard.").

condition in which the person is in danger of loss of life, or serious injury or illness, at any health care facility . . . that maintains and operates an emergency department to provide emergency services to the public."[90] Furthermore, California law requires that a hospital which maintains an emergency department shall not withhold emergency care from anyone requesting it based on that person's "race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or medical handicap, insurance status, economic status or ability to pay for medical services."[91] However, neither a hospital nor health care provider will be held liable for refusing to provide emergency care where an emergency medical condition is determined not to exist,[92] or where "the health care facility does not have the appropriate facilities or qualified personnel available to render those services."[93]

In enacting this legislation regarding emergency care, the California legislature also intended to reduce the incidence of patient dumping by private hospitals. Although not entirely barring a hospital or physician from transferring an emergency care patient, the legislature imposed strict conditions which must be met in order for a transfer to be effected. The legislature determined that before a transfer may be made, the person must be examined by a physician,[94] a physician must determine that the transfer will not "create a medical hazard to the person;"[95] and finally, a doctor at the transferring hospital must notify a doctor at the receiving hospital and obtain the consent of the doctor at the receiving hospital to receive the patient.[96]

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90. CAL. HEALTH & SAFETY CODE § 1317(a) (West Supp. 1989).

91. *Id.* § 1317(b).

92. *Id.* § 1317(c) ("Neither the health facility, its employees, nor any physician . . . shall be liable in any action arising out of a refusal to render emergency services or care if the refusal is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition . . . .").

93. *Id.*

94. *Id.* § 1317.2(a) ("No person needing emergency services and care may be transferred from a hospital to another hospital for any nonmedical reason (such as the person's inability to pay for any emergency service or care) unless . . . (a) [t]he person is examined and evaluated by a physician . . . prior to transfer . . . .")

95. *Id.* § 1317.2(b).

96. *See id.* § 1317.2(c) ("No person needing emergency services and care may be transferred from a hospital to another hospital for any nonmedical reason (such as the person's inability to pay for any emergency service or care) un-

The California legislation applies to all hospitals operating within the state. The statute holds that, as a condition of licensure, all hospitals in California must adopt transfer protocols,[97] and a policy prohibiting discrimination in the rendering of emergency care.[98] Furthermore, as a condition of licensure, hospitals must require that physicians who serve "on-call" in the emergency department not refuse to respond to a call for discriminatory reasons, or because of a patient's inability to pay.[99]

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less . . . (c) [a] physician at the transferring hospital has notified and has obtained the consent to the transfer by a physician at the receiving hospital . . . .").

97. "As a condition . . . of licensure, each hospital shall adopt, in consultation with the medical staff, policies and transfer protocols consistent with this article and staff regulations adopted hereunder." *Id.* § 1317.3(a).

98.

> As a condition of licensure, each hospital shall adopt a policy prohibiting discrimination in the provision of emergency services and care based on race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

Id. § 1317.3(b).

99.

> As a condition . . . of licensure, each hospital shall require that physicians who serve on an 'on-call' basis to the hospital's emergency room cannot refuse to respond to a call on the basis of the patient's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

Id. § 1317.3(c).

Note that the California legislation is broader in this respect than the federal act. The federal act does not require that "on-call" emergency department physicians respond regardless of the patient's ability to pay. The federal act only requires that hospitals wishing to participate in the Medicare program "maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition." 42 U.S.C. § 1395cc(a)(1)(I)(iii) (1988). However, if an on-call physician refuses or fails to respond to the emergency situation and the patient is dumped, the on-call physician is subject to a fine of up to $50,000. *See id.* § 1395(d)(2)(C). For discussion of a proposed amendment to the federal act which would have explicitly required an on-call physician to respond to emergency situations regardless of the patient's ability to pay, see *Your Money or Your Life*, *supra* note 4, at 207.

1) *Enforcement of California Antidumping Legislation*

California antidumping legislation provides for four means of enforcement. Under California law, violators of the antidumping statute are subject to a revocation or suspension of their emergency medical services permit,[100] criminal liability,[101] civil monetary penalties,[102] and private civil suits[103] brought by those who have been harmed by dumping. Each of these means of enforcement will be discussed below.

a) *Revocation or Suspension of a Hospital's Emergency Medical Services Permit*

California law provides that "[a]ny hospital found by the state department . . . to have committed a violation of [the antidumping legislation] . . . may have its emergency medical services permit revoked or suspended by the state department."[104] All alleged violations of the California antidumping legislation "shall be investigated by the state department."[105] Also, "the state department, with the agreement of the local EMS [Emergency Medical Services] Agency, may refer violations . . . to the local EMS agency for investigation."[106] Therefore, a California hospital that violates the statute is subject to losing its EMS permit and thus would be forced to close its emergency department.

Under California law, if either the State Department or EMS agency, in their investigation of a hospital's alleged violation of the antidumping legislation, discover an alleged violation by a physician, they are required to report this violation to the board of medical quality assurance.[107]

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100. *See* CAL. HEALTH & SAFETY CODE § 1317.6(b) (West Supp. 1989).
101. *See id.* § 1317.6(c).
102. *See id.* § 1317.6(a).
103. *See id.* § 1317.6(f).
104. *Id.* § 1317.6(b).
105. *Id.* § 1317.5(a).
106. *Id.*
107. "At the conclusion . . . of its investigation [of a hospital for violations] the state department or the local EMS agency shall refer any alleged violation by a physician to the board of medical quality assurance unless it is determined that the complaint is without a reasonable basis." *Id.* § 1317.5(b).

b) *Criminal Liability*

The federal antidumping legislation, as embodied in COBRA, contains no provision for the imposition of criminal liability. The California legislation is broader than the federal approach in this regard and holds that "[a]ny administrative or medical personnel who knowingly and intentionally violates any provision [of the antidumping legislation] may be charged by the local district attorney with a misdemeanor."[108]

c) *Civil Monetary Penalties*

(1) *Hospital Liability for Civil Monetary Penalties*

Like COBRA, California law provides for the imposition of fines upon hospitals that have violated the antidumping legislation. Whereas, under federal legislation, hospitals that have violated COBRA are liable in civil monetary penalties of up to $50,000,[109] California legislation provides for fines not exceeding $25,000.[110]

The California legislation also sets forth the provision that the state department should take into account several factors in determining the amount of the fine. Such factors include "[w]hether the violation was knowing or unintentional,"[111] "[w]hether the violation resulted, or was reasonably likely to result, in a medical hazard to the patient,"[112] and "[t]he frequency or gravity of the violation."[113]

This approach to the imposition of fines upon hospitals which have violated the antidumping laws establishes a more rigid list of criteria upon which the amount of the fines shall be determined than does the federal schema. To this extent, it can be argued that the California system for levying fines is

108. *Id.* § 1317.6(c).

109. *See* 42 U.S.C. § 1395dd(d)(2)(A) (1988).

110. "Hospitals found by the state department to have committed, or to be responsible for, a violation of the provisions of this article or the regulations adopted hereunder, may each be fined by the state department in an amount not to exceed twenty-five thousand dollars ($25,000) for each hospital violation." CAL. HEALTH & SAFETY CODE § 1317.6(a) (West Supp. 1989).

111. *Id.* § 1317.6(a)(1)(A).

112. *Id.* § 1317.6(a)(1)(B).

113. *Id.* § 1317.6(a)(1)(C).

better than the federal system, for it enumerates specific circumstances which must be examined in determining the amount of the penalty. Additionally, it should be noted that under the California antidumping law fines may be imposed on hospitals that *negligently* violate the law whereas the federal legislation, as it now stands, imposes civil monetary penalties only on hospitals that *knowingly* violate COBRA.[114] In this respect, the California legislation is broader than the federal and, arguably, because of the lesser standard of liability required, will be more effective in deterring patient dumping. For these reasons, COBRA should be amended so that civil monetary penalties can be imposed on hospitals that *negligently* violate the antidumping laws.

Furthermore, the California legislation addresses the problem of a hospital's double liability if said hospital is adjudged to have violated both the federal and California statutes. To this end, the California statute regarding the imposition of civil fines upon hospitals which have violated the antidumping law states:

> It is the intent of the Legislature that the state department has primary responsibility for regulating the conduct of hospital emergency rooms and that fines imposed under this section should not be duplicated by additional fines imposed by the federal government as a result of the conduct which constituted a violation of this section. To effectuate the Legislature's intent, the Governor shall inform the Secretary of the federal Department of Health and Human Services of the enactment of this section and request the federal department to credit any penalty assessed under this section against any subsequent civil monetary penalty assessed [by the federal government] . . . for the same violation.[115]

Thus, California law provides that a California hospital which is assessed a fine for violation of the state antidumping statute may not be liable to the extent of the double liability of a fine assessed by the federal government for the same act which constitutes a violation of COBRA. Of course, the California provision is not binding on the federal government[116]

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114. *See* 42 U.S.C. § 1395dd(d)(2)(A) (1988).

115. CAL. HEALTH & SAFETY CODE § 1317.6(a) (West Supp. 1989).

116. *See* U.S. CONST. art. VI ("This Constitution, and the laws of the United

and it will be within the discretion of the Secretary of the Department of Health and Human Services whether or not to also impose a federal fine.

(2) *Physician's Liability for Civil Monetary Penalties*

Under California law, the board of medical quality assurance shall have sole authority to impose a fine on a physician found to have violated the legislation prohibiting patient dumping. Furthermore:

> Physicians found by the board to have committed, or to be responsible for, a violation of this article . . . are subject to any and all penalties which the board may lawfully impose and may be fined by the board in an amount not to exceed five thousand dollars ($5,000) for each violation.[117]

The amount of a fine which could possibly be levied against an offending physician in California is significantly less than the $50,000 penalty which could be levied against the physician under federal law. The federal fine of up to $50,000 will act as a greater deterrent to patient dumping by physicians than will the California fine of up to only $5,000.

The California legislature also clearly enumerated upon what grounds the board of medical quality assurance could levy fines against offending physicians. The legislature stated that the board could impose a fine whenever it found that "[t]he violation was knowing or willful,"[118] that "[t]he violation was reasonably likely to result in a medical hazard,"[119] or that "[t]here are repeated violations."[120] Thus, unlike the federal system, California law provides for the imposition of a fine against a physician even if the physician did not *knowingly* violate it. It is important to note that under the California antidumping legislation *any* of the three criteria enumerated above can result in an offending physician being fined. Thus, for example, even if a physician did not "knowingly" or "will-

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States which shall be made in pursuance thereof . . . shall be the Supreme law of the land.").

117. CAL. HEALTH & SAFETY CODE § 1317.6(a)(2) (West Supp. 1989).

118. *Id.* § 1317.6(a)(2)(A).

119. *Id.*

120. *Id.*

fully" violate the statute that physician could still be fined if "[t]he violation was reasonably likely to result in a medical hazard."[121] In this respect, the California legislation is, once again, more far-reaching than the federal requirement of a *knowing* violation of COBRA by a physician in order for a fine to be levied. COBRA would benefit by an expansion of the standard of liability for imposing fines against physicians to a negligence standard. In this way, a greater number of physicians would come under the auspices of COBRA, and greater compliance with the federal antidumping law could be achieved.

Finally, the legislation provides that the fines imposed on offending physicians, for violations of California's antidumping law, "shall not duplicate federal fines."[122] Thus an offending physician who has been fined for that violation by the federal government pursuant to the regulations promulgated under COBRA will not be subject to the imposition of a fine by the California board of medical quality assurance for the same occurrence giving rise to the violation.

d) *Private Civil Suits*

The California legislation regarding private rights of action is broader than that of the federal government in that the California legislation allows any person harmed by a violation of the antidumping laws to sue both the hospital and the physician or medical personnel responsible for the violation. California law provides:

> Any person who suffers personal harm and any medical facility which suffers a financial loss as a result of a violation of this article or the regulations adopted hereunder may recover in a civil action against the transferring hospital or responsible administrative, or medical personnel, damages, reasonable attorneys' fees, and other appropriate relief.[123]

Thus, similar to the federal regulations, California law provides that any medical facility which is harmed by the violation may also bring an action to recover damages for the finan-

121. CAL. HEALTH & SAFETY CODE § 1317.6(a)(2)(B).
122. *Id.* § 1317.6(a)(2).
123. *Id.* § 1317.6(f).

cial loss occasioned by the violation. Moreover, California law provides that the "[t]ransferring hospitals from which inappropriate transfers of persons are made . . . shall be liable for the normal charges of the receiving hospital for providing the emergency services and care which should have been provided before transfer."[124]

The California right of private action against a physician who has violated the California antidumping provision seems to be a good enforcement tool. This private cause of action against an offending physician should also be included in the federal law as embodied in COBRA. To that end, the author proposes an amendment creating a private right of action against physicians under COBRA.[125]

III. DEFINITIONAL DEFICIENCIES IN THE ANTIDUMPING LEGISLATION

The next section of this comment will address three "definitional deficiencies" in the federal antidumping legislation: the definition of an "emergency medical condition," the definition of "stable," and the definition of "transfer." In each of these areas the strengths and weaknesses of the federal Act will be compared to, and contrasted with, the California legislation.

A. *Definition of an "Emergency"*

1. *The Federal Approach*

The federal antidumping legislation[126] defines an "emergency medical condition" as a:

> Medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual . . . in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ

124. *Id.*

125. This amendment can be found in the proposal section, section IV, of this comment.

126. 42 U.S.C. § 1395dd (1988).

or part.[127]

The aforementioned definition of an emergency has been criticized by commentators.[128] One commentator[129] has suggested that the federal antidumping legislation should adopt a broader definition of "emergency" such as the one previously postulated by the American College of Emergency Physicians (ACEP).[130]

The definition of "emergency" adopted by ACEP includes:

> (1) Any condition resulting in admission of the patient to a hospital or nursing home within twenty-four hours;
> (2) Evaluation or repair of acute (less than 72 hours) trauma;
> (3) Relief of acute or severe pain;
> (4) Investigation or relief of acute infection;
> (5) Protection of public health;
> (6) Obstetrical crises and/or labor;
> (7) Hemorrhage or threat of hemorrhage;
> (8) Shock or impending shock;
> (9) Investigation and management of suspected abuse or neglect of person which, if not interrupted, could result in temporary or permanent physical or psychological harm;
> (10) Congenital defects or abnormalities in a newborn infant best managed by prompt intervention;
> (11) Decompensation or threat of decompensation of vital functions, such as sensorism [sic], respiration, circulation, excretion, mobility, or sensory organs;
> (12) Management of a patient suspected to be suffering from a mental illness and posing an apparent danger to the safety of himself, herself, or others; or
> (13) Any sudden and/or serious symptom(s) which might indicate a condition which constitutes a threat to the patient's physical or psychological well-being requiring immediate medical attention to prevent possible deterioration, disability or death.[131]

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127. *Id.* § 1395dd(e)(1)(A).

128. *See Preventing Patient Dumping, supra* note 9, at 1210, noting that "neither COBRA nor its legislative history provides adequate guidance for determining when the risks to a patient's health are 'serious.'"

129. *See Preventing Patient Dumping, supra* note 9.

130. The current definition of "emergency" adopted by ACEP is the COBRA definition. *See Preventing Patient Dumping, supra* note 9, at 1210 (footnote omitted).

131. *Preventing Patient Dumping, supra* note 9, at 1211 (quoting ACEP Board Reviews Definitions of Bona Fide Emergencies, ACEP News, Dec. 1982, at 1, col. 1).

It has been argued that this definition of emergency is better than COBRA's definition for it provides those who are subject to the provisions of COBRA with much clearer and more illuminated guidelines.[132] In short, it eliminates the guesswork.

It has been suggested that the absence of a clear definition of "emergency" in the Hill-Burton Act—the federal antidumping precursor to COBRA—was one of the reasons that that act was ineffectual in stemming the tide of dumped private hospital emergency department patients.[133] Following on the heels of this assertion is the fear that COBRA's antidumping provisions will be ineffective, and that COBRA will not be enforced, because the term "emergency medical condition" has not been adequately defined in the statute.[134] However, an examination of the cases decided under COBRA indicates that the courts have no trouble interpreting or understanding the definition of "emergency medical condition" as outlined in the federal statute.[135] Thus, it is the author's contention that COBRA's definition of "emergency medical condition" is sufficiently clear to guide the conduct of those governed by the federal antidumping legislation.

2. *The California Approach*

The definition of an "emergency medical condition" under California's antidumping legislation[136] is as follows:

> 'Emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate

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132. *See Preventing Patient Dumping*, *supra* note 9, at 1211 ("The Department of Health and Human Services should adopt this [the ACEP's] definition [of emergency] for COBRA because it is clear and comprehensive. It will give better guidance to the physicians and nurses who must comply with the anti-dumping statute.").

133. *See Preventing Patient Dumping*, *supra* note 9, at 1209-10 ("Lack of a precise definition of "emergency" has . . . been one of the main . . . weaknesses of . . . the Hill-Burton Act . . . .").

134. *See Preventing Patient Dumping*, *supra* note 9, at 1209-10.

135. *See, e.g.*, Deberry v. Sherman Hosp. Ass'n, 741 F. Supp. 1302 (N.D. Ill. 1990). In *Deberry* the Court had no trouble finding that spinal meningitis constituted an emergency medical condition. *See id.* at 1305.

136. CAL. HEALTH & SAFETY CODE § 1317 (West Supp. 1989).

> medical attention could reasonably be expected to result in any of the following:
> (1) Placing the patient's health in serious jeopardy.
> (2) Serious impairment to bodily functions.
> (3) Serious dysfunction of any bodily organ or part.[137]

Furthermore, the California legislature has defined a "medical hazard" as "a material deterioration in, or jeopardy to, a patient's medical condition or expected chances for recovery."[138]

Essentially the California statute defines "emergency" in the same terms as the federal statute and therefore is, arguably, susceptible to the same problems, i.e., lacking clear guidelines of what constitutes an emergency. However, if the federal cases are any indication, the California courts should have little difficulty in determining if certain factual situations meet the legislature's definition of an emergency medical condition. In other words, the California definition of emergency medical condition is sufficient to provide health care workers with standard criteria for complying with the antidumping law, and is, as well, sufficient to provide a court with a proper standard to review whether a health care professional's activities are within, or without, the parameters of the statute.

B. *Definition of "Stable"*

1. *The Federal Approach*

Federal antidumping legislation (as embodied in 42 U.S.C. 1395dd) provides:

> The term 'to stabilize' means, with respect to an emergency medical condition . . . , 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.[139]

In addition, federal legislation states that "stabilized" means that "[w]ith respect to an emergency medical condition . . . no material deterioration of the condition is likely

137. *Id.* § 1317.1(b).
138. *Id.* § 1317.1(f).
139. 42 U.S.C § 1395dd(e)(3)(A) (1988).

within reasonable medical probability, to result from or occur during the transfer of the individual from a facility."[140] COBRA's definition of "stable" has been criticized as not establishing specifically enough what must be done to stabilize the patient.[141]

The American College of Emergency Physicians (ACEP), in establishing guidelines for the transfer of patients, goes much further than COBRA in defining "stable" and includes a list of procedures which a health care provider should follow in establishing stabilization prior to transfer.

According to ACEP, "stabilization includes adequate evaluation and initiation of treatment to assure that transfer of a patient will not, within reasonable medical probability, result in death or loss or serious impairment of bodily functions, parts or organs."[142]

ACEP further states:

> Evaluation and treatment of patients prior to transfer should include the following:
> (1) Establishing and assuring an adequate airway and adequate ventilation;
> (2) Initiating control of hemorrhage;
> (3) Stabilizing and splinting the spine or fractures when indicated;
> (4) Establishing and maintaining adequate access routes for fluid administration;
> (5) Initiating adequate fluid and/or blood replacement; and
> (6) Determining that the patient's vital signs (including blood pressure, pulse, respiration, and urinary output, if indicated) are sufficient to sustain adequate profusion. The vital signs should remain within these parameters for a sufficient time prior to transfer in order that the physician may be reasonably certain that they will not deteriorate, while the patient is en route to the receiving hospital.[143]

COBRA would benefit from an adoption of the ACEP definition of "stable" and the ACEP guidelines propounded for

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140. *Id.* § 1395dd(e)(4)(B).

141. *See Preventing Patient Dumping, supra* note 9, at 1212-13.

142. *Preventing Patient Dumping, supra* note 9, at 1213 (citing *Guidelines for Transfer of Patients, ACEP,* 14 ANNALS EMERG. MED. 1221, 1221 (1985)).

143. *Preventing Patient Dumping, supra* note 9, at 1213 (citing *Guidelines for Transfer of Patients, ACEP,* 14 ANNALS EMERG. MED. 1221, 1221 (1985)).

effecting stabilization.

2. *The California Approach*

The California antidumping legislation does not define "stable." This is a major shortcoming of the California regulations and they should be amended to include a definition of this term. Presumably, the definition of stable suggested by ACEP would provide the best definition and as such, should be adopted by the California legislature.

C. *Definition of "Transfer"*

1. *The Federal Approach*

It is erroneous and improper to state that COBRA prohibits the transfer of emergency department patients based on a patient's inability to pay or for other nonmedical reasons. Rather, COBRA provides that if a person comes to a hospital emergency room, and that person is determined to have a medical emergency,[144] then the hospital has the option of doing one of two things; the hospital can either provide the necessary medical treatment[145] or transfer the individual to another health care facility.[146]

If the hospital decides to follow the first course outlined above and provides the necessary medical attention, then a COBRA analysis terminates and any acts of negligence on the part of the hospital or attending physicians will be determined according to the forum state's medical malpractice laws.[147] If, on the other hand, the hospital decides to transfer the patient to another hospital, further specific requirements of COBRA relating to the transfer of patients must be met.

First and foremost, COBRA requires as a general rule that before a hospital transfers an individual with an emergency medical condition, the hospital must stabilize the person's

144. *See* 42 U.S.C. § 1395dd(b)(1) (1988).

145. *See id.* § 1395dd(b)(1)(A).

146. *See id.* § 1395dd(b)(1)(B).

147. *See, e.g.*, Evitt v. University Heights Hosp., 727 F. Supp. 495 (S.D. Ind. 1989) (holding that misdiagnosis, a traditional medical malpractice action, was beyond the contemplated scope of COBRA); Stewart v. Myrick, 731 F. Supp. 433 (D. Kan. 1990). *Cf.* Deberry v. Sherman Hosp. Ass'n, 741 F. Supp. 1302 (N.D. Ill. 1990) (failing to detect and diagnose an emergency medical condition is a violation of COBRA).

condition.[148] If a patient has not been stabilized, as that term is defined in COBRA, then the hospital may not undertake to transfer the patient unless (1) a transfer is requested by the individual or the individual's legal representative,[149] (2) a qualified physician (or, if a physician is not available in the emergency department, some other qualified health care provider such as a nurse) has determined that the benefits of transferring the patient to another medical facility outweigh the risks to the patient in delaying treatment and effecting the transfer,[150] or (3) "the transfer is an appropriate transfer."[151]

In order for a transfer to be appropriate, COBRA provides that the receiving hospital or medical facility must have agreed to accept the patient and provide the required and necessary treatment[152] and that the receiving hospital have space available for the patient and qualified personnel on hand to provide care.[153] Furthermore, COBRA states that in order

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148. *See* 42 U.S.C. § 1395dd(c)(1) (1988).
149. *See id.* § 1395dd(c)(1)(A)(i).
150. *See id.* § 1395dd(c)(1)(A)(ii).
151. *Id.* § 1395dd(c)(1)(B).

The complete text of 42 U.S.C. § 1395dd(c)(1) is as follows:

> (c) Restricting Transfers Until Individual Stabilized
>
> (1) Rule
>
> If an individual at a hospital has an emergency medical condition which has not been stabilized . . . the hospital may not transfer the individual unless –
>
> (A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility.
>
> (ii) a physician . . . has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate treatment at another medical facility outweigh the increased risks to the individual from effecting the transfer; or
>
> (iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical personnel . . . has signed a certification described in clause (ii) after a physician . . . in consultation with the person has made the determination described in such clause, and subsequently countersigns the certification; and
>
> (B) the transfer is an appropriate transfer . . . to that facility.

Id.

152. *See id.* § 1395dd(c)(2)(A)(ii).
153. *See id.* § 1395dd(c)(2)(A)(i).

for a transfer to be appropriate the transferring hospital must provide the receiving medical facility with the patient's medical records concerning the transferring hospital's examination and treatment of the patient,[154] and the transfer must be effectuated by qualified medical personnel employing medically appropriate standards of transfer.[155]

COBRA defines "transfer" broadly as:

> the movement (including the discharge) of an individual outside a hospital's facilities at the discretion of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.[156]

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154. *See id.* § 1395dd(c)(2)(C).

155. *Id.* § 1395dd(c)(2)(D).

The text of 42 U.S.C. § 1395dd(c)(2) regarding an appropriate transfer reads as follows:

> (2) Appropriate transfer
>
> An appropriate transfer to a medical facility is a transfer
>
> (A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, ...
>
> (B) in which the receiving facility –
>
> (i) has available space and qualified personnel for the treatment of the individual, and
>
> (ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;
>
> (C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition for which the individual was presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed consent or certification . . . provided under paragraph (1)(A), and the name and address of any on-call physician . . . who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment.
>
> (D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and
>
> (E) which meets such other requirements as the Secretary [of the Department of Health and Human Services] may find necessary in the interest of health and safety of individuals transferred.

Id.

156. *Id.* § 1395dd(e)(4).

The problem with the definition of "transfer" as stated in COBRA is that it does not state explicitly what constitutes a transfer. For example, under COBRA, the question arises whether an "implicit transfer" would arise where a hospital "shuts down" its emergency department to an incoming ambulance and diverts the ambulance to another hospital. The question of whether this would constitute an inappropriate transfer and hence dumping, will be taken up in a later part of this comment.

2. *The California Approach*

In enacting antidumping legislation, the California legislature adopted several clear conditions which must be met before a hospital can transfer a patient with an emergency medical condition for nonmedical reasons. Similar to the federal antidumping legislation, as embodied in COBRA, California antidumping legislation provides that an emergency care patient may not be transferred to another hospital for nonmedical reasons unless the patient has first been examined by a competent physician,[157] the patient has been given the necessary medical care in order to assure with reasonable probability that the transfer will not cause a serious deterioration of the patient's condition,[158] and the transferring facility has obtained the consent of the receiving facility to accept the patient and provide the necessary care.[159] Furthermore, the receiving hospital must have the space to accommodate the patient as well as the appropriate personnel, equipment and services

157. *See* CAL. HEALTH & SAFETY CODE § 1317.2(a) (West Supp. 1989) ("No person needing emergency services and care may be transferred from a hospital to another hospital for any nonmedical reason (such as the person's inability to pay for any emergency service or care) unless . . . (a) [t]he person is examined and evaluated by a physician . . . .").

158. *See id.* § 1317.2(b) ("No person needing emergency services and care may be transferred from a hospital to another hospital for any nonmedical reason . . . unless . . . (b) [t]he person has been provided with emergency services and care so that it can be determined, within reasonable medical probability, that the transfer or delay caused by the transfer will not create a medical hazard to the person.").

159. *See id.* § 1317.2(c) ("No person needing emergency services and care may be transferred from a hospital to another hospital for any nonmedical reason . . . unless . . . (c) [a] physician at the transferring hospital has notified and has obtained the consent to the transfer by a physician at the receiving hospital . . . .").

necessary for the patient's care.[160]

California also requires that the patient's medical records accompany him or her to the receiving facility.[161] Thus far, the California requirements with regard to an emergency patient transfer are substantially the same as the federal requirements as specified in COBRA. California, however, goes further than the federal government in requiring a "transfer summary" to accompany the transferred patient's records.[162] The federal legislation does not require a transfer summary, but instead simply requires:

> the transferring hospital send[] to the receiving facility all medical records . . . related to the emergency condition for which the individual was presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification . . . and the name and address of any on-call physician . . . who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment.[163]

The California requirement of the transfer summary is important in that it mandates that relevant information surrounding the transfer be forwarded to the receiving facility. The transfer summary contains such pertinent non-medical information such as the "person's name, address, sex, race, age, [and] insurance status."[164] Moreover, the transfer summary requires that the transferring physician sign the document, and further requires that the summary contain:

> the name and address of the transferring doctor or emergency department personnel authorizing the transfer; the time and date the person was first presented at the transferring hospital; the name of the physician at the receiving hospital consenting to the transfer, and the time and date of the consent; the time and date of the transfer;

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160. *See id.* § 1317.2(c).
161. *See id.* § 1317.2(e).
162. *See id.* § 1317.2(f).
163. 42 U.S.C. § 1395dd(c)(2)(C) (1988).
164. *See* CAL. HEALTH & SAFETY CODE § 1317.2(f) (West Supp. 1989).

> the reason for the transfer; and the declaration of the signor that the signor is assured, within reasonable medical probability, that the transfer creates no medical hazard to the patient.[165]

One practical result of the California transfer summary is that if litigation should arise as a result of the transfer, the plaintiff-patient will have a single document readily at hand identifying all the allegedly negligent parties. Also, the transferring doctor could use the transfer summary as a defense if the circumstances show that said doctor was correct in his or her conclusion that the transfer would create no medical hazard to the patient.

A further result of the transfer summary is that both the hospital and the California State Department will have accurate records of patient transfers and data regarding said transfers. In addition to requiring a hospital to develop transfer protocols as a condition of licensure,[166] California also requires that "[a]ll hospitals . . . maintain records of each transfer made or received"[167] and that "all hospitals making or receiving transfers . . . file with the state department annual reports . . . which . . . describe the aggregate number of transfers made and received according to the person's insurance status and reasons for transfers."[168]

Furthermore, the California State Department is required:

> on an annual basis [to] publish and provide to the legislature a statistical summary, by county, on the extent of economic transfers of emergency patients, the frequency of medically hazardous transfers, the insurance status of the patient populations being transferred and all violations finally determined by the State Department, describing the nature of the violation, hospitals involved, and the action taken by the State Department in response.[169]

The California requirements regarding the transfer summary, the keeping of adequate transfer records by the hospi-

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165. *Id.*

166. *See id.* § 1317.3(a) ("As a condition of licensure, each hospital shall adopt, in consultation with the medical staff, policies and transfer protocols consistent with this article and regulations adopted hereunder.").

167. *Id.* § 1317.4(a).

168. *Id.* § 1317.4(b).

169. *Id.* § 1317.4(g).

tals, and the requirement of reporting transfers to the State Department will greatly aid the enforcement of the California antidumping legislation. The omission of these requirements in COBRA will make it more difficult to enforce the federal legislation and to bring an action under COBRA.

For all of its strengths, the California antidumping legislation is weak because of the lack of an explicit definition of "transfer." In fact, the California regulations contain no definition of "transfer." The weakness of this definitional omission is that it is not clear whether regular hospital practices, such as "shutting down" the emergency department to incoming ambulances, will constitute inappropriate transfers and hence dumping. This problem will be addressed at greater length in the next section of this comment.

3. *Implicit Transfers*

As already noted in this comment, neither the California nor federal antidumping legislation adequately address the problem of implicit transfer or "constructive dumping."[170] The Federal Emergency Medical Treatment and Labor Act defines "transfer" as "the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital . . . ."[171] The California legislation does not define "transfer" in any manner other than by stating what constitutes an "appropriate transfer."[172]

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170. *Your Money or Your Life*, *supra* note 4, at 206.

171. 42 U.S.C. § 1395dd(e)(5) (1988).

172. CAL. HEALTH & SAFETY CODE § 1317.2 (West Supp. 1989).

An "appropriate transfer" under California law is one in which all of the following conditions are met:

(a) The person is examined and evaluated by a physician, including if necessary, consultation, prior to transfer.

(b) The person has been provided with emergency services and care so that it can be determined within reasonable medical probability, that the transfer or delay caused by the transfer will not create a medical hazard to the person.

(c) A physician at the transferring hospital has notified and has obtained the consent to the transfer by a physician at the receiving hospital and confirmation by the receiving hospital that the person meets the hospital's admissions criteria relating to appropriate bed, personnel and equipment necessary to treat the person.

(d) The transferring hospital provides for appropriate personnel and

Thus, both federal and California legislation leave unanswered whether certain common hospital practices would violate either or both. For instance, the question arises whether the "shutting down" of a hospital's emergency room, with the result that incoming ambulances are diverted to other hospitals, would constitute dumping or improper transfer. As there are no cases addressing this precise question, it is necessary to analyze the statutes, law reviews, and legislative histories for an answer.

In looking at the federal law first, it is clear that "[t]he statutory definition of 'transfer' . . . covers events beyond interhospital transfers. It extends to 'any movement' of a patient outside a hospital's facilities at the direction of any person employed by or affiliated with the hospital."[173] Thus, under COBRA, "simply discharging [a] patient or removing the patient from the hospital building"[174] would constitute a transfer. As a transfer within the meaning of the statute, if this action were not taken in compliance with the rules promulgated under COBRA for effecting a patient transfer[175] then a proper action for "dumping" would result.

Furthermore, a refusal to treat a patient in a hospital's emergency room would be a violation of COBRA.[176] COBRA

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equipment which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use to effect the transfer.

(e) All the person's pertinent medical records and copies of all the appropriate diagnostic test results which are reasonably available are transferred with the person.

(f) The records transferred with the person include a 'Transfer Summary' signed by the transferring physician which contains relevant transfer information.

Id. § 1317.2(a)-(f).

173. *Your Money or Your Life, supra* note 4, at 205 (footnote omitted).

174. *Your Money or Your Life, supra* note 4, at 205.

175. *See* 42 U.S.C. § 1395dd(c)(1),(2) (1988).

176.

Under COBRA, dumping can also include simple refusals to treat, regardless of whether a transfer has occurred. Specifically, refusal to conduct the initial screening examination would constitute a violation giving rise to a cause of action for harm caused by the refusal. Further, if the person is in an emergency medical condition or active labor and the hospital is unable or chooses not to transfer the person, the hospital must provide medical treatment. Refusal to render treatment to such a person would constitute dumping.

Your Money or Your Life, supra note 4, at 206.

explicitly requires that, in hospitals with Emergency Departments, "if any individual . . . comes to the emergency department and a request is made . . . 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 . . . to determine whether or not an emergency medical condition exists."[177]

Thus, under COBRA, the hospital is required at least to take the preliminary steps of conducting a medical examination to determine whether an emergency exists. If a medical emergency does exist, then the hospital must either provide treatment or appropriate transfer.

Similarly, it seems logical to assume that unreasonably long delays in providing treatment to the emergency patient would constitute dumping. COBRA requires that the hospital provide an "appropriate medical screening examination"[178] and a strong and compelling argument can be made for the notion that an "appropriate" medical screening examination would be one which is undertaken in a prompt or reasonable time.[179]

The question remains, however, whether COBRA would apply to and impose liability on a hospital that had "shut down" its emergency department and rerouted an incoming ambulance to another hospital. It seems clear that under the definition of transfer as embodied in COBRA,[180] this action would constitute a transfer. According to COBRA, "transfer" means "the movement . . . of an individual outside a hospital's facilities at the direction of any person employed by . . . the hospital."[181] The act of rerouting the ambulance can easily be seen as the "movement . . . of a patient outside a hospital's facilities." Since the decision to "shut down" the emergency department is generally made by a hospital administrator or physician, this act clearly falls within the "direction of any person employed by . . . the hospital."

Although it seems clear that this action is a "transfer," that

177. 42 U.S.C. § 1395dd(a) (1988).

178. *Id.*

179. For further arguments that "appropriate" means within a reasonable time, see *Your Money or Your Life, supra* note 4, at 206.

180. 42 U.S.C. § 1395dd(e)(4) (1988).

181. *Id.* § 1395dd(e)(4).

fact alone would not be sufficient to impose liability on the hospital. As has already been noted, COBRA does not prohibit the transfer of emergency patients, but rather requires that the hospital must first stabilize the patient, and then effect the transfer with "qualified personnel and transportation equipment."[182]

Furthermore, COBRA requires that the hospital "provide for an appropriate medical examination *within the capability of the hospital's emergency department* . . . to determine whether or not an emergency medical condition . . . exists,"[183] and if "the hospital determines that the individual has an emergency medical condition . . . the hospital must provide . . . *within the staff and facilities available at the hospital,* for such further medical examination and such treatment as may be required to stabilize the medical condition,"[184] or for transfer.

Thus COBRA, within its statutory provisions, gives two defenses to a hospital charged with dumping in the case of rerouting an ambulance because the emergency department is "shut down." First, the hospital must conduct the initial medical screening examination only "*within the capability of the hospital's emergency department.*"[185] According to one commentator, "It is reasonable to evaluate the hospital's capability in terms of available personnel."[186] Furthermore, COBRA provides that a hospital must provide treatment for an emergency patient only "within the staff and facilities available at the hospital."[187] For these reasons, it can be concluded that a hospital which had "shut down" its emergency department, because of inadequate staffing or lack of beds, would not violate COBRA if that hospital rerouted an incoming ambulance to another medical facility.

COBRA offers one further defense to the above named situation of a hospital's rerouting an incoming ambulance to another facility. COBRA provides that a hospital may transfer a patient if "based upon the information available at the time of transfer, the medical benefits reasonably expected from the

182. *Id.* § 1395dd(c)(2)(D).
183. *Id.* § 1395dd(a) (emphasis added).
184. *Id.* § 1395dd(b)(1)(A) (emphasis added).
185. *Id.* § 1395dd(a) (emphasis added).
186. *Your Money or Your Life, supra* note 4, at 206.
187. 42 U.S.C. § 1395dd(b)(1)(A) (1988).

provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual . . . from effecting the transfer."[188] Clearly, this cost/benefit analysis would greatly add to a hospital's defense when charged with patient dumping for rerouting an incoming ambulance. If the hospital's emergency department is understaffed, the hospital would be justified in believing that the benefits to the patient in being transferred to another fully staffed emergency department would outweigh the risks to the patient engendered by the transfer.

Of course, before a hospital that is understaffed may reroute an incoming ambulance, the hospital must comply with other aspects of COBRA, such as securing agreement from the receiving facility to treat the patient,[189] and providing the patient with adequate transfer.[190] Furthermore, the hospital must shut down in good faith, and not merely because the incoming ambulatory emergency room patient is indigent.

Under the California antidumping law, no liability would accrue to a hospital that shuts down its emergency department to an incoming ambulance transporting an emergency patient so long as this shutting down occurs in good faith and because of a lack of facilities or personnel and not merely because of the patient's inability to pay for medical services. From a reading of the California antidumping statutes, it appears that a good faith shutting down of the emergency department would not subject the hospital to liability because, like COBRA, California requires that the hospital provide treatment only "within the capability of the facility."[191] Thus, it would not be within the hospital's capability to accept an incoming emergency pa-

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188. *Id.* § 1395dd(c)(1)(A)(ii).

189. Section 1395dd(c)(2)(B)(ii) provides that an appropriate transfer to a medical facility is a transfer—

> (B) in which the receiving facility—
> (ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment.

Id. § 1395dd(c)(2)(B)(ii).

190. Section 1395dd(c)(2)(B)(ii) provides that an appropriate transfer to a medical facility is a transfer—

> (D) in which the transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

Id. § 1395dd(c)(2)(D).

191. CAL. HEALTH & SAFETY CODE § 1317.1(a) (West Supp. 1989).

tient when the hospital is understaffed, or already overflowing with patients.

However, under California law, before the ambulance can be rerouted certain other requirements must be met if the hospital is to escape liability. First, it must "be determined within reasonable medical probability, that the transfer, or delay caused by the transfer will not create a medical hazard to the patient."[192] Thus if the incoming ambulance were carrying a cardiac arrest patient and the rerouting would cause a delay in the patient's receiving treatment, the transferring hospital would be under a duty to accept that patient and at least stabilize him or her before a transfer could be effected. Additionally, before a rerouting of an incoming ambulance can occur, the hospital must notify the receiving hospital and "obtain[] the consent to the transfer by a physician at the receiving hospital [as well as] confirmation by the receiving hospital that the person meets the hospital's admissions criteria relating to appropriate bed, personnel, and equipment necessary to treat the person."[193] If the above enumerated criteria are met, then under California law, liability will not be imposed upon a hospital that reroutes an incoming ambulance because of a good faith "shut down" of the hospital's emergency department.

IV. PROPOSAL

Several changes should be made to COBRA. These changes include amendments that would (1) require a finding of repeated, willful or knowing violations of COBRA before a hospital could lose its Medicare provider agreement, (2) lessen the standard for the imposition of fines against hospitals and doctors to a negligence standard, and (3) allow a private right of action against physicians. These proposals will be discussed below.

A. *Termination of Medicare Provider Agreement*

The author would suggest that Congress amend the enforcement provisions of COBRA so that revocation of a

192. *Id.* § 1317.2(b).
193. *Id.* § 1317.2(c).

hospital's Medicare provider agreement would be predicated only upon repeated *knowing* or *intentional* violations and not upon the lesser standard of negligence which is all that the statute now requires. The effect of such an amendment would be to preserve the sanction of revocation of the Medicare provider agreement only for hospitals that have egregiously and wantonly disregarded the antidumping provisions of COBRA over an extended period of time. The amended enforcement provision of COBRA, with respect to revocation of the hospital's Medicare provider agreement, would thus read:

> (d) ENFORCEMENT. –
> (1) AS REQUIREMENT OF MEDICARE PROVIDER AGREEMENT. – If a hospital, on a repeated basis, knowingly or willfully fails to meet the requirements of this section, such hospital is subject to –
>
> (A) termination of its Medicare provider agreement, or
>
> (B) at the option of the Secretary of the Department of Health and Human Services, suspension of such Agreement for such period of time as the Secretary determines to be appropriate, upon reasonable notice to the hospital and to the public.

B. *Imposition of Civil Monetary Fines Against Physicians and Hospitals*

COBRA's provision of civil monetary fines against physicians and hospitals that violate the federal antidumping laws will, in the opinion of the author, prove to be a very effective way of ensuring compliance with the legislation. However, as the law now stands, civil monetary penalties can be imposed only on hospitals and physicians who *knowingly* violate COBRA. It would make greater sense in achieving the congressional purpose behind the enactment of COBRA–ensuring that the indigent and uninsured receive adequate emergency medical care–to also allow civil monetary fines to be imposed for negligent violations. Thus, the author suggests the following amendment to COBRA's enforcement provisions which would lessen the standard upon which a civil monetary fine could be imposed upon a hospital or physician to a negligence standard.

> CIVIL MONETARY PENALTIES. –
>
> (A) A participating hospital that knowingly, or negli-

gently, violates a requirement of this section is subject to a civil monetary penalty of not more than $50,000 for each such violation.

(B) Any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital including a physician on-call for the care of such an individual, and who negligently or knowingly violates a requirement of this section is subject to a civil monetary penalty of not more than $50,000. However, this section shall not apply to any emergency department physician who authorizes the transfer of an individual based on the failure or refusal of an on-call physician to treat the individual, and based on the reasonable determination by the emergency department physician that the benefits to the individual from the transfer outweigh the risks of transfer.

C. *Private Right of Action Against Physicians*

One major area in which the California antidumping legislation clearly exceeds COBRA in providing remedies for those persons who suffer harm as a result of a physician's violation of the antidumping laws is in the area of civil actions against physicians. At this time, COBRA does not provide for a private cause of action against a physician; instead, it provides only for civil actions against hospitals. An amendment to COBRA extending the right to bring a civil action against physicians, similar to that provided for under the California antidumping legislation, would undoubtedly compel greater compliance with COBRA's requirements by emergency room physicians, and those physicians on-call at hospital emergency departments. Such an amendment would read as follows:

CIVIL ENFORCEMENT

(B) PERSONAL HARM: LIABILITY OF PHYSICIANS. – Any individual who suffers a personal harm as a direct result of an emergency department physician's, or an on-call physician's, negligent violation of any requirement of this section may, in a civil action against the physician, obtain those damages available for personal injury under the law of the state in which the violation occurred, and such equitable relief as is appropriate.

A physician's liability under this private right of action enforcement arm of COBRA would be predicated on a negli-

gence standard, and not the standard of strict liability upon which a hospital's liability in a civil action is based.[194] A negligence standard of liability will insure greater physician compliance with COBRA's requirements and allow recovery by injured persons against noncomplying physicians, while insulating non-negligent physicians from strict liability for a transferred individual's damages.

V. CONCLUSION

The practice of dumping emergency department patients because of their indigency or lack of insurance is abhorrent. However, it is also unfair and unrealistic, considering the costs and expenses of health care in the United States at the present time, to mandate that private hospitals provide treatment to all persons regardless of their ability to pay. It is between these two competing interests—the interest of the indigent in receiving emergency medical care and the interest of the private hospital in remaining solvent and profitable—that the federal and California antidumping legislation attempt to strike a balance. For the most part, the two statutes are successful in ensuring that the indigent will receive medical care in true emergency situations, and that private hospitals will not be forced to absorb the total cost of providing indigent care. However, as this comment has illustrated, there are still several aspects of the antidumping laws in which a greater balance between the interests of the indigent emergency department patient and the private hospital can be achieved. The purpose of this comment was to highlight potentially problematic aspects of California and federal antidumping legislation, and to propose ways to strengthen them while maintaining the delicate balance of the interests of the indigent emergency department patient against those of the private hospital.

John Patrick Halfpenny

194. *See supra* notes 86-89 and accompanying text for a discussion of the strict liability standard in private civil actions brought against hospitals for COBRA violations.