
EMERGENCY MEDICINE LITIGATION

EMTALA in 2026

The Screening, the Transfer, and the Patients Still Waiting

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EMTALA turns 40 this year, and it's back in the news for several reasons at once. In 2025, HHS and CMS pulled the 2022 guidance on emergency care in states with abortion restrictions, and the underlying legal fight still isn't settled. Then on July 7, 2026, CMS published its proposed outpatient payment rule for 2027 with a provision that would, for the first time, have hospital accrediting organizations check certain EMTALA housekeeping items during routine surveys: signage, the central ED log, on-call lists, and transfer record retention. The heavier questions of screening, stabilization, and transfer would stay with CMS and the OIG. Comments closed August 31.

Meanwhile, emergency departments are full. Patients board for hours or days, psychiatric patients wait longest, and rural labor and delivery units keep closing. Each of those pressures shows up in EMTALA cases. This issue walks through what the statute actually requires, why it isn't a malpractice statute, and how to read the record against it.

WHAT THE LAW REQUIRES

EMTALA (42 U.S.C. § 1395dd, with regulations at 42 C.F.R. § 489.24) applies to hospitals that take Medicare and have an emergency department. Anyone who comes to the ED and asks for care gets an appropriate medical screening exam, within the hospital's capability, to find out whether they have an emergency medical condition. If they do, the hospital has to stabilize it within its capability or arrange an appropriate transfer. An unstable patient can be transferred only if the patient asks for it in writing after being told the risks, or a physician certifies that the benefits outweigh the risks, and even then the transfer has to meet specific conditions. And hospitals with specialized capabilities have to accept appropriate transfers when they have room (§ 1395dd(g)).

There's an administrative layer too: posted signs, a central log of everyone who comes to the ED, an on-call physician list, and five-year retention of transfer records (42 C.F.R. § 489.20(q)–(r)).

A few definitions matter a lot clinically. An emergency medical condition includes severe pain, **psychiatric disturbances, and symptoms of substance abuse** when the lack of immediate attention could reasonably be expected to seriously jeopardize health or impair function. For a pregnant woman having contractions, it includes situations where there isn't enough time for a safe transfer before delivery, or where transfer threatens her or the baby. And "stabilized" means no material deterioration is likely, within reasonable medical probability, to result from or occur during the transfer.

On enforcement, CMS can end a hospital's Medicare agreement, and the OIG can impose penalties, currently up to \$136,886 per violation for larger hospitals after inflation adjustment and less for hospitals under 100 beds. Patients who are harmed can sue the hospital; courts have generally not recognized a private EMTALA claim against individual physicians. The limitations period is two years.

IT ISN'T A MALPRACTICE STATUTE

This trips people up. Courts have generally held that EMTALA doesn't create a federal standard of care. The screening duty is usually read as a duty to apply the hospital's own screening consistently, so the patient gets what the hospital would give anyone else with the same symptoms. A missed diagnosis after a proper screening is normally a malpractice question. Circuits also disagree on whether the stabilization duty requires that the hospital actually knew about the emergency condition. Those are questions for counsel.

What it means in practice is that many cases carry both an EMTALA count against the hospital and a state malpractice claim, and they ask different things of the record. Malpractice asks whether a reasonable clinician would have done better. EMTALA asks whether this patient got the hospital's usual screening, whether an emergency condition was identified, and what the hospital did about it.

A FICTIONAL CASE

A woman in her thirties arrives at a small community hospital with severe abdominal pain and lightheadedness. She's triaged and waits. A later blood pressure is low. Eventually she's found to be bleeding internally. The hospital can't do the surgery she needs, so she's sent to a larger hospital 40 miles away. She arrives in worse shape than she left.

THE SCREENING

Start with the hospital's own protocols for the complaint in question, the ones in effect that day. Most EDs have written pathways for chest pain, abdominal pain, stroke, and pregnancy. Line up what the protocol called for against what the chart shows was done.

Then look at triage. Most EDs use a five-level acuity scale. Did her level fit her vitals and complaint? Was she rechecked while she waited, and did her numbers change? A patient who gets worse in the waiting room without anyone noticing raises both an EMTALA question and a standard-of-care question.

Look at money, too. EMTALA exists because hospitals were turning away people who couldn't pay. Hospitals can't delay screening or stabilization to ask about insurance (42 C.F.R. § 489.24(d)(4)). The timestamps on registration and financial counseling can matter a great deal.

STABILIZATION AND TRANSFER

Here the record should answer some very specific questions. What were her vitals right before she left? What was done to stabilize her: fluids, blood, medications? If she was still unstable, is there a physician certification with the risks and benefits spelled out, or a written request from her? Did the receiving hospital accept her? Were her records sent? Did she travel with the right people and equipment?

The single most useful comparison is often her condition when she left against her condition when she arrived. Pull the transfer form, the certification, the call logs with the receiving hospital, the ambulance run sheet, and the receiving hospital's arrival assessment.

If a specialist was paged and didn't come in, or came late, the on-call list and paging records move to the center of the case. Medical staff bylaws usually set response-time expectations for on-call physicians.

THE PATIENTS WHO WAIT

Boarding happens when a patient needs a bed or a transfer and there isn't one, so they stay in the ED. Psychiatric patients get the worst of it, sometimes waiting days in a space never meant for them.

Once a patient is admitted in good faith as an inpatient, EMTALA generally stops applying (42 C.F.R. § 489.24(d)(2)) and the Medicare Conditions of Participation take over. But for someone still sitting in the ED waiting to be transferred, the stabilization and transfer duties may still be live. Restraint and seclusion have their own federal rules (42 C.F.R. § 482.13(e)–(f)): orders, time limits, monitoring, and face-to-face evaluations.

In a boarding case, I want to know who was responsible for the patient, how often anyone reassessed them, whether their regular medications (psychiatric meds especially) were continued, and whether observation and restraint documentation matched the policy and the regulations. The longer the wait, the more those answers matter.

PREGNANT PATIENTS, ESPECIALLY WHERE THERE'S NO OB UNIT

A hospital without labor and delivery still has EMTALA duties to a pregnant woman who walks into its ED. When was she seen? Was the fetus monitored, and what did it show? Did someone qualified decide whether she was in labor? Since July 1, 2025, CMS has also required hospitals with EDs to keep protocols, supplies, and annual staff training for obstetric emergencies whether or not they deliver babies. Our companion issue on obstetric emergencies covers those requirements.

DON'T SKIP THE EVIDENCE THAT HELPS THE HOSPITAL

A thorough screening that followed policy, documented stabilization, an informed written request to transfer, a confirmed acceptance, and a well-run transport are strong defenses. EMTALA cases are intensely factual, and the chart often decides them.

RECORDS WORTH REQUESTING

- The complete ED record with triage, nursing flowsheets, and every timestamp
- ED protocols for the presenting complaint in effect that day
- The central ED log for the date
- The on-call list plus paging and secure messaging logs
- Transfer form, physician certification or patient request, and consent
- Communications with the receiving hospital and its acceptance record
- Ambulance or critical care transport records
- The receiving hospital's arrival assessment
- Registration and financial counseling timestamps
- For boarded or psychiatric patients: observation logs, restraint and seclusion orders and monitoring, and bed-search records

SOURCES

- 42 U.S.C. § 1395dd; 42 C.F.R. §§ 482.13, 489.20(q)–(r), 489.24
- CMS, CY 2027 OPPS/ASC Proposed Rule, Federal Register Doc. 2026-13656 (July 7, 2026)
- Goodwin Procter, “EMTALA, Abortion Restrictions, and Potential Increased Enforcement” (Aug. 2026)

- Holland & Knight, “CMS Issues Sweeping CY 2027 Hospital OPPS/ASC Proposed Rule” (July 2026)

This newsletter is for education only and isn't medical or legal advice. The case is fictional. EMTALA case law varies by circuit.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have an EMTALA or emergency care case and want the screening, stabilization, and transfer rebuilt against the hospital's own policies and the statute, we'd welcome the conversation.

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