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Emergency Medical Treatment and Labor Act

What Every Physician Should Know About the Federal Antidumping Law

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Since 1986, the Emergency Medical Treatment and Labor Act (EMTALA) has imposed an obligation on hospitals and physicians to evaluate and stabilize patients who present to a hospital ED seeking care. Available sanctions for noncompliance include fines, damages awarded in civil litigation, and exclusion from Medicare. EMTALA uses several terms that are familiar to physicians (eg, "emergency medical condition," "stabilize," and "transfer"), but the statutory definitions do not map neatly onto the way in which these terms are used and understood in clinical settings. Thus, there is potential for a mismatch between a physician's on-the-spot professional judgment and what the statute demands. We review what every physician should know about EMTALA and answer six common questions about the law.

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ABBREVIATIONS: CMS = Centers for Medicare and Medicaid Services; EMTALA = Emergency Medical Treatment and Labor Act; HHS = US Department of Health and Human Services; MCO = managed care organization; OIG = Office of Inspector General; PPACA = Patient Protection and Affordable Care Act

A patient shows up at a hospital ED complaining of a serious medical condition. The intake department conducts a "wallet biopsy" and determines that the patient lacks insurance and is unable to pay for treatment. After subjecting the patient to a long wait, followed by a cursory evaluation, the ED "dumps" the patient, either into the street or onto the local county hospital.

In 1986, Congress responded to the problem of patient dumping by enacting the Emergency Medical Treatment and Labor Act (EMTALA).[1] Before EMTALA, about one-half of the states had laws on the books requiring hospitals to provide emergency care, regardless of the patient's ability to pay. However, state officials typically did little to enforce these laws, and in most states, victims of patient dumping could not bring a lawsuit on their own.[2]

For hospitals and physicians involved directly or indirectly in the provision of emergency medical services, EMTALA was a major legal development. In this article, we outline the basic structure of EMTALA, address some questions commonly asked by physicians about how the law works, and consider the impact of managed care and federal health reforms on the future of EMTALA.

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Key Provisions and Terms

Although EMTALA is often referred to as the "anti-dumping" statute, its provisions sweep more broadly. EMTALA imposes three distinct duties on hospitals and physicians. First, patients who come to a hospital ED must receive an "appropriate" screening examination to determine whether they have an "emergency medical condition."[3] An emergency medical condition is defined as "manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to" place the health of the individual patient (or an unborn child) "in serious jeopardy." For a pregnant woman having contractions, the definition is met if there is insufficient time to effect a safe transfer prior to delivery or if the transfer poses a threat to the woman or her fetus.

Second, EMTALA requires that a patient with an emergency medical condition be stabilized or transferred to another facility.[4] "Stabilized" is defined as sufficient medical treatment "to assure, within reasonable medical probability, that no material deterioration of the condition" is likely to result from transferring the individual. For pregnant women having contractions, it means the delivery of the fetus and placenta. "Transfer" is "the movement (including the discharge) of an individual outside a hospital's facilities" at the direction of any person employed by or affiliated with the hospital. Individuals who are declared dead in the ED are excluded from this definition, as are those who leave against medical advice.

Third, if a decision is made to transfer an unstable patient, certain prescribed conditions must be met for the transfer to be lawful.[5] Specifically, unless the patient or the patient's legal representative requests the transfer in writing, a physician (or "qualified medical person" if no physician is physically present in the ED) must certify that "the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks" associated with the transfer. In addition, the transfer must be "appropriate." EMTALA lays out the elements that constitute an "appropriate transfer": the transferring hospital must use whatever capacity it has to provide treatment that minimizes the risks of the transfer; the receiving facility must have space, qualified personnel on hand, and have agreed to accept the transfer; medical records and other relevant clinical information must be forwarded; and the physical transfer must be done using qualified personnel and appropriate equipment.

A number of the terms that are central to defining obligations under EMTALA—including "emergency medical condition," "stabilization," and "transfer"—are familiar to physicians. However, it is crucial to recognize that the statutory definitions do not map neatly onto the way in which these terms are used and understood in clinical settings. Further complicating this picture is the fact that medical judgment remains an important reference point in the practice requirements set by EMTALA. Thus, the potential for a mismatch between a physician's on-the-spot professional judgment and the after-the-fact evaluations called for by EMTALA is an important source of tension in the implementation of the statute.

Penalties, Enforcement, and the Medical Malpractice Distinction

If any of these three duties are breached, hospitals and physicians (including physicians who are on call to the ED) face civil monetary penalties of up to $50,000 per violation. Violation may also lead to exclusion from the Medicare program—a financial death sentence for most hospitals. In addition, aggrieved patients may bring private lawsuits against hospitals—but not against physicians.

There has been some governmental enforcement of EMTALA. The Office of Inspector General (OIG) and the Centers for Medicare and Medicaid Services (CMS), both part of the federal Department of Health and Human Services (HHS), share responsibility for enforcement. OIG publicly reports details of settlement agreements reached with hospitals and physicians over patient dumping; there have been > 170 since 2002, an average of approximately 13 settlements per year.[6] Hospitals account for most of these cases, but cases involving physician-defendants have resulted in civil monetary penalties as high as $35,000. Such fines are usually not covered by medical malpractice insurance.

There have been many more private suits. Most of these cases have been brought in federal court and centered on allegations that ED staff failed to conduct an appropriate medical screening examination.

Federal courts have sometimes struggled to distinguish these EMTALA-based claims from garden-variety medical malpractice claims. EMTALA explicitly states that it does not preempt state law,[7] and courts have repeatedly held that it should not be interpreted as a federal malpractice statute. To be sure, many types of malpractice allegations do not fit within EMTALA. But in some clinical situations, EMTALA's reliance on terms like

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