

MODERNIZING THE EMERGENCY MEDICAL TREATMENT & LABOR ACT TO HARMONIZE WITH THE AFFORDABLE CARE ACT TO IMPROVE EQUALITY, QUALITY AND COST OF EMERGENCY CARE

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I. INTRODUCTION

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a federal statute passed almost 30 years ago which was designed to ensure equal access to emergency treatment and to halt the practice of “patient dumping.”² Patient dumping is a situation where some patients— typically uninsured, disabled, and minority individuals—receive inferior emergency medical care or are denied emergency medical treatment altogether.³ The goal of EMTALA is to

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² 42 U.S.C. § 1395dd (1986).

³ U.S. Comm’n on Civil Rights, *Patient Dumping*, 1 (Sept. 2014) available at

ensure that everyone coming to the emergency room will receive equal care.⁴

Unfortunately, despite EMTALA, the practice of patient dumping has continued to this day.⁵ The most recent case in the news is the haunting story of a psychiatric hospital, Rawson-Neal in Las Vegas, that purportedly prematurely discharged patients and bussed them out of state.⁶ Starting in 2008, the facility allegedly bused nearly 1,500 patients out of state over several years.⁷ According to one major class action lawsuit filed in 2013, when patients were placed on a bus, they were given a small amount of food and medication for trips that

http://www.usccr.gov/pubs/2014PATDUMPOSD_9282014-1.pdf

⁴ *Id.*

⁵ *Id.* at 8-10. See also Sara Rosenbaum et al., *Case Studies at Denver Health: 'Patient Dumping' in the Emergency Department Despite EMTALA, The Law That Banned It*, 31 HEALTH AFFAIRS 1749 (2012) (reporting on five case studies and concluding that inappropriate discharges and transfers are continuing). See also, Nathan S. Richards, *Judicial Resolution of EMTALA Screening Claims at Summary Judgment*, 87 N.Y.U. L. REV. 591, 592-93 (2012), citing, for example, Heather Rosen et al., *Downwardly Mobile: The Accidental Cost of Being Uninsured*, 144 ARCHIVES SURGERY 1006, 1006, 1010 (2009) (summarizing academic literature showing that "[u]ninsured patients currently face health-related disparities in screening, hospital admission, treatment, and outcomes," and conducting a study finding that, "even after admission to a hospital, trauma patients can have worse outcomes based on insurance status"); Anbesaw Wolde Selassie et al., *The Influence of Insurance, Race, and Gender on Emergency Department Disposition*, 10 ACAD. EMERGENCY MED. 1260, 1266 (2003) (performing multivariate logistic regression on emergency-department data and finding that, "after controlling for a patient's clinical condition ... , patients who were uninsured were consistently less likely to be admitted, regardless of the severity of the injury"); U.S. GOV'T ACCOUNTABILITY OFFICE, EMERGENCY CARE: EMTALA IMPLEMENTATION AND ENFORCEMENT ISSUES 3 (2001) ("Violations of EMTALA continue to occur, underscoring the need for effective education and enforcement."); Michael J. Frank, *Tailoring EMTALA To Better Protect the Indigent: The Supreme Court Precludes One Method of Salvaging a Statute Gone Awry*, 3 DEPAUL J. HEALTH CARE L. 195, 198 (2000) ("[P]atient dumping continues."); Lawrence Bluestone, Note, *Straddling the Line of Medical Malpractice: Why There Should Be a Private Cause of Action Against Physicians via EMTALA*, 28 CARDOZO L. REV. 2829, 2839 (2007) ("Patient dumping continues to happen in busy hospital emergency rooms, with dramatic and unsavory results to patients, normally minorities and normally poor.")

⁶ American Civil Liberties Union of Nevada, *ACLU of Nevada Challenges 'Patient Dumping' by Rawson-Neal Psychiatric Hospital in Las Vegas* (June 12, 2013), available at <http://www.aclunv.org/news/aclu-nevada-challenges-patient-dumping-rawson-neal-vegas> ("Over the last four years, Rawson-Neal Psychiatric Hospital in Law Vegas bused 1500 patients out of state to cities where the patient had no family, no friends or contacts, leaving the patient without arrangements for housing, hospitalization or follow-up care. Agencies investigating the violation of required discharge practices have deplored the patient dumping. The lawsuit, *Brown v. Rawson Neal*, was filed on June 11, 2013").

⁷ *Id.*

sometimes lasted for days.⁸ They were then told to dial 911 or find a shelter upon their arrival in their new city.⁹ One of the allegations in the lawsuit is that hospital officials did not reach out to make arrangements for patient care at these new destinations prior to putting these patients on buses bound for new locations.¹⁰ The news media labeled this practice “Greyhound Therapy.”¹¹

This practice of patient dumping is of great concern to all patients, but particularly for those in our society who are the most vulnerable—children, many elders, and the physically and mentally disabled—as many of these individuals do not have the ability to engage in self-protection. Of particular concern is that the number of elders with mental disabilities, including dementia and Alzheimer’s, will be growing as our population ages.¹²

The dated and flawed EMTALA statute needs to be modernized as it currently negatively impacts the *quality and cost* of healthcare without any positive trade-off for the *equality* of healthcare. In fact, there are four ways that EMTALA may actually be having an affirmatively negative impact on *equality* of care.

First, EMTALA encourages the practice of customary treatment choices and discourages the transition to modern day, evidence-based treatment choices. Many customary care treatment choices lead to the provision of unequal, poor quality and costly care. Second, by encouraging customary treatment choices and discouraging the transition to evidence-based treatment choices, EMTALA works against the quality and equality improvement efforts of the Affordable Care Act, Medicare, and Medicaid, and other government programs. Most particularly, EMTALA discourages the adoption of written, evidence-based, emergency protocols that have significant life-saving potential and that ensure equality of care for all. Third, by

⁸ Original Petition at 5:22-27, James Flavy Coy Brown v. Rawson-Neal Psychiatric Hospital, (2:13-cv-01039), (filed June 11, 2013) *available at* <http://www.aclunv.org/news/aclunvada-challenges=patient-dumping-rawson-neal-vegas>.

⁹ *Id.* at 5:22-27.

¹⁰ *Id.* at 2:18-25.

¹¹ *Id.* at 10:13-15.

¹² JAMES T. O'REILLY & KATHARINE VAN TASSEL, LITIGATING THE NURSING HOME CASE, 130 (2014) (“Currently, approximately 5.3 million Americans of all ages have Alzheimer’s disease. In 2030 approximately 7.7 million people will have Alzheimer’s disease, and the number will increase to 16 million in 2050”).

promoting customary treatment choices, EMTALA perpetuates the use of bias and stereotypes in clinical decision-making. This problem is of particular concern in emergency care. Fourth, by relying on customary care as the exclusive proxy for equality of care, EMTALA renders itself ineffective as an anti-patient dumping tool by facilitating the wide use of procedural tactics to dismiss EMTALA cases before courts can reach the merits.

This Article will propose a very simple, two-step way to modernize EMTALA to deal with this cascade of problems. This solution converts EMTALA into a powerful tool to enhance equal access to healthcare while at the same time changing EMTALA so that it works in tandem with, instead of against, the efforts of the Affordable Care Act, Medicare and Medicaid to improve healthcare quality, cost and equal access.

This solution also works across systems to resolve the conflict between the tort, licensure and hospital peer review systems that all *discourage* evidence-based treatment choices by relying on custom as the exclusive proxy for quality, and the Affordable Care Act, Medicare and Medicaid, that all *encourage* evidence-based treatment choices.

Importantly, if this solution had been in place in 2008, the Rawson-Neal “Greyhound Therapy” scandal involving as many as 1,500 patients would have been avoided as written discharge planning guidelines would have been in place to prevent patient dumping.

This Article starts by explaining the difference between customary and evidence-based treatment choices and why customary care, as a general matter, can have a negative impact on healthcare equality, quality and cost. Then, a review is provided of the government programs that encourage physicians to make evidence-based treatment choices that significantly improve healthcare equality, quality and cost (programs created by the Affordable Care Act, Medicare, and Medicaid) and the legal systems that discourage evidence-based treatment choices (the tort, licensure and hospital peer review systems). This Article next explains how EMTALA joins other legal systems in discouraging evidence-based treatment choices, opens the door to bias and stereotyping in treatment choices, and fosters the overuse of procedural tactics to dismiss EMTALA cases.

Finally, this Article explains how EMTALA can be modified with two easy steps to resolve its current flaws and to harmonize it with the Affordable Care Act, Medicare and Medicaid, as well as with the tort, licensure and hospital peer review systems. These two steps will move disparity reduction efforts from the sole domain of EMTALA and the civil rights arena and into an alternative, but co-existing and complimentary, world of healthcare quality regulation. This move recognizes that the unequal provision of emergency care caused by uncertainty, subconscious bias or stereotyping can be looked at as another variety of human error that can be prevented with a systems approach. These modifications will also allow for the data collection necessary to facilitate the ongoing process of continuing quality improvement to tailor evidence-based treatment protocols on an ongoing basis to ensure that they are both furthering equal access and not inadvertently exacerbating disparities. Thus, a major benefit of this systems reform solution is the use of actual data to both track and create interventions to resolve actual disparities in emergency care.

II. THE NEGATIVE IMPACT OF CUSTOMARY CARE ON HEALTHCARE EQUALITY, QUALITY AND COST

One of the ways that EMTALA negatively impacts healthcare equality, quality and cost is by encouraging the practice of customary treatment choices and discouraging the transition to modern day, evidence-based treatment choices. So what is customary care and how is it different from evidence-based care? To answer this question, this section first provides brief definitions of both. Then, an overview of how and why physicians have traditionally made customary treatment choices is provided. Understanding why custom has historically been the lodestar of the clinical decision-making process provides insight into one of the reasons why changing physician behavior to adopt modern, evidence-based treatment choices is proving to be an uphill battle.

A. Overview of Customary versus Evidence-Based Treatment Choices

As I have explained in a previous article on the problems with

the use of customary care as a proxy for measuring quality of care in hospital peer review, medical malpractice and licensure actions,

[a]s a general matter, “customary care” is the type of care that is typically given by other health care providers under comparable circumstances. Customary care is subjective and is based on the predilections of particular physicians based upon tradition, opinion, personal clinical experience (or other rules of thumb) and not on objective, scientific evidence. The practice of providing customary care, also referred to by many as “eminence-based medicine,” is the normative practice in the United States.¹³

In contrast, the practice of modern medicine involves the use of evidence-based treatment choices.

[T]he evidence-based model of medical practice is centered on empirical data created by comparative effectiveness research and outcomes analysis. As this body of research grows, evidence-based treatment guidelines are being developed using this empirical data. These evidence-based treatment guidelines, called clinical practice guidelines (“CPGs”) can be used to recommend optimal treatments for a steadily increasing number of clinical disorders.¹⁴

Clinical Practice Guidelines reflect the “well considered opinions of expert panels, based upon reviews of the best available data, as to how [health care providers] should approach certain clinical problems.”¹⁵ This use of empirical data generated through scientific methodology to make medical decisions decreases costs while enhancing quality and equal access to care.¹⁶

In other words, making customary treatment choices is what physicians are doing, making evidence-based treatment choices is what physicians *ought to be doing*.

¹³ Katharine Van Tassel, *Using Clinical Practice Guidelines and Knowledge Translation Theory to Cure the Negative Impact of the National Hospital Peer Review Hearing System on Healthcare Quality, Cost, and Access*, 40 PEPPERDINE L. REV. 911, 938 (2013) [hereinafter Van Tassel, *Using Clinical Practice Guidelines*].

¹⁴ *Id.*

¹⁵ Richard R. Leahy, *Rational Health Policy and the Legal Standard of Care: A Call for Judicial Deference to Medical Practice Guidelines*, 77 CALIF. L. REV. 1483, 1506 (1989).

¹⁶ Katharine Van Tassel, *Harmonizing the Affordable Care Act with the Three Main National Systems for Healthcare Quality Improvement: The Tort, Licensure, and Hospital Peer Review Hearing Systems*, 78 BROOKLYN L. REV. 883, 884 (2013) [hereinafter Van Tassel, *Harmonizing the Affordable Care Act*].

B. Cognitive Frameworks that Drive Customary Treatment Choices

Understanding the reasons for customary treatment choices starts with an awareness of how physicians make clinical decisions. The physician first must conduct a physician exam and patient interview in order to create an initial impression of the patient's clinically significant complaints and symptoms.¹⁷ The physician relies on these initial impressions to decide on a plan to reach a definitive diagnosis and then to implement a treatment strategy.¹⁸

In an ideal world, physicians would make clinical decisions using thorough, "systematic evaluations of a patient's symptoms and conditions, with science providing a clear pathway toward diagnosis and treatment."¹⁹ However, until recently, there has been very little empirical evidence to support this ideal. Professor Jessica Mantel explains why physicians have long dealt with a great deal of uncertainty in clinical decision-making:

[b]ecause diagnostic tests may expose patients to risk and involve time and expense, physicians cannot order every conceivable test that may confirm or rule out a diagnosis. Similarly, once they make a diagnosis, physicians must select among available treatments. In choosing among alternative diagnostic tests and treatment therapies, a physician's choice depends in part on her predictions—the probability a patient has a particular condition, the probability that a diagnostic procedure will yield useful information, the probability that a patient will benefit from a therapeutic intervention, or the probability that a procedure will lead to complications or death.²⁰

It is only recently that comparative effectiveness data on various treatment choices has become available. This information void means that physicians have habitually coped with this lack of data by using other decision tools. Professor Mantel explains that physicians customarily have used their intuition to make clinical judgments "guided by . . . cognitive frameworks, or schemas, that organize their knowledge, assumptions, and values."²¹

¹⁷ Jessica Mantel, *The Myth of the Independent Physician: Implications for Health Law, Policy, and Ethics*, 64 CASE W. RES. L. REV. 455, 471 (2013).

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.* at 471-2.

²¹ *Id.* at 471.

“The field of cognitive psychology has shown that our judgments and decisions rarely result from conscious, deductive reasoning based on a systematic approach to the evidence. Our mental processing instead reflects the application of cognitive frameworks, or schemas, that organize our knowledge and beliefs about a situation. In the health care context, schemas provide the ‘personal decision rules’ that physicians use to make clinical decisions, particularly in conditions of uncertainty.

Schemas are the mental processes triggered by a particular situation. Derived from our past experiences, societal roles, and personal morals, schemas organize the rules, assumptions, and values we apply to a given situation. In doing so, they provide cognitive shortcuts that operate outside of conscious awareness, eliminating the need for careful, systematic reasoning. Schemas thus can be understood as the intuitions that shape our judgments and actions.”²²

One of the main influences on cognitive shortcuts for physicians is what their peers would do under similar circumstances.²³ Physicians model their choices on those of their peers in an unconscious attempt to avoid the risk of negative outcomes.²⁴ Physicians also mirror the choices of their peers to “fit in” by conforming to the group’s norms²⁵ to earn their peers’ esteem and avoid criticism. Fitting in is a prerequisite in many groups to securing monetary rewards, prestige, and professional advancement.²⁶ Thus, physicians are likely to adopt the practice “styles and philosophies of their group peers in order to secure their approval, or at least to avoid their disapproval.”²⁷ This means that physicians are likely to follow custom in making clinical decisions. This is referred to as the customary care model of medical practice.

Based on this understanding of why physicians have long relied on customary care choices, Professor Mantel concludes that “physicians employed by or affiliated with health care organizations are part of an organizational dynamic that profoundly influences

²² Jessica Mantel, *The Myth of the Independent Physician: Implications for Health Law, Policy, and Ethics*, 64 CASE W. RES. L. REV. 455, 477-78 (2013).

²³ *Id.* at 488-91.

²⁴ *Id.* at 489.

²⁵ *Id.* at 489-90.

²⁶ *Id.* at 490.

²⁷ Jessica Mantel, *The Myth of the Independent Physician: Implications for Health Law, Policy, and Ethics*, 64 CASE W. RES. L. REV. 455, 490 (2013).

their treatment decisions.”²⁸ This is of particular concern as the norm of physicians at most hospitals is to follow the customary care model of medical treatment. This creates a reinforcing cycle of group acceptance of customary care choices and resistance to change in the form of the adoption of evidence-based treatment choices.

This problem with the integration of evidence-based treatment choices into individual physician practice is a well-studied problem. Scores of studies have revealed that physicians are being exposed to evidence-based medicine in the form of clinical practice guidelines on a regular basis—they go to seminars, listen, agree, then go back to practice and ignore the new information.²⁹ In a recent New Yorker

²⁸ Mantel, *supra* note 17, SSRN Abstract, available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2338601 (“Physicians increasingly are moving away from solo or small group practices and joining large organizations, a trend now accelerating with the implementation of health care reform. Because physicians control as much as 90 percent of all health care spending, understanding how health care organizations influence physicians’ treatment decisions is of fundamental importance, particularly for policymakers, scholars, and ethicists concern with the quality, cost, and rationing of health care. Informed by research in the fields of psychology, sociology, and behavioral economics, this Article argues that physicians employed by or affiliated with health care organizations are part of an organizational dynamic that profoundly influences their treatment decisions. Of particular concern are health organizations with cultures that bias physicians’ clinical decision-making in ways that lead to the provision of poor quality or inefficient care or the withholding of necessary care”).

²⁹ See e.g., Lee A. Green et al., *Translation of Research into Practice: Why We Can't “Just Do It,”* 18 J. AM. BRD. FAMILY PRAC. 541, 541 (2005) (There is “widespread agreement that physicians and healthcare systems simply do not put new knowledge about how to improve our patients’ outcomes into practice nearly quickly enough. . . . For example, consider the guideline that “congestive heart failure patients should be evaluated for use of beta-blockers.” An expert physician may be aware of this recommendation and may wholeheartedly accept it as good practice, but may still fail to adopt it when they happen to see an elderly patient in the clinic who could benefit from beta-blockage. Knowledge of evidence can remain separate from, and not integrated into, the physician’s extensive database of procedures that guides their decision and actions. This makes the likelihood of recognizing that the new knowledge is appropriate and incorporating it into these well-rehearsed procedures very uncertain.”); Illaria Baiardini et al., *Why Do Doctors and Patients Not Follow Guidelines?*, 9 CURRENT OPINION ALLERGY CLINICAL IMMUNOLOGY 228, 228 (2009) (“During the last few years, different studies and theories have tried to explain the reason why doctors and patients do not follow guidelines. . . . [A]lthough the efforts to develop and divulge evidenced-based guidelines, results of studies conducted in the United States and the Netherlands suggest that most of the time, guidelines are not applied; about 30-40% of patients do not benefit from a cure program based on scientific evidence, whereas 20-25% of therapeutic choices may be unnecessary and sometimes even harmful.”); Michael D. Cabana et al., *Why Don't Physicians Follow Clinical Practice Guidelines?*, 282 JAMA 1458, 1458 (1999) (“Despite wide promulgation, clinical practice guidelines have had limited effect on

article, quality-of-care expert and Harvard Professor Atul Gawande noted that there is a disconcerting fifteen-year average lag time in the adoption by physicians of evidence-based practice choices.³⁰

C. Equality Problems with Customary Treatment Choices

Physician resistance to the adoption of evidence-based treatment choices has serious consequences as many customary treatment choices have a negative impact on healthcare equality, quality, and cost. These problems are well-documented thanks to the efforts of researchers such as those working on the Dartmouth Atlas Project (“the Project”).³¹ The Project³² taps into the enormous Medicare claims databases and other sources to track the outcomes and costs of various healthcare treatments.³³

changing physician behavior.”); Justin Timbie et al., *Five Reasons That Many Comparative Effectiveness Studies Fail to Change Patient Care and Clinical Practice*, 31 HEALTH AFF. 2168, 2168 (2012) (“[D]ecades of experience suggest that translating evidence into changes in clinical practice is rarely rapid. . . .”); David A. Davis et al., *Translating Guidelines Into Practice: A Systematic Review of Theoretic Concepts, Practical Experience and Research Evidence in the Adopting of Clinical Practice Guidelines*, 15 CAN. MED. ASS’N J. 408, 408 (1997) (“The evidence shows serious deficiencies in the adoption of CPGs in practice”). Physicians will be incentivized to adopt evidence-based treatment choices if EMTALA requires written protocols, CMS requires that these protocols are created based upon best practices grounded in clinical practice guidelines and hospitals require documentation that protocols are followed or the reasons why they are not.

³⁰ Atul Gawande, *Big Med*, NEW YORKER (Aug. 12, 2012), available at http://www.newyorker.com/reporting/2012/08/13/120813fa_fact_gawande.

³¹ For a full and detailed discussion of a series of studies documenting the problem with the use of customary care standards to measure quality of care, see Van Tassel, *Using Clinical Practice Guidelines*, *supra* note 12, 937-49.

³² DARTMOUTH ATLAS OF HEALTH CARE, *Understanding the Efficiency and Effectiveness of the Health Care System*, <http://www.dartmouthatlas.org/> (last visited Feb 8, 2015). The Dartmouth Atlas describes itself as follows:

For more than 20 years, the Dartmouth Atlas Project has documented glaring variations in how medical resources are distributed and used in the United States. The project uses Medicare data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians. This research has helped policymakers, the media, health care analysts and others improve their understanding of our health care system and forms the foundation for many of the ongoing efforts to improve health and health systems across America. *Id.*

³³ The Dartmouth Atlas Project is a “product of the Center for the Evaluative Clinical Sciences at Dartmouth Medical School.” Press Release, Geisel Sch. of Medicine at Dartmouth, *New Study Shows Need for a Major Overhaul of How United States Manages Chronic*

The Project has identified three separate categories of customary care practices that can have a significant, negative impact on healthcare quality, equal access, and cost. These categories include (1) failure to provide necessary care; (2) preference-sensitive care; and, (3) supply-sensitive care.³⁴ I refer to these categories of unequal use as underuse, overuse and misuse³⁵ in order to highlight how customary care practice undermines equality of care while at the same time negatively impacting its quality and cost.³⁶

Unfortunately, as fully discussed in Section V, EMTALA encourages the use of customary treatment choices by physicians because EMTALA relies on customary care as the exclusive proxy for equality of care.

1. Underuse

Despite over a decade of effort to change physician behavior to adopt evidence-based practice choices,³⁷ a major study released in 2012 suggests that many physicians³⁸ continue to ignore gold-

Illness (May 16, 2006), http://geiselmed.dartmouth.edu/news/2006_h1/16may2006_overhaul.shtml.

³⁴ ELLIOT S. FISHER, ET AL., REGIONAL AND RACIAL VARIATION IN HEALTH CARE AMONG MEDICARE BENEFICIARIES: A BRIEF REPORT OF THE DARTMOUTH ATLAS PROJECT 24 (Kristen K. Bronner ed., 2008), http://www.dartmouthatlas.org/downloads/reports/AF4Q_disparities_Dec2008.pdf.

³⁵ Van Tassel, *Using Clinical Practice Guidelines*, *supra* note 12, at 937-49.

³⁶ Added together, these negative impacts manifest themselves in the creation of unequal care by creating multiple, different tiers of quality of care. The first tier, underuse, is made up of situations of classic patient dumping when no healthcare is provided at all, either based on a customary care choice that is incorrect, or through actual intent based on lack of insurance or other means to pay. The second tier, misuse or overuse, is when customary care is provided that is the incorrect care which worsens the patient's condition, making it poorer than no healthcare at all. The third tier, misuse, is when customary care is provided that is somewhat helpful but is not the best choice of care, so the outcome was not as good as it could have been. The fourth tier, population medicine, is an evidence-based treatment choice that provides results with an optimum outcome for the most people. The fifth tier, personalized medicine, is personalized care based upon genetics, epigenetics, and the microbiome, which provides the best care to optimize the outcome for that particular patient.

³⁷ Van Tassel, *Harmonizing the Affordable Care Act*, *supra* note 15.

³⁸ Minal S. Kale et al., *Trends in the Overuse of Ambulatory Health Care Services in the United States*, 173 JAMA: INTERNAL MED. 142, 142-43 (2013) (describing a study that suggests there has been little improvement on the part of individual physicians in this underuse problem in the seven years since the 2005 Jha study, *infra* note 39).

standard studies that have repeatedly shown that certain medications with lifesaving benefits should be prescribed for patients with serious medical conditions.³⁹ These physicians are sticking to customary-care practices that disregard the use of these medications. These customary omissions represent the *underuse* of health care.⁴⁰ For example, for those with coronary heart disease:

... [D]octors are failing to provide aspirin 35.5 percent of the time, beta-blockers 44.8 percent of the time, and statins 41.4 percent of the time. Aspirin can reduce the occurrence of vascular events, including myocardial infarction and death. Beta-blockers can decrease all cause and cardiovascular mortality, cardiovascular hospitalizations, and the need for revascularization procedures. Statins can reduce the risk of cardiovascular events.⁴¹

This means that many patients are not getting the care they need, while others are, harming equality of care and undermining the goals of EMTALA.

³⁹ *Id.* at 142–43 (“underuse represents the failure to deliver healthcare for which the benefits outweigh the risks (e.g. use of an aspirin in residents with coronary disease); and misuse is the delivery of the wrong care (e.g. the use of an antibiotic other than nitrofurantoin, trimethoprim-sulfamethoxazole or quinolone is the incorrect treatment for uncomplicated urinary tract infections).”).

⁴⁰ Van Tassel, *Using Clinical Practice Guidelines*, *supra* note 12, at 943–45, *citing*, Ashish K. Jha et al., *Care in U.S. Hospitals—the Hospital Quality Alliance Program*, 353 *NEW ENG. J. MED.* 265, 265 (2005) (uncovering the unfortunate failure of both physicians and hospitals to provide treatments that were essential for saving the lives of those who suffered from the most common causes of death, pneumonia, heart attack, and heart failure).

⁴¹ *Id.* at 943–44. “[P]hysicians are failing to provide antithrombotic treatment in 28.1 percent of atrial fibrillation cases. Prescribing antithrombotic drugs decreases the risk of stroke for these patients... Doctors also fail to prescribe beta-blockers in congestive heart failure patients 40.3 percent of the time (beta-blockers ameliorate symptoms and greatly improve mortality) and fail to prescribe statins for diabetes patients 63.8 percent of the time (statins can decrease cardiovascular disease events by 19 percent to 55 percent—a major cause of mortality in diabetes patients). Adding to this surprising picture, physicians fail to prescribe ACE inhibitors in congestive heart failure patients 58.4 percent of the time. ACE inhibitors can, when prescribed in conjunction with standard treatment, slow heart failure progression in patients with mild symptoms, and can have a beneficial impact on mortality, morbidity, and quality of life. Finally, physicians are failing to prescribe antiplatelets for stroke patients 51.3 percent of the time (the use of antiplatelets can significantly decrease the risk of secondary stroke, myocardial infarction, and death) and are failing to prescribe drugs for the treatment of osteoporosis 54.9 percent of the time (the use of pharmacologic treatments can “prevent fractures in women and men with osteoporosis or low bone density”). *Id.*

2. Overuse

The category of *overuse* of healthcare arising from customary care choices includes both preference-sensitive care and supply-sensitive care and is a major concern as the cost of healthcare continues to rise.⁴² Close to one-half of physicians admit to providing their patients too much care.⁴³ The Congressional Budget Office states that as much as 30 percent of U.S. healthcare is unnecessary⁴⁴ to the tune of 700 billion dollars.⁴⁵ A large portion of the estimated \$700 billion spent on healthcare that is wasted every year is related to overuse.⁴⁶

For example, a New York Times analysis of Medicare data released in 2014 suggests that doctors who treat seniors are increasing their revenues by simply expanding the number of tests and procedures of questionable utility.⁴⁷ This data showed that “[i]n

⁴² *Id.* at 946, quoting Robert H. Brook & Kathleen N. Lohr, *Will We Need to Rational Effective Medical Care?* *Issues Sci. & Tech.* 68, 68 (1986) (explaining that overall research on appropriateness indicates “that from one quarter to one third of medical services may be of no value to patients” . . . Van Tassel, *Using Clinical Practice Guidelines*, *supra* note 12, at 946-47 (For example, 11.3 percent of screening EKGs, 25.3 percent of screening urine analyses, 7.0 percent of screening X-rays, and 37.9 percent of complete blood counts are unnecessarily ordered as part of a general medical exam. Antibiotics are unnecessarily prescribed for upper respiratory tract infections 40.2 percent of the time, for acute bronchitis 58.8 percent of the time, and for asthma 6.8 percent of the time.” .

⁴³ *Choosing Wisely: Consumer Reports Is Working with Doctors to Help Patients Avoid Unnecessary and Potentially Harmful Medical Care*, CONSUMERREPORTS.ORG, Dec. 14, 2014, available at <http://consumerreports.org/cro/health/doctors-and-hospitals/choosing-wisely/index.htm>.

⁴⁴ *Id.*

⁴⁵ Kale, *supra* note 38, 142 (citing, THOMSON REUTERS, WHERE CAN \$700 BILLION IN WASTE BE CUT ANNUALLY FROM THE US HEALTH-CARE SYSTEM? (2009), <https://healthleadersmedia.com/content/241965.pdf> “Over use, or the delivery of services for which the risks exceed the benefits, has been identified as a significant component, equaling roughly \$280 billion.”).

⁴⁶ *Id.*

⁴⁷ Elisabeth Rosenthal, *Medical Costs Rise as Retirees Winter in Florida*, NY TIMES, Jan. 31, 2015, available at http://www.nytimes.com/2015/02/01/us/medical-costs-rise-as-retirees-winter-in-south.html?emc=edit_th_20150201&nl=todaysheadlines&nid=67140532.

According to Dr. Elliott Fisher, Director of the Dartmouth Institute for Health Policy and Clinical Practice, “[t]hose high numbers cannot be explained by the presence of sicker patients, better outcomes or a desire by patients there for more treatment.” *Id.*

[H]igh-volume testing is also a good way for physicians to supplement income when insurers are cutting back on payments for individual services. From 1999 to 2008, as Medicare reduced

2012... more than twice the number of nuclear stress tests, echocardiograms and vascular ultrasounds were ordered per Medicare beneficiary in doctor's offices in Florida than in Massachusetts."⁴⁸ According to Dr. Elliot Fisher of the Dartmouth Project, these "high numbers cannot be explained by the presence of sicker patients, better outcomes or a desire by patients there for more treatment."⁴⁹

Adopting evidence-based treatment choices could avoid these types of overuse of healthcare. This overuse has no benefit and adds to costs both to patients and to the healthcare system. Thus, many are getting more care than they need, while others are getting the appropriate amount of care. This inequality of care that provides more care than necessary can result in financial ruin for those who live at the margin economically.⁵⁰ The problem of overuse is most hard-felt by the uninsured as they pay the highest costs for medical care—the privately and publically insured pay deeply discounted costs.⁵¹ Once again, this result undercuts the goals of EMTALA.

3. *Misuse*

There are numerous customary care practices that have no benefit and put patients in danger of harm, but are still affirmatively practiced on a daily basis. This final category of harmful customary care practice is referred to as *misuse* of medical care. In a national initiative called "Choosing Wisely," sixty major medical specialty groups issued recommendations that physicians stop using over 300 different unnecessary, but frequently used, tests and procedures that

reimbursement for many cardiology services, one study found that the number of Medicare claims soared for testing for seniors. Claims for echocardiograms (which use sound waves to produce pictures of the heart's wall and valves) increased by 90 percent. Peripheral vascular ultrasound tests (which look for clogged arteries) nearly tripled. Nuclear stress testing (a complex test for coronary artery disease) more than tripled, even though the procedure takes hours, involves an injection and radiation exposure, and costs thousands of dollars. *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ Robert Pear, *New Rules to Limit Tactics on Hospitals' Fee Collections*, NY TIMES, Jan 11, 2015, available at <http://www.nytimes.com/2015/01/12/us/politics/new-rules-to-limit-tactics-on-hospitals-fee-collections.html>.

⁵¹ *Id.*

can actually be harmful for patients.⁵² Therefore, while many patients are getting safe care, others are receiving harmful care.

For those receiving harmful care, not only could their condition fail to improve, it may worsen through exposure to unnecessary risks of harm, including risks of long-term disability and death. This misuse also results in many patients being required to “double down” financially—they must pay for the initial inappropriate care, then pay for the cost of the follow-up care necessary to recover from the harm from the inappropriate care. And then, to add insult to injury, they must pay for the appropriate care they should have received in the first place. For the uninsured who pay by far the highest cost for care, this category of misuse of care can cause the worst kind of health and financial devastation.

Altogether, it is clear that the customary-care practices encouraged by EMTALA can lead to underuse, overuse and misuse which can have a significantly negative impact on healthcare equality while also negatively impacting its quality and cost.

III. THE AFFORDABLE CARE ACT—ENCOURAGING EVIDENCE-BASED CARE

To address physicians’ reluctance to transition to evidence-based treatment choices, the Affordable Care Act, along with other governmental initiatives, have made significant changes in Medicare, Medicaid and other government programs in order to change physician behavior.⁵³ Working together, these governmental entities have fashioned a structure for both the creation of evidence-based practice choices and for integrating these best practices into the everyday practices of hospitals and physicians through the use of monetary incentives and penalties.⁵⁴

⁵² Robert Wood Johnson Foundation, *\$4.2 Million Grant Program to Support Health Care Organization Implementation of Choosing Wisely® Recommendations*, Jan. 8, 2015, available at <http://www.rwjf.org/en/about-rwjf/newsroom/newsroom-content/2015/01/new--4-2-million-grant-program-to-support-health-care-organizati.html>.

⁵³ For a more detailed overview of these programs, see Van Tassel, *Harmonizing the Affordable Care Act*, *supra* note 15, at 899-906.

⁵⁴ Van Tassel, *Harmonizing the Affordable Care Act*, *supra* note 15 at 904-05. (also, “[c]entral to

The Affordable Care Act has: (1) committed millions of dollars for studies comparing the effectiveness of two or more treatments in order to develop evidence-based clinical practice guidelines to establish “best practices”;⁵⁵ (2) created the Patient-Centered Outcomes Research Institute (PCORI) to oversee comparative clinical effectiveness research and disseminate the results;⁵⁶ and, (3) created the new Center for Quality Improvement and Patient Safety (“CQuiPS”) tasked with facilitating the adoption of these best practices by healthcare providers.⁵⁷ CMS then relies on these best

the ACA are the Health Benefit Exchanges and, in keeping with ACA’s theme of improving the quality and cost of care, these exchanges also work instrumentally to move the ball forward in these areas. To qualify to sell insurance to consumers through these exchanges, insurers must evaluate providers by the same quality benchmarks that are being used by CMS. As with the CMS reimbursements under Medicare, the higher the rating, the greater the private insurance reimbursement will be for health care services. Continuing the parallel, just like Medicare, the insurance companies must also publish the quality of care and patient satisfaction data that they gather.”)

⁵⁵ American College of Physicians, Inc., *Comparative Effectiveness Research* (2013), available at http://www.acponline.org/advocacy/where_we_stand/assets/ii10-comparative-effectiveness-research.pdf. PICORI is “[f]unded through federal appropriations from the Treasury of \$10 million and \$50 million for years 2010 and 2011 respectively. Beginning in 2013 and for each year after, the federal contribution from the Treasury will be \$150,000. Also beginning in 2013, the Institute will receive additional funding of \$1.00 (\$2.00 starting in 2014) from the Medicare Trust Fund for each beneficiary covered under Medicare A for the year, and a similar amount from each insured and self-insured health plan contract offered in the private sector during that year. By 2014, total funding for the Institute from all sources is estimated to be approximately \$500 million.” *Id.*

⁵⁶ Patient-Centered Outcomes Research Institute, *Why PCORI Was Created*, available at <http://www.pcori.org/content/why-pcori-was-created> (last visited February 3, 2015); “The Patient Protection and Affordable Care Act (ACA) established a non-profit, tax exempt corporation, known as the “Patient-Centered Outcomes Research Institute” (PCORI) to provide comparative effectiveness information to assist patients, clinicians, purchasers, and policy makers in making informed health decisions.” American College of Physicians, Inc., *Comparative Effectiveness Research* (2013), available at http://www.acponline.org/advocacy/where_we_stand/assets/ii10-comparative-effectiveness-research.pdf. “The Institute, which was formally established in 2010, is governed by a Board of Directors consisting of the Directors of the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health (NIH) and an additional 17 members appointed by the Comptroller General representing patients and health care consumers, physicians and providers, private payers, pharmaceutical, device, and diagnostic manufacturers or developers, representatives of quality improvement or independent health service researchers, and representatives of the federal government or the states.” *Id.*

⁵⁷ Center for Quality Improvement and Patient Safety (CQuiPS), <http://www.ahrq.gov/cpi/centers/cquips/> (last visited February 3, 2015) (CQuiPS “[c]ollaborates with stakeholders across the health care system to implement evidence-based practices, accelerating and amplifying improvements in quality and safety for patients.”).

practices to create regulations that healthcare organizations must comply with as a condition of participation in Medicare and Medicaid.⁵⁸ CMS also uses these best practices to develop the outcome measures that dictate the level of reimbursement healthcare providers will receive under Medicare.⁵⁹

Together, these governmental programs create a powerful regulatory engine designed to move the United States from a system that follows the customary-care model of medical care to a modern, evidence-based system of medical care grounded in the use of best practices.

IV. THE TORT, LICENSURE AND HOSPITAL PEER REVIEW SYSTEMS—ENCOURAGING CUSTOMARY CARE

Understanding the long-relied upon cognitive frameworks that drive the use of customary treatment choices helps to explain part of the reason why physicians are failing to adopt evidence-based practices. The rest of the answer may lie with the legal system. In a prior series of articles, I have explained how the three major, national systems for improving healthcare quality in the United States—the state medical malpractice system, the state licensure system and the private hospital peer review system—appear to be undermining the federal efforts to encourage the adoption of evidence-based medical practice.⁶⁰ These systems rely on customary care as the exclusive

⁵⁸ In order to meet Medicare's Conditions of Participation, a healthcare organization must be accredited by the Joint Commission to receive Medicare reimbursement. Joint Commission, *Facts about Federal Deemed Status and State Recognition*, http://www.jointcommission.org/facts_about_federal_deemed_status_and_state_recognition/ (last visited Fe. 8, 2015). The Joint Commission (JC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), is a United States-based nonprofit tax-exempt 501(c) organization that accredits more than 20,000 health care organizations and programs in the United States. *Id.* A majority of state governments have come to recognize Joint Commission accreditation as a condition of licensure and the receipt of Medicaid reimbursement. *Id.* The Joint Commission typically conducts inspections, called surveys, to ensure that the healthcare organizations it accredits are complying with Medicare and Medicaid regulations. *Id.* The results of these surveys are available to the public in an accreditation quality report on the Quality Check Web site. *Id.*

⁵⁹ See Van Tassel, *Harmonizing the Affordable Care Act*, *supra* note 53.

⁶⁰ Van Tassel, *Using Clinical Practice Guidelines*, *supra* note 13; Van Tassel, *Harmonizing the Affordable Care Act*, *supra* note 16; Katharine Van Tassel, *Hospital Peer Review Standards and Due Process: Moving from Tort Doctrine Toward Contract Principles Based on Clinical Practice Guidelines*, 36 SETON HALL L. REV. 1179 (2006). Reflecting an understanding of the benefits of evidence-

proxy for *quality* of care.⁶¹ EMTALA joins these other systems in encouraging customary care by making customary care the exclusive proxy for *equality* of care.⁶²

Importantly, if there is a conflict between customary and evidence-based care choices, in spite of the incentives contained in government programs to change,⁶³ physicians are likely to follow the customary care choice to avoid civil liability, licensure sanctions, and loss of hospital staff privileges.⁶⁴ Thus, like the malpractice, licensure and hospital peer review systems, it appears that EMTALA is also likely to be acting instrumentally to encourage the perpetuation of custom-based practices based on what appears to be the desire to avoid liability.

V. EMTALA'S STANDARD OF EQUALITY— ENCOURAGING CUSTOMARY CARE

One of the main reasons patient dumping is continuing in spite of EMTALA is the way the courts have interpreted the statute to encourage customary treatment choices. By its terms, the statute

based treatment choices, a minority of state tort systems have moved away from using customary care as the exclusive proxy for quality of care in medical malpractice actions. These tort systems are allowing the introduction of risk-benefit analysis grounded in empirical science as evidence of what is reasonable care. *See generally* Philip G. Peters Jr., *The Role of the Jury in Modern Malpractice Law*, 87 IOWA L. REV. 909 (2002) (discussing the merits of the role of custom as conclusive evidence of the standard of care in malpractice litigation and the movement by many states to use custom as only some evidence of the standard of care); Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 170 (2000). By virtue of applying their own state law, the state licensure systems of these states are likely to follow suit.

⁶¹ In order to meet the standard of care in a medical malpractice case, a health care provider must “possess and use the care, skill and knowledge ordinarily possessed and used under like circumstances.” *Burns v. Metz*, 513 N.W.2d 505, 509 (Neb. 1994); *Vergara v. Doan*, 593 N.E.2d 185, 188 (Ind. 1992) (judging the physician’s conduct by a “minimum standard of care for the particular practice”). The scope of admissible evidence that may be used to define reasonable care in the majority of states is based on the dated “customary care rule.” For an excellent overview of medical malpractice law, *see* DAN B. DOBBS, *THE LAW OF TORTS* § 242, 631–34 (2000).

⁶² *See infra* notes 63 to 87 and accompanying text.

⁶³ For an example of how this is likely to play out in an actual case, *see* Van Tassel, *Harmonizing the Affordable Care Act*, *supra* note 16, at 909-13.

⁶⁴ Van Tassel, *Using Clinical Practice Guidelines*, *supra* note 13, 950-52 (*citing*, Michael Frakes, *The Impact of Medical Liability Standards on Regional Variations in Physician Behavior: Evidence from the Adoption of National-Standard Rules*, 103 AM. ECON. REV. 257, 257 (2013)). A second study by this same author reinforces this conclusion. Michael Frakes et al., *Does Medical Malpractice Law Improve Health Care Quality?* (Jan. 14, 2014), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2374599.

requires hospitals to medically screen every person who comes to the emergency room requesting medical treatment to assess whether that person suffers from an emergency medical condition.⁶⁵ If an emergency medical condition is found, the hospital must treat and medically stabilize that person.⁶⁶ The courts have interpreted EMTALA to apply a standard of *equality*, not *quality*—and, according to the courts, this “equal care” requirement means that physicians must use the same care typically provided *at that particular hospital* for patients with similar symptoms or face EMTALA liability.⁶⁷

As discussed below, the “same care typically provided in the same hospital” is likely to be based upon the customary-care model of medical practice as this is the normative form of medical practice in the United States.

A. EMTALA’s Emergency Care Obligations

An EMTALA obligation is triggered when an individual “comes to the Emergency Department” seeking screening/treatment of a medical condition.⁶⁸ The hospital is then obligated to provide an appropriate Medical Screening Examination to determine if an Emergency Medical Condition (“EMC”) exists.⁶⁹ An EMC is a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:(1) placing the health of the individual serious jeopardy; (2) serious impairment to bodily functions; or, (3) serious dysfunction of any bodily organ or part.⁷⁰

If an EMC exists, the hospital must either stabilize the EMC or transfer the patient to an appropriate facility.⁷¹ A medical screening exam is “appropriate” if it is the same treatment that a patient with

⁶⁵ Jeffrey C. Moffat, THE EMTALA ANSWER BOOK, 2014 EDITION, xiii (2014).

⁶⁶ *Id.*

⁶⁷ *Id.* at 3-5.

⁶⁸ *Id.* at 3-1.

⁶⁹ *Id.*

⁷⁰ Jeffrey C. Moffat, THE EMTALA ANSWER BOOK, 2014 EDITION, 3-1 (2014).

⁷¹ *Id.*

similar symptoms would have received at that particular hospital⁷² based on the symptoms *subjectively* determined by the physician to be clinically significant.⁷³ An individual will be deemed stabilized if the treating physician determines that the EMC is no longer a threat to the health and safety of the individual.⁷⁴ Upon stabilization of the EMC, the hospital no longer has an EMTALA obligation.⁷⁵

B. The Standard of Review for EMTALA Claims

The Fourth Circuit Court of Appeals case of *Barber v. Hospital Corp of America*⁷⁶ is the case most often cited for the standard of review used for EMTALA claims. In *Barber*, a patient who had stopped taking anti-psychosis medications began drinking heavily. She also began feeling nauseated and agitated.⁷⁷ When she came to the emergency room, she had a seizure and fell, lacerating her head.⁷⁸ Her laceration was stitched. However, the treating physician refused her brother's request that she receive an x-ray of her head.⁷⁹ She became drowsy and was then transferred to a psychiatric facility.⁸⁰ Shortly thereafter, she had a grand-mal seizure and then was transferred

⁷² "Patients are entitled under EMTALA, not to correct or non-negligent treatment in all circumstances, but to be treated as other similarly situated patients are treated, within the hospital's capabilities. It is up to the hospital itself to determine what its screening procedures will be. Having done so, it must apply them alike to all patients." *Summers v. Baptist Medical Center Arkadelphia*, 69 F.3d 902 (8th Cir. 1995), *rev on reh'g*, 91 F.3d 1132 (1996). See also, *Vickers v. Nash General Hospital, Inc.*, 78 F.3d 139, at 143 (4th Cir. 1996); *Correa v. Hospital San Francisco*, 69 F.3d 1184, 1192-93 (1st Cir. 1995) *cert. denied*, 116 S. Ct. 1423 (1996); *Repp v. Anadarko Municipal Hospital*, 43 F.3d 519, 522 (10th Cir. 1994); and *Holcomb v. Monahan*, 30 F.3d 116, 117 (11th Cir. 1994); Moffat, *supra* note 65, at 3-3 to 3-4.

⁷³ *Summers v. Baptist Medical Center Arkadelphia*, 69 F.3d 902 (8th Cir 1995), *rev on reh'g*, 91 F.3d 1132, 1139 (1996) (an examination of a patient who had fallen from a tree stand while hunting was allegedly incomplete because a chest x-ray had not been included when a set of spinal x-rays was ordered. The physician did not believe that the patient had any fractures, and discharged him home, with instructions. The patient presented at another hospital two days later, and he was diagnosed with an acute comminuted vertebral fracture, a sternal fracture, and bilateral hemopneumothoraces secondary to untreated rib fractures); See also, *Phillips v. Hillcrest Hospital*, 244 F.2d 790, 797 (10th Cir. 2001).

⁷⁴ Moffat, *supra* note 65.

⁷⁵ *Id.*

⁷⁶ *Barber v Hospital Corp of America*, 977 F.2D 872 (4th Cir. 1992).

⁷⁷ *Id.* at 875-76.

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *Id.*

back to the hospital where she died several hours later.⁸¹ Her death was the result of a fractured skull and untreated subdural hematoma caused by her fall.⁸²

The *Barber* court determined that federal courts considering an EMTALA claim will not evaluate whether the care provided at an emergency room was reasonable.⁸³ The court explained that whether there was a negligent misdiagnosis⁸⁴ is a medical malpractice question reserved to state courts. Under EMTALA, the appropriate care is equal care.⁸⁵ Equal care is the same treatment as a patient with similar symptoms would have customarily received in that particular hospital.⁸⁶ The goal of EMTALA is equality, not quality,⁸⁷ and the proxy for equality is customary care.

Why is this proxy for equality a problem? EMTALA requires that physicians abide by the custom followed by physicians at that particular hospital when treating patients with similar clinically significant symptoms. Most physicians make customary, rather than evidence-based treatment choices. Therefore, when EMTALA sends the message to physicians—follow the customs of the physicians in the same hospital to avoid liability—this discourages physicians from switching to new, evidence-based treatment choices. This creates a conflict between EMTALA, which encourages customary treatment choices on the one hand, and ACA, Medicare, Medicaid, which encourage evidence-based treatment choices on the other.

IV. EMTALA—BIAS, STEREOTYPING AND THE OVERUSE OF SUMMARY JUDGMENT

EMTALA contributes to the roadblock to the transition toward evidence-based medical practice by encouraging physicians to make

⁸¹ *Barber v Hospital Corp of America*, 977 F.2D 875-76 (4th Cir. 1992).

⁸² *Id.*

⁸³ *Id.* at 880.

⁸⁴ *Id.*

⁸⁵ *Id.* at 880-81.

⁸⁶ *Barber v Hospital Corp of America*, 977 F.2D 880 (4th Cir. 1992).

⁸⁷ *Id.*

customary treatment choices. Relying on customary practice as a proxy for equality seriously undermines equality of treatment through underuse, overuse and misuse, allows for bias and stereotypes in treatment choices, and allows for overuse of summary judgment in EMTALA cases.

A. Opening the Door to the Use of Bias and Stereotyping in Clinical Decision-Making

As described earlier, when physicians ignore evidence-based treatment choices, they fall back on customary care and cognitive shortcuts to make clinical decisions.⁸⁸ These cognitive shortcuts are “personal decision tools” built by physicians’ “past experiences, societal roles, and personal morals.”⁸⁹ As early discussions demonstrated, customary care can lead to inequality of care through underuse, overuse and misuse.⁹⁰ The use of these personal decision tools also allows for “[u]ncertainty, biases, errors, and difference of opinions, motives, and values [that] weaken every link in the chain that connects a patient’s actual condition to the selection of a diagnostic test or treatment.”⁹¹ A large body of research suggests that these unconscious biases and stereotypes can open the door to difference in treatment depending on race. For example, a large and rapidly growing group of studies show that patients of color are less likely than whites to receive a wide range of medical services, including life-saving treatments, based on bias and stereotyping.⁹²

⁸⁸ See *supra* notes 16 to 29.

⁸⁹ Mantel, *supra* note 17, at 477-91.

⁹⁰ See *supra* notes 30 to 50.

⁹¹ Mantel, *supra* note 17, at 471, citing, David M. Eddy, *Variation in Physician Practice: The Role of Uncertainty*, 3 HEALTH AFF. 74, 75 (1984).

⁹² Richards, *supra* note 5, at 623, n. 174 citing as examples Kevin A. Schulman et al., *The Effect of Race and Sex on Physicians’ Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. MED. 618, 623-25 (1999) (describing significant differences in doctor reactions to Black and White individuals reporting identical symptoms); Janice C. Blanchard et al., *Racial and Ethnic Disparities in Health: An Emergency Medicine Perspective*, 10 ACAD. EMERGENCY MED. 1289, 1289-93 (2003) (reviewing “existing research on disparities in the area of emergency medicine,” noting, for example, that “[r]ecent data showed that nonwhites with acute cardiac ischemia were two times more likely to be sent home from the ED, and nonwhites with myocardial infarctions were over four times more likely to be missed,” and contending that “[r]acial bias is an important factor that must be considered in explaining disparities”); Jordan J. Cohen, *Disparities in Health Care: An Overview*, 10 ACAD. EMERGENCY MED. 1155, 1156 (2003)

The risk of unequal treatment arising from customary care choices is more acute in the emergency room as studies have shown that physician fatigue, overload, and time pressure, can decrease cognitive ability and exacerbate problems of stereotyping and bias.⁹³ This problem comes into play at three points in the clinical decision-making process: (1) when deciding which symptoms to recognize as clinically significant and which to ignore; (2) when deciding which diagnostic tools and process to use to make a diagnosis based on the symptoms chosen as clinically significant; and, (3) when deciding which treatment is appropriate based on the results of the prior choices.

EMTALA ignores the fact that bias and stereotyping can occur at the level of symptom selection, which undermines the integrity of the second two steps of the decision-making process. The constellation of chosen symptoms narrows the choice of which screening process and tools to use, which can determine what diagnosis and treatment choices are ultimately made. Thus, if clinically significant symptoms are ignored because of bias or stereotypes, this faulty clinical decision-making process can result in little to no care being provided based on socioeconomic status, race, gender, or disability.⁹⁴ In this

(stating that the "evidence is incontrovertible" that "biases and stereotypes affect patient care"); Arnold M. Epstein & John Z. Ayanian, *Racial Disparities in Medical Care*, 344 NEW ENG. J. MED. 1471, 1471-72 (2001) (explaining that "[m]any studies have shown that black Americans are less likely than whites to receive a wide range of medical services, including potentially life-saving surgical procedures," and suggesting, as one contributing factor, that "both white and black physicians may have subtle biases that are based on other social factors and that influence their judgments about patients' suitability for procedures"); Diana J. Burgess et al., *Why Do Providers Contribute to Disparities and What Can Be Done About It?*, MEDSCAPE NEWS, Dec. 7, 2004, available at <http://www.medscape.com/viewarticle/494312> (collecting research on social cognition and provider decision making, and explaining that, although "[c]linicians are generally expected, and expect themselves, to view each patient objectively and impartially, ... these expectations are highly unrealistic. Providers, like all humans, are likely to unconsciously apply stereotypes when making sense of patients"); Kurt Samson, *Researchers Find Racial Disparities in Care for Epilepsy at Hospitals*, NEUROLOGY TODAY, Jan. 6, 2011, at 1 (reporting a finding that "blacks and Hispanics were less likely to receive neuroimaging or to be admitted to the hospital when seen in their tertiary care emergency department (ED) for an epileptic seizure").

⁹³ Diana J. Burgess et al., *Why Do Providers Contribute to Disparities and What Can Be Done About It?*, MEDSCAPE NEWS 1157 (Dec. 7, 2004), <http://www.medscape.com/viewarticle/494312> ("features of the health care setting that decrease cognitive capacity, such as fatigue, overload, and time pressure" exacerbate problems of "stereotyping and bias.").

⁹⁴ Richards, *supra* note 5, at 621, n. 171 (citing Anthony G. Greenwald & Linda Hamilton Krieger, *Implicit Bias: Scientific Foundations*, 94 CAL. L. REV. 945, 946, 961, 966-67 (2006) (explaining that "the science of implicit cognition suggests that actors do not always have conscious, intentional control over the processes of social perception, impression formation, and judgment that motivate their actions," asserting that "evidence that implicit attitudes produce discriminatory behavior is already substantial and will continue to accumulate," and concluding that "a

scenario, if the physician sends the patient home with no care or provides minimal care, there will be no EMTALA violation as long as this is the normal treatment for a person with the particular set of symptoms that the physician subjectively chose to recognize as clinically significant.

The case of *Summers v Baptist Medical Center Arkadelphia* provides a good example of how the choice of which symptoms to treat as clinically significant can impact the resulting care that a patient receives.⁹⁵ In *Summers*, a patient presented at the emergency room after falling out of a tree stand while hunting.⁹⁶ The physician ordered a set of spinal X-rays, but no chest X-ray.⁹⁷ The patient was sent home after the physician found that the spinal X-rays revealed no problems.⁹⁸ The physician allegedly ignored the popping sounds that the patient made when he breathed in and out.⁹⁹ These symptoms are an obvious indication of problems with fluid in the lungs.¹⁰⁰

The patient presented at another hospital two days later.¹⁰¹ The physician at the second hospital performed a chest X-ray and found that both of the patient's lungs were filled with blood. The patient was diagnosed with an acute comminuted vertebral fracture, a

substantial and actively accumulating body of research evidence establishes that implicit race bias is pervasive"); Kevin A. Schulman et al., *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. MED. 618, 623-25 (1999) (finding similar disparities in physician decisions based on gender); RAYMOND S. DUFF & AUGUST B. HOLLINGSHEAD, *SICKNESS AND SOCIETY* 84-85, 117-18 (1968) (reporting disparate treatment of patients on the basis of socioeconomic status by physicians, nurses, and hospital administrators); Selassie et al., *supra* note 5, at 1266 (finding that the uninsured were less likely to be admitted to a hospital, even after controlling for the patient's clinical condition); Scott Burris, *Dental Discrimination Against the HIV-Infected: Empirical Data, Law and Public Policy*, 13 YALE J. ON REG. 1, 35 (1996) (reporting discrimination against HIV-positive patients in the provision of dental care); *see also* Howe v. Hull, 874 F. Supp. 779, 786 (N.D. Ohio 1994) (denying a defendant hospital's summary judgment motion in an EMTALA case against a hospital that allegedly "did not wish to treat an AIDS patient"); Symposium, *Unconscious Discrimination Twenty Years Later: Application and Evolution*, 40 CONN. L. REV. 927 (2008) (general overview of legal scholarship dealing with unconscious discrimination).

⁹⁵ *Summers v. Baptist Medical Center Arkadelphia*, 69 F.3d 902 (8th Cir. 1995), *rev'd*, 91 F.3d 1132, 1138 (1996).

⁹⁶ *Id.* at 1135.

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

sternal fracture, and bilateral hemopneumothoraces (pockets of blood in the lungs) as a result of untreated rib fractures.¹⁰²

The court found no EMTALA violation as the plaintiff did not produce any evidence that he was treated differently than other patients with the same set of symptoms as those recognized as clinically significant by the treating physician.¹⁰³ The fact that the plaintiff was treated differently than all other patients with his *actual*, clinically significant symptoms (which all physicians would agree were of paramount clinical significance) was not relevant.¹⁰⁴

Studies suggest that this is a common scenario in emergency departments. For example, for children presenting to emergency departments with abdominal pain, minority children are less likely than non-Hispanic white children "to have a pain score documented, receive analgesics for their pain (both narcotic and nonnarcotic), undergo diagnostic testing, or be admitted to the hospital and [are] more likely to have a prolonged [emergency department] length of stay or return visit for the same complaint."¹⁰⁵

Thus, the choice of which symptoms to recognize and which to ignore can be outcome determinative on the issue of whether an appropriate medical screening was performed. And, of course, the choice of one set of screening tools, rather than others, can be outcome determinative on the issue of whether an emergency medical condition existed for the purposes of EMTALA in the first place.

¹⁰² *Id.* at 1135-36.

¹⁰³ *Id.* at 1139.

¹⁰⁴ *Id.*

¹⁰⁵ Tiffani J. Johnson, et al., *Association of Race and Ethnicity With Management of Abdominal Pain in the Emergency Department*, 132 PEDIATRICS e851, e852 (2013), available at <http://pediatrics.aappublications.org/content/132/4/e851.full.html> (in the emergency room, "white children are more likely than other children to undergo diagnostic procedures (eg, blood tests, electrocardiograms, and chest radiographs) for chest pain. White children with intermediate or low-risk injury-severity head trauma are also more likely to undergo head computed tomography (CT) than similarly injured black and Hispanic children. Black female teenagers with abdominal pain or genitourinary symptoms are more likely than whites to be tested for sexually transmitted diseases, even when reporting no sexual activity. Black and Hispanic infants with traumatic brain injury are more likely than white infants to have a skeletal survey to evaluate for child abuse. Similarly, black children with fractures are more likely than whites to be reported for suspected child abuse. Black and Hispanic children also have longer ED wait times compared with white children. Findings of race/ethnicity-based differences in ED care are concerning because minority children are less likely to have a usual source of care and more likely to visit EDs for common complaints."

B. Overuse of Summary Judgment

By relying on customary care as the exclusive proxy for equality of care, EMTALA also renders itself ineffective as an anti-patient dumping tool by facilitating the wide use of summary judgment to dismiss EMTALA cases before the courts can reach the merits.

Commonly, soon after a complaint for an EMTALA violation is filed, hospitals will file a motion for summary judgment with an affidavit of the treating physician in support, attesting that she followed the customs of that particular hospital in the care of the plaintiff.¹⁰⁶ This motion is likely to be granted¹⁰⁷ as, under a motion for summary judgment, all the defendant need do is point out that the plaintiff will be unable to provide evidence on an element on which plaintiff has the burden of proof.¹⁰⁸ The defendant need not disprove the plaintiff's case. This is generally an easy task for the defendant under EMTALA as the plaintiff faces a near impossible task in meeting its burden of production to show dissimilar treatment as that burden has been interpreted by the federal courts.

According to the courts, to meet the plaintiff's burden, EMTALA requires that the plaintiff produce a physician witness who works at the very hospital that the plaintiff received her care. This physician co-worker needs to testify that the plaintiff received care that was different than the care normally provided to patients with the same set of clinically significant symptoms chosen by the treating physician when caring for the plaintiff.

This near impossible requirement is similar to the long-

¹⁰⁶ Richards, *supra* note 5, at 618. This article suggests the further possibility that the defendant hospital could also file a 12(b)(6) Motion to Dismiss under the *Twombly/Iqbal* duo. *Twombly* and *Iqbal* require plaintiffs to plead "factual content [that] allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." Ashcroft v. Iqbal, 129 S. Ct. 1937, 1940 (2009) (citing *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 556 (2007)); *Twombly* and *Iqbal* also assert that "[l]egal conclusion[s] couched as factual allegation[s]" or "[t]hreadbare recitals of a the elements of a cause of action supported by mere conclusory statements" will not stand. Ashcroft, at 1940,1949.

¹⁰⁷ Richards, *supra* note 5, at 618.

¹⁰⁸ Fed. R. Civ. P. 56(c)(1)(B) ("A party asserting that a fact cannot be ... genuinely disputed must support the assertion by ... showing that ... an adverse party cannot produce admissible evidence to support the fact."); *see also* *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986) ("In our view, the plain language of Rule 56(c) mandates the entry of summary judgment, after adequate time for discovery and upon motion, against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial.").

discredited locality rule that has been rejected in most medical malpractice cases.¹⁰⁹ The locality rule mandates that a plaintiff's expert used to establish the standard of care in a malpractice case must come from the same locality where the allegedly negligent care was provided.¹¹⁰ The locality rule was abandoned decades ago by the vast majority of jurisdictions, as it was too difficult to persuade a local physician to testify against another physician who worked in the same local town or region.¹¹¹

EMTALA creates a super-locality rule that is far more onerous than the run-of-the-mill locality rule as it requires the plaintiff to persuade a physician who works in the same hospital as the treating physician to testify against their co-worker. Adding to this already high hurdle, courts have rejected, as unqualified, nurses or other physician extenders as witnesses in EMTALA cases against emergency room physicians.

Once a summary judgment motion with the affidavit of the treating physician is filed by the defendant hospital, the burden of production is placed onto the plaintiff to produce a physician witness who works at the hospital. As the vast majority of plaintiffs are unable to meet this burden, a large number of EMTALA cases are being dismissed summarily.¹¹²

This result is also highly suspect as an evidentiary matter. The treating physician's affidavit will attest that she followed the customs of that particular hospital in the care of the plaintiff. This affidavit is actually likely to have very little probative value. Dozens of empirical studies demonstrate that, in the absence of written protocols, different doctors treat patients differently based on different, highly subjective, rules of thumb under the customary care model of practice.¹¹³ There are substantial discrepancies in physician decisions

¹⁰⁹ Katharine Van Tassel, *Hospital Peer Review Standards and Due Process: Moving from Tort Doctrine Toward Contract Principles Based on Clinical Practice Guidelines*, 36 SETON HALL L. REV. 1179, 1222-23 (2006). See also Marc D. Ginsberg, *Locality Rule Lives! Why? Using Modern Medicine To Eradicate An Unhealthy Law*, 61 DRAKE L. REV. 321, 333-54 (2013).

¹¹⁰ Van Tassel, *supra* note 111, at 1222-23; Ginsberg, *supra* note 111, at 331-32.

¹¹¹ Van Tassel, *supra* note 111, at 1227-28; Ginsberg, *supra* note 111, at 332.

¹¹² See generally, Richards, *supra* note 5.

¹¹³ See Dartmouth Atlas Project, *supra* note 32.

both between and within hospitals.¹¹⁴ One of many examples, too numerous to catalogue here¹¹⁵, is when “family practitioners in Washington State were queried about treating a simple urinary tract infection in women, eighty-two physicians came up with an extraordinary 137 different strategies.”¹¹⁶ A blizzard of studies make it clear that “[w]ithout standardized instruction of some sort from a hospital, it is highly unlikely that screenings performed by different physicians could possibly be uniform.”¹¹⁷

It is worth noting again that a physician’s desire to conform to the group norm in a hospital to engage in customary practice, and eschew evidence-based treatment choices, opens the door to the wide variance in treatment choice for the same medical condition based on the physician’s personal predilections. Thus, one legal commentator reflected that:

[a]n [EMTALA] assessment of uniformity in screening examinations that defers to the perception and judgment of an individual physician in determining what constituted the hospital’s standard protocol will

¹¹⁴ Richards, *supra* note 5, at 619, n. 162 *citing*, MICHAEL L. MILLENSON, DEMANDING MEDICAL EXCELLENCE: DOCTORS AND ACCOUNTABILITY IN THE INFORMATION AGE 4 (1997) (“In the absence of reliable information, physicians’ decisions fluctuate wildly,” noting surprisingly large divergences in care both between and within hospitals, and arguing that implementation of quality measurement and written protocols of best practices could help to reduce inconsistencies). “Millenson cites numerous examples of this throughout his book. *See id.* (“[W]hen family practitioners in Washington State were queried about treating a simple urinary tract infection in women, eighty-two physicians came up with an extraordinary 137 different strategies.”); *id.* at 15-18 (discussing enormous inconsistencies in the treatment of pneumonia patients at eight hospitals in Maine, noting that the researchers in the study “looked in vain for any consistent pattern,” and concluding that “[t]he results in this one small state showed just how deceptive the surface similarities of American medicine can be”); *id.* (noting similar disparities in methods of treating heart attack victims and remarking that one “possible explanation for the variation” was that “[t]he differences could result from physicians’ ‘practice styles’ or ‘preferences,’ the polite terms the medical community uses to describe treatment that varies because doctors vary”); *id.* at 30 (noting dissimilarity among physicians deciding whether or not to remove a child’s tonsils).” *Id.*

¹¹⁵ *See* Dartmouth Atlas Project, *supra* note 32.

¹¹⁶ Richards, *supra* note 5, at 619, n. 162.

¹¹⁷ Richards, *supra* note 5, at 619, n. 163 (Millenson also describes “the experience of one hospital, which, when it attempted to ‘write a protocol spelling out every detail of treatment’ for acute respiratory distress syndrome, encountered substantial problems with physician variance: ‘A treatment regimen that appeared on the surface to be orderly and scientific quickly dissolved into a series of individual ‘rules of thumb’ used by each physician,”; Richards, *supra* note 5, n. 163 *citing*, M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 YALE J. HEALTH POL’Y L. & ETHICS 95, 100 (2001) (“Most medical decisions do not rest firmly on empirical evidence. There are typically multiple diagnostic and therapeutic options, and wide variations in the incidence of many common medical and surgical procedures have been documented within small geographic areas and between individual practitioners.”).

inexorably excuse disparate care.¹¹⁸

Because the courts are giving over-probative value to these affidavits and are regularly dismissing EMTALA cases, hospitals are encouraged by the courts to avoid the creation of written treatment protocols which could make summary judgment far less likely.¹¹⁹ This avoidance runs directly contrary to government programs urging for the adoption of written, evidence-based protocols. This creates a reinforcing cycle based on the unconscious desire of physicians to conform to the norms of the hospital. The result is that physicians, who are increasingly giving up solo practice to join hospitals,¹²⁰ will most likely conform to group norms which follow customary practice and ignore the efforts of government programs to encourage them to adopt, and then follow, written, evidence-based protocols for making treatment decisions.

¹¹⁸ Richards, *supra* note 5, at 619.

¹¹⁹ Richards, *supra* note 5, at 623, n. 174, ("Although some hospitals have written guidelines for the processing of emergency department patients, such as standardized triage instructions or requirements for nurse monitoring, a survey of EMTALA opinions indicates that few hospitals have detailed protocols that guide physicians during screenings," citing as examples the following: "Reynolds v. Maine Gen. Health, 218 F.3d 78, 83-84 (1st Cir. 2000) (discussing a basic policy that required the taking of "complete [medical] history"); Cunningham v. Fredonia Reg'l Hosp., No. 95-3350, 1996 WL 584917, at 2 (10th Cir. Oct. 11, 1996) (involving a policy that determined whether a nurse or a physician would screen a patient depending on the severity of the patient's chest pain); Bode v. Parkview Health Sys., Inc., No. 1:07-CV-324, 2009 WL 790199, at 2, 4 (N.D. Ind. Mar. 23, 2009) (noting that the hospital had a written nursing policy requiring that "nurses ... take each patient's blood pressure," but making clear, in its affidavits, that "[i]t is within the medical judgment of the physician who performs the Medical Screening Examination to determine what history, examination and testing is needed in order to determine whether the patient has an Emergency Medical Condition"); Fuentes Ortiz v. Mennonite Gen. Hosp., 106 F. Supp. 2d 327, 331 (D.P.R. 2000) (noting that, in response to an interrogatory question asking "whether on May 21st, 1998 you had established any policies or procedures for screening patients coming to your emergency room who display or complain of symptoms such as the ones described by plaintiff in his complaint," the hospital administrator stated: "Patient is first screened in Triage Relative to the specific condition of the patient, no protocol exists, other than the applicable standard of care."); see also Timothy H. Bosler & Patrick M. Davis, *Is EMTALA a Defanged Cobra?*, 51 J. MO. B. 165, 169 (1995) ("[M]any hospitals do not provide an established protocol for screening procedures related to even common serious medical conditions Based on our personal experience, many hospitals provide emergency room service through contract physicians and provide little, if any, written screening standards or protocols for the guidance of the individual employees or independent contractors to determine how they will screen a given patient presentation.").").

¹²⁰ See Mantel, *supra* note 27 ("Physicians increasingly are moving away from solo or small group practices and joining large organizations, a trend now accelerating with the implementation of health care reform. Because physicians control as much as ninety percent of all health care spending, understanding how health care organizations influence physicians' treatment decisions is of fundamental importance, particularly for policymakers, scholars, and ethicists concern with the quality, cost, and rationing of health care. . . Of particular concern are health organizations with cultures that bias physicians' clinical decision making in ways that lead to the provision of poor-quality or inefficient care or the withholding of necessary care.").

VII. MODIFYING EMTALA TO IMPROVE EQUALITY OF EMERGENCY CARE—ENCOURAGING EVIDENCE-BASED CARE

The solution recommended in this Article is focused on adoption of systems reform which is the “redesign of the underlying systems of care themselves in order to better serve all patients.”¹²¹ As explained by Professor Sydney Watson,

[i]n a monumental shift from old-style quality oversight, which focused on blaming individuals for errors, systems reform is a non-punitive, forward-looking approach to quality oversight. With the acknowledgment that “to err is human,” it envisions quality improvement as an organizational responsibility. Advocates argue that more can be accomplished by raising the mean performance of all caregivers than by merely eliminating the worst performers. Quality improvement is seen as an ongoing process of evaluation, design adjustment, reevaluation, and further adjustment. The aim is not just to reduce errors but to deliver ever better care.¹²²

A. Moving to Systems Reform and Continuous Quality Improvement

Focusing on systems reform and continuous quality improvement¹²³ moves disparity reduction efforts from the sole domain of EMTALA and the civil rights arena and into an alternative, but coexisting and complimentary, world of healthcare quality regulation.¹²⁴ To institute this systems approach, EMTALA

¹²¹ Sidney D. Watson, *Equity Measures and Systems Reform as Tools for Reducing Racial and Ethnic Disparities*, The Commonwealth Fund, 776, at v, 3 (2005) (“Historically, civil rights law—specifically, Title VI of the 1964 Civil Rights Act—has provided the legal framework for redressing racial and ethnic disparities in health care, but civil rights litigation focuses on identifying blame. Plaintiffs in civil rights cases must prove that a health care provider either intentionally discriminated or used policies, practices, or procedures that had a statistically significant, adverse impact on minority patients. But disparity issues are complex and may be deeply embedded in providers’ actions and patients’ decisions, as well as in institutional policies and practices. Given this genesis, many disparities are unlikely to be suitable to the approach required by civil rights laws. The adoption of systems reform, which moves disparity-reduction efforts from the civil rights arena into the world of health care quality regulation, may ease this limitation.”).

¹²² *Id.* at 2-3.

¹²³ Van Tassel, *Using Clinical Practice Guidelines*, *supra* note 13 (proposing the use of a new system that relies upon the application of knowledge translation theory—along with continuous quality improvement—to integrate evidence-based treatment choices using clinical practice guidelines into physician practice).

¹²⁴ Watson, *supra* note 126, at 2.

should be modified to harmonize with other federal systems in place to improve quality, cost, and equal access through the requirement of written protocols for emergency-department care.

At the same time, CMS regulations should be modified to require that these written protocols be based on evidence-based standards, using clinical practice guidelines. This two-part solution works across systems to ensure equal access to emergency care. This also integrates EMTALA with the continuous quality of care improvement movement that involves an “ongoing process of evaluation, design adjustment, reevaluation, and further adjustment.”¹²⁵ This linkage recognizes that the unequal provision of emergency care caused by uncertainty, subconscious bias or stereotyping can be looked at as another variety of human error that can be prevented with a systems approach.

This approach also ensures that the burden of production stays on the defendant hospital to show that it has a written protocol and that the treating physician followed that protocol; neutralizing the super locality rule currently imposed by the courts that allows for over use of procedural tactics to dismiss EMTALA claims.

B. Modifying EMTLA and CMS Guidelines

Making these changes requires two simple steps. First, EMTALA must be modified to require clearly written protocols and to create a rebuttable presumption of compliance if a hospital produces substantial evidence that it has conformed with its written screening and treatment protocols. It should be noted that this presumption works both ways—failure to comply with the hospital’s written protocol will create a presumption that an EMTALA violation has occurred.

This modification creates a default choice to follow the written protocol, but then allows for individual physician choice in deviating from this default choice if it is reasonable to do so. This exception is rooted in the libertarian paternalism theory developed by Professors Cass Sunstein and Richard Thaler.¹²⁶ It is paternalistic as it provides a

¹²⁵ *Id.* at v.

¹²⁶ Cass Sunstein & Richard Thaler, *Libertarian Paternalism Is Not An Oxymoron* 70 U. CHI. L. REV. 1159 (2003), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=405940 (The SSRN Abstract explains that “[t]he idea of libertarian paternalism might seem to be an

default choice designed to positively influence a physician's choice to follow the hospital's written protocols. It is also libertarian as it gives room for physician choice not to follow the written protocol if it is reasonable to do so. This flexibility allows for the currently high level of scientific uncertainty that exists when it comes to many medical conditions, particularly in the realm of the treatment of outliers. As the practice of evidence-based medicine (population-based medicine, or the treatment of "norm") grows through comparative effectiveness research, and later transitions to personalized medicine based on the treatment of individuals according to their unique genetic, microbiome, and epigenetic profiles; this currently high degree of scientific uncertainty will steadily diminish over the next several decades, reducing the use of this exception.

Second, CMS's *Conditions of Participation: Emergency Services*¹²⁷ must be modified to include regulations that require that "[t]he services provided or arranged by the facility must . . . meet professional standards of care. . . ." ¹²⁸ As part of this modification, the *Interpretive Guidelines for the Conditions of Participation: Emergency Services* should read that "'[p]rofessional standards of quality' means services that are provided according to accepted standards of clinical practice."¹²⁹ A statement should be provided that explains that "accepted standards of clinical practice" can include the use of standards published by a short list of sources, including professional organizations, licensing boards, clinical literature, current professional journals, or the clinical practice guidelines published by

oxymoron, but it is both possible and legitimate for private and public institutions to affect behavior while also respecting freedom of choice. Often people's preferences are ill-formed, and their choices will inevitably be influenced by default rules, framing effects, and starting points. In these circumstances, a form of paternalism cannot be avoided. Equipped with an understanding of behavioral findings of bounded rationality and bounded self-control, libertarian paternalists should attempt to steer people's choices in welfare-promoting directions without eliminating freedom of choice.").

¹²⁷ CTRS FOR MEDICARE & MEDICAID SERVS., *State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases* (as revised on July 16, 2010), available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf.

¹²⁸ This language is taken from the CTRS. FOR MEDICARE & MEDICAID SERVS., CMS Manual System Pub. No. 100-07, *State Operations Provider Certification, Revisions to Appendix PP, State Operations Manual (SOM): Guidance to Surveyors for Long Term Care Facilities (LTC) for Minimum Data Set (MDS) 3.0 Implementation October 1, 2010* (Jan. 7, 2011) (as revised on July 1, 2011) [hereinafter "CMS Survey Guidance"].

¹²⁹ *Id.* at 140.

the Agency of Health Care Policy and Research.¹³⁰ Importantly, the use of “customary care” should not be included on this short list of accepted standards of clinical practice.¹³¹

The result of these changes is that the courts applying EMTALA will be charged with determining if the hospital complied with its written emergency treatment protocols when treating the plaintiff, much as before. However, this reformulation requiring written protocols allows the courts to make a concrete, more easily ascertainable and more substantively accurate assessment of whether the care provided to a particular patient conforms with hospital screening and treatment protocols for all patients. The courts will continue to be concerned solely with *equality* of care, not *quality* of care. This solution avoids the creation of a federal medical malpractice cause of action, leaving medical malpractice issues to the state courts.

Separately, CMS will be tasked with ensuring that these written protocols further *quality* of care by being based on best practices using clinical practice guidelines which is consistent with its mission. This places the obligation to ensure quality of care with CMS which has both the expertise and the resources to do so. By requiring physicians to follow evidence-based protocols, this two-step solution decreases the likelihood that physician choices will be influenced by bias or stereotyping.

¹³⁰ *Id.*

¹³¹ For example, in the context of the care of pressure ulcers in long term care facilities, CMS has identified several organizations that have created clinical practice guidelines that CMS finds acceptable: “There are many recognized clinical resources regarding the prevention and management of pressure ulcers (including wound care, and complications such as infections and pain). Some of these resources include: [1] The Clinical Practice Guidelines from the Agency for Healthcare Research and Quality (AHRQ) www.ahrq.gov (Guideline No. 15: Treatment of Pressure Ulcers and Guideline No. 3: Pressure Ulcers in Adults: Prediction and Prevention) (AHRQ was previously known as the Agency for Health Care Policy and Research [AHCPR]); [2] The National Pressure Ulcer Advisory Panel (NPUAP) www.npuap.org; [3] The American Medical Directors Association (AMDA) www.amda.com (Clinical Practice Guidelines: Pressure Ulcers, 1996 and Pressure Ulcer Therapy Companion, 1999); [4] The Quality Improvement Organizations, Medicare Quality Improvement Community Initiatives site at www.medqic.org; [5] The Wound, Ostomy, and Continence Nurses Society (WOCN) www.wocn.org; and; [6] The American Geriatrics Society guideline “The Management of Persistent Pain in Older Persons,” www.healthinaging.org.” *Id.* at 198.

1. Harmonizing the Customary Care Model of Medical Practice with Evidence-Based Treatment Choices

This solution also works across systems to deal with the problem of the tort, licensure and hospital peer review systems' reliance on customary care as the exclusive proxy for quality. This fixes this disconnect by relying on a preexisting pathway for CMS's evidence-based protocols to become customary practice for hospitals. This path starts with the requirement that all hospitals comply with the CMS's *Conditions of Participation: Emergency Services* in order to be accredited to participate in reimbursement for emergency care by Medicare.¹³² Because hospital emergency rooms go through the accreditation process approximately every three years, this article's suggested changes to CMS's *Conditions of Participation: Emergency Services* will quickly become part of every hospital's customs. A good example of how this works is the case of *Carter v. Hucks-Folliss*.¹³³ In *Carter*, CMS's *Conditions of Participation* used for Medicare accreditation were admissible in a medical malpractice action as evidence of custom.¹³⁴ *Carter* sent the message to hospitals that failure to follow CMS standards could lead to liability.

Thus, following CMS standards leads to the adoption of the evidence-based protocols, which will ultimately become customary practice for hospitals generally. As the number of physicians who are giving up private practice and working directly for hospitals is steadily increasing, and physicians are highly influenced by the social norms of the institution in which they serve, the customs of the physician's in hospitals will likely become the customs for most physicians practicing in the U.S. Thus, over the long run, evidence-

¹³² See Joint Commission, *supra* note 56. CMS has delegated the accreditation process for participation in Medicare to a private, non-profit group called The Joint Commission. In addition, most states have delegated the accreditation process for participation in Medicaid to the Joint Commission. The Joint Commission promulgates accreditation standards and makes inspection visits every three years to ensure that all Medicare and Medicaid regulations are being followed. *Id.*

¹³³ *Carter v. Hucks-Folliss*, 505 S.E.2d 177 (N.C. App. 1998). In *Carter*, the plaintiff was injured during neck surgery. The surgeon not only was not board certified, but had flunked the test for board certification three times. The physician had kept staff privileges for 20 years. The plaintiff sued for negligent credentialing relying, in part, on evidence that the hospital failed to consider lack of board certification as required by the Joint Commission. The court of appeals held that the Joint Commission standards were evidence of custom properly to be considered by the jury.

¹³⁴ *Id.*

based practice will become customary practice and physicians will no longer be forced to forgo an evidence-based treatment choice to avoid liability or loss of licensure.

C. Data Gathering and Outcomes Analysis

Finally, the use of written protocols allows for the use of outcomes analysis to track the results of the use of each particular protocol based upon mental and physical disabilities, race, ethnicity, and insurance status. This data collection based upon mental and physical disabilities, race, ethnicity, and insurance status has become possible under the new data collection obligations created by the ACA. "The ACA requires that federally supported or conducted health programs collect their data in a form that is arrayed by race, ethnicity, sex, primary language, and disability status."¹³⁵

This data collection will allow for the ongoing process of continuing quality improvement to tailor these protocols on an ongoing basis to ensure that they are both furthering equal access and not inadvertently exacerbating disparities.¹³⁶ Thus, a major benefit of this systems reform solution is the use of actual data to both track, and create interventions, to resolve actual disparities in emergency care.

VII. CONCLUSION

One of the main reasons patient dumping is continuing in spite

¹³⁵ U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, IMPLEMENTATION GUIDANCE ON DATA COLLECTION STANDARDS FOR RACE, ETHNICITY, SEX, PRIMARY LANGUAGE, AND DISABILITY STATUSES, *available at* <http://aspe.hhs.gov/datacncl/standards/aca/4302/index.pdf> ("The Affordable Care Act (ACA) includes several provisions aimed at eliminating health disparities in America. Section 4302 (Understanding health disparities: data collection and analysis) of the ACA focuses on the standardization, collection, analysis, and reporting of health disparities data. While data alone will not reduce disparities, it can be foundational to our efforts to understand the causes, design effective responses, and evaluate our progress. Section 4302 requires the Secretary of DHHS to establish data collection standards for race, ethnicity, sex, primary language, and disability status. The law requires that, once established, these data collection standards be used, to the extent practicable, in all national population health surveys. In response to this statutory requirement, this implementation guidance outlines the new minimum data collection standards for race, ethnicity, sex, primary language and disability status for implementation in HHS, along with a description of the data standards development process, the rationale for each data standard, and instructions for their implementation.").

¹³⁶ Watson, *supra* note 126, at 2.

of EMTALA is the way the federal courts have interpreted the statute. By its terms, the statute requires hospitals to medically screen every person who comes to the emergency room requesting medical treatment to assess whether that person suffers from an emergency medical condition. If an emergency medical condition is found, the hospital must treat and medically stabilize that person. The courts have interpreted EMTALA to apply a standard of *equality*, not *quality*—and, according to the courts, this “equal care” requirement means that physicians must use the same care typically provided *at that particular hospital* for patients with the same, clinically significant symptoms or face EMTALA liability.

This interpretation of EMTALA’s standard of equality can have a negative impact on equality of care, actually undermining the goals of EMTALA. This is because the “same care typically provided in the same hospital” is likely to be based upon the customary-care model of medical practice, as this is the normative form of medical practice in the United States.

The customary-care model of medical practice can create serious inequalities in treatment, allow room for bias and stereotypes in treatment choices, and create an overuse of summary judgment to dismiss EMTALA court cases before the merits are reached. In addition to harming health, the increased costs of care associated with misuse and overuse can drive those living at the margin into financial ruin.

The equality, quality and cost problems with the customary-care model have triggered a national movement to transition the United States to a modern, evidence-based medical practice model. Using this empirical data to make treatment choices enhances the equality and quality of care while decreasing its cost. Substantial strides toward transitioning to evidence-based treatment choices have been made through ground-breaking changes in government-provided healthcare, including programs created by the Affordable Care Act, Medicare, and Medicaid. These national measures encouraging evidence-based care directly conflict with EMTALA, which encourages the old practice of customary care.

The solution this article recommends to modernize EMTALA to harmonize with the Affordable Care Act is focused on the adoption of systems reform, which moves disparity reduction efforts from the sole domain of EMTALA and the civil rights arena and into an

alternative, but co-existing and complimentary, world of healthcare quality regulation. This solution calls for the implementation of written protocols and check lists for emergency-department care based on evidence-based protocols, called clinical practice guidelines. This change can be made through just a few simple modifications to EMTALA and the CMS regulations that will allow these two systems to work in tandem according to their different areas of expertise.

EMTALA's effectiveness can be significantly improved by the use of these written, evidence-based protocols. These protocols will greatly simplify the question of whether an EMTALA violation has occurred, avoiding litigation in most cases, and significantly decreasing litigation costs in those that remain. These protocols will also encourage hospital self-regulation by providing more certainty in the steps that hospitals can take to limit potential liability under EMTALA.

This article explains how these simple but powerful changes also avoid the creation of a federal malpractice cause of action by EMTALA—an issue of great concern to federal court judges. Another major benefit of this systems reform solution is the use of actual data to both continuously track, and create interventions to resolve, actual disparities in emergency care.

This solution will harmonize EMTALA with the other federal systems that are working to move the United States to an evidence-based model of medical care.¹³⁷ It also will work across systems to resolve the conflict between the Affordable Care Act, Medicare and Medicaid that all require evidence-based treatment choices and the tort, licensure and hospital peer review systems that rely upon custom as the exclusive proxy for quality.

Importantly, if this solution had been in place in 2008, the Rawson-Neal “Greyhound Therapy” scandal involving as many as 1,500 patients would have been avoided as written discharge

¹³⁷ This proposed solution is forward thinking as it removes the barrier created by EMTALA to evidence-based emergency treatment while also facilitating the transition to personalized medical care based on genetics. This solution also opens the door to important innovations in healthcare delivery. For example, just on the horizon is the development of diagnostic software that will rely upon an individual's unique genetic and epigenetic profile and distinctive microbiome. This type of innovation holds the promise of dramatically improving healthcare quality and equal access while decreasing costs. Of note, in the near future, equal care will mean different care for each individual based on each individual's unique genetic, epigenetic and microbiome profile.

planning guidelines would have been in place to prevent patient dumping.