COURT OF APPEALS
DECISION
DATED AND FILED

October 27, 1998

Marilyn L. Graves
Clerk, Court of Appeals
of Wisconsin

No. 97-0466

STATE OF WISCONSIN **IN COURT OF APPEALS**
DISTRICT I

SHEMIKA A. BURKS, AND
PRIMECARE HEALTH PLAN, INC.,

PLAINTIFFS,

V.

ST. JOSEPH'S HOSPITAL,

DEFENDANT-APPELLANT,

WISCONSIN PATIENTS COMPENSATION FUND,

DEFENDANT-RESPONDENT.

APPEAL from a judgment of the circuit court for Milwaukee County: ARLENE D. CONNORS, Judge. *Reversed.*

Before Fine, Schudson and Curley, JJ.

SCHUDSON, J. St. Joseph's Hospital appeals from the trial court judgment dismissing the action of Shemika A. Burks and PrimeCare Health Plan,

Inc., against the Wisconsin Patients Compensation Fund (Fund). St. Joseph's argues that the trial court erred in concluding that the Fund was not required to provide excess coverage for damages resulting from its alleged refusal or failure to provide hospital care to an infant in violation of the federal Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd. We conclude, consistent with the statutory requirements of Chapter 655, STATS., as clarified by WIS. ADM. CODE § INS 17.35(2)(a), that the Fund is responsible for that portion of damages awarded on an EMTALA claim that exceeds a hospital's underlying insurance mandated by § 655.23, STATS. Accordingly, we reverse.

I. FACTUAL AND PROCEDURAL BACKGROUND

On April 1, 1993, Shemika A. Burks gave birth to a daughter at St. Joseph's Hospital. The child, born approximately four months prematurely, died a few hours after delivery without attempts at resuscitation and after Burks allegedly had requested and been denied medical attention for the infant. St. Joseph's maintained that resuscitation of infant Burks, who according to St. Joseph's Hospital medical records measured eleven inches long and weighed 200 grams at birth, would have been inappropriate.

Burks and her health insurer, PrimeCare Health Plan, Inc., sued St. Joseph's and the Fund, claiming that St. Joseph's personnel negligently "refused and failed to render any care or treatment to the infant, allowing her to die in her mother's arms several hours after her birth, despite her mother's repeated requests that something be done for her daughter," in violation of EMTALA. The Fund moved for partial summary judgment based on its assertion that it "does not provide coverage for damages awarded under" EMTALA. Following the

submission of briefs and a hearing, the trial court issued a written decision granting the Fund's motion.[1]

II. LEGAL BACKGROUND

To analyze the issues in this appeal, it will be helpful to understand the policy concerns leading to the enactment of the Wisconsin Patients Compensation Fund and the Emergency Medical Treatment and Active Labor Act. Regarding the Fund, the supreme court recently explained:

> The Fund was created by the legislature in 1975 in response to a perceived medical malpractice crisis. Concerned about what it viewed as the increasing cost and possible decreasing availability of health care in Wisconsin, the legislature promulgated a new system for processing medical malpractice claims.
>
> As part of this statutory scheme, the legislature established the Fund with the intention that it would finance a portion of the liability incurred by health care providers in medical malpractice actions. Health care providers are required to assume financial responsibility for a limited portion of any malpractice claim filed against them, either by purchasing liability insurance, self-insuring, or posting a cash or surety bond.
>
> Health care providers must also pay annual assessments to the Fund. From these assessments the Fund pays the portion of a successful claim against a health care provider in excess of either the amount of coverage mandated by the statute or the coverage which a provider actually carries, whichever is greater.

[1] Burks also brought claims for negligence and medical malpractice, but she subsequently stipulated to the dismissal of all but the EMTALA claim. She did not do so, however, until after the trial court had ruled on the Fund's motion to dismiss the EMTALA claim. (The Fund did not move for summary judgment on the other two claims, conceding its potential coverage for negligence and medical malpractice.) Thus, the trial court's grant of *partial* summary judgment to the Fund on the EMTALA claim had the ultimate effect of *full* summary judgment once the other claims were dismissed by stipulation.

Wisconsin Patients Compensation Fund v. Wisconsin Health Care Liab. Ins. Plan, 200 Wis.2d 599, 607, 547 N.W.2d 578, 580-81 (1996) (footnotes and statutory citations omitted). It is undisputed that St. Joseph's Hospital is a health care provider qualified to participate in the excess insurance program of the Fund.

Regarding EMTALA, the D.C. Circuit Court of Appeals explained:

> The Emergency Act was passed in 1986 amid growing concern over the availability of emergency health care services to the poor and uninsured. The statute was designed principally to address the problem of "patient dumping," whereby hospital emergency rooms deny uninsured patients the same treatment provided paying patients, either by refusing care outright or by transferring uninsured patients to other facilities. Reports of patient dumping rose in the 1980s, as hospitals, generally unencumbered by any state law duty to treat, faced new cost containment pressures combined with growing numbers of uninsured and underinsured patients.
>
> Congress responded with the Emergency Act, which imposes on Medicare-provider hospitals a duty to afford medical screening and stabilizing treatment to any patient who seeks care in a hospital emergency room.

Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1039-40 (D.C. Cir. 1991) (citations omitted). The court also summarized the EMTALA provisions relating to "stabilizing treatment" that are relevant to the instant case:

> Subsection 1395dd(b) dictates "necessary stabilizing treatment" for emergency conditions, as follows:
>
> > [i]f any individual (whether or not eligible for [Medicare] 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) [governing appropriate standards and procedures for transfer] ….

Id. at 1040 (parentheticals in 42 U.S.C. § 1395dd; internal bracketed words in ***Gatewood***; final bracketed words added). It is undisputed that Burks and her daughter presented "emergency medical condition[s]" and were entitled to the protection of EMTALA.[2]

III. DISCUSSION

Reviewing a trial court's judgment granting partial summary judgment, we, like the trial court, apply the standards set forth in § 802.08, STATS. *See* ***Wisconsin Patients Compensation Fund***, 200 Wis.2d at 606, 547 N.W.2d at 580. The issues in this appeal, involving the interpretation and application of certain provisions of the Wisconsin Patients Compensation Fund under Chapter 655, STATS., present questions of law which we review *de novo*. ***Id.***

A. St. Joseph's Arguments

St. Joseph's challenges the trial court's acceptance of the Fund's theory that § 655.27 (1), STATS., precludes Fund coverage for an EMTALA claim. Section 655.27 (1), STATS., in relevant part, provides:

> There is created a patients compensation fund for the purpose of paying that portion of a *medical malpractice*

[2] Subsection 1395dd(e)(1)(A) of the EMTALA 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 reasonably be expected to result in … placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy ….

> *claim* which is in excess of the limits expressed in s. 655.23 (4) [establishing the minimum amounts of primary health care liability insurance, self-insurance, or cash or surety bond required of health care providers for participation in the excess insurance program of the Fund] or the maximum liability limit for which the health care provider is insured, whichever limit is greater ….

(Emphasis added.) The Fund contended, and the trial court agreed, that an EMTALA claim is a strict liability claim, not a "medical malpractice claim." Thus, the fund asserts, an EMTALA violation would not constitute "medical malpractice" for which the Fund would provide excess coverage.

On appeal, St. Joseph's contends that the legislature "plainly intended" the Fund to provide insurance coverage for a claim that a hospital "failed to provide appropriate medical care to a patient … whether [such claims] arise out of … EMTALA or the Wisconsin common law." Further, St. Joseph argues:

> EMTALA claims are failure to treat cases. They all involve allegations of inadequate or inappropriate medical care against hospitals that pay assessments to the Fund with the reasonable expectation of coverage for such claims. In a failure to "stabilize" case like this one (as opposed to a failure to "examine" case), the plaintiff will have to prove that the hospital failed to provide such treatment as was "necessary to assure within a reasonable medical probability that no material deterioration of a condition [was] likely to result from or occur during transfer of an individual from a facility…." 42 U.S.C. § 1395dd(e) (3) (A). As in a typical medical malpractice case, the claimant will offer expert medical testimony to the effect that the hospital acted unreasonably under the circumstances and thereby caused injury to the patient, based on the nature of

> the patient's condition and the availability of treatment.[3] That is exactly the kind of testimony one finds in the typical Chapter 655 case. There may be no need to prove that a doctor was negligent under Wisconsin common law, but all of the other elements typically present in medical malpractice cases (the nature of the condition, the treatment options and the reasonable medical probability standard) will be present.

(Footnote added.)

While St. Joseph's acknowledges that Chapter 655 does not define "medical malpractice," it offers two alternative theories: (1) "medical malpractice" does encompass a failure to stabilize a patient under EMTALA because a reasonable person would readily conclude that such a failure is a liability against which a health care provider would expect coverage from the Fund; and (2) Chapter 655 also refers to coverage in more expansive terms encompassing conduct that would constitute an EMTALA violation – i.e., the statutes refer not only to "medical malpractice," but also to: "claims against health care providers that have complied with this chapter," *see* § 655.27(1), STATS.; "a claim for damages arising out of the rendering of medical care or services or participation in peer review activities," *see* § 655.27(5), STATS.; "acts or omissions of a health care provider," *see* § 655.017, STATS.; and "professional

[3] We detect at least some inconsistency in St. Joseph's arguments. At oral argument before this court, counsel for St. Joseph's acknowledged that on an EMTALA claim, as distinguished from negligence and medical malpractice claims, a plaintiff may at times prevail without any expert testimony or proof of an unreasonable medical judgment. We note, again, that in this case, the negligence and medical malpractice claims were dismissed, but the EMTALA claim, requiring a very different proof, survived. *See* ***Brooks v. Maryland Gen. Hosp., Inc.***, 996 F.2d 708, 710 (4th Cir. 1993) (EMTALA "was not designed to provide a federal remedy for misdiagnosis or general malpractice); ***Holcomb v. Monahan***, 807 F. Supp. 1526, 1530 (M.D. Ala. 1992) ("The federal cause of action is independent of and wholly separate from any state cause of action for breach of a standard of care."); ***Griffith v. Mt. Carmel Med. Ctr.***, 842 F. Supp. 1359, 1364-65 (D. Kan. 1994) (to prove EMTALA violation, plaintiff need not establish negligence because violation is "predicated on the hospital's violation of a federal statute making the hospital strictly liable for any 'personal harm' that 'directly results' from the violation").

services … that should have been rendered by a health care provider," *see* § 655.44(1), STATS.

Additionally, St. Joseph's points out that courts have interpreted 42 U.S.C. § 1395dd(3)(A), as incorporating state law limitations on medical malpractice recoveries. St. Joseph's cites ***Reid v. Indianapolis Osteopathic Medical Hospital, Inc.***, 709 F. Supp. 853 (S.D. Ind. 1989), in which the court declared:

> [W]hen Congress drafted section 1395dd(d)(3)(A), it was clearly aware of a growing concern in some states that excessive damage awards were fueling a medical malpractice "crisis." As a result, a number of such states had recently enacted ceilings on the amount of damages that could be recovered from medical personnel – ceilings that Congress apparently wished to preserve through the incorporation clause of section 1395dd(d)(3)(A).
>
> Furthermore, it is entirely reasonable to read the language of section 1395dd(d)(3)(A) as incorporating state law caps on medical malpractice damages: the federal statute states that individual plaintiffs can only "obtain those damages available for personal injury under the law of the state," and in those states … with restrictive medical malpractice statutes, the amount of damages that would be "available" for a personal injury claim against a health care provider would be only those damages available under that medical malpractice statute itself.

Id. at 855 (citation omitted). Thus, St. Joseph's concludes, "[b]ecause EMTALA is interpreted to incorporate state medical malpractice damage caps, the federal statute should also be interpreted to incorporate this state's requirement that there be Fund coverage for claims against health care providers who comply with Chapter 655."

B. The Fund's Response

The Fund asserts that, in enacting Chapter 655, "the Wisconsin legislature created an exclusive procedure for the state law tort claim of medical malpractice," and that an EMTALA violation simply is not medical malpractice. The Fund first relies on ***Rineck v. Johnson***, 155 Wis.2d 659, 456 N.W.2d 336 (1990), *overruled on other grounds by* ***Chang v. State Farm Mut. Auto. Ins. Co.***, 182 Wis.2d 549, 514 N.W.2d 399 (1994), in which the supreme court (1) confirmed that Chapter 655 "established an exclusive procedure for the prosecution of malpractice claims against a health care provider," and (2) clarified that Chapter 655 "sets tort claims produced by medical malpractice apart from other tort claims," ***id.*** at 665, 456 N.W.2d at 339.

The Fund further asserts that, according to ***Rineck***, "Chapter 655 incorporates by specific reference certain other statutes which the legislature intended to apply in medical malpractice actions," but did not intend "to incorporate without mention other miscellaneous general provisions," ***Rineck***, 155 Wis.2d at 666-67, 456 N.W.2d at 340. Therefore, the Fund maintains, because Chapter 655 makes no mention of EMTALA, and because an EMTALA claim is not a "medical malpractice" claim, Burks's EMTALA claim is not covered by the Fund. Thus, as counsel for the Fund emphasized at oral argument, this case reduces to a rather simple proposition: if the legislature had decided to incorporate EMTALA in Chapter 655, the Fund would provide excess coverage for Burks's claim; because the legislature did not incorporate EMTALA in Chapter 655, the Fund has no legal basis to provide excess coverage for Burks's EMTALA claim.

The Fund also counters St. Joseph's arguments that Chapter 655, in addition to referring to "medical malpractice claims" in § 655.27(1), STATS., provides several references to coverage in more expansive terms that would encompass an EMTALA violation. The Fund asserts: (1) the words, "claims against health care providers that have complied with this chapter," in § 655.27(1), STATS., refer back to the words, "medical malpractice" in the same section and, thus, are subsumed by the limitation to "medical malpractice claims"; (2) the words, "a claim for damages arising out of the rendering of medical care or services or participation in peer review activities," in § 655.27(5), STATS., also refer back to and are subsumed by the limitation to "medical malpractice claims" in § 655.27(1), STATS.; (3) the words, "acts or omissions of a health care provider," in § 655.017, STATS., can have no bearing on this case because that section was not in effect at the time Burks delivered her child at St. Joseph's, *see* 1995 Wis. Act 10 § 5, effective May 25, 1995; and (4) the words, "professional services … that should have been rendered by a health care provider," in § 655.44(1), STATS., can have no bearing because, in ***McEvoy v. Group Health Cooperative***, 213 Wis.2d 507, 570 N.W.2d 397 (1997), the supreme court could have applied that very provision to expand the scope of Chapter 655 beyond "medical malpractice," but did not.[4] Indeed, the Fund argues, ***McEvoy*** clarifies that "medical malpractice" does not encompass conduct such as patient dumping and, therefore, that ***McEvoy*** erases any lingering doubts about the issue in this appeal.

[4] While the supreme court did not explicitly examine the terms of § 655.44(1), STATS., it did consider the identical language found in § 655.445(1), STATS. *See* ***McEvoy v. Group Health Coop.***, 213 Wis.2d 507, 531 n.9, 570 N.W.2d 397, 407 n.9 (1997).

C. WIS. ADM. CODE § INS 17.35(2)(A)

Following oral argument, we asked the parties to submit supplemental briefs addressing the applicability of WIS. ADM. CODE § INS 17.35(2)(a), which provides:

> **Ins 17.35 Primary coverage; requirements; permissible exclusions; deductibles. (1)** PURPOSE. This section implements ss. 631.20 and 655.24, Stats., relating to the approval of policy forms for health care liability insurance subject to s. 655.23, Stats.
>
> **(2)** REQUIRED COVERAGE. To qualify for approval under s. 631.20, Stats., a policy shall at a minimum provide all of the following:
>
> (a) Coverage for providing or *failing to provide health care services to a patient*.

(Emphasis added.)

St. Joseph's argues that, by requiring it to provide primary insurance coverage for "failing to provide health care services to a patient" in order to gain excess coverage under the Fund, and by assuring it that the Fund would provide coverage "for claims against health care providers that have complied" with these and other requirements, *see* § 655.27(1), STATS., "the legislature intended – and St. Joseph's expected – that the Fund would cover that portion of a claim in excess of the state-mandated minimum primary coverage." Thus, St. Joseph's maintains, the "promise of excess coverage by the Fund proves illusory when a claim for 'failing to provide health care services' is covered by the state-prescribed primary policy, but is *not* covered by the Fund." Therefore, St. Joseph's contends:

> The Fund disingenuously submits that the only question this court need answer is whether an EMTALA claim qualifies as "medical malpractice", as that phrase is used in Wis. Stat. § 655.27(1). In truth, the only way this coverage dispute can sensibly be resolved is to consider Chapter 655 and its accompanying regulations in their entirety. Then

> and only then can this court determine the legislature's intent when it defined the scope of the Fund's coverage obligations. We submit that the Fund was created to serve as an excess insurer for claims covered under primary policies issued to health care providers acting in compliance with the directives of Chapter 655. To hold otherwise is to acknowledge that the Fund's coverage is narrower than the primary insurance health care providers are required to purchase in order to qualify for the purported privilege of paying Fund assessments and receiving excess coverage.

The Fund responds that by its very terms, WIS. ADM. CODE § INS 17.35(2)(a) "relat[es] to the approval of policy forms for health care liability insurance subject to s. 655.23, Stats.," which, in turn, relates to liability "for malpractice."[5] Therefore, the Fund contends, "the regulation only applies to malpractice claims," thus returning the analysis to the singular issue of whether an EMTALA violation is "medical malpractice." And this analysis, the Fund maintains, must return to ***McEvoy*** and its clarification of what does, and does not, constitute "medical malpractice."

We conclude that St. Joseph's is correct. In addition to financial penalties imposed on hospitals that violate its prohibition of patient dumping, *see* 42 U.S.C. § 1395dd(d)(1), EMTALA also permits those injured by the violation to seek tort-relief:

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[5] Section 655.23(5), STATS., provides:

> While health care liability insurance, self-insurance or a cash or surety bond under sub. (3) (d) remains in force, the health care provider, the health care provider's estate and those conducting the health care provider's business, including the health care provider's health care liability insurance carrier, are *liable for malpractice* for no more than the limits expressed in sub. (4) or the maximum liability limit for which the health care provider is insured, whichever is higher, if the health care provider has met the requirements of this chapter.

(Emphasis added.)

> Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

42 U.S.C. § 1395dd(d)(2)(A). Thus, simply stated, the only issue presented by this appeal is whether the Fund is responsible for that portion of damages awarded under EMTALA that exceeds the hospital's underlying insurance mandated by § 655.23, STATS.

Section 655.23(3)(a), STATS., requires health-care providers who do not opt and qualify for self-insurance to "insure and keep insured the health care provider's liability by a policy of health care liability insurance issued by an insurer authorized to do business in this state." The limits of this required insurance are set out in § 655.23(4), STATS. The Fund is liable for "that portion of a medical malpractice claim" that exceeds these limits "or the maximum liability limit for which the health care provider is insured, whichever limit is greater." Section 655.27(1), STATS.

The Fund must "provide occurrence coverage for claims against health care providers that have complied with" Chapter 655. Section 655.27(1), STATS. One of Chapter 655's requirements is that the health-care provider either be an approved self-insurer under § 655.23, or get insurance that complies with that section. Section 655.23(7), STATS.

All forms for insurance coverage under § 655.23, STATS., must be approved by the Commissioner of Insurance. Section 631.20(1), STATS. In order to get approval for these forms, the insurer must "certif[y] that the form complies with chs. 600 to 655 and rules promulgated under chs. 600 to 655." Section 631.20(1), STATS. Under WIS. ADM. CODE § INS 17.35(2)(a), which is a rule

promulgated under Chapter 655, an insurer seeking to qualify under Chapter 655 must provide, among other things, "[c]overage for providing or failing to provide health care services to a patient." Thus, insurance required before a health-care provider is entitled to excess-coverage by the Fund must provide coverage for the very liability that is consequential to a violation of the Emergency Medical Treatment and Active Labor Act.

We must give WIS. ADM. CODE § INS 17.35(2)(a) great weight in interpreting what is a Chapter 655 "medical malpractice claim." *See* 2B NORMAN J. SINGER, SUTHERLAND STATUTORY CONSTRUCTION § 49.05 (5th ed. 1992) (regulations enacted and applied by administrative agencies charged with the duty of administering and enforcing a statute have great weight in determining the operation of the statute); *cf.* ***Fulman v. United States***, 434 U.S. 528, 533 (1978) (regulations contemporaneously construing statute "must be sustained unless unreasonable and plainly inconsistent" with the statute); ***State ex rel. Parker v. Sullivan***, 184 Wis.2d 668, 699, 517 N.W.2d 449, 460 (1994) ("In addition to examining legislative history to determine legislative intent, a court looks to the interpretation of the statute by the administrative agency charged with its enforcement."). Moreover, for Chapter 655 to make sense consistent with its purpose – to provide excess coverage to health-care providers that obtain the requisite underlying insurance, and thus to protect those providers from catastrophic uninsured liability – it must also require the Fund to provide excess coverage coterminous with the required underlying insurance. *See* ***Wisconsin Patients Compensation Fund v. St. Paul Fire and Marine Ins. Co.***, 116 Wis.2d 537, 544, 342 N.W.2d 693, 696 (1984) (Chapter 655 designed to limit health-care providers' liability); Laws of 1975, ch. 37, § 1 (Chapter 655 enacted to decrease costs of professional-liability insurance and costs of health care). Thus, § INS

17.35(2)(a) must be read to require Chapter 655 coverage for "failing to provide health care services to a patient" – exactly what is alleged in an EMTALA claim.

In support of its conclusion that the phrase "medical malpractice claim" does not encompass a failure to provide medical services, the Fund borrows a definition of "medical malpractice claim" from ***McEvoy***, which concluded "that ch. 655 applies only to negligent medical acts or decisions made in the course of rendering professional medical care." ***McEvoy***, 213 Wis.2d at 530, 570 N.W.2d at 406. ***McEvoy***, however, is distinguishable.

Putting aside the significant question of whether turning away someone who needs emergency medical treatment is a "medical act[] or decision[]," which ***McEvoy*** did not decide, ***McEvoy*** holds that when a health maintenance organization acts as an insurer, it is subject to the tort of bad faith, and is not immune from bad-faith liability merely because it also is a health-care provider. ***Id.*** at 528–531, 570 N.W.2d at 405–407 ("To hold otherwise would exceed the bounds of the chapter and would grant seeming immunity from non-ch. 655 suits to those with a medical degree." ***Id.*** at 530, 570 N.W.2d at 406). Unlike the situation in ***McEvoy***, Burks's claim, as clarified by WIS. ADM. CODE § INS 17.35(2)(a), is *not* a "non-ch. 655" lawsuit.[6]

[6] St. Joseph's also argues that the trial court erred in concluding that its liability was not capped at $400,000, as it would have been had the Fund been responsible for excess coverage. The trial court rejected St. Joseph's argument that, if the Fund provided no coverage, St. Joseph's should not be liable for any damages in excess of the $400,000 limit of its primary insurance policy – a policy purchased with what St. Joseph's contends was the reasonable expectation that the Fund would provide excess coverage for a failure to provide services.

We do not address this issue because, based on the oral argument in this court and the correspondence that followed, we understand that neither St. Joseph's nor the Fund disputes Ms. Burks's counsel's representation that, consistent with the Notice of Appeal, the second issue is not properly before this court at this time.

By the Court.—Judgment reversed.

Recommended for publication in the official reports.

No. 97-0466(CD)

SCHUDSON, J. *(concurring in part; dissenting in part).* In ***McEvoy v. Group Health Cooperative***, 213 Wis.2d 507, 570 N.W.2d 397 (1997), the supreme court considered, *inter alia*, whether the Fund was required to provide a health maintenance organization (HMO) with excess coverage under Chapter 655 for a tort claim alleging a bad faith denial of HMO coverage. Concluding that Chapter 655 did not allow for excess coverage for such a claim, the court distinguished medical malpractice from an HMO denial of coverage for medical services. The court explained:

> [A]n examination of the language of chapter 655 reveals that *the legislature did not intend to go beyond regulating claims for medical malpractice.* Wis. Stat. § 655.007 provides:
>
> > On and after July 24, 1975, any patient or the patient's representative having a claim or any spouse, parent or child of the patient having a derivative claim for injury or death *on account of malpractice* is subject to this chapter. (Emphasis added.)
>
> Wis. Stat. § 655.009 states:
>
> > An action to recover damages *on account of malpractice* shall comply with the following…. (Emphasis added.)
>
> Wis. Stat. § 655.23(5) specifies:
>
> > [T]he health care provider … [is] liable for *malpractice*…. (Emphasis added.)
>
> Wis. Stat. § 655.27 states:
>
> > There is created a patients compensation fund for the purpose of paying that portion *of a medical malpractice claim* which is in excess of the limits expressed in s. 655.23(4)…. (Emphasis added.)

> Thus, the language of ch. 655 consistently expresses the legislative intent that *the chapter applies only to medical malpractice claims. While "malpractice" is not defined within the statute, the term is traditionally defined as "professional misconduct or unreasonable lack of skill," or "[f]ailure of one rendering professional services to exercise that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession." See* Black's Law Dictionary 959 (6th ed. 1990).[7]
>
> *We conclude that ch. 655 applies only to negligent medical acts or decisions made in the course of rendering professional medical care. To hold otherwise would exceed the bounds of the chapter and would grant seeming immunity from non-ch. 655 suits to those with a medical degree*. Thus, while certain HMOs may properly be sued for medical malpractice under ch. 655, *claims not based on malpractice, such as a bad faith tort action, survive application of that chapter.*
>
> *The defendant contends that the [plaintiffs'] allegations based on [the HMO medical director's] decision to deny further coverage for [the HMO member's] treatment at [the HMO-referred facility] are really claims for medical malpractice. If this assertion is accurate, ch. 655 controls this case and we need not proceed further in our analysis.… However,…this opinion applies the bad faith cause of action to out-of-network coverage decisions by HMOs. Because such actions are based on a "breach of duty imposed as a consequence of the relationship established by contract," and not on an improper medical action or decision resulting from negligence, the causes of action are distinct.*

[7] The supreme court's reference to the Black's definition is puzzling, given that Wisconsin renounced the locality rule in 1973. *See* ***Shier v. Freedman***, 58 Wis.2d 269, 283-84, 206 N.W.2d 166, 173-74 (1973); *see also* ***Nowatske v. Osterloh***, 198 Wis.2d 419, 438-39, 543 N.W.2d 265, 272 (1996) (standard of care "must be established by a determination of what it is reasonable to expect of a professional given the state of medical knowledge at the time of the treatment"); and WIS J I—CIVIL 1023. This distinction, however, does not relate to the portion of the Black's definition that is most critical to the issue in this appeal: whether medical malpractice, the "failure of one *rendering* professional services," encompasses the failure of one *to render* services at all.

Id. at 529-31, 570 N.W.2d at 406-07 (citation omitted; footnotes omitted; emphasis in block-quoted portions of statutes in ***McEvoy***; all other emphasis added; footnote added).

Here, similarly, the EMTALA claim alleges not "an improper medical action or decision resulting from negligence," but rather, a "breach of duty" imposed by statute. Indeed, as counsel for St. Joseph's conceded at oral argument, the EMTALA claim in Burks's complaint contained *no allegation of any medical decision* by anyone at St. Joseph's. Thus, as counsel for the Fund argued here, this case presents a critical distinction – between *medical treatment,* which is covered under Chapter 655, and a *non-medical decision to prevent treatment,* which is not.

At oral argument, counsel for St. Joseph's attempted to distinguish ***McEvoy*** from the instant case. He argued that the denial of treatment in ***McEvoy*** was an administrative decision, based on HMO policy, at least one full step removed from the patient's treatment. By contrast, he contended, the denial of treatment to Ms. Burks and her child were in the course of treatment by medical personnel. Thus, he maintained, the claim in ***McEvoy*** was for a bad-faith, insurance coverage denial, whereas the claim in the instant case is for medical malpractice.

Although the distinction is intriguing, it is insignificant in comparison to the similarities between the two cases. In ***McEvoy***, the thirteen-year-old patient was receiving treatment for anorexia nervosa, and her HMO was covering her medical treatment including the treatment at an eating disorder program provided by the University of Minnesota Hospital. *See* ***McEvoy***, 213 N.W.2d at 514, 570 N.W.2d at 400. The HMO's medical director approved

payment for the university program, based on the request of the patient's primary care physician. *See* ***id.*** After approving six weeks of treatment in the program, however, the medical director, who was responsible for both the HMO's "cost containment programs and medical management," discontinued coverage contrary to the recommendations of the patient's physician and psychiatrist, and despite the fact that four weeks of inpatient psychological treatment benefits remained under the HMO contract. ***Id.*** at 514-15, 570 N.W.2d at 400.

Thus, in ***McEvoy***, as alleged in the instant case, a patient *was* receiving treatment but, in the course of treatment, was denied further services. In both cases, the patients alleged not a failure of medical judgment, but rather, a non-medical judgment that prevented the very consideration of the medical merits. Whether such a non-medical judgment comes from a doctor on the front line, or from a medical director at a desk somewhere behind the battle, is immaterial. To conclude otherwise would be to provide fiscal insulation for health providers that dump patients, as long as their front-line personnel do the dumping. EMTALA was "designed … to address the problem of 'patient dumping,'" ***Gatewood***, 933 F.2d at 1039, and I read nothing in either EMTALA or Chapter 655 to excuse dumping according to the source of a dumping decision.

I recognize that, depending on the circumstances of each case, the line between the *rendering* of medical services and the decision to *not render* medical services may be an extremely fine one. Further, I appreciate the logic of St. Joseph's arguments regarding "services … that should have been rendered," under § 655.44(1) STATS., and "failing to provide health care services," under WIS. ADM. CODE § INS 17.35(2)(a). In a very close call, however, I accept the Fund's reading of § INS 17.35(2)(a), which, as summarized in the majority opinion, "return[s] the analysis to the singular issue of whether an EMTALA

violation is 'medical malpractice.'" Majority slip op. at 12.[8] I conclude, therefore, that, under the strictly limited definition of "medical malpractice" clarified in ***McEvoy***, Chapter 655 does not provide excess coverage to an insurer for an EMTALA claim.

Chapter 655 "applies only to negligent medical acts or decisions made in the course of rendering professional medical care." ***McEvoy***, 213 Wis.2d at 530, 570 N.W.2d at 406. A non-medical decision effectively precluding the rendering of professional medical care or, as in both ***McEvoy*** and as alleged in the instant case, a non-medical decision interrupting care and effectively precluding the rendering of further treatment – simply is not a "negligent *medical* act[] or decision[] made in the course of rendering professional medical care."

Therefore, although, needless to say, Judge Curley, Judge Fine, and I agree on most of what is expressed in the majority opinion, I slightly and respectfully depart from their view of ***McEvoy*** and § INS 17.35(2)(a). Thus, I conclude that Chapter 655 does not cover an EMTALA claim and, accordingly, I would affirm.

[8] I do not deny the logic of St. Joseph's interpretation of WIS. ADM. CODE § INS 17.35(2)(a), and, in the majority opinion, I have attempted to give St. Joseph's argument full force. I would point out, however, that the Fund's argument also is logical. The Fund urges a literal reading – that § INS 17.35(2)(a) "relate[s]" to nothing more than "the approval of policy forms," *see* § INS 17.35, and addresses nothing more than what a provider's "policy shall at a minimum provide," *see* § INS 17.35(2)(a), in order for the provider to participate in the Fund. Such a literal reading is logical and, indeed, unremarkable, implying nothing more than the proposition that, in enacting § INS 17.35, those administering and enforcing Chapter 655 concluded that, in order to participate in Fund coverage, a provider would have to have its own coverage for "failing to provide health care services to a patient." *See* § INS 17.35(2)(a).