No. 97-53

In the
Supreme Court of the United States

October Term, 1997

Jane M. Roberts Gardian for Wanda Y. Johnson, *Petitioner,*

v.

Galen of Virginia, Inc., formerly d/b/a Humana Hospital -- University of Louisville, d/b/a Louisville Hospital, *Respondents.*

On Writ of *Certiorari to the United States Court of Appeals fot the Sixth Circuit*

BRIEF *AMICI CURIAE NOW LEGAL DEFENSE AND EDUCATION FUND, AMERICAN CIVIL LIBERITES UNION WOMEN'S RIGHTS PROJECT, NATIONAL ORGANIZATION FOR WOMEN FOUNDATION, NATIONAL PARTNERSHIP FOR WOMEN AND FAMILIES, NATIONALWOMEN'S HEALTH NETWORK, AND NATIONAL WOMEN'S LAW CENTER IN SUPPORT OF PETITIONER*

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INTEREST OF AMICI CURIAE

The NOW LEGAL DEFENSE AND EDUCATION FUND ("NOW LDEF"), founded in 1970 by leaders of the National Organization for Women, is a non-profit civil rights organization that performs a broad range of legal and educational services nationally in support of women's efforts to secure equal rights. One of NOW LDEF's priorities is the protection of the health of all women, particularly low-income women and women of color, and NOW LDEF has participated in numerous cases designed to effectuate that goal. *See, e.g., Schenck v. Pro-Choice Network, 117 S. Ct. 855 (1997); Burditt v. U.S. Dep't of Health and Human Services, 934 F.2d 1362 (5th Cir. 1991); and Washington v. Dunn, 916 P.2d 952 (Wash. Ct. App. 1996), rev. denied, 928 P.2d 413 (Wash. 1996). Because the instant case directly implicates the access of poor and uninsured women to adequate health care and to treatment for emergency conditions, NOW LDEF seeks to participate as amicus curiae in support of petitioner.*[1]

The AMERICAN CIVIL LIBERTIES UNION is a nationwide, non-partisan organization of more than 300,000 members dedicated to preserving the Bill of Rights. The ACLU WOMEN'S RIGHTS PROJECT ("ACLU WRP"), founded in 1971, has been a leader in the efforts to eliminate the barriers to women's full equality in American society. Equal access to health care for all women, particularly young women, pregnant women, poor women and women of color, is a priority for the ACLU WRP. The ACLU WRP joins this brief because this case will have a significant impact on the accessibility of health care for all women, especially the uninsured and those in need of emergency care.

The NATIONAL ORGANIZATION FOR WOMEN FOUNDATION ("NOW Foundation") is a 501(c)(3) organization devoted to furthering women's rights through education and litigation. NOW Foundation is affiliated with the National Organization for Women, the largest feminist organization in the United States, with a membership of over 200,000 women and men in more than 600 chapters in all fifty states and the District of Columbia. Since its inception in 1986, a major goal of NOW Foundation has been to ensure full equality for women, including reproductive freedom and fair treatment in health care services. In furtherance of that goal, NOW Foundation has supported related litigation and legislation, and has an ongoing interest in the full and fair health coverage for pregnant women.

The NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES is a non-profit, non-partisan organization that uses public education and advocacy to promote fairness in the workplace, access to quality, affordable health care, and policies that help women and men meet the dual demands of work and family. Founded in 1971 as the Women's Legal Defense Fund, the National Partnership is a voice for women in the managed care debate, promotes access to the full range of reproductive health services, works to prevent discrimination in health care and insurance based on genetic information and other factors, and works to expand health services for low-income women and children.

The NATIONAL WOMEN'S HEALTH NETWORK ("Network") is a non-profit health advocacy organization founded in 1976 to give women a greater voice in the health care system in the United States. The Network advocates for better federal policy on women's health and, through its Information Clearinghouse, provides women with information and resources to assist them in making better health care decisions. The Network, which is supported by 12,000 individual and 300 organizational members, accepts no funding from either pharmaceutical or device manufacturers. The Network focuses its advocacy efforts on improving access to health care for all women. Access to adequate health care and for treatment of emergency conditions for poor and uninsured women is at the heart of this case. For this reason, the Network has signed onto this brief in support of the petitioner.

The NATIONAL WOMEN'S LAW CENTER ("Center") is a non-profit legal advocacy organization that has been working since 1972 to advance and protect women's legal rights. The Center's primary goal is to ensure that public and private sector practices and policies better reflect the needs and rights of women. Access to quality health care remains an elusive goal for many women, especially for poor women, and advocating for better access to quality health care for women is an important Center priority.

SUMMARY OF ARGUMENT

The Emergency Medical Treatment and Active Labor Act (section 1867 of the Consolidated Omnibus Reconciliation Act of 1986, Pub. L. No. 99-272), 42 U.S.C. § 1395dd (hereinafter "EMTALA"), requires hospitals participating in the Medicare program to provide "an appropriate medical screening" to "any individual" who comes to the emergency department. If the hospital determines that the individual has an emergency medical condition, including active labor, the hospital must provide "such treatment as may be required to stabilize the medical condition." Id. There are significant limitations on the transfer of unstabilized patients. See id. An individual who suffers personal harm as a result of a hospital's violation of EMTALA may bring a civil action for damages against the hospital under the law of the state where the hospital is located.

One of Congress' primary aims in enacting EMTALA was to deter hospitals and doctors from refusing to provide care to the poor and the uninsured. In drafting the statute, however, Congress expanded upon the scope of prior federal and state statutes and enhanced EMTALA's deterrent effect by protecting "any individual" who presents at an emergency room, not just those who are indigent, uninsured, or in some other protected category. As every Circuit Court of Appeals other than the Sixth Circuit which has considered the question has concluded, EMTALA does not require proof that the refusal to provide the statutorily required screening or treatment was improperly motivated.

Requiring proof of an improper motive would both contravene the plain words of the statute and undermine Congress's purpose in enacting EMTALA. Congress responded to dire reports of patients who were inappropriately turned away from emergency rooms or transferred in unstable medical condition - i.e., examples of "dumping," practices that have particularly harsh consequences for African-Americans, Hispanics, and pregnant women - by requiring claimants to prove only one essential element: denial of emergency care. Imposing a higher standard of proof would make it more difficult for plaintiffs to prevail on an EMTALA claim, thwart Congress's purpose in enacting EMTALA, and inevitably lead to another litany of tragic stories, with hospitals continuing to deny services to individuals in need of emergency care.

ARGUMENT

I. ON ITS FACE, EMTALA DOES NOT REQUIRE A PLAINTIFF TO PROVE AN IMPROPER MOTIVE ON THE PART OF THE HOSPITAL AND THE CREATION OF SUCH A REQUIREMENT WOULD VITIATE THE PURPOSE OF THE STATUTE.

A. The Plain Words Of The Statute Prohibit Inappropriate Transfers Without Regard To The Motivation Of The Hospital.

The decision below, *Roberts v. Galen of Virginia, Inc., 111 F.3d 405, Jt. App. A1 (6th Cir. 1997), requires that a plaintiff seeking to recover damages under EMTALA prove that a hospital which ordered an inappropriate transfer of an unstabilized patient had an improper motive for effectuating the transfer.*[2] *Contrary to the Sixth Circuit's holding, however, the plain words of EMTALA establish no requirement of an improper motive as an element of recovery in a civil action. Congress's intent in enacting EMTALA was to prevent patient dumping - the turning away or transfer of poor or uninsured persons from emergency treatment because of their inability to pay. However, the language Congress ultimately chose to insert in the final version of the statute did not limit the statute's provisions to the poor or uninsured. Instead, Congress wrote EMTALA to permit "any individual who suffers personal harm as a direct result of a participating hospital's violation" to recover against the offending hospital. 42 U.S.C. § 1395dd(d)(2)(A). Congress's word choice was deliberate, as it was fully cognizant that many of the victims of inappropriate emergency treatment are neither indigent nor uninsured. See Equal Access to Health Care: Patient Dumping: Hearing Before the Human Resources & Intergovernmental Relations Subcomm. of the House Comm. on Government Operations, 100th Cong., 1st Sess. 40 (1987) (statement of Judith Waxman, managing attorney, the National Health Law Program, noting that while 37 million Americans have no health insurance coverage, an additional 50 million have inadequate coverage) (hereinafter "Subcomm. Hearing"). Regardless of the primary evil that Congress sought to cure, the language of the statute is controlling. See, e.g., Brogan v. United States, 118 S. Ct. 805, 809 (1998) ("[T]he reach of a statute often exceeds the precise evil to be eliminated."); Oncale v. Sundowner Offshore Services, Inc., 118 S. Ct. 998, 1002 (1998) ("[S]tatutory prohibitions often go beyond the principal evil to cover reasonably comparable evils, and it is ultimately the provisions of our laws rather than the principal concerns of our legislators by which we are governed.").*

In Roberts, the Sixth Circuit confirmed that its holding in *Cleland v. Bronson Health Care Group, 917 F.2d 266 (6th Cir. 1990) required that a plaintiff prove that a hospital acted with an improper motive to recover under*

EMTALA. Cleland involved a claim arising out of the medical screening requirement in 42 U.S.C. § 1395dd(a), and turned on the court's interpretation of the term "appropriate" as requiring an inquiry into the hospital's motives in administering the screening. The Roberts court went further and held that it could find "no rational reason to set forth differing standards when applying subsection (a) and (b) [the stabilization provision]," Roberts, 111 F.3d at 410 n.3, Jt. App. A12. Neither the text of the statute nor the legislative history provides any basis whatsoever for such a construction of either the medical screening or stabilization provision. Instead, these tools of construction make clear that courts should assess the statute's terms in accordance with medical criteria.

As an initial matter, the Sixth Circuit's interpretation of "appropriate" as containing the notion of motive is highly suspect. 42 U.S.C. § 1395dd(a) requires that "the hospital must provide for an appropriate medical screening examination . . . to determine whether or not an emergency medical condition . . . exists." In this context, the term "appropriate" clearly relates to the purpose of the examination - i.e., that the examination must be appropriate to the determination of whether the patient has an emergency medical condition.

The term "appropriate" also appears in several other places in the statute. For example, § 1395dd(c)(2)(D) requires that "appropriate" life support measures be used if a transfer is effected. Even more important, the statute provides a detailed definition of "appropriate transfer," which makes no mention whatsoever of any anti-discrimination component of the phrase. See 42 U.S.C. § 1395dd(c)(2). Instead, the phrase is defined in terms of the "interest[s] of the health and safety of individuals transferred," focusing on the medical propriety of the transfer rather than the requirement of an improper animus propounded by the Sixth Circuit. As like words should be interpreted alike within a single statute, see Sutherland, Statutory Construction § 47.16, the use of the term "appropriate" should not be construed to give rise to a requirement that a plaintiff show improper motive in order to prove a violation of EMTALA. See also Atlantic Cleaners & Dyers v. United States, 286 U.S. 427, 433 (1932) ("[T]here is a natural presumption that identical words used in different parts of the same act are intended to have the same meaning.").

The statute is equally clear that the stabilization provision does not require an inquiry into the hospital's motives. "[T]o stabilize" is defined in the statute as follows:

> with respect to an emergency medical condition . . . to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result or occur during the transfer of the individual from a facility . . .

42 U.S.C. § 1395dd(e)(3)(A). Similarly, "stabilized" means

> with respect to an emergency medical condition . . . that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility . . .

42 U.S.C. § 1395dd(e)(3)(B). Thus, the statute squarely indicates on its face that the "stability" of a patient is to be assessed in accordance with medical standards, without an inquiry into the motives of defendants.

Nonetheless, ignoring the plain text of the statute, the Sixth Circuit in both *Roberts and Cleland decided that the terms "appropriate" and "stabilize" contained within them the notion of motive. The court's effort to read a motive requirement into the statute is misguided: in interpreting these terms, the court blatantly ignored the primary tools of statutory construction - the text of the statute itself and its legislative history. There is no Committee Report or speech on the Senate floor or any other legislative source to support the assertion that "appropriate" or "stabilize" means "nondiscriminatory." In fact, during the 1987 hearings on implementation of the statute, testimony contrasted EMTALA's broad protection of "all beneficiaries of hospital services," with prior federal laws that protected only victims of discrimination or individuals who were able to prove that their dumping was motivated by economic factors. Subcomm. Hearing at 236 (statement of Richard Kusserow, HHS Inspector General).*

All other federal Courts of Appeal which have considered whether a claim under EMTALA requires proof of an improper motive have looked at the plain wording of the statute and have concluded that it does not. *See Summers v. Baptist Medical Ctr. Arkadelphia, 91 F.3d 1132, 1137-38 (8th Cir. 1996) (en banc) ("[W]e do not agree that evidence of a purpose to 'dump' a patient is required [to establish a violation of EMTALA]. Nor does*

the statute require any other particular motivation. . . . If a hospital fails to provide an appropriate medical screening examination, it is liable, no matter what the motivation was for this failure."); Power v. Arlington Hosp. Ass'n, 42 F.3d 851, 857 (4th Cir. 1994) ("[N]othing in the statute itself . . . requires proof of indigence, inability to pay, or any other improper motive on the part of a hospital as a prerequisite to recovery."); Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1041 n.3 (D.C. Cir. 1991) ("We do not read subsection 1395dd(a) as referring in any way to the 'motives' with which an emergency room acts when it provides something less than its normal screening procedure."); and Burditt v. U.S. Dep't of Health and Human Services, 934 F.2d 1362, 1373 (5th Cir. 1991) (the court refused to "invent a requirement found nowhere in the statute that an improper, or nonmedical, motive for transfer must be proved as an element of all EMTALA transfer violations. As written, EMTALA prevents patient dumping without such a requirement. . . . We refuse to alter the statutory scheme.").[3]

It is worth noting that EMTALA has been amended seven times since its enactment in 1986 - in 1986, 1987, 1988, 1989, 1990, 1994, and 1997[4] - yet the inclusion of an improper motive requirement has never been discussed, let alone adopted. If Congress believed that the Summers, Power, Gatewood, and Burditt decisions were contrary to the statute, it had ample opportunity to amend the statute to include an improper motive requirement. That Congress did no such thing in either the 1994 or 1997 amendments to the statute confirms the statute's plain meaning. *See North Haven Bd. of Educ. v. Bell, 456 U.S. 512, 535 (1982) ("Where an 'agency's statutory construction has been fully brought to the attention of the public and the Congress, and the latter has not sought to alter that interpretation although it has amended the statute in other respects, then presumably the legislative intent has been correctly discerned.' ") (citations omitted).*

B. Congress Was Aware of Analogous Federal and State Laws That Explicitly Require Proof Of Improper Intent And Deliberately Chose Not To Enact Such A Requirement In EMTALA.

Prior to the enactment of EMTALA, hospital emergency services were regulated both by the Hill-Burton Act, 42 U.S.C. §§ 291, *et seq., and by state laws.*[5] *Congress was aware of both of these sources of law when it drafted and later amended EMTALA. See, e.g., Subcomm. Hearing at 2 (statement of Representative Weiss, noting that Hill-Burton Act requires that hospitals receiving funds "must provide emergency care to certain individuals regardless of ability to pay"); Karen I. Treiger, Note, Preventing Patient Dumping: Sharpening the COBRA's Fangs, 61 N.Y.U. L. Rev. 1186, 1201-02 (1986) (describing how Congress referred to the Texas statute in drafting EMTALA). In fact, Congress enacted EMTALA, in part, because the Hill-Burton Act proved ineffective in deterring patient dumping. See S. Rep. No. 1285, 93rd Cong., 2d Sess. 61, reprinted in 1974 U.S.C.C.A.N. 7842, 7900 (concluding that the implementation of Hill-Burton by the Department of Health, Education and Welfare and state agencies has been a "sorry performance").*

The Hill-Burton Act was enacted in 1946, and imposed certain community service obligations on all hospitals receiving Hill-Burton funds. The regulations implementing the Hill-Burton Act specifically provided that

> [a] facility may not deny emergency services to any person who resides . . . in the facility's service area on the ground that the person is unable to pay for those services.

42 C.F.R. § 124.603(b)(1) (emphasis added). The HHS Office of Civil Rights construed these regulations to require, as a prerequisite to establishing a violation, proof that the hospital's decision to deny emergency services was motivated by the patient's inability to pay or some other improper factor. *See, e.g., In re Margaret R. Pardee Memorial Hospital, (Hendersonville, N.C.; HHS/OCR No. 04803173, decided Sept. 4, 1981) (no evidence supported complainant's allegations that emergency services had been denied because he was unable to pay). Given Congress's dissatisfaction with Hill-Burton, Congress deliberately chose not to adopt the restrictive language of the Hill-Burton regulation and, instead, enacted a statute that does not require proof of defendant's motive for denying emergency services.*

Congress was also aware of laws in twenty-two states that regulate the provision of emergency care when it enacted EMTALA. *See H.R. Rep. 241, 99th Cong., 1st Sess., pt. 3, at 5, reprinted in 1986 U.S.C.C.A.N. 726, 726-27 (noting ineffectiveness of state laws and need for additional federal sanctions). These statutes vary tremendously. Some state laws explicitly provide that a defendant violates the law only if he or she was motivated to deny proper care by the patient's indigence. See, e.g., Hawaii Rev. Stat. § 321-232(b) (1997) (emergency medical services shall not be denied "on the basis of the ability of the person to pay therefor or because of lack of prepaid health care coverage or proof of such ability to pay for coverage"). Other state laws*

explicitly prohibit denial of emergency care based upon a variety of improper factors, including indigence. See, e.g., Tex. Health & Safety Code Ann. § 311.022 (1998 Supp.) (emergency services shall not be denied "because a person cannot establish [his] ability to pay for the services or because of race, religion, or national ancestry"). Still other state laws, like EMTALA, contain no such limitations and instead require that emergency services be provided to all who need emergency care. See, e.g., N.Y. Pub. Health Law 2805-b (McKinney 1993) ("hospital shall admit any person who is in need of immediate hospitalization with all convenient speed"). Particularly in light of these alternative models for addressing patient dumping, Congress's deliberately chosen language in EMTALA should be given its plain meaning.

II. IMPOSITION OF A REQUIREMENT THAT A PLAINTIFF PROVE THE MOTIVATION OF THE HEALTH CARE PROVIDER WOULD SUBSTANTIALLY WEAKEN EMTALA, CONTRAVENING CONGRESS'S INTENT TO PROVIDE AN EFFECTIVE MEANS OF ENFORCEMENT.

A. The Burden of Proving The Motivation Of The Hospital Would Be Prohibitively High And Would Undermine Effective Enforcement Of The Statute.

If imposed, the burden of proving discriminatory intent would deter aggrieved individuals from bringing their claims to court and would reduce the likelihood of success for any who might proceed. "[T]he most fundamental problem with the motive requirement," wrote the Fourth Circuit in Power, is the "proof predicament." Power, 42 F.3d at 858. Indeed,

> a requirement that the plaintiff prove discriminatory intent . . . is often a burden that is impossible to satisfy. "Intent, motive and purpose are elusive subjective concepts."

Metropolitan Hous. Dev. Corp. v. Village of Arlington Heights, 558 F.2d 1283, 1290 (7th Cir. 1977), cert. denied, 434 U.S. 1025 (1978) (quoting Hawkins v. Town of Shaw, 461 F.2d 1171, 1172 (5th Cir. 1972) (en banc) (per curiam)). Imposition of this onerous evidentiary burden in EMTALA cases would thwart the purpose of the statute - i.e., the Congressional aim of ensuring access to emergency care for those in need of emergency services and for women in labor. Were such a principle to be adopted, the focus of efforts to recover under EMTALA would necessarily be on the state of mind of treatment providers, rather than upon the objective assessment of how the plaintiff was treated.

B. The Added Burden Of Proof Would Endanger The Lives Of Those In Need Of Emergency Care.

The imposition of an intent requirement would not only undermine the strength of the statute but would also endanger the lives of those in need of emergency care. By encumbering patients, many of them poor or working class, with an additional burden of proof, this requirement would dilute the deterrent effect of the statute.

As the House Committee on Government Operations recognized, "patient dumping has serious medical implications and can result in denial of necessary emergency care and even death." Equal Access Rep. at 5. Patients who are inappropriately transferred risk delays in emergency treatment, life threatening complications, and a higher mortality rate. See id. at 6. See also Subcomm. Hearing at 157 (statement of David A. Ansell, M.D., regarding the results of a study of transfers in Cook County, Illinois); Robert L. Schiff, *et al., Transfers to a Public Hospital, 314 New Eng. J. Med. 552, 555-56 (1986); David U. Himmelstein, et al., Patient Transfers: Medical Practice as Social Triage, 74 Am. J. Public Health 494, 496 (1984).*

Testimony before Congress in 1988 included striking examples of the harms caused by patient dumping. See, e.g., Subcomm. Hearing at 42-43. Sadly there continues to be no shortage of such examples, as evidenced by the egregious nature of a number of 1995-96 EMTALA violations:

- A twenty-eight year old woman went to an emergency room complaining of severe abdominal pain. A pregnancy test was administered and came back positive, but the patient was discharged while continuing to suffer from the abdominal pain. She received no treatment for the pain, and was readmitted three days later in shock with a ruptured ectopic pregnancy. *See Public Citizen Research Group, Hospital Violations of the Emergency Medical Treatment and Active Labor Act: A Detailed Look at "Patient Dumping," app. A-17 (Dec. 1997).*
- *An eleven month old child was brought to an emergency room by his mother. The child needed follow-up treatment for viral gastroenteritis and bilateral ototis media. The child's lab results indicated the child's*

condition was worsening. The child needed intravenous treatment, but emergency room personnel were unable to achieve proper placement. They failed to call the hospital's on-call physicians, and instead had the child transferred before he was stabilized. The child suffered cardiopulmonary arrest soon after arriving at the other hospital. Id. at A-7.

- *In Massachusetts, a two-year old child who was suffering from a 103.2 degree fever, vomiting, and diarrhea was brought to the emergency room by her mother. The emergency room conducted no medical screening exam, and instead referred the patient to a private physician. Approximately seven hours after first going to the emergency room, the child had to be transported back in an ambulance. She was unresponsive upon arrival, and died soon after. Id. at A-12.*

The dangers of dumping are also illustrated in the case presently before this Court.

The impact of the additional hurdle to securing EMTALA protection will be felt most severely by the poor and uninsured - those most at risk of being turned away at the hospital emergency room and those whom Congress intended EMTALA to protect. This group includes the more than 41.7 million Americans without health insurance coverage. See Bureau of the Census, Current Population Reports, Series P60-199, *Health Insurance Coverage: 1996 (1997).*

As women's rights organizations, amici are particularly concerned about women's health, and the denial of emergency room care clearly jeopardizes the health of poor and uninsured women. Currently women represent over sixty-two percent of adult Americans living in poverty. See Bureau of the Census, Current Population Reports, Series P60-198, *Poverty in the United States: 1996 tbl. 2 (1997). Like petitioner here, forty-five percent of Americans without health insurance are women. See The Urban Institute, State-Level Datebook on Health Care Access and Financing (3d ed. 1998).*

In contrast to men, women are more likely to have a publicly-funded source of insurance, such as Medicaid or Medicare - eleven percent of women ages eighteen to sixty-four are covered through the public sector whereas only seven percent of men receive public insurance. *See Institute for Women's Policy Research, Research in Brief, Women's Access to Health Insurance (1996). Women are more likely than men to work in part-time jobs - sixty-eight percent of the part-time workforce are women. See Bureau of Labor Statistics, U.S. Department of Labor, Geographic Profile of Employment and Unemployment 1996 tbl. 2 (1998). The number of hours worked per week is directly related to the likelihood that workers receive health insurance coverage through their employers; thus, women are less likely to have employer-sponsored insurance. See Institute for Women's Policy Research, supra.*

Moreover, changes in welfare policies across the country are leading to reductions in Medicaid coverage. Between 1995-96, when states began changing their welfare policies and reducing their welfare caseloads using federal waivers, overall Medicaid enrollment dropped for the first time in a decade. *See Marilyn Ellwood and Leighton Ku, Welfare and Immigration Reforms: Unintended Side Effects for Medicaid, 17 Health Affairs 137, 143 (May/June 1998). Since 1996 and the adoption of the new federal welfare law, welfare caseloads have dropped even more sharply than during the 1995-96 period. Complete national Medicaid data are not available, but preliminary reports indicate that the decline in Medicaid enrollment, especially among adults, will continue. See id. at 143-45. And it does not appear that most families leaving welfare and Medicaid are obtaining private health insurance. The number and percentage of uninsured Americans rose as Medicaid enrollment dropped. See id. at 145. Furthermore, the prospects for poor women obtaining coverage are not good; a recent study found that three years after leaving Aid to Families with Dependent Children (AFDC), thirty-eight percent of women had private insurance, seventeen percent had Medicaid, and forty-five percent were uninsured. See id. at 150.*

Even when poor women do have health insurance coverage, such insurance is not a shield to the dangers of patient dumping. Poor women, even when insured, remain at risk of being improperly denied medical care. In a study conducted before the enactment of EMTALA, researchers found that forty-six percent of the patients who were dumped were receiving public aid (including Medicaid) and three percent were insured through Medicare. *See Schiff et al., supra, at 553.*

Women are particularly vulnerable to dumping when they face the "emergency" of giving birth. See, e.g., Burditt, 934 F.2d 1362 (pregnant woman in active labor transferred in unstable condition because she was uninsured). *See also Lauren Dame & Sidney Wolfe, Public Citizen Health Research Group, Hospital Violations of the Emergency Medical Treatment and Active Labor Act: A Detailed Look at "Patient Dumping," app. 1*

(Dec. 1997) (patient in labor in Little Rock, Arkansas was transferred, unaccompanied by persons trained for medical emergencies or in the delivery of a baby; patient in Dardanelle, Arkansas who was experiencing contractions every four to five minutes was transferred without qualified personnel or transportation equipment). The language of EMTALA specifically includes labor within the definition of "emergency condition" in order to protect women in labor from improper screening and transfer. See 42 U.S.C. § 1395dd(e)(1)(B). This explicit consideration of women in labor reveals Congress's intention to establish strong protections for poor pregnant women against being "dumped" during childbirth. If pregnant patients must prove discriminatory intent in order to prevail on an EMTALA claim, the force of this safeguard for poor women and newborns will be severely weakened.

The problem of patient dumping also disproportionately affects minorities. More than twenty-eight percent of African-Americans and twenty-nine percent of Hispanics live below the poverty level. See *Poverty in the United States: 1996, supra, tbl. 2. Twenty-one percent of African-Americans and thirty-three percent of Hispanics are uninsured, compared to fourteen percent of whites. See Bureau of the Census, Statistical Abstract of the United States: 1997, at tbl. 171. One survey found that eighty-nine percent of the improper transfers studied were of African-American or Hispanic patients. See Schiff et al., supra, at 553.*

Patients falling into more than one of these categories face even greater risk. For example, the loss of EMTALA protection for pregnant women of color threatens to exacerbate the already tragic maternal and neonatal mortality rate among women of color. *See, e.g., Burditt, 934 F.2d 1362 (Uninsured Hispanic woman transferred while in active labor). In 1992, the maternal mortality rate for women of color was 18.2 per 100,000 live births compared to 5.0 for white women. The 1994 neonatal death rate for infants of color was 8.6 per 1,000 live births compared to 4.2 for white infants. See Statistical Abstract of the United States: 1997, supra, tbl. 123.*

Finally, patient dumping among the insured is becoming a larger problem as hospitals contract with Health Maintenance Organizations ("HMOs") to provide services to their members. Patients who are taken to hospitals that do not have contracts with their HMO are increasingly directed to other hospitals, improperly transferred in unstable conditions, or provided with care that they must later pay for in full. *See Lauren A. Dame, The Emergency Medical Treatment and Active Labor Act: The Anomalous Right to Health Care, 8 Health Matrix 3 (1998). In light of the fact that eighty-one percent of insured Americans are covered by managed care plans, see Public Citizen Research Group Report, supra, at 10 n.15, the problem of patient dumping is likely to affect more and more Americans - even those with insurance.*

No matter what the cause or motivation, the denial of emergency treatment and the inappropriate transfer of patients represent serious barriers to health care access. With the passage of EMTALA, Congress took forceful steps to address these barriers. The imposition of an intent requirement would substantially weaken the statutory scheme established by Congress and would place the lives of those in need of emergency care at greater risk.

CONCLUSION

For the foregoing reasons, the judgment of the Sixth Circuit should be reversed.[6]

Respectfully submitted,

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NOTES:

1 Pursuant to Supreme Court Rule 37.6, amici state that no counsel for a party authored this brief in whole or in part and that no person, other than amici, its members, or its counsel made a monetary contribution to the preparation or submission of this brief.

This brief is submitted with the consent of all the parties and letters of consent from counsel for the parties have been lodged with the Clerk.

2 § 1395dd(a) of EMTALA provides, in pertinent part, that

> [if] any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for an examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition . . . exists.

§ 1395dd(a). In addition, if "any individual" is determined to have an emergency condition or to be in active labor, the hospital must either provide further treatment to stabilize the medical condition or an "appropriate transfer," as defined in 1395dd(c)(2), which meets the "interest of the health and safety of individuals transferred." 1395dd(c)(2)(E). Negligent failure to comply with these requirements exposes the hospital to civil penalties. 1395dd(d)(1). An individual who suffers personal harm as a result of a hospital's violation of EMTALA may bring a civil action against the hospital under the law of the state where the hospital is located. 1395dd(d)(2).

3. *Burditt, like the instant case, involved the transfer of an unstabilized patient. However, the statutory provision at issue in Burditt was 42 U.S.C. 1395dd(d)(1), which provides for the imposition of civil money penalties by the Secretary of Health and Human Services and applies only when a hospital is negligent in violating EMTALA. In the case before this Court, the relevant statutory provision contains no negligence requirement but simply allows "any individual" who suffers harm because of an EMTALA violation to bring a civil action. 42 U.S.C.*

1395dd(d)(2)(A). There is therefore even less of a basis for reading an improper motive requirement into the civil action provision of the statute.

4 See Act of Oct. 21, 1986, Pub. L. No. 99-509, tit. IX, § 9307(c)(4), 100 Stat. 1996; Act of Dec. 22, 1987, Pub. L. No. 100-203, tit. IV, § 4009(a), 101 Stat. 1330-56, 1330-57; Act of Oct. 13, 1988, Pub. L. No. 100-485, tit. VI, § 608(d)(18)(E), 102 Stat. 2419; Act of Dec. 19, 1989, Pub. L. No. 101-239, tit. VI, §§ 6003(g)(3)(D)(xiv), 6211, 103 Stat. 2154, 2245;

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5 At the time that Congress enacted EMTALA, twenty-two states had statutes or regulations governing the provision of emergency services. See Cal. Health and Safety Code §§ 1317, 17409, 1978; Colo. Rev. Stat. §§ 26-15-101-110; Fla. Stat. Ann. §§ 395.0143, 401.45(1); Ga. Code. Ann. §§ 31-8-42, 31-8-43, 31-8-46; Hawaii Rev. Stat. § 321-232(b); Ill. Ann. Stat. Ch. 111 ½, § 86; Ky. Rev. Stat. Ann. §§ 216B.400(1), 216B.990(3); La. Rev. Stat. Ann. §§ 2113.4(2)-2113.4(b); Mass. Gen. Laws Ann. § 70E(m)(e); Mich. Stat. Ann. §§ 14.15(20715), 14.15(20704(4)), 14.15(20703); Mo. Ann. Stat. § 205.989(1); N.J. Admin. Code tit. 8, § 8.43-B1; N.Y. Public Health Law §§ 2805-b, 2806(1); Oregon Admin. Reg. Ch. 333, § 23(15); Pa. Admin. Reg. § 117.1(a), (b); R.I. Gen. Laws § 23-17-26(a); S.C. Admin. Reg. 61-16 § 309; Tenn. Code Ann. §§ 68-69-301, 68-39-302, 68-39-511(12); Tex. Health & Safety Code Ann. § 4438; Utah Code Ann. §§ 26-8-8(1), 26-8-2(12); Wis. Stat. Ann. § 146.301; Wyo. Stat. Ann. § 35-2-115(a).

6 Attorneys for amici would like to acknowledge the assistance of Thomas M. Gorman and Maya Grosz in the preparation of this brief.