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SULLIVAN, C. J., with whom ZARELLA, J., joins, dissenting. The majority concludes that the Appellate Court improperly determined that the plaintiff, Zbigniew Szewczyk,[1] did not suffer from an emergency medical condition as that term is defined in Title XIX of the Social Security Act, 42 U.S.C. § 1396b (v) (3).[2] See *Szewczyk* v. *Dept. of Social Services*, 77 Conn. App. 38, 52, 822 A.2d 957 (2003). Accordingly, the majority concludes that the plaintiff is entitled to medical assistance payments from the defendant, the department of social services (department), pursuant to state regulation. See Department of Social Services, Uniform Policy Manual, § 3005.05 (C) (Uniform Policy Manual).[3] In support of its conclusion, the majority relies heavily on the decision of the United States Court of Appeals for the Second Circuit in *Greenery Rehabilitation Group, Inc.* v. *Hammon*, 150 F.3d 226 (2d Cir. 1998). I believe, however, that the standard for determining whether a person suffers from an emergency medical condition adopted by the court in *Greenery Rehabilitation Group, Inc.*, is both incorrect and unworkable. Accordingly, I would not follow that case. Instead, in light of the legislative history and genealogy of § 1396b (v) (3), I would conclude that that statute was intended to be construed consistently with the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (e) (1).[4] Applying that interpretation, I would conclude that the plaintiff did not receive treatment for an emergency medical condition and, therefore, was not entitled to medical assistance payments from the defendant. Accordingly, I respectfully dissent.

I begin with a review of the relevant statutes and regulations. Medicaid law authorizes medical assistance payments from a state to an illegal alien only for medical care and services necessary for the treatment of an emergency medical condition. See Uniform Policy Manual, supra, § 3005.05 (C); see also 8 U.S.C. § 1621.[5] The Uniform Policy Manual, supra, § 3000.01 provides in relevant part: ''A medical condition is considered an emergency when it is of such severity that the absence of immediate medical attention could result in placing the patient's health in serious jeopardy. This . . . does not include care or services related to an organ transplant procedure.'' Federal medicaid law provides payment by the federal government to the states for medical assistance provided to an illegal alien only if ''such care and services are necessary for the treatment of an emergency medical condition''; 42 U.S.C. § 1396b (v) (2) (A); see also 8 U.S.C. § 1611 (b) (1) (A);[6] and defines '' '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 reason-

ably be expected to result in—(A) placing the patient's health in serious jeopardy, (B) serious impairment to bodily functions, or (C) serious dysfunction of any bodily organ or part.'' 42 U.S.C. § 1396b (v) (3). The United States Department of Health and Human Services (Department of Health and Human Services) has adopted an implementing regulation that adds to this definition the condition that the medical condition must be of ''sudden onset.'' 42 C.F.R. § 440.255.[7]

There is no dispute in this case that the definition of emergency medical condition in the Uniform Policy Manual, supra, § 3000.01, is at least as broad as that contained in § 1396b (v) (3).[8] The parties also agree that the state may provide more generous public benefits, including medical assistance, to illegal aliens than the benefits authorized by federal law only if it has enacted a law after August 22, 1996, providing for such benefits. See 8 U.S.C. § 1621 (d).[9] The Connecticut legislature has passed no such law. Thus, the parties agree that the definition of emergency medical condition in § 3000.01 of the Uniform Policy Manual, supra, is neither more restrictive nor broader than the definition set forth in the federal statute and regulation, which are themselves coextensive.

The parties disagree, however, as to whether the phrase emergency medical condition is broad enough to cover a medical condition that presents with severe symptoms and may require long-term treatment. Although the definition of the phrase may plainly and unambiguously cover certain acute medical conditions, such as a severe laceration, that can be resolved promptly with immediate treatment, it is not clear whether the phrase was intended to encompass a condition, such as the plaintiff's, that presents with severe symptoms but requires longer term treatment and, therefore, reasonably may be characterized as chronic. Thus, the text of the statute is ambiguous as applied in the present case. Accordingly, in construing § 1396b (v) (3), I do not believe that we are limited to the text of the statute, but may look to its genealogy and legislative history, to cases construing its language and to its relationship to other federal statutes and regulations.[10] See *In re Venture Mortgage Fund, L.P.*, 282 F.3d 185, 188 (2d Cir. 2002) (legislative history and other tools of interpretation may be relied upon if terms of federal statute are ambiguous).

The medicaid provision of which § 1396b (v) (3) is a part was enacted in 1986 in response to a ruling by the United States District Court for the Eastern District of New York; see *Lewis* v. *Gross*, 663 F. Sup. 1164 (E.D.N.Y. 1986), rev'd in part, *Lewis* v. *Thompson*, 252 F.3d 567 (2d Cir. 2001); that federal medicaid law placed no restriction on alien eligibility for medicaid assistance. See Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9406, 100 Stat. 1874, 2057–58

(1986), now codified at 42 U.S.C. § 1396b (v); H.R. Conf. Rep. No. 99-1012, 99th Cong., 2d Sess. 399 (1986), reprinted in 1986 U.S.C.C.A.N. 3868, 4044–45. Section 1396b (v) barred medicaid assistance to aliens not residing in the United States under color of law unless the alien suffered from an emergency medical condition. The legislative history of the Omnibus Budget Reconciliation Act of 1986 indicates that the general purpose underlying its disparate provisions was to reduce government expenditures. See generally 1986 U.S.C.C.A.N. 3868 et seq. The legislative history sheds no light, however, on the purpose of the specific provision permitting medicaid payments to the states for medical assistance to an illegal alien for an emergency medical condition or the scope and contours of that term.

A review of the genesis and evolution of the statutory language is instructive, however. The language defining emergency medical condition, as set forth in § 1396b (v) (3), first appeared in 42 C.F.R. § 447.53 (b) (4).[11] That regulation, which was adopted in 1985, implemented a 1982 amendment to the federal medicaid provisions that prohibited the states from imposing cost sharing requirements on individuals who received emergency medical services ''as defined by the Secretary . . . .'' See Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 131, 96 Stat. 324, 367–68 (1982), codified at 42 U.S.C. § 1396o (b) (2) (D); see also 50 Fed. Reg. 23,009, 23,013 (May 30, 1985). In response to the amendment, the Department of Health and Human Services originally had adopted a regulation containing language identical to that set forth at 42 C.F.R. § 440.170 (e), pertaining to medical services that are covered by medicaid.[12] See 48 Fed. Reg. 5732 (February 8, 1983). When it adopted that language, the Department of Health and Human Services solicited comments from the public on whether the language should be revised for purposes of the cost sharing amendment. See id. In response to the comments that it received, the Department of Health and Human Services concluded that the language of the coverage regulation was ''too limited'' for the cost sharing regulation; 50 Fed. Reg., supra, 23,011; and adopted the current version of the regulation; see 42 C.F.R. § 447.53 (b) (4); which includes ''services provided in settings other than the hospital.'' 50 Fed. Reg., supra, 23,011.

In 1986, Congress amended federal medicare law by enacting EMTALA, or the ''patient dumping act.'' See Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99-272, § 1867, 100 Stat. 82, 166 (1986), codified at 42 U.S.C. § 1395dd. The amendment's definition of emergency medical condition contained language substantially identical to the language of 42 C.F.R. § 447.53 (b) (4), with the exception that the statute did not list the facilities at which emergency medical services must be provided or include a sudden onset requirement. See 42 U.S.C. § 1395dd (e) (1). The amend-

ment requires hospitals that participate in the federal medicare program to screen and stabilize patients who come to the hospital with an emergency medical condition, including illegal aliens, if the hospital is capable of doing so. The legislative history of the amendment indicates that it was intended to address the problem of the inappropriate transfer of ''patients in life threatening situations'' from the emergency rooms of private hospitals to public hospitals ''for economic reasons alone . . . .'' 131 Cong. Rec., Pt. 21, 28,568 (1985), remarks of Senator David Durenberger. The legislative history also indicates that the amendment was not intended to be a ''cure-all,'' but a ''modest policy''; id.; and was not intended to solve the ''larger problem'' of providing medical services to the growing number of uninsured patients. Id., 28,569, remarks of Senator Edward Kennedy. Finally, the legislative history indicates that the general accounting office was conducting a study to determine whether refinements in federal medicaid law would be required to advance the purposes of the act. Id., 28,568. Six months after Congress enacted § 1395dd, it enacted the medicaid provision at issue in the present case, § 1396b (v) (3), which uses substantially identical language to define emergency medical condition.[13]

The Department of Health and Human Services expressly recognized the relationship between § 1396b (v) (3) and § 1395dd (e) (1) when, in 1990, it revised 42 C.F.R. § 440.255 (c) (1), which is the implementing regulation for § 1396b (v) (3). See 55 Fed. Reg. 36,816 (September 7, 1990). The Department of Health and Human Services stated that ''we have revised the definition of emergency services to say . . . 'after the sudden onset of a medical condition . . . .' This change will make the definition of emergency services consistent with the definition already in use in the Medicaid program at 42 [C.F.R.] § 447.53 (b) (4) and with the definition contained in section 1867 (e) (1) of the [Omnibus Budget Reconciliation Act of 1985, codified at 42 U.S.C. § 1395dd (e) (1)], relating to hospital emergency [departments'] inappropriate failure to treat certain patients (the anti-dumping provision).''[14] 55 Fed. Reg., supra, 36,816.

This legislative background clearly suggests that § 1396b (v) (2) was intended to ensure that states and hospitals that participate in the medicare and medicaid programs will receive at least partial payment from the federal government for emergency medical services provided to indigent illegal aliens pursuant to § 1395dd.[15] Accordingly, it is clear to me that Congress intended for the phrase emergency medical condition, as defined in § 1396b (v) (3), to have the same scope and contours as that phrase is defined in § 1395dd (e) (1) and for the phrase ''care and services . . . necessary for the treatment of an emergency medical condition'' as used in § 1396b (v) (2) (A) to refer to the treatment required by § 1395dd.[16] Accordingly, in con-

struing § 1396b (v) (3), I believe that we should be guided by the meaning of § 1395dd (e) (1).

The meaning of § 1395dd (e) (1) is determined in part by its relationship to the other provisions of § 1395dd.[17] As I have indicated, the primary purpose of § 1395dd was to prohibit the inappropriate transfer of patients who arrive at a hospital with an emergency medical condition "such that the absence of immediate medical attention could reasonably be expected to result in . . . placing the health of the individual . . . in serious jeopardy . . . ." 42 U.S.C. § 1395dd (e) (1) (A). The statute imposes two basic obligations on participating hospitals: (1) to screen patients who come to a hospital's emergency department; 42 U.S.C. § 1395dd (a); and (2) to stabilize patients suffering from an emergency medical condition. 42 U.S.C. § 1395dd (b). Subsection 1395dd (e) (3) (A) defines " 'to stabilize' " as "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* . . . ." (Emphasis added.) Once a medical condition has been stabilized, the provisions of the statute prohibiting transfer of the patient no longer apply. See 42 U.S.C. § 1395dd (c) (1).

Accordingly, read as a whole, the statutory language indicates that the phrase "immediate medical attention" as used in the definition of " 'emergency medical condition' "; 42 U.S.C. § 1395dd (e) (1) (A); refers to the stabilizing treatment described in § 1395dd (e) (3) (A) and that the phrase "material deterioration of the condition" as used in § 1395dd (e) (3) (A) refers to the adverse results listed in § 1395dd (e) (1) (A) (i), (ii) and (iii). Thus, an emergency medical condition is a condition that requires stabilizing treatment in order 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 his discharge.[18] Moreover, because the term to stabilize is defined entirely in terms of the treatment required in order to transfer an individual safely to another facility; see 42 U.S.C. § 1395dd (e) (3) (A); it is apparent that, if no transfer or discharge is contemplated, the treatment provisions of the statute do not apply.

This interpretation of § 1395dd is consistent with the interpretation of the Department of Health and Human Services. Title 42 of the Code of Federal Regulations, § 489.24 (d) (2), is in the portion of the medicare regulations specifying "the basic commitments and limitations that [a health care] provider must agree to as part of an agreement to provide services." 42 C.F.R. § 489.2. Section 489.24 (d) (2) of 42 C.F.R. provides: "(i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an

emergency medical condition [definition substantially identical to definition in § 1395dd (e) (1)], and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual.'' When it adopted the current version of this regulation, the Department of Health and Human Services stated that it had received several comments requesting clarification on whether § 1395dd would ''apply to inpatients who are stable but who are scheduled for inpatient surgery for an emergency medical condition, such as patients who need an angiogram or bypass surgery, after seeing their physician for chest pain. One commenter requested clarification on the issue of individuals directly admitted to the hospital for an emergency medical condition, for example, appendicitis, although the individual is not seeking emergency services from the hospital.'' 68 Fed. Reg. 53,246 (September 9, 2003). The Department of Health and Human Services responded that ''once an individual has been admitted as an inpatient (including individuals who have been directly admitted as inpatients upon presentation to the hospital), EMTALA no longer applies''; id.; unless the individual was admitted for the purpose of evading the requirements of the statute. Id., 53,245.

In support of this interpretation, the Department of Health and Human Services cited several federal cases that have concluded that ''the statute requires that stabilizing care must be provided in a way that avoids material deterioration of an individual's medical condition *if the individual is being transferred from the facility*.'' (Emphasis added.) Id., 53,244; see, e.g., *Bryan* v. *Rectors & Visitors of the University of Virginia*, 95 F.3d 349 (4th Cir. 1996).[19] ''The courts gave great weight to the fact that hospitals have a discrete obligation to stabilize the condition of an individual when moving that individual out of the hospital to either another facility or to his or her home as part of the discharge process. Thus, should a hospital determine that it would be better to admit the individual as an inpatient, such a decision would not result in either a transfer or a discharge, and, consequently, the hospital would not have an obligation to stabilize under EMTALA.'' 68 Fed. Reg., supra, 53,244. The Department of Health and Human Services also stated that ''[t]he courts have generally acknowledged that this limitation on the scope of the stabilization requirement does not protect hospitals from challenges to the decisions they make about patient care; only that redress may lie outside EMTALA. For example, a hospital may face liability for negligent behavior that results in harm to persons it [treats] after they are admitted as inpatients, but such potential liability would flow from medical malpractice principles, not from the hospital's obligations under EMTALA.'' Id.

This interpretation of § 1395dd (e) (1) is also consis-

tent with the interpretation of the Centers for Medicare and Medicaid Services (CMS), an agency within the Department of Health and Human Services, which is responsible for investigating complaints alleging violations of § 1395dd. See United States General Accounting Office, Report to Congressional Committees, Emergency Care: EMTALA Implementation and Enforcement Issues (June, 2001) p. 1. In 2001, Congress directed the United States general accounting office to examine the effect of the statute on hospitals and physicians who serve emergency departments. Id. During the course of the investigation, the general accounting office learned that hospitals and physicians were uncertain about the amount of care they were required to provide to comply with the statutory requirements and at what point their treatment obligations ended. Id., p. 15. The general accounting office asked CMS: (1) ''[w]hether the determination that a patient is stable for transfer or discharge ends the hospital's EMTALA obligation or whether the hospital must also ensure follow-up care is provided''; and (2) ''[w]hether a hospital must ensure that follow-up care is obtained.'' Id., p. 16. CMS advised the general accounting office that: (1) ''[t]he requirement is fulfilled when a physician determines the patient is stable for transfer or stable for discharge. The regulations on transfer requirements refer to patients who are unstable; therefore they do not apply when a patient is stable for transfer or stable for discharge''; and (2) ''[h]ospitals are not required to ensure that follow-up care is obtained.'' Id. Guidelines issued by CMS state that ''[a]n individual is considered stable and ready for discharge when, within reasonable clinical confidence, it is determined that the individual has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow-up care as part of the discharge instructions. The [emergency medical condition] that caused the individual to present to the dedicated [emergency department] must be resolved, but the underlying medical condition may persist. Hospitals are expected within reason to assist/provide discharged individuals the necessary information to secure the necessary follow-up care to prevent relapse or worsening of the medical condition upon release from the hospital . . . .'' Memorandum from the Director, Survey and Certification Group, Centers for Medicare & Medicaid Services, to State Survey Agency Directors re: Revised Emergency Medical Treatment and Labor Act (EMTALA) Interpretive Guidelines (May 13, 2004), p. 37 (CMS Memorandum), available at http://www.cms.hhs.gov/Medicaid/survey-cert/sc0434.pdf.

With this background in mind, I would conclude that the phrase emergency medical condition as used in § 1395dd (e) (1) (A) means a condition requiring stabilization in order to avoid a material deterioration of an

individual's condition during the course of a transfer to another facility or during discharge.[20] As I have indicated, if no transfer or discharge is contemplated, or if the discharge takes place after admission for inpatient treatment, then the treatment provisions of § 1395dd (b) (1) do not apply. As I have also indicated, I believe that the phrase emergency medical condition as used in both § 1396b (v) (3) and the Uniform Policy Manual, supra, § 3000.01, was intended to be coextensive with the phrase as used in § 1395dd (e) (1) (A). Accordingly, if stabilization is not required or if no transfer or discharge is contemplated, then any treatment received by the individual does not fall within the scope of § 1396b (v) (2) (A) and the individual is not eligible for medical assistance under the Uniform Policy Manual, supra, § 3005.05 (C).[21]

This interpretation not only is consistent with the genealogy and legislative history of § 1396b (v) (3), but it also advances general federal policy. Federal law provides that illegal aliens are ineligible for state and local governments public benefits; see 8 U.S.C. § 1621 (a); unless the state specifically enacts a law providing for such benefits after August 22, 1996. See 8 U.S.C. § 1621 (d). There are a small number of narrowly defined exceptions to this law, including one authorizing states to provide ''[a]ssistance for health care items and services that are necessary for the treatment of an emergency medical condition (as defined in section 1396b [v] [3] of title 42) of the alien involved . . . .'' 8 U.S.C. § 1621 (b) (1). The legislative history of § 1621, which was enacted as part of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (1996) (Welfare Reform Act), indicates that Congress understood the allowance for emergency services under § 1396b (v) (3) to be ''very narrow'' and to apply ''only . . . to medical care that is strictly of an emergency nature, such as medical treatment administered in an emergency room, critical care unit, or intensive care unit.''[22] H.R. Conf. Rep. No. 104-725, 104th Cong., 2d Sess. 380 (1996), reprinted in 1996 U.S.C.C.A.N. 2649, 2768. The legislative history of the Welfare Reform Act also indicates that one of its principal purposes was to ''reduce the size and scope of the Federal Government and to provide tax relief for working American families.'' H.R. Rep. No. 104-651, 104th Cong., 2d Sess. 10 (1996), reprinted in 1996 U.S.C.C.A.N. 2183, 2191. As I have indicated, that was also a primary purpose of the Omnibus Budget Reconciliation Act of 1986, of which § 1396b (v) (3) was a part. Moreover, when Congress enacted the Welfare Reform Act, it explicitly stated that ''[i]t is a compelling government interest to remove the incentive for illegal immigration provided by the availability of public benefits.'' 8 U.S.C. § 1601 (6). It is apparent that a narrow, clearly delineated definition of emergency medical condition, such as that contained in § 1395dd, would

advance these policies far more effectively than a definition broad enough to cover the type of treatment provided to the plaintiff in the present case.[23]

Moreover, EMTALA is the only law *mandating* the *treatment* of an illegal alien's emergency medical condition. Section 1396b (v) merely *authorizes payment* to the states for the treatment of an emergency medical condition after it has been provided. I cannot conceive of any reasons why Congress would require hospitals to provide treatment to an uninsured person who is suffering from an emergency medical condition only to the extent required to stabilize the person for discharge or transfer but then—only months later and using identical language—authorize payment for the treatment of an illegal alien's emergency medical condition for as long as the underlying condition persists. The effect of giving such a broad reading to § 1396b (v) would be to limit the application of the narrow definition in § 1395dd to uninsured citizens and legal aliens. Moreover, I find it unlikely that Congress would simultaneously make illegal aliens ineligible for state and local public benefits in order to discourage illegal immigration; see 8 U.S.C. §§ 1601 (6) and 1621 (a); and authorize states to provide a benefit to illegal aliens that is not provided to uninsured citizens.[24] See 8 U.S.C. § 1621 (b) (1).

The majority concludes, however, that § 1396b (v) (3) is broad enough to cover the treatment of any severe medical condition if the withholding of prompt treatment would be reasonably likely to cause the individual's death or place his health in serious jeopardy and if the condition can be resolved with a finite course of treatment. In support of that conclusion, it relies primarily on *Greenery Rehabilitation Group, Inc.* v. *Hammon*, supra, 150 F.3d 226,[25] and on a number of state court cases construing the term emergency medical condition as used in § 1396b (v) (3) or in substantially identical state regulations implementing the statute. See *Scottsdale Healthcare, Inc.* v. *Arizona Health Care Cost Containment System Administration*, 206 Ariz. 1, 75 P.3d 91 (2003); *Diaz* v. *Division of Social Services*, 166 N.C. App. 209, 600 S.E.2d 877 (2004), review granted, 359 N.C. 320, 611 S.E.2d 409 (2005); *Medina* v. *Division of Social Services*, 165 N.C. App. 502, 598 S.E.2d 707 (2004); *Luna* v. *Division of Social Services*, 162 N.C. App. 1, 589 S.E.2d 917 (2004); see also *Gaddam* v. *Rowe*, 44 Conn. Sup. 268, 271–73, 684 A.2d 286 (1995) (illegal alien entitled to medicaid assistance for ongoing dialysis treatment under § 1396b [v] [2]). In none of those cases, however, did the court consider the relationship between § 1396b (v) and § 1395dd.[26] See 131 Cong. Rec., supra, 28,568 (suggesting that refinements in federal medicaid law would be required to advance purposes of EMTALA); 55 Fed. Reg., supra, 36,816 (expressly recognizing that definition of emergency medical condition in § 1396b [v] was intended to be consistent with definition in § 1395dd).

Instead, the courts relied primarily on the dictionary definitions of several terms used in the statute and on the general expertise of health care providers on the question of when an emergency medical condition exists. See footnote 10 of this dissenting opinion; see also, e.g., *Scottsdale Healthcare, Inc.* v. *Arizona Health Care Cost Containment System Administration*, supra, 7–8 (citing dictionary definitions of " 'acute' " and " 'chronic' " and concluding that when emergency medical condition has ended "should largely be informed by the expertise of health care providers").[27] Accordingly, I do not find the cases persuasive.[28]

Moreover, the rule set forth in *Greenery Rehabilitation Group, Inc.* v. *Hammon*, supra, 150 F.3d 233, and adopted by the majority is impossible to implement in any principled way. The majority implicitly recognizes that there are medical conditions that place an individual's health in serious jeopardy and are likely to result in serious impairment to bodily functions or of a bodily organ or part, but that do not come within § 1396b (v) (3) because they cannot be resolved with a "finite course of treatment." *Luna* v. *Division of Social Services*, supra, 162 N.C. App. 11. In other words, serious and even life threatening conditions that require an immediate but indefinite or unending course of treatment are not emergency medical conditions. It is apparent, however, that it is frequently impossible to determine at the time of admission, or, indeed, at any given point during treatment, if and when a particular condition will be fully resolved. If a patient suffers a serious traumatic head injury and the termination of medical treatment at any point during the remainder of the patient's life would result in immediate death or serious injury, to characterize the injury as either acute or chronic would be arbitrary. The injury is acute in the sense that it was of sudden onset and is severe, and it is chronic in the sense that it cannot be resolved with a finite course of treatment.[29] It is also clear that many indisputably chronic diseases have acute phases. Under the majority's decision, whether such injuries and conditions constitute emergency medical conditions under § 1396b (v) (3) will depend " 'largely,' " which is to say, entirely, on their characterization by medical experts unguided by anything except the vague and ambiguous language of the statute. See *Scottsdale Healthcare, Inc.* v. *Arizona Health Care Cost Containment System Administration*, supra, 206 Ariz. 8.

The majority concludes in the present case that the plaintiff had an emergency medical condition because he was diagnosed with a " 'rapidly fatal' " disease that had " 'reached a crisis stage' " when he arrived at the hospital and because he received a " 'finite course of treatment . . . .' " There is no evidence in the record, however, that the treatment for which the plaintiff seeks reimbursement cured his disease or that he did not require ongoing outpatient treatment or additional hos-

pital admissions after his discharge.[30] Indeed, the record suggests otherwise. See footnote 1 of this dissenting opinion. Accordingly, the majority's conclusions that the plaintiff's condition was not chronic and that he received a " 'finite course of treatment' " ultimately rest on the mere fact that the hospital handled the medical treatment that he received during his admission as a discrete course of treatment for billing purposes.

If our only guide to the meaning of the phrase emergency medical condition were the ambiguous language of § 1396b (v) (3), I might find tolerable an outcome based on the vagaries of hospital billing practices. Courts must do the best they can when confronted with an inherently ambiguous statute and no additional evidence of legislative intent. *Because* the statute is inherently ambiguous, however, we are not limited to its express terms in construing its meaning, but may consider its legislative background. In my view, that legislative background establishes that Congress intended the statute to be construed consistently with § 1395dd (e) (1).

I would conclude that, in order to establish his eligibility for payments under the Uniform Policy Manual, supra, § 3005.05 (C), the plaintiff was required to establish that his condition was such that he could not have been transferred or discharged safely and that the treatment for which he seeks medical assistance payments actually was provided in order to assure, within a reasonable medical probability, that no material deterioration of his condition would occur during the course of his transfer to another facility or during discharge. Although the hearing officer made no factual findings on these issues, the plaintiff does not claim and there is no suggestion in the record that the treatment provided to the plaintiff was intended to stabilize him for transfer to another facility or for discharge so that he could secure the appropriate follow-up care. Rather, the record clearly indicates that the plaintiff was admitted immediately into the hospital as an inpatient for long-term treatment.[31] I would conclude, therefore, that the plaintiff was not eligible for medical assistance under the Uniform Policy Manual, supra, § 3005.05 (C). Accordingly, although I believe that the Appellate Court applied an improper standard, I would conclude that the impropriety was harmless and that its judgment should be affirmed.

[1] After this appeal was filed, counsel for the plaintiff notified this court that the plaintiff had died. Subsequently, this court granted a motion to substitute Michael R. Kerin, the temporary administrator of Szewczyk's estate, as plaintiff. For convenience, references to the plaintiff in this dissenting opinion are to Szewczyk.

[2] Title XIX of the Social Security Act, 42 U.S.C. § 1396b (v) (3), provides: "For purposes of this subsection, the term 'emergency medical condition' means a medical condition (including emergency labor and delivery) 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—

"(A) placing the patient's health in serious jeopardy,

"(B) serious impairment to bodily functions, or

"(C) serious dysfunction of any bodily organ or part."

[3] Uniform Policy Manual, supra, § 3005.05 (C), provides that an alien who does not qualify as an eligible noncitizen "is eligible for [medical assistance] only, if he or she has an emergency medical condition."

[4] The Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (e), provides in relevant part: "(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 . . . in serious jeopardy,

"(ii) serious impairment to bodily functions, or

"(iii) serious dysfunction of any bodily organ or part . . . ."

[5] Title 8 of the United States Code, § 1621, provides in relevant part: "(a) . . . Notwithstanding any other provision of law and except as provided in subsections (b) and (d) of this section, an alien who is not—

"(1) a qualified alien (as defined in [8 U.S.C. § 1641]),

"(2) a nonimmigrant under the Immigration and Nationality Act [8 U.S.C. 1011 et seq.], or

"(3) an alien who is paroled into the United States under section 212 (d) (5) of such Act [8 U.S.C. 1182 (d) (5)] for less than one year,

"is not eligible for any State or local public benefit (as defined in subsection [c] of this section).

"(b) . . . Subsection (a) of this section shall not apply with respect to the following State or local public benefits:

"(1) Assistance for health care items and services that are necessary for the treatment of an emergency medical condition (as defined in section 1396b [v] [3] of title 42) of the alien involved . . . ."

[6] Title 8 of the United States Code, § 1611, provides in relevant part: "(a) . . . Notwithstanding any other provision of law and except as provided in subsection (b) of this section, an alien who is not a qualified alien (as defined in [8 U.S.C. § 1641]) is not eligible for any Federal public benefit (as defined in subsection [c] of this section).

"(b) . . . (1) Subsection (a) of this section shall not apply with respect to the following Federal public benefits:

"(A) Medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396b et seq.] . . . for care and services that are necessary for the treatment of an emergency medical condition (as defined in section 1903 [v] [3] of such Act [42 U.S.C. 1396b (v) (3)]) of the alien involved . . . ."

[7] Title 42 of the Code of Federal Regulations, § 440.255 (c) (1), provides that medical assistance payments are available for treatment of an illegal alien if "[t]he alien has, after sudden onset, a medical condition (including emergency labor and delivery) 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 patient's health in serious jeopardy;

"(ii) Serious impairment to bodily functions; or

"(iii) Serious dysfunction of any bodily organ or part . . . ."

[8] Both the plaintiff and the department point out that federal medicaid law sets certain minimum standards with which participating states must comply; see *Lewis* v. *Thompson*, 252 F.3d 567, 569 (2d Cir. 2001); and suggest that those minimum federal requirements include medical assistance payments for services provided to illegal aliens for treatment of an emergency medical condition as defined in § 1396b (v) (3). Neither party, however, points to any federal medicaid law *requiring* states to provide medical assistance to illegal aliens who receive treatment for an emergency medical condition. Section 1396b (v) (2) merely provides that the federal government will pay states for such medical assistance if it is provided. Because neither party disputes the issue, however, I assume that the definition of emergency medical condition set forth in the Uniform Policy Manual, supra, § 3000.01, is at least as broad as that set forth at § 1396b (v) (3).

[9] Title 8 of the United States Code, § 1621 (d), provides: "A State may provide that an alien who is not lawfully present in the United States is eligible for any State or local public benefit for which such alien would otherwise be ineligible under subsection (a) of this section only through the enactment of a State law after August 22, 1996, which affirmatively provides for such eligibility."

Judge Lavery, in his dissenting opinion, argued that the definition in the Uniform Policy Manual, supra, § 3000.01, was broader than the federal

statutory definition. *Szewczyk* v. *Dept. of Social Services*, supra, 77 Conn. App. 64–66. In his brief to this court, the plaintiff disavows any such claim. He points out that he did not argue to the Appellate Court that the state regulation was broader than the federal statute and, therefore, that he did not have occasion to bring 8 U.S.C. § 1621 (d) to the court's attention.

[10] In *Greenery Rehabilitation Group, Inc.* v. *Hammon*, supra, 150 F.3d 232–33, the United States Court of Appeals for the Second Circuit concluded that § 1396b (v) (3) is ''plain in its meaning'' and ''clearly conveys'' the commonly understood dictionary definition of ''emergency'' as ''a sudden bodily alteration such as is likely to require immediate medical attention. . . . The emphasis is on severity, temporality and urgency.'' (Citation omitted; internal quotation marks omitted.) In my view, however, to define an emergency medical condition as a '' 'sudden bodily alteration such as is likely to require *immediate* medical attention' ''; (emphasis added) id., 232; is merely to rephrase the problem. It is clear that terms such as ''sudden,'' ''acute,'' ''emergency'' and ''immediate'' are relative terms by their very nature. For example, in the present case, the plaintiff's symptoms were of sudden onset in comparison to the symptoms of a person who has had a congenital medical condition since birth, but were not sudden in comparison to an injury suffered in a knife fight. Indeed, although the majority agrees with the court in *Greenery Rehabilitation Group, Inc.*, that the phrase emergency medical condition is plain and unambiguous, it disagrees with the Appellate Court's conclusion that the plaintiff's condition was not sufficiently severe, short-lived and urgent to meet the standard in that case. I also note that federal courts construing § 1395dd (e) (1), which contains language identical to § 1396b (v) (3), have consulted that statute's legislative history. See footnote 19 of this dissenting opinion. Accordingly, I cannot agree with the court's conclusion in *Greenery Rehabilitation Group, Inc.*, that the phrase emergency medical condition is plain and clear in its meaning.

The majority concludes that, because ''[t]he decisions of the Second Circuit Court of Appeals carry particularly persuasive weight in the interpretation of federal statutes by Connecticut state courts''; (internal quotation marks omitted) *Webster Bank* v. *Oakley*, 265 Conn. 539, 555 n.16, 830 A.2d 139 (2003), cert. denied, 541 U.S. 903, 124 S. Ct. 1603, 158 L. Ed. 2d 244 (2004); it finds *Greenery Rehabilitation Group, Inc.*, to be ''highly persuasive guidance . . . .'' I note, however, that although the substantive decisions of the Second Circuit on questions of federal law are ''entitled to great weight,'' we are not bound by those decisions. (Internal quotation marks omitted.) *Kelley Property Development, Inc.* v. *Lebanon*, 226 Conn. 314, 329 n.20, 627 A.2d 909 (1993). I also note that, although the majority finds the portions of *Greenery Rehabilitation Group, Inc.*, that *support* its decision to be highly persuasive, it rejects the portions of the decision that *undermine* its decision. Specifically, it states that it is persuaded by the argument of the court in *Scottsdale Healthcare, Inc.* v. *Arizona Health Care Cost Containment System Administration*, 206 Ariz. 1, 6 n.6, 75 P.3d 91 (2003), that the court in *Greenery Rehabilitation Group, Inc.*, improperly determined that stabilization is '' 'an express factor in determining whether an emergency medical condition exists.' ''

[11] Title 42 of the Code of Federal Regulations, § 447.53 (b) (4), defines ''[e]mergency services'' as ''[s]ervices provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in—

''(i) Placing the patient's health in serious jeopardy;

''(ii) Serious impairment to bodily functions; or

''(iii) Serious dysfunction of any bodily organ or part.''

[12] Title 42 of the Code of Federal Regulations, § 440.170 (e), defines '' '[e]mergency hospital services' '' as services that ''(1) Are necessary to prevent the death or serious impairment of the health of a recipient; and

''(2) Because of the threat to the life or health of the recipient necessitate the use of the most accessible hospital available that is equipped to furnish the services . . . .''

[13] As I have indicated, § 1396b (v) was enacted in response to the decision of a United States District Court in July, 1986. See *Lewis* v. *Gross*, supra, 663 F. Sup. 1164. It is reasonable to conclude, however, that the exception to the ban on federal payment to the states for emergency medical services provided to illegal aliens, as set forth in § 1396b (v) (2), was included in the amendment in recognition of the enactment of § 1395dd six months earlier.

[14] Before the adoption of the final version of the regulation in 1990, set

forth in 42 C.F.R. § 440.255, the proposed rule did not include the sudden onset requirement and was identical to the definition set forth in § 1395dd (e) (1), with the exception that the regulation expressly included emergency labor and delivery. See 53 Fed. Reg. 38,036 (September 29, 1988). Thus, the change made in 1990 did not *make* the medicaid regulation consistent with the medicare statute, but left the provisions substantially consistent.

[15] See also United States General Accounting Office, Report to Congressional Requesters, Undocumented Aliens: Questions Persist about Their Impact on Hospitals' Uncompensated Care Costs (May, 2004) pp. 5–6, 9–10 (costs of providing illegal aliens with emergency medical services pursuant to § 1395dd are covered in part by medicaid provisions applying to illegal aliens). Because not all indigent illegal aliens who receive treatment for an emergency medical condition under § 1395dd are eligible for medical assistance for such treatment under § 1396b (v) (2), some of the costs of providing the treatment mandated by § 1395dd to illegal aliens are uncompensated.

[16] Indeed, the plaintiff in the present case does not argue that § 1396b (v) (3) should be given a broader interpretation than § 1395dd (e) (1). Rather, the plaintiff *assumes* that § 1395dd mandated the treatment of his leukemia and argues that the statutes are coextensive. The department argues that, even if § 1395dd mandated such treatment, § 1396b (v) (3) has a *narrower* meaning than § 1395dd (e) (1) because it relates to payment, not treatment. I see no basis for such a proposition in the language or legislative history of § 1396b (v) (3). In any event, I need not address the department's claim because I would conclude that § 1395dd did not mandate the plaintiff's medical treatment.

[17] Title 42 of the United States Code, § 1395dd, provides in relevant part: "(b) Necessary stabilizing treatment for emergency medical conditions and labor

"(1) In general

"If any individual (whether or not eligible for benefits under this subchapter) 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) of this section. . . .

"(c) Restricting transfers until individual stabilized

"(1) Rule

"If an individual at a hospital has an emergency medication condition which has not been stabilized . . . the hospital may not transfer the individual unless . . .

"(A) . . . (ii) . . . the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual . . . .

"(e) Definitions . . .

"(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 . . . .

"(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 . . . the hospital . . . ."

See footnote 4 of this dissenting opinion for the text of 42 U.S.C. § 1395dd (e) (1) (A), defining emergency medical condition.

[18] As I discuss later in this opinion, § 1395dd does not impose a requirement that the patient must be fully cured before discharge. A discharge complies with the statute even if the patient may need long-term inpatient treatment at some later date and at another facility, as long as the patient has been stabilized to the point that it is not reasonably likely that his condition will materially deteriorate before he can secure such treatment.

[19] In *Bryan* v. *Rectors & Visitors of the University of Virginia*, supra, 95 F.3d 350, the plaintiff's decedent had been transferred to the defendant hospital for treatment of an emergency medical condition, respiratory distress. The hospital treated the plaintiff's decedent for twelve days and then determined, pursuant to its internal procedures and against the wishes of her family, that no further efforts to prevent her death should be taken and entered a " 'do not resuscitate' " order. Id. The plaintiff's decedent died eight

days later. Id. The plaintiff brought an action in the United States District Court for the Eastern District of Virginia claiming that the hospital's refusal to resuscitate the decedent was a failure to stabilize her in violation of § 1395dd. The court dismissed the action, concluding that the statute imposed no obligation on the hospital after the patient had been admitted. Id.

On appeal, the United States Court of Appeals for the Fourth Circuit affirmed the judgment of the District Court and rejected the plaintiff's interpretation that ''every presentation of an emergency patient to a hospital covered by EMTALA obligates the hospital to do much more than merely provide immediate, emergency stabilizing treatment with appropriate follow-up. Rather, without regard to professional standards of care or the standards embodied in the state law of medical malpractice, the hospital would have to provide treatment indefinitely—perhaps for years—according to a novel, federal standard of care derived from the statutory stabilization requirement.'' Id., 351. Instead, the court concluded that ''EMTALA is a limited anti-dumping statute, not a federal malpractice statute. . . . Its core purpose is to get patients into the system who might otherwise go untreated and be left without a remedy because traditional medical malpractice law affords no claim for failure to treat. . . . Numerous cases and [EMTALA's] legislative history confirm that Congress's sole purpose in enacting EMTALA was to deal with the problem of patients being turned away from emergency rooms for non-medical reasons.'' (Citations omitted; internal quotation marks omitted.) Id.

The court also stated that ''[o]nce EMTALA has met that purpose of ensuring that a hospital undertakes stabilizing treatment for a patient who arrives with an emergency condition, the patient's care becomes the legal responsibility of the hospital and the treating physicians. And, the legal adequacy of that care is then governed not by EMTALA but by the state malpractice law that everyone agrees EMTALA was not intended to preempt. That being the legal reality, there is no justification for [the] assertion [of the plaintiff's decedent] that, under such a reading of EMTALA, a hospital could simply treat for a few days or hours and then refuse treatment if they could not stabilize quickly and cheaply. . . . Such refusal of treatment after the establishment of a physician-patient relationship would be regulated by the tort law of the several states. See, e.g., 61 Am. Jur. 2d, Physicians, Surgeons and Other Healers, § 234 ([T]he relation of physician and patient, once initiated, continues until it is ended by the consent of the parties . . . or until his services are no longer needed, and until then the physician is under a duty to continue to provide necessary medical care to the patient.), § 238 (Failure of the patient to pay for the physician's services does not justify the physician in abandoning the patient while he still is in need of medical attendance . . . .) (1981). And, EMTALA is quite clear that it is not intended to preempt state tort law except where absolutely necessary.'' (Citation omitted; internal quotation marks omitted.) *Bryan* v. *Rectors & Visitors of the University of Virginia*, supra, 95 F.3d 351–52.

The court then cited the language of § 1395dd (e) (3) (A) and concluded that ''[t]he stabilization requirement is thus defined entirely in connection with a possible transfer and without any reference to the patient's long-term care within the system. It seems manifest to us that the stabilization requirement was intended to regulate the hospital's care of the patient only in the immediate aftermath of the act of admitting her for emergency treatment and while it considered whether it would undertake longer-term full treatment or instead transfer the patient to a hospital that could and would undertake that treatment.'' Id., 352; see also *Harry* v. *Marchant*, 291 F.3d 767, 771 (11th Cir. 2002) (42 U.S.C. § 1395dd does not impose guidelines for care and treatment of patient who is not transferred); *Bryant* v. *Adventist Health System/West*, 289 F.3d 1162, 1168 (9th Cir. 2002) (statutory stabilization requirement ends when individual is admitted for inpatient care); *Correa* v. *Hospital San Francisco*, 69 F.3d 1184, 1190 (1st Cir. 1995) (to establish EMTALA violation, patient must show that hospital turned away, discharged or transferred patient without first stabilizing emergency medical condition); *Brooker* v. *Desert Hospital Corp.*, 947 F.2d 412, 415 (9th Cir. 1991) (statute requires only that hospital refrain from transferring patient until patient is stabilized); *Estate of Rivera* v. *Doctor Susoni Hospital, Inc.*, 288 F. Sup. 2d 161, 166 (D.P.R. 2003) (when hospital neither transferred nor discharged patient there can be no violation of statutory duty to provide treatment necessary to assure that no material deterioration would occur during transfer); *Torres Nieves* v. *Hospital Metropolitano*, 998 F. Sup. 127, 133 (D.P.R. 1998) (''[w]hile EMTALA imposes a duty to stabilize a patient, it does not impose a duty to fully cure an emergency condition before transferring or

discharging a patient'').

[20] As I have indicated, if a discharge is contemplated and follow-up care is required, § 1395dd requires only that the hospital stabilize the individual's condition to the extent that it will not materially deteriorate before follow-up care can be secured. See CMS Memorandum, supra, p. 37. It does not require the hospital to provide treatment necessary to assure that no material deterioration of the individual's condition will *ever* occur.

[21] The majority states that my ''extensive discussion'' of EMTALA ''does not provide any insight with respect to the kind of emergency medical conditions that Congress intended would be subject to the specific statute at issue, namely § 1396b (v)'' and that I ''[beg] the question'' when I conclude that *EMTALA* no longer applies after a patient has been admitted to the hospital. The flaw in this criticism is that it incorrectly assumes that I have not established as a preliminary matter that Congress enacted § 1396b (v) to advance the purposes of EMTALA; see 131 Cong. Rec., supra, 28,568; and that Congress intended the meaning of emergency medical condition as used in § 1396b (v) to be consistent with the meaning of the phrase as used in § 1395dd (e) (1). See 55 Fed. Reg., supra, 36,816. These conclusions require me to determine the meaning of the phrase as used in § 1395dd (e) (1), hence my ''extensive discussion'' of that statute. Because my analysis establishes beyond dispute that EMTALA does not apply after a patient has been admitted to the hospital, it necessarily follows that § 1396b (v) does not apply. I see nothing circular or elliptical about this reasoning.

[22] The legislative history also indicates that the exception authorizing testing and treatment of communicable diseases for illegal aliens; see 8 U.S.C. § 1621 (b) (3); was intended ''only [to] apply where absolutely necessary to prevent the spread of such diseases. This is only a stop-gap measure until the deportation of a person or persons unlawfully here. It is not intended to provide authority for continued treatment of such diseases for a long term.'' H.R. Conf. Rep. No. 104-725, 104th Cong., 2d Sess. 379–80 (1996), reprinted in 1996 U.S.C.C.A.N. 2649, 2767–68. This further supports the view that Congress did not intend to authorize full treatment of an emergency medical condition if such treatment is not necessary to safely discharge or transfer the patient.

[23] When the Department of Health and Human Services revised the definition of emergency services in 42 C.F.R. § 440.255 (c) (1), it stated that ''we believe the broad definition allows States to interpret and further define the services available to aliens covered by [§ 1396b (v) (2)] which are any services necessary to treat an emergency medical condition in a consistent and proper manner supported by professional medical judgement. Further, the significant variety of potential emergencies and the unique combination of physical conditions and the patient's response to treatment are so varied that it is neither practical nor possible to define with more precision all those conditions which will be considered emergency medical conditions.'' 55 Fed. Reg., supra, 36,816. In my view, this language merely recognizes that the definition of emergency medical condition is broad in the sense that it applies to a wide variety of conditions requiring stabilizing treatment. Clearly, it would be impossible to catalogue all such conditions. The definition is not broad, however, in the sense that it authorizes an expansive course of treatment for each such condition.

[24] I recognize that, even under my reading of § 1396b (v) (3), illegal aliens receive a benefit that uninsured citizens do not, namely, medical assistance payments for treatment of an emergency medical condition to the extent required to stabilize the patient for transfer or discharge. Uninsured citizens are assured of receiving such treatment under § 1395dd, but my research reveals no provision authorizing medical assistance payments for such treatment if the patient is not covered by medicaid. Under a broad reading of § 1396b (v) (3), however, an illegal alien would receive not only this narrow benefit, but would also receive treatment and reimbursement for conditions that, if suffered by an uninsured citizen, would not even entitle the citizen to treatment. For example, I am aware of no medicaid or medicare provision that even arguably would entitle an uninsured citizen to the treatment that the plaintiff in the present case received or to reimbursement for such treatment.

[25] See footnote 10 of this dissenting opinion.

[26] The court in *Scottsdale Healthcare, Inc.* v. *Arizona Health Care Cost Containment System Administration*, supra, 206 Ariz. 6 n.6, did recognize that the definition set forth in § 1395dd (e) (1) is identical to the definition in § 1396b (v) (3), but concluded that the stabilization requirement of § 1395dd (e) (1) was not a factor under § 1396b (v) (3). The court failed,

however, to examine the legislative history of the statutes and, therefore, failed to discover that § 1396b (v) (3) was enacted only months after the enactment of § 1395dd and that the definitions were intended to be consistent.

The majority states that it finds "persuasive the Arizona Supreme Court's explanation of the relationship between EMTALA and § 1396b (v)" in *Scottsdale Healthcare, Inc.* The majority does not deny, however, that the legislative history and genealogy of § 1396b (v) indicate that the statute was enacted in response to the enactment of § 1395dd and was intended to be consistent with § 1395dd. It states only that it is constrained from looking at that legislative background because the court in *Greenery Rehabilitation Group, Inc.* v. *Hammon*, supra, 150 F.3d 233, failed to do so.

[27] See also *Scottsdale Healthcare, Inc.* v. *Arizona Health Care Cost Containment System Administration*, supra, 206 Ariz. 8 (rejecting claim that stability is primary criterion of emergency medical condition under § 1396c [v]); id., 8 n.9 (term " 'immediate' " as used in statute "contemplates a range of time frames, as opposed to some fixed standard").

[28] I do not dispute that the expertise of health care providers has a role in determining whether an emergency medical condition exists. That expertise, however, cannot be exercised in a vacuum, but must be guided by the proper legal standard.

[29] The majority may respond that, for a condition to be acute, it must be sudden, severe *and* resolvable with a finite course of treatment. My point, however, is that the phrase "finite course of treatment"; *Luna* v. *Division of Social Services*, supra, 162 N.C. App. 11; is not susceptible to principled definition. In the case of a head injury, for example, any determination that treatment of the acute injury has terminated and treatment of the chronic condition has commenced necessarily will be arbitrary. The court in *Greenery Rehabilitation Group, Inc.* v. *Hammon*, supra, 150 F.3d 232, attempted to resolve this dilemma by suggesting that an emergency medical condition ends when the patient is "stabilized and the risk of further direct harm from [the] injuries [is] essentially eliminated." The court rejected the District Court's conclusion that the patients in that case were suffering from emergency medical conditions because "the absence of continuous medical attention could reasonably be expected to place their health in serious jeopardy." Id., 233. The Court of Appeals reasoned that, even if it could be established that the patients' health would be jeopardized by the absence of immediate medical attention, they were not suffering from emergency medical conditions because their medical conditions were not manifested by acute symptoms. Id. In my view, this reasoning is circular. The patients were receiving long-term medical treatment *because* the termination of the treatment would result immediately in acute symptoms which would then require emergency medical treatment. Thus, in the absence of the legislative evidence indicating that § 1396b (v) (3) was intended to be interpreted consistently with § 1395dd (e) (1), I would agree with the majority that the court in *Greenery Rehabilitation Group, Inc.*, improperly concluded that whether the patients had been stabilized was a dispositive factor in determining whether they suffered from emergency medical conditions.

[30] Thus, the majority does not follow its own holding that the "determination of the existence of an emergency medical condition should largely be informed by the expertise of health care providers . . . ." (Citation omitted; internal quotation marks omitted.) It points to no medical evidence on the question of whether a medical condition is acute or chronic when it is rapidly fatal if untreated and, if treated, long-term and incurable. This description appears to apply to the condition of the patients in *Greenery Rehabilitation Group, Inc.* v. *Hammon*, supra, 150 F.3d 233, which the court found to be chronic.

The majority states that "there is nothing in the statute or interpretive case law remotely suggesting that whether a treatment ultimately is successful renders the nature of the underlying condition any more or less emergent." My point, however, is not that the treatment must be ultimately successful. Indeed, under my interpretation, I do not believe that to be the case. Rather, my point is that, because the open-ended treatment of a patient's chronic condition can always be broken down arbitrarily into multiple finite courses of treatment, there is no principled way under the majority's interpretation to distinguish between a serious chronic condition and an emergency medical condition. The majority also states that its "focus on the compensability of the initial treatment rendered is the product of the limited scope of the plaintiff's claim . . . ." To the extent that the majority suggests that, under its interpretation, an *unlimited* claim probably would not be compensable,

I do not find that limitation on the scope of § 1396b (v) (3) to be particularly helpful. The majority simply has failed to articulate the principle that it believes limited the plaintiff's claim.

[31] The trial court found that the plaintiff was admitted to the hospital's emergency room. The portion of the hospital record cited by the court states, however, that the plaintiff ''was directly admitted to [Stamford Hospital] for continuous course of [chemotherapy].'' I have carefully reviewed the rest of the record and have discovered no evidence that the plaintiff was admitted to the emergency room. Even if he was, however, there is no evidence that he received stabilizing treatment there for the purpose of transferring him to another facility or discharging him.

I do not, as the majority states, suggest either that § 1396b (v) applies only to treatment provided in the emergency room or that all treatment provided in an emergency room is emergency medical treatment under the statute. Rather, as I have repeatedly stated, I would conclude that the statute applies to treatment provided for the purpose of stabilizing a patient's condition so that he may be safely transferred or discharged, regardless of where that treatment takes place. The majority finds this result ''beyond irrational, and clearly inconsistent with the letter and purpose of § 1396b (v).'' The ''letter'' of § 1396b (v) (3), however, is identical to the ''letter'' of § 1395dd (e) (1), which indisputably means what I have said it means. As to the ''purpose'' of § 1396b (v), I see nothing in the majority's opinion indicating what it believes that purpose is beyond authorizing payment for the treatment of an emergency medical condition. In contrast, my analysis shows that the underlying purpose of the statute was to advance the purposes of EMTALA. My interpretation of § 1396b (v) (3), unlike the majority's, accomplishes that purpose.