



*Protecting Patients' Rights and Access to Care*  
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**An analysis of the potential applicability of EMTALA to the restrictive policies of Connecticut Catholic hospitals in treating rape victims**

Background on CT Catholic hospital policies

Catholic hospitals are nonprofit health care facilities that function both as corporations subject to civil law and as canonical entity subject to Catholic doctrine. The Church issues official guidelines for health care, most commonly through the National Conference of Catholic Bishops, which publishes the Ethical and Religious Directives for Health Care Services (ERDs).<sup>1</sup> The bishop of the diocese in which the hospital is located has the authority to interpret these guidelines, which are adopted as part of the hospital board corporate bylaws.

There are currently four Catholic hospitals in Connecticut<sup>2</sup> licensed by the state to serve the general public in their catchment areas. Their patients are from many different backgrounds and faiths. For example, in Hartford County, where one of the Catholic hospitals (St. Francis Hospital and Medical Center) is located, 38 percent of the population identify as Catholic, but a majority are either affiliated with other faiths or say they are not affiliated with any religious organization (43 percent).<sup>3</sup> Like non-Catholic hospitals, the four Connecticut Catholic hospitals receive funding in the form of Medicaid and Medicare reimbursements and government grants.<sup>4</sup>

In August 2005, Archbishop Henry J. Mansell of Hartford and Bridgeport Bishop William E. Lori issued guidelines for treatment of rape victims in the emergency

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<sup>1</sup> United States Conference of Catholic Bishops, Inc, Ethical and Religious Directives for Health Care Services, Fourth Edition, available at <http://www.nccbuscc.org/bishops/directives.shtml> (Accessed 8/17/06).

<sup>2</sup> St. Mary's in Waterbury, the Hospital of Saint Raphael in New Haven, St. Vincent's Medical Center in Bridgeport, and St. Francis Hospital and Medical Center in Hartford.

<sup>3</sup> The historically African American denominations are not included in the 2000 congregation and membership totals. Hartford County, CT Membership Report, 2000. Association of Religion Data Archives. [http://www.thearda.com/mapsReports/reports/counties/09003\\_2000.asp](http://www.thearda.com/mapsReports/reports/counties/09003_2000.asp) (Accessed 8/23/06).

<sup>4</sup> The State of CT's Office of Health Care Access Hospital Budget System and Hospital Inpatient Discharge Database. <http://www.ct.gov/ohca/lib/ohca/publications/mediweb.pdf#search=%22Office%20of%20Health%20Care%20Access%20Hospital%20Budget%20System%20and%20Hospital%20Inpatient%20Discharge%20Database%22> (Accessed 8/23/06).

department of Connecticut's Catholic hospitals based on a strict interpretation of Directive 36 of the ERDs, which states:

Compassionate and understanding care should be given to a person who is the victim of sexual assault...a female who has been raped should be able to defend herself against a potential conception from sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or recommend treatments that have as their purpose or direct effect the removal, destruction or interference with the implantation of a fertilized ovum.<sup>5</sup>

According to the Connecticut bishops' interpretation of Directive 36, medications that interfere with implantation are morally equivalent to abortion. Therefore, women cannot defend themselves against an unintended pregnancy by sexual assault if there is a chance that conception has occurred. As a result, rape victims being treated in an emergency department of a Catholic hospital in Connecticut are being required to submit to an ovulation test in order to determine their eligibility to receive emergency contraception (EC) within the bishops' interpretation of Directive 36.<sup>6</sup> (A clinical analysis of this protocol, appended to this briefing paper, raises serious questions about its accuracy.) If it is found "more likely than not" that the patient is ovulating, EC will not be administered, nor will the patient be given a prescription to obtain EC elsewhere.<sup>7</sup> Patients "should then be informed in a neutral manner of other sites in the community or region which may offer treatment with such medications."<sup>8</sup> Further, only if the rape victim requests a transfer will the emergency department facilitate one following the hospital's transfer policies.<sup>9</sup>

The protocol being followed by Connecticut's Catholic hospitals resembles what is known as the Peoria Protocol, a policy developed by the Bishop in Peoria, IL, and imposed at Catholic hospitals in that diocese. That protocol is based on the assumption that EC may act to interfere with implantation of a fertilized ovum on the uterine wall. While some scientists theorize that EC may have that mechanism of action some time, there is no scientific proof of this theory. EC's proven mechanism of actions are preventing ovulation or interfering with the process of fertilization.<sup>10</sup>

Such a policy for treatment of rape victims is by no means the standard approach of Catholic hospitals in the United States. National and state surveys of hospital policies

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<sup>5</sup> *Ethical and Religious Directives for Health Care Services, Fourth Edition*. United States Conference of Catholic Bishops, Inc: Washington, D.C., 2001.

<sup>6</sup> Sexual Assault Protocol of the Connecticut Catholic Hospitals. Copy provided to MergerWatch by Planned Parenthood Connecticut.

<sup>7</sup> Sexual Assault Protocol of the Connecticut Catholic Hospitals.

<sup>8</sup> Ibid.

<sup>9</sup> Ibid.

<sup>10</sup> Emergency Contraception's Mode of Action Clarified, Population Briefs, Population Council, May 2005, Vol. 11. No. 2, posted at [http://www.popcouncil.org/publications/popbriefs/pb11\(0\)\\_3.html](http://www.popcouncil.org/publications/popbriefs/pb11(0)_3.html).

have found considerable variation among Catholic hospitals. For example, a national survey by Ibis Reproductive Health in 2002 found that only 28 percent of Catholic hospital emergency departments would provide EC to rape victims.<sup>11</sup> In 2006, a survey by the same organization revealed how Catholic hospitals have been responding to laws enacted in three states (CA, WA, NY) mandating that all hospital emergency departments offer emergency contraception to rape victims. (Such a law has been proposed in Connecticut, but has been stalled due to the opposition of the state's Catholic bishops.) The survey found that of those Catholic hospitals reporting that they treat sexual assault victims, 86 percent stated they complied with their state policy by routinely offering emergency contraception. However, callers asking hospital staff about EC availability received contradictory answers in many cases.

There is considerable debate among Catholic leaders about how to interpret Directive No. 36, according to an article published in *Health Progress*, the journal of the Catholic Health Association, by the association's senior director of ethics, Ronald Hamel,<sup>12</sup> Hamel supports the approach taken by some Catholic hospitals of administering a pregnancy test (not an ovulation test). Such a test – if administered within several days of a sexual assault -- could only detect a pregnancy that began prior to the rape. If the test result is negative, emergency contraception is then offered to the rape victim. This approach does not, of course, detect the present of a fertilized egg. No test is presently available that could detect fertilization. Moreover, if EC were given to a patient who was already pregnant prior to the rape, the medication would have no effect whatsoever on the developing pregnancy. However, Hamel endorses the use of pregnancy testing as a morally permissible and preferred approach that allows Catholic health care providers to administer compassionate care that focuses on the victim of sexual assault's well-being and recovery.

#### Purpose of the analysis

This analysis seeks to explore whether the use of ovulation tests to screen rape victims at Connecticut's four Catholic hospitals may violate the federal Emergency Medical Treatment and Active Labor Act (EMTALA). This is a novel approach, as a review of the literature has found no reported instances in which such a protocol has been challenged as a potential violation of EMTALA. The analysis will review the potential arguments that these four hospitals, as recipients of Medicare and Medicaid, may be violating EMTALA by denying access to emergency services to rape victims through the use of a screening protocol that is designed to ensure conformance with religious teachings, at the expense of standard medical care. An overview of EMTALA will be followed by an analysis of three primary obligations this law imposes upon hospitals. These requirements will then be applied to Catholic hospitals' treatment of rape victims. The analysis concludes with recommendations about the most effective potential arguments that could be made regarding the Catholic hospital protocol within the legal parameters of EMTALA.

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<sup>11</sup> "Second Chance Denied: Emergency Contraception in Catholic Hospital Emergency Rooms," Ibis Reproductive Health for Catholics for a Free Choice.

<sup>12</sup> Hamel, Ronald P. & Panicola, Michael R. "Emergency Contraception and Sexual Assault: Assessing the Moral Approaches in Catholic Teaching." *Health Progress*, 83 (5): September-October, 2002.

## Overview of EMTALA

All hospitals that accept Medicare and Medicaid have a duty to screen and stabilize individuals who arrive at their emergency department requesting medical treatment. This basic obligation is federally mandated by EMTALA, enacted in 1985. Originally, Congress passed EMTALA in response to a growing trend of emergency departments denying emergency care to indigent or uninsured patients, or transferring them to other facilities for purely economic reasons. Today, EMTALA governs virtually all aspects of a hospital's delivery of emergency services to protect the general public against discriminatory practices. Approximately 98 percent of all hospitals in the United States are required to comply with EMTALA.<sup>13</sup> Hospitals that are exempt include those that do not accept Medicare funds, such as some Veterans' Administration or military hospitals, and a few private psychiatric facilities.

Two agencies within the Department of Health and Human Services enforce EMTALA: the Centers for Medicare and Medicaid Services (CMS) which is responsible for the federal Medicare program, and the Office of Inspector General (OIG), which is charged with promoting efficiency, effectiveness, and integrity of HHS programs.

CMS authorizes an investigation based on a complaint by an individual or state agency, determines if a violation has occurred, and has the authority to withdraw a hospital's Medicare provider agreement without due process or medical peer review. However, CMS' stated policy is not to exclude hospitals from Medicare participation (which could effectively close some hospitals), but rather to encourage hospitals' compliance with the law, as CMS interprets it. In fact, as of 2001, only four hospitals have been terminated from the Medicare program because of EMTALA violations, all more than 11 years ago (one in 1987, two in 1988, and one in 1989). Two of the four hospitals were later recertified.<sup>14</sup>

New England hospitals – including those in Connecticut – are under the jurisdiction of Boston Regional Office of CMS.<sup>15</sup> Between 1997 and 1999 four Connecticut hospitals were cited by CMS. No Connecticut violations were cited between 2000 and 2003.<sup>16</sup>

Whenever CMS finds an EMTALA violation, it refers the case to the OIG for review for possible sanctions. By considering the nature and circumstances of the violation and the effect a fine would have on a hospital's ability to provide care, IOG can fine hospitals a maximum of \$50,000 per violation. For hospitals with fewer than 100 beds, a maximum fine of \$25,000 can be imposed. In addition, any physician responsible for examination, treatment, or transfer of an individual in a participating hospital, including an on-call physician, who negligently violates a requirement of the statute, may be fined a maximum of \$50,000 in civil monetary penalties, and excluded from the Medicare

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<sup>13</sup> Bitterman, Robert A., *Providing Emergency Care Under Federal Law: EMTALA*, 2000:17.

<sup>14</sup> *Emergency Care EMTALA: Implementation and Enforcement Issues*. Report to Congressional Committees. United States General Accounting Office, June 2001: 20.

<sup>15</sup> Health Standards & Quality CMS JFK Federal Building Room 2325 Boston, MA 02203-0003 617-565-1298

<sup>16</sup> The Connecticut Health Policy Report. *Report of the Commission on the Future of Hospital Care in Connecticut*. January 7, 2003.

program by the OIG for repeated or “gross and flagrant violations.”<sup>17</sup>

To be found in violation of EMTALA, a physician or hospital does not have to be found responsible for causing harm to a patient or found to have acted with improper motives. Those individuals who are harmed by a hospital or physician violation are empowered by EMTALA to file a civil suit against the hospital (but not the physician) for damages resulting from the violation.<sup>18</sup> Importantly, a civil suit is allowed to proceed regardless of whether CMS investigated a hospital for EMTALA compliance and even if the investigation found no violations by the hospital. Three types of lawsuits permitted under EMTALA are discussed in detail at the end of this paper.

Three primary obligations imposed upon hospitals by EMTALA are most significant to this analysis: the emergency medical screening requirement, the stabilization of patients with emergency medical conditions and transferring of patients.

### **A. The Emergency Medical Screening Requirement**

If an individual comes to a hospital emergency department and requests examination or treatment for a medical condition, the hospital must provide an appropriate medical screening examination (MSE) to determine if an emergency medical condition (EMC) exists.<sup>19</sup>

According to an extensive analysis of EMTALA by Robert A. Bitterman, published by the American College of Emergency Physicians,<sup>20</sup> if a rape victim comes to an emergency department solely to provide evidence for a criminal investigation, no medical screening examination is required because that individual is not requesting medical care. However, if the victim complains of pain or an injury or asks for pregnancy or sexually transmitted disease prophylaxis, that individual is requesting an examination or treatment for a medical condition and must be provided a medical screening examination.<sup>21</sup>

#### ***What is the medical screening examination standard?***

Each hospital determines its own standard screening procedures, depending upon capabilities and services available within its emergency department. Once a hospital defines its standard screening protocol, however, it must be applied equally to all individuals. Any departure from that standard screening process is a de facto violation of EMTALA.

EMTALA, however, cannot be used to determine whether a hospital’s standard MSE is itself adequate or appropriate. EMTALA’s only MSE concern is whether the hospital’s MSE, as defined by the hospital, was administered uniformly.<sup>22</sup> Any legal challenge

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<sup>17</sup> 42 CFR 1003.105(a)(1).

<sup>18</sup> EMTALA 42 USC 1395dd(d)(2)(A).

<sup>19</sup> 42 USC 1395dd(a) in Bitterman, 2000:15.

<sup>20</sup> Much of this text is indebted to Robert A. Bitterman’s, *Providing Emergency Care Under Federal Law: EMTALA*. Dallas: American College of Emergency Physicians, 2000.

<sup>21</sup> Bitterman, 2000: 39.

<sup>22</sup> Bitterman, 2000: 50.

regarding the quality of care given during the MSE must be addressed through a medical malpractice claim instead.

The Connecticut Catholic hospitals' use of an ovulation test to decide emergency contraception eligibility for rape victims appears to be an MSE that is applied uniformly to all rape victims (or, at least to all rape victims likely to be at risk of pregnancy due to their age and the exposure to unprotected sex). In order to use EMTALA as a basis for a challenge to the Catholic hospitals' treatment of rape victims, it would have to be demonstrated that a female victim of sexual assault is being treated differently than other classes of similarly-situated patients. Because only rape victims who are women are subjected to this MSE, comparison groups might include male rape victims or all victims of assault. In order to use EMTALA as a basis for a challenge to the Connecticut Catholic hospitals' policy, it would have to be proven that a female victim of sexual assault is being treated differently than other types of assault victims during the screening process.

### ***What is an emergency medical condition?***

According to George J. Annas, a bioethicist and professor of health law at Boston University School of Public Health, no completely satisfactory definition of a medical emergency has ever been formulated.<sup>23</sup> The general guidelines as defined by EMTALA, however, state that an emergency medical condition (EMC) exists if an individual has:

Acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in

- Placing the health of the individual in *serious* jeopardy
- *Serious* impairment to bodily functions, or
- *Serious* dysfunction of any bodily organ or part.<sup>24 25</sup>

Because of the frequent use of the word "serious" in this definition, it is important to clarify the meaning of this word, as interpreted by the courts. In *Camp v Harris Methodist Fort Worth*, a Texas appeals court articulated the meaning of "serious" by stating, "an emergency medical condition exists only if the patient is in 'imminent' danger of death or a worsening condition that could be life threatening."<sup>26</sup> In that case, a young woman who presented at an emergency room with shoulder pain and signs of anemia was discharged with a recommendation to see her doctor in the morning. She died the next day due to complications of an undiagnosed gastric ulcer. The court ruled in favor of the hospital for successfully completing the examination requirement. The relevant factor is whether the hospital perceived the patient to have an EMC, not whether the patient actually had an EMC nor whether the hospital or attending physician should have known the EMC existed. This subjective standard provides a good faith defense for providers in the court setting.

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<sup>23</sup> Annas, George J. *The Rights of Patients* 2004: 90.

<sup>24</sup> 42 USC 1395dd(e)(1)(A).

<sup>25</sup> *Italic added for emphasis.*

<sup>26</sup> *Camp v Harris Methodist Fort Worth*, 983 SW2d 876 (Tex App December 31, 1998) in Bitterman, 2000: 24.

***Who decides what constitutes an emergency medical condition: the patient or the doctor?***

For medical and legal purposes, a “medical condition” becomes an “emergency medical condition” as determined by the on-call physician after the MSE is completed. The definition of an “emergency medical condition” from the perspective of the patient is made before the MSE and may be utilized only for payment purposes (such as for meeting managed care plan requirements that any prudent layperson would have perceived, as the patient did, that his or her medical condition might be an emergency).<sup>27</sup> Once a MSE determines that an emergency condition is not present, a hospital’s obligation to fulfill further EMTALA requirements ends.

***Is rape an emergency medical condition?***

Determining whether an EMC is present or absent is critical because these are key determining factors in whether EMTALA duties and liabilities apply. According to the federal judge in *Burditt v US Dept of HHS*,<sup>28</sup> all EMTALA terminology is based on legal definitions, not medical definitions, meaning that the standard of emergency medical care is defined according to principles of law and not according to accepted medical practice.<sup>29</sup>

It is debatable whether rape itself can be qualified as an EMC. The related physical injuries sustained from the assault, however, could be considered emergency medical conditions, depending on the severity and impact on the victim’s health. When a rape victim requests treatment from an emergency department, injuries such as bruises, lacerations, abrasions, and possible internal injuries will presumably be examined during the screening process. Each one of these injuries could qualify as an EMC if her life becomes threatened without immediate medical attention.

***Is risk of pregnancy from a sexual assault an emergency medical condition?***

Considering that the standard protocol for treating rape victims as endorsed by the American College of Gynecologists (ACOG)<sup>30</sup> and the American Medical Association (AMA)<sup>31</sup> includes prescribing emergency contraception, one could argue that risk of pregnancy from rape is regarded as an emergency medical condition in need of stabilization. Even the Connecticut Catholic hospitals acknowledge that pregnancy prevention is an indicated procedure for treating victims of rape, although it is only offered as a treatment after religiously-based approval is given based on an ovulation test.

Taken out of the context of rape, unintended pregnancy could be considered an emergency medical condition for those women whose health may be endangered by pregnancy. Medical contraindications to pregnancy include certain autoimmune diseases,

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<sup>27</sup> Bitterman, 2000: 61.

<sup>28</sup> *Burditt v US Dept of HHS*, 934 F2d 1362 (5<sup>th</sup> Cir 1991).

<sup>29</sup> Bitterman, 2000: 20.

<sup>30</sup> ACOG practice bulletin. Emergency oral contraception. Number 25, March 2001.

<sup>31</sup> American Medical Association House of Delegates 75.985, Access to Emergency Contraception (2002).

sickle cell disease, cardiac or renal disease, uncontrolled diabetes, certain prescription drugs, cancer treatments and psychiatric history.<sup>32</sup>

***Does the ovulation test as part of a MSE violate EMTALA?***

According to Bitterman’s analysis of EMTALA, in order to establish an EMTALA cause of action for failure to provide a standardized MSE, a plaintiff must prove *all* of the following:<sup>33</sup>

- The hospital was covered by EMTALA
- The patient came to the hospital’s emergency department and requested examination and treatment for a medical condition.
- The hospital provided no screening, or provided screening of such a low standard to constructively constitute no screening, or provided disparate screening in violation of its own standards and procedures.
- The plaintiff suffered compensable damages as a direct result of the hospital’s failure to provide an appropriate MSE as defined by the law.

These requirements define what is known in the courts as “the disparate treatment test.” In order to scrutinize the ovulation test it would have to be proven to be substandard or disparate causing “compensable damages” to a rape victim.

***Is the use of the ovulation test an example of disparate treatment?***

In order to meet the disparate treatment test, the MSE would have to be proven to be either substandard or disparate based on the use of the ovulation test. For example, a religiously-based perception of contraception that leaves the most vulnerable rape victims without access to EC and contradicts standard medical knowledge may be conceivably framed as substandard. It could be arguably disparate if the differing treatment plans for rape victims based on ovulation test results is emphasized. The rape victim would also have to prove how additional delays caused by denying her access to EC multiplied the stress and trauma of the sexual assault.

***Is there another way to question the validity of the ovulation test?***

Yes. The 6<sup>th</sup> Circuit Court of Appeals has held that a plaintiff must prove that a hospital failed to provide an appropriate MSE. but also permits an argument that the hospital had an illicit motive for failing to follow its standard procedures.<sup>34</sup> This “improper motive test” was first articulated by judges in a 1991 6<sup>th</sup> Circuit Court of Appeal case.

We can think of many reasons other than indigency that might lead a hospital to give less than standard attention to a person who arrives at the emergency room. These might include: prejudice against the race, sex, or ethnic group of the patient; distaste for the patient's condition (*e.g.*, AIDS

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<sup>32</sup> <http://www.medceu.com/course-no-test.cfm?CID=1558> Continuing Education for Medical Professionals (Accessed 8/0-4/06).

<sup>33</sup> Bitterman, 2000: 187.

<sup>34</sup> Bitterman, 2000: 46.

patients); personal dislike or antagonism between the medical personnel and the patient; disapproval of the patient's occupation; *or political or cultural opposition*. If a hospital refused treatment to persons for any of these reasons, or gave cursory treatment, the evil inflicted would be quite akin to that discussed by Congress in the legislative history, and the patient would fall squarely within the statutory language.”<sup>35 36</sup>

While the U.S. Supreme Court has held that the improper motive test does not apply to claims under EMTALA stabilization requirements, it declined to address the conflict between the courts’ use of the disparate treatment test and the improper motive test when applied to the screening requirement, leaving the courts divided on the issue of which legal standard to use.<sup>37</sup>

***Could the improper motive test be applied to show that the use of an ovulation test to avoid administering EC for religious reasons is substandard care based on “political or cultural opposition?”***

Perhaps. Foremost, any challenge using the improper motive test could only be used in the courts in the 6<sup>th</sup> Circuit— Michigan, Ohio, Kentucky and Tennessee—and the few state courts that utilize the test as well. In the majority of these cases, the improper motivation is based on more common factors such as lack of insurance, race, sexual orientation, disease state, drunkenness, HIV status or spite.

A rape victim subjected to an ovulation test and denied EC in a Catholic emergency department would need to prove the hospital’s religious interpretation of EC’s mechanism of action was discriminatory. However, in order to examine the protocol in this way, the courts must be convinced that rape or risk of pregnancy from rape qualifies as an EMC. Once that hurdle is crossed, the plaintiff would have to prove that Catholic hospital’s specific intent for using an ovulation test is based on a cultural opposition to contraception.

According to Bitterman, the improper motive test tends to be more “hospital friendly” than the disparate treatment test, because it is difficult to prove that a hospital acted out of an improper motivation and provided a substandard MSE.<sup>38</sup> In *Adams v Grace Hospital*,<sup>39</sup> an uninsured man was examined for abdominal pain and then discharged from an emergency department with a note fixed to his shirt stating: “If lost, send him...home.” He returned the next day with urosepsis<sup>40</sup> and subsequently died. Despite finding that the MSE was cursory and did not include basic blood work, the courts held that there was not enough evidence to find the discharge was motivated by the patient’s lack of insurance.

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<sup>35</sup> Cleland v. Bronson Health Care Group, Inc, 917 F2d 266 (6<sup>th</sup> Cir 1990).

<sup>36</sup> Italic added for emphasis.

<sup>37</sup> Roberts v Galen of Virginia, Inc, 111 F3d 405 6<sup>th</sup> Cir 1997), 119 Sct 685 (1999).

<sup>38</sup> Bitterman, 2000: 185.

<sup>39</sup> 962 F Supp 101 (S Mich 1997).

<sup>40</sup> Acute blood poisoning

***Who has the authority to question whether a patient has an emergency medical condition or not?***

CMS and OIG may second-guess physicians' judgment by retrospectively deciding that a patient had an EMC and then bringing actions against the providers for failure to stabilize it, regardless of whether the physician discovered it.<sup>41</sup>

In civil cases, however, the courts have held that the relevant factor is whether the hospital perceived the patient to have an EMC and not whether the physician or hospital should have known the EMC existed. With this subjective standard, the courts provide hospitals with a good faith defense.<sup>42</sup>

***Do pharmaceutical services, such as the provision of EC, fall under EMTALA requirements?***

According to the Department of Health and Human Services 2003 clarification of EMTALA policies, if an individual presents to an emergency department and requests preventive care services, then the hospital is not obligated to provide a medical screening examination under EMTALA. Only if an individual specifically asks for an examination or treatment -- or her appearance/behavior would cause a "prudent layperson observer" to believe that she needed such attention -- do EMTALA rules then apply.<sup>43</sup>

However, DHHS goes on to clarify that pharmaceutical services in an emergency department may be for medical conditions and are, therefore, subject to EMTALA.<sup>44</sup> Preventive properties of pharmaceuticals do not necessarily qualify such services as preventive. Examples supplied by DHHS include anti-psychotic medications. Using EMTALA to challenge the refusal to provide EC might involve filing a request to DHHS to designate EC as a pharmaceutical that is used in emergency situations.

**B. Stabilization of Patients with Emergency Medical Conditions**

Once a hospital determines that an individual has an EMC, it is required to provide "further medical examination and such treatment as may be required to stabilize the medical condition."<sup>45</sup> If a rape victim has an emergent condition, but is denied all necessary treatments without a medically acceptable reason, the hospital has violated EMTALA.

***What does it mean to stabilize an emergency medical condition?***

With respect to an emergency medical condition, the legal term "to stabilize" means to provide necessary medical treatment to assure, within reasonable medical probability, that no "material deterioration" of the condition is likely to result from or occur during

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<sup>41</sup> Eg, *Inspector General v Samuel T Bowen*, Department of HHS, DAB Docket No. C-98-233/Decision No CR618 (September 29, 1999) in Bitterman, 2000: 24.

<sup>42</sup> *Harris v Health and Hospital Corporation*, 852 F Supp 701 (SD Ind 1994) in Bitterman, 2000: 24.

<sup>43</sup> Department of Health and Human Services, 42 CFR Parts 413, 482, 489 Medicare Programs; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical Conditions; Final Rule. *Federal Register* 68(174), September 9, 2003: 53235.

<sup>44</sup> *Ibid.*

<sup>45</sup> 42 USC 1395dd(b)(1)(A).

the transfer of the individual from a facility.<sup>46</sup> The most vexing issue here revolves around whether pregnancy risk can be legally interpreted as “material deterioration” and whether eliminating that possibility with time-sensitive emergency contraception can be legally interpreted as “stabilization.” Considering the violent nature of sexual assault, risk of pregnancy from rape has the potential to be defined as “material deterioration” in the right legal setting. Emergency contraception also may fit into the legal parameters of stabilization, considering its declining efficacy if taken more than 72 hours after the assault.

If a treating hospital is unable to stabilize a patient in its emergency department, it must meet EMTALA requirements for transferring the individual to another facility that does have the capacity to provide more complete care.

### **C. Transferring Patients Under EMTALA**

A transfer is technically either a complete discharge of a patient or the movement of the patient from one health care facility to another. Any discharge that, to the knowledge of those conducting it, left a patient with an "emergency medical condition" in an "unstable" condition would be actionable under EMTALA.<sup>47</sup>

Only if the medical condition of a rape victim who was refused EC is legally defined as an “unstable emergency medical condition,” can the discharge of such an individual be considered an illegal transfer under EMTALA.<sup>48</sup>

#### ***What are the transfer requirements under EMTALA?***

If a patient cannot be stabilized, the hospital may transfer the patient to another facility. The patient must consent and the attending physician must sign the appropriate documents to complete EMTALA requirements. According to federal judges, physician responsible for the transfer certification provision can violate EMTALA one of the following ways:

- failing to actually deliberate and weigh the medical risks and benefits of transfer before executing the certificate
- making an improper (discriminatory) consideration a significant factor in the process
- concluding that medical risks outweigh the medical benefits of transfer but certifies that the opposite is true
- or misrepresenting the patient’s medical condition.<sup>49</sup>

Transfer of a rape victim without dispensing emergency contraception could be considered a violation only if:

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<sup>46</sup> 42 USC 1395dd(e)(3)(B).

<sup>47</sup> Cleland v. Bronson Health Care Group, Inc, 917 F2d 266 (6<sup>th</sup> Cir 1990).

<sup>48</sup> Thornton v Southwest Detroit Hosp. 895 F2d 1131, 1134-1135 (6<sup>th</sup> Cir 1990); Roberts v Galen of Virginia, Inc, 111 F3d 405 6<sup>th</sup> Cir 1997), 119 Sct 685 (1999) in Bitterman, 20000: 20.

<sup>49</sup> Bitterman, 2000: 107

- CMS finds that rape qualifies as an “emergency medical condition”
- the hospital misrepresented the patient’s medical condition, or
- the religious considerations for the transfer are found to be improper.

If rape or the risk of pregnancy is successfully framed as an EMC, the inaccuracy of the ovulation test deserves to be scrutinized as a misrepresentation of a victim’s medical condition. First, no test can detect whether fertilization has occurred. Second, the Catholic interpretation of EC’s action mechanism goes against what respected organizations such as the American Medical Women’s Association,<sup>50</sup> the National Institute of Health<sup>51</sup> and ACOG<sup>52</sup> declare about how EC pills work -- as contraception, not as an abortifacient. It could be argued that the ovulation test serves only to fulfill a religious function of the institution, and thereby denies the general public an expected emergency care service. Within this context, discharging a rape victim without dispensing emergency medication could be deemed an illegal transfer.

***What if a rape victim requests a transfer to another hospital in order to receive emergency contraception?***

If she does not have an EMC as determined by an appropriate MSE and is qualified as stabilized, she can be transferred at any time, to any hospital, for any reason and the transferring hospital is not required to arrange EMTALA mandated transfers. Only if she has an unstabilized EMC caused by the assault do EMTALA rules apply for an “appropriate” transfer. The transferring hospital must provide treatment within its capacity prior to the transfer, arrange for another hospital to accept the patient, send appropriate data to the accepting facility, and perform the transfer using qualified personnel and means of transportation.<sup>53</sup>

Any non-medical reason for a transfer of an unstabilized patient must be carefully examined by the receiving hospital. Hospitals who receive transfers they consider unlawful are required to report the transporting hospital to CMS.<sup>54</sup>

EMTALA enforcement results

As of 2000, close to 35 percent of all hospitals have been investigated by state agencies under the authority of CMS.<sup>55</sup> Screening violations are the most common citation, but there are increasing citations of stabilization violations made by a hospital physician and of failure of hospitals to accept patients in transfer.<sup>56</sup> Because widespread inconsistencies in the interpretation of the law exist among regions and various state

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<sup>50</sup> American Medical Women’s Association. *Position Statement on Emergency Contraception*, Alexandria, VA, 1996.

<sup>51</sup> <http://www.nlm.nih.gov/medlineplus/ency/article/007014.htm> (Accessed 8/23/06).

<sup>52</sup> ACOG practice bulletin. Emergency oral contraception. Number 25, March 2001.

<sup>53</sup> 42 USC 1395dd(c)(2).

<sup>54</sup> 42 CFR 489.20(m).

<sup>55</sup> Bitterman, 2000: 2.

<sup>56</sup> *Ibid.*

agencies involved, CMS amended EMTALA regulations in 2003.<sup>57</sup> The new changes have subsequently narrowed EMTALA's applicability to the hundreds of complaints CMS processes every year.

From January 1, 1995, through March 30, 2001, the OIG processed a total of 605 EMTALA violation cases: 237 cases were settled and 368 cases were declined.<sup>58</sup> Overall, the OIG has declined about 61 percent of the violation cases forwarded by CMS.<sup>59</sup> OIG considers a range of issues in deciding whether an additional enforcement action is warranted, taking into account its resources and what it is trying to accomplish in education and future compliance. Some of the major factors that may influence its decision include the seriousness of the violation, CMS' enforcement activity that has already occurred, additional information discovered during the 60-day peer review process or brought to the OIG's attention by the hospital, and whether the hospital has been privately sued for its actions.<sup>60</sup>

From 1995 through 2000, the OIG imposed fines totaling over \$5.6 million on 194 hospitals and 19 physicians. The majority of hospital fines were \$25,000 or less. Twenty-eight physicians were fined by the OIG for EMTALA violations between its passage and 2001.<sup>61</sup>

### Civil enforcement of EMTALA

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.<sup>62</sup>

Only hospitals, not physicians, can be sued for damages under EMTALA. Under EMTALA all physicians act directly as agents of the hospital, making the hospital legally responsible for the actions of any of its employees. Plaintiffs have a right to sue a hospital in either federal or state courts; whichever forum is more likely to be strategically beneficial.<sup>63</sup>

Based on the three primary obligations imposed on hospitals described above, there are three types of lawsuits possible under EMTALA all of which preempts any state and local law requirement that directly conflicts with one of its requirements.<sup>64</sup> This is

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<sup>57</sup> Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 Fed. Reg. 53222-64 (Sept. 9, 2003) 42 C.F.R. pts. 413, 482, 489.

<sup>58</sup> GAO, 2001: 4.

<sup>59</sup> GAO, 2001: 24.

<sup>60</sup> Ibid.

<sup>61</sup> Ibid.

<sup>62</sup> 42 USC 1395dd(d)(2)(A).

<sup>63</sup> Bitterman, 2000: 185.

<sup>64</sup> 42 USC 1395dd(f).

advantageous for plaintiffs in states that do not mandate EC availability in emergency departments or in states with a law that exempts Catholic hospitals from compliance.

### **1. Failure to Provide an Appropriate Medical Screening Examination**

The courts use two legal formulas to define “appropriate:” the improper motive test and the disparate treatment test. Both tests give a plaintiff the framework to prove that a hospital failed to conduct a legally acceptable emergency medical screening based on uniformity not on quality. The first test is used only by the 6<sup>th</sup> Circuit and a few state courts; though it is possible that other courts could be persuaded to adopt it. The disparate treatment test is the standard utilized by the majority of the federal circuit courts.

### **2. Failure to Stabilize an Emergency Medical Condition**

To make this claim, three critical elements must be met. First, the individual must have an EMC as defined by law. Childbirth, an ankle fracture, and suicidal tendencies have all been debated in federal court at length about whether each qualifies as an EMC.<sup>65</sup> It is, therefore, conceivable that the status of rape as emergent could be debated in court as well. Second, the hospital must have actually known the individual had an EMC. Here the plaintiff could use the ovulation test to her advantage as proof that the attending physician was aware of the risk of pregnancy as a result of rape. Third, it must be proven by the plaintiff that the hospital failed to stabilize the EMC according to its legal definition. This requirement is judged by the objective standard based on professional testimony describing the standard of care for EMC stabilization. In this case, the definitive declarations of the World Health Organization,<sup>66</sup> ACOG<sup>67</sup> and the American Medical Association<sup>68</sup> on the morning-after pill as the proper standard of care for treating and stabilizing rape victims would be essential.

### **3. Failure to Effect an Appropriate Transfer**

To bring a claim under EMTALA transfer provisions the plaintiff must prove that the hospital did not stabilize a known EMC, failed to arrange for an appropriate transfer as defined by the law, and caused the plaintiff harm as a result. This type of claim is also judged under an objective standard similar to the failure to stabilize claim.

### **EMTALA claims in Connecticut**

As the trial courts of the federal court system, United States district courts have jurisdiction to hear nearly all categories of federal cases, including both civil and criminal matters. The 94 U.S. judicial districts are organized into 12 regional circuits, each of which has a United States court of appeals. A court of appeals hears appeals from the district courts located within its circuit, as well as appeals from decisions of federal

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<sup>65</sup> *Burditt v US Dept of HHS*, 934 F2d 1362 (5<sup>th</sup> Cir 1991); *Phipps v Bristol Regional Medical Center*, US Ct App (6<sup>th</sup> Cir 1997) (1997 US App LEXIS 17919; *Fleming v HCA Health Services of Louisiana*, 691 So2d 1216 (La Supp Ct 1997).

<sup>66</sup> World Health Organization. Improving access to quality care in family planning: medical eligibility criteria for contraceptive use. Geneva 1996; 31-33 (WHO/FRH/FPP/96.9).

<sup>67</sup> ACOG practice bulletin. Emergency oral contraception. Number 25, March 2001.

<sup>68</sup> American Medical Association House of Delegates 75.985, Access to Emergency Contraception (2002).

administrative agencies. Connecticut is home to three U.S. District courts in Hartford, New Haven and Bridgeport and is under the jurisdiction of the 2<sup>nd</sup> Circuit Court of Appeals along with New York and Vermont.<sup>69</sup>

Since 1992, only a handful of claims based on EMTALA regulations have been filed in the Second Circuit.<sup>70</sup> In the majority of them, the court ruled in favor of the defending hospital. Four cases were dismissed due to time restraints for a notice of claim. For instance, in 1999,<sup>71</sup> the Second Circuit found that a plaintiff must comply with state notice-of-claim requirements before filing an EMTALA claim.<sup>72</sup> Another four cases failed to qualify as EMTALA causes of action. Two case discussed below demonstrate how the 2<sup>nd</sup> Circuit court has examined the nuances of EMTALA.

In the first case,<sup>73</sup> a woman named Antoinette Carodenuto was mugged in an early November evening of 1988. Police responded and arranged for her to be taken to a local hospital to treat her injury, a bruised head. The emergency department completed the required examination and stabilization and then sent her home with Tylenol and written instructions for head injuries. She returned to the same emergency room later that night with nausea, chills and dizziness stating that she had lost consciousness and hit her head again at home. Arrangements were made for more tests but she ultimately went into a coma. She was transferred to another facility for neurosurgery and remained hospitalized for months. At the time of the trial four years later, she suffered from severe brain damage.

The court ruled in favor of the hospital because it found:

..the fact that the plaintiff suffered a serious adverse result after her discharge from the emergency room is insufficient to establish liability... an inaccurate emergency room diagnosis is not, per se, a failure to perform "appropriate medical screening". Moreover, the facts are in dispute as to whether plaintiff was suffering from an "emergency medical condition" and whether she was "stabilized" within the meaning of the statute.<sup>74</sup>

The courts defended the hospital's compliance with statutory requirements by completing an "appropriate medical screening" and "stabilization" at the time of her first visit to the emergency department. What happened after she was discharged could not be disputed using an EMTALA cause of action.

If this reasoning were to be applied to a rape victim, one might argue that risk of pregnancy after leaving the emergency room is not impossible to predict, unlike the risk

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<sup>69</sup> The Federal Judiciary website <http://www.uscourts.gov/index.html> (Accessed 7/25/06).

<sup>70</sup> [www.healthlaw.org](http://www.healthlaw.org) (Accessed 7/25/06).

<sup>71</sup> *Hardy v New York City Health & Hospital Corporation*, 164 F.3d 789 (N.Y.)

<sup>72</sup> Connecticut's General Assembly statute concerning claims against the state requires that plaintiff's file claim within one year of injury or no more than three years if injury caused by event was delayed (Connecticut General Statutes, Sec. 4-148).

<sup>73</sup> *Carodenuto v New York City Health & Hospitals Corp*, 156 Misc. 2d 361; 593 N.Y.S.2d 442; 1992 N.Y. Misc. LEXIS 601

<sup>74</sup> *Ibid*.

of Ms. Carodenuto suffering brain damage. In fact, the presence of an ovulation test as part of Catholic hospital's screening process implies that pregnancy from rape is understood as a definite possibility. But again, the risk of pregnancy must be legally interpreted as an emergency medical condition in need of stabilization in order to claim a transfer violation.

The second case presented the Second Circuit with an opportunity to explicitly define "emergency medical condition." Connecticut's state courts as well as other state courts in Arizona and North Carolina have considered this case, *Greenery Rehabilitation Group, Inc. v Hammon*,<sup>75</sup> as persuasive authority in determining the meaning of "emergency medical condition" as clear and unambiguous.

This case involved a nursing home seeking payment for medical expenses of three illegal immigrants with severe brain injuries by suing the New York City Human Resources Administration, the agency in charge of the city's Medicaid program. Generally undocumented aliens or aliens not otherwise permanently residing in the United States are not entitled to full Medicaid coverage. The only exception to this exclusion is payment for medical assistance that is "necessary for the treatment of an emergency medical condition" as defined by EMTALA<sup>76</sup> and by DHHS regulations.<sup>77</sup> In its opinion, the Second Circuit defended EMTALA's statutory language as plain in its meaning.

An 'emergency medical condition' must be manifested by acute, rather than chronic symptoms. It must necessitate immediate medical treatment, without which the patient's physical well-being would likely be put in jeopardy or serious physical impairment or dysfunction would result.<sup>78</sup>

Bolstering this declaration, the Second Circuit sought guidance from the Webster's Third New International Dictionary, which defines "emergency" as "a sudden bodily alternation such as is likely to require immediate medical attention" with "the emphasis on severity, temporality, and urgency."<sup>79</sup> Further, the Second Circuit court in this case found that this definition is "consistent with the general concept of a medical emergency as commonly understood by those in the medical professions."<sup>80</sup> It quoted Dorland's Medical Dictionary definition of "emergency" as " 'an unlooked for or sudden occasion; an accident; an urgent or pressing need.' "<sup>81</sup>

A subsequent trial lawsuit was filed in Connecticut in which the plaintiff's estate fought for Medicaid benefits entitlements based on an emergency department presentation of undiagnosed acute myelogenous leukemia.<sup>82</sup> The plaintiff was admitted into the hospital

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<sup>75</sup> 150 F. 3d. Docket Nos. 97-6236, 97-6238, U.S. Court of Appeals for the Second Circuit, 150 F.3d 226; 1998 U.S. App. LEXIS 17097, supra. 233.

<sup>76</sup> 42 USC 1396b (v) (3) "Medical assistance to aliens not lawfully admitted for permanent residence."

<sup>77</sup> 42 C.F.R. § 440.255(b)(1) "Limited services available to certain aliens."

<sup>78</sup> *Greenery Rehabilitation Group, Inc. v Hammon*, supra, 150 F.3d 233.

<sup>79</sup> *Ibid.*, 233.

<sup>80</sup> *Ibid.*, 232.

<sup>81</sup> *Ibid.*, quoting from *Dorland's Illustrated Medical Dictionary* (28<sup>th</sup> Ed. 1994).

<sup>82</sup> *Zbigniew Szewczyk v. State of Connecticut, Department of Social Services*, CV000501046S. Superior Court of

and treated for cancer for a month. The state's department of social service's refused to pay the hospital charges because the plaintiff did not suffer from an emergency medical condition as defined by EMTALA.

The trial court as well as the Appellate Court<sup>83</sup> on appeal agreed with the hearing officer who reasoned that the plaintiff "would not have died immediately if he had not received treatment."<sup>84</sup> The estate then appealed to the Supreme Court of Connecticut who reversed the judgment of the Appellate Court, stating that both lower courts correctly relied upon, but misapplied, the Second Circuit's explanation of the term "emergency medical condition."<sup>85</sup> The Supreme Court of Connecticut reminded its audience "the decisions of the Second Circuit Court of Appeals carry particularly persuasive weight in the interpretation of federal statutes by Connecticut state courts."<sup>86</sup>

The Second Circuit's authoritative interpretation of what constitutes an emergency medical condition has properly broadened the application of the term. Consequently patients' access to emergency care and a hospitals' responsibilities under EMTALA have been strengthened. It is, therefore, conceivable that the risk of pregnancy from a sexual assault could be understood as an acute condition in need of immediate emergency care since the emphasis of the definition is on suddenness and urgency.

### **Conclusion**

At this time, only one court has ruled that a rape victim who has been denied access to EC by a Catholic hospital may have a cause of action and this case did not involve an EMTALA claim.<sup>87</sup> In *Brownfield v Daniel Freeman Marina Hospital*, the court held that the California law exempting religious institutions from performing abortions did not give a Catholic hospital the right to refuse to provide EC information to a rape victim. Though the plaintiff could not collect damages because she ultimately did not become pregnant from the assault, the court nonetheless recognized the claim as a possible cause of action in state courts. No one has ever challenged the Catholic hospital protocol for rape victims on the federal level.

Denial of emergency care based on ideological opposition to contraception may be in violation of EMTALA in three distinct ways. The best course of action depends upon which one of these possible violations offers the best argument within the stringent parameters of EMTALA enforcement.

As review, any woman who comes to an emergency department after a sexual assault is protected by federal law to receive medical attention upon request. All hospitals that

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Connecticut, Judicial District of New Britain at New Britain 2001 Conn. Super. LEXIS 1821.

<sup>83</sup> Szewczyk v. Dep't of Soc. Servs., 77 Conn. App. 38, 822 A.2d 957, 2003 Conn. App. LEXIS 241 (2003).

<sup>84</sup> Ibid. 53-54.

<sup>85</sup> Zbigniew Szewczyk v. Department of Social Services, SC 17034, Supreme Court of Connecticut, 275 Conn. 464; 881 A.2d 259; 2005 Conn. LEXIS 343.

<sup>86</sup> Webster Bank v. Oakley, 265 Conn., 830 A.2d 139 (2003) in Zbigniew Szewczyk v. Department of Social Services, 275 Conn. 464; 881 A.2d 259; 2005 Conn. LEXIS 343.

<sup>87</sup> 256 Cal. Rptr. 240 (Ct App. 1989).

receive support from federal and state government must first provide the patient an emergency medical screening. If an emergency medical condition is found based on this initial screening, the hospital must stabilize it. If the hospital is unable to do so, it must make arrangements to transfer the patient to another facility where the stabilization requirement can be completed.

In order for a rape victim to make an EMTALA claim after being denied EC, she must prove three important points: (1) the risk of pregnancy after a sexual assault is an emergency medical condition in need of immediate attention, (2) possible pregnancy from rape is material deterioration in need of stabilization and (3) emergency contraception is a pharmaceutical service for an emergency condition subject to EMTALA regulation.

If rape victims treated by Connecticut's Catholic hospitals are indeed protected by EMTALA, it is important to distinguish which course of action would be most effective to protect patients' rights in this particular scenario:

*Emergency Medical Screening.* As long as the Catholic hospitals are uniformly administering EC to rape victims according to their protocol, there is no EMTALA violation. However, one could argue that the ovulation test is disparate or substandard or that the attending physicians are not diligently referring rape victims to other sources of EC, but it is not the strongest case.

*Stabilization.* Proving that rape victims are legally entitled to the morning-after pill would be an important legal victory. If risk of pregnancy is determined to be an emergency medical condition in need of stabilization, Catholic hospitals could be held liable for discharging rape victims improperly.

*Transfer.* If rape victims can be defined as patients with an emergency medical condition in need of stabilization, Catholic hospitals then would have a legal duty to either administer EC or, perhaps, to supply transportation for women in need of EC to another hospital that can supply the pharmaceutical services promptly. This cause of action holds the most promise for women who have been violated as patients in need of medical assistance at precisely the moment when she needs it the most— the moment when she is discharged from an emergency department having been denied the standard of care for sexual assault and victimized by a hospital's self-serving restrictions. Risk of pregnancy from rape must be legally interpreted as "material deterioration" and EC as pharmaceutical services covered by EMTALA in order to mandate such a transfer policy.

Connecticut's Catholic hospitals claim their use of the ovulation protocol is protected by the nation's constitutional protection of freedom of religion. However, hospitals affiliated with the Catholic Church are separately incorporated as non-profit entities, rely heavily on Medicaid and Medicare funds and are licensed to serve the general public. Numerous court decisions have held that generally applicable laws that are not enacted with the specific purpose of discriminating against religious entities may be applied to all subject entities, or all employers, without regard to the resulting effect of overturning religiously-

based policies. For example, courts in both California and New York have upheld contraceptive coverage equity laws against challenges by Catholic-sponsored hospitals, colleges and social service agencies on the grounds that they are generally applicable laws.

When patients cannot reasonably choose emergency care facilities or know that hospital services they have requested will not be provided, institutional religious privileges must cede to patients' rights. This is especially true for victims of rape who have a short window of time in which treatment has to be given to protect against pregnancy and disease, preserve evidence for criminal investigation, and receive counseling services. A federal interest in curtailing discrimination through EMTALA may be a powerful influence in protecting rape victims' right to make medical decisions and guaranteeing their universal right to receive prompt emergency care in all medical institutions.

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