Hospital Liability—Non-Patients Have Standing to Sue Under EMTALA, Which Requires More Than Mere Inpatient Admission—*Moses v. Providence Hosp. & Med. Ctrs., Inc.*, 561 F.3d 573 (6th Cir. 2009)

Ilenna Elman Stein*

The federal Emergency Medical Treatment and Active Labor Act (EMTALA) imposes duties on any hospital that receives Medicare funding and has an emergency department. However, the statute does not definitively specify who has standing to sue and what the hospital’s full obligations are under the act.

1 Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2006). First, the hospital must screen any person seeking an assessment or treatment who arrives at the emergency department to establish whether an emergency medical condition is present. See id. § 1395dd(a). Second, if such a condition exists, the hospital must either treat and stabilize the patient’s condition within the hospital facilities or transfer the patient to another facility which can stabilize the patient’s condition. See id. § 1395dd(b). However, a hospital may not transfer a patient with an emergency medical condition unless certain conditions are satisfied, such as the patient requests a transfer in writing, the physician believes and certifies in writing that the advantages of the transfer outweigh the potential hazards, and the transfer is appropriate, as outlined in the statute. See id. § 1395dd(c).

2 See 42 U.S.C. § 1395dd(e)(3)(B) (2006); infra note 18 (discussing the definition of “stabilized” and what satisfying the term requires); see also Maria Saez, Recent Court Decision on EMTALA is Problematic for Hospitals, MICHIGAN HEALTH LAW Link, (Apr. 16, 2009), http://www.michiganhealthlawlink.com/2009/04/articles/compliance/recent-court-decision-on-emtala-is-problematic-for-hospitals/ (arguing the case-in-chief created EMTALA compliance ambiguity and expanded the scope of EMTALA). Compare § 1395dd(d)(2)(A) (providing that “[a]ny individual who suffers personal harm as a direct result of a participating hospital’s violation of a requirement of this section may [sue]”), with § 1395dd(e) (defining terms used in the statute, but not “any individual” as used in § 1395dd(d)(2)(A)), further discussed infra note 20. Further, Saez asserts that the case-in-chief was wrongly decided because the holding contradicts legislative history and intent. See Saez, supra note 2. In addition, Saez contends the holding evokes issues
the United States Court of Appeals for the Sixth Circuit considered two distinct issues of law: whether non-patients have standing to sue hospitals for EMTALA violations and the extent of a hospital's obligations if an emergency medical condition exists. The Sixth Circuit held that non-patients have standing to sue under EMTALA and that hospitals are required to determine a patient's emergency medical condition has actually been stabilized before discharging the patient; thus, a patient must be treated and not merely admitted to an inpatient unit to satisfy EMTALA's obligations.

In December of 2002, Marie Moses-Irons ("Moses-Irons") took her husband, Christopher Howard ("Howard"), to Providence Hospital and Medical Centers' ("Providence Hospital") emergency room. Howard's symptoms included, "slurred speech, disorientation, hallucinations and delusions," as well as, "severe headaches, muscle soreness, high blood pressure and vomiting." After admission to the hospital, three physicians including a psychiatrist, Dr. Paul Lessem ("Dr. Lessem"), examined Howard and determined that Howard should be transferred to the hospital's psychiatric unit for further testing and stabilization. However, the hospital discharged Howard unresolved by Congress, that to answer would effectively make EMTALA a federal malpractice statute, which it is not. See Saez, supra note 2.

In general, the court considered whether the district court's finding for summary judgment in favor of the defendants—the hospital and individual physician—was appropriate. Moreover, the court analyzed whether there was a genuine issue of material fact with regard to whether the patient had been diagnosed with an emergency medical condition and whether that condition still existed at the time of the patient's discharge. The court also briefly analyzed whether an individual practitioner can be sued under the EMTALA statute.

Howard appeared to be sick and acted in a threatening manner. In addition, Howard's behavior caused Moses-Irons to fear for her safety.

Dr. Lessem concluded Howard was not "medically stable from a mental health emergency is encompassed by the definition of emergency medical condition. Id. at 585.

Moses, 561 F.3d at 582-84. The court noted the impact of this decision stating, "[w]e recognize that our interpretation of the civil enforcement provision may have consequences for hospitals that Congress may or may not have considered or intended[.]" thus demonstrating that Congress has the power to amend the law to better reflect its intent. Id. at 581. The Sixth Circuit also ruled that summary judgment was in error against the hospital defendant but appropriate against the individual physician because a person's private right of action under EMTALA only applies to hospitals and not individual practitioners. Id. at 587-88. See also 42 U.S.C. § 1395dd (d)(2)(A) (2006). More specifically, the court held that summary judgment was in error with respect to the hospital because evidence suggested a question of fact as to whether the patient had an emergency condition upon arrival to the hospital and whether he was stabilized at the time of discharge. Moses, 561 F.3d at 585-87. The court additionally determined that a mental health emergency is encompassed by the definition of emergency medical condition. Id. at 585.
before he was transferred to the psychiatric floor as Dr. Lessem recommended. Ten days after his release from Providence Hospital, Howard murdered Moses-Irons in her sleep.

Alleging an EMTALA violation, the personal representative on behalf of Moses-Irons’ estate, the plaintiff, filed suit in federal court against both Providence Hospital and Dr. Lessem. Initially, Providence Hospital and Dr. Lessem filed a motion for summary judgment attacking the estate’s standing to sue and arguing they had satisfied their duty under EMTALA because Howard was admitted to the hospital. However, it was not until oral argument that they introduced a new theory, which suggested that EMTALA did not apply because Howard was not in fact diagnosed as having an emergency medical condition. The district court granted the motion for psychiatric standpoint,” as he was potentially suicidal, as well as suffering from “atypical psychosis” and “depression.” Therefore, Dr. Lessem determined that Howard should be transferred to the psychiatric floor of the hospital servicing “acutely mentally ill” patients.

Howard was discharged after six days, but the issue here is whether at the time of his discharge Howard was stabilized in accordance with EMTALA to support the summary judgment grant for Providence Hospital. Evidence supporting a stable condition included a progress report another physician signed stating “[a]ffect is brighter[,] [n]o physical symptoms now . . . [d]enies suicidality[,]” and Howard’s discharge papers which concluded that Howard “[could not] stay as he [was] medically stable.” However, a final diagnosis indicated Howard still suffered from “atypical psychosis [with] delusional disorder” and that Moses-Irons still feared him. Moses, 561 F.3d at 577.

Before the motion for summary judgment, Providence Hospital and Dr. Lessem filed a motion to dismiss, attacking Moses-Irons’s estate’s standing to sue under EMTALA because the decedent was not the patient seeking treatment. The judge, who did not directly rule on this issue, expressed that an injured third party was not prohibited by plain language of the statute from initiating suit. However, on their motion for summary judgment, the defendants once again raised this argument, as well as a claim that since Howard was admitted into the hospital, EMTALA compelled no further duties by the hospital. The defendants provided no evidence to support either of these allegations in the motion. Moses, 561 F.3d at 577.

An emergency medical condition is defined 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.” 42 U.S.C. § 1395dd(e)(1)(A) (2006).
summary judgment in favor of both defendants, reasoning that Providence Hospital admitted Howard, thoroughly screened him, and did not find an emergency medical condition present. Moses-Irons’ estate appealed and attached expert testimony from a psychiatrist who determined Howard should not have been discharged because he had an emergency medical condition that was not stabilized before his release. The Sixth Circuit affirmed summary judgment in favor of Dr. Lessem, agreeing with other circuit courts’ rulings. In their decision, the court found that the difference between the language of the government enforcement and the civil enforcement provisions indicate that EMTALA was not intended to be imposed in private actions against individual practitioners in violation of the statute’s provisions. However, the court reversed and remanded the summary judgment as to Providence Hospital, concluding that upon determining an emergency medical condition existed, Providence Hospital first had to treat Howard and establish he was stable before releasing him; merely admitting him to an inpatient unit was insufficient to meet the EMTALA requirement.

14 Moses, 561 F.3d at 577-78. Given the district court’s finding and reasoning that EMTALA did not appear violated, dismissing the claim and granting the motion seemed appropriate. Id. at 578.
15 Id. at 578. Moses-Irons’s estate representative contended that she did not have adequate warning of Providence Hospital and Dr. Lessem’s new argument introduced at the oral argument. Id. Had she known, the estate representative would have introduced into evidence the aforementioned expert report. Id.
16 Moses, 561 F.3d at 587-88. The Sixth Circuit considered the issue of whether EMTALA applies against individuals for the first time in this case, though other circuit courts have previously established that it does not apply. Id. at 587. See e.g., Eberhardt v. City of Los Angeles, 62 F.3d 1253, 1257 (9th Cir. 1995); King v. Ahrens, 16 F.3d 265, 271 (8th Cir. 1994); Delaney v. Cade, 986 F.2d 387, 393-93 (10th Cir. 1993); Baber v. Hosp. Corp. of America, 977 F.2d 872, 877 (4th Cir. 1992) (all holding that EMTALA claims do not apply against individual physicians).
17 The Sixth Circuit reasoned that the government enforcement provision specifically states that action may be brought against “any physician,” whereas the civil enforcement provision only mentions private action against hospitals. Moses, 561 F.3d at 587 (citing 42 U.S.C. § 1395dd(d)(1)(B) (2006); 42 U.S.C. § 1395dd(d)(2)(A) (2006)). The Court determined the distinction must have been intentional, which legislative history supported as well. Moses, 561 F.3d at 587 (citing H.R. REP. NO. 99-241, pt. 1, at 132).
18 Moses, 561 F.3d at 583-88. “Stabilized,” as statutorily defined, means “that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.” 42 U.S.C. § 1395dd(e)(3)(B) (2006). Additionally, the term “transfer” “means the movement (including the discharge) of an individual outside a hospital’s facilities.” Id. at § 1395dd(e)(4). As such, the Sixth Circuit held that merely admitting a patient is insufficient to satisfy the stabilization requirement. Moses, 561 F.3d at 583. But, to reach this conclusion, the court rejected the Centers for Medicare and Medicaid’s (“CMS”) federal regulation, which describes the necessary treatment required to stabilize a patient in a medical emergency. Provider Agreements and Supplier Approval, 42 C.F.R. § 489.24(d)(1)(i)-(ii) (2009). The exception to the provision states that stabilization is not necessary and obligations are met “with respect to [a] patient” if a patient is screened, determined to have
Congress passed EMTALA, commonly referred to as the “Anti-Dumping Act,” because it was concerned with the rising number of hospitals denying uninsured patients treatment due to the patients’ inability to pay for services. EMTALA provides a private right of action for “any individual,” yet the term “any individual” is not defined in the statute. Nonetheless, federal circuit courts have understood EMTALA as applying to all patients, not just uninsured patients, who present themselves to an emergency department of a qualifying hospital seeking treatment of an emergency condition. As EMTALA was not intended to be a federal malpractice statute, many
federal appellate court cases specifically distinguish EMTALA claims from state malpractice claims. However, like malpractice claims, EMTALA claims also require the plaintiff to prove proximate cause between the hospital’s failure to detect and stabilize an emergency condition and the direct personal harm the individual bringing the suit suffered.

held the closer hospital may nonetheless be liable for violating EMTALA because “com[ing] to the emergency department” is interpreted as including traveling to any hospital property. Id. at 1070-72. Further, hospital emergency staff members are not permitted to refuse patients who are traveling to the hospital, but for a few exceptions not claimed as defenses here, so the court reversed and remanded the district court’s dismissal of the EMTALA claim based on lack of physical presence at the hospital. Id. at 1069, 1072-74. See also Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 270 (6th Cir. 1990) infra notes 22 and 33, (determining, in regard to whether EMTALA only applies to the uninsured, “[t]he words of the statute on basic eligibility are quite plain, and interpreting them as such does not lead to an absurd result”).

22 See Cleland, 917 F.2d at 268 (discussing that EMTALA was not intended to be a federal malpractice statute). Additionally, the Cleland court explained that § 1395dd(f) specifically states EMTALA does not preempt state laws, such as malpractice laws. Id. at 270. See also Bryant v. Adventist Health Sys./W., 289 F.3d 1162, 1166 (9th Cir. 2002) (holding hospital’s failure to detect condition does not violate EMTALA; state malpractice law remedies available). Specifically, the patient had an abscess on his lung, but the hospital did not identify it, only diagnosed him with pneumonia and asthma, and released the patient because he appeared stable, though he later died. Id. at 1164. However, the court held that since EMTALA is not intended as a malpractice statute, a hospital cannot be liable under EMTALA for its negligent failure to detect a condition. Id. at 1166. Other common EMTALA issues include establishing what constitutes a violation of the “appropriate medical screening” provision, and determining the sufficiency of evidence necessary to demonstrate a violation of the stabilization provision. See e.g., Repp v. Anadarko Mun. Hosp., 43 F.3d 519, 522 (10th Cir. 1994) (finding hospital must follow its internal screening provisions to avoid violation of EMTALA screening clause); Green v. Touro Infirmary, 992 F.2d 537, 537 (5th Cir. 1993) (affirming summary judgment because insufficient evidence to prove hospital violated EMTALA by inappropriately stabilizing patient).

23 42 U.S.C. § 1395dd(d)(2)(A) (2006) (defining a private right of action for, “[a]ny individual who suffers personal harm as a direct result of a participating hospital’s violation of a requirement”) (emphasis added). See generally Medcalf v. Wash. Heights Condo. Ass’n, Inc., 747 A.2d 532, 535-36 (2000) (holding the nature of one’s injury must be within scope of foreseeable risk created by defendant’s negligence); Palsgraf v. Long Island R.R. Co., 162 N.E. 99, 101(1928) (establishing a plaintiff must be within the class of people to whom a duty is owed). As such, the plaintiff’s injury would be within the scope of foreseeable risk. Palsgraf, 162 N.E. at 101; see also Why Judges Matter, Part 2, THE WIZARD OF LAWS, (Apr. 8, 2009), http://wizardoflaws.blogspot.com/2009/04/why-judges-matter-part-2.html (arguing Howard’s psychiatric diagnosis was not related to his murdering Moses-Irons). Further, the WIZARD OF LAWS blogger contends that the case-in-chief was wrongly decided because of this proximate cause issue. Id. Consequentially, he maintains that the decision will result in overall increased health care costs, higher health insurance premiums, and limited availability of hospital beds since hospitals will be reluctant to discharge patients. Id.
While federal appellate courts have not contemplated the issue of whether non-patients have standing to sue under EMTALA, federal district courts have considered it. In *Zeigler v. Elmore County Health Care Auth.*, the mother of a baby who was denied a medical screening upon arrival at an emergency department sued the hospital in her individual capacity (as well as in her representative capacity) for an EMTALA violation. The court held that the term "any individual" referenced in the EMTALA right of action provision, refers to the right to action by patients, thus precluding the mother's suit in her individual capacity. Similarly, in *Malave Sastre v. Hosp. Doctor's Ctr., Inc.*, the patient was severely injured in a car accident and received inappropriate emergency care at the hospital she went to, resulting in the patient, her husband, and her daughter all filing EMTALA claims. Like in *Zeigler*, the court in *Malave Sastre* analyzed

24 Lori Greene, *Sixth Circuit Rules Third Parties May Sue For Damages Under EMTALA*, KING & SPALDING HEALTH HEADLINES, (Apr. 13, 2009), http://www.kslaw.com/portal/server.pt?space=KSPublicRedirect&control=KSPublicRedirect&PublicationId=1910. The closest federal appellate case analyzing the issue of a third party's standing to sue under EMTALA, though still distinguishable, is *Correa v. Hosp. San Francisco*. 69 F.3d 1184 (1st Cir. 1995). Here, the deceased patient's son brought the patient, suffering chest pains, dizziness, and chills, to the emergency room, but he left once his sister, the patient's daughter, arrived to relieve him. *Id.* at 1188-89. The son and daughter, along with the patient's other children and grandchildren, brought the EMTALA claim for inappropriate lengthy screening and transfer procedures causing their mother's death. *Id.* at 1189. The court affirmed that close relatives have standing to sue under EMTALA on behalf of a deceased patient, as well as recover for their pain and suffering on a loss of consortium basis. *Id.* at 1195-97. The court explained that it is reasonable for the EMTALA right of action "any individual" language to be interpreted as naturally extending to someone with a special, close relationship with the patient who suffered direct harm from an EMTALA violation. 69 F.3d at 1196. Additionally, it seems that while the defendant in this case opposed the plaintiff's relatives' standing to sue, the defendant did not do so in a timely manner, so the First Circuit determined that the defendant waived the right to object. *Id.* at 1195-97.

25 *Zeigler v. Elmore County Health Care Auth.*, 56 F. Supp. 2d 1324, 1324-26 (M.D. Ala. 1999). One of the issues before the court was the defendant's motion for summary judgment on the ground that the mother had no standing to sue in an individual capacity. *Id.* The court analyzed the legislative history, which suggested that Congressional intent was that only individual patients with an emergency condition could bring private action. *Id.* at 1326-27.

26 *Id.* at 1326-27. The court reasoned that the plain language of the statute is consistent with such an interpretation, for the "any individual" who arrives at the emergency department seeking a screening or treatment, is the same "any individual" who has standing to sue. *Id.* at 1327. Therefore, the court granted the defendant's motion for summary judgment on the issue of the mother's individual capacity to sue, but not on the issue of the mother's representative capacity to bring an EMTALA claim. *Id.* at 1328.

27 *Malave Sastre v. Hosp. Doctor's Ctr., Inc.*, 93 F. Supp. 2d 105, 106 (D.P.R. 2000). More specifically, the patient, whose injury affected her right leg, arrived at the emergency department at 1:15pm, where she received an x-ray on her uninjured left leg; had an improperly constructed
the legislative history and held that only patients, not their relatives, have standing to sue for EMTALA violations. In addition to statutory standing to sue, a plaintiff must have a constitutional standing to sue; the United States Supreme Court’s interpretation of Article III of the U.S. Constitution requires that the plaintiff:

(1) [have] suffered an ‘injury in fact’ that is (a) concrete and particularized and (b) actual or imminent, not conjectural or hypothetical; (2) the injury is fairly traceable to the challenged action of the defendant; and (3) it is likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision.

Various circuits have ruled differently as to whether EMTALA’s stabilization provision applies only to patients with emergency conditions who present themselves in the emergency department or patients who arrive anywhere in the hospital. For cast put on, resulting in permanent disfigurement and loss of movement; and was still waiting to see an orthopedic surgeon eight hours later at 9:30pm. Id. at 106-07.

Id. at 111. The court accepted the defendant hospital’s argument that the terms “individual” and “direct,” as used within the EMTALA private right of action provision should be interpreted as only giving the patient a right of action. Id. Additionally, the court considered the holding of Correa, discussed supra note 24, but distinguished the facts and the scope of the holding of that case because the patient was deceased, whereas in Malave Sastre, the patient was alive. Id. Ultimately, the court granted the defendant’s motion for summary judgment on the patient’s husband and daughter’s EMTALA claims. Id.

U.S. Const. art. III, § 2 (“The judicial power shall extend to all cases, in law and equity, arising under this Constitution, the laws of the United States, and treaties made, or which shall be made, under their authority . . .”); Loren v. Blue Cross & Blue Shield of Mich., 505 F.3d 598, 606-07 (6th Cir. 2007) (quoting Friends of the Earth, Inc. v. Laidlaw Envtl. Servs., 528 U.S. 167, 180-81 (2000)). Though distinguishable from Moses, because it involved a breach of a fiduciary duty claim under the Employee Retirement Income Security Act (ERISA), the Loren case also dealt with the issue of third party standing. Loren, 505 F.3d at 603. There, the plaintiffs withdrew from coverage under their ERISA administered health insurance plans after their claim was filed, so the defendants argued that the plaintiffs lacked standing because, “they [were] not participants in, or beneficiaries of, an ERISA plan[.]” Id. at 602-03. Regarding the plaintiffs claim seeking monetary relief, the Sixth Circuit agreed with the defendants and affirmed the district court’s order to dismiss because the plaintiffs injury was too hypothetical, so they failed to establish Article III standing. Id. at 607-09.

For an illustration of the circuit split, see generally Vickers v. Nash Gen. Hosp. 78 F.3d 139 (4th Cir. 1996); Miller v. Med. Ctr. of S.W. La., 22 F.3d 626 (5th Cir. 1994) (establishing patients must arrive at emergency room with emergency condition to trigger EMTALA stabilization duties); cf. Lopez-Soto v. Hawayek, 175 F.3d 170 (1st Cir. 1999); Urban v. King, 43 F.3d 523 (10th Cir. 1994) (holding patients need not specifically arrive in emergency room with emergency condition to trigger EMTALA stabilization duties). The reasoning accounting for the difference in opinion depends on whether the requirements set out in section 1395dd(a) (“an individual . . . comes to
instance, in *Thornton v. Sw. Detroit Hosp.*, the Sixth Circuit Court of Appeals previously determined that although emergency care is frequently initiated in the emergency department, a hospital must continue to give emergency care until a patient's condition has been stabilized whether or not the patient remains in the emergency room. In contrast, the Fourth Circuit Court of Appeals has held that once a patient has been admitted to an inpatient unit, the hospital can no longer be liable under EMTALA for failure to stabilize, since it is unreasonable to expect a hospital to provide indefinite

the emergency department” requires screening) and in section 1395dd(b) (“an individual . . . comes to a hospital” requires treatment and stabilization or to be transferred) should be read conjunctively or disjunctively. Lopez-Soto v. Hawayek, 988 F. Supp. 41, 44-46 (D.P.R. 1997). To be afforded protection of stabilization before discharge or transfer under EMTALA, the above distinction in analysis affects where patients with an emergency medical condition must arrive: the emergency department specifically, if a conjunctive interpretation; or the hospital in general, if a disjunctive interpretation. See id. See also *Mazurkiewicz v. Doylestown Hosp.*, 305 F. Supp. 2d 437, 443-48 (E.D. Pa 2004). In *Mazurkiewicz*, the court looked at the rulings of the Fourth, Ninth, and Eleventh Circuits, which established that the EMTALA stabilization provision only applies to the emergency department, so a hospital that admits patients to an inpatient unit cannot be liable under EMTALA because it has met its duty. Id. The court compared those interpretations with the holdings of the First and the Sixth Circuits, which ruled that patient dumping is not limited to the emergency department so neither is EMTALA’s stabilization provision. Id. The court then synthesized a rule for the Third Circuit District Court that unless a patient’s admission to an inpatient unit is a marked, pre-textual effort to evade the EMTALA requirement, it constitutes a defense. Id. In *Mazurkiewicz*, the plaintiff was admitted and treated for a diagnosis of a “Parapharyngeal Abscess,” though the physician insists that the patient did not actually have an abscess during his hospitalization. Id. at 349. Rather, the physician was concerned that the patient would develop an abscess and wanted him hospitalized to monitor his condition. Id. Five days later the patient was discharged, experienced worsening symptoms, and presented himself at the emergency department of a different hospital, where the physicians detected an abscess and performed surgery. *Mazurkiewicz*, 305 F. Supp. 2d at 440-41. However, the court dismissed the patient’s EMTALA claim because it held there was no evidence that the first hospital admitted the patient as a pre-textual effort to evade EMTALA liability. Id. at 447-48.

31 *Thornton v. Sw. Detroit Hosp.*, 895 F.2d 1131, 1134 (6th Cir. 1990). The issue presented in *Thornton* was whether by discharging the patient plaintiff prior to the stabilization of her condition, the defendant hospital thus violated EMTALA. Id. Here, the Sixth Circuit held that the particular patient, a woman who had a stroke and was discharged after twenty-one days in the hospital only to deteriorate in condition thus requiring admission to a rehabilitation hospital, presented no dispute of material fact regarding her stabilization to survive summary judgment. Id. at 1132, 1135. Nonetheless, the rule that it is irrelevant where in the hospital the stabilization occurs, as long as the patient is stabilized before being released, is good law. Id. at 1135. Furthermore, this case is often cited for its analysis of a federal court’s subject matter jurisdiction over EMTALA claims, given that the statute itself is silent regarding whether suits may be brought in federal court. Id. at 1133.
Moreover, in *Cleland v. Bronson Health Care Group, Inc.*, the Sixth Circuit Court of Appeals also previously held that if the emergency medical condition is unknown to the hospital, or wrongly diagnosed, then the hospital cannot be liable under EMTALA for failure to stabilize a patient’s condition.

In *Moses*, the court considered the holdings of *Zeigler v. Elmore Health Care Auth.* and *Malave Sastre v. Hosp. Doctors Ctr., Inc.* in analyzing whether Moses-Irons’s estate had standing to sue Providence Hospital under EMTALA given that Moses-Irons was not the patient. However, the court rejected the holdings of both cases. The court distinguished these cases, where relatives of the harmed patient sued in their individual capacities, from *Moses*, where the estate of a person directly harmed, though not the patient, sued. Instead the court used the cannons of interpretation and looked to the

---

32 Bryan v. Rectors & Visitors of Univ. of Va., 95 F.3d 349, 351 (4th Cir. 1996). In *Bryan*, the case was initiated because a woman died upon the failure of physicians to stabilize a life threatening episode that she developed while already hospitalized for her original emergency respiratory distress. *Id.* at 350. The court explained that upon meeting the legislative goal of requiring hospitals to treat and stabilize patients, rather than “dumping” them, the hospital and its practitioners then become liable for a patient’s care under state malpractice laws, not EMTALA. *Id.* at 351. As such, a hospital cannot merely treat a patient temporarily before discharging the patient, if the patient is not ready for release, because the hospital may face malpractice and tort claims. *Id.*

33 *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (6th Cir. 1990). The *Cleland* court went on to describe how this new rule is consistent with the *Thornton* rule, for only once the patient’s emergency medical condition is discovered does the hospital owe the patient a duty to stabilize the condition; if the condition is never detected, the hospital owes the patient no duty. *Id.* Additionally, the court expressed that the meaning of stabilize, within the EMTALA statute, was not meant to provide a promise regarding the result of care. *Id.* See, e.g., *Roberts v. Galen of Va.*, Inc., 325 F.3d 776, 786 (6th Cir. 2003) (affirming *Cleland* and holding actual knowledge of emergency condition is required for hospital EMTALA liability); *Bryant v. Adventist Health Sys./W.*, 289 F.3d 1162, 1164-65, 1170 (9th Cir. 2002) (holding hospital did not violate EMTALA stabilization provision because patient’s misdiagnosis led to undetected emergency condition).


35 *Id.* at 581. Since neither case is binding on this court, as both are district court opinions from other circuits, it is not particularly controversial that the Sixth Circuit Appellate Court did not follow their holdings. *Id.* Additionally, the court noted that no other federal court of appeals, that it knew of, had considered this question, so no cases directly on point existed for reference. *Id.*

36 *Id.* at 581. Unlike in *Correa v. Hosp. San Francisco*, where the estate of a deceased patient initiated
plain meaning of the statute, which states "any individual who suffers personal harm as a direct result of a participating hospital's violation" has a right of action under EMTALA.\(^3\)

Therefore, the court held that because Moses-Irons suffered personal harm as a direct result of Providence Hospital's EMTALA violation, the broad verbiage of the statute applied and her estate had the appropriate standing to sue.\(^3\)

In analyzing the issue of what a hospital is obligated to do upon determining a patient has an emergency medical condition, the court again first looked to the plain

the suit, in this case, Moses-Irons was not a patient, so had the court considered Correa, it probably would have similarly distinguished it. 69 F.3d 1184, 1185 (1st Cir. 1995). Nonetheless, the Correa court's reasoning that a right of action exists for people with a special, close relationship with the patient who suffered direct harm from an EMTALA violation, expanded EMTALA's right of action grant as well. \(\text{Id.}\) at 1196. This reasoning is consistent with the United States Supreme Court test explained in Friends of the Earth, Inc. v. Laidlaw Env'l Servs., stating that in order to have standing to sue, a plaintiff must have suffered an "injury in fact." 528 U.S. 167, 180-81 (2000). See supra text accompanying note 29 (describing the requirements to establish constitutional standing to sue).

\(^3\) 42 U.S.C. § 1395dd(d)(2)(A) (2006) (emphasis added); Moses, 561 F.3d at 580-82. Based on the plain meaning of the very broad language ("any individual") used on the face of the statute, the Moses-Irons's estate appeared to be included. Moses, 561 F.3d at 580. However, because no section of the statute even references non-patients, Providence Hospital and Dr. Lessem argued that "any individual" is meant to only be applied to the individual who "comes to the emergency department" and the individual who "comes to a hospital" in the screening and stabilization provisions respectively. \(\text{Id.}\) But the court rejected these interpretations for two reasons: first, the "individual" in each provision is not the same, so Congress must not have meant for the statute to only apply to the same "individual" throughout; and second, because Congress specifically limited the group to whom the EMTALA duty is owed, the broad language in the enforcement provision must have been intentional. \(\text{Id.}\) Additionally, Providence Hospital and Dr. Lessem relied on legislative history to show that the statutory amendments suggest that recovery under EMTALA was designed to allow a right of recovery solely for individual patients harmed by violations. \(\text{Id.}\) at 581. However, the court rejected this too, explaining that where the plain meaning of the written language and the legislative history conflict, the court must interpret the statute according to the plain meaning, so as not to encourage unrepresentative members or unelected staffers from manipulating interpretations of statutory text in accordance with their unachieved goals. \(\text{Id.}\) Moreover, the court noted that it was unnecessary to look to legislative history since the plain meaning of the language is unambiguous. \(\text{Id.}\)

\(^3\) Moses, 561 F.3d at 581-82 (indicating the breadth of EMTALA’s enforcement provision, “[u]nfortunately . . . Congress wrote a statute that plainly has no such limitation on its coverage” (quoting Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 269 (6th Cir. 1990))). In Cleland, the hospital defendant argued that only the uninsured can initiate a suit under EMTALA, but that argument was rejected for the above given reason. \(\text{Id.}\) at 581-82. This also applies to Providence Hospital and Dr. Lessem’s argument here that only patients have standing to sue under EMTALA. \(\text{Id.}\)
language of the statute. To further explain how the court read the statute, and to reject Providence Hospital’s contentions that because it admitted Howard for six days, it satisfied the stabilization duty owed under EMTALA, the court relied on Thornton v. Sw. Detroit Hosp. The court also rejected Providence Hospital’s alternative argument that its EMTALA interpretation was consistent with CMS regulations regarding the requirements of stabilizing a patient with an emergency medical condition. Accordingly, the court held that to satisfy the EMTALA requirements upon discovering a patient’s emergency medical condition, more than merely admitting a patient to the hospital is involved; rather, a hospital must in fact treat the patient until the patient’s emergency medical condition has been stabilized.

39 Id. at 582. The EMTALA statute instructs that a person with an emergency medical condition must be afforded “treatment as may be required to stabilize the medical condition.” 42 U.S.C. § 1395dd(b)(1)(A) (2006). The statute explains that a patient is “stabilized” when “no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.” 42 U.S.C. § 1395dd(e)(3)(B) (2006). It also mandates that an individual with an emergency medical condition cannot be transferred unless the condition is first stabilized. 42 U.S.C. § 1395dd(c)(1) (2006). Additionally, the definition of “transfer” includes discharging a patient from the hospital facility. 42 U.S.C. § 1395dd(e)(4) (2006). As such, the court interpreted the above language as requiring a hospital to treat a patient to prevent material deterioration of the condition by providing more care than merely admitting the patient and then releasing the patient. Moses, 561 F.3d at 582.

40 Moses, 561 F.3d at 582 (“[E]mergency care does not always stop when a patient is wheeled from the emergency room into the main hospital... Emergency care must be given until the patient’s emergency medical condition is stabilized” (quoting Thornton v. Sw. Detroit Hosp., 895 F.2d 1131,1135 (6th Cir. 1990))).

41 Moses, 561 F.3d at 583. Providence Hospital and Dr. Lessem argued that by admitting Howard, their treatment falls into the exception provision of the Centers for Medicare and Medicaid (“CMS”) regulation. Id. The exception states that if in good faith a hospital admits a patient, who was screened and discovered to have an emergency medical condition, the hospital has satisfied the stabilization requirements. Provider Agreements and Supplier Approval, 42 C.F.R. § 489.24(d)(2)(i) (2009). However, the court rejected the constrictive CMS analysis because it was inconsistent with the clear legislative intent. Moses, 561 F.3d at 583. The court wrote “it is unreasonable to believe that ‘treatment as may be required to stabilize’ could mean simply admitting the patient and nothing further.” Id. Thus, the court concluded that a hospital must first determine that a patient’s condition has actually been stabilized before discharging the patient, and the court indicated that merely admitting a patient is not enough to meet the EMTALA requirement. Id. Thus, the court found the CMS regulation to be inconsistent with the legislative intent and did not use it to interpret the statute. Id. Nonetheless, the CMS regulation would still not apply to this case even if it was “somehow deemed consistent with the statute” because there is presumption against retroactivity. Id. at 583-84.

42 Moses, 561 F.3d at 582-84. Furthermore, a question of fact exists as to whether Providence Hospital satisfied this obligation, but considering Providence Hospital merely admitted Howard to an inpatient unit, it was not automatically entitled a summary judgment grant. Id. at 584.
The court correctly decided the issue of who has standing to sue under EMTALA. Because this was an issue of first impression on the federal appellate level, the court's ruling on this issue is vulnerable to criticism from those who view it as significantly expanding EMTALA liability or creating ambiguity as to EMTALA's meaning. Critics will feel that the proximate cause of Moses-Irons's death is too indirect or remote in time to be within the scope of foreseeable risk created by Providence Hospital's negligence in releasing Howard prior to stabilization. Others may merely argue that the holding is contrary to legislative intent, which was narrowly designed to give uninsured patients a right of action. However, the court understood the marked change its interpretation represented and signaled Congress to amend the law as it deems necessary to clarify their original intent.

With no applicable precedent to rely on to resolve the issue of who has standing to sue under EMTALA, the court sought to interpret the text of the statute, which perhaps despite legislative intent, or the desire of hospitals, plainly grants a right of action to "any individual who suffers personal harm as a direct result of a . . . hospital's

---

43 Id. at 582-84.
44 See Saez, supra note 2 (arguing that Moses was wrongly decided and created compliance ambiguity); Why Judges Matter, Part 2, supra note 23 (asserting negative effects of the Moses decision will include increased health care costs, raised insurance premiums, and decreased hospital bed availability); see also 42 U.S.C. § 1395dd(d)(2)(A) (2006) (defining a private right of action under EMTALA); Bryan v. Rectors & Visitors of Univ. of Va., 95 F.3d 349, 351 (4th Cir. 1996) (discussing that EMTALA was not intended as a federal malpractice statute).
45 See Why Judges Matter, Part 2, supra note 23 (arguing Howard's diagnosis and crime were unrelated). However, this simply highlights the importance of characterizing foreseeable risk, and here, Congress clearly characterized the nature of the injury (direct harm to an individual) and the class of people to whom a duty is owed (any individual) as within the scope of foreseeable risk of an EMTALA violation. See 42 U.S.C. § 1395dd(d)(2)(A) (2006); Medcalf v. Wash. Heights Condo. Ass'n, Inc., 747 A.2d 532 (2000); Palsgraf v. Long Island R.R. Co., 162 N.E. 99 (1928). Further, the way in which the injury occurs is irrelevant if the nature of the injury is within the scope of foreseeable risk. See supra note 23. Therefore, the way in which a patient could cause direct harm to "any individual" is irrelevant, as long as direct harm is a foreseeable risk of a hospital discharging a non-stabilized, psychiatric patient. See 42 U.S.C. § 1395dd(d)(2)(A) (2006).
46 See Saez, supra note 2 (contending the Moses decision is contrary to both legislative history and intent); see also H.R. REP. NO. 241(I), supra note 19 (describing the goals of EMTALA). Although Congress originally passed EMTALA with the uninsured in mind, the statute nonetheless applies to all patients because EMTALA does not limit its application only to uninsured patients. See H.R. REP. NO. 241(I), supra note 19. Likewise, the fact that the civil enforcement right is broadened to literally include "any individual" cannot be undermined by the argument that EMTALA's legislative intent only had patients in mind. See H.R. REP. NO. 241(I), supra note 19.
47 Moses, 561 F.3d at 581-84. See supra notes 5 and 38 (quoting the court's cues to Congress to amend EMTALA if the Moses interpretation is inconsistent with Congressional intent).
violation." Also, it is hard to not be persuaded by the facts of this case, which perfectly fit into the EMTALA enforcement provision, as Moses-Irons (constituting any individual) suffered personal harm (death) as a direct result of Providence Hospital’s failure to stabilize Howard’s psychiatric condition prior to discharging him. Moreover, the Sixth Circuit’s holding seems to be a logical extension of a First Circuit ruling, which had previously broadened the EMTALA right of action to allow recovery for someone other than the direct person harmed. The significance and effect of the Moses v. Providence Hosp. & Med. Ctrs., Inc. holding regarding standing to sue is that hospitals may be subject to increased liability, but such liability is nonetheless limited by the EMTALA provisions as well as case law. Thus, even if there is an increase in lawsuits, liability for

48 See 42 U.S.C. § 1395dd(d)(2)(A) (2006)(emphasis added); see also supra note 37 (discussing the court’s reasoning). While no binding precedent existed, it is worth noting that the district judge who granted the summary judgment motion first denied a motion to dismiss, reasoning that a non-patient is not precluded from suing based on the language of the statute. Moses, 561 F.3d at 577-78, 581.

49 See 42 U.S.C. § 1395dd(d)(2)(A) (2006); Moses, 561 F.3d at 576-77. Again, critics may argue a murder ten days later is not a direct result of an EMTALA violation; however, Congress specifically characterized “any individual who suffers personal harm as a direct result of [an EMTALA] violation.” 42 U.S.C. § 1395dd(d)(2)(A) (2006) (emphasis added). See Why Judges Matter, Part 2, supra note 23. Certainly, an injury less than death would satisfy the harm requirement, and the statute contains no provision regarding a time constraint for an injury to be considered a direct result of an EMTALA violation. 42 U.S.C. § 1395dd(d)(2)(A) (2006). But see Eberhardt v. City of Los Angeles, 62 F.3d 1253, 1257 (9th Cir. 1995), summarized supra note 19 (discussing district court did not reach causation issue regarding delay in time since sufficient evidence was lacking). In addition, Moses-Irons established Article III standing to sue because the facts show she satisfied each element necessary to establish an “injury in fact.” Friends of the Earth, Inc. v. Laidlaw Envtl. Servs., 528 U.S. 167, 180-181 (2000). Moses-Irons’s death certainly constitutes a “(a) concrete and particularized and (b) actual . . . not conjectural or hypothetical” injury. Id. In other words, Moses-Irons suffered a harm that was actual and genuine, as opposed to an imagined or non-existent. Id. Further, but for Providence Hospital’s EMTALA violation, Moses-Irons would not have died, thus making her “injury . . . traceable to the challenged action of the defendant.” Id. Lastly, a favorable decision would actually, “as opposed to merely speculative[ly],” compensate her estate for her death. Id.

50 Correa v. Hosp. San Francisco, 69 F.3d 1184, 1195-97 (1st Cir. 1995). See supra notes 24, 28 and 36. Arguably, the Moses holding is actually less expansive than the Correa holding because in Moses, the right of recovery was still awarded to the individual who suffered direct harm, as opposed to a person bringing a derivative claim. Moses, 561 F.3d at 582.

51 See supra notes 20, 26 and 28. EMTALA, when read in whole, provides that the cause of harm to the plaintiff must result from the hospital failing to stabilize a patient’s emergency condition prior to discharge or transfer. 42 U.S.C. § 1395dd (2006). Moreover, case law has established that only the individual injured, as opposed to family members suing in individual capacities, may bring EMTALA claims. See supra notes 26 and 28. Note that in Zeigler v. Elmore Health Care Auth. and Malave Sastre v. Hosp. Doctors Cr, Inc., the right of action was limited to patients only, but even if those jurisdictions were to adopt the Sixth Circuit’s standing interpretation, the rules
harm to individuals other than the patient will only apply in specific circumstances where a hospital’s violation of its statutory duty caused personal and direct harm.\textsuperscript{52}

While not as controversial given the various jurisdictional interpretations, though still somewhat contentious for rejecting the CMS regulations, the court’s holding that the EMTALA stabilization requirement is not limited to the emergency department may seem especially onerous when coupled with the holding expanding who has standing to sue.\textsuperscript{53} However, the court’s progression in reasoning on this issue is logical.\textsuperscript{54} The Sixth Circuit’s holding followed their prior decision in Thornton v. Sw. Detroit Hosp. and was consistent with its ruling in Cleland v. Bronson Health Care Group, Inc.\textsuperscript{55} Thus, its most recent decision in Moses is not as radical as some may claim, and is consistent with previous Sixth Circuit Court of Appeals’ rulings.\textsuperscript{56} The effect of requiring hospitals to stabilize patients with emergency conditions is that hospitals must actually treat patients with emergency medical conditions; merely admitting patients is inadequate to satisfy the obligations EMTALA imposes.\textsuperscript{57}

promulgated in these cases would not be inconsistent with allowing a non-patient to sue. See supra notes 26 and 28. The reason the holdings are compatible is that the injured patients’ family members who were not themselves personally directly harmed brought the EMTALA claims in Zeigler and Malave Sastre, so they would still lack statutory standing under the Sixth Circuit’s interpretation because EMTALA requires an individual suffer personal harm. See supra note 20.\textsuperscript{52} See supra notes 46, 49 and accompanying text.\textsuperscript{53} See supra notes 39-41 and text accompanying note 42.\textsuperscript{54} See supra notes 37 and 41.\textsuperscript{55} See Thornton v. Sw. Detroit Hosp., 895 F.2d 1131, 1135 (6th Cir. 1990); Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 271 (6th Cir. 1990); see also supra notes 31, 33 and accompanying text. While some courts have held that admitting a patient in good faith to an inpatient unit acts as a defense to EMTALA liability because at that point state malpractice laws kick in, that has never been the interpretation of the Sixth Circuit. See Mazurkiewicz v. Doylestown Hosp., 305 F. Supp. 2d 437, 447-48 (E.D. Pa 2004); see also supra notes 30 and 32. Thus the holding in Moses is not surprising. See supra text accompanying note 31.\textsuperscript{56} See Thornton, 895 F.2d at 1135; Cleland, 917 F.2d at 271 (establishing prior Sixth Circuit holdings). But see Saez, supra note 2; Why Judges Matter, Part 2, supra note 23 (criticizing the Moses decision).\textsuperscript{57} See supra note 42 and accompanying text; see also supra note 30 (examining the circuit split where in a hospital a patient must arrive before a hospital is required to stabilize the patient). Note that the discussion regarding where in a hospital a patient must arrive is related to the court’s holding that a patient with an emergency condition must be treated prior to discharge because the standard of when the stabilization requirement is triggered is currently jurisdictional. See supra note 30. As such, some circuits have held that the EMTALA stabilization provision only applies when a patient arrives to the emergency room, so EMTALA is satisfied if the patient is admitted to an inpatient unit. See also supra note 30. However, in the holding here, the Moses court is clarifying what the standard is within the Sixth Circuit, and the significance is that hospitals cannot evade the EMTALA stabilization requirement by merely admitting patients to an inpatient
In *Moses v. Providence Hosp. & Med. Ctrs., Inc.*, the court considered whether a non-patient has standing to sue under EMTALA and what a hospital’s obligations are upon discovering an emergency medical condition. The court held that any individual, including non-patients, who suffered direct personal harm from a hospital's violation of the EMTALA provisions, has standing to sue. Additionally, the court ruled that the requirement to stabilize a patient’s condition before discharging or transferring the patient is not satisfied by merely admitting a patient to an inpatient unit and then releasing the patient. Rather, appropriate treatment must be rendered such that the patient's condition has actually been stabilized prior to discharge, regardless of whether treatment occurs in the emergency department or elsewhere in the hospital. Though susceptible to criticism for expanding the law and creating compliance ambiguity, the court appropriately and logically looked to the plain language of the EMTALA statute where no cases on point existed regarding standing, as well as ruled according to precedent on the issue of stabilization. With precedent now established, other appellate courts should feel comfortable following the Sixth Circuit's lead in ruling that injured non-patients have standing to sue, particularly in cases like *Moses* where the facts precisely fit the plain language and meaning of EMTALA.

---

58 See supra text accompanying note 4.
59 See supra text accompanying notes 5 and 37.
60 See supra notes 5, 18, 42 and accompanying text.
61 See supra notes 18, 39, 40 and accompanying text.
63 See supra note 49 and accompanying text.