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ARTICLE

WHO CARES?: THE EVOLUTION OF THE LEGAL DUTY TO PROVIDE EMERGENCY CARE

*Karen H. Rothenberg**

INTRODUCTION

The refusal to treat those in need of emergency care remains a fact of life in this country.¹ The following two reports are recent examples of a problem that will not go away:

Terry Takewell was a young diabetic. Gasping for breath, he was taken by ambulance to the only local hospital in Fayette County, Tennessee. Takewell was not treated, but instead was carried out the door by a hospital administrator and set on the edge of the parking lot. He was picked up by neighbors and brought home. He died the next day. Terry had no insurance and owed the hospital a lot of money.²

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1. This Article will primarily focus on the evolution of the legal duty to provide access into the emergency room and not on the inappropriate transfer of patients, commonly referred to as "dumping," from private to public hospitals. This distinction should be clear throughout the discussion of the common law. Refer to Sections I, II & III *infra*. The evolution of legislative efforts, however, does not make such a clear distinction. Some recent state and federal legislation is comprehensive in scope and addresses both the duty to examine those who present themselves at emergency rooms, as well as the inappropriate transfer of these patients. Refer to Sections IV A & V *infra*.

2. See *Equal Access to Health Care: Patient Dumping: Hearing Before the Subcommittee on Human Resources & Intergovernmental Relations of the House Committee on Government Operations*, 100th Cong., 1st Sess. 14-20 (1987) [hereinafter *Equal Access*] (statement of Zettie Mae Hill).

"Jane Doe" was six and a half months pregnant. She went to the local hospital in Fredricksburg, Virginia, bleeding heavily and in severe pain. The hospital nurse told her nothing could be done for her because she did not have a private doctor on staff. She was instructed, after a few hours elapsed, to go to University Hospital — a two hour drive away. When she finally reached University Hospital, the doctor could not prevent the delivery of a premature baby. The baby died soon after birth.³

These cases should never have happened. The hospitals were breaking the law. In 1986, Congress passed comprehensive legislation, commonly referred to as "COBRA,"⁴ requiring hospitals receiving Medicare to examine all persons who present themselves for care in the emergency room.⁵ Those patients in an emergency condition or in active labor must be provided treatment until they are stabilized. Tough enforcement provisions include termination or suspension of the Medicare provider's agreement and civil penalties. Perhaps most significantly, the statute provides for a private right of action in which any individual harmed by a hospital's violation of the statute may obtain damages and equitable relief.⁶

One can only appreciate the potential of such legislative action by understanding the legal responses, reactions, and frustrations of the past. Toward that goal, this Article will analyze the evolution of the legal duty to provide emergency care.

The first section examines the major legal factors that contributed to the delay in creating a duty to treat. Nineteenth century tort theory established a distinction between misfeasance and non-feasance. Thus, even in an emergency, there was no legal duty for any person, including a physician, to rescue or care for a person.⁷

3. *Equal Access*, *supra* note 2, at 43 (statement of Judith Waxman, Managing Attorney, National Health Law Program).

4. The Medicare amendments were incorporated as a part of a major spending bill, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. Refer to note 291 *infra* and accompanying text.

5. Virtually all hospitals receive Medicare reimbursement. This legislation went into effect on August 1, 1986 and is codified at 42 U.S.C. § 1395dd (Supp. IV 1986).

6. Refer to Section V *infra*.

7. Refer to Section IA *infra*. Physicians have no *legal* duty to treat anyone who desires medical treatment. Courts will not find a duty to treat on the part of a physician unless there has been an implied or expressed consensual agreement creating a physician-patient relationship. *See, e.g.,* Childs v. Weis, 440 S.W.2d 104, 107 (Tex. Civ. App.—Dallas 1969, no writ). There may be, however, an *ethical* duty. The American Medical Association Principles of Medical Ethics provides: "[a] physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve . . ." AMERICAN MED. ASS'N, PRINCIPLES OF MEDICAL ETHICS VI (1980), reprinted in BEAUCHAMP & CHILDRESS, PRINCIPLES

Theoretically, the same rule applied to the hospital.⁸ Any attempt to challenge this legal theory as applied to the hospital was delayed for at least half a century by the shield of charitable immunity. To a large extent, charitable immunity, retarded the creation of a duty by protecting the hospitals from suit. A challenge to the no-duty rule posed a concurrent, undesired challenge to charitable immunity. Furthermore, what little case law existed on the issue of a duty to treat was often misinterpreted.

Section II analyzes the search for a legal duty, which began in the early 1960s and failed to find a common-law stronghold. This

OF BIOMEDICAL ETHICS 331-32 (1983) [hereinafter AMA].

8. Limitations inherent in the traditional hospital structure may have created a further barrier to imposing clearly delineated duties to provide emergency care. At least three different hospital-physician relationship models exist in the emergency room. First, the emergency room physicians may be hospital employees. These physicians may work in the emergency room as part of a series of rotations through different departments or may work exclusively there, but in either case they are reimbursed through a salary which is paid by the hospital. Second, the physicians may be private physicians with hospital privileges who rotate through the emergency room as "on-call" physicians. Reimbursement in this situation generally comes directly from the patient. Finally, the physicians may be part of a group that has contracted with the hospital to perform emergency services. Reimbursement is generally from the hospital under the terms of the contract, but the physicians are considered independent contractors and not employees. This group does not normally have admitting privileges.

Since *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957), courts have found little difficulty in holding hospitals liable for the negligence of employee-physicians under the doctrine of *respondeat superior*. Generally, if the hospital exerts significant control over the physician, the hospital may be held vicariously liable for any negligence.

The second and third types of relationships have posed greater problems. Because physicians in these situations are not considered employees, the doctrine of *respondeat superior* does not apply. In utilizing one of these arrangements, the hospital may avoid liability for the negligence of emergency room physicians.

The courts, however, soon recognized the unfairness of allowing hospitals to "contract away" their liability, and found ways to circumvent these situations using the doctrines of ostensible or apparent agency and corporate negligence. For a more detailed discussion, see Comment, *Medical Malpractice by Emergency Physicians and Potential Hospital Liability*, 75 Ky. L.J. 633, 638-41 (1987). See also *Mehlman v. Powell*, 281 Md. 269, 378 A.2d 1121, 1124 (1977) (apparent agency; absent notice to the contrary, a hospital represents that the staff of its emergency room are its employees); *Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253, 260-61 (1965), *cert. denied*, 383 U.S. 946 (1966) (corporate negligence; hospital may be held liable for the negligence of a private physician in failing to review and monitor treatment and in failing to enforce its own medical staff bylaws).

Another problem in this area involves the role of the "on-call" specialist who serves the emergency room. Necessity often dictates that in an emergency the emergency room physician call in a neurosurgeon, orthopedic surgeon, plastic surgeon, or in the case of active labor, an obstetrician. If these physicians refuse to treat, how can one hold the hospital liable? Unless these specialists are employees, which is most unusual, difficulty arises under current doctrines in holding the hospital liable under common law. Refer to Section V *infra*.

section includes an in-depth review of *Wilmington General Hospital v. Manlove*⁹ and its progeny—or lack thereof. Many commentators predicted over twenty-five years ago that after *Manlove*, the legal solution to the problem was found.¹⁰ *Manlove* established that when a hospital customarily renders emergency care service, and such undertaking is relied on by a person in need of emergency care, the hospital has a *duty* to provide service to such person. Contrary to popular belief, this reliance theory failed to provide the solution. The applications of, limitations of, and accommodations to the *Manlove* reliance theory will be examined.

Section III analyzes the common-law search for an alternative to the *Manlove* theory. In 1975, in *Guerrero v. Copper Queen Hospital*,¹¹ the Arizona Supreme Court created a duty based on a public policy theory, requiring hospitals to provide emergency care.¹² The theory was quite innovative, but not widely adopted outside the state.

Given that the common law, at best, has met with only limited success in assuring that emergency care is provided, Section IV briefly examines state legislation and past federal initiatives. With few exceptions, state laws and federal Hill-Burton Act¹³ obligations have had a limited impact on creating a statutory duty to provide emergency services.

COBRA has perhaps the greatest potential for enforcing a legal duty to provide nationwide emergency care. Yet certain ambiguities remain that may undercut its impact. Section V analyzes COBRA in detail and suggests ways to strengthen its effect. Particular attention is focused on the civil enforcement provision which provides, in part, for a private right of action for any individual harmed by a hospital's violation. This provision symbolizes the present endpoint to the evolution of the legal duty to provide emergency care. The evolution, however, will continue as the courts begin to interpret the new federal law. How the courts define the scope of the law and enforce the remedies available may ultimately determine whether the legal solution to the problem of access to emergency care has been found.¹⁴

9. 54 Del. 15, 174 A.2d 135 (1961).

10. Refer to Section II *infra*.

11. 112 Ariz. 104, 537 P.2d 1329 (1975)(en banc).

12. 537 P.2d at 1331.

13. 42 U.S.C. § 291c (1982). Refer to Section IVB *infra*.

14. Although beyond the scope of this Article, it is obvious that any legal solution is

I. WHY NO DUTY?

A. *The No-Duty Rule*

During the nineteenth century, neither the hospital nor the physician had a duty to help those in need of emergency care, even if the help was readily available. Although injury, mental anguish, pain and death might result, the traditional common law provided no remedy; at least, that was the perception.

Tort theory embraced the distinction between nonfeasance and misfeasance.¹⁵ Essentially, the no-duty rule provides that no tort liability is imposed for nonfeasance, or failing to aid one in peril. Liability attaches only when one is guilty of misfeasance, or active misconduct that injures another. There exist several narrow classes of exceptions to this rule, but none is traditionally applied to hospitals.¹⁶

The misfeasance-nonfeasance dichotomy theoretically results in no legal obligation to treat an injured, sick, or dying person appearing at an emergency room door.¹⁷ If treatment is initiated, however, the hospital and its staff have a duty to act with reasonable care under the circumstances and will be liable for harm caused by a breach of that duty.¹⁸ This breach is misfeasance.

As a result, tort law was perceived to provide no legal incentive to treat. To the contrary, the hospital was better off, from a liability standpoint, if it refused to treat at all. Of course, this perception was merely theoretical because, for a number of reasons, hospitals generally did not get sued.

compounded by the economic burden of providing this care to many without insurance—and without a mechanism for reimbursing hospitals for these expenses.

15. W. KEETON, D. DOBBS, R. KEETON & D. OWEN, *PROSSER AND KEETON ON TORTS* § 56 (5th ed. 1984) [hereinafter *PROSSER & KEETON*].

16. The list of exceptions includes public carriers, innkeepers, and employers. *Id.*

17. Although not *legally* binding, the Joint Commission on Accreditation of Hospitals, a *voluntary* accreditation agency, has issued policy statements which provide that “[a]ny individual who comes to the hospital for emergency medical evaluation or initial treatment shall be properly assessed by qualified individuals, and appropriate services shall be rendered within the defined capability of the hospital.” *JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS* 17 (1985). The agency further requires that “[i]ndividuals shall be accorded impartial access to treatment or accommodations that are available or medically indicated, regardless of race, creed, sex, national origin, or sources of payment for care.” *Id.* at ix.

18. *RESTATEMENT (SECOND) OF TORTS* § 323 (1965).

B. Charitable Immunity

Historically, most hospitals were run as charitable or public institutions,¹⁹ and consequently were protected by charitable or sovereign immunity. Courts could not hold a hospital liable, without dismantling established immunity protections. The duty to treat was rarely mentioned until the 1960s, when a number of factors, including the increasing abrogation of charitable immunity, cleared the way for suits against hospitals. Therefore, the imposition of any duty to treat in an emergency was at least delayed by the shield of immunity.²⁰

In 1876, one of the first cases to mention, in dictum, that there was no right to demand medical care, also recognized the charitable immunity doctrine in the United States for the first time.²¹ In

19. For an outstanding discussion of the evolution of hospitals and their changing role over the last two centuries in the United States see C. ROSENBERG, *THE CARE OF STRANGERS: THE RISE OF AMERICA'S HOSPITAL SYSTEM* (1987).

20. The significance of sovereign or governmental immunity, as applied to public hospitals, continues to be modified to a large degree by state tort claims acts. The rule of governmental or sovereign immunity and its effect have been largely state-specific; however, the general rule is that a government cannot be sued without its consent. The rule stems from the legal fiction, which grew up in Europe, that "the King can do no wrong," based, in part, on the idea that a claim cannot be enforced against the authority that created the claim. The impact of governmental immunity has been uneven, depending not only on the presence or absence of statutory authorization allowing suits against the government, but also on court distinctions between governmental and proprietary activities.

In the context of a hospital, courts impose liability for proprietary activities, but governmental functions remain protected by immunity, barring a statute to the contrary. The courts, however, have not been consistent in their distinctions between governmental and proprietary functions. For example, some courts have decided that if a hospital is operated by a governmental agency or unit, and takes at least some nonpaying patients, its activities are governmental. Others have held that charging patients is evidence of a proprietary function and have disallowed immunity, at least as to a paying patient. See generally Annotation, *Immunity from Liability for Damages in Tort of State or Governmental Unit or Agency in Operating Hospital*, 25 A.L.R.2d 203 (1952); 5 F. HARPER, F. JAMES & O. GRAY, *THE LAW OF TORTS* §§ 29.1-29.15A (2d ed. 1986) [hereinafter GRAY].

Furthermore, it is the public hospital that accepts the heavy, ever-increasing burden of treating emergencies for those without insurance. Not-for-profit hospitals, which traditionally served almost two-thirds of the poor population, face changes in hospital funding that do not allow for cross-subsidizing the care of the uninsured. With recent competitive pressures to reduce costs, many of these supposedly charitable institutions are shifting their indigent emergency patients to the already overcrowded and underfunded public hospitals. See *Equal Access*, *supra* note 2, at 105 (statement of Arnold Relman, M.D., Editor, *NEW ENGLAND JOURNAL OF MEDICINE*). The focus of this Article will be on the nonprofit, private hospital and the significance of charitable immunity as borne out in the history of the cases.

21. *McDonald v. Massachusetts Gen. Hosp.*, 120 Mass. 432 (1876). The court therein noted, in discussing the character of a charitable hospital, that the trustees were responsible for determining those "who are to be the immediate objects of the charity, and that no

McDonald v. Massachusetts General Hospital,²² the plaintiff brought an action against the hospital, alleging that his leg had been negligently set by an intern.²³ The court, relying on an 1861 English case, denied recovery based on a charitable immunity doctrine.²⁴ The court reasoned, under the "trust fund theory," that the hospital, as a public charity, could not use donated funds to pay tort damages.²⁵ What apparently was unknown to the *McDonald* court, however, was that the English decision on which it relied had been overruled some ten years earlier.²⁶

Nevertheless, charitable immunity took a strong hold in America. By 1938, more than forty state courts had adopted the doctrine.²⁷ Charitable immunity is an *exception* to the general rule that one is liable for one's own negligence, and several theories have been used to justify the doctrine.²⁸ The four major theories are: (1) the "trust fund" theory; (2) the inapplicability of respon-

person has individually a right to demand admission to its benefits" *Id.* at 435.

22. 120 Mass. 432 (1876).

23. *Id.*

24. *Id.* at 436 (citing *Holliday v. St. Leonard's*, 142 Eng. Rep. 769 (1861)).

25. The court stated:

[The hospital] has offered to [plaintiff] freely those ministrations which, as the dispenser of a public charity, it has been able to provide for his comfort It has no funds which can be charged with any judgment which he might recover, except those which are held subject to the trust of maintaining the hospital. [I]f there has been no neglect on the part of those who administer the trust and control its management, and if due care has been used by them in the selection of their inferior agents, even if injury has occurred by the negligence of such agents, it cannot be made responsible.

Id.

26. See *Mersey Docks Trustees v. Gibbs*, 11 Eng. Rep. 1500, 1501 (1866) (overruling *Holliday* in principle before it was later overruled by name in *Foreman v. Mayor of Canterbury*, L.R. 6 Q.B. 214, 218 (1871)). The court in *President of Georgetown College v. Hughes*, 130 F.2d 810 (D.C. Cir. 1942) noted:

In this state of the English decisions, Massachusetts adopted the repudiated rule of *Holliday v. St. Leonard* in *McDonald v. Massachusetts General Hospital*, . . . and Maryland followed [the overruled case of *Feoffees of Heriot's Hospital v. Ross*, 8 Eng. Rep. 1508 (1846)] in *Perry v. House of Refuge*, 1885, 63 Md. 20, 52 Am. Rep. 495. Apparently both courts acted in ignorance of the English reversal. In any event, they resurrected in America a rule already dead in England, and thereby gave Lord Cottenham's dictum [in *Heriot's Hospital*] a new lease on life in the New World.

130 F.2d at 816.

27. Note, *The Quality of Mercy: "Charitable Torts" and Their Continuing Immunity*, 100 HARV. L. REV. 1382, 1384 (1987) [hereinafter *Charitable Torts*].

28. For an excellent detailed analysis of charitable immunity, see GRAY, *supra* note 20, §§ 29.16 - 29.17. See also note 30 *infra* (discussing the four major theories justifying the charitable immunity doctrine).

deat superior theory; (3) the implied waiver theory; and (4) the "public policy" theory.²⁹ All four theories have been subject to substantial criticism.³⁰

With time and various challenges to the theories of charitable immunity, the doctrine fell into disfavor. As early as 1915, and peaking in the 1950s and 1960s, states abrogated the doctrine through either judicial decision or legislative action.³¹

29. GRAY, *supra* note 20, at § 29.6.

30. The *McDonald* case is an example of the trust fund theory, explained by Lord Cottenham in *Feoffees of Heriot's Hospital v. Ross*, 8 Eng. Rep. 1508 (1846): "To give damages out of a trust fund would not be to apply it to those objects whom the author of the fund had in view, but would be to divert it to a completely different purpose." *Id.* at 1510.

The trust fund theory has been rejected in part due to the argument that donors do not intend to and cannot lawfully exempt the benefactors of their donations from their rights under the law. GRAY, *supra* note 20, § 29.16, at 755. Essentially, the trust fund theory is illogical. It assumes what it is trying to prove, that payment of tort damages is not a charitable purpose. *Id.*

The second theory rests on the argument that since a charity does not financially benefit from the labor of its employees, the principle of *respondeat superior* is inapplicable to a charitable institution. The theory has been soundly criticized as inconsistent with the basis for *respondeat superior*, the employer's right to control his or her employee through direction and selection. *Widell v. Holy Trinity Catholic Church*, 19 Wis. 2d 648, 121 N.W.2d 249, 253 (1963). For further discussion, see GRAY, *supra* note 20, § 29.16, at 759.

The third theory is the implied waiver theory. This is based on the legal fiction that one who accepts the benefits of a charity impliedly waives any right to recover for injury due to negligence. The theory is widely criticized and represents perhaps the most unsupportable reason for the application of charitable immunity. See generally Note, *The Diminishing Doctrine of Charitable Immunity: An Analysis*, 19 DRAKE L. REV. 187, 193 (1969). To require the patient in need of charitable assistance to give up any right to damages if he or she is injured seems unjust. While some courts hold that the implied waiver does not apply to paying patients, this does not relieve the heavy burden on the poor individual who must seek treatment at a charitable hospital. GRAY, *supra* note 20, § 29.16, at 760-62.

A broad public policy theory has also been used to justify charitable immunity. The rationale is based on the notion that since charities are "good," the law should protect and foster their existence. It is believed that immunity encourages donations while liability would make persons less willing to donate to charities, although the evidence is to the contrary. *Id.*

Logically, the public policy theory must fail. First, if the threat of tort liability acts to deter bad medical practice, then immunity tends to foster negligence, and promoting charitable negligence is hardly consistent with the public good. Second, if donors are benevolent persons who wish to help others, leaving victims of negligence with no remedy defeats donors' intentions. *Id.*

Immunity as a means of sustaining a charity's existence has also been challenged, especially given the availability of insurance to guard against large tort judgments. Although insurance availability has become problematic, hospitals have pooled resources and developed self-insurance funds to address current needs. *Id.*

31. For the view that charitable immunity has not been abolished to the extent generally believed, see *Charitable Torts*, *supra* note 27, at 197. See also 2 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* § 17.22 (1988) for a complete listing of the status of charitable immunity in each state.

Not surprisingly, as use of the doctrine diminished, cases against hospitals, including those asserting a right to treatment, began to appear in the courts. For example, the first case to deal with a hospital's duty relating to emergency care was a 1934 Alabama case, *Birmingham Baptist Hospital v. Crews*.³² Alabama was one of the first states to abolish the charitable immunity doctrine—as applied to employees and paying beneficiaries in 1915,³³ and then as to invitees in 1933.³⁴ The next case to deal directly with this issue was a 1960 New York case, *O'Neill v. Montefiore Hospital*.³⁵ The *O'Neill* court decided this case only three years after New York abrogated its charitable immunity doctrine.³⁶ The great majority of cases dealing with the duty of a hospital to treat appeared in the 1960s as the charitable immunity doctrine fell into increasing disfavor.³⁷

C. *The Misinterpretation of the Case Law*

Even without immunity, the few courts that addressed the duty to treat misinterpreted the case law, further confusing the issue and retarding new development in the area. When describing the character of a charitable trust, the *McDonald* court stated, in 1876, that “no person has individually a right to demand admis-

32. 229 Ala. 398, 157 So. 224 (1934). Refer to notes 43-53 *infra* and accompanying text.

33. *Tucker v. Mobile Infirmary Ass'n*, 191 Ala. 572, 68 So. 4, 9 (1915).

34. *Alabama Baptist Hosp. Bd. v. Carter*, 226 Ala. 109, 145 So. 443, 445 (1932), *aff'd*, 227 Ala. 560, 151 So. 62 (1933). Liability as to nonpaying beneficiaries is still an open question in Alabama.

35. 11 A.D.2d 132, 202 N.Y.S.2d 436 (N.Y. App. Div. 1960). Refer to notes 54-60 *infra* and accompanying text.

36. *Bing v. Thunig*, 2 N.Y.2d 656, 667, 143 N.E.2d 3, 9, 163 N.Y.S. 2d 3, 12 (1957).

37. See, e.g., *Wilmington Gen. Hosp. v. Manlove*, 54 Del. 15, 174 A.2d 135, 140 (1961) (private hospital's duty to treat in an unmistakable emergency); *Durney v. St. Francis Hosp., Inc.*, 46 Del. 350, 83 A.2d 753, 758 (1951) (Delaware abolished charitable immunity); *Wilson v. Lee Memorial Hosp.*, 65 So. 2d 40, 41 (Fla. 1953) (abolishing the immunity doctrine in Florida); *Ruvio v. North Broward Hosp. Dist.*, 186 So. 2d 45, 46 (Fla. Dist. Ct. App. 1966), *cert. denied*, 195 So. 2d 567 (Fla. 1966) (no liability in the absence of the hospital's negligence); *LeJuene Road Hosp., Inc. v. Watson*, 171 So. 2d 202, 203 (Fla. Dist. Ct. App. 1965) (private hospital has no duty to admit any patient); *New Biloxi Hosp., Inc. v. Frazier*, 245 Miss. 185, 146 So. 2d 882, 887 (1962) (hospital providing emergency treatment must provide suitable medical attention); *Mississippi Baptist Hosp. v. Holmes*, 214 Miss. 906, 55 So. 2d 142, 156 (1951), *aff'd*, 214 Miss. 906, 56 So. 2d 709 (1952) (Mississippi abolished the immunity doctrine); *Stanturf v. Sipes*, 447 S.W.2d 558, 562 (Mo. 1969) (duty to treat when reducing medical services); *Abernathy v. Sisters of St. Mary's*, 446 S.W.2d 599, 606 (Mo. 1969) (en banc) (Missouri abolished charitable immunity). Refer to Section II *infra*.

sion to [a charity's] benefits."³⁸ This statement had no relationship to the controversy, nor was it supported by any case law. It had its impact nonetheless. In 1924, in *VanCampen v. Olean General Hospital*,³⁹ a New York court noted that "[t]he law does not require a [hospital] to furnish its services and accommodations to everyone who applies, whether patient or physician."⁴⁰ Similarly, in *Levin v. Sinai Hospital*,⁴¹ the Maryland Court of Appeals stated that "[a] private hospital is not under a common-law duty to serve every one who applies for treatment or permission to serve."⁴² *McDonald*, *Van Campen*, and *Levin* dealt only with a hospital's right to grant or revoke staff privileges, not the right to emergency care. Yet, to this day, courts continue to cite these cases for the no duty to treat rule.

*Birmingham Baptist Hospital v. Crews*⁴³, decided fifty-eight years after *McDonald*, did involve treatment in an emergency room. The plaintiff brought his daughter to the hospital for treatment of diphtheria.⁴⁴ The staff administered antitoxin and oxygen, but refused to admit her as a regular patient, fearing contagion.⁴⁵ She died soon after leaving the hospital.⁴⁶

The child's father brought a wrongful death action, charging that the hospital had "received her for hospital service and then wrongfully refused to render that service, and required her to be carried away, at a time when she needed it, resulting in an acceleration of her death."⁴⁷ The court rejected the plaintiff's argument, carefully distinguishing between "treatment in an emergency," and "full hospital service."⁴⁸ The court found that the hospital administered proper emergency treatment, and acted appropriately in following its established policy of refusing admission to persons with contagious diseases.⁴⁹

38. 120 Mass. at 435. Refer to note 21 *supra*.

39. 210 A.D. 204, 205 N.Y.S. 554 (1924) (physician challenge to arbitrary cancellation of hospital privileges).

40. *Id.* at 209, 205 N.Y.S. at 558 (dictum).

41. 186 Md. 174, 46 A.2d 298 (1946) (physician challenge of denial of hospital privileges).

42. *Id.* at 180, 46 A.2d at 301.

43. 229 Ala. 398, 157 So. 224 (1934).

44. *Id.* at 399, 157 So. at 225.

45. *Id.* at 400, 157 So. at 225.

46. *Id.*, 157 So. at 225.

47. *Id.* at 399, 157 So. at 225.

48. *Id.*, 157 So. at 225-26.

49. *Id.* at 400, 157 So. at 225-26.

Apparently, the court recognized a two-stage process: (1) emergency treatment; and (2) in-patient care. The distinction supported the holding that there was no abandonment of the patient upon completion of the care at the first stage when care at the second stage had not begun. The reasons for the distinctions are not clearly stated, although the opinion alludes to a fear that hospitals would be put in a no-win situation if held liable for abandonment even after taking every possible step to help a victim.⁵⁰

Despite the *Crews* court's distinction between emergency and in-patient care, the case is often cited erroneously as support for the proposition that a hospital may refuse to treat persons, *even in an emergency situation*.⁵¹ The *Crews* court did state that a private hospital was under "no duty to accept any patient not desired by it,"⁵² but whether that statement applied to emergency or in-patient care or both is uncertain. Clearly, the *Crews* holding does not reach the question of the duty to provide emergency medical care. The court explicitly states that proper emergency care was given.⁵³

By the time of the *Crews* decision, there was no case holding that denied the existence of a duty of emergency care. The *McDonald* court's statement was dictum, discussing only the character of a charitable trust. The *VanCampen* and *Levin* cases both involved physician staff privileges and did not discuss a duty to give medical treatment. Finally, although the *Crews* case dealt with treatment, the duty to provide *emergency* medical treatment

50. *Id.*, 157 So. at 225-26. The court explained:

Our judgment is that the only fair inference from these facts is that the treatment given was but an emergency treatment as the only hope in a desperate situation, administered as soon as the trouble was diagnosed, and that, since it is admitted to have been the appropriate thing to do in such emergency, it does not justify an inference that defendant undertook to do more than was immediately apparent as the only hope. We think that such treatment does not justify an inference that defendant undertook to render ordinary hospital service in violation of its rules, and so as to endanger the life or health of other patients. . . . The willingness of defendant to provide such treatment should not be used to its prejudice. . . .

Id., 157 So. at 225-26.

51. See, e.g., *Thompson v. Sun City Community Hosp., Inc.*, 141 Ariz. 597, 602 n.3, 688 P.2d 605, 610 n.3 (1984); *Wilmington Gen. Hosp. v. Manlove*, 54 Del. 15, 21, 174 A.2d 135, 138 (1961); *LeJuene Road Hosp. v. Watson*, 171 So. 2d 202, 203 (Fla. Dist. Ct. App. 1965); *Fjerstad v. Knutson*, 271 N.W.2d 8, 11 (S.D. 1978); *Mercy Medical Center of Oshkosh, Inc. v. Winnebago County*, 58 Wis. 2d 260, 266, 206 N.W.2d 198, 200 (1973).

52. 229 Ala. at 399, 157 So. at 225.

53. *Id.* at 400, 157 So. at 225. The court refers to the action of the hospital as "an emergency treatment" and "the appropriate thing to do in such an emergency." *Id.*, 157 So. at 225.

was not at issue.

The 1960s, however, saw various courts begin to struggle with the "assumed" general rule that there was no duty on the part of a hospital to treat, even in an emergency. *O'Neill v. Montefiore Hospital*⁵⁴ was the first case to approach the issue directly. The court framed the issue as whether "there was a duty owing respectively by the hospital and the doctor to examine and treat plaintiff's deceased husband."⁵⁵ The nurse in the emergency ward had made a phone call for the decedent, to his doctor.⁵⁶ The court queried "whether the conduct of the nurse in relation to the deceased was in the nature of a personal favor to him or whether her conduct was that of an attaché of the hospital trying to discharge her duty."⁵⁷ In other words, the court wanted a determination as to whether by her actions she "undertook to provide medical attention for the deceased."⁵⁸

By focusing on this aspect of the case, the court sidestepped the issue of a hospital's duty to treat and focused on a more traditional abandonment issue. Apparently, the opinion assumes that absent a hospital-patient relationship, analogous to the physician-patient relationship,⁵⁹ there is no duty to treat. If the nurse in some way began medical treatment by making the phone call, then the hospital could be held liable. If the call was only a "favor," the court intimates that there would be no basis for liability.⁶⁰

Although the *O'Neill* court asked, but did not directly answer, the question of whether a hospital must treat in an emergency, its questionable justification for liability—that through its agent, the hospital began some form of medical treatment by phoning a doctor—suggests an attempt at a solution and a dissatisfaction with the perceived state of the common law.⁶¹ This frustration set the

54. 11 A.D.2d 132, 202 N.Y.S.2d 436 (N.Y. App. Div. 1960).

55. *Id.* at 133, 202 N.Y.S.2d at 438.

56. *Id.* at 134, 202 N.Y.S.2d at 438.

57. *Id.* at 135, 202 N.Y.S.2d at 440.

58. *Id.*, 202 N.Y.S.2d at 440.

59. Refer to note 8 *supra*.

60. *O'Neill*, 11 A.D.2d at 135, 202 N.Y.S.2d at 440.

61. Courts have found that a hospital, by initiating some treatment, created a sufficient hospital-patient relationship (*i.e.*, an "implied admission") and, therefore, had a duty to provide care. See *Methodist Hosp. v. Ball*, 50 Tenn. App. 460, 362 S.W.2d 475 (1961); *Bourgeois v. Dade County*, 99 So. 2d 575 (Fla. 1957); *Citizens Hosp. Ass'n. v. Schoulin*, 262 So. 2d 303 (Ala. Ct. App. 1972). *Ball*, *Bourgeois*, and *Schoulin* apparently were motivated by the same concerns expressed in *O'Neill*. See also Fine, *Opening the Closed Doors: The Duty of Hospitals to Treat Emergency Patients*, 24 WASH. U.J. URB. & CONTEMP. L. 123,

stage for the first case that imposed a duty to treat in an emergency.

II. THE *MANLOVE* CASE: THE SEARCH FOR A DUTY

The facts of *Wilmington General Hospital v. Manlove*⁶² were compelling. Parents brought their infant son, suffering from diarrhea and a high fever, to the local hospital.⁶³ The nurse on duty refused to treat the child because hospital policy dictated that in the absence of a "*frank indication of emergency*,"⁶⁴ patients already attended by a private doctor must be admitted by that doctor before receiving treatment.⁶⁵ The child died of bronchial pneumonia a few hours later.⁶⁶ The parents brought a wrongful death action against the hospital, presenting the Delaware court with a new legal challenge to the no-duty rule.⁶⁷

A. *The Superior Court Decision: The Quasi-Public Theory*

The hospital filed a motion for summary judgment⁶⁸ in the Superior Court, relying on the no-duty rule and characterizing the nurse's action as nonfeasance.⁶⁹ The hospital argued that there was no duty to treat, diagnose, or admit the Manlove baby.⁷⁰ To avoid the established rule, the plaintiff contended that the nurse's inaction constituted an *incorrect* diagnosis that no emergency existed and was therefore misfeasance.⁷¹

Acknowledging the importance in tort law of the misfeasance-nonfeasance doctrine, the Superior Court rejected the plaintiff's reasoning, stating that it "beg[ged] the issue."⁷² The court also noted the analogy between this case and the common-law rule that

129-31 (1983) (discussion of cases circumventing application of the no-duty rule); Powers, *Hospital Emergency Service and the Open Door*, 66 MICH. L. REV. 1455, 1464-75 (1968) (factual analysis of several cases showing judicial dissatisfaction with the no-duty rule).

62. 54 Del. 15, 174 A.2d 135 (1961).

63. *Id.* at 16-17, 174 A.2d at 136.

64. *Id.* at 18, 174 A.2d at 137 (emphasis by the court).

65. *Id.* at 17, 174 A.2d at 136.

66. *Id.*, 174 A.2d at 136.

67. *Id.*, 174 A.2d at 136.

68. *Manlove v. Wilmington Gen. Hosp.*, 53 Del. 338, 339, 169 A.2d 18, 19 (Del. Super. Ct.), *rev'd*, 54 Del. 15, 174 A.2d 135 (1961).

69. 53 Del. at 342, 169 A.2d at 20.

70. *Id.*, 169 A.2d at 20.

71. *Id.*, 169 A.2d at 20.

72. *Id.*, 169 A.2d at 20.

a private physician is "under no legal duty to accept any person for treatment, no matter how extreme the emergency. . . ." ⁷³ Not satisfied with the result, the court proposed an innovative basis for liability, by reasoning that the hospital should be classified as a "quasi-public" institution because it received tax exemptions, public subsidies, and a corporate charter under Delaware law. ⁷⁴ These public benefits were enough to alter the character of a "private" hospital, such that it "should be required at all times to render reasonably needed aid in those instances where an emergency involving death or serious bodily impairment might reasonably be said to exist." ⁷⁵ Therefore, the Superior Court held that the defendant's nonfeasance theory and analogy to the no-duty rule governing private physicians in an emergency situation failed because acceptance of public funds and tax benefits "changed [the hospital's] characterization to that of a quasi public [sic] institution, thereby forfeiting to a measured extent the degree of privacy that it otherwise possessed." ⁷⁶

The Superior Court struggled to find a theoretical basis for recognizing a duty. By characterizing the hospital as a quasi-public entity, it obligated the private institution to act in the public interest by providing emergency services. The duty accrued in return for receipt of public benefits such as tax exemptions and government funding. Whatever the rationale, this theory was short-lived—at least in Delaware. ⁷⁷

B. *The Supreme Court Decision: The Reliance Theory*

On appeal, the Supreme Court of Delaware affirmed the order of the Superior Court, but rejected its reasoning. ⁷⁸ In so doing, it cited *Crews*, *McDonald*, and *VanCampen*—perhaps incorrectly—as supporting the general proposition that "[a] private hospital owes the public no duty to accept any patient not desired by

73. *Id.* at 345, 169 A.2d at 21.

74. *Id.* at 346, 169 A.2d at 22.

75. *Id.* at 345, 169 A.2d at 22.

76. *Id.*, 169 A.2d at 22.

77. A few courts have used the quasi-public hospital theory to prevent secular hospitals from refusing to provide treatment to achieve "moral" objectives. *See, e.g., Doe v. Bridgeton Hosp. Ass'n*, 71 N.J. 478, 366 A.2d 641, 647 (1976) (nonsectarian, nonprofit hospital may not refuse abortion services).

78. *Wilmington Gen. Hosp. v. Manlove*, 54 Del. 15, 27, 174 A.2d 135, 141 (1961).

it. . . .”⁷⁹ The court then explicitly stated that receipt of public funds and exemption from taxation do not convert a private hospital into a public or quasi-public hospital.⁸⁰ The Delaware Supreme Court also noted that since a hospital is “privately owned and operated, it would follow logically that its trustees or governing board alone have the right to determine who shall be admitted to it as patients. No other rule would be sensible or workable.”⁸¹

The court distinguished, however, between a duty to accept an in-patient and a duty to “give treatment in an emergency case, i.e., one obviously demanding immediate attention.”⁸² The former duty is nonexistent as to a private hospital, but the latter duty arises, under a court-fashioned reliance theory, “if the patient has relied upon a well-established custom of the hospital to render aid in such a case.”⁸³

The Delaware court found this situation analogous⁸⁴ to the reliance theory set forth in section 323 of the *Restatement (Second) of Torts*, which states:

One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if

(a) his failure to exercise such care increases the risk of harm,
or

(b) the harm is suffered because of the other's reliance upon the undertaking.⁸⁵

There are, however, problems with the analogy. The *Restatement* rule generally means that liability attaches when one has actually begun to *perform* some sort of service. In fact, the *Restatement* contains a caveat explicitly expressing “no opinion” as to whether the making of a “gratuitous promise, without in any way entering upon performance, is a sufficient undertaking to result in liability

79. 54 Del. at 21, 174 A.2d at 138 (quoting 41 C.J.S. *Hospitals* § 8, at 345 (1944)). (citing also *Crews* and *McDonald*); *id.* at 22, 174 A.2d at 139 (citing *Van Campen*). Refer to notes 21-53 and accompanying text.

80. *Id.* at 19, 174 A.2d at 137.

81. *Id.* at 21, 174 A.2d at 138.

82. *Id.* at 22, 174 A.2d at 139.

83. 174 A.2d at 140 (quoted language omitted from the Delaware Reports opinion).

84. 54 Del. at 23, 174 A.2d at 139.

85. RESTATEMENT (SECOND) OF TORTS § 323 (1965).

under the rule. . . ."⁸⁶

One might question whether "reliance on a well-established custom" even rises to the level of a "gratuitous promise." The court, however, found that when a person in need of emergency care relies on an established custom to render it, "such a refusal might well result in worsening the condition of the injured person, because of the time lost in a useless attempt to obtain medical aid," seeming to parallel the increased-risk-of-harm language in section 323 (a).⁸⁷ Nevertheless, the recurrent issue is the extent to which performance of the undertaking has started. Therefore, the court's analogy between the *Manlove* reliance theory and the *Restatement* theory is not clear. The court states that the analogy exists, but does not explain how.⁸⁸

The decision by the Supreme Court of Delaware was a turning point in the search for a common-law duty to treat, representing the first time that a court went beyond the constraints of both the traditional tort misfeasance-nonfeasance theory and the requirement of a hospital-patient relationship to find a new basis of liability.

An analysis of the *Manlove* test must focus on its four elements: (1) the hospital must maintain an emergency room;⁸⁹ (2) an "unmistakable emergency" must exist;⁹⁰ (3) a *well-established custom* to render care in such circumstances must be found;⁹¹ and (4) the injured party must have relied on that custom.⁹²

The first element states the obvious and is a factual matter. As to the second, however, the court was less than clear. What constitutes an "unmistakable emergency"? As a secondary issue, who decides if there is an emergency and to what standard of care will he be held?

The court defined "emergency" as a condition "obviously demanding immediate attention."⁹³ The next question is: Obvious to whom? The court answered that "someone on behalf of the hospital must make a *prima facie* decision whether it exists," and the court recognized that since some hospitals cannot reasonably be

86. *Id.*

87. 54 Del. at 23, 174 A.2d at 139.

88. *Id.*, 174 A.2d at 139.

89. *Id.*, 174 A.2d at 139.

90. *Id.* at 22, 174 A.2d at 139.

91. *Id.* at 23, 174 A.2d at 140.

92. *Id.*, 174 A.2d at 140.

93. *Id.* at 22, 174 A.2d at 139.

expected to have a doctor on duty at all times, a nurse may of necessity make the decision.⁹⁴ The court found that there must be "evidence that an experienced nurse should have known that such symptoms constituted unmistakable evidence of an emergency."⁹⁵

Does the *Manlove* test require an *actual examination* of the prospective patient by the person making the *prima facie* decision as to whether there is an emergency?⁹⁶ Again, the answer is unclear from the language of the opinion. The court does say that, especially in the case of a disease (as opposed to physical injury), "some degree of experience and knowledge is required" to make such a judgment.⁹⁷ One might also assume that without an actual examination, the emergency nature of a disease is indiscernable. Yet the court later stated that the question of the nurse's liability rested on whether she was "derelict in her duty . . . in not recognizing an emergency from the symptoms *related to her*."⁹⁸ Furthermore, the court relieved the decisionmaker of liability unless her decision was "clearly unreasonable."⁹⁹

One is drawn to the conclusion that although *Manlove* attempted to impose some sort of liability on the hospital, the resulting burden on the plaintiff is unreasonably heavy. The plaintiff must prove that an "unmistakable emergency existed," while the hospital need only exercise reasonable medical judgment, perhaps without even the requirement of an examination.

The third and fourth elements of the *Manlove* test are even more problematic. What constitutes a "well-established" custom? How does the plaintiff prove reliance? *Manlove* indicated that simply having an emergency room may be enough to show a "well-established" custom,¹⁰⁰ noting that while a private hospital is under no legal obligation to maintain an emergency room, it has become "a well-established adjunct to the main business of a hospital."¹⁰¹ Additionally, the court never really defined reliance. Even though it asked: "What is standard hospital practice when an applicant for aid seeks medical aid for sickness at the emergency

94. *Id.* at 24, 174 A.2d at 139.

95. *Id.* at 25, 174 A.2d at 140.

96. COBRA imposes a duty to perform a screening examination on all who present themselves to the emergency room. Refer to note 296 *infra* and accompanying text.

97. 54 Del. at 26, 174 A.2d at 140.

98. *Id.*, 174 A.2d at 141 (emphasis added).

99. *Id.* at 24, 174 A.2d at 140.

100. *Id.* at 23, 174 A.2d at 139.

101. *Id.*, 174 A.2d at 139.

ward?,"¹⁰² the court was referring only to the question of who generally determines whether an emergency exists—a nurse or a doctor.¹⁰³

It is questionable whether the *Manlove* test requires that the injured person actually *prove* reliance. The court remanded the case for a determination as to whether there was an unmistakable emergency,¹⁰⁴ but did not ask for, nor define, appropriate evidence of reliance or a well-established custom. Perhaps simply going to the emergency room is enough. The language of the opinion, however, imposes liability in the case of an unmistakable emergency "if the patient has relied upon a well-established custom of the hospital to render aid in such a case,"¹⁰⁵ suggesting that something more must be proved. Another problem is whether reliance is presumed or ignored as an element when the injured person is brought to the hospital by ambulance, and perhaps unconscious, as is often the case in an emergency.

C. *The Manlove Progeny: Applications, Limitations & Accommodations*

Despite these problems, *Manlove* received acclaim as the answer to the need for a common-law duty to treat. One commentator described it as "a recognition of new public attitudes toward the issues of health, hospitals, and emergency rooms," and possibly "the first step toward the establishment of health care as a right, legally guaranteed to all Americans."¹⁰⁶ Although this hope seems overly optimistic, the truth is that the *Manlove* reliance theory has done very little to change the case law. Over its twenty-six year history, *Manlove* is cited in less than twenty-five court decisions, successfully in only a few cases.¹⁰⁷ Usually, *Manlove* is cited for its traditional negligence analysis;¹⁰⁸ as an example of reliance on a gratuitous promise;¹⁰⁹ or for the proposition that there is no legal

102. *Id.* at 26, 174 A.2d at 141.

103. *Id.*, 174 A.2d at 141.

104. *Id.* at 26-27, 174 A.2d at 141.

105. 174 A.2d at 140 (quoted language omitted from the Delaware Reports opinion).

106. Gold, *Emergency Room Medical Treatment: Right or Privilege?*, 36 ALB. L. REV. 526, 535 (1972).

107. Refer to notes 112-19 *infra* and accompanying text.

108. See, e.g., *Larrimore v. Homeopathic Hosp. Ass'n*, 54 Del. 235, 245, 176 A.2d 362, 367 (1961) (evidence of skill and care must be proved by expert testimony).

109. See *Brown v. MacPherson's, Inc.*, 85 Wash. 2d 17, 24, 530 P.2d 277, 281 (1975) (involving an action for failure to warn of a hazardous condition).

duty for a hospital to maintain an emergency room.¹¹⁰ The *Manlove* test has also appeared in cases in which the issue was not a duty to render emergency care; these cases involved negligent emergency care or improper transfer following admittance as a patient.¹¹¹

1. *Successful Application.* The *Manlove* test has been successfully applied in at least one case: *Stanturf v. Sipes*.¹¹² In *Stanturf v. Sipes*, the plaintiff sought treatment for frostbite of his feet, but the hospital refused treatment because he was unable to pay a twenty-five dollar fee. After almost a week, another hospital admitted the plaintiff, but both feet required amputation.¹¹³ In reversing a summary judgment for defendants, the court applied the *Manlove* test to show that issues of fact existed.¹¹⁴ The court found that the hospital maintained an emergency room and that the pleadings, depositions, and admissions supported a finding that plaintiff's condition was an emergency situation.¹¹⁵

Citing section 323 of the *Restatement (Second) of Torts*, the court also noted that the defendant was the only hospital in the immediate area, and that it was "the long established rule of the hospital to accept all persons for treatment upon the payment of a \$25 admittance fee."¹¹⁶ These facts, the court stated, gave the plaintiff reason to rely on the practice of rendering emergency care.¹¹⁷ In searching for causation, the court found that the decline in Mr. Stanturf's condition could have been caused by the delay in obtaining treatment.¹¹⁸

Thus, the facts in *Stanturf* seem to fit the elements of the *Manlove* test rather well. Of course, the admission by the hospital that its policy was to admit anyone offering a twenty-five dollar fee played a large part in the decision.¹¹⁹ In the absence of such concrete evidence, reliance may well be more difficult to prove.

Other courts do appear to accept the reliance test without spe-

110. *Schagrin v. Wilmington Medical Center*, 304 A.2d 61, 64 (Del. Super. Ct. 1973).

111. Refer to notes 178-96 *infra* and accompanying text.

112. 447 S.W.2d 558 (Mo. 1969).

113. 447 S.W.2d at 560.

114. *Id.* at 562-63.

115. *Id.* at 562.

116. *Id.*

117. *Id.*

118. *Id.*

119. *Id.*

cifically citing the *Manlove* opinion.¹²⁰ For example, in *Valdez v. Lyman-Roberts Hospital*,¹²¹ the decedent was a pregnant woman, apparently seriously ill, who was turned away from two area hospitals.¹²² She died upon her return home.¹²³

Proximate cause was the only issue on appeal, since the defendant hospitals admitted their breach of duty.¹²⁴ The court recognized the defendants' negligence, noting the principles embodied in the *Manlove* test:

While a private hospital may conduct its business largely as it sees fit, liability on the part of the hospital may be predicated on the refusal of service to a patient in the case of an unmistakable emergency if the patient has relied upon the custom of the hospital to render aid in such a case.¹²⁵

The court found that there was evidence in the record of the hospitals' "reputation" of treating emergencies.¹²⁶

2. *Limitations.* The reason for the limited success of *Manlove* test probably lies in difficulties with both application and proof of the various elements. When triggering application of the test, the plaintiff must prove the presence of an unmistakable emergency and reliance on a well-established custom.¹²⁷ These factors, however, merely establish the duty to treat. Plaintiff must then prove the remaining elements of a common-law tort action: breach of duty, consequent harm and proximate cause.¹²⁸ Ironically, the very nature of a true emergency may increase the difficulty of proof.¹²⁹

120. Annot., *Liability of Hospital for Refusal to Admit or Treat Patient*, 35 A.L.R.3d 841, 844, 846 (1971).

121. 638 S.W.2d 111 (Tex. App.—Corpus Christi 1982, writ ref'd n.r.e.).

122. *Id.* at 113-14.

123. *Id.* at 114.

124. *Id.* at 114 n.1.

125. *Id.* (relying on Annot., *supra* note 120, at 841).

126. *Id.*

127. Refer to notes 90-92 *supra* and accompanying text.

128. PROSSER & KEETON, *supra* note 15, at 164-65.

129. The *Manlove* court concluded:

If plaintiff cannot adduce evidence showing some incompetency of the nurse, or some breach of duty or some negligence his case must fail. Like the learned judge below, we sympathize with the plaintiff in their loss of a child; but this natural feeling does not permit us to find liability in the absence of satisfactory evidence.

54 Del. at 26-27, 174 A.2d at 141. Refer also to note 167 *infra* and accompanying text.

*Hill v. Ohio County*¹³⁰ is an example of the difficulties encountered in establishing a duty to treat. In *Hill*, plaintiff's decedent arrived at the local public hospital concerned about giving birth before reaching her doctor in Illinois.¹³¹ The nurse in charge was unable to get either the "on-duty" physician or the "on-call" physician to treat an obstetrics case.¹³² Decedent was referred to other hospitals, but elected to go home.¹³³ She gave birth that night, apparently unattended, and called an ambulance in the morning.¹³⁴ One of the physicians who had refused treatment the night before instructed the ambulance driver to take the mother and child to another hospital.¹³⁵ The mother was dead on arrival.¹³⁶ In the subsequent wrongful death action, the court found that the hospital's rules were such that no patient could be admitted without an order from a doctor, and that "[t]he trustees or governing board of a public hospital alone determine the right of admission to the benefits of the institution, and their discretion in this regard will not be reviewed by the courts."¹³⁷ The court also found that no "element of critical emergency" was apparent.¹³⁸

Hill is an example of a major flaw in the *Manlove* reliance theory. If the condition of a patient fails to reach the level of an "emergency," then an injured plaintiff cannot use the doctrine. The *Hill* court apparently did not characterize labor as a life-threatening, traumatic, or "unmistakable" emergency.¹³⁹

Once the emergency is proven, the next hurdle is proof of reliance on a well-established custom. The Delaware Supreme Court itself provided at least a hint as to what would satisfy this requirement in *Vanaman v. Milford Memorial Hospital*.¹⁴⁰ In *Vanaman*, the plaintiff alleged that the defendant physician improperly set

130. 468 S.W.2d 306 (Ky. 1971), *cert. denied*, 404 U.S. 1041 (1972).

131. 468 S.W.2d at 307.

132. *Id.*

133. *Id.*

134. *Id.*

135. *Id.* at 308.

136. *Id.*

137. *Id.* (quoting 40 AM. JUR. 2D *Hospitals and Asylums* § 12 (1968)).

138. *Id.* at 309. Noting that the plaintiff relied on *Manlove*, the court made no mention of the reliance theory nor of any duty to treat in an emergency, but only quoted the "warning" in *Manlove* that plaintiff needed to prove "some incompetency of the nurse or some breach of duty or some negligence." *Id.* at 308.

139. The COBRA statute specifically includes active labor within its provisions. Refer to note 296 *infra* and accompanying text.

140. 272 A.2d 718 (Del. Sup. 1970).

her left leg in a cast which was too tight and caused permanent injury.¹⁴¹ The main issue on appeal was whether the hospital was liable under the doctrine of *respondeat superior*, even though the physician was not its employee.¹⁴² Did the hospital represent that the physician was its agent or did it merely "refer" the plaintiff to the physician, on call in the emergency room?¹⁴³ If the hospital merely made a "referral" to the physician as an independent contractor, it avoided liability.¹⁴⁴

The plaintiff in *Vanaman* was actually treated, so *Manlove* appears to be inapplicable. The court cited *Manlove*, however, and noted that the plaintiff offered evidence establishing that the hospital "maintained an emergency facility [and] that facility was offered to the public and the public was directed to it."¹⁴⁵ Although this evidence appears extraneous, it takes on significance in light of the fact that the issue was whether the hospital was liable at all for plaintiff's treatment. The plaintiff attempted to establish the hospital's liability for treatment received there, irrespective of whether it was provided by an independent contractor or by an employee. Although the court's holding did not rely on this theory, it offered a strong hint as to what might satisfy the "reliance on a well-established custom" requirement of the *Manlove* test.

A Pennsylvania court's decision in *Fabian v. Matzko*¹⁴⁶ is perhaps the best example of a court's confusion over the *Manlove* reliance test.¹⁴⁷ In *Fabian*, the plaintiff developed "an intense and sudden headache, stiffness in her neck, and nausea."¹⁴⁸ Her personal physician examined her and determined that she had a viral infection.¹⁴⁹ When her condition had not improved several hours later, her husband called the hospital and spoke with the emergency room physician, relating his wife's symptoms and indicating

141. *Id.* at 719. Factually, the case was a modern day *McDonald*. Refer to notes 21-23 *supra* and accompanying text.

142. 272 A.2d at 719. Refer to note 8 *supra*.

143. 272 A.2d at 720.

144. *Id.*

145. *Id.* at 720-21. In a footnote, the court referred to the deposition of the hospital's administrator, who was questioned concerning the separate status of the emergency room, its availability to the general public, and whether the hospital posted and maintained signs and directions to the emergency unit. *Id.* at 721 n.4.

146. 236 Pa. Super. 267, 344 A.2d 569 (1975).

147. The majority, a concurrence and a dissent offered conflicting views of its proper application.

148. *Id.* at 269, 344 A.2d at 570.

149. *Id.*, 344 A.2d at 570.

that he wanted her admitted to the hospital.¹⁵⁰ In accordance with hospital policy, the emergency room physician asked if the plaintiff had seen a physician, and informed the husband that she could not be admitted unless the arrangements were made by their personal physician.¹⁵¹ The husband tried, but was unable, to contact their doctor.¹⁵²

Over the next several days, the plaintiff's condition seemed to improve, but she then suffered another attack and was admitted to the hospital by her physician.¹⁵³ An examination revealed a "cerebral hemorrhage with permanent brain damage, loss of speech, partial paralysis, loss of hearing and loss of vision."¹⁵⁴ The plaintiff alleged that the injuries were caused by the hospital's negligence in failing to admit and treat her, relying on *Manlove* and section 323 of the *Restatement (Second) of Torts*.¹⁵⁵

The court first rejected section 323 as a basis for liability, stating that the emergency room physician never undertook to render medical services.¹⁵⁶ The court then considered the *Manlove* and *Stanturf*¹⁵⁷ decisions, characterizing them as "concerned with the fact that a person in need of immediate medical care uses valuable time when he goes to an emergency facility."¹⁵⁸ The court found the *Manlove* test inapplicable, stating:

In the present case, appellant did not rely on a policy of rendering emergency care. Appellant did not go to the hospital, and thus did not waste valuable time. Furthermore, this was not an unmistakable emergency. In fact, there were no facts which would have indicated to Dr. Cahill that this was an emergency situation. . . . Finally the hospital in this case did not depart from one of its standard procedures, as did the hospital in *Stanturf*.¹⁵⁹

Given that the plaintiff never actually went to the emergency room, one can understand why the court was reluctant to hold the hospital liable.

Fabian is otherwise factually comparable to *Manlove*, but il-

150. *Id.*, 344 A.2d at 570.

151. *Id.*, 344 A.2d at 570.

152. *Id.*, 344 A.2d at 570.

153. *Id.*, 344 A.2d at 570.

154. *Id.* at 269-70, 344 A.2d at 570.

155. *Id.* at 270, 344 A.2d at 571.

156. *Id.*, 344 A.2d at 570.

157. Refer to notes 112-19 *supra* and accompanying text.

158. 236 Pa. Super. at 271-72, 344 A.2d at 572.

159. *Id.* at 273, 344 A.2d at 572.

lustrative of the limitations of applying the reliance test. First, does "valuable time" refer to the time it takes to drive to and apply for treatment at the emergency room or to the time lost in not seeking further aid?¹⁶⁰ Of course, since the plaintiffs did not actually go to the hospital, the emergency room physician had no chance to examine the plaintiff. The lack of an opportunity to examine is the legitimate reason for the court's refusal to impose liability. The question left open in *Manlove*, however, becomes pertinent here. Is there a duty to actually examine a patient in determining the presence or absence of an emergency,¹⁶¹ or are symptoms related by a third party sufficient? Perhaps the courts are afraid to impose such a requirement because an examination may be enough to establish a relationship with the patient.¹⁶² Once the relationship is established, a duty to the patient is also established.¹⁶³

In addition, the *Fabian* court appears to have misinterpreted the *Manlove* requirements for proving reliance. The court found that the *Manlove* test was based on the concern that "the injured person's condition will deteriorate because he relied on the hospi-

160. The dissent notes that the plaintiff was told, "[y]ou are not a doctor to make a diagnosis; if your doctor said it is a virus, it is a virus." *Id.* at 278, 344 A.2d at 575. Was not valuable time lost in a reassurance that an apparently serious condition was only a virus?

161. Another problem with the *Fabian* court's analysis lies in its assertion that no unmistakable emergency was apparent. Both the concurrence and the dissent agreed that this was a jury question. 236 Pa. Super. at 273, 277, 344 A.2d at 572, 576.

162. Refer to the discussion of *Richard v. Adair Hosp. Found. Corp.*, 566 S.W.2d 791 (Ky. App. 1978) in notes 199-208 *infra* and accompanying text.

163. As noted above, the concurring judge agreed with the dissent that an emergency may have been present, but based his concurrence on the finding that the emergency room physician did not undertake to render medical care via the phone call. In other words, no "sufficient relationship" was established. 236 Pa. Super. at 276, 344 A.2d at 574. This reasoning is more plausible than the majority opinion, but it comes very close to reverting to the common-law rule that a private hospital may refuse to establish any relationship and will thereby not be held liable.

The dissent, on the other hand, found that it was at least *possible* that the emergency room physician undertook to establish a relationship by "confirming [a] medical diagnosis based upon an evaluation of the recited symptoms." *Id.* at 279, 344 A.2d at 575. This is reminiscent of the *O'Neill* court's attempt to find a hospital-patient relationship via a nurse's phone call on behalf of the patient. Refer to notes 54-60 *supra* and accompanying text. The dissent also found that the rule relied upon by the plaintiffs was that a "hospital which maintains an emergency room is under a duty to recognize and respond to a genuine medical emergency." 236 Pa. Super. at 276, 344 A.2d at 575. This characterization, of course, ignores the reliance element of the *Manlove* test.

The COBRA statute requires an examination of the patient to determine if an emergency condition exists. Refer to note 296 *infra* and accompanying text.

tal's *policy* of rendering emergency care."¹⁶⁴ With these words, the court incorporated a fact in *Stanturf*¹⁶⁵ as a *requirement* in meeting the reliance test. Reliance on a well-established *custom* to render aid may be very different from reliance on a particular hospital's admitted *policy* to render aid in emergencies. A policy may serve as evidence of a custom, but the requirement that a policy be in existence and subsequently broken narrows the *Manlove* test almost to an impossibility. Further, the hospital policy in *Fabian*—no admittance except by personal physician—is the same policy evidenced in *Manlove* and common to many hospitals nationwide.¹⁶⁶

Even if the plaintiff establishes a duty under *Manlove* and its breach, he still has the difficult burden of proving causation. *Ruvio v. North Broward Hospital District*¹⁶⁷ illustrates the problem. Ruvio sought admission to North Broward Hospital two days after suffering a coronary infarction, but was told that he was not an emergency case and could be admitted only under doctor's orders.¹⁶⁸ After leaving the hospital, Ruvio went to his physician's office and made arrangements for his immediate admittance.¹⁶⁹ Ruvio was, in fact, in an emergency condition and died 48 hours after his admission to the hospital.¹⁷⁰

The wrongful death action claimed the hospital had wrongfully refused Ruvio admission, and the focus on appeal was proximate cause.¹⁷¹ There was expert testimony on the record that the delay in admission would not have made any difference in Ruvio's condition. The court held that the plaintiff, Ruvio's widow, "failed to establish that any action or inaction on the part of the hospital was the proximate cause of the death . . . or that there was any breach of duty on the part of the hospital staff."¹⁷² The court then cited *Manlove*, stating that "[t]he same conclusion was reached in

164. 236 Pa. Super. at 272, 344 A.2d at 572 (emphasis added).

165. 447 S.W.2d at 562 (Mo. 1969). Refer to notes 112-19 *supra* and accompanying text.

166. *Manlove*, 54 Del. at 17, 174 A.2d at 136. Refer to note 8 *supra* and accompanying text.

167. 186 So. 2d 45 (Fla. Dist. Ct. App.), *cert. denied*, 195 So. 2d 567 (Fla. 1966).

168. 186 So. 2d at 45.

169. *Id.*

170. *Id.*

171. *Id.* at 46.

172. *Id.*

a case involving similar circumstances."¹⁷³

The court's statement is somewhat puzzling. Obviously, the overall conclusions reached in *Manlove* and *Ruvio* are different, since *Manlove* was remanded to determine if an unmistakable emergency existed.¹⁷⁴ The Florida court seems to refer to the following language in *Manlove*:

We should add, however, that if plaintiff cannot adduce evidence showing some incompetency of the nurse, or some breach of duty or some negligence, his case must fail. . . . [W]e sympathize with the parents in their loss . . . but this natural feeling does not permit us to find liability in the absence of satisfactory evidence.¹⁷⁵

Thus, a plaintiff's burden of proving an unmistakable emergency and reliance on a well-established custom is just the beginning. She must then prove that the refusal to treat caused or aggravated the harm. In emergencies, particularly where death results, such evidence may be very difficult to establish.

3. *Accommodations: Capturing the "Spirit" of Manlove.* Because of, or perhaps in spite of, the problems of application, some courts have cited *Manlove* in order to find a duty to provide emergency care; but they have disregarded the finer points of the reliance test, as evidenced by the use of *Manlove* in cases in which the patient was legally admitted.¹⁷⁶ After finding an existing hospital-patient relationship, these courts declined to discuss reliance on a well-established custom, leaving unclear whether these courts would have required reliance in the absence of such admission.¹⁷⁷

For example, soon after *Manlove* was decided, a Mississippi court faced a compelling set of facts in *New Biloxi Hospital, Inc. v. Frazier*.¹⁷⁸ A black¹⁷⁹ veteran was rushed by ambulance to the

173. *Id.*

174. 54 Del. at 26, 174 A.2d at 141.

175. 54 Del. at 26-27, 174 A.2d at 141.

176. See, e.g., *LeJuene Road Hosp., Inc. v. Watson*, 171 So. 2d 202, 204 n.5 (Fla. Dist. Ct. App. 1965); *New Biloxi Hosp., Inc. v. Frazier*, 245 Miss. 185, 186, 146 So. 2d 882, 887-88 (1962). Refer to notes 185-86, 196, 207 & 212 *infra* and accompanying text.

177. Refer to notes 188 & 195 *infra* and accompanying text.

178. 245 Miss. 185, 146 So. 2d 882 (1962).

179. Racism, as well as economic factors, plays a role in the denial of care. See generally *Equal Access*, *supra* note 2, at 3-4 (majority of dumped patients are minorities). *Frazier* preceded the passage of Title VI of the Civil Rights Act of 1964, Pub. L. No. 88-352, §601, 78 Stat. 252-53 (1962), but later cases have raised racial discrimination claims without success. See, e.g., *Campbell v. Mincey*, 413 F. Supp. 16, 21 (N.D. Miss. 1975) (plaintiff's race and indigency unrelated to hospital's refusal to treat), *aff'd*, 542 F.2d 573 (5th Cir. 1976).

emergency room, bleeding profusely from a gunshot wound.¹⁸⁰ The nurse took his blood pressure and pulse and summoned the doctor, neglecting to inform the doctor of the amount of blood lost.¹⁸¹ The doctor arranged for transfer to a Veteran's Administration hospital.¹⁸² Meanwhile, the wounded veteran lapsed into shock after two hours in the emergency room.¹⁸³ The doctor did nothing to stop the bleeding, and the veteran died shortly after the transfer to the V.A. hospital.¹⁸⁴

In the wrongful death action, the court found that the hospital received and recorded the veteran as an emergency room patient.¹⁸⁵ Citing numerous cases, including *Manlove* and *O'Neill*, the court stated, "Under such circumstances, the [h]ospital and its employees had a duty to use reasonable care in protecting his life and well-being."¹⁸⁶

Under the facts of *Frazier*, the *Manlove* reliance theory was not dispositive. *Frazier* was a negligence case and the evidence supported the holding that the decedant bled to death in the hospital's emergency room due to the negligence of the hospital's nurses and doctor.¹⁸⁷ The court found that a hospital-patient relationship existed concurrently with the duty to provide reasonable care under the circumstances.¹⁸⁸

A similar analysis appears in *LeJuene Road Hospital, Inc. v. Watson*.¹⁸⁹ A mother, on the advice of her doctor, took her minor son to the hospital for an operation to remove his appendix.¹⁹⁰ The boy was taken upstairs to the examining room, undressed, examined and given medication.¹⁹¹ After two hours, a hospital employee required them to leave, apparently because of their inability

Refer to notes 233-41 *infra* and accompanying text.

180. 245 Miss. at 193, 146 So. 2d at 885.

181. *Id.*, 146 So. 2d at 885-86.

182. *Id.* at 195, 146 So. 2d at 886.

183. *Id.* at 194, 146 So. 2d at 886.

184. *Id.*, 146 So. 2d at 886.

185. *Id.*, 146 So. 2d at 887.

186. *Id.* at 198, 146 So. 2d at 887-88 (citing, among other sources, both *Wilmington Gen. Hosp. v. Manlove*, 54 Del. 15, 174 A.2d 135 (1961), and *O'Neill v. Montefiore Hosp.*, 11 A.D.2d 132, 202 N.Y.S.2d 436 (N.Y. App. Div. 1960)).

187. *Id.* at 195, 146 So. 2d at 886.

188. *Id.* at 198, 146 So. 2d at 887.

189. 171 So. 2d 202 (Fla. Dist. Ct. App. 1965).

190. *Id.* at 203.

191. *Id.*

to pay a two hundred dollar admittance fee.¹⁹² The child was transferred to a public hospital for the necessary operation.¹⁹³

In the wrongful discharge suit, the court first miscited *Crews* for the proposition that "it is permissible for a private hospital to reject for whatever reason, or no reason at all, any applicant for medical and hospital services."¹⁹⁴ The court then distinguished the case at bar on the fact that the hospital physically and "legally admitted" the boy, establishing a basis for liability.¹⁹⁵

Watson does not appear to rely on *Manlove*, but the court refers the reader to the Delaware decision in a puzzling footnote, and declines to discuss a hospital's obligation to an emergency patient.¹⁹⁶ Rather than depend on the *Manlove* reliance test, which the court could have applied, it apparently felt safer characterizing the facts as an admission and applying traditional negligence terms.

Other courts have found a duty to treat emergencies in cases lacking evidence of a hospital-patient relationship.¹⁹⁷ These courts, accepting the "spirit" of *Manlove*, make no mention of, nor require reliance on a well-established custom.¹⁹⁸

In *Richard v. Adair Hospital Foundation Corp.*,¹⁹⁹ the plaintiff brought his daughter to the emergency room twice in one day, leaving without treatment each time.²⁰⁰ The nurse first declined to examine the infant, but on the second trip felt her head before deciding there was no emergency.²⁰¹ The child's condition worsened and the next day another hospital admitted her.²⁰² The diagnosis was bronchial pneumonia and although the hospital adminis-

192. *Id.*

193. *Id.*

194. *Id.* (citing *Birmingham Baptist Hosp. v. Crews*, 229 Ala. 398, 157 So. 224 (1934) (private hospital owes no duty to admit contagious patient in violation of its rules)).

195. Refer to note 61 *supra*.

196. 171 So. 2d at 203-04 n.5 "what has been said above [distinguishing *Crews* and finding an admission to the hospital] does not in any way affect a hospital's obligation when presented with an emergency patient. For an excellent discussion of the law applicable thereto, see *Wilmington General Hospital v. Manlove*."

197. See, e.g., *Richard v. Adair Hosp. Found. Corp.*, 566 S.W.2d 791, 792 (Ky. Ct. App. 1978); *Mercy Medical Center of Oshkosh, Inc. v. Winnebago County*, 58 Wis. 2d 260, 263, 206 N.W.2d 198, 200-01 (1973).

198. Refer to notes 199-212 *infra* and accompanying text.

199. 566 S.W.2d 791 (Ky. Ct. App. 1978).

200. *Id.* at 792.

201. *Id.*

202. *Id.*

tered emergency treatment, she died within five hours.²⁰³

In the wrongful death action, an expert testified that the child's chances of recovery would have been substantially greater had she been treated earlier.²⁰⁴ In reversing a summary judgment for the defendant, the court stated that "[i]n a non-emergency situation there is no duty on the part of a county hospital to admit or treat a patient. . . ."²⁰⁵ The court recognized an exception to the general rule in the case of emergencies, citing *Manlove* for the proposition that pneumonia may rise to the level of an emergency situation.²⁰⁶ The court left the ultimate question of liability to the jury.²⁰⁷

Richard fails to mention reliance or a custom to render emergency care, noting only that liability may be predicated on refusal to treat in an emergency situation and that pneumonia was an emergency under the circumstances.²⁰⁸ The court was obviously less concerned with requiring proof of a well-established custom than with accepting the moral and ethical basis, or the "spirit," of *Manlove*.

The "spirit" of *Manlove* possessed the Supreme Court of Wisconsin in *Mercy Medical Center v. Winnebago County*.²⁰⁹ The case was an action to recover the cost of emergency hospital treatment from the county.²¹⁰ Holding the county liable, the court discussed the patient's right to treatment.²¹¹ Citing *Manlove* and recounting essentially the entire history of the issue, the court concluded:

[T]he courts holding a hospital liable for failure to give emergency treatment are still in the minority. . . . We think, however, that today, without [sic] our society's emphasis upon a concern for the health of its citizens, private hospitals with emergency wards and facilities for emergency services have a duty to admit those in need of aid. It would shock the public conscience if a person in need of medical emergency aid would be turned down at the door of a hospital having emergency service because that

203. *Id.*

204. *Id.*

205. *Id.* at 793.

206. *Id.*

207. *Id.* (the question was "whether appellee was negligent in twice refusing hospital admission to the infant . . . when an unmistakable situation may have existed").

208. *Id.*

209. 58 Wis. 2d 260, 206 N.W.2d 198 (1973).

210. *Id.* at 261, 206 N.W.2d at 198.

211. *Id.* at 262, 206 N.W.2d at 200-01.

person could not at that moment assure payment for the service. The public expects such service. . . .²¹²

While certain jurisdictions have cited *Manlove* for one proposition or another, the reliance test did not significantly expand the duty to treat in an emergency. Contrary to the predictions, *Manlove* did not gain nationwide judicial acceptance as an enforcement tool to expand the right to emergency care.

III. THE GUERRERO CASE: THE SEARCH FOR AN ALTERNATIVE THEORY

In 1975, the Arizona Supreme Court summarily rejected the *Manlove* theory, embraced by the Arizona Court of Appeals,²¹³ and replaced it with a theory of its own. In *Guerrero v. Copper Queen Hospital*,²¹⁴ two children received severe burns when a stove exploded in their home in Mexico.²¹⁵ The Guerreros brought them for treatment to the Copper Queen Hospital, located close to the Mexican border.²¹⁶ The hospital refused treatment, forcing a trip to another hospital.²¹⁷ The children sued through a guardian ad litem, alleging that the delay in treatment caused them to suffer additional injury and prolonged convalescence.²¹⁸

The Guerreros urged the court to adopt the rule set forth in *Manlove*.²¹⁹ The defendants asserted the common-law rule that a private hospital is under no obligation to accept any patient.²²⁰ The court found the parties' reliance on either rule misplaced, holding that "[a] private hospital has no duty to accept a patient or serve everyone *unless* a different public policy has been declared by statute or otherwise."²²¹

The court then advanced an argument neither briefed nor argued by the plaintiffs,²²² borrowing from the theoretical basis of

212. *Id.* at 267-68, 206 N.W.2d at 201.

213. 22 Ariz. App. 611, 612, 529 P.2d 1205, 1206 (1974).

214. 112 Ariz. 104, 537 P.2d 1329 (1975).

215. *Id.* at 105, 537 P.2d at 1330.

216. *Id.*, 537 P.2d at 1330.

217. *Id.*, 537 P.2d at 1330.

218. *Id.*, 537 P.2d at 1330.

219. *Id.*, 537 P.2d at 1330.

220. *Id.* at 105-06, 537 P.2d at 1330-31. The hospital was a division of the Phelps Dodge Corporation. *Id.* at 105, 537 P.2d at 1330.

221. *Id.* at 106, 537 P.2d at 1331 (emphasis added).

222. *Id.* at 107, 537 P.2d at 1332 (Struckmeyer, C.J., concurring).

the Superior Court opinion in *Manlove*.²²³ The court found that “[t]he character of private hospitals in Arizona has been changed by statute and regulations.”²²⁴ The court noted that private hospitals must be licensed by the state to operate, that the state board of health had authority to adopt rules and regulations for licensed hospitals, and that since 1964 regulations required a general hospital to maintain an emergency room.²²⁵ Thus, the court held that Arizona public policy required a general hospital to maintain facilities for the provision of emergency care, and “that such a hospital may not deny emergency care without cause.”²²⁶

With this duty clearly established, the court rejected the hospital’s attempt to come within the protection of Arizona’s Good Samaritan statute, which immunizes individuals from liability for withholding aid in emergency situations.²²⁷ The court held the statute inapplicable to emergency medical treatment, since the hospital had a *public duty* to provide emergency services.²²⁸

Guerrero offers an alternative theory for establishing a duty to treat emergencies. Arizona licensing laws altered the common-law no-duty rule by requiring the maintenance of emergency services for the public benefit, without regard for ability to pay. Because the *Manlove* theory garnered only limited acceptance nationwide, and because the hospital industry was highly regulated, numerous statutes, regulations, and bylaws existed on which to base this theory of liability.

In *Thompson v. Sun City Community Hospital, Inc.*,²²⁹ the Arizona Supreme Court affirmed and expanded *Guerrero*.²³⁰ The opinion reiterated the rule that “licensed hospitals in this state are required to accept and render emergency care to all patients who

223. Refer to notes 68-76 *supra* and accompanying text.

224. 112 Ariz. at 106, 537 P.2d at 1331.

225. *Id.*, 537 P.2d at 1331.

226. *Id.*, 537 P.2d at 1331. The concurring opinion urged the acceptance of the *Manlove* rule, arguing that the majority’s statutory argument was not properly raised in the lower court and should not serve as the basis for the decision. *Id.* at 107, 537 P.2d at 1332 (Struckmeyer, C.J., concurring).

227. *Id.* at 106, 537 P.2d at 1331.

228. *Id.*, 537 P.2d at 1331. For further discussion of the application of Good Samaritan laws to emergency room settings, refer to notes 355-63 *infra* and accompanying text.

229. 141 Ariz. 597, 688 P.2d 605 (1984).

230. *Id.* at 602, 688 P.2d at 610. See also *Hiser v. Randolph*, 126 Ariz. 603, 611, 617 P.2d 774, 777 (1980) (physician contractually bound to bylaws and rules of hospital obligated to treat emergency room patients).

present themselves in need of such care."²³¹ It further established that in Arizona, there are only three possible defenses to the denial of emergency care: (1) the hospital is not obligated or capable under its state license to provide the needed emergency care; (2) there is a valid *medical* cause to refuse emergency care; or (3) there is no true emergency.²³²

The *Guerrero* approach has met with less success in other jurisdictions. An example is *Campbell v. Mincey*,²³³ decided shortly after *Guerrero*. The plaintiff was a black woman, in labor, who was refused treatment by Marshall County Hospital.²³⁴ She gave birth to her son in the hospital parking lot, in the front seat of a neighbor's car.²³⁵ Plaintiff based her claim, in part, on the violation of certain state statutes which mainly dealt with the licensing requirements for Mississippi hospitals.²³⁶ The court, however, found that these statutes were "irrelevant to the issues litigated in the cause."²³⁷ The one statute the court did find "germane" to the issues required hospitals to comply with certain rules and regulations promulgated by the Mississippi Commission on Hospital Care or face revocation of their licenses.²³⁸ The court decided, however, that the regulations imposed duties only upon the hospital, and not its managers or employees.²³⁹ The hospital was not a party defendant to the suit.²⁴⁰

The *Campbell* court also recognized a common-law "trend" toward imposing liability on hospitals for refusing to treat in emergency situations, but found that these cases all involved an arbitrary refusal to treat which was a

marked departure from previous hospital custom and procedure. The refusal of the staff of the Marshall County hospital to admit or treat the plaintiffs here was in compliance with, rather than a departure from hospital policy not to admit patients who are not

231. 141 Ariz. at 602, 688 P.2d at 610.

232. *Id.* at 603, 688 P.2d at 611.

233. 413 F. Supp. 16 (N.D. Miss. 1975), *aff'd mem.*, 542 F.2d 573 (5th Cir. 1976).

234. 413 F. Supp. at 18.

235. *Id.* at 19.

236. *Id.* The plaintiff also alleged racial discrimination, but the court rejected her contention as against the weight of the evidence. *Id.* at 21-22.

237. *Id.* at 19.

238. *Id.*

239. *Id.*

240. *Id.* at 20.

referred by local physicians.²⁴¹

In making this statement, the court is simply wrong, or at least confused. Several cases following the "trend" involved hospitals with an admittance policy similar to that of Marshall County Hospital.²⁴² Admittance as an in-patient following emergency treatment was not an issue.

In addition, the *Campbell* court emphasized that no physical harm or injury resulted to either plaintiff or her son, which the court considered as proof that there was not an emergency.²⁴³ The birth was "normal in all respects other than the location and the absence of a doctor at the immediate time of the birth."²⁴⁴ Therefore, the plaintiff's active labor was not a "true" emergency, and hospital admission regulations were inapplicable under the circumstances.²⁴⁵ *Campbell* was a major set back for legal advocates who hoped that *Campbell* would further the trend toward establishing a duty to provide emergency care.

In fact, the *Guerrero* approach had little impact outside Arizona.²⁴⁶ Also, while *Guerrero* did not involve the same application problems that plagued the *Manlove* test, it required courts to make the leap from statutes and regulations—designating certain standards for hospital licensing—to a duty to treat any and all persons in need of emergency care, based on broad public policy concerns. Morally, the connection is desirable, but legally, it required the creation of a private cause of action implied from state licensing statutes. Particularly in light of the perceived malpractice "crisis" in the mid-1970s, courts may have been reluctant to expand duties without specific guidance from the legislature.

IV. STATE LAW AND FEDERAL HILL-BURTON: LIMITED IMPACT

A. State Legislation

Almost half of the states have legislation requiring hospitals to

241. *Id.* at 20.

242. See, e.g., *Manlove*, 54 Del. at 17, 174 A.2d at 136; *Hill*, 468 S.W.2d at 308; *Fabian*, 236 Pa. Super. at 269, 344 A.2d at 570. Refer to notes 65, 137 & 151 *supra* and accompanying text.

243. 413 F. Supp. at 21.

244. *Id.* at 19.

245. *Id.* at 22-23.

246. The reason is not completely clear, but may be due to the fact that *Guerrero* depended on Arizona statutory policy with little precedential value elsewhere.

provide emergency care regardless of ability to pay, some requiring that patients be in stable condition before transfer to another hospital.²⁴⁷

As early as 1927, Illinois law required that every licensed hospital "which provides general medical and surgical hospital services shall provide a hospital emergency service . . . and shall furnish such hospital emergency services to any applicant who applies for the same in case of injury or acute medical condition where the same is liable to cause death or severe injury or serious illness."²⁴⁸ This statute has never been successfully applied to establish a private cause of action for failure to treat a patient.²⁴⁹ Furthermore, the law lacks effective public enforcement. Cook County Hospital physicians continue to report an increase in "dumping" of emergency patients from the private hospitals in Chicago.²⁵⁰

In recent years, a few states have passed "antidumping" laws requiring hospitals to give emergency room patients the care necessary to stabilize their condition and regulating the manner of transfer from one hospital to another, regardless of ability to pay.²⁵¹ The various approaches include providing for notice to pa-

247. See, e.g., CAL. HEALTH & SAFETY CODE §§ 1317, 1317.2-.2a, 1798.170-.172 (West Supp. 1988); COLO. REV. STAT. §§ 26-15-101 to -104, -106 (Supp. 1987); FLA. STAT. ANN. §§ 395.0143-.0145, 401.45 (West 1986 & Supp. 1988); GA. CODE ANN. §§ 31-8-40 to -46 (1985); HAW. REV. STAT. § 321-232(b) (1985); KY. REV. STAT. ANN. §§ 216B.400(1)-.990(3) (Michie/Bobbs-Merrill 1982); LA. REV. STAT. ANN. §§ 40.2113.4(A)-(B), -2113.6 (West Supp. 1988); MASS. GEN. LAWS ANN. ch. 111, § 70E(k), (n) (West 1983 & Supp. 1988); MICH. COMP. LAWS ANN. §§ 333.20703, -.20704(4), -.20715 (West Supp. 1987); TENN. CODE ANN. §§ 68-39-301, -302, -511(12) (1987); TEX. REV. CIV. STAT. ANN. art. 4438a (Vernon Supp. 1988); UTAH CODE ANN. §§ 26-8-2(11), -8(1) (1984); WIS. STAT. ANN. § 146.301 (West Supp. 1987); WYO. STAT. § 35-2-115(a) (1977).

248. ILL. STAT. ANN. ch. 111 ½, para. 86 (Smith-Hurd 1977).

249. In *Johnson v. St. Bernard Hosp.*, 79 Ill. App. 3d 709, 399 N.E.2d 198 (1979), the Appellate Court of Illinois held that the statute did not impose a duty upon a hospital to assume responsibility for the practice of medicine within an independently operated emergency room. 399 N.E.2d at 203. The refusal of treatment actually occurred, however, after the hospital admitted the patient. *Id.* at 200. The suit also alleged a claim of negligent emergency room care. *Id.* at 204.

Other cases discussing the statute deal only with questions of payment for an indigent's emergency care. *Methodist Medical Center v. Ingram*, 82 Ill. 2d 511, 413 N.E.2d 402, 406 (1980); *Lazzara v. Dreyer Medical Clinic*, 120 Ill. App. 3d 721, 458 N.E.2d 958, 960-61 (1983); *Gasbarra v. St. James Hosp.*, 85 Ill. App. 3d 32, 406 N.E.2d 544, 551-52 (1979); *St. John's Hosp. of the Hosp. Sisters of the Third Order of St. Francis v. Town of Capital*, 75 Ill. App. 2d 222, 226, 220 N.E.2d 333, 335 (1966).

250. Ansell & Schiff, *Patient Dumping*, 257 J. A.M.A. 1500, 1500 (1987).

251. CAL. HEALTH & SAFETY CODE §§ 1317, 1317.2-.2a, 1798.170,-.172 (West Supp. 1988); FLA. STAT. ANN. § 395.0144 (West Supp. 1988); LA. REV. STAT. ANN. § 40.2113.6(C) (West Supp. 1988); MD. HEALTH-GEN. CODE ANN. § 19-308.2 (1987); MASS. GEN. LAWS ANN.

tients of their rights to treatment; strengthening enforcement mechanisms, including private causes of action; and creating penalties for failure to comply.²⁵²

A few state approaches are illustrative. In Massachusetts, the "Patient's Bill of Rights" provides a right to prompt life-saving treatment in an emergency regardless of ability to pay.²⁵³ The requirement to provide this care is extended to both the health care facility and the physician in the facility.²⁵⁴ Treatment may not be delayed to discuss payment if such delay imposes material risk to the potential patient.²⁵⁵ A recent amendment to this law provides the patient with a right to "prompt and safe transfer to a facility which agrees to receive and treat such patient."²⁵⁶ The statute recognizes that a private cause of action may be filed by a person whose rights have been violated.²⁵⁷ The statute makes no clear provision for state-imposed penalties.²⁵⁸

California recently passed comprehensive legislation that mandates all licensed health care facilities with emergency departments to provide emergency services to any person requesting care for an emergency condition.²⁵⁹ The emergency services shall be rendered without first questioning the person about his or her ability to pay.²⁶⁰ Further, the statute provides for the recovery of "damages, reasonable attorneys' fees, and other appropriate relief" in a civil action.²⁶¹ The health facility, its employees and physicians, dentists, and podiatrists, however, shall not be liable if the refusal of services "is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition"²⁶²

ch. 111, § 70E(n) (West Supp. 1988); 35 PA. CONS. STAT. ANN. § 449.8(a) (Purdon Supp. 1988); TENN. CODE ANN. § 68-11-701 to -705 (1987); TEX. REV. CIV. STAT. ANN. art. 4437f, §§ 5(b) & (d), 9c (Vernon Supp. 1988).

252. Waxman & Dorn, *States Take the Lead in Preventing Patient Dumping*, 22 CLEARINGHOUSE REV. 136, 136 (1988).

253. MASS. GEN. LAWS ANN. ch. 111, § 70E (West 1983 & Supp. 1988).

254. *Id.* §§ 70E(a) & (k).

255. *Id.* § 70E(k).

256. *Id.* § 70E(n).

257. *Id.* § 70E.

258. *Id.*

259. CAL. HEALTH & SAFETY CODE § 1317(a) (West Supp. 1988).

260. *Id.* § 1317(d).

261. *Id.* § 1317.6(f).

262. *Id.* § 1317.6(g). Florida recently adopted a similar emergency care statute. FLA. STAT. ANN. § 395.0144 (West Supp. 1988).

In Texas, state law provides that all general hospitals must provide emergency services to patients regardless of ability to pay.²⁶³ The Texas Hospital Licensing Law and its implementing regulations also provide comprehensive emergency transfer standards.²⁶⁴ A strict enforcement scheme allows any person harmed by the failure of a hospital "to timely adopt, implement, or enforce a patient transfer policy" to seek injunctive relief or "remedies for civil damages existing under current common law."²⁶⁵

Most state laws, however, do not recognize the right of an injured party to sue the hospital for failure to comply. Without express statutory authority, courts are reluctant to create such a right. For example, New York has a statute requiring general hospitals to admit and provide emergency medical treatment to all in immediate need, without advance payment or questioning as to payment.²⁶⁶ In *Quijije v. Lutheran Medical Center*,²⁶⁷ the plaintiff sued a public hospital for failure to "render timely medical treatment to plaintiffs' infant daughter when advance payment therefore could not be made."²⁶⁸ The court struck down a motion to amend the complaint and assert a cause of action on behalf of the mother, individually, for emotional distress arising from observing the suffering and death of her baby.²⁶⁹ In asserting the additional cause of action, the mother relied on the statute noted above, but the court held that it provided an insufficient basis for the claim, noting that "if [the statute] creates any specific duty at all, such duty would run from the hospital to the individual needing medical care."²⁷⁰

In fact, most state laws have limited enforcement potential. First, many laws still lack implementing regulations. The definition of an emergency lacks clarity or is defined too narrowly. Many state laws do not address the problems of transfer that arise from a lack of appropriate services, and most laws allow transfer after "stabilization," a term often used to justify economic, not medical,

263. TEX. REV. CIV. STAT. ANN. art. 4438a (Vernon Supp. 1988).

264. *Id.* art. 4437f, §§ 5(b)-(d), 9c (Vernon 1976 & Supp. 1988).

265. *Id.* § 9c.

266. N.Y. PUB. HEALTH LAW § 2805-b (McKinney 1985 & Supp. 1987). *See also* *People v. Flushing Hosp. & Medical Center*, 122 Misc. 2d 260, 471 N.Y.S. 2d 745 (N.Y. Crim. Ct. 1983).

267. 92 A.D.2d 935, 460 N.Y.S.2d 600 (N.Y. App. Div. 1983).

268. *Id.* at 935, 460 N.Y.S. 2d at 600.

269. *Id.* at 935-36, 460 N.W.S.2d at 600-01.

270. *Id.* at 936, 460 N.Y.S.2d at 601.

reasons.²⁷¹ In addition, state laws experience little meaningful enforcement. Only a few states levy fines, usually minimal, for violations.²⁷² Given the failure of the common law and most state legislation to *uniformly* mandate a duty, can federal legislation provide the solution?

B. Hill-Burton: An Ineffective Approach

With its passage in 1946, the Hospital Survey and Construction Act, commonly referred to as the Hill-Burton Act, provided federal funds for the construction and modernization of public and private nonprofit health care facilities.²⁷³ Over half the hospitals nationwide received assistance.²⁷⁴ In consideration for funds, Hill-Burton hospitals must provide a certain percentage of uncompensated care for twenty years and continue to satisfy certain community service obligations.²⁷⁵

The community service obligations prevent a Hill-Burton facility from denying emergency services to any person who resides, or for Title XVI facilities, works, in the facility's service area because that person is unable to pay.²⁷⁶ A facility may discharge or transfer a person to another facility for necessary treatment only after appropriate personnel determine that the transfer will not subject the person to a substantial risk of deterioration in medical condition.²⁷⁷

271. See Ansell & Schiff, *supra* note 250, at 1500-02; see also *Equal Access*, *supra* note 2, at 106 (statement of Arnold Relman, M.D., Editor, NEW ENGLAND JOURNAL OF MEDICINE).

272. Dowell, *Indigent Access to Hospital Emergency Room Services*, 18 CLEARINGHOUSE REV. 483, 487 (1984).

273. 42 U.S.C. § 291 (1982); 42 C.F.R. § 124 (1979).

274. Dowell, *supra* note 272, at 487.

275. 42 U.S.C. § 291c(e) (1982); see generally Wing, *The Community Service Obligation of Hill-Burton Health Facilities*, 23 B.C.L. REV. 577, 597 (1982) ("[T]o conclude . . . that Congress could not have intended to condition receipt of funds on the provision of either uncompensated service or . . . community service, is simply a leap of logic not justified by any reading of the legislative history . . ."). The 20-year limitation is not expressly part of the statute. *American Hosp. Ass'n v. Schweiker*, 721 F.2d 170, 181 (7th Cir. 1983).

276. 42 C.F.R. § 124.603 (1979).

277. *Id.* The regulations do not define the term "emergency," but the Office of Civil Rights (OCR) of the Department of Health and Human Services (HHS) provides in its policy manual that emergency services are those "necessary to prevent the death or serious impairment of the health of the individual." DEPARTMENT OF HEALTH & HUMAN SERVICES, OFFICE OF CIVIL RIGHTS, A GUIDE TO PLANNING THE HILL-BURTON COMMUNITY SERVICE COMPLIANCE REVIEW 31 & Tab B (1981) [hereinafter OCR COMMUNITY SERVICE GUIDE] (cited in A. FREIFELD, THE RIGHT TO HEALTH CARE: AN ADVOCATE'S GUIDE TO THE HILL-BURTON UN-

Inability to pay is not a valid reason for denying emergency service, nor is the fact that the person does not have a physician with admitting privileges at the Hill-Burton facility.²⁷⁸ Appropriate hospital personnel must at least make a sufficient appraisal of the person's condition before denying emergency services or transferring the patient.²⁷⁹

Until the early 1970s, however, hospitals basically ignored community service obligations. Legal service advocates looked to Hill-Burton obligations as a new source of access for the poor into the emergency room. *Cook v. Ochsner Foundation Hospital*²⁸⁰ established that the Hill-Burton Act did, in fact, mandate community service obligations.²⁸¹ Unlike the uncompensated care obligation, no durational limit attached to community service, including the provision of emergency services.²⁸² In 1983, the Seventh Circuit, in *American Hospital Association v. Schweiker*,²⁸³ finally affirmed the current regulations, originally issued in 1979, mandating a continuing obligation to provide community service, including emergency care services to all in a hospital's area, regardless of ability

COMPENSATED CARE AND COMMUNITY SERVICES REQUIREMENTS 40 (National Health Law Program 1986) [hereinafter ADVOCATE'S GUIDE]). Furthermore, the OCR COMMUNITY SERVICE GUIDE clarifies that pregnant women who present themselves at an emergency room should be accepted for treatment "as soon as labor is established." OCR COMMUNITY SERVICE GUIDE, *supra*, at Tab B. In at least two compliance actions, the Office of Civil Rights held that Hill-Burton hospitals cannot deny service because the women received little or no prenatal care. *In re Johnston Memorial Hosp.*, HHS/OCR No. 03813146 (Abingdon, Va., Apr. 7, 1983); *In re St. Francis Hosp. & Medical Center*, HHS/OCR No. 07823004 (Topeka, Kan., Oct. 29, 1982) (as reported in ADVOCATE'S GUIDE, *supra*, at 43-44, 81 n.59). Additionally, an examination is required before denial even if the hospital alleges that treatment is unnecessary or unavailable. See ADVOCATE'S GUIDE, *supra*, at 40-44.

278. 42 C.F.R. § 124.603(b)(2) (1979).

279. *Id.* §§ 124.603(a)(1) & (b)(1). In *Aguinaga v. Castro County Hosp. Dist.*, Civ. No. CA 2-79-205 (N.D. Tex.) (settled Jan. 13, 1984) (as reported in ADVOCATE'S GUIDE, *supra* note 277, at 44, 82 n.61), an eleven-month-old baby died after the hospital refused admission for lack of a \$450 advance deposit. *Id.* In the settlement, the hospital agreed to (1) provide emergency services regardless of ability to pay; (2) condition hospital privileges on a certain amount of emergency care and supervision; (3) transfer patients only if the other hospital agreed to provide the care; and (4) pay for the care of a transferred patient. *Id.* *Aguinaga* is one of the rare cases when the injured was able to exhaust all administrative remedies and file suit against the hospital.

280. 61 F.R.D. 354 (E.D. La. 1972).

281. *Id.* at 360.

282. *Lugo v. Simon*, 426 F. Supp. 28, 36 (N.D. Ohio 1976). See 42 U.S.C. § 291c (1982) (uncompensated care obligation of twenty years). Prior community service regulations imposed a time limit, but *Lugo* invalidated them. 426 F. Supp. at 36. See also *Wing*, *supra* note 275.

283. 721 F.2d 170 (7th Cir. 1983), *cert. denied*, 466 U.S. 958 (1984).

to pay.²⁸⁴

Court victories have been few and far between.²⁸⁵ Attempts to bring court action are delayed by the requirement that a complainant must first exhaust all administrative remedies.²⁸⁶ Nor does the statute expressly provide for a private right of action. In cases involving an implied private right of action, the statute's vague language has sometimes made it difficult for the court to provide meaningful remedies.²⁸⁷ As recently as 1985, the Sixth Circuit²⁸⁸ held that plaintiffs had no cause of action to force investigation or effect compliance by the regulated facilities. The Hill-Burton Act continues to be plagued with little or no enforcement.²⁸⁹ Legal advocates on behalf of the poor have been frustrated. Clearly, the Hill-Burton Act has not proved to be an effective enforcement tool for establishing a duty to provide emergency care.²⁹⁰

284. 721 F.2d at 178.

285. See, e.g., *Lane v. Lincoln County Hosp.*, 537 F. Supp. 114, 120 (E.D. Tenn. 1982) (current regulations not applicable to hospital, receiving Title VI assistance, that did not provide adequate assurances). See also *Newsom v. Vanderbilt Univ.*, 653 F.2d 1100, 1107-10 (6th Cir. 1981) (failure to comply not proven).

286. 42 C.F.R. § 124.606(a)(4)(1987). Administrative complaints require dismissal before civil action is proper. *Id.* The complainant, however, is not notified of their satisfaction of the exhaustion requirements or that a suit is maintainable. ADVOCATE'S GUIDE, *supra* note 277, at 96. See also *Barlow v. Marion County Hosp. Dist.*, 495 F. Supp. 682, 690-93 (M.D. Fla. 1980) (exhaustion requirement not effected by alleging civil rights claims).

287. See Rosenblatt, *Health Care Reform & Administrative Law: A Structural Approach*, 88 YALE L.J. 243, 273-76 (1978) (citing *Perry v. Greater S.E. Community Hosp. Found.*, No. 725-71 (D.D.C. June 28, 1972) (no relief)); *Cook v. Ochsner Found. Hosp.*, 319 F. Supp. 603, 606 (E.D. La. 1970) (granting relief). See also Note, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. Rev. 1186, 1200 (1986) [hereinafter Note, *Preventing Patient Dumping*].

288. *Gillis v. United States Dep't of Health and Human Servs.*, 759 F.2d 565, 578 (6th Cir. 1985).

289. HHS has not provided facilities with formal technical assistance nor clear policies and procedures for implementing community service assurances. Its Office for Civil Rights has also been lax in review of violations. Dowell, *supra* note 272, at 487-88.

290. Another potential enforcement tool is the tax law. Under both state and federal law, nonprofit hospitals are eligible for tax exemption. Legal advocates have been successful in a few instances in having the tax exempt status revoked for the hospital's failure to provide necessary hospital services to those unable to pay as a denial of a charitable purpose. Of course, such action does not provide the poor with a private cause of action, but the threat of change in tax status may work as an effective enforcement tool. See Dowell, *supra* note 272, at 489-90. See also *Lugo v. Miller*, 640 F.2d 823 (6th Cir. 1981) (low income individuals brought class action challenging revenue ruling which states that hospitals are not compelled to provide free non-emergency care to maintain tax exempt status.) At least one attempt has been made to use the violation of Medicare regulations regarding emergency care conditions of participation to prove negligence in a private cause of action. See *Distad v. Cubin*, 633 P.2d 167 (Wyo. 1981).

V. THE COBRA STATUTE: THE FEDERAL SOLUTION?

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, effective August 1, 1986, added a new section to the Medicare provisions, entitled "Examination and Treatment for Emergency Medical Conditions and Women in Labor."²⁹¹

The Ways and Means Committee of the House of Representatives introduced the new provision because it was greatly concerned about the increasing number of reports that hospital emergency rooms were refusing to accept or treat patients with emergency conditions if the patient did not have medical insurance.²⁹² The main concern of the Committee was that medically unstable patients were being treated inappropriately. There continued to be reports of cases in which treatment was simply not provided and of patients in an unstable condition who had been transferred improperly, sometimes without the consent of the receiving hospital.²⁹³

A. *The Provisions*

COBRA applies to hospitals that participate in the Medicare program. This includes virtually all hospitals. However, hospitals without an emergency service, any facility that is not a hospital, free-standing emergency facilities that are not owned or formally affiliated with a hospital, and ambulatory care facilities and their staff physicians are all exempt from the federal law.²⁹⁴ The law protects *all* persons who come to an emergency room, whether or not such persons are eligible for Medicare benefits.²⁹⁵ All persons who show up at the emergency door must be treated alike, whether

291. The new statute is found at 42 U.S.C. § 1395dd (1986). The emergency care provisions generally are referred to as "COBRA." Proposed rules were not issued until June 1988. 53 Fed. Reg. 22,513 (proposed June 16, 1988) (to be codified at 42 C.F.R. pts. 405, 489, 1001, 1003). Refer to note 4 *supra* and accompanying text.

292. H.R. REP. No. 241, 99th Cong., 1st Sess., pt. 1, at 21 (1985). Refusal to treat indigent patients has increased because fewer patients have adequate health insurance and most insurers, including Medicare and Medicaid, will not pay hospitals for the extra cost of cross-subsidizing cases of those unable to pay. With new competitive pressures to cut costs, there is even less economic incentive to subsidize emergency care than there was a decade ago. The growth of investor-owned for-profit hospitals, which generally discourage treatment of the nonpaying patient, has further exacerbated the problem. *See Equal Access, supra* note 2, at 98-99, 105 (statement of Dr. Relman).

293. H.R. REP. No. 241, 99th Cong., 1st Sess., pt. 1, at 21 (1985).

294. 42 U.S.C. § 1395dd(a) (1986).

295. *Id.*

or not they are insured. This duty is not conditioned on any guarantee of government reimbursement.

The federal statute requires that the hospital examine each person who requests medical treatment to determine if an emergency situation exists or if the individual is in active labor.²⁹⁶ If such person is in active labor or in need of emergency care, then the hospital must: (1) provide treatment to stabilize the emergency condition; (2) provide treatment for labor; or (3) provide for an "appropriate transfer" of the patient to another medical facility.²⁹⁷

An "appropriate transfer" is carefully defined under the statute. If the patient has not been stabilized, or is in active labor, the hospital *may not* transfer unless: (1) the patient or legally responsible person acting on behalf of the patient requests a transfer;²⁹⁸ or (2) a physician, or other qualified person when a physician is not readily available, signs a certification to the effect that the "medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer."²⁹⁹ A patient *may* be transferred *only if*: (1) the receiving hospital or facility has available space, qualified personnel for treatment of the patient, has agreed to the transfer and has been provided with the appropriate medical records from the transferring hospital;³⁰⁰ and (2) the transfer is made using proper

296. *Id.* The statute defines an "emergency medical condition" as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in —

- (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."

Id. § 1395dd(e)(1).

"Active labor" is defined as "labor at a time at which —

- (a) delivery is imminent,
- (b) there is inadequate time to effect safe transfer to another hospital prior to delivery or,
- (c) a transfer may pose a threat to the health and safety of the patient or the unborn child."

Id. § 1395dd(e)(2).

297. *Id.* § 1395dd(b). The statute also provides that the hospital has met its duty if medical treatment is refused by the patient, or if the patient refuses an "appropriate" transfer. *Id.*

298. *Id.* § 1395dd(c)(1).

299. *Id.* For example; the patient is badly burned and the transfer hospital has a special burn trauma unit.

300. 42 U.S.C. § 1395dd(c)(2) (1986).

personnel and equipment;³⁰¹ and (3) the transfer meets any other requirements which the Secretary of Health, Education and Welfare may deem necessary.³⁰²

Violations of the statute subject a hospital to suspension or termination of its Medicare provider agreement.³⁰³ In addition, both the hospital and the "responsible physician"³⁰⁴ may be charged a fifty-thousand-dollar civil penalty for each knowing violation of the statute.³⁰⁵ The penalty provisions were a matter of controversy. The original bill provided for the imposition of criminal penalties on a "responsible physician," allowing fines of up to 100,000 dollars and imprisonment for up to one year, or both.³⁰⁶ This provision was harshly criticized,³⁰⁷ and the House Committee

301. *Id.* This includes the use of necessary and appropriate life support measures.

302. *Id.*

303. *Id.* § 1395dd(d)(1).

304. A "responsible physician" is defined as one who is employed by or under contract with the hospital and, within the scope of his/her employment or duties under the contract "has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred." *Id.* § 1395dd(d)(2). The proposed rule further expands on this definition. 53 Fed. Reg. 22,513, 22,525 (proposed June 16, 1988).

305. *Id.* This amount was raised from \$25,000 to \$50,000 for violations occurring on or after December 22, 1987 pursuant to the Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4009(a)(1), 101 Stat. 1330, 1330-57 (1987). Further technical amendments were made in the Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 411(b)(8), 102 Stat. 683, 771 (1988).

306. H.R. REP. NO. 241, 99th Cong., 1st Sess., pt. 3, at 14 (1985).

307. Paul M. Bunge, representing the Miami, Florida law firm of Kenny, Nachwalter & Seymour, wrote to the Judiciary Committee and charged that criminal sanctions were too harsh:

The availability of insurance coverage for violations of [the proposed bill] is questionable. Most policies specifically exclude coverage for damages incurred as a result of criminal acts, and insurance in such circumstances may otherwise be prohibited as a matter of public policy. . . . The Committee should also bear in mind that most States require the revocation of a medical license upon conviction of a felony related to the practice of medicine Thus the violation, purposeful or inadvertent, of [the bill] by a physician will almost always result in that physician's removal from the profession. . . . I fear that [the proposed bill] is overbroad in its application, vague in its requirements and unnecessarily severe in its sanctions.

Id. at 19-20.

The American College of Emergency Physicians also wrote to the Judiciary Committee:

Although we are in agreement with the objective of the legislation (i.e., to eliminate inappropriate patient transfers), we believe the statutory language is excessively punitive to emergency physicians without truly addressing the patient transfer problem. The language as approved by the Ways and Means Committee is so intimidating to emergency physicians that transfers which are in the best interest of patient care may be avoided or delayed. Because of the uncertain na-

on the Judiciary deleted it because it was "unnecessary, unwise, and raise[d] serious Constitutional questions under the due process clause."³⁰⁸

The "civil enforcement" provision provides that any individual who suffers personal harm due to a hospital's violation of the statute may institute a civil action to obtain damages and equitable relief.³⁰⁹ Any medical facility that suffers a direct financial loss due to a violation of the statute may also institute a private cause of action against the participating hospital for damages and equitable relief.³¹⁰ There is a two-year statute of limitation for these actions.³¹¹

Such comprehensive enforcement provisions are unprecedented in a Medicare statute, yet the bill passed with little notice by the general public. No hearings on the proposed bill were held in the House or the Senate,³¹² and two letters received by the House Judiciary Committee on the penalty provision appear to be the only public reaction received.³¹³

B. . Prospects and Problems

COBRA answers many of the concerns of plaintiffs who have been trying to find a duty on the part of hospitals to provide emergency medical treatment since *O'Neill v. Montefiore Hospital*.³¹⁴

ture of the practice of emergency medicine and because of the retrospective standards of liability of this provision, emergency physicians may avoid transfers in order to protect themselves against criminal penalties and ultimate loss of their medical licenses because of the potential of felony convictions. Extreme caution could also result in prolonged detentions and unnecessary admissions. Neither is in the interest of patient care and both would increase health care costs.

Id. at 21-22.

308. *Id.* at 7.

309. 42 U.S.C. § 1395dd(d)(3)(A) (1986). The section specifically allows "damages available for personal injury under the law of the State in which the hospital is located." *Id.* For a discussion of this provision, refer to notes 343-70 *infra* and accompanying text. It is the position of one hospital attorney that the statute "is a litigation time bomb waiting to explode." Dooley, *New Federal Law Helps Medical Malpractice Plaintiffs*, 6 *LAW ALERT* 330 (1987).

310. 42 U.S.C. § 1395dd(d)(3)(B) (1986).

311. 42 U.S.C. § 1395dd(d)(3)(C) (1986). The federal statute also specifically states that its provisions do not preempt any state or local law requirement, except to the extent that there is a direct conflict between them and the requirements of the federal law. *Id.* § 1395dd(f). Refer to notes 347-55 *infra* and accompanying text.

312. H.R. REP. No. 241, 99th Cong., 1st Sess., pt. 3, at 6 (1985).

313. Refer to note 307 *supra*.

314. 11 A.D.2d 132, 202 N.Y.S.2d 436 (1960). Refer to notes 54-60 *supra* and accompa-

Of course, the greatest achievement of the COBRA statute is the creation of a statutory duty to offer at least stabilizing treatment in an emergency. The requirement of a medical screening examination establishes the relationship between the hospital and the patient; therefore, there is no longer a need for courts to creatively interpret the facts of a case to find this relationship.³¹⁵ Also, there is no further need for courts to find theories on which to base liability such as those evidenced in *Manlove*³¹⁶ and *Guerrero*.³¹⁷ The statute provides that one need only prove a violation of the statute to establish a breach of the duty to examine or treat each individual who comes to the emergency department.³¹⁸

The statute also addresses the concerns of the plaintiffs in *Hill v. Ohio County*³¹⁹ and *Campbell v. Mincey*³²⁰ by placing "active labor" in the same status as an emergency condition and thereby requiring treatment.³²¹ Furthermore, the plaintiff in *Campbell* should at least have been able to collect nominal damages. In fact, it appears that *anyone* who suffers "personal harm" as a result of a hospital's violation of the statute may collect damages.³²² Therefore, relatives such as the mother of the child who died in *Quijije*³²³ might be able to recover for emotional distress.

COBRA does not, however, answer all of the problems that typically face plaintiffs. Some problems may be rectified by final regulations, but others may require amendments.³²⁴ First, it will be

nying text.

315. *Id.*

316. 54 Del. 15, 174 A.2d 135 (1961). Refer to notes 62-105 *supra* and accompanying text.

317. 112 Ariz. 104, 537 P.2d 1329 (1975). Refer to notes 214-28 *supra* and accompanying text.

318. 42 U.S.C. § 1395dd(d) (Supp. IV 1986).

319. 468 S.W.2d 306 (Ky. 1971), *cert. denied*, 404 U.S. 1041 (1972). Refer to notes 130-39 *supra* and accompanying text.

320. 413 F. Supp. 16 (N.D. Miss. 1975), *aff'd*, 542 F.2d 573 (5th Cir. 1973). Refer to notes 233-45 *supra* and accompanying text.

321. 42 U.S.C. § 1395dd(a) (Supp. IV 1986).

322. 42 U.S.C. 1395dd (d)(3)(A) (1986).

323. 92 A.D.2d 935, 460 N.Y.S.2d 600 (1983). Refer to notes 267-70 *supra* and accompanying text.

324. It is beyond the scope and purpose of this Section to discuss all of the limitations of the federal statute given its focus on inappropriate *transfer* of patients. Therefore, the analysis in this Section will emphasize the ways in which the statute does or does not deal with the problem of *refusal to render emergency care*, focusing particularly on the private cause of action as an effective enforcement tool. For an excellent analysis of the statute as to its effect on interhospital transfers, see *Preventing Patient Dumping*, *supra* note 287, at 1204-09.

difficult to prove a violation. Vague definitions control whether a person comes within the protection of the statute. For example, an "appropriate medical screening exam" is not defined, nor is there any indication as to who may or must conduct this exam.³²⁵ The definitions of "emergency" and "active labor"³²⁶ are also not specific enough to clearly indicate when the statute applies.³²⁷ Therefore, courts may still be left with much latitude to decide what is or is not an "emergency" or "active" labor. Perhaps *Hill v. Ohio County*³²⁸ would not have been decided so very differently under COBRA.³²⁹ The American College of Emergency Physicians (ACEP) has suggested the use of a more extensive definition of "emergency medical condition."³³⁰ A more detailed definition of "active labor" exists in the Hill-Burton policy manual and it should be used as a model from which to draft COBRA regulations.³³¹ As noted above, these definitions are the key to whether patients come within the protection of the statute, and should be as detailed and easy to interpret as possible.

325. Nurses generally conduct this exam or "triage," and the regulations should make clear whether this practice may continue. There is no description of what elements this examination must include. See *Preventing Patient Dumping*, *supra* note 287, at 1216; See also Kellermann & Hackman, *Emergency Department Patient "Dumping" in Memphis, Tennessee: An Analysis of Interhospital Transfers to the Regional Medical Center at Memphis*, reprinted in *Equal Access*, *supra* note 2, at 122, 125 (recommending that "appropriate screening exam" be defined and judged against a national standard of care).

326. Refer to note 296 *supra*.

327. See *Equal Access*, *supra* note 2, at 154 (statement of David Ansell, M.D., Attending Physician, Division of General Medicine/Primary Care, Cook County Hospital, Chicago, Illinois); *Preventing Patient Dumping*, *supra* note 287, at 1209, 1212.

328. 468 S.W.2d 306 (Ky. 1971), *cert. denied*, 404 U.S. 1041 (1972).

329. Refer to notes 130-39 *supra* and accompanying text.

330. For the ACEP definition of an "emergency," see *ACEP Board Reviews Definitions of Bona Fide Emergencies*, ACEP News, Dec. 1982, at 1, col. 1. See also *Preventing Patient Dumping*, *supra* note 287, at 1210-11 (recommending HHS adoption of previous, broader ACEP definition); Ansell & Schiff, *Patient Dumping: Status, Implications, and Policy Recommendations*, 257 J. A.M.A. 1500, 1502, reprinted in *Equal Access*, *supra* note 2, at 175, 177 (recommending use of ACEP definitions of "emergency").

331. The definition of "active labor" used by the Health and Human Services Office for Civil Rights is:

A woman giving birth for the first time should be admitted when her contractions are regular, progressively hard and closer and occurring at about five minute intervals. A woman who has given birth before should be admitted as soon as her contractions are regular and the diagnosis of labor seems likely. The overall principle guiding these rules is that admission to the hospital should, if possible, be delayed until labor is established but not so long that there is a risk of delivery outside the hospital.

Advocate's Guide, *supra* note 277, at 41 (quoting *OCR Community Service Guide*, at Tab B). See *Preventing Patient Dumping*, *supra* note 287, at 1212.

The statute also suffers from problems of scope. In other words, there are a number of ways in which hospitals and physicians can evade the purposes of the statute, without actually violating it. For example, the law does not explicitly provide for a penalty for on-call physicians who refuse to respond in an emergency. Smaller hospitals may not have an emergency physician on the premises at all times, and many hospitals use the services of on-call specialists in the emergency room.³³² The statute and the proposed regulations define "responsible physician"³³³ in a manner that may be broad enough to include the on-call physician. However, the final regulations or an amendment to the statute should clarify this point. The on-call physician's refusal to treat is a growing problem.³³⁴

Another potential loophole in the statute involves "pre-dumping," that is, advance agreements with ambulance services directing indigent persons to public hospitals and away from private hospitals.³³⁵ This problem is not covered in the statute as it now reads, yet could become a widely used method by which to avoid its goals. Therefore, the federal statute should be amended to prohibit such agreements.

A third problem of scope is known as "reverse dumping," in which the transferee hospital refuses to accept the patient because

332. See *Hastings v. Baton Rouge Gen. Hosp.*, 498 So. 2d 713, 715-16 (La. 1986) (the thoracic surgeon on-call inquired as to whether the victim of a stabbing had insurance and, upon receiving a negative reply, refused to come to the hospital and ordered that the patient be transferred).

A similar incident took place in a rural Idaho hospital which used an on-call emergency physician. A child, suffering from severe stomach pains and a high fever, was brought into the emergency room by her parents. The doctor, after determining that the family had no insurance, stated that he could not come in for several hours. The child was eventually treated and recovered, but was subjected to hours of pain, distress, and anxiety. *Equal Access*, *supra* note 2, at 45 (statement of Judith Waxman, Attorney, National Health Law Program).

333. Refer to note 304 *supra*.

334. *Equal Access*, *supra* note 2, at 39, 52 (statement of Judith Waxman, Attorney, National Health Law Program); *id.* at 261-62 (statement of Lois Salisbury, attorney representing Coalition to Stop Patient Dumping). Hospitals may also address the problem by tying on-call duties to hospital staff privileges. A hospital's failure to do so might result in loss of licensure. See CAL. HEALTH & SAFETY CODE § 1317.3(c) (West Supp. 1988).

335. *Equal Access*, *supra* note 2, at 241 (statement of Richard P. Kusserow, Inspector General, Office for Civil Rights); *id.* at 260 (statement of Salisbury). See also *Wideman v. Shallowford Community Hosp.*, No. 86-8512 (11th Cir., Sept. 8, 1987) (woman in labor repeatedly asked to be taken to a specific hospital, but was taken, in accordance with the ambulance service's agreement with the county, to a public hospital) (discussed in *11th Circuit Finds No Constitutional Right to Medical Treatment*, 10 HEALTH L. VIGIL 1 (1987)).

the patient has no insurance or because of some other, nonmedical reason. For example, a large, rural, tertiary hospital in McAllen, Texas, implemented a policy in which it would not accept transfers of Medicaid patients or patients without insurance. As a result, a smaller hospital in the area was denied permission to transfer a teenager with a gunshot wound who was in need of tertiary care. Thus, it advised the boy's parents to simply "show up" at the emergency room of the tertiary hospital where it would have to treat him. The hospital did not violate the "letter" of the law, but it certainly violated its "spirit."³³⁶ COBRA should be amended to include within its scope a prohibition against "reverse dumping."³³⁷

Perhaps the greatest problems with the COBRA statute lie in its enforcement provisions. Although federal officials claim that the law can be implemented without regulations,³³⁸ the facts do not bear this out. As noted earlier, *proposed* rules were not issued until June 1988.³³⁹ As of September 30, 1988, only 224 investigations had been filed with HHS.³⁴⁰ At a Congressional hearing held on July 22, 1987, physicians testified that the statute had "no perceptible impact" on their hospitals.³⁴¹ One reason for the ineffectiveness of the COBRA statute may be a lack of public information. In fact, most filed complaints originated in Texas and California, the states with strict emergency care statutes and much media attention to persistent refusals by hospitals to treat emergency patients.³⁴²

336. The boy died a few days later. *Equal Access*, *supra* note 2, at 44-45 (statement of Judith Waxman, Attorney, National Health Law Program).

337. See *Preventing Patient Dumping*, *supra* note 287, at 1221; see also H.R. REP. NO. 531, 100th Cong., 2d Sess. 22 (1988).

338. *Equal Access*, *supra* note 2, at 202 (statement of William Roper, M.D., Administrator, HCFA).

339. Refer to note 291 *supra* and accompanying text.

340. Of the 224 investigations authorized, 212 have been completed and 12 are pending. Of those hospitals investigated, 146 were found in compliance, 61 out of compliance and 5 are still under review. Two hospitals have had their provider agreements terminated: York Plaza Hospital, Houston, Texas and Mary E. Dickerson Hospital, Jasper, Texas. Telephone discussion on Nov. 2, 1988 with Spencer Colburn, Chief, Acute Care Services Branch, Office of Survey & Certification, Health Standards & Quality Bureau, Health Care Financing Admin., HHS, Baltimore, Md.

341. *Id.* at 13-14; *Equal Access*, *supra* note 2, at 181-82 (statements of Drs. Ansell & Kellermann).

342. H.R. REP. NO. 531, 100th Cong., 2d Sess. 13 (1988); *Equal Access*, *supra* note 2, at app. at 434-39. To achieve compliance nationally, a greater effort must be made to inform the public as to the new law's existence. This can be done, in part, through the media and

Potentially, the most powerful enforcement tool is the threat of civil enforcement. This enforcement provision provides, in part, that

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.³⁴³

should include the posting of notices in emergency rooms. Making pamphlets or some other form of written notice available to emergency room patients would increase knowledge of the statute and would be a major first step in the direction of enforcement. See *Equal Access*, *supra* note 2, at 52 (statement of Judith Waxman, Attorney, National Health Law Program). H.R. REP. No. 531, 100th Cong., 2d Sess. 17, 21 (1988); *Preventing Patient Dumping*, *supra* note 287, at 1220.

The next step would be regulations which clarify the proper procedure to file complaints. Included in these regulations would be procedures by which the proper HHS agency would respond to the complainants. Numerous problems exist in ensuring that those who file complaints receive notice of receipt of the complaint and notice of the final outcome of the investigation. *Equal Access*, *supra* note 2, at 229 (statement of Rep. Ted Weiss, New York).

Several other enforcement issues should be addressed by the final regulations or by amendment. First, when is an investigation warranted, and what guidelines should be used in the investigation? *Equal Access*, *supra* note 2, at 239-40. Second, a method of monitoring should be instituted, involving written records of all transfers or discharges of emergency room patients, and review of such records by JCAHO or by an agency of HHS should be done on a regular basis. See *Equal Access*, *supra* note 2, at 65 (statement of Judith Waxman); *id.* at 159 (statement of Dr. Ansell). See also H.R. REP. No. 531, 100th Cong., 2d Sess. 15, 19 (1988) (recommendation of Dr. Arthur L. Kellerman, medical director of emergency medical services, The Regional Medical Center, Memphis, Tenn., that hospitals receiving transferred patients file reports of all dumping cases which could be periodically audited by an agency such as JCAHO); *Preventing Patient Dumping*, *supra* note 287, at 1219 (recommending prompt investigation by HHS personnel). Third, because of reluctance of hospitals, who are often in the same community or hospital association, to report violations the law should require hospitals to report incidents of patient dumping. *Equal Access*, *supra* note 2, at 39, 53 (statement of Judith Waxman). The proposed regulations do provide this provision. 53 Fed. Reg. at 22,523 (1988) (to be codified at 42 C.F.R. pt. 489.24) (proposed June 16, 1988).

343. 42 U.S.C. 1395dd(d)(3)(A) (Supp. IV 1986). The House originally provided broader language: "Any person who suffers personal harm . . . may bring a civil action, in an appropriate Federal district court against the participating hospital, for damages and other appropriate relief." See CONFERENCE COMMITTEE REPORT ON THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (H.R. 3128), reprinted in *Medicare & Medicaid Guide* (CCH) Special 4, No. 481, at 476. (Jan. 13, 1986).

The Senate bill made no provision for a private right of action. The conference agreement modified the House language with the following explanation:

The civil enforcement provision was restructured to clarify its application. In addition, the courts are directed, on the issue of damages, to apply the law of the State in which the violating hospital is located, for actions brought by a harmed

If this provision is to have an impact, it must be clarified and strengthened.³⁴⁴ To date, only a handful of cases have been filed by individuals harmed by a hospital's violation of the statute.³⁴⁵

The first problem plaintiffs face is one of causation, proving that harm was *directly caused* by a hospital's violation. Most people who enter an emergency room are by definition sick or injured. If their conditions deteriorate or they die it may not be possible to prove that harm was the direct result of the denial of care or patient transfer.³⁴⁶

Another problem with this provision is the language that provides the individual with damages available for personal injury under *state law*. Does this provision bring us full circle, back to the old common law? Is this language meant to limit the amount of damages based on each state's personal injury law or exclude damages altogether under certain circumstances? For example, would plaintiffs in some states be prevented from receiving punitive damages for a hospital's violation?

The COBRA statute does provide that it will not "preempt any state or local law *requirement*, except to the extent that the requirement *directly conflicts* with a *requirement* of this section."³⁴⁷ At a minimum, this provision appears to address requirements pursuant to state or local emergency care statutes.³⁴⁸ Under

individual or a hospital which suffers a financial loss. The language allowing courts to grant 'other appropriate relief' was also modified to read 'other equitable relief as appropriate,' to give the courts clearer direction that such relief should be within the courts [sic] regular equitable powers and should be granted for the purpose of remedying the violation or deterring subsequent violations.

Id.

344. H.R. REP. NO. 531, 100th Cong., 2d Sess. 14-19 (1988).

345. The National Law Journal, June 6, 1988 at 1, col. 1, 29, col. 4. It has been reported that only one civil damage law suit has been filed in Chicago and six cases are on file in Boston alleging COBRA violations. One expert predicts the "full impact of the law will not be felt until several cases go through the appeal process." *Id.* at 30, col. 4.

346. Consider for example, the case of Terry Takewell, who was diabetic and very ill when he was denied treatment in the emergency room. Refer to note 2 *supra* and accompanying text. Since necessary tests were never done, it might be extremely difficult to prove that the hospital's violation directly caused his death. Furthermore, because he died, his direct testimony of what happened will not be available. See *Equal Access*, *supra* note 2, at 298, 300 (letter from Gordon Bonnyman, Staff Attorney, Legal Services of Middle Tennessee).

347. 42 U.S.C. 1395dd(f) (Supp. IV 1986) (emphasis supplied).

348. State or local laws that set looser standards and directly conflict with COBRA should be preempted. Based on the intent of Congress it would be fair to argue that stricter state standards should be maintained, unless there is clearly strong evidence of a direct conflict with federal law. See, e.g., *Hillsborough County v. Automated Medical Laboratories*,

the Supremacy Clause of the Constitution,³⁴⁹ however, federal preemption will also be implied if a state law frustrates the intent and purpose of the federal statute.³⁵⁰ Although health and safety matters are traditionally local concerns, Congress expressed its intent to seek a national solution to assuring access to emergency care.³⁵¹ On the other hand, the civil enforcement provision specifically relies on state law for obtaining damages and equitable relief.

How then does the federal right of action apply to state law? Would charitable immunity, sovereign immunity, or "good samaritan" immunity laws apply?³⁵² Would "caps"³⁵³ on damages and other tort reforms limit the amounts available under the statute or be preempted in favor of a uniform federal law for these cases?³⁵⁴ Without a legislative history, one can only speculate whether Congress would have intended to do away with "caps" and other tort reform measures implemented by the states to achieve goals such as lowering medical malpractice insurance rates or encouraging physicians to continue practicing their profession. The answer may depend on whether such reforms apply equally to all plaintiffs for personal injury.

The COBRA statute should preempt certain immunities. If this were not so, then states could enact statutes which revive certain immunities and avoid the new statute's requirements altogether. In fact, this is a very real threat in light of recent state legislation which attempts to apply good samaritan laws to hospital emergency rooms.³⁵⁵

471 U.S. 707 (1985)(holding county regulations governing blood plasma centers not preempted by Food and Drug Administration regulations establishing minimum standards).

349. U.S. CONST. art. VI, cl. 2.

350. See, e.g., *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 211 (1824); *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941).

351. Refer to note 348 *supra*.

352. One hospital attorney argues that COBRA appears to preempt all state law. See Dooley, *New Federal Law Helps Medical Malpractice Plaintiffs*, 6 LAW ALERT 330, 332 (June 15, 1987).

353. If caps are just limited to "medical malpractice" awards, one might argue that this does not apply to awards for "personal injury," the term used in the COBRA provision. If the cap covers all personal injury, however, it might limit the award under this COBRA provision. Discussion with Stephen Frew and Robert Dooley, legal consultants on emergency care (July 15, 1988).

354. Refer to note 352 *supra*.

355. All states and the District of Columbia have adopted good samaritan laws. Such laws protect health care professionals and others who render emergency assistance from civil liability for damages for any injury they cause or enhance. These statutes range from mere codifications of the common law to grants of absolute immunity. The first statute was

Few cases have interpreted the use of good samaritan laws. The first attempt to utilize such protection in a refusal to treat case was *Guerrero*.³⁵⁶ Since then, these laws have been utilized as defenses when negligent treatment was rendered in the hospital.³⁵⁷

As early as the 1960s, commentators were shocked at the prospect that these immunity statutes might be applied to emergency rooms.³⁵⁸ Yet other commentators have urged more uniform inclu-

passed in 1959 in California. See generally Note, *Good Samaritans and Hospital Emergencies*, 54 S. CAL. L. REV. 417 (1981) [hereinafter *Good Samaritans*].

The intent of good samaritan laws is to encourage physicians and others to respond to emergencies (typically at the scene of an accident) when they have no legal duty to do so. The hope is that emergency care would then be provided to those who would otherwise not receive it. Since there would be no threat of suit, health care professionals would be more willing to provide assistance. Throughout the 1960s this legislation spread, in spite of a 1963 American Medical Association study which found that the laws made no significant difference in a physician's behavior. *First Results: 1963 Professional Liability Survey*, 189 J. A.M.A. 859, 865 (1964). In the study, 51.5% of the physicians in states which had enacted good samaritan law said they would stop to furnish aid, and 47.7% of physicians in states that did not have good samaritan statutes said they would do so. *Id.*

Nevertheless, by the time of the malpractice insurance "crisis" of 1974, state legislatures were anxious to respond, and expansion of the good samaritan statutes was a popular solution. B. FURROW, S. JOHNSON, I. JOST & R. SCHWARTZ, *HEALTH LAW: CASES MATERIALS AND PROBLEMS* 134-35 n.2 (West 1987). At that time no cases had been found in which a physician had been sued for malpractice for rendering emergency care outside of a medical office or hospital. See 2 LOUISELL & WILLIAMS, *MEDICAL MALPRACTICE* ¶ 21.01, at 21-3, 21-4 (1988). Rather, most reported cases involved attempts by physicians to invoke good samaritan protection for negligence within the hospital. *Id.* at 21-4. This occurred although the majority of state statutes continued to exclude medical services rendered in the hospital from good samaritan immunity. Most jurisdictions require that the care be given at the scene of the emergency, which may be defined to specifically exclude the hospital or the presence of medical equipment. Although less clear, the language of other statutes implies that the hospital setting is excluded. See *Good Samaritans*, *supra* note 355, at 428; See also Note, *Good Samaritan Statutes: Time for Uniformity*, 27 WAYNE L. REV. 217, 228 (1980). A few jurisdictions, such as Alaska, Kansas, Texas, and Michigan do expressly include emergencies within a hospital. ALASKA STAT. § 09.65.90 (1983); KAN. STAT. ANN. § 65-289(c) (1985 & Supp. 1987); TEX. CIV. PRAC. & REM. CODE ANN. § 17.001 (Vernon 1986); MICH. COMP. LAWS ANN. § 691.1502 (West 1987). Texas, however, does not provide immunity to a person who "regularly administers care in the emergency room, . . . an admitting physician, . . . or a treating physician associated by the admitting physician." TEX. CIV. PRAC. & REM. CODE § 17.001 (Vernon 1986).

356. 112 Ariz. 104, 537 P.2d 1329 (1975). Refer to text accompanying note 228 *supra*.

357. See, e.g., *Colby v. Schwartz*, 78 Cal. App. 3d 885, 888, 144 Cal. Rptr. 624, 625 (1978) (physicians acting in normal course of practice not immune); *McKenna v. Cedars of Lebanon Hosp.*, 93 Cal. App. 3d 282, 286, 155 Cal. Rptr. 631, 633 (1979) (resident not "on call" for emergencies protected by statute); *Gragg v. Neurological Assocs.*, 152 Ga. App. 586, 263 S.E.2d 496, 497-98 (1979) (crisis during hospital procedure not emergency within protection of statute).

358. See, e.g., Comment, *Good Samaritans and Liability for Medical Malpractice*, 64 COLUM. L. REV. 1301, 1310 (1964); Note, *Good Samaritan Legislation: An Analysis and a Proposal*, 38 TEMP. L.Q. 418, 425 (1965); *Good Samaritans*, *supra* note 355, at 430.

sion of the hospital emergency room and its personnel within the protection of such statutes.³⁵⁹ This protective approach is seen as a means of assuring that emergency care is provided without the fear of liability. This position has political appeal, particularly as state legislatures attempt to respond to the most recent boycotts of emergency rooms by physicians protesting rising malpractice rates.

Now that both hospitals and physicians have affirmative duties under COBRA to provide treatment to those in need of emergency care, will such good samaritan statutes frustrate the intent and purpose of the federal statute? In theory, good samaritan statutes should not apply where an affirmative duty has already been established. In practice, there will be confusion over the federal statute and how it applies to these recent expansions in immunity. Two recent state legislative initiatives are illustrative.

During the 1987 legislative session, Virginia was faced with a "crisis." Obstetricians were threatening to reduce their "on call" services to emergency rooms, particularly for poor women in active labor. Responding to increases in malpractice insurance rates, the physicians argued that emergency room practice increased their exposure to suit. Pregnant women, either on Medicaid or without any health insurance, would show up at the emergency door in active labor, without a regular physician and with no medical records. The physicians characterized their role in treating these women as "good samaritans." Although physicians would not be required under state law to treat, the new law provides that, in the absence of gross negligence, "any person" would be granted immunity from civil damages for acts or omissions resulting from the rendering of emergency obstetrical care.³⁶⁰ Under COBRA, would participating hospitals still be liable, even though the responsible physician was immune from suit?

359. See, e.g., Tuttle, *Hospital Emergency Rooms—Application of Good Samaritan Laws*, 31 MED. TRIAL TECH. Q. 145 (1984).

360. Senate Bill 408 passed March 23, 1987, amending § 8.01-225 of the Code of Virginia:

Any person who, in the absence of gross negligence, renders emergency obstetrical care or assistance to a female in active labor who has not previously been cared for in connection with the pregnancy by such person or by another professionally associated with such person and whose medical records are not reasonably available to such person shall not be liable for any civil damages for acts or omissions resulting from the rendering of such emergency care or assistance. The immunity herein granted shall apply only to the emergency medical care provided.

Discussion and background materials (unpublished) provided by Josephine Foehrenbach, Harvard Fellow, Va. Poverty Law Center, Inc., Richmond, Va. (1987).

In Georgia, similar efforts were successful to immunize health care providers *and hospitals*, among others, from liability for damages for injury or death resulting from an act or omission in rendering professional services when the services provided "voluntarily and without the expectation or receipt of compensation".³⁶¹ Once again, the legislation was framed as a "good samaritan" bill to encourage the provision of services without threat of suit.³⁶²

Although these statutes may make political sense, they should be discouraged in the context of providing emergency room care. Physicians and hospitals have an affirmative duty under COBRA to examine and treat all emergency patients and those women in active labor regardless of ability to pay. The law was passed to assure access without undermining the standards applicable to their care. To allow this immunity will result in a continued two-tiered system for emergency care. Clearly, this result is contrary to the legislative purpose of the new federal statute, which was to promote access and quality of service regardless of income. There is no credible evidence that such immunity will in fact reduce insurance rates or increase access to care. Any attempt through the use of an immunity statute to compromise such a goal should be pre-

361. Emphasis added. § 51-1-29.1 of Georgia Code provides:

(a) [U]nless it is established that injuries or death were caused by gross negligence or willful or wanton misconduct:

(1) No health care provider. . . who voluntarily and without the expectation or receipt of compensation provides professional services, within the scope of such health care provider's licensure, for and at the request of a hospital, public school, nonprofit organization, or an agency of the state or one of its political subdivisions or provides such professional services to a person at the request of such organization, which organization does not expect or receive compensation with respect to such services from the recipient of such services; or

(2) No licensed hospital, public school, or nonprofit organization, which requests, sponsors, or participates in the providing of the services under the circumstances provided in paragraph (1) of this subsection shall be liable for damages or injuries alleged to have been sustained by the person nor for damages for the injury or death of the person when the injuries or death are alleged to have occurred by reason of an act or omission in the rendering of such services.

(b) This Code section shall apply only to causes of action arising on or after July 1, 1987.

GA. CODE ANN. § 51-1-29.1 (Supp. 1988). A number of more general immunity statutes have passed nationwide to immunize "volunteers" who provide medical services, regardless of the setting of such services. See, e.g., NATIONAL CONFERENCE OF STATE LEGISLATURES, 1987 SUMMARY LIABILITY INSURANCE: MAY 31, 1987, (1987).

362. Discussion with Linda Lowe, Staff Member, Georgia Legal Services Program, Atlanta, Ga. (Spring 1987).

empted by federal statute.³⁶³ If not, the statute must be specifically amended to prohibit immunity under state law for violations of the COBRA statute.

In fact, research shows no correlation between low income and a proclivity to file suits against physicians and hospitals.³⁶⁴ The poor do not tend to file suits. Personal injury cases are expensive and lawyers are reluctant to take such cases on a contingency basis from poor people without an assurance of substantial dollar worth.³⁶⁵ Ironically, the failure of the poor to sue may limit the ultimate impact of civil enforcement.

Of course, the "preventive effect of the statute is diluted if only those cases which command a large damage award are brought."³⁶⁶ It has been proposed that the award of attorney's fees would correct this problem.³⁶⁷ Similar fee-shifting provisions already exist in antitrust, consumer protection, and tax appeal statutes. These statutes recognize the importance of attracting competent counsel and the belief that it is only fair for the wrongdoer to pay the cost of vindicating federal rights.³⁶⁸

Another approach suggested to strengthen civil enforcement is to provide for liquidated damages to be paid to the individual

363. Refer to notes 348-54 *supra* and accompanying text.

364. See, e.g., DANZON, *MEDICAL MALPRACTICE* 75 (1985). Danzon states that the percentage of the population on welfare, the unemployment rate and the per capita income had no significant effect on claim frequency or severity of claims filed. *Id.* See also Rudov, Myers & Mirabella, *Medical Malpractice Insurance Claims Files Closed in 1970* (Appendix), in REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, (DHEW No. (OS) 73.89, 1, 11-12 (1973)).

365. See Rosenblatt, *Rationing "Normal" Health Care: The Hidden Legal Issues*, 59 TEXAS L. REV. 1401, 1415-16 (1981) for an excellent summary of why traditional malpractice law does not serve the interests of protecting the poor. Rosenblatt notes that the poor have low expectations regarding treatment and results; little incentive to seek recovery because they must return part of the award to the welfare department; and difficulty obtaining access to legal services. Nor can legal service attorneys accept such "fee-generating" cases from poor clients. *Id.* at 1415 n.87, citing 42 U.S.C. § 2996f(b)(1) (1976 & Supp. IV 1980).

366. H.R. REP. No. 100-531, 100th Cong., 2d Sess. 19 (1988).

367. *Id.* See also *Equal Access*, *supra* note 2, at 55, 262-63, 302. The following language was suggested: "In any action or proceeding charging a violation of section 1867 of the Social Security Act [the COBRA antidumping amendment], the court in its discretion may allow the individual or hospital harmed by the violation reasonable attorney's fees as part of the costs." *Id.* at 55 (letter of Judith Waxman). See also CAL. HEALTH & SAFETY CODE § 1317.6(f) (West Supp. 1988)(providing for the award of reasonable attorney's fees).

368. *Equal Access*, *supra* note 2, at 55, 57-58 (statement of Judith Waxman); *id.* at 261-62 (statement of Lois Salisbury, Attorney, Coalition to Stop Patient Dumping); *id.* at 299 (letter of Gordon Bonnyman, Staff Attorney, Legal Services of Middle Tennessee); H.R. REP. No. 531, 100th Cong., 2d Sess. 19, 22 (1988).

harmed by the hospital's violation.³⁶⁹ Under common law, lost wages are an important measure of compensatory damages. Yet, the poor are often disabled or unemployed and thus, there is little expectation of any compensatory damages for economic loss. It is often not worth the expense of suing the hospital. Thus, even when an injury is not serious and an award of substantial compensatory damages is not likely, the hospital will at least be forced to pay a minimum amount of monetary damages to the victim. A liquidated damages provision would strengthen the rights of the poor to utilize the threat of a private cause of action as an effective enforcement tool.³⁷⁰

CONCLUSION

An understanding of the evolution of the legal duty to provide emergency care should put the current state of the law in a more meaningful context. It should also alert us to the problems that still remain.

Traditional tort law did not provide the basis for establishing a duty to treat those in need of emergency care and in active labor. The no-duty rule, immunity, and misinterpretation of the scant case law slowed any progress toward the search for a duty. It was not until the 1960s that the *Manlove* reliance theory offered a potential source for expansion of liability. Neither the *Manlove* reliance theory nor the approach of the *Guerrero* court, which found the source of the duty in state licensing laws, provided a satisfactory solution. With few exceptions, state law has also been limited in its approach to the problem, although Texas and California have provided leadership. These state approaches do not provide for a nationwide solution. Use of the federal Hill-Burton law has also been ineffective in enforcing a duty to provide emergency care.

The COBRA statute does provide a source for the duty to provide emergency care. At a minimum, every individual who enters an emergency room must be examined without regard to ability to pay. The hospital-patient relationship has been established by law. Nevertheless, problems of definition and scope may impact on enforcement. How effective will civil enforcement be? The answer de-

369. *Equal Access*, *supra* note 2, at 301-02 (Letter of Bonnyman). Such a provision exists in the federal Truth in Lending Act. 15 U.S.C. § 1640(a) (1982).

370. Liquidated damages might be set at \$50,000, to match the civil penalty provision. Refer to notes 304-05 *supra* and accompanying text.

depends on the barriers the injured plaintiff will face when bringing a private cause of action to obtain damages or appropriate equitable relief under state law. Conflicts will arise between this new federal cause of action and state law. Without strict judicial action, COBRA may follow in the footsteps of past attempts to find the solution to a problem that will not go away.

In any case, the law does have limits. The economic marketplace dictates many of the choices, and society has to continue to address the problem of access to health care for all, regardless of ability to pay. In the end, it is the duty of the health care institutions, the providers, and our society to ensure that all persons, rich or poor, obtain medical care—at least when they are most vulnerable: at the entrance to the emergency room.