NO. 08-169

IN THE

Supreme Court of the United States

SOCIEDAD ESPAÑOLA DE AUXILIO MUTUO Y BENEFICENCIA, ET AL.,

Petitioners,

v.

CAROLINA MORALES, ET AL.,

Respondents.

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

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTION PRESENTED

The Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd(a), prohibits hospital emergency rooms from refusing treatment to a patient who "comes to" an emergency room, even if the patient lacks health insurance and cannot afford to pay for medical care. In its petition for certiorari, petitioner does not dispute that it is a hospital covered by EMTALA, that respondent Carolina Morales was suffering severe pain and acute blood loss resulting from an ectopic pregnancy, that an ambulance transporting Morales to the hospital requested emergency treatment for her, and that the hospital turned the ambulance away because Morales lacked health insurance.

The question presented is whether the Court should review the First Circuit's decision that EMTALA covers the hospital's refusal to treat Morales even though the ambulance in which she was riding had not yet reached hospital property at the time she was turned away, where the First Circuit's decision follows the only other decision—state or federal—to have considered the issue.

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INTRODUCTION

Two days after being diagnosed with an ectopic pregnancy, respondent Carolina Morales suddenly collapsed at work. Pet. at 3; Pet. App. at 3a. While an ambulance rushed her to the hospital, paramedics called the hospital's emergency-room director to explain Morales's condition and her need for emergency treatment. Pet. App. at 3a-4a. The director asked whether Morales had medical insurance and, when the paramedics did not reassure him that she did, abruptly hung up the phone. *Id.* The ambulance was then forced to take Morales to a different hospital. *Id.*

In its petition for certiorari, Hospital Español Auxilio Mutuo does not dispute that it turned Morales away because she lacked insurance—the precise conduct that Congress designed the Emergency Medical Treatment and Active Labor Act (EMTALA) to prohibit. Pet. App. at 3a-4a. Instead, the hospital argues that Morales was not entitled to protection under EMTALA because, at the time the hospital refused to treat her, she was in an ambulance that had not yet arrived on hospital property. *Id.* The hospital argues that a patient "comes to" an emergency room, as required by EMTALA, only when the patient is *physically present* at the emergency room. Pet. at 5-6. The First Circuit rejected this argument, noting that the hospital's interpretation would create a gaping hole in the statute's coverage that would allow hospitals to evade the law's requirements simply by turning away patients who lack health insurance before they reach the hospital. Pet. App. at 16a-17a.

Contrary to the hospital's argument, the First Circuit's decision does not create a split in the federal courts of appeals. Indeed, the First Circuit reached the same result as the only other case to have considered the issue, *Arrington v. Wong*, 237 F.3d 1066 (9th Cir. 2001).

The hospital's petition asks this Court to overturn both these decisions and decide, for the first time, that EMTALA does not cover an emergency room's refusal to treat a patient, even when the patient is in an ambulance and has requested emergency medical care.

The decisions of the First and Ninth Circuits are supported by EMTALA's language, which covers a patient that "comes" (in the present tense) to an emergency room and not, as the hospital reads it, only a patient that "arrives" at the hospital. 42 U.S.C. § 1395dd(a). Moreover, the courts' reading of the statute is bolstered by the applicable agency regulations, which define "comes to" to include a variety of situations where a patient has not yet physically reached the emergency room, and provide that a hospital may turn away a non-hospital-owned ambulance only when the hospital lacks the resources to take on any more emergency cases. For these reasons, the petition should be denied.

STATEMENT

On March 10, 2004, Morales's obstetrician diagnosed her with an ectopic pregnancy, a form of pregnancy that can cause dangerous and possibly fatal bleeding. Pet. App. at 3a-4a. Two days later, when Morales began suffering severe abdominal pain and vomiting at work, her coworkers called 911. Pet. App. at 3a-4a, 2e-3e. An ambulance arrived and began rushing Morales to petitioner Hospital Español Auxilio Mutuo, where Morales's obstetrician had his private practice. Pet. App. at 3a-4a. On the way to the hospital, the ambulance crew called ahead to the emergency department and notified the department's director, Dr. Salvador Márquez, of Morales's condition and the need for emergency treatment. *Id.* Dr. Márquez told the paramedics that he was very busy and to call back when they had more information. *Id.* When the paramedics called back a few minutes

later, Dr. Márquez asked whether Morales had health insurance and, when the paramedics could not reassure him that she did, hung up the phone. *Id.* The paramedics were then forced to take Morales to a different hospital. *Id.*

Morales and her husband sued the hospital under EMTALA and several state-law causes of action. *Id.* at 4a. Hospitals that participate in Medicaid and Medicare programs agree to be bound by EMTALA, which prohibits its emergency rooms from refusing to treat patients who lack medical insurance or are unable to pay for services. 42 U.S.C. § 1395dd(a). Petitioner hospital is an EMTALA hospital and therefore subject to EMTALA. Pet App. at 3a. Morales's claim specifically invoked subsection (a) of the statute, which provides that, "if any individual . . . comes to the emergency department and a request is made . . . for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination." *Id.* The hospital moved for summary judgment on this claim, arguing that it was free to deny treatment to Morales on the basis of her lack of insurance because Morales had not yet reached hospital property at the time she was refused service and therefore had not "come to" the emergency room for treatment. Pet. App. at 5e. The district court accepted this argument and granted the motion, disagreeing with the Ninth Circuit's decision in *Arrington v. Wong*, 237 F.3d 1066, the only other case to have addressed the issue. Pet. App. at 7e-9e.

On appeal, the only question before the First Circuit was whether the district court erred in holding that Morales had not come to the emergency department under EMTALA. *Id.* at 2a. The First Circuit held that the language "comes to," standing alone, could mean either that a patient is in the process of coming to the hospital or that the patient has already arrived. *Id.* at 9a. Con-

cluding that the statute is ambiguous on this point, the court turned to U.S. Department of Health and Human Services (HHS) regulations interpreting the statute, which apply the "comes to" language to a range of situations where patients have not physically arrived at an emergency room. *Id.* at 10a. Although holding that the regulations did not wholly resolve the ambiguity, the court concluded, like the Ninth Circuit in *Arrington*, that the best reading of the regulatory language was that "an individual can come to the emergency department for EMTALA purposes without physically arriving on the hospital's grounds as long as the individual is en route to the hospital and the emergency department has been notified of her imminent arrival." *Id.* at 2a.

The court found support for its reading of the statute in the "manifest purpose" of EMTALA. *Id.* at 19a. As the court noted, if a hospital could refuse treatment by turning away an ambulance before it reached the emergency room, the hospital could easily evade EMTALA's requirements and freely discriminate against patients who lack insurance. *Id.* As a result, patients "could be bounced around like a ping-pong ball in search of a willing provider," in exactly the way that EMTALA was designed to prevent. *Id.* at 17a.

The court of appeals therefore reversed the district court's decision and remanded for further proceedings. *Id.* at 20a. The court also denied the hospital's petition for rehearing and for rehearing en banc. *Id.* at 1c-2c.

REASONS FOR DENYING THE WRIT

I. The First Circuit's Decision Expressly Agrees with the Only Other Decision to Address the Question Presented.

Contrary to petitioners' assertion, the First Circuit's decision does not conflict with the decision of any other federal court of appeals. Indeed, the only other

court to have considered the issue held, in a "situation virtually identical to the one here," Pet. App. at 7e-8e, that EMTALA *does* cover a patient in an ambulance on its way to a hospital when the ambulance has called ahead to request treatment. *Arrington*, 237 F.3d at 1074.

In *Arrington*, an ambulance had radioed ahead to an emergency room to inform doctors that it was bringing in a patient suffering a heart attack. *Id.* at 1068. Instead of agreeing to treat the patient, the emergency room diverted the ambulance to a more distant hospital. *Id.* As here, the hospital argued that the patient had not "come to" the hospital for purposes of EMTALA. *Id.* The Ninth Circuit rejected the hospital's argument for essentially the same reasons as the First Circuit here. *Id.* at 1070-71. The court held that the statute's plain language could mean "either physical arrival at the emergency room or the act of traveling from the scene of an emergency to or towards the hospital," but that the HHS regulations interpreting the statute specified that a hospital could divert a non-hospital-owned ambulance only if the hospital was in "diversionary status"—meaning that the hospital lacked the resources to take additional emergency cases. *Id.* at 1070-72. Because, as here, the hospital was not in diversionary status, the Ninth Circuit held that EMTALA applied. *Id.* at 1072-73.

Other than the First Circuit below and the Ninth Circuit in *Arrington*, no state or federal court of appeals has addressed the question presented by the hospital here, nor has any other district court published a decision on the subject. The hospital's claim of a conflict among the federal courts of appeals hinges on its reading of decisions from the Fifth and Seventh Circuits. Both the First Circuit below and the Ninth Circuit in *Arrington*, however, concluded that those cases involved very different factual circumstances and presented no conflict. *See* Pet. App. at 17a (explaining that "neither . . . is

on point"); *Arrington*, 237 F.3d at 1073 ("Neither decision . . . is inconsistent with the result we reach here.").

The first case, *Miller v. Medical Center of Southwest Louisiana*, involved a patient who had been admitted at a hospital and whose doctor had called a *second* hospital to request a transfer. 22 F.3d 626, 629 (5th Cir. 1994). Because the patient was already admitted at the first hospital and had "never even beg[u]n the journey" to the second, the First Circuit held that the patient "could not in any sense be said to have come to the second hospital" for purposes of EMTALA. *Id.* at 629 n.5; *see* Pet. App. at 18a (noting that the facts in *Miller* were a "far cry from the case at bar"); *see also Arrington*, 237 F.3d at 1073. Moreover, *Miller* recognized other decisions where courts held that a patient had "come to" an emergency room even when the patient was not physically present there, and explicitly left open the question of whether it would require physical presence under different circumstances. *Id.* at 629 n.5.

Unlike the patient in *Miller*, the patient in the second case, *Johnson v. University of Chicago Hospitals*, was in an ambulance at the time she was allegedly refused service. 982 F.2d 230 (7th Cir. 1992). The ambulance in *Johnson*, however, had never made contact with a hospital emergency room. *Id.* at 232-33. Instead, the ambulance contacted a telemetry system shared by several hospitals, which, because the nearest hospital was in "partial bypass" (the equivalent of "diversionary status"), directed the ambulance elsewhere. *Id.*; *Arrington*, 237 F.3d at 1073. As the First Circuit noted, a telemetry system is distinct from a hospital's emergency room, and, because the ambulance had never requested service from an emergency room, no emergency room had ever denied the patient service. Pet. App. at 18a. Here, in contrast, it was the director of the hospital's emergency department that denied Morales service. *Id.*

at 3a-4a. Moreover, because the hospital in *Johnson* was in the equivalent of diversionary status, both the First and Ninth Circuits agreed that the hospital would not have been required to take any more patients. *See* Pet. App. at 18a; *Arrington*, 237 F.3d at 1073. *Johnson* left open the possibility that it might reach a different result in a case where an ambulance contacted an emergency room directly, or where a telemetry system diverted an ambulance not because a hospital was in diversionary status but as part of a scheme to deny service to the uninsured. 982 F.2d at 233 n.7.

The hospital also argues that the First Circuit's decision is inconsistent with that court's "own previous cases dealing with EMTALA." Pet. at 8. In support of this argument, the hospital cites several cases where the First Circuit described EMTALA as covering patients who "arrive" at or are "visiting" a hospital emergency room. *Id.* at 6-7. That the court would use such language is not surprising, given that the patients in those cases had physically arrived at hospital emergency rooms. *See Correa v. Hosp. San Francisco*, 69 F.3d 1184 (1st Cir. 1995); *Reynolds v. Me. Gen. Health*, 218 F.3d 78 (1st Cir. 2000); *Carmen Guadalupe v. Negrón Agosto*, 299 F.3d 15 (1st Cir. 2001); *Malavé Sastre v. Hosp. Doctor's Ctr., Inc.*, 93 F. Supp. 2d 105 (D.P.R. 2000); *Medero Díaz v. Grupo De Empresas De Salud*, 112 F. Supp. 2d 222 (D.P.R. 2000). As the First Circuit noted below, however, none of these cases "attempt[ed] to define that terminology" or "dealt with any fact pattern remotely resembling the scenario that is alleged here." Pet. App. at 18a-19a.

In any case, even assuming that the intra-circuit split alleged by the hospital were real, it would not be a basis for review by this Court. *See* S. Ct. Rule 10. The First Circuit itself "reject[ed] any suggestion that [its] holding . . . [was] inconsistent with prior decisions of [the] court" and denied the hospital's petition for recon-

sideration en banc. Pet. App. at 18a-19a, 1c-2c. Whether the First Circuit correctly interpreted its own case law was an issue for that court, not for this one.

II. The First Circuit's Decision Was Correct.

Although the hospital makes a token effort to demonstrate a circuit split, its primary argument is that the "case merits review by this Court to correct fundamental legal errors by the Court of Appeals." Pet. at 5. According to the hospital, the First Circuit's decision was wrong because it "ignored the plain language of EMTALA" and HHS's supporting regulations. *Id.* at 4. Contrary to the hospital's contentions, however, the First Circuit devoted its entire opinion to determining the meaning of the statute and regulations, in the process "carefully considering the language of EMTALA, the regulation addressing the pertinent statutory text, and the policies that underlie the statute." Pet. App. at 2a. Like the Ninth Circuit before it, the court concluded that, although the language of both the statute and regulations is somewhat ambiguous, the best reading of that language is that a patient cannot be turned away for lack of insurance while the patient is riding in a non-hospital-owned ambulance en route to an emergency room. *Id.* The First Circuit's conclusion was correct.

A. The Statutory Language Supports the First Circuit's Reading.

The hospital asserts that the plain meaning of "comes to" under EMTALA requires a patient's physical presence at an emergency room. Pet. at 5-6. Other than its bald assertion, however, the hospital provides no explanation or authority supporting its narrow reading of the statutory language. As the First Circuit noted, EMTALA does not define "comes to," and the phrase "has more than one meaning in common parlance." Pet. App. at 9a. Dictionaries defining the word "come" generally

provide "to move toward" or "approach" as the first listed definition of the word, not, as the hospital would read it, "to arrive at." Merriam-Webster Online Dictionary, http://www.merriam-webster.com/dictionary/come; *see also, e.g.*, Oxford English Dictionary (2d ed. 1989), http://dictionary.oed.com/cgi/entry/50044630 ("[T]he hitherward motion of a voluntary agent . . . . To move towards, approach."); American Heritage Dictionary of the English Language (4th ed. 2000), http://www.bartleby.com/61/10/C0501000.html ("To advance toward the speaker or toward a specified place; approach."). This broader meaning of the word as a *process* of movement, rather than just its end result or arrival, is also consistent with common usage: "California, here I come" does not mean "California, I am here;" Shakespeare's "something wicked this way comes" does not mean that something wicked has arrived; and Mighty Mouse's "here I come to save the day!" means that he is on his way, not that he is already here.[1]

Other than to say that it disagrees with this interpretation, the hospital essentially has no response to the court's analysis of the statute's plain language. Pet. at 8. Instead, the hospital argues that a "reading of the statute as a whole" and consideration of the "Congressional purpose and intent behind it" demonstrate that the statute requires a patient's physical presence at the hospital. Pet. at 8. The hospital is wrong on both counts.

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[1] "To" is "used as a function word to indicate movement or an action or condition suggestive of *movement toward a place* . . . ." Merriam-Webster Online Dictionary, *supra*, http://www.merriam-webster.com/dictionary/to (emphasis added). As the Oxford English Dictionary notes, "to" is "[t]he preposition naturally following come," though it can be replaced with other words "in which the notion to is contained or involved," such as "into, unto, towards," and similar words. Oxford English Dictionary, *supra*.

First, reading the disputed language in the context of the statute as a whole shows only that, when Congress meant to impose a physical presence requirement, it did so with much clearer language. In contrast to the right to emergency screening and treatment at issue in this case, which apply when an "individual . . . comes to a hospital," EMTALA's prohibition on releasing patients before they have been stabilized applies to an "individual *at* a hospital." 42 U.S.C. § 1395dd(c) (emphasis added). The use of the word "at" distinguishes EMTALA's subsection (c) from the otherwise similarly worded subsections (a) and (b), and indicates Congress's understanding that a rule governing *release* of patients, as opposed to rules governing initial screening and treatment, can apply only to patients who are physically present in the emergency room. Congress used even more precise language in subsection (c)(1)(iii), which provides procedures for transferring a patient when there is no physician in the emergency room. There, the statute simply refers to whether the physician is "physically present in the emergency department." 42 U.S.C. § 1395dd(c)(1)(iii).

The problem with the hospital's interpretation is underscored by the fact that, throughout its petition, it substitutes the actual statutory language with language more supportive of its position. Not only does the hospital replace the verb "comes" with "arrives," it changes the statute's use of the present tense "comes" with "has come" and "arrived," words that indicate movement that is complete rather than ongoing. Pet. at 6, 9, 13. *Compare* 42 U.S.C. § 1395dd(c)(2)(C) (referring to cases where a physician "failed to appear" and the "emergency condition for which the individual has presented"); 42 C.F.R. § 489.24 (referring to situations where a patient "has presented at a hospital's dedicated emergency department").

As for the purpose of the statute, given that hospitals are concededly required to accept emergency patients once they have arrived on hospital property, it is difficult to imagine what statutory purpose would support allowing a hospital to turn patients away shortly *before* arrival. The hospital's only argument on this point is its unexplained assertion that the First Circuit's decision "could seriously affect the healthcare industry." Pet. at 5. However, the hospital has not identified even a single case during the seven years since *Arrington* was decided in which an emergency room was subjected to any unwarranted burden as a result of the Ninth Circuit's decision. Indeed, other than *Arrington*, the First Circuit's decision below is the only published decision in which the issue has been raised.

Even if there were otherwise a risk of subjecting hospitals to an undue burden, that risk would be resolved by HHS's implementing regulations. As previously discussed, the regulations provide that a hospital is in "diversionary status," and thus allowed to turn away non-hospital-owned ambulances, when it lacks the staff or facilities to receive new patients. 42 C.F.R. § 489.24. The effect of this rule is that "[a] hospital may not prevent a non-hospital owned ambulance from coming to the hospital unless it has a valid treatment-related reason for doing so." *Arrington*, 237 F.3d at 1072. The First Circuit's reading would therefore only prohibit the hospital from turning away a patient in an ambulance when the hospital has the necessary staff and resources to adequately treat the patient.

On the other hand, as the First Circuit held below, the hospital's interpretation of the statute would be "antithetic to the core policy on which EMTALA is based." Pet. App. at 16a-17a. EMTALA was adopted in response to concerns "that hospital emergency rooms [were] refusing to accept or treat patients with emer-

gency conditions if the patient [did] not have medical insurance." *Correa*, 69 F.3d at 1189 (quoting H.R. Rep. No. 241(I), 99th Cong., 1st Sess. 27 (1986), reprinted in 1986 U.S.C.C.A.N. 42, 605). Adopting the hospital's position would "encourage[] easy evasion of the statutory mandate and open[] a gaping hole in the fabric of the remedial scheme." Pet. App. at 16a-17a; *see also Arrington*, 237 F.3d at 1073-74 (holding that a broader meaning of "comes to" is supported by the "overarching purpose" of the statute to "ensure that patients, particularly the indigent and underinsured, receive adequate emergency medical care") (internal quotations and alterations omitted).

If hospitals could escape EMTALA's reach simply by turning away ambulances before they reach the hospital, uninsured patients could be endlessly directed from hospital to hospital in search of a hospital willing to take them. *See* Pet. App. at 16a-17a. The inevitable result would be injury or death for those who do not reach an agreeable emergency room in time. Moreover, because hospitals would still be obligated to treat a patient in an ambulance once the ambulance has reached hospital property, ambulance crews would have a perverse incentive to take uninsured patients to the emergency room without calling ahead, thus depriving the hospital of an opportunity to prepare for the emergency. Pet. App. at 17a. "Upon arrival, the emergency room would be required to examine and/or treat the individual, but precious time would have been lost." *Id.*

B. Agency Regulations Also Support the First Circuit's Position.

The hospital also argues that the First Circuit failed to defer to HHS regulations interpreting EMTALA's statutory language. Pet. at 9. The First Circuit rejected the hospital's position, however, not because it

refused to defer to the agency's interpretation of the statute, but because it concluded that the agency adopted a position *opposite* to the one the hospital advances. Pet. App. at 16a-17a.

HHS's regulations provide that a person "comes to" an emergency room when the person

> [i]s in a ground or air nonhospital-owned ambulance on hospital property for presentation for examination and treatment for a medical condition at a hospital's dedicated emergency department. However, an individual in a nonhospital-owned ambulance off hospital property is not considered to have come to the hospital's emergency department, even if a member of the ambulance staff contacts the hospital by telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and treatment. *The hospital may direct the ambulance to another facility if it is in "diversionary status," that is, it does not have the staff or facilities to accept any additional emergency patients.*

42 C.F.R. § 489.24 (emphasis added).

In interpreting this provision, the hospital focuses exclusively on the second sentence, which, read in isolation, appears to support its position that a non-hospital-owned ambulance outside hospital property does not trigger the hospital's obligations under EMTALA. The second sentence, however, does not appear in isolation, but is qualified by the immediately following sentence. That sentence provides that a hospital may divert an ambulance "if . . . it does not have the staff or facilities to

accept any additional emergency patients." *Id.* Read together, the second and third sentences of the subsection provide that a hospital may turn away a patient in a non-hospital-owned ambulance if limitations on its resources justify its decision to do so. Pet. App. at 15a-17a; *see also Arrington*, 237 F.3d at 1074. They do not also empower a hospital to turn away a patient simply because the patient lacks health insurance or the ability to pay—the core evil that EMTALA was designed to prevent.

The reason given by the district court for ignoring the qualifying third sentence was that the sentence "adds nothing" to the regulation. Pet. App. at 12a. As the First Circuit recognized, however, to ignore the third sentence would violate the longstanding principle that a statute or regulation should be not be interpreted in way that renders any portion of the statute or regulation meaningless. Pet. App. at 12a-13a. If hospitals could turn away patients in non-hospital-owned ambulances for *any* reason, including lack of health insurance, there would have been no reason for HHS to state that hospitals can turn away patients for the *specific* reason that the hospital is in diversionary status. By reading the third sentence out of the regulation, it is the hospital, not the First Circuit, that ignores the regulation's plain language.

Far from supporting the hospital's view that EMTALA requires a patient's physical presence, HHS's implementing regulations adopt the opposite approach. HHS "has taken an expansive approach to the scope of the phrase 'comes to the emergency department,'" *Arrington*, 237 F.3d at 1066, defining it to encompass situations where a patient, although requesting treatment from an emergency room, stops somewhere short of the emergency room's physical boundaries. Indeed, although HHS's regulations provide several provisions specifying when a person "comes to" an emergency room under

EMTALA, only one of these provisions requires the patient's physical presence. *See* 42 C.F.R. § 489.24 (defining "comes to" to cover situations where a patient has "presented at a hospital's dedicated emergency department").

In addition to physical presence, the regulations provide that a patient "comes to" the emergency room when that person "has presented on hospital property . . . *other than* the dedicated emergency department." *Id.* (emphasis added). This provision extends the requirement of physical presence from the emergency room itself to the entire hospital campus, "including the parking lot, sidewalk, and driveway." *Id.* Moreover, following a case where a hospital refused to treat a teenager who collapsed and bled to death just outside a hospital's property line, the agency further extended the regulations to cover an area extending 250 yards beyond the borders of the hospital's property. 42 C.F.R. § 413.65(a)(2). In that case, HHS "concluded that the statutory intent of EMTALA was to protect those patients who clearly were attempting to reach the [emergency room] and in doing so had come to the hospital's attention." William M. McDonnell, *Will EMTALA Changes Leave Emergency Patients Dying on the Hospital Doorstep?*, 38 J. Health L. 77 (Winter 2005). Finally, the agency applies EMTALA to cases where the patient is not on hospital property at all, but is being brought to the emergency room in a hospital-owned ambulance. 42 C.F.R. § 489.24. The hospital does not dispute the agency's authority to define "comes to" in a way that includes these situations. To the contrary, the hospital stresses the need to defer to the agency's interpretation of the statutory language.

If the plain language of EMTALA allows HHS to regulate patients in areas outside of the emergency room, including hospital-owned ambulances, there is no

reason why it would not allow HHS to regulate patients in non-hospital-owned ambulances as well. The hospital advances no plausible reason why HHS would choose to condition a patient's entitlement to potentially life-saving treatment—and the hospital's entitlement to discriminate against those without the ability to pay—on who happens to own the ambulance responding to a 911 call. The fact that a hospital has not voluntarily accepted responsibility for a patient in a non-hospital-owned ambulance does not explain the distinction, because hospitals are obligated to treat patients who arrive at an emergency room unannounced, as they would have been obligated to treat Morales if the paramedics had disregarded the hospital's instructions and taken her there anyway. Indeed, the whole purpose of EMTALA is to require hospitals to treat patients in situations where they otherwise would have turned them away.

An additional consideration counsels against this Court's involvement here. If the hospital were correct that HHS intended to allow hospitals to turn away non-hospital-owned ambulances because an occupant lacks insurance, the agency could solve that problem simply by clarifying its regulations. Since *Arrington* adopted its reading of the statutory language seven years ago, however, HHS has made no effort to require a different result. In an analogous context, the Supreme Court often takes Congress's failure to amend a statute in the face of the Court's interpretation of the statutory language as an indication that the Court's interpretation is correct. *See Johnson v. Transp. Agency*, 480 U.S. 616, 629-30 n.7 (1987) ("[W]hen Congress has been displeased with [the Supreme Court's] interpretation [of a statute], . . . it has not hesitated to amend the statute to tell [the Court] so."). An agency's failure to respond to a judicial interpretation of its regulations is just as telling. *Cf. Braxton v. United States*, 500 U.S. 344, 348-49 (1991) ("Congress

itself can eliminate a conflict concerning a statutory provision by making a clarifying amendment to the statute, and agencies can do the same with respect to regulations.").

III. The Lack of Finality of the Third Circuit's Ruling Underscores the Conclusion that Review Should Be Denied.

Finally, the hospital ignores another compelling reason to deny review: the interlocutory nature of the ruling below. Although this Court has jurisdiction to review interlocutory decisions of federal courts of appeals under 28 U.S.C. § 1254(1), it seldom does so, and this case is not the rare case in which interlocutory review is appropriate. "Ordinarily, in the certiorari context, 'this court should not issue a writ of certiorari to review a decree of the circuit court of appeals on appeal from an interlocutory order, unless it is necessary to prevent extraordinary inconvenience and embarrassment in the conduct of the cause.'" Robert L. Stern, et al., *Supreme Court Practice* § 4.18, at 258 (8th ed. 2002) (quoting *American Constr. Co. v. Jacksonville, T. & K.W. Ry. Co.*, 148 U.S. 372, 384 (1893) (emphasis added)); *see also, e.g.*, *Hamilton-Brown Shoe Co. v. Wolf Bros. Co.*, 240 U.S. 251, 258 (1916) (interlocutory decisions are reviewed only "in extraordinary cases").

The posture of this case is anything but extraordinary. The court of appeals reversed the judgment of the district court on the purely legal ground that the district court erred in concluding that, reading the facts in the light most favorable to Morales, she had not "come to" the hospital. The court remanded the case to the district court for further proceedings, noting that, among other things, the factfinder would have to consider whether the emergency-room director's act of hanging up the phone constituted a denial of service under EM-

TALA. Pet. App. at 5a-6a, 20a. On remand, the court or jury will be free to find for the hospital on any lawful ground, in which case review of the question presented would not be necessary (or appropriate).

This case is an even less appropriate vehicle for immediate, interlocutory review than was *Virginia Military Institute v. United States*, 508 U.S. 946 (1993) (*VMI*). There, the Fourth Circuit had issued a final decision holding that the Commonwealth of Virginia's sponsorship of a military college that excluded women was unconstitutional, but the district court had yet to rule on the appropriate remedy. The Court denied certiorari on the ground that the decision was not sufficiently final because the remedy phase had not been completed. *See id.* at 946 (Scalia, J., concurring). The Court recognized that there would be time enough to review the decision if that were necessary after the remedial portion of the case had concluded, *id.*, and, in fact, it later did so. *See United States v. Virginia*, 518 U.S. 515 (1996). Here, there is no decision regarding liability, let alone the appropriate remedy.

Of course, plaintiffs believe that they will prevail on the merits. If they do, the hospital may appeal from the final decision and, ultimately, petition the Court on the meaning of "comes to" (and any other properly preserved federal issue). *See VMI*, 508 U.S. 946 (Scalia, J., concurring). Moreover, unlike the *VMI* case, which was sui generis, here, if petitioner is correct that the meaning of "comes to" arises frequently in the courts of appeals, there will be any number of appropriate future vehicles that would allow this Court to resolve the question. In the meantime, the Court should stay its hand and allow the case to run its course.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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