Dumping EMTALA: Restoring the Fiduciary Ethic, Improving Community Care, and Increasing Efficiency through the Membership Model

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Abstract:

The U.S. healthcare system is breaking. Hospital emergency departments ("EDs") disproportionately bear this burden. EMTALA, the federal law that mandates treatment in an emergency, is responsible. By forcing a hospital to provide medical treatment, despite a patient's inability to pay, EMTALA has altered treatment standards for the worse. In this note, I suggest that repealing EMTALA will allow the market to capture the treatment values that motivated EMTALA's passage. Permitting EDs to base treatment on a patient's pre-existing hospital membership encourages better treatment than EMTALA. A market driven ED will succeed where EMTALA has failed.
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Introduction

We can agree there are market pressures in our health care system. The promise of better treatment creates more demand and drives up prices. People pay top dollar for the top cancer clinics, top surgeons, and top hospitals. Those that cannot pay do not have top dollar, and thus get something less than top care. This is the reality of the U.S. health care system. Almost. The Emergency Medical Treatment and Active Labor Act ("EMTALA") suspends this reality in one instance.\(^1\) A "dedicated emergency department"\(^2\) must provide stabilizing treatment to those who arrive in an "emergency medical condition."\(^3\) This right to treatment exists independent of financial capacity, resisting market pressure, in reverence to a societal maxim: the value of human health supersedes the financial burdens of an indigent patient in a medical emergency.

We like the way that sounds. It reminds us that the bottom line is not always the dollar, sometimes it is the patient. Rule VIII of the AMA's Principles of Medical Ethics espouses this belief, "A physician shall, while caring for a patient, regard responsibility to the patient as paramount."\(^4\) EMTALA purported to layout a statutory scheme for achieving this ethical standard in an emergency context.\(^5\) However, its disconnection from costs has exacerbated medical, financial, and social costs at every level of emergency health care. This paper proposes embracing the economic motivations EMTALA attempts to legislate against. I argue that

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unhinging hospitals from EMTALA’s duty to treat will allow emergency rooms the flexibility to provide cost-effective treatment which far exceeds today's standards. A market competitive emergency department will succeed where EMTALA has failed. Patient dumping, burdensome litigation, and excessive costs will subside.

Part I of this paper offers a brief historical background to EMTALA. Part II examines EMTALA’s failure to prevent patient dumping, and the negative externalities that have resulted. Part III draws conclusions from EMTALA’s failure. Part IV argues that these conclusions call for repealing EMTALA and a restoration of the physician fiduciary ethic. Part V considers the advantages of transitioning into an era of market driven emergency rooms.

I. Historical Impetus for EMTALA

"By the time she arrived at the third hospital, the baby's heartbeat was barely detectable. Although the county hospital rushed to perform a Cesarean section, the baby was stillborn."6 Told with great fervor, this story, and others like it, animated Congress’ overwhelming endorsement of EMTALA. The bill grew out of the public perception that emergency departments ("EDs") were turning away patients because they appeared unable to pay for treatment.7 Although state law imposed a duty to treat patients in an emergency, the public perceived these laws as incapable of fixing the problem. Called "patient dumping," the practice received national attention through media outlets such as 60 minutes and The Washington Post.8 Public outrage boiled as stories of the suffering poor proliferated.

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7 Id. at 147 n.11 (“[T]he patient dumping issue . . . has gained much attention over the last year. The CBS News show ‘60 Minutes’ ran a segment exposing the inappropriate transfer of a number of seriously ill patients from the emergency rooms of private hospitals to public hospitals . . .”) (quoting statement of Sen. Durenberger, 131 Cong. Rec. S13,892 (daily ed. Oct. 23, 1985)).
8 Id.
A few early studies on patient transfers supported the prevalence of patient dumping. In
the Himmelstein study, researchers reviewed 458 patient transfers to one public hospital from
local private hospitals during a six-month period and found that 97% of the transferees had
Medicaid or no insurance. The study also noted that some instances of transfer resulted in a
worsening of the patient's condition. Other studies confirmed that inability to pay motivated the
transfer of patients the majority of the time.

Thus, supported by strong public opinion, tear-jerking anecdotes, and some data,
Congress passed EMTALA in 1986. However, it has proven difficult to extrapolate its original
intent from its broad support. Hospitals argued that EMTALA actions required a financially
motivated refusal, while patients characterized it as a greater assurance of equal emergency
treatment for all. The circuit courts clarified, holding that Congress designed it to prevent
hospitals from "dumping [indigent] patients . . . by either refusing to provide emergency medical
treatment or transferring patients before conditions were stabilized," but then added "that the Act
applies to any and all patients, not just to patients with insufficient resources." Accordingly,
EMTALA achieves these goals by requiring hospitals to fulfill two obligations. First, an ED
"must provide [a presenting patient] an appropriate medical screening examination . . . to
determine whether or not an emergency medical condition exists." A medical condition
qualifies as an emergency if it manifests symptoms that if left untreated would result in
jeopardizing the health of the individual, serious impairment of bodily functions, serious

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10 See Robert L. Schiff et al., Transfers to a Public Hospital, 314 NEW ENGL. J. MED. 552, 552 (1986).
12 James v. Sunrise Hosp., 86 F.2d 885, 886 (9th Cir.1996).
dysfunction of a bodily organ, or jeopardizing the health of a woman in labor.\textsuperscript{14} When a condition fails to fall into one of these categories, the hospital is free to refuse treatment. If a patient does have an emergency medical condition, EDs are under a second obligation to provide stabilizing treatment until the material deterioration of the patient's condition is unlikely.\textsuperscript{15} At this point the ED discharges the statute's requirements and may transfer the patient to a public hospital.\textsuperscript{16} An ED's noncompliance with either obligation can result in civil fines up to $50,000 dollars, the elimination of Medicaid funding, and a private suit by the offended.\textsuperscript{17}

Despite the apparent clarity of these guidelines, history has shown EMTALA ambiguous. Circuit courts were left to sort out the lexical ambiguities. Hospitals stretched key terms, like "appropriate screening," to their benefit, while patients tried the same trick, stretching "stabilization" into a full treatment obligation.\textsuperscript{18} Artful attorneys also joined the confusion, attempting to convert EMTALA into a federal malpractice statute.\textsuperscript{19} Even now the confusion persists, as physicians and hospitals remain unsure about the extent of their obligations.\textsuperscript{20} The prevalence of the dumping itself resists assessment, as it can assume less detectable forms, such as delays in treatment and referrals.\textsuperscript{21} One thing is clear: EMTALA's inherent confusion leaves room for improvement.

\begin{itemize}
\item \textsuperscript{14} \textit{Id.} § (e)(1)
\item \textsuperscript{15} \textit{Id.} § (b)(1), (c)(1).
\item \textsuperscript{16} \textit{Id.}
\item \textsuperscript{17} \textit{Id.} § (d)(1)-(2).
\item \textsuperscript{18} Iscan, \textit{supra} note 11, at 1208-09.
\item \textsuperscript{21} \textit{Id.} at 2.
\end{itemize}
II. EMTALA's Failure

Since EMTALA's enactment various studies have suggested that patient dumping continues. "Data from 1986 to 1999 indicates that there has been an approximately 100-fold increase in patient dumping hospital violators and a 139-fold increase in patient dumping violations concerning the lack of performance of a medical screening examination."\(^\text{22}\) Even the government's most recent Congressional report concedes the persistence of EMTALA violations. However, these studies all note that there are inherent problems with identifying violations.\(^\text{23}\) Better understood than these explicit failures, is EMTALA's exacerbation of existing ED problems.

A. Overcrowding

Between 1993 and 2003, nationwide ED visits rose from 90.3 million to 113.9 million.\(^\text{24}\) During the same period the number of EDs declined by 425.\(^\text{25}\) With more patients than ever, and declining alternative providers, ED overcrowding is now the norm.\(^\text{26}\) Commentators and ED physicians argue that EMTALA creates this overcrowding, and thus contributes to escalating rates of patient dumping.\(^\text{27}\) Studies show that patients without financial resources use the ED as their primary medical care provider.\(^\text{28}\) They either wait until a non-emergency condition has reached an emergency state, or they go to an ED hoping for treatment despite the lack of emergency.\(^\text{29}\) Fully aware that these visits are free, EMTALA creates a cost-avoidance incentive that focuses an entire socio-economic group into a single provider source. A bottlenecking in

\(^{23}\) See GAO, EMTALA Issues, *supra* note 20, at 2.
\(^{25}\) *Id.*
\(^{26}\) *Id.*
\(^{27}\) *Id.* at 38-40
\(^{28}\) *Id.* at 42-46 (providing a thorough discussion on EDs serving as "Safety Nets" for the indigent).
\(^{29}\) *Id.*
treatment occurs and five hour waits for treatment result.\textsuperscript{30} The overburdened staff and the delays in treatment, work in conjunction to discourage the screening needed to discharge an EMTALA obligation.\textsuperscript{31}

Other commentators argue that EMTALA is one of many causes of ED overcrowding. The well insured also misuse EDs as it is often the quickest way for them to receive treatment from a specialist.\textsuperscript{32} General Practitioners seeking to avoid liability exposure have an incentive to encourage their patients to go to an ED, rather than wait to schedule a specialist appointment.\textsuperscript{33} Financial incentives strengthen this incentive for quicker specialist access, as many state laws obligate an HMO to cover reasonable ED visits.\textsuperscript{34}

Others speculate that overcrowding is the result of hospital management models designed to cut costs.\textsuperscript{35} Hospitals that serve larger groups of uninsured may intentionally reduce available staff, in order to mitigate the losses associated with serving patients that will not provide them full reimbursement.\textsuperscript{36} That hospitals eliminated over 400 EDs between 1990 and 1999, despite annual increases in ED usage, suggests the ED's declining profitability. The remaining overburdened EDs may structure themselves first toward loss reduction, and service efficiency as an afterthought.\textsuperscript{37}

Regardless of EMTALA's role in causing ED overcrowding, its failure to respond to the problem is undeniable. Its' failure to address overcrowding is unforgivable. With steady increases in ED demand, and steady decreases in ED availability, overcrowding has created a

\textsuperscript{30} Id. at 40
\textsuperscript{33} Id.
\textsuperscript{34} Id.
\textsuperscript{36} Id.
\textsuperscript{37} Id.
supply shortage. The resulting turmoil lends itself to patient dumping through outright discriminatory selection and calculated treatment delays. Violations escape detection as the large numbers of patients facilitate concealment of unlawful decisions. At best, EMTALA fails to address its primary enabler, excessive demand; at worst, EMTALA is the primary enabler.

**B. Costs**

From its inception EMTALA frowned upon reconciling provision of emergency medical treatment with financial concerns. Unsurprisingly, EMTALA did not stipulate additional funding to hospitals. Rather since EMTALA’s enactment, hospitals have suffered further funding shortages through a decline in Medicaid reimbursement. All time highs in ED usage now exacerbate the shortage, creating greater disparity between treatment rendered and cost recovered. EMTALA ends up supporting a cost model that shifts onto hospitals the burden of providing emergency treatment to 43.6 million Medicaid recipients. Although EDs absorb the most loss, they do manage some cost dispersal among paying patients. When dispersal is inadequate, often entire communities pay the price.

This price is disproportionately high for urban minority communities. Over the last decade 60 EDs have closed in the Los Angeles area. Many of these catered to the local Latino and black communities. In the 1980s, Chicago closed three Level I trauma centers that served as the main emergency providers for victims of gang violence and drug abuse. As recently as

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38 See Lee, supra note 5, at 150.
39 See Institute of Medicine, supra note 24, at 52.
40 Id.
41 Id.
44 Id.
45 See Lee, supra note 5, at 171.
2008, Atlanta announced the closing of 115-year-old Grady Hospital. Long revered for "treating a population afflicted with both physical and social ills . . . Grady is emblematic of the crippling effect America's Healthcare crisis has had on public hospitals around the nation." These hospitals bear "unsustainable losses" by serving uninsured marginal communities. They provide 24% of the nation's uncompensated care, and yet they only represent 2% of the nation's EDs. Under this burden they are breaking, leaving the communities they served without critical access to emergency care.

Often paying patients bear the cost when EDs can shift their losses, as they charge paying patients excessive rates in order to cover the costs of non-paying patients. The Congressional Budget Office estimated that in 1991 paying patients absorbed $20.3 billion in medical treatment costs shifted from the uninsured. ED patients are particularly susceptible to this shifting as the urgency of receiving treatment precludes cost comparisons. However, arguably the rise of HMOs has reduced this shifting, as HMOs monitor their reimbursement rates for excessive pricing. Still commentators theorize that this price shifting remains built into current service rates.

Whether dispersed or concentrated, the government's cost shifting creates a path of negative externalities. The hospitals that close leave behind marginal communities that require health access at higher rates than their more affluent counterparts. These counterparts end up bearing an even greater cost per patient, as the scarcity forces the indigent to travel farther while

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47 Id.
48 Id.
50 See Cost Shifting, supra note 42.
51 See Friedrich Heubel, Patients or Customers: Ethical Limits of Market Economy in Health Care, 45 J.MED. & PHIL. 240, 244 (2000) (“Consumers in their role as patients are not rational agents in the sense of the market. They are unable to choose among the services offered and to assess their prices.”).
their condition deteriorates further. Thus, the remaining EDs experience overcrowding, and the patients from that hospital's community must wait longer for treatment. Faced with the growing prospect of insolvency, these hospitals then shift the costs onto their paying patients.\footnote{See Cost Shifting, supra note 42.}

EMTALA helps reinforce this system. For the indigent with non-emergencies, EMTALA gives them financial incentive to use EDs rather than a physician. This contributes to urban hospitals experiencing greater uncompensated profit loss. For the indigent with emergencies, EMTALA forces these urban hospitals to accept a disproportionate number of emergency patients. Such patients require more care and resources, and thus impose more uncompensation. Thus, EMTALA helps focus the social burdens of the poor onto urban hospitals and ignores the ensuing long-term effects.

\textit{C. Treatment and Litigation}

With fewer resources, for more patients, EDs foster an environment uniquely fertile for malpractice claims. The procedures are often inherently risky and performed under time pressures that belie optimal preparation.\footnote{See Institute of Medicine, supra note 24, at 209.} EMTALA has increased this liability exposure, as ED physicians seeking to perform EMTALA's bare obligations can inadvertently violate it.\footnote{See GAO, EMTALA Issues, supra note 20, at 15 (“Providers have raised questions about the amount of care they are required to give patients to comply with certain EMTALA requirements and about when their obligations under EMTALA end.”).} Aware that these violations can subject them to private suits, hospitals may seek to reduce liability by making EMTALA compliance their primary goal.\footnote{See U.S. DEP’T OF HEALTH & HUMAN SERVICES, CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 5 (2002), http://aspe.hhs.gov/daltcp/reports/litrefm.pdf (stating that in general, “[b]ecause the litigation system does not accurately judge whether an error was committed in the course of medical care, physicians adjust their behavior to avoid being sued”).} Ironically, this reduces the quality of patient treatment.
The precise point at which an EMTALA obligation discharges is a mystery to many physicians. It is as much a subjective determination, as it is a function of location. In a majority of the circuits, EDs satisfy the screening obligation as long as the patient receives the same screening exam as paying patients. However, the First and Ninth Circuits mandate an objectively reasonable standard of screening, independent of relative comparisons. The specifics of the medical issue complicate the consideration, as varying screening methods are often available. Large differences in cost for nearly identical methods add another layer to the decision, and help to foster a vast gray area of possible liability.

Some EDs have responded to this haziness by trying to define the exact parameters of their obligations. Common questions include; what qualifies as a main building such that the "within 250 yards rule" is triggered, whether a hospital must ensure that follow up care is obtained, and whether screening is required at satellite facilities. This shared preoccupation with the details of the statute suggests fulfillment has become the central objective, and resolution of the emergency secondary. Recent EMTALA regulations lobbied for by EDs illustrate the impulse. In 2003, the Centers for Medicaid and Medicare Service ("CMS") promulgated that EMTALA ceases to apply upon the good faith admission of a screened patient. In so doing CMS contravened the Supreme Court's ruling in Roberts v. Galen that

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56 Victoria K. Perez, Note, EMTALA: Protecting Patients First by Not Deferring to the Final Regulations, 4 SETON HALL CIR. REV. 149, 162-165 (2007). I DON'T THINK THIS JOURNAL NAME IS RIGHT, CHECK IT AGAIN
57 Id.
58 See Institute of Medicine, supra note 24, at 138 (“The rise in the number and severity of medical malpractice claims, especially in the high-risk fields such [as] emergency medicine, has led to an increasingly defensive approach to providing care in the ED.”).
59 Id.
60 See GAO, EMTALA Issues, supra note 20, at 16.
61 Perez, supra note 56, at 176 (relating that "[t]he Final Regulations clearly state that ‘a hospital’s obligations under EMTALA end once an inpatient is admitted for inpatient care’").
EMTALA continued to apply after admission. CMS rationalized that EDs wanted and needed to know at what point EMTALA liability ceased. That physicians asked for the clarification, admits their focus on the statute. That CMS provided them with this precise clarification admits their preference for clarity over increased incentives for better treatment. Efforts to clarify EMTALA end up deifying it, and thus detract from focusing on better patient treatment. Were *Roberts* decided today, neither an EMTALA violation, nor the liability incentive it created, would exist. EMTALA's clear lack of applicability to post admittance would provide the treating doctor a point of obligation discharge.

At first glance this criticism lends itself to a larger criticism of all regulatory statutes. However, human health possesses an intrinsic value, which distinguishes it from the objects of other regulatory schemes. EPA regulations permit pollution on a parcel of land within acceptable levels. Similarly, the Securities and Exchange Acts permit publicly traded companies to withhold some information even though release would achieve more accurate stock prices. In both cases, the government intentionally sets the respective goal of the regulatory scheme at a sub-optimum level. This makes sense in both cases because we recognize that stocks and land are commodities. Somewhat fungible and purely instrumental, stocks and land derive value from their perceived utility in markets. Both regulations act to protect the market utility of their objects by creating thresholds of quality. Implicit in the creation of these thresholds is an

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63 See Perez, *supra* note 56, at 176-77.
64 *Id.*
65 See Schaffner, *supra* note 22, at 1037 (stating that “[i]t is apparent that the new regulations relax the obligations previously imposed on hospitals and emergency department physicians . . . [and as a result] patients may find it more difficult to win damages in court for injuries caused by EMTALA violation”).
66 ROBERT V. PERCIVAL ET AL., ENVIRONMENTAL REGULATION: LAW, SCIENCE, AND POLICY 247 (Vicki Been et al. eds., 2006) (“[Congress] has instructed agencies to control potentially dangerous substances by using technology based standards, usually up to the point at which further reductions are no longer ‘feasible,’ or sometimes simply to regulate so as to ‘protect public health.’”).
67 See STEPHEN J. CHOI & A.C. PRITCHARD, SECURITIES REGULATION: CASES AND ANALYSIS 48 (Robert C. Clark et al. eds., 2005) (stating that “there is no general duty [for a public company] to disclose all material information”).
68 See Heubel, *supra* note 51, at 244.
69 *Id.*
acceptance of varying levels of quality.\textsuperscript{70} In the commodities context, the pursuit of market value through exchangeability, gives the holders an incentive to exceed the threshold requirements. Similarly, this exchangeability forces non-holders to recognize its objective value as they entertain the possibility of ownership.\textsuperscript{71} The inherent separateness of a stock or a parcel of land from the party that owns it, necessitates a market value.

Conversely, the object of EMTALA, human health, has an intrinsic value that by its nature defies market valuation. Health's identity with the person that accords it value rules out exchangeability. No one can select a different state of health in an emergency. Consequently, non-holder participants are not forced to assign an objective value through the real possibility of ownership. The protections of objectively identifying, and discounting in the market, .003 of land contamination per cubic meter, are unavailable to a medical patient. And yet EMTALA obligations create a threshold similar to the SEC's disclosure requirements and implicitly accept varying levels of quality. However, unlike with a regulated commodity, a person's health is not exchangeable and so lacks a valuation mechanism to protect it. Where the SEC relies on recognition of market value and the prospect of alternatives to push disclosure levels beyond their threshold, EMTALA lacks a mechanism that pushes for treatment beyond its obligations. The quality of fixedness that gives health its intrinsic and superior value prevents its participation in a system based on the valuation protections inherent to exchangeable objects.

This insight casts EMTALA as the ultimate hypocrite. Its rhetoric champions separating emergency treatment from financial concerns, while it relies on a regulatory scheme that depends

\textsuperscript{70} Id.

\textsuperscript{71} See Edmund Pellegrino, The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm Shift from a Professional to a Market Ethic, 24 J. MED. & PHIL. 243, 249 (1999) (“In a commodity transaction . . . [the parties] are focused on the object or the product, on the commodity to be traded. Their relationship does not extend beyond the sale . . . .”).
on the commodified aspects of its object. Consequently, there is sparse incentive to exceed the obligations which the threat of liability brings to prominence. Treatment standards suffer.

**D. Patient Dumping 2.0**

Despite designing statutory language, subsequent amendments, and new regulations to prevent EMTALA shirking, modern EDs have innovated. Loss avoidance behavior now extends far from the point of treatment, as "the hospital's adaptive responses [...] take place earlier in the cycle."\textsuperscript{72} It is unclear when some of these cost avoidance responses trigger EMTALA violations and become full-fledged dumping.\textsuperscript{73} Regardless, the impulse that generates the foresight is indistinguishable from the classic cases that animated the passage of EMTALA.

Reverse patient dumping ranks among the easiest to identify. In *Arrington v. Wong*, a private ambulance picked up a heart-attack victim and radioed to the closest hospital asking if they would provide urgently needed treatment.\textsuperscript{74} Even though the patient was in "severe respiratory distress," the doctor asked who was the patient's physician.\textsuperscript{75} When the EMT responded that the patient probably received his medical treatment from a local Army Medical Center, the doctor said, "I think it would be ok to go [there]."\textsuperscript{76} The Ninth Circuit recognized this as the ED's attempt to "avoid its obligation to treat emergency patients simply by preventing individuals in dire straits from reaching the emergency room."\textsuperscript{77} By preemptively refusing a patient unable to pay, the ED demonstrated Epstein's theory of shifting the avoidance earlier in

\textsuperscript{72} Epstein, *supra* note 35, at 95.
\textsuperscript{73} See Lawrence E. Singer, *Look What They've Done to My Law, MA: COBRA's Implosion* 33 Hous. L. Rev. 113, 128 (1996) ("The actual incidence of dumping is hard to measure in large part because of the insidious forms it can take.").
\textsuperscript{74} *Arrington v. Wong*, 237 F.3d 1066, 106 (9th Cir. YEAR).
\textsuperscript{75} *Id.*
\textsuperscript{76} *Id.*
\textsuperscript{77} *Id.* at 1072.
the cycle. Other courts have noted that EDs may be creating entire prophylactic schemes dedicated to redirecting indigent patients through telemetry systems.\footnote{See Johnson v. Univ. of Chicago Hosp., 982 F.2d 230, 233 (7th Cir. 1992).}

Corporate planning facilitates more efficient and less illegal avoidance schemes. Evidence suggests that proximity to indigent patients often figures into the where investor owned hospitals decide to locate.\footnote{See Bradford H. Gray, The Profit Motive and Patient Care 108 (1991) (providing a discussion of tactics hospitals use to avoid low income patients).} Such hospitals intentionally situate far from low income areas in order to reduce their level of uncompensated care.\footnote{Id.} Existing hospitals, unable to change locations, employ similar foresight by eliminating programs heavily used by indigent patients.\footnote{Id. at 107.} In fact, some speculate that most investor owned hospitals refrain from becoming modern teaching hospitals and expanding services because the specialized capability will increase their transfer rate of uncompensated patients.\footnote{Id.} While these ingenuities fall outside the purview of EMTALA, they represent management strategies that bypass EMTALA's rationale. The result is a business model premised on mass poor patient avoidance.

Other EDs have shown even more creativity. In Jones v. Hosp. Authority of Gwinnett County, one ED pioneered the reverse-reverse dump.\footnote{See, e.g., Hospital Liable for Punitive Damages for Improper Ambulance Policy, 9 Verdicts Settlements & Tactics 173 (June 1989) for a summary of this unreported case.} In this case, a hospital diverted a burn victim in an ambulance helicopter to their hospital despite their lack of a burn treatment center. Repeating a procedure they had practiced "hundreds of times over a five year period," they based their decision on the "belief that the victim had lucrative insurance coverage."\footnote{Id.} The delay in proper treatment resulted in the victim's death.\footnote{Id.} Outside EMTALA, and for once directly damaging to the paying patient, this case also illustrates a cost effort diversion taking place.\footnote{Id.}
earlier in the treatment cycle. Yet, the loss avoidance here manifests itself as coveting the patient for his promise of profitability. Like most dumping this designation owes itself to EMTALA's propensity for encouraging prospective profit valuations by an ED. Although this patient could pay, the ED based their scheme on avoiding the profit loss EMTALA causes.

III. Common Themes

A. Doctor-Patient Relationship

In the details of these failings emerges EMTALA's central weakness. It distorts the sanctity of the doctor-patient relationship by forcing obligations which may cause financial detriment to an ED physician. Doctors must worry about maintaining the solvency of their hospital, while also worrying about treating their patient. When these concerns conflict, the aforementioned debasements of the profession can occur. Preemptive dumping, apathy to overcrowding, and strategic withdrawal from poor areas show that this conflict resolves in itself in favor of the doctor's well being.

Subordinating the patient's treatment beneath profit concern is a departure from traditional conceptions of the doctor-patient relationship. As far back as ancient Greece, societies have viewed doctors as fiduciaries, expected "not only to look after the interests of patients, but also [to work] positively for the good of patients." Implicit in this conception was the doctor's integration within the community he served and the trust this intimacy created. This integration hinged on a fee-for-service system where the rationing of service and trust creating advice occurred. Without the fee-for-service aspect of this relationship, a physician

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86 See GAO, EMTALA Issues, supra note 20, at 12-13 (stating that physicians complained that EMTALA posed a serious impediment for ensuring that they received compensation for their services).
87 See Barbara M. Osborn, INTRODUCTION TO COMMUNITY HEALTH 20-21 (Allyn and Bacon, Inc. 1964) (1967) for an overview of the historical development of medicine.
88 Eugene C. Grochowski, Ethical Issues in Managed Care: Can the Traditional Physician-Patient Relationship be Preserved in the Era of Managed Care or Should it be Replaced by a Group Ethic? 32:4 U. MICH. J.L. REFORM 619, 628 (1999).
89 See Pellegrino, supra note 71, at 249 (stating "confidence and trust are crucial as is a continuing relationship").
abstains from true integration as his lack of dependency on the community separates him from the community.\textsuperscript{90} By mandating provision of service without pay, the dependency that coheres the physician is absent. The community then becomes an external drain.\textsuperscript{91} Thus, EMTALA abstracts ED physicians from the \textit{quid pro quo} service rationing that helps to integrate them into a community and foster their fiduciary status. Now ED physicians function more as assembly-line workers, disconnected from the fruits of their labor, without incentive to exceed minimum production. EMTALA exemplifies the disassociation that decreases the fiduciary ethic.

\textbf{B. The Primacy of Profit}

Financial motive has filled this fiduciary vacancy. EDs categorize patients foremost on their ability to pay, and second according to their medical condition. The classic fee-for-service exchange not only avoided this by integrating physicians into the community, but relied on the truism that "patients generally prefer the risk of too much care to the risk of too little care."\textsuperscript{92} Thus, fee-for-service doctors had to deny their patients' excessive treatment desires which reduced their fees. EMTALA has inverted this dichotomy, so that doctors now deny their patients' just-above minimal treatment desires, in order to increase their profits. In the former scenario the fiduciary ethic curbed physician self interest. In the latter, the ED's abstraction precludes fiduciary-dependency and strips the treatment down to a bare profit assessment. EMTALA has enabled the profit seeking that Congress intended it to prevent. In its porous flaws there has developed a host of ingenious profit strategies, each united in their subordination of classical doctor-patient values.

\textsuperscript{90} See Daniel Callahan, \textit{Medicine and the Market: A Research Agenda} 24 J. MED. & PHIL. 224, 232 (1999) ("[P]hysicians have never been hostile to small-time market practices, in which they have gladly taken part. What they appear to find most objectionable is a massive industrialization of medicine turning them into assembly-line workers who have lost their independence and sense of personal integrity.").
\textsuperscript{91} \textit{Id.} ("The [regulated] market creates a zone of pressure and interference between the physician and the moral norms of the profession.").
\textsuperscript{92} Laurence B. McCullough, \textit{A Basic Concept in the Clinical Ethics of Managed Care: Physicians and Institutions as Economically Disciplined Moral Co-Fiduciaries of Populations as Patients} 24 J. MED. & PHIL. 77, 89 (1999).
C. Worse Treatment

These themes of changing physician attitudes and the unmitigated elevation of profit have led to a reduction in treatment standards. EDs run like factories, regularly make patients wait hours for much needed treatment. Specialists avoid providing much needed ED services for fear of uncompensation. ED doctors' ration their treatments according to statute rather than need. The poor and uninsured receive worse treatment, as they bring higher rates of medical problems to an ever-shrinking pool of public hospitals. Meanwhile, investor hospitals implement business plans designed to avoid serving the poor, and thus help to focus more indigent care on already over stressed EDs. EMTALA's participation in transforming the ED physician from a patient fiduciary into an agent of profit has helped to diminish emergency care standards. In so doing, EMTALA contravenes the goal of remedying the emergency, by worsening the emergency.

IV. A Basic Premise and a Bold Proposal

One could call the U.S. health care system a postmodern phenomenon. Like a signed urinal placed on display in a museum, it once addressed a basic human need. But now its displacement from its original context has rendered it a spectacle ripe for ideological appropriation. The theories that emerge express their own agendas and further the abstraction. No one thinks first to use the urinal. Similarly, EDs are subject to HMO plans that redefine the boundaries of necessary treatment, Medicare funding designed to fall short of actual need, and a treatment statute born of impassioned rhetoric, but unclear in its objectives. ED physicians exemplify this appropriation as their traditional fiduciary ethic has given way to uncertainty as

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93 See Institute of Medicine, supra note 24, at 223.
they serve their various masters. The HMOs, the insurers, and the Congressmen, with their own agendas, do not think first of the ED's utility.

Thus, the systems that constrain the operations of an ED, work to separate it from the community it serves. This separation limits responsiveness to patients and increases ED apathy. Overcrowding and worse treatment results. Cost inefficiencies multiply and disproportionate burdens develop. I propose that resolution of these problems begins with mending the separation between EDs and their patients. This will require incentives for EDs to connect with their communities.

EMTALA stands as the main impediment to such incentives. As one commentator notes, "in its structure, EMTALA reinforces long-held views as hospitals as passive spaces . . . without an independent community presence." EDs assume this passive character because active integration into the community occurs at their expense. For some hospitals, the more patients they serve the higher their losses. Survival requires withholding resources from the community. Passivity emerges as a coping strategy for the difficult fiduciary conflict EMTALA creates: the physician's livelihood vs. the patient's health.

But passivity is not an ideal. Indeed, a fiduciary duty requires an agent actively to work for the good of his principal. How then can we encourage EDs actively to work for their patients? By eliminating the conflict and allowing for a system that ceases to ask EDs to bear unsustainable losses. Permitting the classic fee-for-service relationship in the ED context will accomplish a return to the fiduciary ethic. If EDs no longer must worry about their livelihood,

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96 See Sara Rosenbaum et al., EMTALA and Hospital "Community Engagement": The Search for a Rational Policy, 53 BUFF. L. REV. 499, 518 (YEAR).
97 Id.
98 Id.
99 Grochowski, supra note 88, at 628.
they can focus on providing optimal treatment. Necessarily, this involves permitting EDs to refuse treatment.

A world without EMTALA looks much different. In it, EDs have few reasons to view their patients as potential drains. Rather, EDs will view their patients as necessary to their livelihood. They will have an incentive to provide treatment that coincides with a patient's expectations. Ideally, this involves guarantees of immediate and optimum treatment, without lengthy check-ins, insurance screening, long waits, or preliminary screening. People will want a doctor familiar with their child's medical history, and maybe even their child's face. They will want to eliminate all uncertainty, and thus the emergency itself. Thus, the expectations of patients will help to drive treatment standards to levels at least commensurate with the fiduciary ethic. 100 In working to meet these expectations, EDs will need to shake out of their passive roles and involve themselves with the community they serve.

However, central to meeting the desires of patients, is the assurance that they will receive treatment in the first place. Consequently, EDs will need to offer people memberships. These will guarantee patients admittance, and provide EDs with some assurance of a patient's ability to pay. While this will likely result in a tiered system, with "higher end" EDs serving wealthier clients, this tiering will contribute to better medical care for all.

V. A Community Perspective

EMTALA's legacy of passive EDs discourages innovations in treatment efficiency. As such, it largely ignores that recognition of maladies common to certain groups can increase treatment efficiency. Tiering helps to distribute patient groups according to the health problems

\[\text{100} \text{ Cf. Huebel, supra note 51, at 244 (arguing convincingly that patients are not rational consumers). From this one could deduce that their expectations may be dissonant from what is their best course of treatment. To the extent that this could happen, it will be mitigated by the fact that what patients really want is the most effective treatment.}\]
they are likely to encounter. The strong variable relationship between financial capacity, location, and a patient's treatment needs, renders tiering an ideal distribution mechanism. It increases efficiency through homogeneity.

Consider the Urgent Matters project where researchers targeted overcrowded EDs which were to an extent already tiered. They hypothesized that these hospitals were inefficient because of high demand "by medically underserved persons with low incomes . . . who rely on emergency departments for treatments of conditions that could be treated" in less costly settings. They then implemented a sifting model which quickly categorized their patients' medical issues with greater precision. This allowed the EDs to direct the patient to appropriate services, and if needed expand upon those services. After 12 months many of the hospitals reported an average reduction of at least 40% in the duration of an ED visit.

The Urgent Matters project exemplifies the efficiency gains from categorizing patients. The project took a group already similar in its finances, and further categorized them according to their medical problem, and as a result they received quicker treatment from the appropriate source. The membership model offers analogous efficiency gains because EDs will be able to identify the medical needs specific to their community. In the Urgent Matters study, the hospitals responded to a group's needs by expanding primary care services. Another group, for example a middle class community with many blacks, may have other needs. Tiering would allow an ED to

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101 MARY E. LOUNGE & ANNE WOLF, PROMOTING COMMUNITY HEALTH THROUGH INNOVATIVE HOSPITAL-BASED PROGRAMS 26-32 (1984) (supporting the idea that "differentiat[ing] populations with respect to their health status before they show signs of illness" can result in better health programs. Moreover, the best way to differentiate is to "look at statistical data about the community or targeted segments.").

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103 The George Washington University Medical Center, Lessons Learned by the Urgent Matters Learning Network (2004) [hereinafter Urgent Matters]

104 Rosenbaum, supra note 96, at 520.

105 Id. at 521.

106 Id.

107 Id. at 522-23.
generate programs aimed at the medical issues in that community, such as the higher incidence of diabetes among blacks.\textsuperscript{108} By categorizing communities, the membership model promotes responsiveness to those communities. Overall efficiency and health benefits increase.

Those without the resources to purchase memberships also benefit. Many public hospitals operate on out-dated business models.\textsuperscript{109} They have costly surgery and trauma units which the uninsured use more often than the insured.\textsuperscript{110} As Medicaid reimbursements provide most of their income, they perennially operate at a deficit.\textsuperscript{111} The membership model would siphon away the last few paying patients and financially break these EDs. However, many of them already operate at levels that jeopardize their accreditation.\textsuperscript{112} The few paying patients that use them reinforce substandard EDs, and delay needed reform. Through isolating the indigent as a definable constituent and threatening to break their last safety net, their plight appears more objectionable. Delusions of attaining market competitiveness and increases in piecemeal Medicaid surpluses will evaporate as the public hospital approaches serving a patient group 100\% insolvent. Memberships prevent government cost shifting on to private hospitals, and force the social cost of the indigent into a two-way dichotomy. The indigent cannot absorb this cost; consequently the government will have to absorb the cost. Reform will occur.

At every level this model fosters patient-physician relationships through recognizing existing community frameworks. The market permits communities with like medical issues to cohere as patient communities. EMTALA artificially disrupts this impulse.\textsuperscript{113} The idea of

\textsuperscript{108} See Office of Minority Health, Diabetes (Data and Statistics), available at http://www.omhrc.gov/templates/content.aspx?ID=2913 (finding that black are 2.1 times more likely to develop diabetes than whites).
\textsuperscript{109} Dewan & Sack, supra note 46.
\textsuperscript{110} Id.
\textsuperscript{111} Id.; see also Urgent Matters, supra note 103, at 13.
\textsuperscript{112} Id.
\textsuperscript{113} See Rosenbaum, supra note 96, at 529 (stating that: EMTALA implicitly adheres to the essentially passive character of hospitals; despite their obligations, they are permitted to remain institutions whose duties are triggered when individuals either are electively admitted or else seek them out when in dire need of care.)
allowing any person to use any ED subverts a conception of an ED serving a specified group. Extending the community destroys the community, as the possibility of serving any patient diminishes the financial incentive to specialize ED service for a particular group. EDs that serve diverse groups end up responding less to the specific concerns of the various communities they serve. EDs that primarily serve the poor recoil from their communities through passivity. EDs that mostly serve the solvent, strive toward services which exclude poor communities. Thus, EMTALA distorts community relation between EDs and patients. Mending this schism improves treatment and helps resolve EMTALA’s failures.

A. Overcrowding

Knowing how many patients hold memberships to an ED will allow an ED to approximate the staff size needed to ensure prompt treatment. However, a definable patient group also allows an ED to address less simple contributors of overcrowding. EDs looking to remain market competitive can assess their patient data and locate the detrimental trends. Under EMTALA the lack of incentive and the less defined patient group precludes such analysis.

For instance, hospitals will learn to identify patients sent to the ED as a shortcut for obtaining an appointment from a specialist.114 Learning what specialties are requested most often, they the can act accordingly by expanding those services.115 Similarly, EDs can locate health issues best served by a primary care provider and expand those services accordingly.116 In the Urgent Matters project, Boston Medical responded to a heightened need for primary care by providing a clinic adjoining their emergency room. Their amount of time on diversion status (e.g.

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114 See Lounge & Wolf, supra note 101, at 33 (stating "that once the information about the community, its needs, potential consumers’ behavior, and the hospital's available resources is gathered" a hospital can more effectively respond to a community's needs).
115 Id.
116 Id.
the amount of time they were at capacity) decreased by 40%. 117 In either circumstance, the ED could take preventative steps to ensure such patients begin with the proper provider next time.

Although adapting to provide services beyond the traditional may encourage more ED arrivals for more non-traditional reasons, that is not so bad. The advantage of the membership model is its responsiveness to the needs of the community. If specialties and primary care physicians are that need, responsiveness only works to the benefit of the community. Adaptations are not a departure from an ideal, but movement toward an ideal community integration through responsiveness. Thus, a multi-dimensional appreciation of a defined patient group enables an ED to address causes of overcrowding.

**B. Costs and the Poor**

Group analysis does have limits though; among them, curing the overcrowding in many public hospitals. The 43.6 million Medicaid recipients that often use public hospitals have on average a higher healthcare demand than the rest of America. Yet, these EDs and the communities they serve, still stand to benefit from the membership model. In the long run these benefits work to reduce costs.

First, the membership model forces public hospitals to recognize that they are safety nets to a specific population. As such, they are incapable of the market competitiveness that their operating models presuppose. 118 EMTALA impedes this realization as it champions the idea anyone can use any ED, so paying patients are attainable. Recognizing the disparity between the community's needs and the needs a current ED is designed to serve will spur management innovation. EDs will structure themselves as hospitals for the poor. In effect, the emphasis on the poor will render them specialized hospitals, dedicated to remedying maladies common to the

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indigent.\textsuperscript{119} Like specialty hospitals, these hospitals will adopt leaner and less costly management structures as their service provisions adapt to patient demand. Efficiency increases at the management level.

Second, better recognition of the indigent as a community highlights their most common and costly treatment deficiency: a dearth of preventive treatment and primary care.\textsuperscript{120} A need to reduce costs gives specialized public EDs an incentive to develop initiatives towards this end. As the indigent become their only patients, the incentive increases. The Veteran's Administration exemplifies both this incentive and the results a specialized government health-care provider can achieve. The VA "invests heavily and systematically in preventive care because . . . it can expect to realize financial benefits from measures that keep its clients out of the hospital."\textsuperscript{121} This helps the VA operate its hospitals and clinics at a far lower cost than today's private sector counterparts.\textsuperscript{122} As with the VA, recognizing an indigent patient as a continuous client reduces costs through engaging the community.

In the context of the indigent, preventive and primary care can create tremendous cost savings and health benefits. The \textit{Primary Health Care in Urban Communities} project demonstrates the value of preventive treatment for EDs, patients, and their communities.\textsuperscript{123} It centered on the idea of training health advocates in preventive health strategies and placing them in Chicago's urban communities.\textsuperscript{124} Anecdotally, these health advocates reported identifying and positively impacting nutritional deficiencies, child abuse, and unsafe sexual activity in their

\textsuperscript{119} See Mike J. Wyatt, \textit{Leveling the Healing Field: Specialty Hospital Legal Reform as a Cure for an Ailing Health Care System}, 46 WASHBURN L.J. 547, 550 (noting that "the concentrated operations \[of specialty hospitals\] enhance[s] efficiency and increase[s] profitability").
\textsuperscript{120} See Institute of Medicine, \textit{supra} note 24, at 43 (stating that "[j]ust over half of ED visits in 2003 were categorized as emergent or urgent"). For safety net EDs this figure is even higher.
\textsuperscript{121} FIRST NAME HALL \textit{ET AL.}, \textit{HEALTH CARE LAW AND ETHICS} 1147 (2007).
\textsuperscript{122} \textit{Id.} at 1146.
\textsuperscript{123} BEVERLY J. McELMURRY, \textit{PRIMARY HEALTH CARE IN URBAN COMMUNITIES} pg # (1999).
\textsuperscript{124} \textit{Id.} at 2-3.
communities.\textsuperscript{125} Their statistical achievements include increasing immunizations rates by 45\% at public housing sites\textsuperscript{126} showing a statistically verifiable "reduction of clients' perceived barriers to health and social services,"\textsuperscript{127} and an average increase of 4.8 service referrals to more specialized health providers.\textsuperscript{128} While the net social benefit of these preventive measures eludes quantification, their known national net cost is suggestive. With preventable medical conditions costing the U.S. economy $100 billion dollars each year, extending preventive measures on a national scale has significant cost reduction promise.\textsuperscript{129} A public ED structured to address these preventable maladies will work towards this promise.

Despite the considerable cost reductions specialization and preventive campaigns will provide, public hospitals require financing reform. The specialized community engagement model offers a framework on which to base the reform. Its principle of integrating health care within the community has proven more successful and less costly than EMTALA's disassociative impulse. Its design traces the contours of classic health care rationing.\textsuperscript{130}

\textbf{C. Costs and the Solvent}

Memberships threaten the dominance of today's health care rationing regimes. To varying extents, insurers allocate risk among the patient groups they create.\textsuperscript{131} Their efficacy depends on shifting the costs of higher risk clients onto lower risk clients. Similarly, hospitals shift the costs of non-paying patients onto paying patients.\textsuperscript{132} In both instances, these systems insert patients into a cost allocation scheme based upon maximizing financial benefit to the providing

\textsuperscript{125} Id. at 57-59.
\textsuperscript{126} Id. at 107.
\textsuperscript{127} Id. at 123.
\textsuperscript{128} Id.
\textsuperscript{130} The Hippocratic Oath exemplifies the classical integration of the physician in the literal homes of patients; "In every house where I come I will enter only for the good of my patients . . .".
\textsuperscript{131} See HALL, \textit{supra} note 121, at 976 (providing a basic description of this mechanism).
\textsuperscript{132} Id.
institution. EMTALA's discouragement of patient driven market communities, isolates patients, and thus precludes group resistance to disproportionate allocations.

ED memberships empower patients with the ability to subvert imbalance and restore proportionate costs. This grouping, combined with market induced physician responsiveness, lends itself to a cost allocation scheme better tailored to their specific costs. These costs will inevitably be less as they are no longer paying for insolvent patients and because their solvency indicates overall better group health. Indeed, membership EDs could use competitive insurance rates as a market competition tool. The solvent would stand to see significant decreases in the price of health care.

What about the insolvent, the uninsured, and the high risk? Does aligning an individual's true costs with their health needs force those that need the most help to bear the burden alone? Not necessarily. A reduction in the cost of insurance will help the non-insured middle class obtain insurance. Between 2000 and 2004, the middle class accounted for 44% of the increase in non-insured Americans. By 2005, the middle class accounted for 52% of America's uninsured. These figures indicate that recent increases in insurance costs have out priced a sizeable group previously capable of insuring themselves. Moreover, non-group insurance plans, where disproportionate cost allocation is highest, caused the majority of this out pricing. In tandem, these conclusions suggest that reductions in price will allow the middle class once again to obtain insurance sustainable through membership grouping. With the middle class comprising

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133 See JAMES A. MONROE & LAWRENCE R. JACOBS, HEALTHY, WEALTHY, & FAIR PG # (2005) (providing a discussion of how higher financial solvency correlates with reduced incidence of health problems).
135 Id. at 16.
136 Id. at 6-7.
52% of America's uninsured, significant progress is possible. Aligning an individual to their costs does not just help the well off.

This also helps the very poor. As stated throughout this paper, allowing communities to form around their most salient features, permits better analysis and interaction. It also permits more effective cost allocation. Better-defined groups allow the government to better recognize the savings realized by the well off. This enables the government to reallocate some of this savings into the public reform initiatives already mentioned. Insurers are then usurped as the primary arbiters of cost, and so too their goal of profits. The government, motivated by net social utility, becomes the primary allocator. However, as EMTALA proves, government beneficence by itself is insufficient to ensure efficient allocation. Accurate transfers depend on identifying the source and its destination. Market stratification facilitates the fluid exchanges that EMTALA's characteristic of market undifferentiation frustrates. Thus, memberships increase net social benefit and decrease net costs.

D. Better Treatment and Less Litigation

Where under EMTALA EDs served many masters, memberships either eliminate or reduce their significance. The guarantee of patient payments relegates the concerns of insurers, HMOs, and threshold treatment obligations to a subordinate position with respect to the ED's primary source of income, patients. Memberships empower patients, transforming them from possible sources of financial drain into objects of ED competition. They are won or lost depending on an ED's ability to meet their treatment expectations.

In the process, anti-Hippocratic attempts to define the doctor's bare responsibility become less of an issue. Rather, the market drives responsibility standards upwards, reducing the need for a formulation. This market driven system does not require Federal statutes clarifying just
enough treatment. It allows ED health care to stop chasing the embarrassing specter of a numerically precise threshold. Satisfying ED financial concerns will restore treatment to its proper pedestal.

The improved patient-physician communication that results will keep treatment standards high. In a membership model, both patient and doctors have the expectation that the same group of physicians will always be the treating physicians. This fosters a higher level of communication and trust that can aid in treatment, and adds another level of humanity to the relationship. In total, these benefits alleviate some of the causes of the malpractice insurance which cost physicians an estimated $6.3 billion dollars in premiums in 2002. And of course, memberships would eliminate patient dumping actions. In redeeming treatment standards, the market fortifies healthcare against one of its primary drains.

Conclusion

Some implementation features of the membership model are outside the scope of this paper. Topics such as its lack of viability in rural areas and a traveler's need for reciprocal use agreement, although important, remain tangential. I have focused on the incentives that emerge in an ED market freed from EMTALA and proposed a model that helps realize these desires. I have hypothesized that the resultant grouping encourages community and health care integration. This cohesion increases physician responsiveness and reduces industry inefficiencies; allowing the fiduciary ethic to once again exalt a patient's health above all other concerns. EDs transform from passive spaces to institutional expressions of a community's health needs.

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137 See Pellegrino, supra note 71, at 249 (stating "confidence and trust are crucial as is a continuing relationship").
138 Lowering Costs by Fixing Our Medical Liability System, supra note 55, at 3.