NO. 24-_____

In the Supreme Court of the United States

RANDAL JEROME DALAVAI,
SUCCESSOR IN INTEREST TO 'DECEDENT' GEETHA DALAVAI AND SON OF GEETHA DALAVAI,

Petitioner,

v.

THE REGENTS AND ELIZABETH HOSPICE,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

Eric Nelson, Esq.
Counsel of Record
54 Florence Street
Staten Island, NY 10308
(718) 356-0566
ericnelson@ericnelsonesq.com

December 19, 2024 *Counsel for Petitioner*

SUPREME COURT PRESS ♦ (888) 958-5705 ♦ BOSTON, MASSACHUSETTS

QUESTION PRESENTED

Whether a hospital's obligation under the Emergency Medical Treatment & Labor Act ("EMTALA") ends when the patient is admitted to the hospital, as the Ninth Circuit held here, or even if the hospital properly admitted the patient, it may not release a patient with an emergency medical condition without first determining that the patient has actually stabilized, as at least two other Circuits have held.

LIST OF PROCEEDINGS

U.S. Court of Appeals for the Ninth Circuit

No. 23-55412

Randal Jerome Dalavai, Successor in Interest to 'Decedent' Geetha Dalavai and Son of Geetha Dalavai, *Plaintiff-Appellant,* v.
The Regents; Et Al., *Defendants-Appellees.*

Memorandum Opinion: August 16, 2024

U.S. District Court, S.D. California

No. 22-cv-1992

Randal Jerome Dalavai, *Plaintiff*, v.
The Regents, Et Al., *Defendants.*

Final Order: April 5, 2023

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PETITION FOR A WRIT OF CERTIORARI

Petitioner respectfully prays that a writ of certiorari issue to review the judgment below.

OPINIONS BELOW

The opinion of the district court has not been officially report but may be found at 2023 U.S. Dist. LEXIS 60441, 2023 WL 2801201 and in the Appendix at App.5a. The decision of the United States Court of Appeals for the Ninth Circuit has not been reported but may be found at 2024 U.S. App. LEXIS 20757, 2024 WL 3842100 and in the Appendix at App.1a.

JURISDICTION

The Court of Appeals issued its decision on August 16, 2024. (App.1a) Justice Kagan extended the time to file the petition to November 28, 2024. (No. 24A420). This Court has jurisdiction pursuant to 28 U.S.C. § 1254.

STATUTORY PROVISIONS AND REGULATIONS INVOLVED

42 U.S.C. § 1395dd

(a) Medical screening requirement. In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title [42 USCS §§ 1395 et seq.]) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor.

(1) In general. If any individual (whether or not eligible for benefits under this title [42 USCS §§ 1395 et seq.]) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) Refusal to consent to treatment. A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer. A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized.

(1) Rule. If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B)), the hospital may not transfer the individual unless—

(A)

(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1861(r)(1) [42 USCS § 1395x(r)(1)]) has signed a certification that[,] based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1861(r)(1) [42 USCS § 1395x(r)(1)]), in consultation with the person, has made the determin-

ation described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer. An appropriate transfer to a medical facility is a transfer—

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility—

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility with all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and

the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement.

(1) Civil monetary penalties.

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1128A [42 USCS § 1320a-7a] (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a) [42 USCS § 1320a-7a (a)].

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treat-

ment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who—

(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section, is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this title [42 USCS §§ 1395 et seq.] and State health care programs. The provisions of section 1128A [42 USCS § 1320a-7a] (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1128A(a) [42 USCS § 1320a -7a (a)].

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital

on its list of on-call physicians (required to be maintained under section 1866(a)(1)(I) [42 USCS § 1395cc(a)(1)(I)]) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement.

(A) Personal harm. 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.

(B) Financial loss to other medical facility. Any medical facility that suffers a financial loss 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 financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions. No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with quality improvement organizations. In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1) or in terminating a hospital's participation under this title [42 USCS §§ 1395 et seq.], the Secretary shall request the appropriate quality improvement organization (with a contract under part B of title XI [42 USCS §§ 1320c et seq.]) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this title [42 USCS §§ 1395 et seq.] for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital

or physician consistent with confidentiality requirements imposed on the organization under such part B [42 USCS §§ 1320c et seq.].

(4) Notice upon closing an investigation. The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.

(e) Definitions. In this section:

(1) The term "emergency medical condition" means—

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means a hospital that has entered into a provider agreement under section 1866 [42 USCS § 1395cc].

(3)

(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the

facility without the permission of any such person.

(5) The term "hospital" includes a critical access hospital (as defined in section 1861(mm)(1) [42 USCS § 1395x(mm)(1)]) and a rural emergency hospital (as defined in section 1861(kkk)(2) [42 USCS § 1395x(kkk)(2)]).

(f) Preemption. The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination. A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment. A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination and treatment required under subsection (b) in order to inquire about the individual's method of payment or insurance status.

(i) Whistleblower protections. A participating hospital may not penalize or take adverse action against a qualified medical person described in

subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

42 CFR 489.24(d)

(2) Exception: Application to inpatients.

(i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual.

STATEMENT OF THE CASE

According to the complaint, whose allegations must be accepted as true, Petitioner's mother, Geetha Dalavai (the "Decedent"), visited the Inland Valley Medical Center Emergency Room ("IVMC") on September 1, 2020, due to shortness of breath. She was admitted to IVMC shortly after her arrival at the hospital. The Emergency medical condition indicated on the death certificate was diagnosed during her time at IVMC. On September 16, 2020, the Decedent was transferred to Jacobs Medical Center at UCSD Health after IVMC determined that she required a higher level of care.

The emergency medical situation that the Decedent presented was not stabilized. On October 1, 2020, UCSD Health discontinued providing further medical examinations and treatment within the hospital's staff and facilities in order to stabilize the medical condition for which Decedent Geetha Dalavai came to the Emergency Room or transfer her to another facility.

UCSD Health determined the Decedent was not a candidate for a lung transplant and transferred the Decedent to The Elizabeth Hospice. In transferring her to The Elizabeth Hospice, UCSD Health prevented Decedent from being transferred to another facility to receive life-saving treatment.

The district court dismissed the claim against Elizabeth Hospice for lack of subject matter jurisdiction over the claims alleged against them. It dismissed the claim against the Regents for failure to state a claim and as barred by the statute of limitations.

The Ninth Circuit affirmed, holding that its "precedent is clear that EMTALA liability 'normally ends when [an emergency room patient] is admitted for inpatient care.'" (quoting *Bryant v. Adventist Health Sys./W.*, 289 F.3d 1162, 1167 (9th Cir 2002). It did "not assess his other argument that the district court improperly dismissed his EMTALA claim based on expiration of the statutory limitations period."

REASONS FOR GRANTING THE PETITION

The petition for certiorari raises a serious question as to whether a hospital's obligation under the Emergency Medical Treatment & Labor Act ("EMTALA") ends when the patient is admitted to the hospital, as the Ninth Circuit held here, or even if the hospital properly admitted the patient, it may not release a patient with an emergency medical condition without first determining that the patient has actually stabilized, as some Circuits have held. Compare *Bryant v. Adventist Health Sys./W.*, 289 F.3d 1162, 1168 (9th Cir. 2002) ("We hold that EMTALA's stabilization requirement ends when an individual is admitted for inpatient care.") and *Bryan v. Rectors & Visitors of the Univ. of Vir.*, 95 F.3d 349 (4th Cir. 1996) with *Moses v. Providence Hosp. & Med. Ctrs., Inc.*, 561 F.3d 573, 583 (6th Cir. 2009), cert. denied 561 U.S. 1038 (2010)[1] (holding that "a hospital may not release a patient with an emergency medical condition without first determining that the patient has actually stabilized, even if the hospital properly admitted the patient").[2]

In *Moses*, the Sixth Circuit addressed the matter for the first time since the CMS's 2003 regulations.

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[1] The denial was "likely due to an amicus brief of the United States. In its brief, the United States requested that the Court refuse to hear the case because '[t]he conflict among the circuits is shallow' and because '[the Department of Health and Human Services] has committed to initiating rulemaking to reconsider the issue in the coming year." Note: *Moses v. Providence Hospital: the Sixth Circuit Dumps the Federal Regulations of the Patient Anti-dumping Statute*, 27 J. CONTEMP. HEALTH L. & POL'Y 213, 242 (2010). That, parenthetically, never happened.

Disregarding CMS regulations, the court reversed the district court's order granting summary judgment, holding that admission to a hospital's inpatient care unit was insufficient to meet the hospital's stabilization requirement under EMTALA.

The court began by reciting the relevant provisions of the Act. When a patient is diagnosed with an emergency medical condition, the hospital must offer "such treatment as may be required to stabilize the medical condition." A patient is deemed stabilized when "no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during transfer." "'Transfer' is defined in the statute to include moving the patient to an outside facility or discharging him." Thus the court determined that "EMTALA requires a hospital to treat a patient with an emergency [medical] condition in such a way that, upon the patient's release, no further deterioration of the condition is likely." In other words, meeting EMTALA's stabilization criteria is solely determined by the patient's medical state.

The court then examined the hospital's claim that the CMS regulation enabled patient admission to meet the EMTALA's stabilization criterion. The court began by emphasizing that regulations produced by administrative agencies can be overturned if they are clearly contradictory to congressional intent. The court determined congressional purpose based on the text of the stabilization provision and the accompanying defin-

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[2] The First Circuit seems congruent with the Sixth Circuit. *See Lima-Rivera v. UHS of Puerto Rico, Inc.*, 476 F. Supp. 2d 92 (D. P.R. 2007), relying upon *Lopez-Soto v. Hawayek*, 175 F.3d 170 (1st Cir. 1999).

itions, and concluded that permitting entry to fulfill the stabilization requirement violated the statute. Because the CMS regulation contradicted the plain wording of the Act, the court rejected it and denied it respect.

That the Sixth Circuit's analysis is correct is corroborated in Charlotte Fillenwarth, *Beyond the Emergency Room Doors: Rejecting Patient Admittance as Satisfaction of Hospital Obligations under EMTALA*, 11 IND. HEALTH L. REV. 793 (2014). The author emphasizes that *Moses* comports with both the statutory language and legislative intent.

Courts like the Ninth Circuit have relied upon CMS regulations to hold that there is no duty under that EMTALA when an individual is admitted for inpatient care. *See Thomas v. Christ Hosp. & Med. Ctr.*, 328 F.3d 890, 893-96 (7th Cir. 2003) (referring to the CMS regulations for guidance in evaluating an EMTALA claim); *Torretti v. Main Line Hosps., Inc.*, 580 F.3d 168, 174 (3d Cir. 2009) (stating that "CMS has the congressional authority to promulgate rules and regulations interpreting and implementing Medicare-related statutes such as EMTALA," and observing that "[g]enerally, we defer to a government agency's administrative interpretation of a statute unless it is contrary to clear congressional intent" (citations omitted)); *Thornhill v. Jackson Parish Hosp.*, 184 F.Supp.3d 392, 399 (W.D. La. 2016) ("The vast majority of courts that have considered a hospital's duty under EMTALA since CMS promulgated the regulations have given the regulations controlling weight, or have cited them in support. . . . "); *Preston v. Meriter Hosp., Inc.*, 700 N.W.2d 158 (Wisc. App. 2005) rev. denied 749 N.W.2d 662 (Wisc. 2008).

The contrary decisions rely upon so-called *Chevron* deference. *Chevron USA v. National Resources Defense Council*, 467 U.S. 837 (1984). *Chevron* was overruled in *Loper Bright Enterprises v. Raimondo*, 603 U.S. __, 144 S. Ct. 2244 (2024). Even before *Loper Bright*, the Sixth Circuit had held in *Moses* that the regulation could not trump the statute's clear and unambiguous provisions.

In short, the conflict in the Circuits should be settled.

CONCLUSION

For the reasons stated, the petition for a writ of certiorari should be granted, or, alternatively, the judgment vacated and the matter remanded for further consideration in light of *Loper Bright*.

Respectfully submitted,

Eric Nelson, Esq.
Counsel of Record
54 Florence Street
Staten Island, NY 10308
(718) 356-0566
ericnelson@ericnelsonesq.com

Counsel for Petitioner

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