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Karen E. Martin

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# **The Emergency Medical Treatment Statute: A Federal "How To" on Avoiding Mandatory Arbitration of Medical Malpractice Claims**

*Brooks v. Maryland General Hospital, Inc.*<sup>1</sup>

## **I. INTRODUCTION**

The health care arena has been so invaded by claims of medical malpractice that physicians, patients, and society as a whole are feeling the harmful side effects. Medical malpractice claims affect doctors in the form of higher malpractice insurance premiums. Patients are affected because they pay higher medical costs and increased premiums, or worse, have no medical insurance altogether. In addition, both doctors and patients are hurt by the practice of defensive medicine and the decrease of creativity in treatment.

To combat the explosion of medical malpractice claims, some states have made arbitration a mandatory prerequisite to filing medical malpractice suits. These states hope that mandatory arbitration will decrease the number of claims and lessen the impact of medical malpractice suits. The federal government has created an obstacle to this effort in the form of the emergency medical treatment statute. This federal statute regulates emergency room care, but courts have been hesitant to call it a medical malpractice statute. As a result of the ambiguity in the federal statute, claimants are able to avoid state-mandated arbitration, thereby circumventing the goals of reducing the number of claims and lessening their impact. This problem is illustrated in the case of *Brooks v. Maryland General Hospital, Inc.*<sup>2</sup> This Note addresses the problem and offers solutions.

## **II. FACTS AND HOLDING**

On October 5, 1989, at 2:00 in the afternoon, Robert Brooks went to the emergency room at Maryland General Hospital "complaining of acute weakness and sudden inability to walk."<sup>3</sup> He had no medical insurance.<sup>4</sup> Brooks was first

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1. 996 F.2d 708 (4th Cir. 1993).

2. *Id.*

3. *Id.*

4. *Id.*

examined six hours later, but did not receive any treatment or evaluation.<sup>5</sup> Over three hours later, he was transferred to the University of Maryland Medical System's emergency room.<sup>6</sup> Three hours after the transfer, at approximately 3:15 the following morning, Brooks underwent a pan-myelogram and a CAT scan.<sup>7</sup> Due to technical difficulties, the results of the CAT scan could not be read for three more days.<sup>8</sup> As a result of Brooks' condition, he suffered serious damage to his spinal cord.<sup>9</sup>

Brooks filed suit against both hospitals and several doctors alleging that "the delay caused by the refusal of both hospitals and their professional personnel to diagnose and stabilize his condition" resulted in permanent spinal cord damage, requiring surgery and lengthy rehabilitation.<sup>10</sup> Brooks' claim was filed in the Federal District Court in Maryland under the Emergency Medical Treatment and Active Labor Act (EMTALA).<sup>11</sup>

The defendant hospitals and doctors moved to dismiss Brooks' complaint for failure to first arbitrate his claim as required by the Maryland Health Care Malpractice Claims Act<sup>12</sup> (the Maryland Malpractice Act).<sup>13</sup> The district court granted the defendants' motion to dismiss and held that Brooks' claim fell within the Maryland Malpractice Act; that the EMTALA did not preempt this state law; and therefore, that arbitration was required in this case.<sup>14</sup> Brooks appealed the dismissal to the Fourth Circuit Court of Appeals.<sup>15</sup>

The Court of Appeals affirmed the dismissal of the claims against the individual physicians.<sup>16</sup> However, the court reversed the dismissal of the claim against both hospitals, holding that a claim brought under the EMTALA is not

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5. *Id.*

6. *Id.*

7. *Id.*

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.* Emergency Medical Treatment and Active Labor Act, Pub. L. No. 99-272, § 1921, 100 Stat. 164, 165-67 (1986) (codified as amended at 42 U.S.C. § 1395dd (1988 & Supp. III 1991)). This statute, enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1986, requires all hospitals which receive Medicare and have emergency rooms to screen every individual that comes into the emergency room for emergency medical conditions and to stabilize any emergency medical conditions found prior to release or transfer. See *infra* notes 19 - 69 and accompanying text.

12. MD. CTS. & JUD. PROC. CODE ANN. §§ 3-2A-01 to -09 (1989). This statute requires a plaintiff to enter into nonbinding arbitration prior to filing a claim for medical malpractice in Maryland. See *infra* notes 70 - 100 and accompanying text.

13. *Brooks*, 996 F.2d at 709.

14. *Id.* at 709-10.

15. *Id.* at 710.

16. *Id.* at 710 n.2. The Fourth Circuit affirmed the dismissal because 42 U.S.C. § 1395dd(d)(2)(A) limits private civil actions brought under EMTALA to actions solely against hospitals. This portion of the holding was not at issue in this case and will not be discussed in this Note.

within the scope of the Maryland Malpractice Act, and therefore, need not be arbitrated.<sup>17</sup>

### III. LEGAL BACKGROUND<sup>18</sup>

#### A. *The Emergency Medical Treatment and Active Labor Act*

Under early common law, hospitals were under no duty to treat any patient and, further, did not have to justify their refusal.<sup>19</sup> However, such a duty to render emergency treatment exists in the common law of several states today.<sup>20</sup> Moreover, these common law duty principles have been supplemented or replaced in some states by statutes which require hospitals to render emergency care and/or regulate transfers of emergency patients.<sup>21</sup> The most all-inclusive regulations in this area of health care came in 1986, when the United States Congress passed the Emergency Medical Treatment and Active Labor Act<sup>22</sup> as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA).<sup>23</sup>

The EMTALA was enacted in response to the growing problem of "patient dumping."<sup>24</sup> Patient dumping is the practice by private hospitals of refusing to treat emergency patients, who lack insurance or the ability to pay, by "dumping" or transferring them to other public hospitals.<sup>25</sup> Because of the rising costs of

17. *Brooks*, 996 F.2d at 710.

18. For clarification purposes, the Legal Background section of this Note will be divided into two sections. The first section will discuss the history and interpretation of the federal emergency medical treatment statute, and the second section will discuss the history and interpretation of Maryland's malpractice statute. The Instant Decision section will discuss how the court combined these legal histories to reach its decision.

19. *Birmingham Baptist Hosp. v. Crews*, 157 So. 224, 225 (Ala. 1934); James P. McHugh, Comment, *Emergency Medical Care For Indigents: All Hospitals Must Provide Stabilizing Treatment or Pay The Price*, 93 W. VA. L. REV. 165, 168 n.20 (1990) (citing several courts which uphold this no-duty rule).

20. Andrew J. McClurg, *Your Money Or Your Life: Interpreting the Federal Act Against Patient Dumping*, 24 WAKE FOREST L. REV. 173, 183 n.51 (1989) (citing cases from 14 states recognizing this common law duty).

21. McClurg, *supra* note 20, at 190 n.84 (citing 26 states which impose these statutory regulations).

22. 42 U.S.C. § 1395dd(a)-(i) (1988 & Supp. III 1991).

23. Pub. L. No. 99-272, 100 Stat. 164 (1986) (codified as amended at 42 U.S.C. § 1395dd (1988 & Supp. III 1991)).

24. Diane K. Falstrom, Comment, *Decisions Under the Emergency Medical Treatment and Active Labor Act: A Judicial Cure For Patient Dumping*, 19 N. KY. L. REV. 365, 365 (1992) (quoting the REPORT OF THE HOUSE COMMITTEE ON WAYS AND MEANS, H.R. REP. NO. 241, 99th Cong., 1st Sess., pt. 1 (1986), reprinted in 1986 U.S.C.C.A.N. 579).

25. See generally Karen I. Treiger, Note, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. REV. 1186 (1986).

health care, the progressive role of hospitals as competitive businesses,<sup>26</sup> and the growing population of uninsured patients,<sup>27</sup> hospitals, which were previously charitable organizations, have subsequently become financially-oriented, rather than care-oriented.<sup>28</sup>

Congress enacted the EMTALA to preserve and restore the tradition of hospitals giving emergency medical aid to anyone in need, thus preventing hospitals from dumping patients unable to pay for their care.<sup>29</sup> As a result of the EMTALA, when "any individual comes to the emergency department" and requests examination or treatment for a medical condition, "the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department . . . to determine whether or not an emergency medical condition exists."<sup>30</sup> The hospital must utilize all "ancillary services routinely available to the emergency department."<sup>31</sup>

Two appellate courts<sup>32</sup> defined "appropriate medical screening" as requiring the hospital to provide similar examinations to all patients.<sup>33</sup> Appropriateness is determined "by reference to a hospital's standard screening procedures," not by reference to the particular outcome of a particular patient.<sup>34</sup> The Fourth Circuit attempted to further clarify this ambiguity in *Baber v. Hospital Corp. of America*.<sup>35</sup> The *Baber* court held that the EMTALA was not a malpractice statute, and that its purpose was not to ensure that all patients were diagnosed correctly or even that they received adequate care. Rather, the purpose of the EMTALA was to ensure that patients know that they will receive whatever services a hospital can provide when they are truly in need.<sup>36</sup>

The requisite "appropriate medical screening" is used to determine if an emergency medical condition exists. For purposes of the EMTALA, a patient suffers an emergency medical condition if he or she is in imminent danger of death or serious disability.<sup>37</sup> If no emergency medical condition exists, the

26. McClurg, *supra* note 20, at 179.

27. Danielle Lombardo Trostorff, *King Cobra Recoils*, 37 FED. B. NEWS & J. 442, 443 (1990).

28. McClurg, *supra* note 20, at 179-80.

29. Thornton v. Southwest Detroit Hosp., 895 F.2d 1131, 1132 (6th Cir. 1990).

30. 42 U.S.C. § 1395dd(a) (1988 & Supp. III 1991).

31. *Id.*

32. Gatewood v. Washington Healthcare Corp., 933 F.2d 1037 (D.C. Cir. 1991); Cleland v. Bronson Healthcare Group, Inc., 917 F.2d 266 (6th Cir. 1990).

33. Gatewood, 933 F.2d at 1041; Cleland, 917 F.2d at 272.

34. Gatewood, 933 F.2d at 1041.

35. 977 F.2d 872 (4th Cir. 1992).

36. *Id.* at 880.

37. Thornton, 895 F.2d at 1134. This section defines an "emergency medical condition" as: [A] medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

*Id.* (quoting 42 U.S.C. § 1395dd(e)(1)(A)).

EMTALA does not apply.<sup>38</sup> If an emergency medical condition does exist, the hospital must either provide the necessary stabilizing treatment<sup>39</sup> or transfer the patient to another medical facility, according to statutory guidelines.<sup>40</sup>

Stabilization requires "such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual . . . ." <sup>41</sup> Once patients are stabilized, "COBRA no longer applies and hospitals are free to refuse further treatment or transfer patients for purely economic reasons."<sup>42</sup> Similarly, the hospital is under no further obligation if a patient refuses treatment after being informed of the risks and benefits of the examination and treatment, or if the patient consents to transfer prior to stabilization.<sup>43</sup>

A transfer prior to stabilization is appropriate only after (1) the transferring hospital "provides the medical treatment within its capacity which minimizes the risks to the individual's health;"<sup>44</sup> and (2) the receiving hospital agrees to accept the transfer and is willing and qualified to provide the necessary medical treatment.<sup>45</sup> In addition, if the patient, after being informed of the hospital's obligations, requests a transfer in writing or the physician makes the proper certification, a transfer will also be appropriate.<sup>46</sup> For purposes of the EMTALA, a "transfer" encompasses all movement outside of the hospital, including discharge, at the direction of anyone associated with the hospital.<sup>47</sup> Therefore, the EMTALA applies to both emergency room patients and inpatients who entered the hospital with emergency medical conditions.<sup>48</sup>

The EMTALA can be enforced through penalties on participating hospitals<sup>49</sup> and physicians by the Federal Healthcare Financing Administration (HCFA), as well as through private causes of action brought by harmed patients against

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38. See generally *Thornton*, 895 F.2d 1131.

39. 42 U.S.C. § 1395dd(b)(1)(A) (1988 & Supp. III 1991).

40. *Id.* § 1395dd(b)(1)(B).

41. *Id.* § 1395dd(e)(3)(A).

42. Robert A. Bitterman, *A Critical Analysis of the Federal COBRA Hospital "Antidumping Law": Ramifications for Hospitals, Physicians, and Effects on Access to Healthcare*, 70 U. DET. MERCY L. REV. 125, 146 (1992).

43. 42 U.S.C. § 1395dd(b)(2) (1988 & Supp. III 1991).

44. *Id.* § 1395dd(c)(2)(A).

45. *Id.* § 1395dd(c)(2)(B).

46. *Id.* § 1395dd(c)(1). This section provides that the doctor must certify that "the medical benefits reasonably expected from the provision of the appropriate medical treatment at another medical facility outweigh the increased risks to the individual . . . from effecting that transfer." *Id.*

47. 42 U.S.C. § 1395dd(e)(4) (1988 & Supp. III 1991).

48. See *Thornton*, 895 F.2d at 1134.

49. "Participating hospital" is defined in 42 U.S.C. § 1395dd(e)(2), which refers to 42 U.S.C. § 1395cc. However, for purposes of this Note, a participating hospital is one that receives Medicare payments and has an emergency department.

participating hospitals.<sup>50</sup> The EMTALA allows for "[a]ny individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement" to seek damages for personal injury and financial loss "under the law of the State in which the hospital is located, and such equitable relief as is appropriate."<sup>51</sup> As such, the statute does not directly provide for a private cause of action against a physician.

These private causes of action against participating hospitals have forced courts to interpret ambiguous portions of the EMTALA. Various courts have interpreted the federal statute differently, resulting in problems. One of these interpretation problems arises in determining who may bring an action under this statute. In the past, courts relied on legislative intent that the statute was to prevent the withholding of treatment to indigent patients.<sup>52</sup> These courts held that a cause of action must include an allegation that the hospital's refusal of treatment was for economic reasons.<sup>53</sup> Later courts rejected this argument and relied solely on the language in the statute itself.<sup>54</sup> These courts interpreted the EMTALA as providing protection for all patients and rejected any previous limitations on its coverage.<sup>55</sup> The court in *Brooker v. Desert Hospital Corp.*<sup>56</sup> held that the language of the act did not "set forth any specific economic status criteria" limiting the type of individual covered by EMTALA, and that the court "need not resort to the statute's legislative history" for its interpretation.<sup>57</sup> One court has implied that discrimination based upon race or religious belief could constitute a basis for an EMTALA claim.<sup>58</sup> Therefore, as the law presently stands, any person, regardless of his or her economic situation, may bring a federal EMTALA claim.

A second issue facing courts interpreting the EMTALA is whether it preempts state malpractice law. The EMTALA specifically states that its provisions "do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of [the EMTALA]."<sup>59</sup>

50. 42 U.S.C. § 1395dd(d)(1)-(2) (1988 & Supp. III 1991). Although there are several different penalties imposed by the HCFA, this Note will focus on the availability of private causes of action discussed in Section 1395dd(d)(2).

51. 42 U.S.C. § 1395dd(d)(2) (1988 & Supp. III 1991).

52. See *Thornton*, 895 F.2d at 1132; *Stewart v. Myrick*, 731 F. Supp. 433, 435 (D. Kan. 1990); *Evitt v. University Heights Hosp.*, 727 F. Supp. 495, 497 (S.D. Ind. 1989); *Nichols v. Estabrook*, 741 F. Supp. 325, 329 (D.N.H. 1989).

53. *Stewart*, 731 F. Supp. at 434-35; *Evitt*, 727 F. Supp. at 498; *Nichols*, 741 F. Supp. at 330.

54. See *Gatewood*, 933 F.2d at 1040; *Cleland*, 917 F.2d at 267; *Burrows v. Turner Memorial Hosp.*, 762 F. Supp. 841 (W.D. Ark. 1991); *Delaney v. Cade*, 756 F. Supp. 1476 (D. Kan. 1991); *Deberry v. Sherman Hosp. Ass'n*, 741 F. Supp. 1302 (N.D. Ill. 1990).

55. *Gatewood*, 933 F.2d at 1040; *Cleland*, 917 F.2d at 267; *Burrows*, 762 F. Supp. at 842; *Delaney*, 756 F. Supp. at 1486; *Deberry*, 741 F. Supp. at 1306.

56. 947 F.2d 412 (9th Cir. 1991).

57. *Id.* at 414.

58. *Verhagen v. Olarte*, No. 89 CIV. 0300(CSH), 1989 WL 146265 (S.D.N.Y. Nov. 21, 1989) (memorandum opinion and order).

59. 42 U.S.C. § 1395dd(f) (1988 & Supp. III 1991).

A primary case addressing the application of state law to EMTALA claims is an Indiana federal court's decision in *Reid v. Indianapolis Osteopathic Medical Hospital, Inc.*<sup>60</sup> Indiana medical malpractice claims are statutorily limited in two ways: (1) caps on damages;<sup>61</sup> and (2) mandatory review panels prior to filing a claim.<sup>62</sup> The *Reid* court held that because damage caps were substantive in nature, and did not directly conflict with any provisions of EMTALA, they could be applied.<sup>63</sup> However, the court held that the review panel requirement was procedural, and in direct conflict with the EMTALA's provisions allowing an immediate cause of action "whenever '[a]ny individual . . . suffers personal harm as a direct result of a participating hospital's violation of a requirement of [Section 1395dd(d)(3)(A)].'"<sup>64</sup> Thus, the *Reid* court ruled that the EMTALA did not incorporate the procedural limitation of mandatory medical panel review.<sup>65</sup>

Several other courts have followed *Reid* in adopting only state substantive law,<sup>66</sup> despite the fact that the provisions of the EMTALA do not mention or differentiate between the preemption of state substantive or procedural laws.<sup>67</sup> However, this rule is not controlling in all federal courts.<sup>68</sup> Conversely, the First Circuit has supported a state-mandated medical review panel of federal causes of action stating, in dicta, that "[d]octors and hospitals, and, ultimately, their other patients, need screening protection against frivolous claims as much under the federal statute as they do for other malpractice charges."<sup>69</sup>

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60. 709 F. Supp. 853 (S.D. Ind. 1989).

61. *Id.* at 854.

62. *Id.*

63. *Id.* at 855-56.

64. *Id.* at 855 (quoting 42 U.S.C. § 1395dd(d)(3)(A) (1988)).

65. *Id.* at 855-56.

66. See, e.g., *Green v. Touro Infirmary*, Civ. A. No. 90-4860, 1991 WL 17259, at \*1 (E.D. La. Feb. 4, 1991) (citing *Reid*, review by a medical panel was not required because of the direct conflict with federal statute); *Owens v. Nacogdoches County Hosp. Dist.*, 741 F. Supp. 1269 (E.D. Tex. 1990) (allowing claim for emotional distress because such claims are allowed under state medical malpractice law); *Maziarka v. St. Elizabeth Hosp.*, No. 88 C 6658, 1989 WL 13195, at \*2 (N.D. Ill. Feb. 16, 1989) (holding by memorandum opinion and order that no punitive damages were allowed in federal EMTALA claim because they were not allowed under state medical malpractice law); *Falstrom*, *supra* note 24, at 381-83.

67. 42 U.S.C. § 1395dd(f) provides that "the provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section." 42 U.S.C. § 1395dd(f) (emphasis added).

68. See *Power v. Arlington Hosp.*, 800 F. Supp. 1390 (E.D. Va. 1992).

69. *Wilson v. Atlanticare Medical Ctr.*, 868 F.2d 34, 35 (1st Cir. 1989) (The court did not reach the merits of the case because it was dismissed for procedural reasons. Therefore, the court's support of this proposition is only in the form of dictum).



### B. Maryland's Health Care Malpractice Claims Statute

Maryland's Malpractice Act<sup>70</sup> was enacted in 1976 in the face of a medical malpractice crisis and was designed "to counteract rapidly rising insurance rates and to ensure adequate coverage for medical personnel and facilities."<sup>71</sup> The legislature's purpose was to "reduce the number of medical malpractice court suits by screening out frivolous claims at the arbitration level."<sup>72</sup> This legislative act requires that individuals with medical malpractice claims attempt to resolve their disputes before an arbitration panel as a prerequisite to formal court action.<sup>73</sup> The goals of this condition precedent to litigation are: (1) to level off the rising cost of health care due to "exorbitant" malpractice insurance premiums; (2) to curb the practice of defensive medicine by lawsuit-fearful doctors; and (3) to restore faith in the traditional tort system as it relates to medical malpractice claims.<sup>74</sup>

The statute, in effect, augments the existing structure of tort claim resolution by adding a procedural layer of arbitration to all medical injury claims.<sup>75</sup> Any medical malpractice claim "by a person against a health care provider,"<sup>76</sup> for any sum greater than \$5,000,<sup>77</sup> must be filed with the Director of the Health Claims Arbitration Office.<sup>78</sup> All claims must include a certificate from a qualified expert attesting to a departure from the standard of care which is the proximate cause of the alleged injury.<sup>79</sup> The Director then forwards a copy of the claim to each health care provider involved, and the procedure is underway.<sup>80</sup> At any time prior to the Health Claims Arbitration Office hearing, parties may mutually agree to waive arbitration.<sup>81</sup>

70. MD. CTS. & JUD. PROC. CODE ANN. §§ 3-2A-01 to -09 (1989).

71. Matthew Zimmerman, *The Constitutionality of Medical Malpractice Mediation Panels: A Maryland Perspective*, 9 BALT. L. REV. 75, 75 (1979).

72. Newell v. Richards, 594 A.2d 1152, 1159 (Md. 1991). See also Wyndham v. Haines, 503 A.2d 719, 721-22 (Md. 1986); Attorney General v. Johnson, 385 A.2d 57, 59 (Md. 1978), appeal dismissed, 439 U.S. 805 (1978), overruled by Newell, 594 A.2d 1152.

73. Johnson, 385 A.2d at 59.

74. Kevin G. Quinn, *The Health Care Malpractice Claims Statute: Maryland's Response To The Medical Malpractice Crisis*, 10 BALT. L. REV. 74, 74-75 (1980).

75. *Id.* at 81.

76. The statute defines "health care provider" to include hospitals or related institutions, physicians, osteopaths, optometrists, chiropractors, registered or licensed practical nurses, dentists, podiatrists, psychologists, licensed certified social workers-clinical, or physical therapists. MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-01(e) (1989 & Supp. 1993).

77. MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-02(a) (1989).

78. *Id.* § 3-2A-04(a). As stated in Section 3-2A-03(a), the Health Claims Arbitration Office is a unit of the Executive Department, and the Director is "appointed by the Governor with the advice and consent of the Senate." *Id.* § 3-2A-03(a).

79. *Id.* § 3-2A-04(b)(1).

80. *Id.* § 3-2A-04(a).

81. *Id.* § 3-2A-06A(a).

The Director has a prepared list comprised of three categories of qualified persons willing to serve as arbitrators.<sup>82</sup> The list contains the names of attorneys, individuals who are health care providers, and persons from the general public who are neither attorneys, health care providers, or agents or employees of an insurance company.<sup>83</sup> The Director delivers to each party the names and biographical information of six persons from each category to be possible panelists.<sup>84</sup> Each party then strikes the names of any unacceptable panelists and returns the list to the Director.<sup>85</sup> The Director compares these lists and selects the first mutually agreeable person in each category to comprise the arbitration panel.<sup>86</sup>

After some discovery and other procedural matters, the panel rules on all issues of law<sup>87</sup> and fact<sup>88</sup> and determines if the health care provider is liable to the claimant.<sup>89</sup> If liability is found, the panel then determines the extent of "appropriate damages."<sup>90</sup> The arbitration panel may award compensatory and nominal damages, as well as punitive damages.<sup>91</sup>

Neither party is bound to accept the award, and it may be rejected for any reason within thirty days.<sup>92</sup> If neither party rejects the award, it becomes final and binding, and is filed with the appropriate circuit court, resulting in a final judgment.<sup>93</sup> If a party is displeased and desires to nullify the award, that party may do so by filing an action in court and filing a copy of that action with the Director.<sup>94</sup> An award may be vacated on the grounds of corruption, fraud, partiality, or the like.<sup>95</sup> If it is not vacated, it is admissible as evidence at trial and presumed to be correct.<sup>96</sup>

82. *Id.* § 3-2A-03(c).

83. *Id.* § 3-2A-03(c)(2).

84. *Id.* § 3-2A-04(c).

85. *Id.* § 3-2A-04(d).

86. *Id.* § 3-2A-04(e).

87. *Id.* § 3-2A-05(a) (Issues of law and prehearing procedure are determined by the attorney member of the panel, who serves as the panel chairperson). *Id.* § 3-2A-05(c).

88. MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-05(a) (1989) (Issues of fact are decided by the panel as a whole).

89. *Id.* § 3-2A-05(e).

90. *Id.*

91. *Bishop v. Holy Cross Hosp. of Silver Spring*, 410 A.2d 630, 632 (Md. Ct. Spec. App. 1980).

92. MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-06(a) (1989).

93. *Id.* § 3-2A-05(i).

94. *Id.* § 3-2A-06(b).

95. *Id.* § 3-2A-06(c) (citing MD. CTS. & JUD. PROC. CODE ANN. § 3-224(b)(1)-(4)).

96. *Id.* § 3-2A-06(d). Courts have held that if the claimant is successful at the arbitration level, and the health care provider is the party seeking to set aside the award, the "arbitration award in favor of [the] claimant is admissible and presumed correct, but it does not shift the common law burden of proof to the health care provider." *Newell*, 594 A.2d at 1160. Thus, the claimant remains as the plaintiff in the action and retains the burden of proof as to the factfinder; the health care provider's burden of proof under the statute relates only to the award as a specific item of evidence to be rebutted. See *Newell*, 594 A.2d at 1158-69 for extensive instruction on this shift of the burden.

The final section of the Maryland Malpractice Act provides that "[t]he provisions of this subtitle shall be deemed procedural in nature and shall not be construed to create, enlarge, or diminish any cause of action not heretofore existing."<sup>97</sup> A federal court interpreted this provision in *Davison v. Sinai Hospital of Baltimore*.<sup>98</sup> The *Davison* court interpreted this "Construction of Subtitle" section of the EMTALA as indicating the intent of the legislature to not create a new cause of action with this statute.<sup>99</sup> Further, the *Davison* court held that the Maryland Malpractice Act was substantive in nature, and therefore, under the *Erie* doctrine, must be applied by federal courts as the substantive law of Maryland.<sup>100</sup>

#### IV. THE INSTANT DECISION

In the case at bar, the Fourth Circuit Court of Appeals decided the question of "whether a plaintiff seeking relief under EMTALA must first pursue arbitration required by state law for medical malpractice claims."<sup>101</sup> This was a question of first impression for this court.<sup>102</sup> The *Brooks* court chose to analyze this issue by answering two questions:<sup>103</sup> (1) whether the EMTALA claim fell within the Maryland Malpractice Act;<sup>104</sup> and (2) whether the EMTALA incorporates or preempts the terms of Maryland's Malpractice Act.<sup>105</sup> The court decided that Brooks' EMTALA claim did not fall within the terms of Maryland's Malpractice Act,<sup>106</sup> but refrained from ruling on whether the state law requirement applied in a suit based on federal question jurisdiction.<sup>107</sup> In reaching its decision, the *Brooks* court discussed: (1) the effects and interpretation of the EMTALA; (2) the effects and interpretation of the Maryland Malpractice Act; and (3) the application of the EMTALA to the Maryland Malpractice Act.<sup>108</sup>

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97. MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-09 (1989).

98. 462 F. Supp. 778 (D. Md. 1978), *aff'd*, 617 F.2d 361 (4th Cir. 1980). *Davison* was a federal suit based on diversity jurisdiction. *Id.* at 779.

99. *Id.* at 780.

100. *Id.*

101. *Brooks*, 996 F.2d at 710.

102. *Id.*

103. *Id.* at 713.

104. *Id.*

105. *Id.*

106. *Id.*

107. *Id.* at 711.

108. *See generally Brooks*, 996 F.2d at 710-15.

*A. The Effects and Interpretation of the EMTALA*

In analyzing the EMTALA and its implications, the court in *Brooks* first discussed the Congressional intent of the statute and its original application.<sup>109</sup> The court summarized the two duties which the EMTALA places on the hospitals which receive Medicare and have emergency rooms. First, there is the duty "to provide to anyone presented for treatment 'an appropriate medical screening . . . to determine whether or not an emergency medical condition . . . exists,'" and second, the duty "to stabilize the condition or, if medically warranted, to transfer the person to another facility if the benefits of transfer outweigh its risks."<sup>110</sup> The *Brooks* court then defined how a person may recover from a breach of these duties under applicable state law,<sup>111</sup> briefly discussed the means for the proper transfer of a patient under the EMTALA, and focused on the applicable standard of care in an EMTALA cause of action.<sup>112</sup>

The court reiterated its holding in *Baber v. Hospital Corp. of America*<sup>113</sup> that the EMTALA is not a malpractice statute because its purpose is not to guarantee proper diagnosis or even ensure adequate care.<sup>114</sup> As such, the *Brooks* court stated that the hospital's duty of appropriate screening and stabilization is measured "by reference to a hospital's standard screening procedures."<sup>115</sup> In other words, the standard of care by which the hospital is measured is simply whether it applied the same screening procedures to all patients uniformly.

*B. Effects and Interpretation of the Maryland Malpractice Act*

The *Brooks* court next interpreted Maryland's Malpractice Act to determine whether it applied to the instant cause of action. The court described the underlying goals of the malpractice statute as "facilitat[ing] access to insurance by health care providers and . . . lessen[ing] the cost of health care."<sup>116</sup> The court summarized the Act as requiring nonbinding arbitration as a condition precedent to filing a medical malpractice claim.<sup>117</sup> The *Brooks* court stated that the purpose of this condition precedent is to screen out frivolous claims, thereby lowering the number of medical malpractice suits that reach trial.<sup>118</sup> The court explored specific provisions of the Act, such as to whom it applies, who qualifies

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109. *Brooks*, 996 F.2d at 711.

110. *Id.* at 710 (quoting EMTALA, 42 U.S.C. § 1395dd(a) (1988 & Supp. III 1991)).

111. *Id.* (citing 42 U.S.C. § 1395dd(d)(2)(A) (1988 & Supp. III 1991)).

112. *Id.* at 710-11.

113. 977 F.2d 872 (4th Cir. 1992).

114. *Brooks*, 996 F.2d at 711 (citing *Baber*, 977 F.2d at 880).

115. *Id.*

116. *Id.*

117. *Id.*

118. *Id.* at 712 (citing *Newell*, 594 A.2d at 1159).

as a "health care provider," and what constitutes a "medical injury."<sup>119</sup> Further, the court explained the following: (1) the requirement of an expert attestation for the departure from the standard of care;<sup>120</sup> (2) the composition of the arbitration panel;<sup>121</sup> (3) the role of the panel in determining liability and assessing damages;<sup>122</sup> and (4) the parties' options following the panel decision.<sup>123</sup> Finally, the *Brooks* court emphasized the final section of the Act, which provides that the Maryland Malpractice Act "shall be deemed procedural in nature and shall not . . . create, enlarge, or diminish any cause of action not heretofore existing."<sup>124</sup>

The *Brooks* court concluded that the application of Maryland's Malpractice Act has been limited. The court has applied the Act "to traditional malpractice claims arising from the breach by a professional of his duty to comply with a standard of care."<sup>125</sup> The court cited examples of "[c]laims for injuries arising from other causes in connection with health care" which were not covered by the act.<sup>126</sup>

The court noted a final limitation to the applicability of the Maryland Malpractice Act. A health care provider is liable only if the care given "is not in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time of the alleged act."<sup>127</sup>

### *C. Application of the EMTALA on the Maryland Malpractice Act*

In the third phase of its decision, the *Brooks* court, using its discussion of the two statutes, answered its original questions of whether Brooks' claim is covered by the EMTALA, and if so, whether the EMTALA should apply the state law procedural requirement.<sup>128</sup> Although it appears, at first glance, that an EMTALA claim would fall under the Maryland Malpractice Act, the court held

119. *Id.* (citing MD. CTS. & JUD. PROC. CODE ANN. §§ 3-2A-01(e)-(f), 3-2A-02 (1989)).

120. *Id.* (citing MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-04(b)(1) (1989)).

121. *Id.* (citing MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-04 (1989)).

122. *Id.* (citing MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-05(g) (1989)).

123. *Id.* (citing MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-06 (1989)).

124. *Id.* (citing MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-09 (1989)).

125. *Id.* (citing *Cannon v. McKen*, 459 A.2d 196, 201 (Md. 1983)).

126. *Id.* For example, in *Cannon*, where a patient was allegedly injured when a piece of dental equipment fell from the wall and injured her, a claim against the dentist was not covered by the Act as malpractice. *Canon*, 459 A.2d at 202. In addition, the court in *Miles Laboratories, Inc. v. Doe*, 556 A.2d 1107 (Md. 1989) held that the Maryland Malpractice Act did not apply to a claim against the Red Cross by a recipient of HIV-infected blood for "failure to adopt proper testing and screening procedures." *Id.* at 1125.

127. *Brooks*, 996 F.2d at 713 (citing MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-02(c), amended by 1993 MD. LAWS 9, §1).

128. *Id.*

that Brooks' claim did not fall under the Act.<sup>129</sup> First, Maryland's Malpractice Act has been limited in its application to traditional malpractice claims;<sup>130</sup> and second, Brooks' right of recovery under his EMTALA claim is limited to the hospital's breach of the EMTALA duties.<sup>131</sup> Therefore, the *Brooks* court, in answering the first question presented, held that because Brooks' claim is one of "disparate screening," which is a breach of a hospital's duty under the EMTALA, rather than a breach of a traditional standard of care duty, the Maryland Malpractice Act did not apply.<sup>132</sup>

The *Brooks* court considered, but refrained from ruling on, how the EMTALA is affected by state law.<sup>133</sup> The district court in *Brooks* dismissed Brooks' claim for lack of subject matter jurisdiction, based on the holding in *Rowland v. Patterson*.<sup>134</sup> The *Rowland* court held that state-mandated arbitration did not conflict with the requirements of EMTALA.<sup>135</sup> Instead, it was a "condition precedent to legal action," which had substantive aspects, and therefore, must be honored by federal courts.<sup>136</sup> However, the Fourth Circuit disagreed with the district court and distinguished *Brooks* from *Rowland*, finding that *Rowland* was brought in federal court under diversity jurisdiction, while Brooks' claim is one of federal question.<sup>137</sup> Therefore, since Brooks' claim was brought as a federal question, the *Rowland* decision is not binding. Further, the *Brooks* court stated that in determining how state law affects the EMTALA, it must "decide the nature and scope of [the] federal cause of action."<sup>138</sup>

Accordingly, the *Brooks* court assessed the key to solving this dilemma as being whether the EMTALA explicitly or impliedly incorporates state law.<sup>139</sup> In considering this, the court looked to the statute itself. First, the court stated that Congress' intent in passing the EMTALA was to fill the gaps in state malpractice law and impose limited duty.<sup>140</sup> Second, the court recognized the limited preemption of the EMTALA as being only to the extent that a state or local requirement directly conflicts with a requirement of the EMTALA.<sup>141</sup>

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129. *Id.*

130. *Id.*

131. *Id.*

132. *Id.*

133. *Id.* at 714.

134. 882 F.2d 97 (4th Cir. 1989) (a medical malpractice claim brought in federal court under diversity jurisdiction must employ state-mandated arbitration because it is a substantive issue).

135. *Id.* at 99.

136. *Brooks*, 996 F.2d at 714 (citing *Rowland*, 882 F.2d at 99).

137. *Id.*

138. *Id.*

139. *Id.* The court reached this point after explaining that, in a federal cause of action, substantive state limitations will be given effect in interpreting federal statutes only "if Congress has evinced an intention to give state law persuasive or binding effect." *Id.* (quoting *Reconstruction Finance Corp. v. Beaver County*, 328 U.S. 204, 209-10 (1946)).

140. *Id.* at 714-15.

141. *Id.* at 715 (citing 42 U.S.C. § 1395dd(f) (1988 & Supp. II 1990)).

Finally, the *Brooks* court suggested that the EMTALA expressly adopts state-imposed limitations on damages by providing for recovery of "those damages available for personal injury under the law of the State in which the hospital is located."<sup>142</sup> From this analysis, the *Brooks* court proposed a possible argument that state-mandated arbitration comes within "a broader penumbra of the Congressional intent to weave EMTALA duties into the fabric of state malpractice law."<sup>143</sup>

However, the Fourth Circuit refrained from ruling on whether the EMTALA incorporates or implicitly tolerates state-mandated arbitration procedures. Finally, the court held that regardless of whether the EMTALA incorporates or tolerates the Maryland Malpractice Act requirement, Brooks' EMTALA claim does not fall within the Act, and therefore, need not be arbitrated.<sup>144</sup>

## V. COMMENT

While the decision in *Brooks* that an EMTALA claim does not fall within the Maryland Malpractice Act is understandable, and the court was correct in its legal analysis, the issues involved are certainly not as black and white as the court seems to believe. In fact, further examination of the surrounding law and policies involved supports an argument that this EMTALA claim should be treated as medical malpractice for the purpose of state-mandated arbitration.

First, it is arguable that the EMTALA has become a federal malpractice statute in its practical application. In fact, some would say that "COBRA has really been a federal malpractice law all along."<sup>145</sup> The *Brooks* court is adamant about what it perceives as an "obvious" difference between the EMTALA and state medical malpractice.<sup>146</sup> However, the distinct lines which separated these entities have faded to some extent. The most notable neutralization of this distinction involves the concept of a hospital's duty under the federal statute. Specifically, the answers to such questions as to whom this duty is owed, and what this duty consists of, lend themselves to the argument that the EMTALA is indeed a medical malpractice statute.<sup>147</sup>

142. *Id.* (citing 42 U.S.C. § 1395dd(d)(2)(A) (1988 & Supp. II 1990)).

143. *Id.* The court further explained the necessity of inquiring whether mandatory arbitration was inconsistent with other portions of the EMTALA. In doing so, it would be confronted with such questions as: (1) whether the expert attestation under the Maryland Malpractice Act conflicts with the proof required under EMTALA; (2) whether the presumption of correctness of the arbitration award conflicts with the Federal Rules of Evidence; and (3) whether state arbitration requirements have an adverse effect on EMTALA's statute of limitations. *Id.*

144. *Id.*

145. Demetrios G. Metropoulos, *Son of COBRA: The Evolution of a Federal Malpractice Law*, 45 STAN. L. REV. 263, 264 (1992).

146. *Brooks*, 996 F.2d at 711.

147. Metropoulos, *supra* note 145, at 270-78 (extensively discussing this evolution into federal malpractice).

As discussed initially, the purpose of this statute was to prevent patient dumping.<sup>148</sup> However, as time has passed since its enactment, this purpose has fallen by the wayside. Courts have chosen to interpret the EMTALA according to the plain meaning of its words, rather than its legislative history.<sup>149</sup> As a result, the duties of this federal statute apply to "any and all" emergency room patients, not just those who are indigent or uninsured.<sup>150</sup> Due to this expansion, hospitals and physicians are exposed to a considerably greater amount of liability than originally anticipated under this statute.

Further, the question of the duty owed under the EMTALA has undergone revision and interpretation, and lends support to the argument that the EMTALA is a medical malpractice statute, not just a procedural statute. While the standard of care, interpreted by the *Brooks* court as requiring uniform screening procedures for every patient, appears to be completely subjective, it has several analogous elements of the objective standard of care required in state medical malpractice claims.

In traditional medical malpractice claims, a breach of duty is measured with an objective standard, comparing the actions of a physician or hospital with those of a reasonable medical person under the circumstances.<sup>151</sup> This reasonableness is proven by the requirement of expert medical testimony.<sup>152</sup> For purposes of this analysis, the standard of duty required under the EMTALA will be divided into the three obligations provided by the statute: (1) screening; (2) stabilization; and (3) transfer or discharge.<sup>153</sup>

First, the EMTALA requires that the hospital must provide "an appropriate medical screening examination within the capabilities of [its] emergency department."<sup>154</sup> This duty is subjective and has been interpreted as requiring the same screening offered to any paying patient.<sup>155</sup> Second, the EMTALA requires stabilization to prevent material deterioration with reasonable medical probability.<sup>156</sup> This stabilization is to be determined by outside expert testimony concerning the treatment given<sup>157</sup> and asks whether the medical treatment was "reasonable under the circumstances."<sup>158</sup> Finally, prior to transfer, a doctor must perform a risk-benefit analysis weighing "the medical benefits reasonably expected

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148. See *Thornton*, 895 F.2d at 1132-33.

149. See, e.g., *Collins v. DePaul Hosp.*, 963 F.2d 303, 308 (10th Cir. 1992); *Brooker v. Desert Hosp. Corp.*, 947 F.2d 412, 414 (9th Cir. 1991); *Gatewood*, 933 F.2d at 1040.

150. *Cleland*, 917 F.2d at 268-70.

151. See *Hahn v. Suburban Hosp. Ass'n, Inc.*, 461 A.2d 7, 13 (1983).

152. *Id.*

153. See generally 42 U.S.C. § 1395dd(a)-(c) (1988 & Supp. III 1991).

154. 42 U.S.C. § 1395dd(a) (1988 & Supp. III 1991).

155. *Cleland*, 917 F.2d at 268.

156. 42 U.S.C. § 1395dd(e)(4) (1988).

157. *Burditt v. United States Dep't of Health and Human Servs.*, 934 F.2d 1362, 1369 (5th Cir. 1991).

158. *Lee by Wetzel v. Alleghany Regional Hosp. Corp.*, 778 F. Supp. 900, 903 (W.D. Va. 1991) (quoting *Deberry v. Sherman Hosp. Ass'n*, 741 F. Supp. 1302, 1305 (N.D. Ill. 1990)).



from the provision of appropriate medical treatment at another medical facility" with the increased risks of transfer.<sup>159</sup> This analysis is similar to the cost-benefit analysis performed in tort cases concerning reasonable care.<sup>160</sup> The objective elements involved in determining a breach of these duties, coupled with the expansion of the availability of EMTALA claims to all patients, undermines the *Brooks* court's continued holding that the EMTALA is definitely not a federal malpractice statute.

Next, according to the *Brooks* interpretation of the statute, it would seem that there is minimal preemption of state or local law by the EMTALA.<sup>161</sup> For the EMTALA to preempt state law, either substantive or procedural, the state law must be in direct conflict with a requirement of the EMTALA.<sup>162</sup> Application of this preemption provision, and interpretations of how to apply state law, have revealed several inconsistencies. First, there are other state medical malpractice limitations which are imposed on EMTALA claims. Specifically, both state law damage caps<sup>163</sup> and state prohibitions of punitive damages have been incorporated.<sup>164</sup> In addition, a claim for severe mental anguish, as defined by state substantive law, was allowed as a "personal injury" in an EMTALA claim.<sup>165</sup> The preemption provision of the federal statute makes no differentiation between state substantive and state procedural law. In fact, certain procedural requirements, such as state statutory notice requirements, have been held not to be in direct conflict with, and therefore remain in effect during, claims under the EMTALA.<sup>166</sup> However, to respond to the argument that only state substantive law should be incorporated, a federal district court in *Davison v. Sinai Hospital of Baltimore*<sup>167</sup> found the Maryland Malpractice Act to be substantive in nature.<sup>168</sup>

This discussion leaves two unanswered questions: (1) If this is not a medical malpractice statute, why are certain medical malpractice limitations being applied?; and (2) Is the conflict between the EMTALA and the Maryland Malpractice Act really as direct as the court would have us believe? The courts have never addressed these questions. It is inherently inconsistent for the court to go out of its way to keep the EMTALA from being called a medical malpractice statute, while, at the same time, it applies certain state medical malpractice limitations.

159. 42 U.S.C. § 1395dd(c)(1) (1988 & Supp. III 1991).

160. See Metropoulos, *supra* note 145, at 276, for a discussion of Learned Hand's cost-benefit analysis of reasonable care as found in *United States v. Carrol Towing Co.*, 159 F.2d 169, 173 (2d Cir. 1947).

161. *Brooks*, 996 F.2d at 715.

162. 42 U.S.C. § 1395dd(f) (1988).

163. *Reid*, 709 F. Supp. at 855-56.

164. *Maziarka*, 1989 WL 13195 at \*2.

165. *Owens*, 741 F. Supp. at 1280.

166. *Draper v. Chiapuzio*, 755 F. Supp. 331, 333 (D. Or. 1991).

167. 462 F. Supp. 778 (D. Md. 1978) (this analysis was made for *Erie* purposes in a case of diversity jurisdiction).

168. *Id.* at 780.

Further, state-mandated arbitration does not terminate or prohibit any means of civil enforcement found in the EMTALA. It merely postpones litigation for important policy reasons. Therefore, the Maryland Malpractice Act is not in "direct conflict" with the federal statute. This "federal preemption provision may single-handedly dismantle state malpractice tort reforms that have been enacted over the last two decades."<sup>169</sup>

Finally, where required by state law, EMTALA claims should be arbitrated simply because the policy considerations favoring arbitration in these cases are the same as those supporting arbitration of state malpractice claims. There is just as great a need to prevent frivolous EMTALA claims as there is to prevent frivolous state statute-based malpractice claims. One court stated that "[d]octors and hospitals, and ultimately, their other patients, need screening protection against frivolous claims as much under the federal statute as they do for other malpractice charges."<sup>170</sup> The same damage to a physician or hospital occurs in the form of expensive litigation costs, increased malpractice insurance costs, and possible extensive damage to reputation, regardless of whether it involves a frivolous EMTALA claim or a medical malpractice claim. This, in turn, affects the policy regarding the need to reduce health care costs by reducing health care insurance costs. Finally, mandatory arbitration reduces the need for doctors and hospitals to increasingly practice defensive medicine or act conservatively in their treatment out of fear of litigious patients. If arbitration of EMTALA claims can prevent frivolous claims, reduce insurance and health care costs, and improve health care by lessening the need for doctors to practice defensive medicine, then by all means, these claims should go to arbitration.

## VI. CONCLUSION

Even though courts have succeeded in finding differences in the make-up of traditional medical malpractice statutes and the EMTALA, the results and effects of claims stemming from either are the same and are dangerous. The United States is presently seeking to overhaul a troubled health care system. Providing individuals with a means to bring suit against health care providers, while side-stepping the drawbacks of traditional suits, will open the door to more numerous and larger medical malpractice claims. Courts should stop putting forth an effort to create "obvious" distinctions, where they do not exist, and instead, send *all* medical malpractice claims to arbitration.

KAREN E. MARTIN

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169. Bitterman, *supra* note 42, at 179.

170. Wilson v. Atlanticare Medical Ctr., 868 F.2d 34, 35 (1st Cir. 1989).

