Examining The Impacts Of Current Malpractice Frameworks And EMTALA on Emergency Medicine

Sai Balasubramanian*
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Abstract

Emergency medicine is a relatively new medical specialty, and has gained popularity in the last decade for both its irreplaceable role in the healthcare system, as well as the numerous social, legal, and administrative developments that have emerged as a result of the field’s exponential growth.1 Emergency medicine is defined by the American College of Emergency Physicians (“ACEP”) as “the medical specialty dedicated to the diagnosis and treatment of unforeseen illness or injury.”

KEYWORDS: medicine, emergency, examining
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## I. Introduction

Emergency medicine is a relatively new medical specialty, and has gained popularity in the last decade for both its irreplaceable role in the healthcare system, as well as the numerous social, legal, and administrative developments that have emerged as a result of the field’s exponential

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growth. Emergency medicine is defined by the American College of
Emergency Physicians (“ACEP”) as “the medical specialty dedicated to the
diagnosis and treatment of unforeseen illness or injury.” The actual
rendering of emergency care proceeds with initially evaluating the patient;
consulting with any specialists as required; issuing a diagnosis; providing
treatment and performing any acute, stabilizing, or emergency procedures;
and, finally, transferring the patient to the appropriate specialist for more
acute care as needed. Emergency medicine was first recognized as an
independent and standalone medical specialty in 1979 by the American
Board of Medical Specialties (“ABMS”), which acknowledged the need for
dedicated emergency training and care. Moreover, physician organizations
and universities around the country started to become aware of the increasing
trend of Emergency Department (“ED”) visits by the public, which further
illustrated the need for specially trained physicians rather than physicians of
other specialties filling in on a transient basis. Since then, emergency
medicine as a field has continued to grow, and has shown increased demand
both from the perspective of physician specialty choice as well as patient
care. Regarding increased demand for emergency patient care, data as
recent as 2009 reported “124 million [ED] visits [for that year], compared to
[just] 90.3 million [visits] in 1996,” indicating a sharp 35% increase. Notably, emergency services have also catered to the increasingly “aging
population, with over 60 visits per 100 persons” correlating to individuals
aged 75 years and older. In 2011 alone, a “National Hospital Ambulatory
Medical Care Survey revealed that EDs in the United States saw more than

1. See Robert E. Suter, Emergency Medicine in the United States: A
Systemic Review, 3 WORLD J. EMERGENCY MED. 5, 6–9 (2012).
2. Definition of Emergency Medicine, AM. C. EMERGENCY PHYSICIANS,
(last visited Apr. 9, 2017). The ACEP is a professional organization of emergency medicine
physicians in the United States, which is committed to developing, improving, and
promulgating best practices in emergency care. About ACEP, AM. C. EMERGENCY
PHYSICIANS, http://www.acep.org/aboutus/about/ (last visited Apr. 9, 2017). With more than
30,000 physician members, the organization is the leading advocate for emergency physicians.
Id.
3. Definition of Emergency Medicine, supra note 2.
4. AAEM History, AM. ACAD. EMERGENCY MED.,
5. See Suter, supra note 1, at 6, 9.
6. See id.
7. Id. at 9.
8. Id.
136 million patient[s],” noting this figure to be the highest number of visits to date.\(^9\)

Accordingly, to meet the increasing demand for emergency physicians, the respective medical associations and education boards have made strong efforts to emphasize the specialized training of medical students for the field.\(^10\) Therefore, today there are over 160 board certified and accredited emergency medicine residency training programs available to medical students.\(^11\) There are also several certified and recognized fellowship or subspecialty options available to physicians that complete residency training in emergency medicine, intended for practitioners that want to pursue a specific course of study within emergency services.\(^12\) The most common of these include hyperbaric medicine, which entails training in the treatment of decompression and altitude based illnesses, and using hyperbaric chambers for therapeutic measures; ultrasound medicine, which trains physicians in using ultrasound technology as a diagnostic and treatment tool; wilderness medicine, which entails training to address natural, tropical, and wilderness based injuries; sports medicine, which trains physicians in preventing and diagnosing athletic and sports related injuries and the respective recovery therapies; medical toxicology, which entails training on how to diagnose and manage acute and immediate injuries related to poison or toxin exposure; and medical administrative fellowships, which focus on training physicians in the administrative and management functions of a hospital system.\(^13\) This emphasis on general emergency medicine training, as well as specialization in acute skills, is a direct response to an aging population, an increasing proclivity by the public to seek emergency room (“ER”) care, and a quickly growing general and primary care physician shortage.\(^14\) Accordingly, thanks to the growth, flexibility, and expansiveness

\(^10\) See Suter, supra note 1, at 9.
\(^12\) Id.; see also Suter, supra note 1, at 9.
\(^13\) Megan Boysen, Fellowship Opportunities in Emergency Medicine, AAEMRSA, http://www.aaemrsa.org/UserFiles/fellowship_opportunities_novdec08.pdf (last visited Apr 9, 2017); Emergency Medicine, supra note 11.
\(^14\) Suter, supra note 1, at 9–10; Christopher Cheney, Physician Shortage to Quadruple Within Decade, AAMC Says, HealthLeaders Media (Jan. 4, 2011), http://www.healthleadersmedia.com/physician-leaders/physician-shortage-quadruple-within-decade-aamc-says?nopaging=1. The report determines that the American healthcare system will reach a shortage of 91,500 physicians by 2020. Cheney, supra. Specifically, as mentioned in the HealthLeaders Media Article, the Association of American Medical Colleges
of the field, emergency medicine has become a comprehensive, necessary, and vital discipline of medicine in society.\textsuperscript{15} 

As with any other field of medicine, legislative bodies, regulatory agencies, and the judicial system have independently and collaboratively designed intricate frameworks and laws to try and keep up with the expansion of emergency medicine.\textsuperscript{16} The need for these frameworks is critical, as the field inherently entails a wide spectrum of services, ranging from the front lines of general medical care, all the way to disaster management and public health crises.\textsuperscript{17} These frameworks, congruent to the field’s growth and graduation to an independent specialty, have been promulgated in order to protect both the community and the respective healthcare providers.\textsuperscript{18} However, while many of these frameworks and legal developments have indeed achieved their promises of helping fuel and grow the field while protecting the public and the providers, others have unequivocally stifled progress, and have made the actual delivery and execution of emergency care unnecessarily onerous.\textsuperscript{19} 

The purpose of this Article is to provide an examination of two such legal areas, which have significantly affected the field of emergency medicine.\textsuperscript{20} These areas are: 1) malpractice/negligence frameworks in emergency medicine and 2) the Emergency Medical Treatment and Labor Act (“EMTALA”).\textsuperscript{21} 

The reasons for focusing on these two issues is multifold. Most of the scholarship centered around legal medicine topics has increasingly become narrowed down to specific case scenarios or particular practice area pain points, especially on subjects which have resulted in significant legal outcomes or have raised novel ethical questions.\textsuperscript{22} While these subjects are vital in promoting the discussion of intricate legal issues, as related to the nuances in the practice of medicine, there is also a critical need to reengage conversation and continuously reconsider larger legal frameworks and issues as well, especially given that the field of medicine is in a particularly dynamic growth and development period globally.\textsuperscript{23} 

\textsuperscript{15}See Suter, supra note 1, at 9–10.  
\textsuperscript{16}Id. at 6–7.  
\textsuperscript{17}See Boysen, supra note 13.  
\textsuperscript{18}See Suter, supra note 1, at 7–10.  
\textsuperscript{19}See infra Section II.C.  
\textsuperscript{20}See infra Parts II–III.  
\textsuperscript{21}See infra Parts II–III.  
\textsuperscript{22}See infra Part II.  
\textsuperscript{23}See infra Part II.
Therefore, this Article takes a hybrid approach. The first part of this Article addresses a relatively dormant, yet expansive, area of legal scholarship in the recent years, providing a macroscale view of the development, nuances, and impact of ER malpractice and negligence frameworks. While whitepapers and court cases on this topic are numerous, the fact remains that there has been a shift away from the larger perspective of how malpractice in emergency medicine has transformed over the years, and if there is a need to revisit the system to enact change in this arena.

The second portion of this Article is focused on issues regarding EMTALA, which is specific legislation that has had significant impacts on both emergency medicine providers and larger hospital systems, both of which are ultimately accountable to patients and financial stakeholders. EMTALA has been a household name for hospitals and emergency physicians for a few decades, but remains contentious with regards to its financial, legal, and value-based costs. These areas of contention and the nuances of the legislation deserve revived analysis, as EMTALA continues to affect healthcare from both microscopic and systemic perspectives.

Overall, this Article serves to review both of these topics in order to provide an in-depth analysis of their impacts on emergency medicine, propose potential solutions for identified problem areas, and speculate what future practitioners can expect of these issues.

II. MEDICAL MALPRACTICE AND NEGLIGENCE IN EMERGENCY MEDICINE

A. What Exactly Is Medical Malpractice/Negligence?

Medical negligence—also known as medical malpractice—entails a suit against a physician, which comports with the traditional legal elements of negligence. For a plaintiff to be successful in a suit against a physician, he or she must prove a duty, a breach of duty, causation of harm as a result of the breach of duty, and damages. In medical terms, the patient must first

24. See infra Part II.
25. See infra Sections II.B–E.
26. See infra Part III.
27. See infra Section III.B.
28. See infra Sections III.B–C.
29. See infra Parts II–IV.
prove that the physician had a duty to treat. 32 This is essentially established in accordance with the patient-physician relationship, when a physician agrees to take on a patient and begin the diagnostic process. 33 Whereas, for most other specialties, this is a matter of choice—an emergency physician’s right of refusal is extremely limited and, therefore, will often meet this prong of the negligence test by default, especially in an ER context. 34 The second prong of negligence requires that there is a breach of duty. 35 Essentially, this requires the patient to prove that the physician fell short of the standard of care, the same standard that would have been afforded to a similarly situated patient presenting a similar medical issue. 36 The definition of the standard of care has evolved over time, leaving physicians with mixed results and thresholds by which they can gauge the care that they provide. 37 However, it is generally accepted in modern litigation that the standard of care is established by employing the knowledge and the methods an average, congruently situated physician would have employed given a similar context and set of circumstances—hence, what a reasonable physician in the same situation would have done. 38 The third prong requires a showing of causation. 39 That is, the patient has to show that there was a causal relationship and a direct link between the physician’s breach of duty and the

32. Bal, supra note 30, at 342.
34. See 42 U.S.C. § 1395dd(b)(1) (2015); David A. Ansell & Robert L. Schiff, Patient Dumping: Status, Implications, and Policy Recommendations, 257 JAMA 1500, 1500–01 (1987); Bailey, supra note 33. See discussion below regarding an emergency physician’s responsibility to treat per the EMTALA of 1986. See infra Section II.B.
35. Bal, supra note 30, at 342; Moffett & Moore, supra note 30, at 109.
37. See Moffett & Moore, supra note 30, at 109, 112.
38. Bal, supra note 30, at 342; Moffett & Moore, supra note 30, at 109, 112.
injury faced by the patient. The final prong, damages, is typically the category that determines the compensation award that is granted as a result of the suit. This is where the plaintiff has an opportunity to show the extent of damages the harm has caused him or her. The extent of damages caused will take into account a variety of factors, including economic and non-economic losses, which may entail categories ranging from lost income and wages, to the need for future medical care, to pain and suffering.

While the above standards dictate the general parameters which define a malpractice suit, individual states mandate the specific nuances behind personal injury cases and the respective negligence claims.

B. Medical Malpractice in the ER

Emergency medicine, inherently based on real-time, unplanned, and immediate decisions, is a breeding ground for potential medical errors, and must comply with the same negligence standards—discussed above—as all other medical specialties. Given the nature of the field, emergency physicians often do not have the time to assert their decisions based on the full calculus of context and history, but rather they are forced to make spontaneous calls to mitigate trauma and damage as much as possible.

40. Id. Causation, as a legal principal, has many different splits. See But-for Cause, BLACK’S LAW DICTIONARY (10th ed. 2014); Proximate Cause, BLACK’S LAW DICTIONARY (10th ed. 2014); Superseding Cause, BLACK’S LAW DICTIONARY (10th ed. 2014). The most commonly used versions entail but-for causation or proximate causation. See But-for Cause, supra; Proximate Cause, supra. Black’s Law Dictionary defines but-for causation as “[t]he cause without which the event could not have occurred.” But-for Cause, supra. Proximate causation is defined as “[a] cause that is legally sufficient to result in liability.” Proximate Cause, supra. For negligence claims generally, showing a superseding cause can null causation by a party. See Superseding Cause, supra. Black’s Law Dictionary defines a superseding cause as “[a]n intervening act or force that the law considers sufficient to override the cause for which the original tortfeasor was responsible, thereby exonerating that tortfeasor from liability.” Id.

41. Bal, supra note 30, at 342.
42. See id. at 340.
43. Id. Aside from damages accounted for economic and non-economic losses, courts may also sometimes grant punitive damages, in cases of extreme recklessness or wanton negligence. Id. at 342. Black’s Law Dictionary defines punitive damages as “[d]amages awarded in addition to actual damages when the defendant acted with recklessness, malice, or deceit; specifically, damages assessed by way of penalizing the wrongdoer or making an example to others.” Punitive Damages, BLACK’S LAW DICTIONARY (10th ed. 2014).
44. See Bal, supra note 30, at 340; Moffett & Moore, supra note 30, at 112.
45. See Moffett & Moore, supra note 30, at 109.
This elevated level of acuity also has to be balanced with a constant inflow of patients into the ER, often which the physicians themselves cannot control.\(^47\) Various methods of the triage process aid this balancing act.\(^48\) Often utilizing mid-level staff, initial and brief assessments are conducted on incoming patients to determine the severity of their issues, which are then used to index patients in the hierarchy of workflow for the attending—supervising—physician.\(^49\) This triage process is essential to both the overall inflow metrics and quality of care standards of an ER.\(^50\) Allowing physicians to prioritize which patients to see first provides primary attention to the most severe problems and also keeps the throughput of the hospital flowing so that patients can be assessed, treated, and discharged in an organized and efficient manner.\(^51\) There have been important efforts and initiatives made towards standardizing this process, so as to expand and promote ER management and efficiency uniformly across the country.\(^52\) In addition to maintaining an efficient ER, physicians also have to simultaneously worry about professional metrics, such as patient per hour ("PPH") rates, which are commonplace in ERs around the country as viable metrics to determine the efficacy of physician performance.\(^53\) Ultimately, this variety of factors and pressures places an inordinate burden on emergency physicians to master

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\(^47\) See AGENCY FOR HEALTHCARE RESEARCH & QUALITY, supra note 46, at 1.
\(^48\) See id.
\(^49\) Id.
\(^50\) Id.
\(^51\) Id.
\(^52\) See AGENCY FOR HEALTHCARE RESEARCH & QUALITY, supra note 46, at 1.

“The Emergency Nurses Association ("ENA") and the [ACEP] formed a Joint Triage Five Level Task Force in 2002 to review the literature and make a recommendation for EDs throughout the United States regarding which triage system should be used.” Id.


[PPH] rates have long been used in Emergency Medicine as a rough guide to determine emergency physician (“EP”) “productivity” and to compare individual workloads—relative to peers in the same work environment. Indeed, PPH rates are a component of fee-for-service (“FFS”) and other volume-based payment systems. While there is a speed versus quality of care trade-off for the individual patient being treated—being too fast can compromise patient safety—there is also a speed versus quality of care trade-off for the patients waiting: If I am moving too slowly, I am compromising the care of those who are “Waiting to be Seen.” Ideally, individually, we should be aiming for that “Goldilocks” optimized PPH rate—not too fast and not too slow.

Id.
their diagnosis and decision-making skills in the face of a consistently uncertain patient population. 54

Regarding the difficulties of patient evaluation in an ER setting, studies have shown that decision-making processes condense to two primary categories, both of which become especially pertinent when confronted with traumatic stimulus. 55 The first, the intuitive/reflexive approach, is centered around pattern recognition, and becomes second nature to the physician over years of reflecting on the same patient presentations, though it has a proclivity for error in judgment. 56 The second is the analytical/problem solving approach, which involves higher levels of critical thinking and evaluation based on context and permissible alternatives; this method has been shown to be far more reliable in terms of preventing medical errors for the simple fact that it gives a physician time to work through the problem solving method for the issue at hand. 57 Both methodologies have their benefits and are used in various ER settings. 58

Take, for example, a patient that arrives with a fall injury, complaining of arm pain and presenting no other immediate symptoms or wounds. This patient can likely afford the physician taking the analytical/problem solving approach. 59 Here, the nurse evaluates the patient, determines his placement in the pain/triage scale, and hands him off to the physician who can then do an initial evaluation, order tests, review the results, and prescribe the pertinent treatment to qualify the patient for discharge. 60 Contrast this with a trauma situation, which is equally likely to be presented to an ER physician. 61 The same patient enters except now he or she arrives in an ambulance, bleeding out from his or her arm, and is not able to provide any context or history of the incident, as the patient is unconscious. Here, the physician will likely revert to a combination of both the reflexive and problem solving methods, resorting to pattern recognition to determine the closest case in his repertoire to create an immediate diagnosis plan, while balancing it with the problem solving method to determine if that plan of action is best, given the current emergency. 62

54. See id.
56. Id.
57. Id.
58. See id.
59. See id.
60. See AGENCY FOR HEALTHCARE RESEARCH & QUALITY, supra note 46, at 1.
61. Id. at 10.
62. See Helman, supra note 55.
However, given the immediate trauma and circumstances of the presenting patient, this decision-making and balancing process must happen in a fraction of the time as compared to the first, broken-arm patient scenario.\(^\text{63}\)

It is important to note that the underlying principal of both the above scenarios still relies on the physician’s competence to pull from his or her clinical knowledge base.\(^\text{64}\) Evidence-based diagnostic decision making plays a significant role in patient recovery, and is intended to:

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\begin{align*}
(1) & \text{ make the ethical care of the patient its top priority;} \\
(2) & \text{ demand [individualized] evidence in a format that clinicians and patients can understand;} \\
(3) & \text{ use expert [judgment] rather than mechanical rule following;} \\
(4) & \text{ share decisions with patients through meaningful conversations;} \\
(5) & \text{ communicate risk whilst incorporating the patient’s values; and} \\
(6) & \text{ apply these principles at the community level for evidence based public health.}\(^\text{65}\)
\end{align*}
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These inherently heavy balancing factors are important aspects to consider when broaching the subject of emergency medicine malpractice.\(^\text{66}\) The discussion must also be premised with the fact that while almost every other specialty gets to choose exactly what walks into the door on a given day, emergency medicine is unique in that attending physicians have no idea what could present itself during a given shift.\(^\text{67}\) There are no appointments made, or rosters of patients that the physician can view before doing rounds for the day.\(^\text{68}\) This lack of patient choice impacts both the clinical decision-making ability and the care delivery process for emergency physicians.\(^\text{69}\) Furthermore, given the nature of emergency care, physicians cannot turn patients away from ERs unlike other specialties, which can refuse patients

\begin{footnotesize}
\begin{align*}
63. & \text{ See id.} \\
64. & \text{ See id.} \\
66. & \text{ See id.; Walter Kuhn, } \textit{Malpractice and Emergency Medicine, Augusta U.}, \text{http://www.augusta.edu/mcg/clerkships/em/documents/malpracticeandem.pdf} (last visited Apr. 9, 2017). \\
67. & \text{ Marc Gorelick, } \textit{Pediatric Primary Care in the ER: Is It Better Than Waiting for an Appointment?}, 8 AMA J. Ethics 717, 718 (2006). \\
68. & \text{ See id.} \\
69. & \text{ See id. at 719–20.}
\end{align*}
\end{footnotesize}
based on potential malpractice, the evaluated risk, profitability margins, the effort of care required, and numerous other metrics of their own choice.\textsuperscript{70}

C. \textit{Impacts and Effects}

Emergency medicine malpractice rates can be as high as 20\% of all the claims that a hospital faces, second only to surgery and obstetrics.\textsuperscript{71} In a study of malpractice premiums as determinants of high-risk medical specialties, emergency medicine was identified as a top five-risk specialty, among surgery, obstetrics/gynecology, anesthesiology, and radiology.\textsuperscript{72} A similar study based on defensive medicine in high-risk specialties once again identified emergency medicine as a top six contender, only after four other surgical specialties and radiology.\textsuperscript{73} Given the heavy procedural aspects of the surgical specialties, one would reasonably expect the margins of error to be higher for surgery than a medical specialty such as emergency medicine.\textsuperscript{74} However, one can likely account for the similar rates in emergency medicine due to the difficult nature of the diagnosis, decision-making, and treatment processes discussed above.\textsuperscript{75}

Furthermore, failure to diagnose, lack of timely diagnosis, or improper diagnosis, contributes to a significant portion of the malpractice claims, accounting for nearly 57\% of emergency medicine claims.\textsuperscript{76} These claims demonstrate the prevalence of malpractice related to the inability of the physician to be able to attend to his or her patients in a timely and attentive manner—bringing light to the fact that overcrowded ERs somewhat
CONTRIBUTE TO MALPRACTICE. 

Claims against emergency physicians are five times more likely to occur if the patient waited more than thirty minutes to be seen by the physician. This systemic issue has no waning in sight, as the number of ER visits nationally have increased, while the available resources and ERs remain stagnant or slowly decline; from 1990 to 2009, it was found that “the number [of] hospital-based ERs in non-rural areas decreased by 27% . . . [while] the number of ER visits increased [by] 44%.”

Understandably, the more crowded an ER gets, the less time the physician has available to spend with each patient. Given the limited supply of staff, this also means less time with mid-level staff per patient. In turn, this leads to quicker triaging methods and the expediting of an already spontaneous decision-making process—all culminating in a higher likelihood of misdiagnosis or diagnostic error.

A report by the Government Accounting Office (“GAO”) found that patients in the ER who were designated to the sickest triage category—those deemed to be a priority to be seen by the physician—were on average waiting twice the recommended length to be seen by an attending physician, due to physician and staff unavailability. Further studies by Academic Emergency Medicine correlated overcrowding “to increased in-hospital mortality rates and delays in timely treatments for conditions such as acute pain and pneumonia,” problems which are likely easily resolvable when provided with the full attention and time of an experienced attending physician under normal circumstances. Related studies in Canada showed “that reducing ER length of stay by [one] hour could decrease the number of deaths in high-risk patients by 6.5% and by almost 13% in lower-risk patients.” Hence, the impact of overcrowding on patient care is empirically evident.

In this regard, emergency medicine physicians are automatically placed on the lower end of the playing field.

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78. Id.
79. Robert A. Barish et al., Emergency Room Crowding: A Marker of Hospital Health, 123 TRANSACtIONS AM. CLINICAL & CLIMATOLOGICAL ASS`N 304, 305 (2012). The study found that the number of ER visits increased “from 88 million to 127 million” per year, while the number of ERs decreased from 2446 to 1779 units. Id.
80. See AM. COLL. OF EMERGENCY PHYSICIANS, supra note 77, at 8.
81. See id.
82. See id.; THE DOCTORS Co., supra note 76.
83. Barish et al., supra note 79, at 307.
84. Id.
85. Id.
86. See id.
with an unfair advantage as compared to other medical specialties, given their inability to control their patient inflow and workload for a given shift.\textsuperscript{87}

These significant intricacies of emergency physician liability and malpractice are further compounded by the fact that there is not one federal standard by which these physicians can operate or tailor their care; rather, while the practice of medicine stays relatively the same across state lines, certain states may have personal injury laws more favorable than others.\textsuperscript{88} This means that certain states become higher target locations for physicians to practice in.\textsuperscript{89} For example, a state like Tennessee, where from 1995 to 2005 physicians saw liability premiums increase from 127\% to 212\%, would not be an attractive location for a physician to move to, knowing well that physicians there can expect high insurance premiums and costs.\textsuperscript{90} Accordingly, in those same years, Tennessee saw a significant lack of providers available in the state’s ninety-five counties: 85\% reported not having “a residing neurosurgeon in patient care,” 52\% reported not having an “orthopedic surgeon in patient care,” 49\% reported not having an emergency physician in patient care, and 44\% reported not having an obstetrician/gynecologist in patient care.\textsuperscript{91} This lack of standardized metrics across state lines creates disparity in malpractice payments, eventually leading to systemic problems in a community’s access to healthcare.\textsuperscript{92} A study by The National Practitioner Data Bank found that the risk of malpractice payments ranges anywhere from “0.73\% per physician, per year, in Alabama to a high 3.7\% [for the same metric] in Wyoming.”\textsuperscript{93}

Due to this lack of accountability and standardization in liability, many emergency physicians are forced to practice \textit{defensive medicine}, or the practice of medicine and the execution of medical decisions in fear of medical malpractice.\textsuperscript{94} Surveys indicate that 75\% of physicians admit to ordering “more tests, procedures, and medicines” than medically relevant, purely to ensure protection against malpractice.\textsuperscript{95} This number is likely

\begin{footnotesize}
\begin{enumerate}
\item See id.
\item See id.
\item Id.
\item Id.
\item Id.
\item Navid Fanaeian & Elizabeth Merwin, \textit{Malpractice: Provider Risk or Consumer Protection?}, 16 AM. J. MED. QUALITY 43, 43 (2001).
\item Daniel P. Kessler et al., \textit{Impact of Malpractice Reforms on the Supply of Physician Services}, 293 JAMA 2618, 2623 (2005).
\item Hal Scherz & Wayne Oliver, \textit{Defensive Medicine: A Cure Worse Than the Disease}, FORBES (Aug. 27, 2013, 10:52 AM).
\end{enumerate}
\end{footnotesize}
much higher in ERs, which are often the first points of contact for symptomatic patients. Accordingly, it was reported that between 2001 and 2005, 50% of emergency physicians in California “were concerned with . . . malpractice litigation.” Two studies that were presented to the ACEP highlighted this trend of fear-based medical decision-making. One study concluded that the common driver of admitting cardiac patients through the ER was malpractice litigation, while the second study equally corroborated this statistic, indicating a significant “increase in admissions for [congestive heart failure] over a 14 year period,” which the authors of the study concluded was due to the increasing fears of litigation.

A noteworthy aspect of the former study by David Newman indicated that many emergency physicians accounted for their admissions based on legal concerns rather than the actual medical risk indicated by presenting coronary symptoms; many of these physicians also reported that they would not have chosen to be admitted to the hospital had they been in the position of the patients themselves. Overall, this fear and malpractice driven approach to patient care is “estimated to cost $46 billion annually.” Most of these costs come directly from unnecessary patient admittance and hospitalization. The cost of defensive medicine extends across to increased harm for the patient as well. Putting the patient through unnecessary and burdensome tests and procedures will likely result in psychological and physical harm to the patient in the form of increased invasive procedures, the potential for false positives and the resulting anxiety, and the general “risk of physical injury to patients” due to the increased testing measures.

These onerous burdens created by emergency physician liability frameworks beg for reform. It is neither sufficient, nor plausible, to fully
delegate protection of emergency physicians to the standard of care notion, hoping that negligence cases against the physicians will remain equitable and just by pursuing an analysis of what another emergency physician would have done in a similar situation.\textsuperscript{105} Proponents of this approach may argue that this method provides apt coverage and takes into account all the difficulties that these physicians specifically must work with.\textsuperscript{106} However, this method attempts to dismiss the frontline nature of emergency medicine and the inherently high burden of risk that practitioners of the field take onto themselves, instead of relying on a hindsight, “what should have been done” approach.\textsuperscript{107} The elevated, real-time decision-making and diagnostic burdens of emergency medicine make it non-conducive and inequitable for retrospective arbitration on the proper standard of care.\textsuperscript{108} Therefore, given these arduous burdens, one must ask: Why should emergency medicine practitioners answer to the same standards of malpractice as every other medical specialty, rather than the sweeping, dynamic level of protection offered to them?\textsuperscript{109} What standards should be used to adjudicate on errors and mishaps in a field which is inherently centered on instantaneous decision-making?\textsuperscript{110}

D. Potential Solutions

A sweeping movement towards some type of malpractice standardization across the nation is the concept of tort reform.\textsuperscript{111} Tort reform laws are state laws passed which limit the amount of money that can be received for non-economic damages as a result of tort actions, and sometimes also include limits on punitive damages.\textsuperscript{112} The purpose of these laws is to weed out overly exaggerated tort claims and retain legitimacy in negligence actions.\textsuperscript{113} Namely, many proponents state that tort reform is necessary to protect physicians from frivolous lawsuits and vital to keep

\begin{thebibliography}{99}

\bibitem{105} Id. at 438.
\bibitem{106} See id.
\bibitem{107} See id. at 437–39.
\bibitem{108} See Black, \textit{supra} note 103, at 437–39.
\bibitem{109} See id. at 438.
\bibitem{110} See id.
\bibitem{112} Roslund, \textit{supra} note 111; Santiago, \textit{supra} note 111.
\bibitem{113} Roslund, \textit{supra} note 111; Santiago, \textit{supra} note 111.
\end{thebibliography}
premiums down for both physicians and healthcare systems.\textsuperscript{114} Accordingly, it was found that states that enacted caps on their tort payouts, such as “California, Colorado, Kansas, and Texas” saw a significant decrease in malpractice litigation and malpractice premiums for physicians.\textsuperscript{115} In contrast, in places where tort reform was not enacted, such as “New York, [Washington] D.C., Pennsylvania, New Jersey, and Delaware,” litigation was commonplace and malpractice payouts were numerous.\textsuperscript{116} Texas especially has seen tremendous value in adopting this change.\textsuperscript{117} Since the tort reform adoption, litigation, paid claims, and premium prices have been almost cut in half in the state, while the demand for medical licenses has surged.\textsuperscript{118} “The Texas Medical Association reported that since 2003, the [year that tort reform legislation went into effect], more than 28,000 new physicians” have become licensed to practice in Texas.\textsuperscript{119} This accounts for nearly 3135 new physicians annually, over 770 more new physicians than the state saw on “average in the nine years prior to” the reform legislation.\textsuperscript{120} The state also boasts the country’s lowest malpractice payout per capita.\textsuperscript{121} Data indicates that since the reform legislation was enacted, “medical malpractice claims [and] lawsuits resolved in a [given] year [decreased] by nearly two-thirds” and that the “average payout declined [twenty-two] percent to [approximately] $199,000.”\textsuperscript{122} “[A]verage malpractice . . . premiums have [also] fallen 46[\%]” in the state.\textsuperscript{123} In addition to payout rates, reforming the tort liability system, and limiting the number of frivolous claims, there are also significant positive benefits to community healthcare systems.\textsuperscript{124} Namely, many physicians accounted for their departure from the practice of medicine due to high insurance liabilities; fortunately for Texas, tort reform measures helped revive the stamina for many to remain in practice, averting a significant healthcare access crisis.\textsuperscript{125} These effects were no different for

\begin{itemize}
\item \textsuperscript{114} Roslund, \textit{supra} note 111; Santiago, \textit{supra} note 111.
\item \textsuperscript{115} Roslund, \textit{supra} note 111.
\item \textsuperscript{116} \textit{Id}.
\item \textsuperscript{117} \textit{Id}.
\item \textsuperscript{118} \textit{Id}.
\item \textsuperscript{120} \textit{Id}.
\item \textsuperscript{121} Roslund, \textit{supra} note 111.
\item \textsuperscript{122} 10 Years of Tort Reform in Texas Bring Fewer Suits, Lower Payouts, \textit{supra} note 119.
\item \textsuperscript{123} \textit{Id}.
\item \textsuperscript{124} \textit{See id.; Roslund, \textit{supra} note 111.}
\item \textsuperscript{125} \textit{See Crystal Zuzek, Gone to Texas, \textit{TEX. MED. ASS’N} (Sept. 2013), http://www.texmed.org/Template.aspx?id=27834.} Albert Gros, M.D., Chief of Obstetrics and Gynecology at an Austin Center, reported that the hospital lost nearly one-third of its

\url{https://nsuworks.nova.edu/nlr/vol41/iss2/6}
emergency physicians, who reported higher confidence that the reform measures would “help decrease the cost of medicine over time” due to a decline in defensive medicine and decreased overcrowding due to unnecessary testing.  

Other solutions entail increasing the standard of care threshold for negligence actions and state-law based tort claims against emergency physicians, considering their unique occupational burdens. Given the onerous decision-making processes explained above, the current threshold provides an overly low bar for patients to meet. Various increased threshold models could be implemented. One such model is for wider acceptance of the safe harbor method, which proposes that the threshold for the standard of care should be defined by established, pre-determined guidelines for a given medical situation, eliminating the need for expert witnesses, and instead imploring judges and juries to accept unambiguous and fixed guidelines as the conclusive standard of care.  

Given the onerous decision-making processes explained above, the current threshold provides an overly low bar for patients to meet. Various increased threshold models could be implemented. One such model is for wider acceptance of the safe harbor method, which proposes that the threshold for the standard of care should be defined by established, pre-determined guidelines for a given medical situation, eliminating the need for expert witnesses, and instead imploring judges and juries to accept unambiguous and fixed guidelines as the conclusive standard of care. One iteration of this method in practice entails that if the physician documents his or her “adherence to evidence-based clinical-practice guidelines, [uses the] qualified health information-technology systems,” and uses the decision support systems, which provide guidelines for providers regarding diagnostic procedures and treatment protocols, then the physician would be entitled to use the same guidelines as the standard of care in any resulting litigation. The American College of Surgeons notes that ultimately, established guidelines such as these could provide numerous benefits, eliminating ambiguity for providers and help increase the standardization of care provided for patients. The College further specifies:

obstetricians prior to reform legislation in 2003, due to the lack of economic feasibility with malpractice insurance; he also notes this drain in the physician pool created dire risk of lack of healthcare access, and that without the liability protections that tort reform offers, many physicians are “less willing to [treat] high-risk, uninsured patients.” Id.

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126. Id.
127. See id.; Zeke Emanuel et al., Reducing the Cost of Defensive Medicine, CTR. FOR AM. PROGRESS (June 11, 2013, 9:00 AM), http://www.americanprogress.org/issues/healthcare/reports/2013/06/11/65941/reducing-the-cost-of-defensive-medicine/.
128. Zuzek, supra note 125.
129. See Maxwell J. Mehlman, Medical Practice Guidelines as Malpractice Safe Harbors: Illusion or Deceit?, 40 J.L. MED. & ETHICS 286, 298–99 (2012); Emanuel et al., supra note 127.
131. Emanuel et al., supra note 127; see also Mehlman, supra note 129, at 298.
132. Ong & Kachalia, supra note 130.
By providing direct guidance for negligence determinations, safe harbors may help ameliorate some of the current ambiguities in today’s litigation system for both patients and providers. At any stage in litigation, safe harbors can be a mechanism to facilitate rapid and accurate evaluation of claims for their merit. Due to the fact that they are described and documented in advance of a case, safe harbors may actually help patients—and their attorneys—better evaluate whether a claim is worth bringing forward.\(^{133}\)

The availability of protection against tort claims for following approved standards may lead to greater standardization in care and better patient outcomes across the states as well.\(^ {134}\) This standardization would also likely help quell issues of defensive medicine.\(^ {135}\) If physicians are provided straightforward guidelines and the necessary steps to achieve and meet the standard of care required for a given patient, they will be less likely to order unnecessary procedures and tests, given the assurance that the guidelines will act as a safeguard for any breached standard of care claims.\(^ {136}\)

However, an important component of implementing such a safe harbor system would have to entail wider latitude for the emergency medicine community.\(^ {137}\) While established guidelines that dictate procedures and expected clinical outcomes work for scheduled patient visits and time-insensitive medical issues, emergency situations cannot always be based on predictable guidelines or outcomes.\(^ {138}\) While most other medical specialties commonly see atypical symptomatic presentations and pathology in non-emergent circumstances, emergency medicine is forced to see these presentations in an extremely time-sensitive environment.\(^ {139}\) Therefore, reconciling this unpredictability in clinical presentation with standardized diagnostic guidelines would require wide discretion given to the physician; otherwise, the guidelines will only stand to mitigate physician discretion and will ultimately degrade patient care.\(^ {140}\)

One solution, which would maintain standardization while providing discretion, could be to create a Most Commonly Seen (“MCS”) system, which would entail the establishment of standardized guidelines for the most

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133. Id.
134. Id.
135. Id.
136. See id.; Emanuel et al., supra note 127; Zuzek, supra note 125.
137. See Ong & Kachalia, supra note 130; Zuzek, supra note 125.
138. See Ong & Kachalia, supra note 130.
139. See Ong & Kachalia, supra note 130; Zuzek, supra note 125.
140. See Ong & Kachalia, supra note 130.
common and typical presentations seen in an ER. This could be determined per local community standards, which would take into account local clinical outcomes and common emergencies that a community faces. While these guidelines would establish the standard of care for a given community for a set of common presentations, novel presentations that do not fit into the MCS guidelines could remain as discretionary areas for the attending physician, providing latitude in the traditional manner for the physician to employ his judgment in developing the appropriate patient-physician relationship and treatment plan. Though this may entail some form of defensive medicine, it will allow tailor-made solutions for otherwise rare presentations of symptoms. Implementing this type of safe harbor system will require intricate legal frameworks and a dynamic definition of the standard of care. The frameworks will have to provide increased attention to developing guidelines for standard situations, while providing physicians the discretion to use their medical judgment in an emergent and atypical medical situation.

E. Future Prospects

Ultimately, whether the solution entails a modification of the standard of care for emergency medicine physicians, some type of dynamic safe harbor policy, or something as expansive as blanket liability protection, one thing is certain: Emergency medicine as a field cannot be sustained so long as emergency physicians are forced to perform in environments which inherently force substandard cognitive capabilities, while simultaneously being offered zero to little elevated levels of liability protection. This failure to provide extra protection may ultimately create larger systemic problems, which will have ripple effects on the larger healthcare industry, specifically regarding the already desperate climate that healthcare is facing with the shortage of emergency physicians. Instead, lawmakers and
administrators should view this as a potential opportunity to incentivize the entry of more physicians into this field to help curtail some of the overall capacity and healthcare access problems.

III. EMTALA

A. A Brief History

The EMTALA was sanctioned in 1986 as a part of a larger and more expansive piece of legislation named the Consolidated Omnibus Reconciliation Act.149 The intention behind the act was to ensure the provision of timely emergency medical services by ERs regardless of a patient’s ability to pay, and to mitigate the transferring of patients in need of emergency care to other hospitals purely for financial reasons.150 This practice of transferring patients quickly gained notoriety and became informally known as patient dumping, indicating the refusal of medical services to patients simply for financial or economic reasons.151 It was repeatedly found that this practice had been on the rise, as prior to EMTALA, there was no duty for physicians to treat individuals, and hospitals could blatantly refuse patients regardless of condition or status.152 This blatant refusal policy created situations of extreme desperation and despair.153 The bleakest of scenarios ranged from refusing care to nearly fatal patients and transferring them to other institutions, to pregnant women


150. Joseph Zibulewsky, The Emergency Medical Treatment and Active Labor Act (EMTALA): What It Is and What It Means for Physicians, 14 BAYLOR U. MED. CTR. PROC. 339, 339 (2001). “The law’s initial intent was to ensure patient access to emergency medical care and to prevent the practice of patient dumping, in which uninsured patients were transferred, solely for financial reasons, from private to public hospitals without consideration of their medical condition or stability for the transfer.” Id.

151. Ansell & Schiff, supra note 34, at 1500. Patient dumping specifically refers to the transfer from a private to a public hospital. Id.


on the verge of giving birth in hospital parking lots, waiting to be admitted into the hospital for care.\textsuperscript{154} There were also public policy concerns, as a good number of the patients being \textit{dumped} or transferred belonged to historically estranged classes, including those of minority races and those belonging to lower socio-economic classes.\textsuperscript{155} Increasing cost pressures on hospitals and health systems further exacerbated the situation, which paved way for hospitals to continue to take advantage of the right of refusal and only accept patients that were fiscally promising for the services provided to them.\textsuperscript{156} Ultimately, however, the hue and cry of the larger public policy concerns highlighted the pressing need for legislative changes and was instrumental in the eventual passing of EMTALA.\textsuperscript{157}

Congress intended EMTALA to be the solution to patient dumping and believed that the legislation would enforce a duty on physicians and ERs to at least provide enough care to stabilize patients in dire conditions, and then pursue appropriate transfer protocols if necessary.\textsuperscript{158} Congress also carefully designed the statute to require participation by all hospitals that receive federal funding through the Medicare program.\textsuperscript{159} While seemingly a limited condition, it is noteworthy to recognize that nearly 98\% of hospitals fall under this category.\textsuperscript{160} Given that significant portions of hospital funding come from these federal sources, many hospitals are undoubtedly forced to abide by this statute.\textsuperscript{161}
B. **Provisions of the Statute**

The legislation contains a number of important stipulations. The first provision is the mandate for a medical screening examination ("MSE"), which requires that hospital ERs provide individuals an examination to determine if an emergency medical condition ("EMC") exists upon the patient’s presentation to the ER, regardless of his or her financial status or ability to pay. The statute itself does not dictate the exact provisions of what an MSE should entail, but only dictates that the screening must be conducted under the hospital’s inherent capabilities and as deemed sufficient to determine if an EMC exists. Generally, practitioners have accepted this stipulation to mean that the MSE must be able to identify an EMC and must ensure the same standard of care that would be provided to a similarly situated patient. Therefore, as long as there is no disparity between the assessment offered to the EMTALA patient and any other patient, and the screening provided is capable of revealing any critical issues, a physician would be considered as compliant with the statute. The statute does not protect patients against misdiagnosis but only against disparate treatment. Instead, courts have deferred any misdiagnosis claims or mistakes during the treatment process to traditional state malpractice law.

163. Id. § 1395dd(a).
164. Id.
165. Correa v. Hosp. S.F., 69 F.3d 1184, 1192 (1st Cir. 1995) (citing Baber Hosp. v. Hosp. Corp. of Am., 977 F.2d 872, 879 (4th Cir. 1992); Gatewood v. Wash. Healthcare Corp., 933 F.2d 1037, 1041 (D.C. Cir. 1991)). A hospital fulfills its statutory duty to screen patients in its [ER] if it provides for a screening examination reasonably calculated to identify critical medical conditions that may be afflicting symptomatic patients and provides that level of screening uniformly to all those who present substantially similar complaints. The essence of this requirement is that there be some screening procedure, and that it be administered even-handedly.
166. See Correa, 69 F.3d at 1192 (citing Brooks v. Md. Gen. Hosp., 996 F.2d 708, 711 (4th Cir. 1993); Barber, 977 F.2d at 879; Gatewood, 933 F.2d at 1041).
168. See 42 U.S.C. § 1395dd; Vickers, 78 F.3d at 141. Upholding appellant’s EMTALA claims would eviscerate any distinction between EMTALA actions and state law actions for negligent treatment and misdiagnosis. Under appellant’s reasoning, every claim of misdiagnosis could be recast as an EMTALA claim, contravening Congress’ intention and this circuit’s repeated admonition that EMTALA not be used as a surrogate for traditional state claims of medical malpractice.

Vickers, 78 F.3d at 141; see also 42 U.S.C. § 1395dd.
The statute also dictates that necessary measures must be taken by the hospital to stabilize a patient with an identified EMC.\(^{169}\) This entails that the hospital either provide the requisite care to manage the symptoms, or as the second part of the statute mentions, to transfer the patient to another hospital or facility that can provide the requisite care, after obtaining the proper patient consent as dictated by the statute.\(^{170}\) Refusal for treatment is also covered: Hospitals are deemed to be compliant as long as stabilizing medical treatment is offered and the hospital takes reasonable measures to document the patient’s refusal of care.\(^{171}\)

Expounding on the transfer element, a patient who has not been stabilized may not be transferred to another facility without meeting certain stipulations.\(^{172}\) These include that either the patient requests the transfer, or a provider determines that “based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer.”\(^{173}\) The transfer must also be deemed to be an appropriate transfer—meaning that the receiving facility has both available space and consents to the transfer of the patient, the receiving facility obtains all pertinent medical documentation and test results related to the transferred patient from the original facility, and that “the transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.”\(^{174}\) However, there are protections put into place so that the transfer provisions do not enable hospitals to revive patient dumping protocols.\(^{175}\) If the receiving hospital can provide no additional value to the stabilization of the patient, it can determinatively refuse the patient transfer, forcing the initial hospital to either treat the patient or find an alternative.\(^{176}\)

The penalties enforced by the statute are also noteworthy.\(^{177}\) Hospitals and physicians that are in violation of the statutory provisions can

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170. Id. The statute also includes provisions that dictate when transfer to another facility is appropriate and the requisite conditions to do so. See id. § 1395dd(c).
171. Id. § 1395dd(b)(2).
172. Id.
173. 42 U.S.C. § 1395dd(c)(1)–(2).
174. Id.
175. See id.
177. See 42 U.S.C. § 1395dd(d).
face up to $50,000 per violation. Patients can also file civil actions against
the provider or the hospital for violation of the statute, pursuant to local
jurisdictional and state personal injury law. A key penalty is the risk of
the hospital losing its Medicare funding agreement. Critics maintain that
this Medicare death penalty is among the most significant motivating and
driving factors towards compliance.

C. The Costs of EMTALA: Unreimbursed Care

One of the largest sources of cost from EMTALA is the legislation’s
promulgation of unreimbursed care. Given that the legislation essentially
mandates emergency care for any patient that arrives at the ED with an
EMC, physicians and hospitals are on the front lines of collecting the
payments for the services rendered under EMTALA. Ultimately, if that
patient is uninsured or unable to pay, the hospital may never receive
compensation, especially since there is little that the provider can do against
either the federal government or the unpaying patient, besides accepting the
$50,000 penalty and not treating the patient in the first place. Although
uninsured patients may be covered by Medicaid, the services that hospitals
provide for the MSEs and the EMCs often go unreimbursed or insufficiently
reimbursed. Even as early as 2000, before the exponential rise in
healthcare costs, emergency physicians accounted 61% of their bad debt to
EMTALA mandated care. As of 2003, this unreimbursed care accounts

178. Id. § 1395dd(d)(1).
179. Id. § 1395dd(d)(2).
180. M. STEVEN LIPTON ET AL., EMTALA — A GUIDE TO PATIENT ANTI-
DUMPING LAWS 1.2 (8th ed. 2012). Upon a confirmed violation of EMTALA, CMS has the
authority to notify a hospital of the termination of its Medicare provider agreement. Id. To
retain Medicare provider status, a hospital must submit an acceptable plan of correction and
pass a follow-up survey. See id.
181. Ashley E. Booth, Focus on — The Emergency Medical Treatment and
Labor Act, ACEP (Aug. 2008), http://www.acep.org/Clinical---Practice-Management/Focus-
on---The-Emergency-Medical-Treatment-and-Labor-Act/.
182. The Uninsured: Access to Medical Care Fact Sheet, AM. EMERGENCY
9, 2017).
183. See id.
184. Mark L. Plaster, Who Pays the Tab for Unfunded Care?, EMERGENCY
“Of course, the physician can always pursue the patient for payment. But, if they cannot or
will not pay, there is very little further recourse for the physician. And the government that
mandated the care is deemed exempt from any liability for the bill.” Id.
185. The Uninsured: Access to Medical Care Fact Sheet, supra note 182.
186. The Impact of Unreimbursed Care on the Emergency Physician, AM. C.
EMERGENCY PHYSICIANS, http://www.acep.org/clinical---practice-management/the-impact-of-
for an average loss of $138,000 each year for approximately a third of emergency physicians. Accordingly, some of the largest hospital systems in the country continue to increase their forecasts and provisions for bad debt, accommodating for shortfalls in the hundreds of millions of dollars. With projections indicating that bad debt levels could reach $200 billion by 2019, hospitals are forced to be proactive in their planning. A prime example of this is Community Health Systems, which operates 195 hospitals and is the second largest for-profit hospital chain in the United States. The company was forced to revise its 2015 fourth-quarter forecast for bad debt to

unreimbursed-care-on-the-emergency-physician/ (last visited Apr. 9, 2017). Bad debt is defined by Black’s Law Dictionary as “[a] debt that is uncollectible and that may be deductible for tax purposes.” Bad Debt, BLACK’S LAW DICTIONARY (10th ed. 2014). A 2016 report by the American Hospital Association determined that “bad debt consists of services for which hospitals anticipated but did not receive payment.” AM. HOSP. ASS’N, UNCOMPENSATED HOSPITAL CARE COST FACT SHEET 2 (2016).

187. The Uninsured: Access to Medical Care Fact Sheet, supra note 182. Referencing an AMA study: In which the American Medical Association stated that “[m]ore than one-third of emergency physicians lose an average of $138,300 each year from EMTALA-related bad debt . . . .” Id.

188. See id.


The number of patients enrolled in high-deductible health plans has been increasing since 2005, but has accelerated over the past two years. At a growing number of companies, high-deductible plans are the only option. A survey from Aon Hewitt found that 44% of the employers it surveyed showed they are increasing deductibles and/or copayments as a way to manage their healthcare costs. At $2086, the average deductible for a consumer-directed health plan was nearly double the average annual deductible of $1097 for all health plans in 2012, according to the Kaiser Family Foundation.

Id. The Modern Healthcare article mentioned in footnote above also notes that hospitals are attempting to change their collection models in hopes of getting reimbursed for care from patients who are able to pay. Id. The article notes:

Many hospitals are still using the old system of billing patients after services are provided and hoping the checks come in. But savvy medical centers are taking a more proactive approach: calling patients weeks in advance of service, using screening tools to assess their ability to pay and then setting them up with financial counselors to work out a payment plan when necessary. . . . But hospitals seeking to improve collections have to be careful, as state regulators have pushed back against overly aggressive debt-collection practices—particularly in cases where treatment was delayed or family members were denied access to a patient until bills were paid.

account for an additional deficit of $169 million.\textsuperscript{191} In the last sixteen years, hospitals have provided more than half a trillion dollars in uncompensated care to their patients.\textsuperscript{192}

These metrics play a substantial role in the vitality of healthcare organizations.\textsuperscript{193} Debt figures are often significant considerations when large systems negotiate mergers and acquisitions and contemplate the overall financial prospects of a potential acquisition or buyout.\textsuperscript{194} This aspect becomes additionally vital as community and rural hospitals, which frequently do not have enough margin to afford significant bad debt, often seek to or are forced to merge with larger hospital systems.\textsuperscript{195} These large systems also begin targeting and absorbing smaller systems, perhaps in hopes of gaining consumer market share or eliminating a barrier to entry in a specific region.\textsuperscript{196} Either way, these mergers lead to increased consolidation of market share and the slow monopolization of macro-scaled segments, reducing competition in the healthcare marketplace, and allowing hospitals to drive up costs and fees for services.\textsuperscript{197} When merger or bailout is not

\textsuperscript{191} Id.
\textsuperscript{192} Brooke Murphy, 21 Statistics On High-Deductible Health Plans, BECKER’S HOSP. REV. (May 19, 2016), http://www.beckershospitalreview.com/finance/21-statistics-on-high-deductible-health-plans.html. The report also displays the annual AHA survey, illustrating the upward trajectory of uncompensated care costs for the last fifteen years. AM. HOSP. ASS’N, supra note 186, at 2–3. In 1990, the costs of uncompensated care, nationally, were estimated to be around $12.1 billion. Id. at 3. This nearly doubled to $21.6 billion by the year 2000. Id. By 2015, this figure grew to $35.7 billion. Id. These figures exclude underpayments or non-payments on the part of Medicaid or Medicare, which would highlight the even deeper financial woes of many hospitals. See id.


\textsuperscript{194} See DIXON HUGHES GOODMAN LLP, supra note 193, at 4, 8.
\textsuperscript{195} See Lauerman, supra note 190. “‘We have [thirty-nine] hospitals that have negative margins and the majority of them are rural,’ . . . ‘They have less of a financial cushion to absorb the losses of bad debt.’” Id.
\textsuperscript{197} See Curfman, supra note 196. The article also notes that while economists are focused on the reduced competition and increased prices that come with large hospital system mergers, administrators behind these mergers paint a different picture, citing the positive effects of mergers, including improved efficiency, increased quality of care, and even the potential for lower costs in the long run due to increased access to care. Id. “[W]hen a smaller hospital merges with a larger, better-equipped hospital system, patients at the smaller hospital may acquire better access to specialists and to advanced medical
possible, the hardest hit organizations are forced to shut down, leaving entire communities void of immediate healthcare services. Further effects of the erosion of rural hospital networks beyond the lack of access to critical care include job loss, drop in gross domestic product figures, and, accordingly, a general decline in the economic fortitude of a community.

D. Because It Is Unreimbursed, Is EMTALA Unconstitutional?

Some treatment has been given to the fact that EMTALA potentially violates the Fifth Amendment of the U.S. Constitution. This school of thought was first proposed and advocated by E.H. Morreim, who has advanced the theory that the lack of just and sufficient compensation for medical services provided is no different from a traditional government taking. That is, the government is taking private services in order to promulgate a government objective.

The Takings Clause of the Fifth Amendment states that “nor shall private property be taken for public use, without just compensation.” This has traditionally been applied to the claiming or diminution of the value of private property by the government, including issues of eminent domain, seizure of property, and physical invasion of private property. The purpose behind the original amendment was to ensure that the federal government took all steps necessary to protect private property, as a technologies, such as high tech imaging procedures and electronic medical record systems."


199. See Michael Wyland & Michelle Lemming, Death by a Thousand Cuts: The Flickering Lights of the U.S. Rural Hospital, NONPROFIT QUARTERLY (Feb. 23, 2016), http://nonprofitquarterly.org/2016/02/23/death-by-a-thousand-cuts-the-flickering-lights-of-the-u-s-rural-hospital/ (A study found that closure of 673 vulnerable rural hospitals would entail 11.7 million lost in patient encounters, 99,000 healthcare jobs lost, 137,000 community jobs lost, and a $277 billion loss to gross domestic product over the course of ten years.)

200. E.H. Morreim, Dumping the Anti-Dumping Law: Why EMTALA is (Largely) Unconstitutional and Why It Matters, 15 MINN. J. L. SCI. & TECH. 211, 217 (2014); see also U.S. CONST. amend. V.

201. Morreim, supra note 200, at 212.

202. Id.

203. U.S. CONST. amend. V.

fundamental requirement of a legitimate government. Proponents of the takings argument against EMTALA contend that the legislation creates a taking with regards to for-profit hospitals in requiring those hospitals to provide emergent and unreimbursed medical care. Namely, the requirements of a taking are met: Property, which does not entail a single person’s property but instead refers to the hospital itself, including medical equipment, pharmaceuticals, and the time of the physicians and staff; the actual taking, which comprises of requiring emergency evaluation and treatment; public use, as EMTALA entitles any member of the public to receive this care; and finally, the lack of just compensation, as EMTALA care does not itself receive any reimbursement. A notable argument by proponents of EMTALA remains that hospitals do indeed receive compensation for EMTALA-based care, as the legislation only mandates Medicare participating hospitals to provide this care, ergo, giving hospitals an opportunity to extend their patient populations to include and collect from those covered by the Medicare program. The logic behind this school of thought reasons that hospitals receive incentives through Medicare payouts, and if hospitals do not find it conducive to subscribe to EMTALA, even with Medicare payouts, they can simply refuse participation in the Medicare program. However, for a majority of hospitals in the country, Medicare reimbursements represent such a large proportion of compensation and profits, that pulling out of the program would be a death sentence. Hence, this proposition provides a binary choice of assured failure, and, essentially, acts as a gun to the head: Either the hospital decides to drastically reduce its margins and income via the refusal of the Medicare program and all Medicare patients, or it chooses to provide billions of dollars of unreimbursed care. This situation creates an unduly coercive choice, given that the Medicare program accounts for as much as 30% of many hospital systems’ budgets, a figure that has a strong proclivity to rise with the

205.  _Takings Clause_, HERITAGE GUIDE TO CONST., http://www.heritage.org/constitution/#/amendments/5/essays/151/takings-clause (last visited Apr. 9, 2017). The drafter of the original takings clause, James Madison, provided that “[a] Government is instituted to protect property of every sort... This being the end of government, that alone is a just government, which impartially secures to every man, whatever is his own.” _Id._


207.  _Id._ at 211–12.

208.  _Id._ at 248.

209.  _Id._ at 219, 248.

210.  _Id._ at 220.

211.  Morreim, _supra_ note 200, at 220; see also Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2604–05 (2012) (“In this case, the financial _inducement_ Congress has chosen is much more than ‘relatively mild encouragement’—it is a gun to the head.”).
aging population, as people above the age of sixty-five now make up more than 13% of the entire population—indicating increased Medicare participation in the future. Therefore, the option to opt out of Medicare is not a viable possibility for the majority of hospitals.

E. The Costs of EMTALA: Overcrowding

An anyone can enter policy has also posed severe capacity problems for ERs across the country. Namely, given that participating hospitals now have an additional responsibility of conducting MSEs—to determine if there is an EMC—and provide care accordingly, ER providers have an additional patient load. Given the guaranteed access that the legislation has provided, ERs have essentially become synonymous with a primary care physician’s office. Patients that cannot afford primary care services such as a family clinic or an internist at a local hospital, can now turn to the ER, where they can be diagnosed with accuracy and without any real obligation of payment. Multiple hospital and ER representatives cite EMTALA as the cause for overuse of the ED for non-emergency needs, which increases both patient load and ER throughput. Though physicians are under no obligation to treat if there is not an emergency medical condition identified, the process of conducting the initial screening and determining the nature of the situation still adds a burden to an already overloaded physician and hospital. This is further exacerbated with the general growing trend of


214. See Peggy Eastman, It’s Official: EMTALA Contributes to Overcrowding Delays in Care, 23 EMERGENCY MED. NEWS 9, 9 (2001).


216. Id.


219. See id.; Gorelick, supra note 67, at 719.
patients preferring the ER to a regular primary care setting, under the belief of more available, flexible, acute, and quality oriented care.\textsuperscript{220} Overcrowding has deeper impacts on the general state of emergency care, as it causes a cyclical and self-propagating issue with large rates of patient boarding.\textsuperscript{221} Specifically, a \textit{boarded patient}, which the ACEP defines as “a patient who remains in the [ED] after the patient has been admitted to the facility, but has not been transferred to an inpatient unit,” has been empirically proven to cause ripple effects in ER throughput.\textsuperscript{222} ACEP also notes that,

\begin{quote}
[t]he primary cause of overcrowding is boarding: the practice of holding patients in the [ED] after they have been admitted to the hospital, because no inpatient beds are available. This practice often results in a number of problems, including
\end{quote}

\textsuperscript{220} Gorelick, \textit{supra} note 67, at 719–20. The Academy of Emergency Medicine article goes into further detail, stating that the findings reveal that the convenience of ED care was a very frequently cited reason for using the ED. Convenience, as defined in our study, includes factors related to the hours of operation of the ED, the ease of traveling to the ED relative to other health care facilities, and the availability of immediate medical attention.

Deborah Fish Ragin et al., \textit{Reasons for Using the Emergency Department: Results of the EMPATH Study}, 12 \textit{ACAD. EMERGENCY MED.} 1158, 1163 (2005). It goes on to mention that the immediate availability of the ED appeals to those who desire care without an appointment or who are unwilling to wait for a scheduled appointment. Very often, the ED is chosen because it offers care when needed and wanted, rather than when providers choose to make themselves available.

\begin{quote}
Preference for the ED is also driven by the comprehensive range of services available in a single location, a more attractive option than multiple visits to varying locations for laboratory tests, imaging studies, and specialty consultation. These findings, along with those regarding the convenience of the ED, suggest that structural and operational changes in primary care practices will be required to decrease ED utilization.
\end{quote}

\textit{Id.} The study concluded that for most people, resorting to the ED was not a calculus of last resort, but simply came down to the belief that they had a medical emergency. \textit{Id.} In addition to this, the choice to go to an ER over a primary care physician is a choice of convenience, flexibility, and the perception of superior operational efficiency. \textit{Id.} This refers back to a larger conversation of potential solutions to solving ER overload and overcrowding. \textit{Id.} Inherently, in order to solve these issues, there will have to be simultaneous attention given to solving the issues that mitigate access to other healthcare providers, namely via addressing the primary care crisis and making primary care services more accessible and affordable to the community. \textit{See infra} Section III.C.


\textsuperscript{222} \textit{Id.}
ambulance refusals, prolonged patient waiting times, and increased suffering for those who wait, lying on gurneys in [ED] corridors for hours, and even days, which affects not only their care and comfort but also the primary work of the [ED] staff taking care of [ED] patients. When EDs are overwhelmed, their ability to respond to community emergencies and disasters may also be compromised.  

Ultimately, these issues of overcrowding have significant tangible effects: 50% of all ERs report “operating at or above capacity,” and “500,000 ambulances are diverted each year” due to ER overcrowding. This translates to costs of nearly $38 billion wasted annually due to ER overuse, $1086 per diverted ambulance, and between $9000 to $13,000 in revenue lost daily caused by each hour of ER boarding.

F. Potential Solutions

Specifically addressing the issue of unreimbursed care, some respite has been found with the introduction of the Affordable Care Act, which has managed to expand insurance coverage across the country. Ascension Health, another expansive health network, actually saw a reduction in its bad debt in 2015. Though the figure was still at an exorbitant $1.1 billion, Ascension likely saw a slight dip in uncompensated care due to the expansion of insurance coverage. However, it would be a fallacy to posit an exclusively symbiotic relationship between the expansion of insurance coverage and its effect on uncompensated care provided through EMTALA. Although insurance coverage has gone up significantly, there

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223. Id.
225. Id. The GWU findings also illustrate other impacts of overcrowding. Id. Namely, the studies indicate that patients face a 5% increased chance of dying before being discharged, if admitted to the hospital when the ER is overcrowded. Id. Additionally, it states that due to the overstretching of emergency personnel and staff that often results from ER overcrowding, providers may also find it difficult to respond to potential public health crises and disasters. Id.
227. Id.
228. Id.
has been a significant prevalence of high deductible insurance plans.\(^{230}\) Surveys of employers indicate a 67% increase in deductibles since 2010.\(^{231}\) A Modern Healthcare finding noted that “24% of people under age [sixty-five] with private health insurance were enrolled in high-deductible health plans and another 13% in high-deductible plans with Health Savings Accounts (“HSAs”) to help pay expenses on a pre-tax basis. That compares with 16% and 7%, respectively, in 2009,” citing a study released in 2015 by the National Center for Health Statistics.\(^{232}\)

This significant rise in deductibles makes for an interesting situation in the payer landscape; though more patients now enter the ER with insurance, many still have to take the payment liability on themselves due to not meeting the deductible threshold.\(^{233}\) This effectively renders those patients back in the initial category of uninsured patients.\(^{234}\) Although proponents insisted that high deductibles would encourage consumer shopping, and therefore help increase competition between healthcare providers, empirical studies proved that this was not the case.\(^{235}\) Instead, the inability to pay these high out-of-pocket costs causes a high number of patients to delay getting routine and basic medical care, which further propagates the use of emergency services, often still at an unaffordable price.

\(^{230}\) Barkholz, supra note 226.


\(^{232}\) Barkholz, supra note 226. The article also notes: “The ascendency of high-deductible health insurance is challenging hospitals and physicians across the country to change the way they prepare for and collect payments from people getting hit with large out-of-pocket costs for care.” \textit{Id.} Regarding the progress made by some hospitals on debt collection, it notes:

But the rising prevalence of high-deductible plans, both on and off the exchanges, threatens to undermine that progress. Instead of a small number of people paying none of their bill, hospitals are starting to see a larger number of people struggling to pay the deductibles, which can come to thousands of dollars for a single hospital visit.

\textit{Id.}

\(^{233}\) See DOLAN, supra note 231, at 3; Barkholz, supra note 226.

\(^{234}\) See Deane Waldman, Funding the Unfunded Mandate, AM. THINKER (Dec. 8, 2014), http://www.americanthinker.com/articles/2014/12/funding_the_unfunded_mandate.html.

\(^{235}\) Anna D. Sinaiko et al., Cost-Sharing Obligations, High-Deductible Health Plan Growth, and Shopping for Health: Enrollees with Skin in the Game, 176 JAMA INTERNAL MED. 395, 396 (2016). “Simply increasing a deductible, which gives enrollees skin in the game, appears insufficient to facilitate price shopping.” \textit{Id.} The editor further adds: “It is true that high-deductible health plan enrollees have ‘skin in the game.’ However, these enrollees are exposed to substantial out-of-pocket cost risk with little evidence that this risk exposure will incentivize higher-value health care decisions.” \textit{Id.} at 397–98.
point.\textsuperscript{236} Additionally, given that uncompensated care through EMTALA comes via the identification of an emergency medical condition, there is little opportunity for patients to indulge in emergency care shopping even if they wanted to, due to the immediate need for medical attention.\textsuperscript{237} In congruence with this cyclical logic, polls of emergency medicine physicians in 2015 indicated that ER visits have increased since the enactment of the Affordable Care Act.\textsuperscript{238} Ultimately, the Affordable Care Act and other insurance mechanisms which offer high deductible solutions provide little to no value as a solution in specifically addressing reimbursements for uncompensated care, as they cannot solve for the millions of dollars lost due to patients that fail to meet insurance thresholds and therefore fail to pay.\textsuperscript{239}

Another important issue to consider is the arena of malpractice, specifically regarding patients that receive care under EMTALA.\textsuperscript{240} Given that both providers and hospitals must face the same liability towards the standard of care, regardless of whether there is reimbursement or not, perhaps there is room for a creative solution to recoup the costs of EMTALA-related care through this avenue.\textsuperscript{241} One such proposition may be to make the negligence standard significantly more lenient for providers when administering care to EMTALA patients.\textsuperscript{242} That is, a patient would come in, be determined as unable to pay, and be codified as such in the medical records.\textsuperscript{243} If a negligence issue arises later on, a federally mandated definition of negligence, one that would be much more lenient than the general state standards, would be applied to the physician as a way of reducing the number of payouts a hospital would have to make and, therefore, provide one way of recouping costs.\textsuperscript{244} However, this is not a viable, ethical, or safe precedent to create, as this could create lack of

\begin{thebibliography}{99}

\bibitem{236} Murphy, supra note 192. “When patients delay necessary or preventive medical care, they may end up in hospitals’ [ERs] for treatment.” \textit{Id.} “About 80\% of emergency physicians said they are treating insured patients who have sacrificed or delayed medical care due to unaffordable out-of-pocket costs, co-insurance or high deductibles . . . .” \textit{Id.}

\bibitem{237} See Morreim, supra note 200, at 214.

\bibitem{238} \textit{The Uninsured: Access to Medical Care Fact Sheet}, supra note 182 (noting a significant increase from 2014).

\bibitem{239} See Barkholz, supra note 226.

\bibitem{240} \textit{The Impact of Unreimbursed Care on the Emergency Physician}, supra note 229.

\bibitem{241} See Plaster, supra note 184.

\bibitem{242} See Black, supra note 103, at 438.

\bibitem{243} \textit{See Impact of Unreimbursed Care on the Emergency Physician}, supra note 229.

\bibitem{244} See Bal, supra note 30, at 340; supra Section II.A. To meet negligence, a plaintiff has to prove the same elements discussed: Duty, breach of that duty, harm, and causation. See Bal, supra note 30, at 340; supra Section II.A.

\end{thebibliography}
motivation for providers to exercise their best medical judgment when confronted with a patient who they know will not be able to pay. Leniency in standards of care or in the breach of duty will only create future issues of malpractice and raise important ethical concerns—namely, the concern of why patients that cannot afford healthcare or those that must resort to ERs in times of desperate need should be provided with substandard levels of care.\footnote{See Fanaeian & Merwin, supra note 93, at 43.} Rather, as healthcare can be considered a basic human need, physicians should be incentivized to provide their best services and judgment in all scenarios, regardless of whether the patient is profitable or not.\footnote{See Santiago, supra note 111.} A patient receiving intentional substandard care may as well not receive care at all.

Instead, a solution that could actually curtail negligence liability and provide cost relief to hospitals through the window of malpractice could be a federal mandate providing liability funding for physicians that face negligence claims arising out of EMTALA-based treatment.\footnote{See Bal, supra note 30, at 340.} Given the above discussed cognitive decision-making short-comings that emergency physicians already face, attaching the same standards for liability related payments across the board, for both paying patients as well as non-paying patients that present to the ER, places an unfair burden on hospitals, which ultimately have to shoulder the burden of payment regardless of whether profit was made off the patient or not.\footnote{See The Uninsured: Access to Medical Care Fact Sheet, supra note 182.} Thus, a mandate could be enforced that dictates that non-paying patients who utilize EMTALA’s treatment procedures be categorized into a different codification in a hospital’s records systems, and given any issues of negligence, federal funding will be used to cover legal fees or malpractice payments on behalf of the hospital and provider. While this will likely not cover the full extent of unreimbursed care by the provider, as federal compensation will be paid out only if there is a negligence suit, it may provide some respite to hospitals, which are currently forced under the threat of malpractice regardless of whether there is any monetary value derived from a patient. Overall, this would not only reduce the amount that hospitals would have to pay out in liability, hence, helping to keep their bottom lines and profitability margins stable, but would also create strong incentives for hospitals to retain their Medicare participation status and continue to see patients under EMTALA.

Many have also proposed cost-shifting as a viable measure.\footnote{See Morreim, supra note 200, at 259.} This proposed model suggests that in order to recover the costs for unreimbursed care due to EMTALA, hospitals simply increase the payments and costs
required by paying and insured patients.\textsuperscript{250} However, this model relays back to the original contention of EMTALA violating the Takings Clause; that is, the fact that the payment for the medical services provided has been shifted to a party that can afford it is no less a taking, but has rather just shifted the burden of unjust seizure of property to another person, whether through higher insurance premiums or lower savings remaining for that other payer.\textsuperscript{251}

Instead, what may be another permanent, viable solution, is a stable and guaranteed funding source for hospitals to recoup their costs on lost EMTALA funds.\textsuperscript{252} The most obvious call would be for federal funding of the mandate.\textsuperscript{253} Congressional ability to spearhead a piece of legislation as critical as EMTALA should include with it a responsibility to create funding mechanisms.\textsuperscript{254} While traditional routes of funding, such as the opportunity to draw from Medicare benefits, exist and can likely provide further benefits, declining reimbursement rates and expansion of mandated care is crippling providers.\textsuperscript{255} A more viable mechanism for federally funding the mandate may be the creation of mandatory HSAs for all Americans, funded by tax dollars and providing tax incentives for those who want to contribute more than the pre-allocated amount given by the federal government.\textsuperscript{256} These HSAs could be further mandated as being able to bypass insurance requirements and usable solely for emergency care purposes.\textsuperscript{257}

Alternatively, instead of providing the funds directly to the consumer, perhaps the federal funding could come in the form of dynamic payments to hospital systems instead.\textsuperscript{258} This would entail identifying each Medicare participating hospital—ergo EMTALA participating hospitals—and providing a payout specific to that hospital’s unreimbursed care on an annual basis.\textsuperscript{259} Payments would remain dynamic, as the rate of this reimbursement would change from year to year.\textsuperscript{260} This would require that

\textsuperscript{250} Id. at 259 n.267.
\textsuperscript{251} Id. at 260–61. “The fact that the costs of the initial taking have now been diffused onto a broader variety of parties does not render it any less a taking, nor does it mean that the death of government compensation has somehow become just.” Id. at 260.
\textsuperscript{252} Waldman, supra note 234.
\textsuperscript{253} Id.
\textsuperscript{255} See id.
\textsuperscript{256} Waldman, supra note 234.
\textsuperscript{257} See id.
\textsuperscript{258} See Morreim, supra note 200, at 261.
\textsuperscript{259} See id. at 267–68.
\textsuperscript{260} See id. at 266, 268 n.294.
each hospital present to the government their unreimbursed EMTALA-related costs at the end of a given fiscal year, and then propose a budget for the following year.\textsuperscript{261} Throughout the course of the year, providers would have to indicate all of the patients that they see and the respective services provided under the parameters of EMTALA, helping to account for the final costs at the end of the year.\textsuperscript{262} Providers and hospitals can work together to evaluate the cost per unit of services provided by taking into account the pharmaceuticals used, the time value of the provider, and the general cost of care to present a composite figure to the authorities without heavy problems of proof.\textsuperscript{263} Instead of simply providing an opportunity to earn money through Medicare participation, federal undertaking of these costs would allow for hospitals to be justly compensated for the services provided.\textsuperscript{264} Though this would ultimately be a government cost, it would help shift the burden from hospitals to the federal government, requiring it to provide compensated and basic healthcare for the entire population.\textsuperscript{265} The government could utilize many sources to fund these costs.\textsuperscript{266} Different sources could include increasing taxes for insurance carriers that charge high premiums or mandating a separate fund from general tax revenue towards this purpose.\textsuperscript{267}

An auxiliary solution, though not a comprehensive one, would be to address the issue of the use of ERs for non-emergency uses, or essentially mitigating the use of ERs as primary care facilities.\textsuperscript{268} Uninsured patients that turn to the ER as a means to get basic primary and family care add fuel to the fire by increasing the burden on hospitals.\textsuperscript{269} Given that the demand for primary care physicians is projected to grow 14\% by 2020, the misuse of ERs will only continue to grow.\textsuperscript{270} The sheer lack of access to primary care

\begin{itemize}
  \item \textsuperscript{261} See id. at 268.
  \item \textsuperscript{262} See id. at 263 n.279.
  \item \textsuperscript{263} Morreim, supra note 200, at 262; see also Loretto v. Teleprompter Manhattan CATV Corp., 458 U.S. 419, 437–38 (1982) (pointing out that per se takings tend to present fewer problems of proof, compared with regulatory takings).
  \item \textsuperscript{264} See Morreim, supra note 200, at 262–63.
  \item \textsuperscript{265} Id. at 260; Taylor, supra note 254.
  \item \textsuperscript{266} See Morreim, supra note 200, at 219–20.
  \item \textsuperscript{267} See id.
  \item \textsuperscript{268} Low-Income Patients Say ER Is Better Than Primary Care, ROBERT WOOD JOHNSON FOUND. (July 9, 2013), http://www.rwjf.org/en/library/articles-and-news/2013/07/low-income-patients-say-er-is-better-than-primary-care.html.
  \item \textsuperscript{269} See id.
\end{itemize}
physicians in many areas forces patients to turn to ERs. Furthermore, excessive barriers to primary care have been cited as the reason why many patients prefer a straightforward visit to the ER, including: convenience factors—the lack of flexibility and unavailability of appointments for primary care physicians; costs—primary care physicians often promote or advise referrals, resulting in multiple high copays for patients as opposed to the ER where patients can often get comprehensive care in a single visit; and quality—a stronger focus is given to acute care in the ER.

G. Future Prospects

Ultimately, it is uncontested that EMTALA fulfills a basic societal requirement: access to healthcare for those that require it, regardless of their ability to pay. However, as this requirement is indeed an aspect of community welfare, the burdens should not be shouldered by providers and hospitals. Forcing this extra financial burden will only continue to make hospital systems more unsustainable in the years to come. Given the changing landscape of insurance coverage, an increasing number of people will attempt to take advantage of legislation such as this to pass their healthcare costs onto ERs, rather than taking the financial responsibility onto themselves. With increasing rates of financial turmoil and hardship for health systems, this carefree attitude by government entities, which mandate such legislation upon private systems, will not bode well for the healthcare industry in the years to come. Rather, it will only translate to increased healthcare costs for consumers, as hospitals will be forced to indulge in their own methods of cost shifting to maintain their respective positions as profitable market players.

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271. Low-Income Patients Say ER Is Better Than Primary Care, supra note 268.
272. Id.
273. CAROL K. KANE, AM. MED. ASS’N, THE IMPACT OF EMTHALA ON PHYSICIAN PRACTICES 1 (2003); Perez, supra note 157, at 156; TAYLOR, supra note 254.
274. See KANE, supra note 273, at 1.
275. See id. at 4.
276. See id. at 1.
277. See The Impact of Unreimbursed Care on the Emergency Physician, supra note 229.
278. See KANE, supra note 273, at 4.
IV. CONCLUSION

A. What’s Next for Emergency Medicine?

Both the larger issues regarding medical malpractice/negligence and the impacts created by EMTALA are significant points of contention regarding the current state of emergency medicine practice. However, they are by no means the only issues that need to be addressed. Emergency medicine providers still face many difficult legal battles and are riddled with litigation in subject areas ranging from consent based issues, against-medical-advice directives, and poor charting practices, just to name a few. Indeed, the sheer amount of litigation centered on these topics provides the legal community with an even stronger reason to develop and tailor policies and frameworks for the field, as generic and across-the-board policies cannot be reconciled with such an intricate and complicated field of medicine.

Moreover, the legal community will be forced to remain dynamic and on alert in the coming years with regards to the development of frameworks suited to emergency medicine, as the field is rapidly evolving. As mentioned in the beginning of this Article, given both the growing aging population as well as the demand for primary care services, emergency medicine will be at the forefront of providing healthcare for the public. Accordingly, EDs and hospitals alike will have to strike a balance between cost and quality, ultimately carrying the heavy burden of showing that improved quality of care will decrease long-term costs. This efficiency will be augmented by the continuous growth of healthcare information technology, which will provide the valuable information that providers need.

279. Black, supra note 103, at 439.
280. See id.
281. See Kuhn, supra note 66.
282. See Black, supra note 103, at 437; Kuhn, supra note 66.
283. David P. Sklar et al., The Future of Emergency Medicine: An Evolutionary Perspective, 85 ACAD. MED. 490, 490 (2010); see also supra Part I.
284. Sklar et al., supra note 283, at 493. The article also states that an important premium will be placed on medical research to determine the exact factors that have the largest room for improvement in the cost and quality of care debate:

Research in practice areas that overlap health services and clinical improvement will be increasingly important and will warrant funding by EM organizations and foundations. Growth will be in areas of demonstrated quality and cost reduction: [T]ime-sensitive conditions, disease-state-specific care pathways, guideline-based clinical protocols, checklists, and reductions in the variability of care—as in sepsis care and abdominal pain workups. Observational and short-stay diagnostic strategies will flourish to reduce inpatient costs and improve patient satisfaction.

Id.
on a real-time basis, aiding the diagnostic and patient management process.285

Related to the growth of health information technology, telemedicine will also affect emergency medicine.286 Telemedicine technology has allowed the field of medicine to take advantage of cutting-edge telecommunication systems to deliver quality healthcare.287 It was reported that nearly fifteen million people received care through this medium in 2015—a figure which is expected to rise.288 However, this large number of users is not surprising, as companies have already developed the technology to bring telemedicine to the daily smartphone user via mobile applications.289 This healthcare application revolution has increasingly allowed consumers to have access to physician consultations directly through their mobile phones, bringing the power of diagnosis and disease management to their fingertips.290 It will be interesting to examine the effects of these technologies on emergency medicine generally, and their impacts on the profitability metrics of EDs around the country in the decades to come. Aside from financial conundrums, this technology poses questions of liability that legal experts will be forced to address in the coming years.291

Should physicians be able to refer their patients to an ER through a mobile consultation?292 If so, will the referring mobile app physician share some of the liability as a part of the stream of diagnosis, or will the recipient physician in the ER still hold ties to all liability, as he or she had the opportunity for a physical examination?293

Furthermore, given the expansive reach of Internet and mobile data, telemedicine is not easily controlled by state lines or tangible boundaries.294 Rather, states will have to continue to collaborate and together develop procedures that address the discrepancies in state licensing laws, ultimately enacting changes to encourage physicians to practice medicine across state

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285. Id.
286. Id. at 492.
288. Id.
289. Id.
290. See id.
291. See id.
292. See Donohue, supra note 287.
293. See id.
Issues such as these will require heavy involvement of both the legal and medical community in developing apt frameworks that will allow the efficient use of healthcare technology to benefit society. \footnote{See id. “One of the major hurdles that telemedicine will have to face in the coming years is the differences that exist in state physician licensing laws.” Id.} 

Ultimately, emergency medicine as a distinct field of medicine still remains in its infancy, posing an onerous burden for legal scholars who attempt to gauge the exact trajectory the field will pursue in the coming generations. \footnote{See id.} However, certain elements will remain inherent to this medical specialty, such as the need for highly trained and intelligent providers; the critical service that ERs provide in fulfilling a basic societal need for healthcare services; and the growth potential of the field in terms of technology, innovation, and the promise of making healthcare more accessible. \footnote{See Sklar et al., supra note 283, at 494.} Thus, the legal community must remain cognizant of these elements, as it strives to not only protect patients and providers alike, but also in order to ensure the continued promulgation of frameworks and regulations in a manner that continues to fuel the growth and development of this vital field of medicine.