In terms of national constitutions, a 2004 survey reported that some two-thirds of constitutions worldwide address health or health care, and that almost all of these do so in universal terms, rather than being limited to certain populations.[13] For example, consider the health-related constitutional aspects of four politically and culturally diverse countries—Italy, the Netherlands, South Africa, and Poland—that have some type of "right to health": Italy's Constitution guarantees a right to health; under the Dutch Constitution, the government is mandated "to promote the health of the population"; the Constitution of South Africa imposes on government the obligation to provide access to health services; and under Polish constitutional law, citizens are guaranteed "the right to health protection" and access to publicly financed healthcare services.[14]

Of course, including language respecting health rights in a legal document—even one as profound as a national constitution—does not guarantee that the right will be recognized or enforced. As in the United States, multiple factors might lead a foreign court or other tribunal to construe rights-creating language narrowly or to refuse to force implementation of what is properly considered a right. Examples of these factors include the relative strength of a country's judicial branch vis-a-vis other branches in its national governance structure and a foreign court's view of its country's ability to provide services and benefits inherent in the health right.

**BOX 6-2 Discussion Question**

Depending on one's personal experience in obtaining health care, or one's view of the role of physicians in society, of law as a tool for social change, of the scope of medical ethics, or of the United States' place in the broader global community, the no-duty principle might seem appropriate, irresponsible, or downright wrong. Imagine you are traveling in a country where socialized medicine is the legal norm, and your discussion with a citizen of that country turns to the topic of your countries' respective health systems. When asked, how will you account for the fact that health care is far from being a fundamental right rooted in American law?



## INDIVIDUAL RIGHTS AND THE HEALTHCARE SYSTEM

The "global perspective" you just read was brief for two reasons. First, a full treatment of international and foreign health rights is well beyond the scope of this chapter, and second, historically speaking, international law has played a limited role in influencing this nation's domestic legal principles. As one author commented, "Historically the United States has been uniquely averse to accepting international human rights standards and conforming national laws to meet them."[15(p1156)] This fact is no less true in the area of health rights than in any other major area of law. As described earlier in this chapter, universal rights to health care are virtually nonexistent in the United States, even though this stance renders it almost solitary among industrialized nations of the world.

This is not to say that this country has not contemplated health care as a universal, basic right. For instance, in 1952, a presidential commission stated that "access to the means for attainment and preservation of health is a basic human right."[16(p4)] Medicaid and Medicare were the fruits of a nationwide debate about universal healthcare coverage. And during the 1960s and 1970s, the claim that health care was not a matter of privilege, but rather of right, was "so widely acknowledged as almost to be uncontroversial."[17(p389)] Nor is it to say that certain populations do not enjoy healthcare rights beyond those of the general public. Prisoners and others under the control of state governments have a right to minimal health care,[18] some state constitutions expressly recognize a right to health or healthcare benefits (for example, Montana includes an affirmative right to health in its constitution's section on inalienable rights), and individuals covered by Medicaid have unique legal entitlements. Finally, it would be inaccurate in describing healthcare rights to only cover rights to obtain health care in the first instance, because many important healthcare rights attach to individuals once they manage to gain access to needed healthcare services.

The remainder of this section describes more fully the various types of individual rights associated with the healthcare system. We categorize these rights as follows:

1. Rights related to receiving services explicitly provided under healthcare, health financing, or health insurance laws; for example, the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act, Medicaid, and the Affordable Care Act.
2. Rights concerning freedom of choice and freedom from government interference when making healthcare decisions; for example, choosing to have an abortion.
3. The right to be free from unlawful discrimination when accessing or receiving health care; for example, Title VI of the federal Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, or national origin by entities that receive federal funding.[12(p12)],[19]

### Rights Under Healthcare and Health Financing Laws

We begin this discussion of rights-creating health laws with the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act (also referred to as EMTALA, which is the acronym for the law's original name—the Emergency Medical Treatment and Active Labor Act—or, for reasons soon to become clear, the "patient anti-dumping statute"). We then briefly discuss the federal Medicaid program in a rights-creating context and wrap up this section with a brief discussion of the ACA.

#### *Rights Under Health Care Laws: Examination and Treatment for Emergency Medical Conditions and Women in Labor Act*

Because EMTALA represents the only truly universal legal right to health care in this country—the right to access emergency hospital services—it is often described as one of the building blocks of health rights. EMTALA was enacted by Congress in 1986 to prevent the practice of "patient dumping"—that is, the turning away of poor or uninsured persons in need of hospital care. Patient dumping was a common strategy among private hospitals aiming to shield themselves from the potentially uncompensated costs associated with treating poor and/or uninsured patients. By refusing to treat these individuals and instead "dumping" them on public hospitals, private institutions were effectively limiting their patients to those whose treatment costs would likely be covered out-of-pocket or by insurers. Note that the no-duty principle made this type of strategy possible.

EMTALA was a conscious effort on the part of elected federal officials to chip away at the no-duty principle: By creating legally enforceable rights to emergency hospital care for all individuals regardless of their income or health insurance status, Congress created a corresponding legal *duty* of care on the part of hospitals. At its core, EMTALA includes two related duties, which technically attach only to hospitals that participate in the Medicare program (but then again, nearly every hospital in the country participates). The first duty requires

covered hospitals to provide an "appropriate" screening examination to all individuals who present at a hospital's emergency department seeking care for an "emergency medical condition." Under the law, an appropriate medical 109110screening is one that is nondiscriminatory and that adheres to a hospital's established emergency care guidelines. EMTALA defines an emergency medical condition as 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 with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.[20]

The second key duty required of hospitals under EMTALA is to either stabilize any condition that meets the above definition or, in the case of a hospital without the capability to treat the emergency condition, undertake to transfer the patient to another facility in a medically appropriate fashion. A proper transfer is effectuated when, among other things, the transferring hospital minimizes the risks to the patient's health by providing as much treatment as is within its capability, when a receiving medical facility has agreed to accept the transferred patient, and when the transferring hospital provides the receiving facility all relevant medical records.

The legal rights established under EMTALA are accompanied by heavy penalties for their violation. The federal government, individual patients, and "dumped on" hospitals can all initiate actions against a hospital alleged to have violated EMTALA, and the federal government can also file a claim for civil money penalties against individual physicians who negligently violate an EMTALA requirement.

***Rights Under Healthcare Financing Laws: Medicaid***

Many laws fund programs that aim to expand access to health care, such as state laws authorizing the establishment of public hospitals or health agencies, and the federal law establishing the vast network of community health clinics that serve medically underserved communities and populations. However, the legal obligations created by these financing laws are generally enforceable only by public agencies, not by individuals.

The Medicaid program is different in this respect. (Medicaid has been covered elsewhere in greater depth, but because of its importance in the area of individual healthcare rights, we mention it also in this context.) Although most certainly a law concerning healthcare financing, Medicaid is unlike most other health financing laws in that it confers the right to individually enforce program obligations through the courts.[21(pp419–424)] This right of individual enforcement is one of the reasons why Medicaid, nearly 50 years after its creation, remains a hotly debated public program. This is because the legal entitlements to benefits under Medicaid are viewed as a key contributor to the program's high cost. Yet whether Medicaid's legal entitlements are any more of a factor in the program's overall costs than, say, the generally high cost of health care, is not clearly established.

***Rights Under Health Insurance Laws: The Affordable Care Act***

As you will learn in subsequent chapters, the ACA is far more than a law that just concerns health insurance; in fact, it is a sweeping set of reforms that touch on healthcare quality, public health practice, health disparities, community health centers, healthcare fraud and abuse, comparative effectiveness research, the health workforce, health information technology, long-term care, and more. However, for purposes of this chapter, we mention it briefly it in terms of its impact on the rights of individuals to access health insurance and to equitable treatment by their insurer. Details concerning the ACA's effect on the public and private insurance markets are discussed elsewhere.

Through a series of major reforms to existing policies, the ACA reshapes the private health insurance market, transforming private health insurance from a commodity that regularly classified (and rejected) individuals based on their health status, age, disability status, and more into a social good whose availability is essential to individual and population health.[22] The key elements of this shift include: a ban on exclusion and discrimination based on health status or pre-existing health conditions; new protections that ensure that, once covered by insurance, individuals will have access to necessary care without regard to artificial annual or lifetime expenditure caps; a guarantee that once insurance coverage is in place, it cannot be rescinded except in cases of applicant fraud; a ban on additional fees for out-of-network emergency services; the provision (by 2019) of financial subsidies for an estimated 19 million low- and moderate-income individuals and for some 4 million small businesses; the inclusion, in the individual and small group insurance markets, of a package of "essential health benefits" that must be covered; and the creation of state health insurance "exchanges" through which individuals and small employer groups can purchase high-quality health

# EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN LABOR[298]

SEC. 1867. [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) 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) 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)) 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)), in consultation with the person, has made the determination 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 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 (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).

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, 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 and State health care programs. The provisions of section 1128A (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).

(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)) 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[299] 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, the Secretary shall request the appropriate quality improvement[300] organization (with a contract under part B of title XI) 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 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.

(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.

(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)).

(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.

[298] See Vol. II, P.L. 108-173, §945, with respect to an emergency medical treatment and labor act technical advisory group and §1011, with respect to the Federal reimbursement of emergency health services furnished to undocumented aliens.

[299] P.L. 112-40, §261(a)(3)(E), struck out "PEER REVIEW" and inserted "QUALITY IMPROVEMENT", applicable to contracts entered into or renewed on or after January 1, 2012.

[300] P.L. 112-40, §261(a)(3)(C), struck out "utilization and quality control peer review" and inserted "quality improvement", applicable to contracts entered into or renewed on or after January 1, 2012.