ProLife OB|GYNS
AAPLOG American Association *of* Pro-life Obstetricians & Gynecologists

AAPLOG Statement on Ohio Senate Bill 208
Born Alive Infant Protection Act
SUPPORT
Presented to the Senate Health, Human Services, and Medicaid Committee

October 14, 2019
Written Testimony Donna J. Harrison M.D., Executive Director

Thank you, Chairman Burke, Vice Chair Huffman, and Ranking Member Antonio for allowing the American Association of Pro-Life Obstetricians and Gynecologists to present this letter of support for Senate Bill 208.

As Executive Director of the American Association of Pro-Life Obstetricians and Gynecologists, I speak on behalf of our over 4000 members, supporting Senate Bill 208. AAPLOG's support of this bill echos the support of over 30,000 physicians who submitted joint letter[1] of testimony in support of the Born-Alive Abortion Survivors Protection Act before the United States Congress. AAPLOG applauds the Ohio Senate for unanimously passing Resolution 41 supporting that same Federal legislation. In addition, as someone who was born in Zanesville, Ohio, and educated in Akron, Ohio, I am glad to submit this testimony on behalf of the smallest citizens of Ohio.

Physicians who practice according to the Hippocratic Oath understand that no matter the circumstances of their birth, infants who are born alive must be given appropriate medical care.

Any infant who is born alive, at any stage of development, is a person entitled to the protections of the law and appropriate care as a new patient. There is no scientific or legal reason to distinguish between human beings born after an attempted abortion and human beings born after attempted live birth. A distressed newborn should get immediate emergency care and a professional evaluation to determine appropriate steps to promote his/her health and well-being. Obviously, a distressed newly born baby presents for emergency medical care at the moment of her or his birth, regardless of whether that birth results from an abortion attempt or attempted live delivery.

The Center for Medicaid and Medicare Services (CMS) issued a guidance document[2] in which CMS explicitly stated that EMTALA mandates hospital personnel to examine and treat any infant after delivery, because such newly delivered infants are persons who present for emergency medical care. Infants born after an attempted abortion in a hospital are to be treated in an equal fashion as infants born after delivery at comparable gestational ages. It is clear that CMS recognizes that infants born after abortion attempts deserve the same EMTALA protections as any other human being at a comparable gestational age. It stands to reason that infants born alive after an attempted abortion also deserve the same protection. SB208 ensures compliance with that protection.

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[1] Attached as Appendix A
[2] Attached as Appendix B also available at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/QSO-05-26.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending

These same principles apply in cases in which the human being in utero has a disability or has been given a life-limiting diagnosis, such as anencephaly. Human beings who are disabled at birth deserve the same respect and dignity afforded to able-bodied children at similar gestational ages. The terms "incompatible with life" or "fatal fetal malformations" are not medical terms. For many children with medical conditions previously labelled as such, survival for years has been accomplished[3], and is very possible when supportive care is provided.

Despite the fact that abortions are illegal after 20 weeks in the State of Ohio, 106 abortions occurred after 21 weeks gestation, according to the 2018 Ohio Abortion Report[4], and 382 occurred between 19 and 20 weeks. It is unknown how accurate those dates are, because pregnancies which are dated by ultrasound at those gestational ages have a known +/- 2 week error in dating. So it is possible that some of the 382 abortions reportedly occurring between 19 and 20 weeks gestation may have been performed on fetuses who were actually at 21-22 weeks gestation.

The fact that abortions are occurring beyond the 20 week limit in Ohio reveals that some Ohio abortionists are willing to ignore or thwart the law. Senate Bill 208 provides a real mechanism for enforcement, by providing for real penalties when the laws of the State of Ohio are ignored or thwarted.

Further Senate Bill 208 requires accurate medical record keeping concerning the number of babies born alive after abortion attempts. Accurate record keeping is essential to meaningful public policy. Since abortion clinics as a rule do not participate in the electronic health records required of most physicians and hospitals, this record-keeping represents the bare minimal requirement that should be expected of abortion providers, as the human beings born alive after abortions are persons under the law and are protected by the same laws as protect other citizens of Ohio.

Senate Bill 208 provides a scientifically sound, medically accurate, and respectful approach to ensure that the innocent human being who survives an attempted abortion will be treated with the same human dignity and respect that similarly aged human beings receive in the course of good neonatal medical care. Senate Bill 208 also ensures that human beings with disabilities are not targeted for intentional killing at the moment of birth.

For all of these reasons, we urge passage of Senate Bill 208

Respectfully submitted,

Donna J Harrison, M.D.

Donna J. Harrison M.D. Executive Director
American Association of Pro-Life Obstetricians and Gynecologists[5]

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[3] Wilkinson DJ, Thiele P, Watkins A, De Crespigny L. Fatally flawed? A review and ethical analysis of lethal congenital malformations. BJOG. 2012 Oct;119(11):1302-8. doi: 10.1111/j.1471-0528.2012.03450.x.

[4] Available at: https://odh.ohio.gov/wps/wcm/connect/gov/534ddb3a-febd-4e2a-99ee-90249240bcdd/VS-AbortionReport2018.pdf.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-534ddb3a-febd-4e2a-99ee-90249240bcdd-mS77yg-

[5] The American Association of Pro-Life Obstetricians and Gynecologists is a 4,600 member organization consisting of OB/GYNs and other physicians and medical professionals who work in the field of reproductive health, and who practice according to the Hippocratic Oath. The mission of AAPLOG is to provide an evidence-based defense of both our pregnant patient and her unborn child.

ProLife OB|GYNS
AAPLOG American Association of Pro-life Obstetricians & Gynecologists

February 13, 2019

Joint Medical Statement on S. 311
Born Alive Abortion Survivors Protection Act
SUPPORT
Presented to the 116th Congress U.S. Senate

As medical professional organizations and individuals representing over 30,000 physicians who practice according to the Hippocratic Oath, we write in support of S. 311, the Born Alive Abortion Survivors Protection Act.

Medical facts are important.

Fact 1. It is an undisputed scientific fact that a distinct, living human being exists in the womb of a pregnant mother.

From the moment of fertilization, a human being meets all of the scientific criteria for a living organism[1] and is completely distinct from her/his mother, not a part of her/his mother's body. This is scientific fact. It is therefore scientifically correct for S. 311 to identify the living survivors of abortions as human persons and afford those human beings the full protection of the law in the same way that infants of similar gestational ages are currently protected.

Fact 2. Abortion is NOT healthcare, much less an essential part of women's health care and abortions in the third trimester are NOT done to save a woman's life[2].

The fact that over 85% of ob-gyns in a representative national survey do not perform abortions on their patients[3] is glaring evidence that abortion is NOT an essential part of women's healthcare. The vast majority of abortions are done by abortion providers who do not provide any other kind of medical care for the woman. Abortion treats no disease. Pregnancy is not a disease, and deliberately killing the unborn child by abortion is NOT healthcare.

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[1] Condic M When Does Human Life Begin? The Scientific Evidence and Terminology Revisited University of St. Thomas Journal of Law and Public Policy 8(1) Fall 2013 Article 4. Available at http://www.embryodefense.org/MaureenCondicSET.pdf
[2] Greene-Foster D and Kimpart K Who Seeks Abortions at or After 20 weeks? Perspectives on Sexual and Reproductive Health 2013 45(4):210-218 doi:10.1363/4521013.
[3] Stulberg D, Dude A, Dahlquist B, Curlin F. Abortion Provision Among Practicing Obstetrician-Gynecologists Obstet Gynecol. 2011 September ; 118(3): 609–614. doi:10.1097/AOG.0b013e31822ad973.

It is clear from testimony by abortion practitioners during the Partial Birth Abortion Ban hearings[4] that, unlike a delivery, which separates the mother and her fetus for the purpose of life, an abortion separates the mother and the fetus with the purpose of guaranteeing that the baby is born dead. That's why a fetus who survives an abortion is called a "failed abortion". The separation did not fail to occur. What "failed" to occur in a "failed abortion" is the guarantee of a dead baby.

There are rare circumstances in which a mother's life is in jeopardy due to either pre-existing conditions or pregnancy complications. It is extremely rare for this to occur prior to the point of viability (currently 22 weeks after last menstrual period, 20 weeks after fertilization). After 20 weeks fertilization age, it is NEVER necessary to intentionally kill the fetal human being in order to save a woman's life.[5] In cases where the mother's life actually is in danger in the latter half of pregnancy, there is not time for an abortion, because an abortion typically is a two to three-day process. Instead, immediate delivery is needed in these situations, and can be done in a medically appropriate way (labor induction or C-section) by the woman's own physician. We can, and do, save the life of the mother through delivery of an intact infant in a hospital where both the mother and her newborn can receive the care that they need. There is no medical reason to intentionally kill that fetal human being through an inhumane abortion procedure, e.g. dismembering a living human being capable of feeling pain[6] [7] [8](*Also see Appendix A*), or saline induction which burns off the skin (*See Appendix B*), or feticide with subsequent induction.

Obstetricians who abide by the Hippocratic oath strive, to the best of our ability, to save both lives when at all possible. There are two patients under our care. We never intentionally target the unborn child during the separation procedure in order to guarantee that the baby is born dead.

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[4] Gonzales v Carhart USSC available at https://www.supremecourt.gov/opinions/06pdf/05-380.pdf
at p 9 "*Yet one doctor would not allow delivery of a live fetus younger than 24 weeks because "the objective of [his] procedure is to perform an abortion," not a birth. App. in No. 05–1382, at 408–409. The doctor thus answered in the affirmative when asked whether he would "hold the fetus' head on the internal side of the [cervix] in order to collapse the skull" and kill the fetus before it is born. Id., at 409; see also Carhart, supra, at 862, 878. Another doctor testified he crushes a fetus' skull not only to reduce its size but also to ensure the fetus is dead before it is removed*."
See also p 11 "(*b) As used in this section— "(1) the term 'partial-birth abortion' means an abortion in which the person performing the abortion— "(A) deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing <u>an overt act that the person knows will kill the partially delivered living fetus</u>; and "(B) <u>performs the overt act, other than completion of delivery, that kills the partially delivered living fetus</u>;…*" [underline mine]

[5] Dublin Declaration on Maternal Health. Available at https://www.dublindeclaration.com/ (last visited 2019 02 13)
"*As experienced practitioners and researchers in obstetrics and gynaecology, we affirm that direct abortion – the purposeful destruction of the unborn child – is not medically necessary to save the life of a woman.*
We uphold that there is a fundamental difference between abortion, and necessary medical treatments that are carried out to save the life of the mother, even if such treatment results in the loss of life of her unborn child.
We confirm that the prohibition of abortion does not affect, in any way, the availability of optimal care to pregnant women."

[6] Testimony of Dr. Maureen Condic District of Columbia H R.179J, 23 May 2013 available at: https://www.govinfo.gov/content/pkg/CHRG-113hhrg81175/pdf/CHRG-113hhrg81175.pdf page 36-46

[7] American Association of Pro-Life Obstetricians and Gynecologists Practice Bulletin 2 Fetal Pain. Available at: https://aaplog.org/wp-content/uploads/2019/02/PB-2-Fetal-Pain.pdf__

[8] American Association of Pro-Life Obstetricians and Gynecologists Fetal Pain Fact Sheet available at: https://aaplog.org/wp-content/uploads/2019/02/2019-02-13-AAPLOG-FACT-SHEET-FETAL-PAIN.pdf

Fact 3. No matter the circumstances of their birth, infants who are born alive must be given appropriate medical care.

Any infant who is born alive, at any stage of development, is a person entitled to the protections of the law and appropriate care as a new patient. There is no scientific or legal reason to distinguish between human beings born after an attempted abortion and human beings born after attempted live birth. A distressed newborn should get immediate emergency care and a professional evaluation to determine appropriate steps to promote his/her health and well-being._Obviously, a distressed newly born baby presents for emergency medical care at the moment of her or his birth, regardless of whether that birth results from an abortion attempt or attempted live delivery. EMTALA mandates hospitals to examine and treat any person who presents for emergency medical care.

These same principles apply in cases in which the human being in utero has a disability or has been given a life-limiting diagnosis, such as anencephaly. Human beings who are disabled at birth deserve the same respect and dignity afforded to able-bodied children at similar gestational ages. The terms "incompatible with life" or "fatal fetal malformations" are not medical terms. For many children with medical conditions previously labelled as such, survival for years has been accomplished[9], and is very possible when supportive care is provided.

Additionally, as health care professionals, we are notoriously poor predictors of whether infants will live or die when supportive medical care is offered[10]. If a fetus has a potentially life-limiting diagnosis which is expected to result in death shortly after birth, families should be presented with the potential benefits of medical care and, accepting that such care might only prolong an inevitable death, be offered perinatal hospice. [11] [12]

Perinatal hospice respects the human dignity of the newborn and allows the family to hold and care for their child after birth, celebrating the precious time they have together as well as allowing them to grieve the brevity of this same gift. Perinatal hospice provides optimal care for the mother, honors the life of her child and allows the family the opportunity to acknowledge, love, and mourn its newest member. Literature comparing outcomes of delivery and perinatal hospice care with abortion in cases of anencephaly reveals significantly better mental health outcomes for mothers who do not abort. [13] [14] [15] Perinatal hospice is compassionate and comprehensive health care for women whose fetuses have life-limiting diagnoses.

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[9] Wilkinson DJ1, Thiele P, Watkins A, De Crespigny L Fatally flawed? A review and ethical analysis of lethal congenital malformations. BJOG. 2012 Oct;119(11):1302-8. doi: 10.1111/j.1471-0528.2012.03450.x. Epub 2012 Jul 25

[10] Meadow W et al. Just, in time: ethical implications of serial predictions of death and morbidity for ventilated premature infants. Pediatrics. 2008 Apr;121(4):732-40.

[11] Perinatal Hospice and Palliative Care https://www.perinatalhospice.org/

[12] American Association of Pro-Life Obstetricians and Gynecologists Practice Bulletin 1 Perinatal Hospice. Available at: _https://aaplog.org/wp-content/uploads/2019/02/PB-1-Perinatal-Hospice.pdf_

[13] Cope H, Garrett ME, Gregory S, Ashley-Koch A Pregnancy continuation and organizational religious activity following prenatal diagnosis of a lethal fetal defect are associated with improved psychological outcome. Prenat Diagn. 2015 Aug;35(8):761-768.

[14] Calhoun BC, Reitman JS, Hoeldtke NJ. Perinatal Hospice: A Response to Partial Birth Abortion for Infants with CongenitalDefects. Issues in Law and Medicine 1997; 13(2): 125-143.

[15] Calhoun BC, Hoeldtke NJ, Hinson RM, Judge KM. Perinatal Hospice: Should all centers have this service? Neonatal Network 1997;16(6):101-102

S.311 provides a scientifically sound, medically accurate, and respectful approach to ensure that the innocent human being who survives an attempted abortion will be treated with the same human dignity and respect that similarly aged human beings receive in the course of good neonatal medical care. S. 311 ensures that human beings with disabilities are not targeted for intentional killing at the moment of birth.

For all of these above reasons, we, the undersigned medical organizations and individuals, strongly urge you to pass S. 311. Thank you for your consideration of these views.

Respectfully submitted,

Donna J. Harrison M.D. Executive Director
American Association of Pro-Life Obstetricians and Gynecologists[16]

Michelle Cretella M.D. Executive Director
American College of Pediatricians[17]

John Schirger, M.D. President,
Catholic Medical Association[18]

David Stevens, CEO
Christian Medical & Dental Associations[19]

Jane Orient, Executive Director
Association of American Physicians and Surgeons[20]

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[16] The American Association of Pro-Life Obstetricians and Gynecologists is a 4,600 member organization consisting of ob-gyns and other physicians and medical professionals who work in the field of reproductive health, and who practice according to the Hippocratic Oath. The mission of AAPLOG is to provide an evidence-based defense of both our pregnant patient and her unborn child.

[17]The American College of Pediatricians is a Hippocratic medical organization dedicated to using the best available science to promote the optimal health of all children from their conception until natural death.

[18] The Catholic Medical Association is a national, physician-led community of over 2,300 healthcare professionals consisting of 109 local guilds. CMA mission is to inform, organize, and inspire its members, in steadfast fidelity to the teachings of the Catholic Church, to uphold the principles of the Catholic faith in the science and practice of medicine.

[19]The Christian Medical and Dental Associations is a 19,000+ member organization in the United States, consisting of healthcare professionals from multiple disciplines including medicine, dentistry, physician assistants, nurse practitioners, physiotherapists, optometrists, pharmacists, and many others. The mission of CMDA is to motivate, educate, and equip Christian healthcare professionals to glorify God by serving with professional excellence as witnesses of Christ love and compassion to all peoples and by advancing biblical principles of healthcare within the church and to our culture.

[20] AAPS was founded in 1943 to preserve and promote the practice of private medicine. It upholds the sanctity of the patient-physician relationship and the ethical principles in the Oath of Hippocrates.

Additional Signatures

Marie Hilliard MS, M.A. PhD, JCL, R.N. President
National Association of Catholic Nurses

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Center for *Clinical Standards & Quality*/*Quality, Safety & Oversight* Group

Ref: *QSO*-05-26
Revised 06/27/2019

DATE: ***April 22, 2005***

TO: State Survey Agency Directors

FROM: Director
Quality, Safety and Oversight Group

SUBJECT: Interaction of the Emergency Medical Treatment and Labor Act (EMTALA) and the Born-Alive Infants Protection Act of 2002

NOTE: *This memorandum is being reissued to remind hospitals of their obligation to comply with EMTALA as it relates to the Born-Alive Infant Protection Act. This is NOT new policy.*

Letter Summary

- The Born-Alive Infants Protection Act of 2002 (Pub. L. 107-207) adds to the United States Code a definition of the term "individual" to include every infant who is born alive, at any stage of development; it also adds a definition of the term "born alive."

- The Emergency Medical Treatment and Labor Act (EMTALA) provides certain rights to "any individual" who comes to an emergency department and "any individual" who comes to a hospital. In particular, hospitals must provide an appropriate medical screening examination to any individual who comes to an emergency department, and either stabilizing treatment or an appropriate transfer for an individual who comes to a hospital and who is determined to have an emergency medical condition.

- **Attachment:** The attached Guidance provides direction to regional office and state survey agency personnel on how to apply EMTALA in investigations when the Born-Alive Infants Protection Act is potentially implicated.

The purpose of this memorandum is to provide guidance to regional office (RO) and state survey agency (SA) personnel regarding the enforcement of the Emergency Medical Treatment and Labor Act (EMTALA) during investigations of hospitals where the Born-Alive Infants Protection Act could be potentially implicated. It has recently come to the agency's attention that there may be occasions where, in hospitals, an infant may be born alive within the meaning of the definition added to the U.S. Code by the Born-Alive Infants Protection Act, but where hospitals have failed to comply with the requirements of EMTALA.

Under the Born-Alive Infants Protection Act, such an infant is defined as an "individual." Since EMTALA provides protection to "individual[s]," RO and SA personnel conducting EMTALA investigations need to be aware of the interaction of both statutes in order to appropriately comply with their obligations to conduct EMTALA surveys. This memorandum provides guidance on the interaction of the two statutes.

Background

Congress enacted EMTALA to ensure public access to emergency services, regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when an individual comes to the emergency department and a request is made for examination or treatment for a medical condition, including active labor, regardless of an individual's ability to pay. In addition, when an individual comes to a hospital, and the hospital determines that the individual has an emergency medical condition, the hospital is required to provide either stabilizing treatment within its capabilities, or to effect an appropriate transfer. If a hospital is unable to stabilize an individual with an emergency medical condition within its capability, or if the individual requests, an appropriate transfer should be implemented.

To help promote consistent application of the regulations concerning the special responsibilities of Medicare-participating hospitals in emergency cases, the Centers for Medicare & Medicaid Services (CMS) has occasionally published regulations clarifying hospitals' responsibilities and obligations under EMTALA. Most recently, in September of 2003, CMS published such regulations. Shortly after those regulations became effective, we issued revised Interpretive Guidelines to implement those regulations. We also amended our State Operations Manual to incorporate the new regulations. From time to time, we also issue guidance to surveyors to use when conducting an investigation and assessing a hospital's compliance with EMTALA.

Effective Date: Immediately. Please orient surveyors and implement procedures to ensure that the information in this memorandum is operational within 60 days.

Training: This information should be distributed to all survey and certification staff, their managers, and the state/RO training coordinators.

/s/
Karen Tritz
Acting Director

cc: Survey and Certification Regional Office Management

Attachment

Attachment

GUIDANCE ON THE INTERACTION OF THE BORN-ALIVE INFANTS PROTECTION ACT AND EMTALA

Summary of the Born-Alive Infants Protection Act

The Born-Alive Infants Protection Act, Pub. L. 107-207, amended title 1 of the United States Code by defining the terms “person,” “human being,” “child,” and “individual.” In particular, the statute instructs that,

> [i]n determining the meaning of any Act of Congress, or of any ruling, regulation, or interpretation of the various administrative bureaus and agencies of the United States, the words “person”, “human being”, “child”, and “individual”, shall include every infant member of the species homo sapiens who is born alive at any stage of development.
>
> 1 U.S.C. § 8(a).

The statute goes on to define the term “born alive” with respect to the species homo sapiens, as any member of that species expelled or extracted

> from his or her mother … at any stage of development, who after such expulsion or extraction breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, cesarean section or induced abortion.
>
> 1 U.S.C. § 8(b).

Summary of the Emergency Medical Treatment and Labor Act (EMTALA)

The EMTALA statute is codified at section 1867 of the Social Security Act, 42 U.S.C. § 1395dd. Hospitals and physicians generally have three obligations under EMTALA. The first is commonly referred to as the screening requirement, and applies to any individual who comes to the emergency department of a hospital and for whom a request is made for examination or treatment for a medical condition. Such an individual is entitled to have a medical screening examination to determine whether or not an emergency medical condition exists. The second is commonly referred to as the stabilization requirement, and applies to any individual who comes to the hospital and whom the hospital determines has an emergency medical condition. Such an individual is entitled to stabilizing treatment within the capability of the hospital. The third obligation flows from the second, and also applies to any individual in a hospital with an emergency medical condition. This obligation is sometimes known as the transfer requirement, and restricts the ability of the hospital to transfer that individual to another hospital unless the

individual is stabilized. If the individual is not stabilized, they may only be transferred if the individual requests the transfer or if the medical benefits of the transfer outweigh the risks.

In addition to the basic requirements of EMTALA, the statute contains "whistleblower" protection. In particular, section 1867(i) of the Act prohibits a hospital from taking adverse action against an employee because the employee reports a violation of the section. EMTALA is enforced by penalties that can be imposed against the hospital in an amount up to $50,000 per violation ($25,000 per violation in the case of a hospital with less than 100 beds); hospitals that violate EMTALA also put their Medicare provider agreements at risk. A physician that violates EMTALA is subject to a penalty of $50,000 per violation and, if the violation is gross or flagrant, or repeated, to exclusion from the Medicare and Medicaid programs. In addition, EMTALA can be enforced by a private right of action brought in the U.S. District Courts by any individual harmed as a direct result of an EMTALA violation by a hospital. *Note: The Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 sets the civil monetary penalties annually for EMTALA enforcement actions.*

The 2003 regulations included some modifications and clarifications to hospitals' responsibilities and obligations under EMTALA. For example, the regulations clarified the screening requirement and made clear that it applied to any individual who presented to an area of the hospital that met the definition of a "dedicated emergency department" and made a request for a medical screening examination. The regulation defined dedicated emergency department as the area of the hospital that met any one of three tests: that it is licensed by the state as an emergency department; that it held itself out to the public as providing emergency care; or that during the preceding calendar year, at least one-third of its outpatient visits were for the treatment of emergency medical conditions. The preamble to the regulation noted that it is possible that the labor and delivery department of a hospital could meet the definition of dedicated emergency department. (See 68 Fed. Reg. at 53229 (September 9, 2003)).

The regulation also clarified other circumstances in which the screening requirement may apply. For example, an individual who comes to certain locations on the hospital's campus, but not to the dedicated emergency department, is entitled to the protection of EMTALA in certain circumstances. In particular, if the individual comes to the hospital and makes request for examination or treatment for an emergency medical condition, then the screening requirement will apply. If the individual does not make a verbal request, but a prudent layperson observer would conclude, based on the person's appearance or behavior, that the person needed emergency examination or treatment, the screening requirement also applies.

In addition, the regulation also clarified the application of EMTALA with respect to inpatients. Prior to the issuance of the regulations, CMS had never made clear whether EMTALA applied to inpatients. With the new regulations, as codified at 42 C.F.R. § 489.24(d)(2), it is clear that EMTALA does not apply to inpatients, whether admitted after the individual has been admitted through the emergency department or whether the individual has been admitted for an elective procedure.

Notably, the regulations retained an earlier requirement that any individual (whether or not that individual is a Medicare beneficiary) who comes to the hospital and who is determined to have

an emergency medical condition is protected by both the stabilization requirement and the transfer requirement if the individual is not admitted. (See 42 C.F.R. § 489.24(d)(1)). The retention of this requirement meant that CMS continued to intend for hospitals to stabilize any individual (or to meet the applicable transfer requirements for any individual) who has not been admitted as an inpatient, but who is determined by the hospital to have an emergency medical condition. The preamble to the regulation also notes that it would be a violation of EMTALA to admit an individual to the hospital in a bad faith attempt to evade EMTALA obligations.

The preamble to the regulation also noted that even though EMTALA does not apply to inpatients, hospitals were still bound by the Medicare conditions of participation (CoPs) to provide appropriate care to inpatients *(42 CFR 482.1 through 482.58)*. In particular, the preamble noted four CoPs that are potentially applicable when a hospital provides treatment for an admitted patient. For example, hospital governing bodies must ensure that the hospital medical staff has written policies and procedures for appraisal of inpatients who develop an acute medical condition while admitted. The preamble also notes the discharge planning CoP, which requires that hospitals have a discharge planning process that applies to all patients. Hospitals must also have an organized medical staff that is responsible to the hospital's governing body for the quality of medical care provided to patients. Finally, the hospital governing body must ensure that the hospital has an organization-wide quality assessment and performance improvement program to evaluate the provision of patient care. These CoPs are intended to protect patient health and safety, and to ensure that high quality medical care is provided to all patients. Failure to meet these CoPs could result in a finding of noncompliance at the condition level for the hospital and lead to termination of the hospital's Medicare provider agreement.

Interaction of the Born-Alive Infant Protection Act and EMTALA

With the definition of the terms "person" and "individual" codified at 1 U.S.C. § 8, it is clear that there may be some circumstances where EMTALA protections can attach to an infant who is born alive, as that term is defined in 1 U.S.C. § 8(b). For example, assume that a hospital's labor and delivery department meets the definition of a "dedicated emergency department" under the new regulations. If an infant were born alive (again, as that term is defined in 1 U.S.C. § 8(b)) in that dedicated emergency department, and a request were made on that infant's behalf for screening for a medical condition, (or if a prudent layperson would conclude, based on the infant's appearance or behavior, that the infant needed examination or treatment for an emergency medical condition and that a request would have been made for screening) the hospital and physician could be liable for violating EMTALA for failure to provide such a screening examination. This follows because the born-alive infant is a "person" and an "individual" under 1 U.S.C. § 8(a), and the screening requirement of EMTALA applies to "any individual" who comes to the emergency department.

Another example could occur were an infant to be born alive elsewhere on the hospital's campus (i.e., not in the hospital's dedicated emergency department) and a prudent layperson observer concluded, based on the born-alive infant's appearance or behavior, that the born-alive infant were suffering from an emergency medical condition. In such a circumstance, the hospital and its medical staff would be required to perform a medical screening examination on that born-alive infant to determine whether or not an emergency medical condition existed. If the hospital

or its medical staff determined that the born-alive infant were suffering from an emergency medical condition, there would then arise an obligation to admit the infant, or to comply with either the stabilization requirement or the transfer requirement, or risk a finding of an EMTALA violation. This follows because the born-alive infant is a "person" and an "individual," as described above, and the stabilization and transfer requirements of EMTALA apply to "any individual" who comes to the hospital.

Finally, a third example could occur if the hospital were to admit a born-alive infant. As noted above, EMTALA does not apply to inpatients. Were an infant born alive and then admitted to the hospital, EMTALA would not apply to protect the infant in most circumstances. However, the CoPs described above clearly would apply to the infant once he or she was admitted to the hospital as an inpatient. If a hospital were to violate those CoPs, it would put at risk its Medicare provider agreement.

Conduct of Investigations

EMTALA is a complaint-driven statute. If you receive a complaint that suggests that a born-alive infant has been denied a screening examination, stabilizing treatment, or an appropriate transfer, you should treat that complaint as potentially triggering an EMTALA investigation of the hospital. Note that it is not necessary to determine that the hospital acted with an improper motive in any failure to provide a screening examination, stabilizing treatment, or an appropriate transfer in order to conclude that an EMTALA violation has occurred. The Supreme Court of the United States has held that a finding of improper motive is not required to conclude that an EMTALA violation has occurred.