No. 18-132

# In The
# Supreme Court of the United States

JAMIE ELMHIRST,

*Petitioner,*

v.

McLAREN NORTHERN MICHIGAN HOSPITAL, d/b/a NORTHERN MICHIGAN EMERGENCY MEDICINE CENTER, and McLAREN HEALTH CARE CORPORATION, jointly and severally,

*Respondents.*

**On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit**

## BRIEF IN OPPOSITION

MICHAEL L. VAN ERP*
ROBERT M. WYNGAARDEN
VERLIN R. NAFZIGER
JOHNSON & WYNGAARDEN P.C.
3445 Woods Edge Drive
Okemos, MI 48864
(517) 349-3200
mlv@jwynlaw.com
*Counsel of Record

COCKLE LEGAL BRIEFS (800) 225-6964
WWW.COCKLELEGALBRIEFS.COM

## QUESTIONS PRESENTED

The Emergency Medical Treatment and Active Labor Act of 1986 ("EMTALA") requires that any hospital with an "emergency department" provide an "appropriate medical screening examination" to "any individual" who requests evaluation. 42 U.S.C. § 1395dd(a). "Appropriate" is not defined in the statute. The Sixth Circuit held, in *Cleland v. Bronson Health Care Group, Inc*., 917 F.2d 266, 272 (6th Cir. 1990) that "appropriate" should be evaluated by reference to "the motives with which the hospital acts."

Petitioner maintains that, under *Cleland*, a plaintiff must show a *malicious* motive. Respondents submit that *Cleland's* primary holding is that emergency department staff must attempt to provide a similar screening to all patients, and a knowing failure to provide a proper screening for any reason or motive violates EMTALA.

Respondents submit that the questions presented to this Court are more properly stated as follows:

I. Whether there is a material difference between holdings in the Sixth Circuit that disparate treatment which is knowingly, deliberately provided for any reason violates the "appropriate medical screening" requirement of the Emergency Medical Treatment and Active Labor Act, and holdings in other Circuits that disparate treatment violates the "appropriate medical screening" requirement, such that the holdings establish a conflict which requires resolution by this Court.

**QUESTIONS PRESENTED** – Continued

II. Whether, when determining if a hospital has complied with the "appropriate medical screening" requirement of the Emergency Medical Treatment and Active Labor Act, liability attaches only if a plaintiff can prove that disparate treatment in the form of an inadequate screening was knowingly, deliberately provided, or liability can attach when disparate treatment is alleged but there is insufficient evidence to demonstrate a knowing, deliberate decision to provide an inadequate screening.

## PARTIES TO THE PROCEEDINGS AND RULE 29.6 CORPORATE DISCLOSURE STATEMENT

Petitioner is Plaintiff Jamie Elmhirst, an individual.

Respondents are Defendants McLaren Northern Michigan Hospital, d/b/a Northern Michigan Emergency Medicine Center, and McLaren Health Care Corporation. McLaren Northern Michigan Hospital is a wholly owned subsidiary of McLaren Health Care Corporation, a private nonprofit corporation incorporated in the State of Michigan, with its principal place of business in Grand Blanc, Michigan. McLaren Health Care Corporation has no parent company.

Respondents are, for all practical purposes pertinent to this case, a single entity. Therefore, Respondents will be referred to in the body of the brief as "McLaren."

TABLE OF CONTENTS

TABLE OF CONTENTS – Continued

TABLE OF AUTHORITIES

## STATEMENT OF THE CASE

### 1. Factual Background.

Respondents McLaren Northern Michigan Hospital d/b/a Northern Michigan Emergency Medicine Center and McLaren Health Care Corporation (hereinafter "McLaren") concur with Petitioner's summary of the relevant factual background, with one exception. Petitioner, at page three, asserts:

> Plaintiff went to the emergency department of a hospital operated by defendant with symptoms that developed after she had been treated by a chiropractor. (App. pp. 14-15.) Although her symptoms were consistent with vertebral dissection, a known sequela of chiropractic manipulation, she was discharged without further examination.

Petitioner's statement suggests that she went to a hospital, had symptoms, and was discharged without examination. However, her complaint alleged:

> Elmhirst was seen for medical care by Dr. Craig Reynolds, in his professional capacity at McLaren. (*Id.*) Reynolds noted that Elmhirst's symptoms included high blood pressure, elevated white blood cell count, presence of red blood cells in urine, presence of a fever, and dizziness with a worsened headache the night before presenting at the hospital. (*Id.*) There were no other imaging or other diagnostic studies or tests ordered or performed on Elmhirst. (*Id.*) (App. p. 14.)

It would have been impossible for Dr. Reynolds to note high blood pressure, elevated white blood cell count, red blood cells in urine, and fever unless some screening evaluation was performed. Petitioner may allege an inadequate screening, but this is not one of those EMTALA cases that alleges a refusal to screen at all.

**2. Proceedings Below.**

McLaren concurs with Petitioner's summary of the proceedings below, with two exceptions. First, McLaren submits that Petitioner incorrectly states that this Court appeared to question *Cleland* in *Roberts v. Galen of Virginia*, *Inc*., 525 U.S. 249, 119 S. Ct. 685, 142 L. Ed. 2d 648 (1999), a case applying the adjoining subsection of the statute, 42 U.S.C. § 1395dd(b). The Court actually stated:

> The question of the correctness of the *Cleland* Court's reading of § 1395dd(a)'s "appropriate medical screening" requirement is not before us, and we express no opinion on it here. *Id.* at 253.

Second, Petitioner errs in summarizing the basis for the dismissal of this action by the District Court. Petitioner asserts:

> Because plaintiff could not support a claim under the "screening" requirement, she was also unable to maintain a claim for violation of the "stabilization" provision of the act.

McLaren submits that Petitioner was unable to maintain a claim for violation of the "stabilization" provision as she did not plead that an emergency condition was discovered by the initial screening, and thus failed to plead a necessary element of a stabilization claim.

## REASONS TO DENY THE PETITION

### 1. The Test Applied in the Majority of the Pertinent Circuit Court Decisions is Not Significantly Different From the Analysis Applied in *Cleland*.

Petitioner's argument is based on the premise that *Cleland* crafted a flawed interpretation of the screening requirement, based on the insertion of a motive element. Petitioner points to decisions from other Circuits which have rejected *Cleland*, as they understand it. McLaren submits that, when *Cleland* is analyzed in detail, its holding is not substantively different from the decisions from other Circuits, and the apparent conflict stems from the use of the word "motive" to describe the state of mind element which the screening requirement necessarily incorporates.

### A. *Cleland's* Inclusion of a Motive Element was One Minor Aspect of a Broader Rule Requiring a Hospital to Attempt to Provide Similarly Situated Patients With a Similar Screening.

The *Cleland* Court began its analysis by noting that, although the available legislative history suggested that EMTALA was directed at refusal to treat patients who could not pay, the statute as written did not limit its scope to that class of patients. In doing so, the Court explained the essence of its decision:

> We hold Congress to its words, that this statute applies to any and all patients. However, we interpret the vague phrase "appropriate medical screening" to mean a screening that the hospital would have offered to any paying patient. . . . *Id.* at 917 F.2d 268.

After more detailed analysis regarding the application of the statute to all patients, not just those unable to pay, the Court addressed the proper interpretation of the screening requirement. It noted the difficulty caused by the word "appropriate" and its solution to that conundrum:

> "Appropriate" is one of the most wonderful weasel words in the dictionary, and a great aid to the resolution of disputed issues in the drafting of legislation. Who, after all, can be found to stand up for "inappropriate" treatment or actions of any sort? Under the circumstances of the act, "*appropriate" can be taken to mean care similar to care that would have*

> *been provided to any other patient, or at least not known by the providers to be insufficient or below their own standards*. Plaintiffs essentially contend that "appropriate" denotes, at a minimum, the full panoply of state malpractice law, and at a maximum, includes a guarantee of successful result.
>
> In one sense, in hindsight, the screening provided in this case could scarcely be called appropriate. The patient came in, he had a condition that was at least conceivably ascertainable by medical science, the condition was not ascertained, and he died within 24 hours. At the same time, there is not the slightest indication that this outcome would have been any different for a patient of any other characteristics. Had his sex, race, national origin, financial condition, politics, social status, etc., been anything whatsoever, as far as can be gleaned from the complaint, the outcome would have been the same. Under these circumstances, we hold that the complaint simply fails to allege any inappropriateness in the medical screening in the sense required by the Act. *Id.* at 271 (emphasis added).

The rule to take away from this analysis is that a patient should receive the same screening as similar patients, and that the intentional provision of a deficient screening for any reason is a violation of EMTALA. The Court later reaffirmed this analysis:

> We believe that the terms of the statute, specifically referring to a medical screening exam by a hospital "within its capabilities"

> precludes resort to a malpractice or other objective standard of care as the meaning of the term "appropriate." Instead, "appropriate" must more correctly be interpreted to refer to the motives with which the hospital acts. If it acts in the same manner as it would have for the usual paying patient, then the screening provided is "appropriate" within the meaning of the statute. *Id.* at 272.

It is the use of the word motive in this passage which has caused concern. In a subsequent paragraph, the Court expanded on its analysis, explaining that the focus was on the reason a screening was inadequate, without using "motive":

> A hospital that provides a substandard (by its standards) or nonexistent medical screening for any reason (including, without limitation, race, sex, politics, occupation education, personal prejudice, drunkenness, spite, etc.) may be liable under this section. *Id*.

In a later passage, the Court referred to a "good faith" screening:

> On the other hand, if, as appears to be the case here (and as is not contradicted in the pleading), a hospital provides care to the plaintiff that is no different than would have been offered to any patient, and, from all that appears, is "within its capability" (that is, constitutes a good faith application of the hospital's resources), then the words "appropriate medical screening" in the statute should not be

> interpreted to go beyond what was provided here. *Id*.

Based on the references to state of mind in these passages, it is clear that the Court felt that the state of mind of treatment providers is key. The Court could just as well have used "motivation," "intent," or "reason" instead of "motive." The rule to be taken from *Cleland* is that "appropriate" must be evaluated by considering whether an inadequate screening was intentional or accidental.

To appreciate the significance of *Cleland's* analysis, one must recognize that the heart of an emergency department screening is the evaluation by a health care provider, who then uses his or her professional judgment to formulate a diagnosis and establish a plan of care. The screening any patient should receive is a screening which consists of an examination and diagnosis utilizing the skills and knowledge of the care provider, resulting in a plan of care representing the best judgment of treatment providers. It logically follows, then, that disparate treatment occurs when health care providers deliberately fail to provide a good faith effort to properly screen a patient.

The problem with *Cleland* is the selection of motive as the word used to characterize the state of mind element. Motive is a somewhat "loaded" word, most often used in relation to criminal behavior. Petitioner herself, in her formulation of the question presented to this Court for review, has asserted that the motive

element in *Cleland* requires a plaintiff to prove malicious intent.

Petitioner has given *Cleland* a more sinister characterization than the opinion justifies. *Cleland* is more properly seen not as holding that a particular motive must be shown, but rather that any knowing and deliberate failure to provide a proper screening, for any reason or motive, violates EMTALA.

While the use of motive may troublesome, and a better word could have been chosen, confusion and disagreement regarding the use of motive is not a sufficient reason to reject the insightful analysis of the *Cleland* Court. Its emphasis on intentionally disparate treatment provides a workable rule which does not conflict with the analysis offered by opinions from other Circuits.

### B. Other Relevant Circuit Court Decisions Represent Some Variation of a Rule Requiring a Hospital to Provide All Similarly Situated Patients with a Similar Screening.

Petitioner argues that several decisions from various Circuits contradict the motive requirement adopted in *Cleland*. After thorough scrutiny, it becomes apparent that the approach most frequently advocated in other Circuits is not substantively different from that utilized in *Cleland*.

Chronologically, a starting point is *Gatewood v. Washington Healthcare Corp.*, 290 U.S. App. D.C. 31, 933 F.2d 1037 (D.C. Cir. 1991), which was released a year after *Cleland*. A brief passage is sufficient to see the similarity between the two opinions. The *Gatewood* Court wrote:

> The appellant relies primarily on subsection 1395dd(a) of the Act, arguing that an emergency room violates the "appropriate medical screening" requirement whenever it negligently misdiagnoses a patient's condition. Like the Sixth Circuit in *Cleland, see* 917 F.2d at 271-72, we read the requirement of "appropriate medical screening" differently. As its history makes clear, the Act is intended not to ensure each emergency room patient a correct diagnosis, but rather to ensure that each is accorded the same level of treatment regularly provided to patients in similar medical circumstances. Thus, what constitutes an "appropriate" screening is properly determined not by reference to particular outcomes, but instead by reference to a hospital's standard screening procedures. *Id.* at 1041.

This passage also identifies the divergence from *Cleland*. The *Gatewood* Court focused on standard screening procedures, as did several other opinions reviewed hereinafter. The interpretation and implementation of any test which relies on standard emergency department procedures is discussed in a subsequent section of this brief.

A year later, *Baber v. Hospital Corp. of America*, 977 F.2d 872 (4th Cir. 1992) was issued. Once again, the interpretation of the screening requirement was couched in terms of providing all patients with a uniform approach:

> Thus, the goal of "an appropriate medical screening examination" is to determine whether a patient with acute or severe symptoms has a life threatening or serious medical condition. The plain language of the statute requires a hospital to develop a screening procedure designed to identify such critical conditions that exist in symptomatic patients and to apply that screening procedure uniformly to all patients with similar complaints.
>
> We recognize that application of the procedure necessarily requires the exercise of medical training and judgment. Hospital personnel must assess a patient's signs and symptoms and use their informed judgment to determine whether a critical condition exists. Thus, while EMTALA requires a hospital emergency department to apply its standard screening examination uniformly, it does not guarantee that the emergency personnel will correctly diagnose a patient's condition as a result of this screening. [Footnote omitted.]

This opinion is interesting for its focus on standard screening procedures, while simultaneously recognizing the importance of professional judgment, which (as will be discussed later) is central to any attempt to implement EMTALA's screening requirement.

Brief mention of *Williams v. Birkeness*, 34 F.3d 695, 697 (8th Cir. 1994) is in order. The Court held that a plaintiff alleging failure to provide an appropriate screening must prove that hospital personnel treated the patient "differently from other patients."

The next relevant decision is *Correa v. Hospital San Francisco*, 69 F.3d 1184, 1192-1193 (1st Cir. 1995). The Court emphasized the need to treat all patients the same, and noted the distinction between a deliberately flawed screening and a negligent screening:

> A hospital fulfills its statutory duty to screen patients in its emergency room if it provides for a screening examination reasonably calculated to identify critical medical conditions that may be afflicting symptomatic patients and provides that level of screening uniformly to all those who present substantially similar complaints. The essence of this requirement is that there be some screening procedure, and that it be administered even-handedly.
>
> We add a caveat: EMTALA does not create a cause of action for medical malpractice. Therefore, a refusal to follow regular screening procedures in a particular instance contravenes the statute . . . but faulty screening, in a particular case, as opposed to disparate screening or refusing to screen at all, does not contravene the statute.

In *Vickers v. Nash Gen. Hosp.*, 788 F.3d 139 (4th Cir. 1996), the Court concurred with the rule that a

screening is tested by whether all patients are treated the same.

> EMTALA's requirement that individuals seeking emergency care receive an "appropriate screening examination" obligates hospitals to "apply uniform screening procedures to all individuals coming to the emergency room." The screening provision, "at the core," thus "aims at disparate treatment." *Id.* at 143 (citations omitted).

The Court later added an observation which recognized that a screening claim includes an analysis of the subjective state of mind of treatment providers:

> EMTALA is implicated only when individuals who are *perceived* to have the same medical condition receive disparate treatment. *Id.* at 144 (emphasis is original).

The reference to the perceptions of treatment providers is strikingly close to *Cleland's* reliance on state of mind.

A relatively lengthy portion of *Summers v. Baptist Medical Ctr. Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996) should be considered. The Court emphasized the importance of distinguishing between a screening which was flawed due to negligence versus a deliberately deficient screening:

> Plaintiff, for example, concedes that he has to show non-uniform or disparate treatment in order to succeed. He takes the position, however, that he has met this requirement.

According to the hospital's own admission, a patient complaining of snapping and popping noises in his chest would have been given a chest x-ray. Plaintiff, as we must assume for purposes of this motion for summary judgment, did make just such a complaint, but was not given the chest x-ray. He was therefore treated differently from other patients, and differently from the treatment prescribed by the hospital's normal screening process. Therefore he is entitled to recover under EMTALA.

The argument has a surface appeal, and, indeed, the panel that initially heard this case adopted this very approach. On reflection, we are not convinced.

The important point for us is that the very respect in which the plaintiff's screening is said to be non-uniform – failure to order a chest x-ray for a patient complaining of popping noises in his chest – is nothing more than an accusation of negligence. We accept for purposes of this appeal from a summary judgment the proposition that Summers in fact made this complaint, and that the doctor did not hear him, or forgot what had been said. (There is no contention that the doctor deliberately failed to order a chest x-ray.) This may have been medical malpractice, but if it is also an EMTALA violation, that statute has been converted into a federal cause of action for a vast range of claims of medical negligence. *It would almost always be possible to characterize negligence in the screening process as non-uniform treatment, because any hospital's*

> *screening process will presumably include a non-negligent response to symptoms or complaints presented by a patient*. To construe EMTALA this expansively would be inconsistent with the principles and cases set out earlier in this opinion. *Id.* at 1138-1139 (emphasis added).

The Court then reviewed *Vickers*, *supra* and agreed with the need for a subjective analysis:

> The key phrase in this holding is "perceived to have." The emergency-room physician is required by EMTALA to screen and treat the patient for those conditions the physician perceives the patient to have. So here, the physician, we must assume through inadvertence or inattention, did not perceive Summers to have cracking or popping noises in his chest, or pain in the front of his chest. This is why no chest x-rays were taken. In the medical judgment of the physician, Summers did not need a chest x-ray. Summers did receive substantial medical treatment. It was not perfect, perhaps negligent, but he was treated no differently from any other patient perceived to have the same condition. *Id.* at 1139.

The Court concluded with a summary of its analysis, clearly expressing a belief that EMTALA was intended to address intentional and disparate treatment, but not negligence:

> In sum, we hold that instances of "dumping," or improper screening of patients for a discriminatory reason, or failure to screen at all,

> or screening a patient differently from other patients perceived to have the same condition, all are actionable under EMTALA. But instances of negligence in the screening or diagnostic process, or of mere faulty screening, are not. *Id*.

In *Marshall v. East Carroll Parish Hosp. Serv. Dist*., 134 F.3d 319, 323 (5th Cir. 1998), the Court commented on the relationship between negligence and EMTALA claims. While repeating the requirement that all patients be treated similarly, the Court also noted that the test was influenced by whether a patient was treated equitably, writing:

> Accordingly, an EMTALA "appropriate medical screening examination" is not judged by its proficiency in accurately diagnosing the patient's illness, but rather by whether it was performed equitably in comparison to other patients with similar symptoms. If the Hospital provided an appropriate medical screening examination, it is not liable under EMTALA even if the physician who performed the examination made a misdiagnosis that could subject him and his employer to liability in a medical malpractice action brought under state law. . . . Therefore, a treating physician's failure to appreciate the extent of the patient's injury or illness, as well as a subsequent failure to order an additional diagnostic procedure, may constitute negligence or malpractice, but cannot support an EMTALA claim for inappropriate screening. *Id.* at 322-323 (citations omitted).

This analysis is consistent with *Cleland's* rule that the motive or state of mind of the treatment provider must be taken into account, as an accidental mistake cannot impose liability, and EMTALA is satisfied if the effort is made to treat all patients equally when screening in the emergency department.

In *Phillips v. Hillcrest Med. Ctr.*, 244 F.3d 790, 796-797 (10th Cir. 2001) (footnote and citations omitted) the Court held that all patients had to be provided with consistent attention, while adding the requirement for uniform screening procedures. Each patient was to be treated in a uniform manner. The Court wrote:

> The underlying principle behind section 1395dd(a) is to ensure all patients, regardless of their perceived ability or inability to pay for medical care, are given consistent attention. EMTALA's requirement of an "appropriate screening examination" undeniably requires HMC to "apply uniform screening procedures to all individuals coming to the emergency room." . . . To the extent it was unclear before, this court holds, as it implicitly did in *Repp*, a hospital's obligation under EMTALA is measured by whether it treats every patient perceived to have the same medical condition in the same manner. "Disparate treatment" is simply another term for describing or measuring a hospital's duty to abide by its established procedures. Unless each patient, regardless of perceived ability or inability to pay, is treated in a uniform manner in accordance with the existing procedures, EMTALA liability attaches.

*Phillips* is yet another case which concluded that liability under EMTALA for failure to provide an appropriate screening should be evaluated based upon whether patients are treated similarly or disparately. This common thread, running through not only *Cleland* but also the other Circuit opinions, is important to keep in mind when reading the next section of this brief.

A final observation under this heading is in order. To the extent that there is a claimed disagreement between *Cleland* and the other Circuits, it arises from the use of the word motive. This disagreement can be resolved by considering what is meant by motive. Petitioner has drawn the same conclusion which seems to be relied on in the other Circuits, that being the conclusion that motive connotes a malicious reason for failing to provide an appropriate screening. This is an understandable interpretation, in light of the way that motive is used in everyday conversation. However, when the *Cleland* opinion is viewed in its entirety, it is clear that there is no requirement for a malicious motive, or any particular motive for that matter. *Cleland* simply requires that there be a motive, a reason, for disparate treatment. The decisions from the other Circuits also focus on disparate treatment. In light of the fact that there is universal disagreement that EMTALA does not punish treatment which is disparate due to negligence, the only remaining possibility is disparate treatment due to some motive, any motive. There really is not a significant difference between *Cleland* and the other Circuits.

### C. Emergency Department Screenings Cannot Follow a Standard Procedure, and Require the Exercise of Professional Judgment by Treatment Providers.

To the extent that courts have ruled that an emergency department must follow standard emergency department procedures, and thus provide each patient with the screening that any similarly situated patient would receive, those courts have failed to recognize the unique nature of every patient, and the importance of exercising professional judgment when evaluating and treating a patient. Compliance with a standardized screening process is not the answer, as it fails to take into account the realities of the practice of medicine.

A starting point is the realization that medicine is not an exact science. When Hippocrates penned his famous oath somewhere around 400 years B.C., he repeatedly described the practice of medicine as an art. That description remains true today. While science has become an ever more important part of modern healthcare, the practice of medicine is still, in many ways, an art. There is a saying in the medical field:

> Half of what is true today will be proven to be incorrect in the next five years. Unfortunately we don't know which half that is going to be.

New medicines, diagnostic tests and equipment are constantly coming into use. There may be any number of different procedures or treatment modalities which would fit any given patient, each of which would be acceptable. In short, a standard procedure for an

emergency department presentation is not always, or even often, available. The practice of medicine requires a great deal of judgment to identify the significant signs and symptoms, diagnose the problem(s) and select from among the various available means of treatment.

Another complicating factor is that a particular patient cannot simply be classified by his or her presenting complaints. Regardless of the subjective description a patient provides, a great deal more must be known. There is a reason that doctors don't diagnose and treat people by phone. Anyone who has ever been through a medical examination (which essentially includes all of us) is familiar with the variety of different questions which will be asked, and tests which will be performed. If it were as simple as just knowing the patient's complaints, there would be no need for an examination.

Yet another factor to consider is the uniqueness of each individual patient. Even with knowledge of the presenting complaints and a full examination, more must be taken into account. Treaters must factor in characteristics such as gender, age, prior medical history, family history, physical fitness and body habitus, diet, ethnic background, consumption of alcohol, tobacco and drugs (both legal and illegal), and a host of other factors. All of the various characteristics which make up a particular presentation must be evaluated by a treatment provider, based upon his or her knowledge, training and experience, as well as the available facilities. As noted in *Power v. Arlington Hosp. Ass'n*, 42

F.3d 851, 858 (4th Cir. 1994), the application of the screening procedure "necessarily requires the exercise of medical training and judgment."

When EMTALA's screening requirement is seen in this light, motive or state of mind is properly used as a relevant factor in analyzing a claim of a deficient screening. If treatment providers approach each unique emergency department presentation with the intent to do their best, an appropriate screening is provided, even if subsequent events establish that the diagnosis and/or treatment plan contained errors. On the other hand, if treatment providers intentionally conduct a screening which does not reflect a good faith application of professional skills and judgment, EMTALA's screening requirement is violated. The intent or state of mind of treatment providers is critical in determining if a patient received the same screening as any other patient would have been provided.

### D. It is the Good Faith Application of Professional Judgment which Results in a Similar Screening for All Patients.

There is no basis to disagree with the general principle that all patients should receive a proper screening, and that discrimination against any patient or class of patients is inexcusable. Some decisions would accomplish this by requiring standard screening procedures. However, when one understands that each patient requires an individualized assessment and treatment plan, it becomes clear that equitable

treatment of all patients is not identical treatment according to a standard procedure. The exercise of professional judgment is necessary. In fact, it is only the application of professional judgment which can provide each patient with the same quality of screening which any other patient would receive. Put another way, when treatment providers make a good faith effort to provide a proper screening, tailored to the needs of a particular patient, then and only then are all patients given a similar screening.

Of course, even the best exercise of professional judgment can be mistaken, but this does not violate the appropriate screening requirement. The case law universally recognizes that EMTALA is not intended to guarantee an accurate screening, or to establish a medical malpractice cause of action. It does not sanction a negligent exercise of professional judgment. This leaves only a deliberate failure to properly apply medical judgment to the patient at issue. This is simply another way of saying that disparate treatment occurs when treatment providers deliberately fail to provide a patient with the screening which they know the patient requires.

Given the importance of professional judgment, *Cleland* is properly seen as holding that any knowing, intentional deviation from such standard procedures as can be crafted, and/or any knowing, intentional failure to properly evaluate a patient, for whatever reason or motive, imposes liability. An appropriate screening should be defined as one which attempts to provide an adequate screening based on a particular presentation,

in light of a hospital's available resources and normal practices. This interpretation allows an EMTALA claim for a screening which is known to be defective. At the same time, it does not impose EMTALA liability for medical malpractice. Likewise, it does not impose liability when a bad outcome occurs in spite of the provision of a screening which completely satisfies the applicable standard of care but, unfortunately, nonetheless fails to identify an emergent medical condition.

Decisions from other Circuits have implicitly recognized and applied this understanding. In *Baber*, *supra* at 977 F.2d 879 the Court referred to a screening procedure but, in the same passage, noted that "the goal of 'an appropriate medical screening examination' is to determine whether a patient with acute or severe symptoms has a life threatening or serious medical condition." In the following paragraph, the Court noted "that application of the procedure necessarily requires the exercise of medical training and judgment." This analysis seems to show a recognition that it is the intent or goal to properly evaluate a patient which is required. In *Correa*, *supra* at 69 F.3d 1192-1193, the Court described a hospital's obligation as being to provide "a screening examination reasonably calculated to identify critical medical conditions that may be afflicting symptomatic patients and provides that level of screening uniformly to all those who present substantially similar complaints." Again we see a recognition of the fact that an attempt to provide a proper screening satisfies EMTALA's requirements. *Vickers*, *supra* at 788 F.3d includes a telling observation:

> EMTALA is implicated only when individuals who are *perceived* to have the same medical condition receive disparate treatment. (Emphasis in original.)

The use of "perceived" cannot be overlooked. It is a clear statement that intent/state of mind is crucial. *Vickers* was followed in 91 F.3d 1139, where the Court noted:

> The key phrase in this holding is "perceived to have." The emergency-room physician is required by EMTALA to screen and treat the patient for those conditions the physician perceives the patient to have.

Once again, the perception of the treatment providers is key. Although it may not be explicitly stated, a common thread running through these decisions is that determining whether a screening was appropriate requires evaluation of the state of mind of treatment providers.

This interpretation of an "appropriate screening" is consistent with the frequently cited rule that all patients must be treated the same, and that disparate treatment results in liability under EMTALA. If the screening requirement is satisfied by a good faith effort to provide each patient with a proper evaluation, each patient will be treated the same, in that each patient will receive the hospital's best effort to diagnose any emergency condition. With this understanding, the decisions from *Cleland* and the other Circuits which

have weighed in are not dissimilar in their essential holdings.

**2. Should the Court Wish to Consider Whether EMTALA's Screening Requirement Includes an Intent/State of Mind Element, Review of a Case from Another Circuit which has Rejected an Intent/State of Mind Element would Present a Better Opportunity.**

If the Court accepts the premise that *Cleland* properly concluded that a state of mind element applies to an EMTALA screening claim, and the other circuits have taken the wrong approach, this leads to the conclusion that the present case is not an appropriate vehicle to review the issue. *Cleland* should be left to stand for the present. The analysis applied in other Circuits is more properly addressed by considering a case from one of those Circuits, one which has taken a view contrary to *Cleland*. This would provide a better opportunity for this Court to consider the specific analysis which disagreed with the reasoning of the *Cleland* Court.

**3. The Issue Presented for Review is Effectively Moot as Petitioner has a Full Opportunity to Recover All Claimed Damages in a Pending State Court Medical Malpractice Action.**

It should be brought to the attention of this Court that Petitioner has not been left without a remedy. Damages available to the successful EMTALA plaintiff

are "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." 1395dd(d)(A). Petitioner's complaint alleges that certain diagnostic tests which should have been performed were not. Petitioner essentially attempts to state a medical malpractice cause of action.

After the dismissal of this action, Petitioner filed a case in state court arising from the same operative facts as were relied on in her complaint herein. It is a matter of public record that Petitioner filed an action in the Emmet County, Michigan, Circuit Court, File No.: 17-105927-NH. This complaint was voluntarily dismissed by Petitioner because of a procedural error, and she filed a second Emmet County complaint, File No.: 17-105942-NH. That action is being developed in the state court, and is likely to be resolved one way or another during the first half of 2019. Petitioner will have her day in court, and will be able to ask for all damages which she might have recovered if she had presented a viable EMTALA claim.

### 4. Petitioner Elected to Plead an EMTALA Claim Without Complying with the Established Rule in *Cleland*, and Should Not Be Granted Relief for Pleading a Claim Which Was Defective on its Face.

In considering whether this is an appropriate case to grant leave and consider the EMTALA question at issue, it is important to recognize the manner in which

Petitioner chose to plead her case in the federal district court. *Cleland* has been controlling authority in the Sixth Circuit since 1990. Petitioner must be charged with knowledge of the law. In the Sixth Circuit, a plaintiff is required to plead an improper motive, and plead facts which would support allegations of an improper motive. Petitioner in this case chose not to do so. She elected to submit a complaint which generally alleged an improper motive, in conclusory terms and without identifying facts which would tend to show such a motive. The district court dismissed the action for failure to plead the necessary facts. Petitioner did not even request an opportunity to amend and attempt to plead facts in support of her EMTALA claim. On appeal, the only issue Petitioner raised was the strictly legal question of whether she was even required to plead an improper motive. The Circuit Court concluded that it was well established that she did have to plead motive, and affirmed the lower court's dismissal.

An interesting observation under this heading is that Petitioner had the option of filing her medical malpractice claim along with her EMTALA claim. Admittedly, she was not required to do so. However, as detailed earlier in this brief when discussing the factual background of this case, the allegations in her complaint assert that some level of screening occurred in the McLaren emergency department. Although she tried to present the facts as a complete failure to provide a screening, the events which made up the screening, and the alleged actions that should have been taken, clearly present a claim of an inadequate screening, not

a complete failure to screen. The fact that Petitioner has filed a medical malpractice action in state court arising out of the same operative facts is conclusive proof that she could have filed a malpractice action in the federal district court.

Given that Petitioner chose not to include a medical malpractice claim in federal court, and failed to allege any specific facts which would establish an improper motive in relation to her EMTALA claim, one has to wonder if her federal action was seriously intended to recover her alleged damages. There is reason to suspect that the federal action was filed solely for the purpose of creating an opportunity to challenge the holding in *Cleland*. Whether or not this is the case, the case before this Court never included a viable EMTALA claim. In that sense, there is no true issue in controversy, and this case is nothing more than an academic exploration of the appropriate screening requirement and the *Cleland* decision.

In common vernacular, one could say that Petitioner made her bed, and now she must sleep in it. McLaren submits that an appropriate response is to deny the current Petition, and require Petitioner to accept the consequences of failing to plead an essential element of the claim.

## CONCLUSION

Petitioner asks this Court to overturn *Cleland* based on an alleged conflict between *Cleland* and decisions from five other Circuits. McLaren submits that *Cleland's* holding – that intentionally disparate treatment for any reason violates EMTALA – is not essentially different from the holdings from other Circuits – that disparate treatment which results from something more than negligence violates EMTALA. In short, there is really no conflict at all, and intervention by this Court is unnecessary.

Date: Aug. 30, 2018

Respectfully submitted,

MICHAEL L. VAN ERP*
ROBERT M. WYNGAARDEN
VERLIN R. NAFZIGER
JOHNSON & WYNGAARDEN P.C.
3445 Woods Edge Drive
Okemos, MI 48864
(517) 349-3200
mlv@jwynlaw.com
**Counsel of Record*