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Opening the Closed Doors: The Duty of Hospitals to Treat Emergency Patients

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OPENING THE CLOSED DOORS: THE DUTY OF HOSPITALS TO TREAT EMERGENCY PATIENTS

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I. INTRODUCTION

The hospital emergency department has become a major component in our health care delivery system. Over 70 million Americans visit hospital emergency departments annually.[1] The public has come to view the emergency department as a community health center, especially in urban areas.[2] For the most part, hospitals have responded to the increased demand to provide outpatient care. Undeniably, already overburdened emergency rooms are being called

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1. H.R. REP. No. 1089, 94th Cong., 2d Sess., 5-6, *reprinted in* 1976 U.S. CODE CONG. & AD. NEWS 6103, 6108. It is estimated that by 1984, emergency room visits will total 160 million per year. M. MANCINI & A. GALE, EMERGENCY CARE AND THE LAW 43 (1981).

2. M. MANCINI & A. GALE, *supra* note 1, at 43-44; J. KNOWLES, HOSPITALS, DOCTORS, AND THE PUBLIC INTEREST 25 (1965); AMERICAN HOSPITAL ASSOCIATION, EMERGENCY SERVICES 6 (1972); Harrigan, *Grady Hospital, Haven for the Poor of Atlanta, Falls Critically Ill Itself*, Wall St. J., Mar. 2, 1981, at 1, col. 1. Several factors are involved in the increased use of hospital emergency departments. Population growth and an overall increase in accidents have contributed to emergency room utilization. In addition, physicians have generally abandoned the practice of making house calls and tend not to be available evenings or on weekends. Furthermore, more physicians have become affiliated with hospitals and prefer to treat injured or ill patients at an emergency facility rather than at their offices. Finally, public awareness has spread that emergency rooms can be appropriate places to seek care. *See* AMERICAN HOSPITAL ASSOCIATION, EMERGENCY SERVICES 73-74 (1972).

upon to render aid in non-emergency situations, as well as in life-threatening emergencies.[3] Yet it is a disturbing fact that hospitals occasionally deny treatment to persons who require immediate medical attention.[4]

The standards of the medical profession,[5] as well as the general consensus of public sentiment, are offended by a hospital's refusal of emergency treatment to those who need it.[6] The American College of Surgeons has released the following official statement:

> The function of an emergency department is to give adequate appraisal and initial treatment or advice to any person who considers himself acutely ill or injured and presents himself at the emergency department door.[7]

The American Hospital Association has urged that "no patient with a complaint serious enough to bring him to the emergency department of the hospital should be denied appropriate examination and dispo-

3. S. KLAW, THE GREAT AMERICAN MEDICINE SHOW 54-57 (1976); J. SPENCER, THE HOSPITAL EMERGENCY DEPARTMENT 1-21 (1972); Letourneau, *Legal Aspects of the Hospital Emergency Room*, 16 CLEV.-MAR. L. REV. 50, 56-57 (1967).

4. Signor, *Shifted from Hospital with Knife in His Back*, St. Louis Post-Dispatch, Oct. 26, 1980, at 1, col. 4; Vaughn, *Ejected from Barnes with Knife in his Back; Sues for $1,000,000*, St. Louis Am., Mar. 5, 1981, at 1, col. 2. These articles describe the treatment Barnes Hospital rendered to a knife-wound victim on October 13, 1980. The victim arrived at Barnes by city ambulance with a knife imbedded in his back. Emergency room residents checked his vital signs and took x-rays. The victim's stepfather related to admitting personnel that the victim had no insurance. Hospital personnel advised that the victim be transferred to City Hospital, where treatment would be free. Consequently, two hours after arrival at Barnes, the victim was transferred with the knife still in his back. An operation was performed at City Hospital, but the victim claims that the transfer aggravated his condition. He has sued Barnes for negligence. More than two years after the incident, the matter is still in the pre-trial discovery stage. Little v. Barnes Hospital, No. 812-1047 (St. Louis Cir. Ct., filed Feb. 26, 1981). *See* cases cited *infra* notes 21-72 and accompanying text. *See also* E. KENNEDY, IN CRITICAL CONDITION: THE CRISIS IN AMERICAN HEALTH CARE 80-88 (1972).

5. The American Medical Association Principles of Medical Ethics state, at § 5:

> A physician may choose whom he will serve. *In an emergency, however, he should render care to the best of his ability*. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. (emphasis added)

Principles of Medical Ethics, *reprinted in* T. BEAUCHAMP, PRINCIPLES OF BIOMEDICAL ETHICS 283 (1979).

6. Powers, *Hospital Emergency Service and the Open Door*, 66 MICH. L. REV. 1455, 1475 (1968).

7. AMERICAN MEDICAL ASSOCIATION, EMERGENCY DEPARTMENT—A HANDBOOK FOR THE MEDICAL STAFF 129-30 (1966).

sition by a physician."[8] Despite these pronouncements, persons in need of emergency care are not always afforded access to such care.

This Note examines the case law that has addressed a hospital's duty to treat emergency patients. It then surveys the nature and scope of duties imposed by state statutes. Finally, rationales are advanced to support the thesis that a hospital that operates an emergency room has a duty to treat all persons requiring emergency care.

II. THE COMMON LAW

The common law distinction between misfeasance and nonfeasance has shaped the law regarding a hospital's duty to provide emergency medical care. In tort law, courts have imposed liability for intentional or negligent misfeasance but not for failure to act, or nonfeasance.[9] Hence, failure to render aid to one in peril was not grounds for liability since there was no duty to act.[10] The most commonly cited justification for not imposing affirmative duties was the individualistic philosophy upon which the common law was based.[11] Judges restrained the commission of affirmative acts that caused harm, but were reluctant to restrict an individual's freedom by compelling him to come to the aid of another.

Regardless of the explanations, it is clear that the law was slow to recognize liability for nonfeasance. Gradually, however, courts have created exceptions to the general rule. The first exception concerned those who have a special relationship with the person in peril.[12] Courts imposed duties to aid and protect on common carriers, innkeepers, employers and shopkeepers.[13] These classes of persons have undertaken a duty to give service, and the expected economic benefit

8. J. SPENCER, THE HOSPITAL EMERGENCY DEPARTMENT 1 (1972). *See also* JOINT COMM'N ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS, *reprinted in* M. BERTOLET & L. GOLDSMITH, HOSPITAL LIABILITY, LAW AND TACTICS 327, 351 (1980).

9. W. PROSSER, HANDBOOK ON TORTS 338-39 (4th ed. 1971).

10. RESTATEMENT (SECOND) OF TORTS § 314 (1965) [hereinafter cited as RESTATEMENT].

11. W. PROSSER, *supra* note 9, at 339. Hale, *Prima Facie Torts, Combination and Nonfeasance*, 46 COLUM. L. REV. 196, 214 (1946). Prosser also suggests that common law courts were too busy adjudicating cases of misfeasance to be concerned with individuals who merely failed to act, although serious harm may have resulted. W. PROSSER, *supra* note 9, at 338.

12. *Id.* at 339.

13. *Id.* at 341-42; RESTATEMENT, *supra* note 10, §§ 314A, 314B.

justifies the imposition of an affirmative duty.[14]

Courts and commentators have recognized a second exception when an individual's own conduct has placed another peril.[15] Even those who innocently cause harm to another are required to aid those who have been injured.[16] Since the actor's conduct created the harm, or the possibility of harm, an obligation arose to assist in the mitigation of that harm.

The common law recognized another exception to the general rule when the defendant voluntarily rendered aid and a person relied to his detriment upon the gratuitous undertaking.[17] In a famous example,[18] a railroad that voluntarily employed a signalman at a street crossing was required to perform that function with due care. Liability could be incurred for failing to perform the undertaking when performance was to be expected.[19] Once an individual has begun rendering assistance to another, reasonable care must be exercised.[20]

The general rule and its exceptions provide the analytical framework for analyzing disputes between persons seeking emergency medical care and hospitals maintaining emergency departments.

III. THE EMERGENCY DEPARTMENT CASES

A. *Traditional Rule*

Based on the general rule, courts have been reluctant to impose a duty upon hospitals to accept all patients who seek admission.[21] Similarly, courts do not require physicians to treat every applicant who requires service.[22] Like the competent swimmer who may watch a

14. W. PROSSER, *supra* note 9, at 339.

15. *Id.* at 342-43; RESTATEMENT, *supra* note 10, § 322.

16. W. PROSSER, *supra* note 9, at 342-43; RESTATEMENT, *supra* note 10, § 322.

17. W. PROSSER, *supra* note 9, at 346; RESTATEMENT, *supra* note 10, § 323.

18. Erie R.R. v. Stewart, 40 F.2d 855 (6th Cir.), *cert. denied*, 282 U.S. 843 (1930).

19. *Id.* at 857.

20. *Id.* This exception also encompasses the situation where one takes charge of another who is helpless and discontinues aid in a manner that aggravates the other's condition. *See* RESTATEMENT, *supra* note 10, § 324.

21. *E.g.*, Hill v. Ohio County, 468 S.W.2d 306 (Ky. 1971) (public hospital had no duty to admit pregnant woman who was about to give birth), *cert. denied*, 404 U.S. 1041 (1972); Le Jeune Rd. Hosp., Inc. v. Watson, 171 So. 2d 202 (Fla. Dist. Ct. App. 1965) (private hospital may reject any patient that it does not desire).

22. *E.g.*, Childs v. Weiss, 440 S.W.2d 104 (Tex. Civ. App. 1969) (absent a contractual obligation, a physician is under no duty to render services to those who request

child drown, physicians and hospitals are under no legal duty to rescue, although their professional codes of ethics provide otherwise.[23]

The earliest case addressing the duty of a hospital to render emergency treatment is *Birmingham Baptist Hospital v. Crews*.[24] The parents of a child stricken with diphtheria took the child to the defendant hospital. The house physician examined the child and administered oxygen and antitoxin. The hospital refused to admit the child, however, because the hospital's policies prohibited the admission of patients with contagious diseases. The child died within fifteen minutes after returning home. In a subsequent wrongful death action, the Alabama Supreme Court reversed a verdict for the plaintiff, holding that the hospital was a private corporation that owed no duty to the plaintiff.[25] The court also rejected the contention that the hospital had undertaken to render ordinary hospital services by providing emergency care. The provision of such care did not create a duty to hospitalize the patient because emergency aid in a "desperate" situation was appropriate conduct.[26]

Although many courts[27] cite *Crews* as authority for the general rule that a private hospital has no duty to treat an emergency patient, the Alabama Supreme Court was satisfied that the hospital provided appropriate emergency care. The case more accurately held that a hospital has no duty to admit a patient after it has provided emergency care. It strains credulity, however, to suggest that when the child left the hospital, the emergency had abated.[28] The hospital provided some treatment, but it abandoned that care before the patient's condition had stabilized. The imposition of liability would be fully

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them); Buttersworth v. Swint, 53 Ga. App. 602, 186 S.E. 770 (1936) (physician is not obligated to treat every individual who applies to him).

23. *See supra* note 5 and accompanying text. *See also* T. BEAUCHAMP, *supra* note 5, at 135-45.

24. 229 Ala. 398, 157 So. 224 (1934).

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

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

27. *E.g.*, Fjerstad v. Knutson, 271 N.W.2d 8, 11 (S.D. 1978); Le Jeune Rd. Hosp., Inc. v. Watson, 171 So. 2d 202 (Fla. Dist. Ct. App. 1965).

28. The attending physicians treated the child during the entire time she was in the emergency room. The child's condition showed some signs of improvement and the progress no doubt resulted from the treatment rendered. But the physicians discontinued the treatment abruptly, before full recovery. The doctors agreed that the child should avoid exertion and should be at rest, yet they dismissed her nonetheless. 229 Ala. at 400, 157 So. at 226.

consistent with the exception to the general rule that one who undertakes to aid another in peril must do so with reasonable care.[29]

Many courts have followed the broad reading of *Crews*. In *Hill v. Ohio County*,[30] a public county hospital refused to admit a woman who thought she was in labor. Consequently, the child was born at home without medical attention and the woman died shortly after giving birth. The court simply stated that an emergency did not exist[31] and that the hospital had breached no duty.[32] The case is significant because the *Crews* court expressly addressed the obligations of a private hospital.[33] The hospital in *Hill*, on the other hand, was owned and operated by the county. The court found no duty by extending *Crews* beyond its facts.

The Alabama Supreme Court reaffirmed *Crews* in *Harper v. Baptist Medical Center-Princeton*.[34] The plaintiff, an accident victim, was taken by ambulance to the emergency room of a private hospital. The hospital treated the victim but refused to admit him for surgery because he lacked insurance. Four hours after arrival, the plaintiff was transferred to a charitable hospital where he underwent surgery. The plaintiff alleged that his permanent foot drop condition resulted from the delay in treatment. The court affirmed a directed verdict for the defendant, because the hospital was under no duty to admit the patient after having stabilized him.[35] Furthermore, the plaintiff failed to sustain his burden of proof that the delay in surgery, rather than the initial injury, had caused the permanent condition.[36]

None of these cases addresses the question of whether the hospital, private or public, had a duty to provide emergency treatment. The Alabama courts seem to have assumed that the undertaking of some care was appropriate under the circumstances.[37] The provision of

29. *See supra* notes 17-20 and accompanying text.

30. 468 S.W.2d 306 (Ky. 1971), *cert. denied*, 404 U.S. 1041 (1972).

31. *Id.* at 309. For an excellent article discussing the medical complications of childbirth, see Dallek, *Labor and Delivery as a Medical Emergency*, 10 CLEARINGHOUSE REV. 947 (1977).

32. 468 S.W.2d at 309.

33. Birmingham Baptist Hosp. v. Crews, 229 Ala. 398, 399, 157 So. 224, 225 (1934).

34. 341 So. 2d 133 (Ala. 1976).

35. *Id.* at 134-35.

36. *Id.* at 135.

37. *See supra* note 26 and accompanying text.

some emergency care, however, did not create the duty to provide additional medical treatment.

B. *Implied Admissions*

Many courts have circumvented the general rule by finding that the hospital, by initiating some treatment or care, admitted the patient.[38] These courts are quick to find the formation of a hospital-patient relationship, with a resulting duty of due care. Illustrative of this line of cases is *Methodist Hospital v. Ball*.[39] In *Ball*, a city ambulance transported a young accident victim to the emergency room of a private hospital. The intern checked the victim's vital signs and abdomen, but was preoccupied with other patients whom he thought were in more critical condition. The victim was left on a stretcher in a corridor for forty-five minutes before transfer to another hospital. He died soon after the transfer.

In a wrongful death action, the court found for the plaintiff, rejecting the hospital's argument that the victim had never been admitted to the hospital. The court simply concluded that the victim had been admitted.[40] The court gave no guidelines, however, as to what action results in admission to a hospital.

A similar result ensued in *New Biloxi Hospital, Inc. v. Frazier*.[41] While suffering from a gunshot wound and bleeding profusely, Frazier was taken to the emergency room. The hospital staff there virtually ignored him. After twenty minutes, a nurse checked his pulse and blood pressure but did nothing to stop the bleeding. The physician on call arrived thirty minutes later and conducted a cursory examination. Upon discovering that the victim was a veteran, the physician arranged for his transfer to a veteran's hospital. Frazier expired shortly after the transfer. The Mississippi Supreme Court concluded that a hospital-physician relationship existed, since Frazier had been recorded as a patient and spent two hours in the emergency room.[42] Under these circumstances, the court held that the

38. *E.g.*, Bourgeois v. Dade County, 99 So. 2d 575 (Fla. 1957) (brief clinical examination sufficient to create hospital-patient relationship); O'Neill v. Montefiore Hosp., 11 A.D.2d 132, 202 N.Y.S.2d 436 (1960) (jury could find that nurse's telephone call to physician established physician-patient relationship).

39. 50 Tenn. App. 460, 362 S.W.2d 475 (1961).

40. *Id.* at 469, 362 S.W.2d at 479.

41. 245 Miss. 185, 146 So. 2d 882 (1962).

42. *Id.* at 197-98, 146 So. 2d at 887.

hospital breached its duty to use reasonable care in protecting Frazier's life.

While the results of these decisions may be laudable, their impact on the law has not been positive. The courts failed to clarify how and when patient status begins. It is not surprising, then, that courts have struggled with the question of determining what criteria lead to admission.[43] As one court ruled, that question must vary with the circumstances.[44] Even the slightest undertaking may give rise to a hospital-patient relationship.[45] Although motivated by humanitarian ends, courts that seize on any pretext to support creation of patient status may produce unwanted results. Rather than running the risk of creating a hospital-patient relationship, the hospital may refuse to undertake any action at all. A hospital that flatly refuses to allow an applicant through its doors could thus escape liability, while another that provides minimal emergency care could be made subject to liability.[46]

The decisions are equally unsatisfying because of their misreading of *Crews*. The opinions cite dicta in *Crews*, which states that a hospital may reject any applicant for medical and hospital services. *Crews*, however, held that a hospital need not admit a patient after it has provided some degree of emergency care.[47] Unfortunately, courts emphasize the broad dicta of *Crews* rather than its specific holding. In order to overcome the "settled rule" that a hospital was under no

43. *See* cases cited *supra* note 38 and accompanying text.

44. Le Jeune Rd. Hosp., Inc. v. Watson, 171 So. 2d 202, 203 (Fla. Dist. Ct. App. 1965).

45. The most glaring example of this line of cases is O'Neill v. Montefiore Hosp., 11 A.D.2d 132, 202 N.Y.S.2d 436 (1960). The plaintiff's decedent, suspecting that he had suffered a heart attack, walked to the defendant hospital. The emergency room nurse refused to treat him because the hospital did not accept his insurance coverage. Instead, she telephoned a doctor participating in the victim's insurance plan. The doctor conversed with the victim and apparently suggested that the victim seek treatment at a clinic that honored the insurance plan. After hanging up, the decedent again requested treatment and the nurse again refused. The decedent expired soon after returning home.

The trial court dismissed plaintiff's claim against the hospital. The appellate court reversed and remanded for a jury determination of whether, by her conduct, the nurse had undertaken to render aid to the decedent. Rather than sending the case to a jury, the hospital chose to settle by paying $45,000. For criticism of the decision, see Note, *Liability of Private Hospital Emergency Rooms for Refusal to Provide Emergency Care*, 45 Miss. L.J. 1003, 1009 (1974).

46. Note, *supra* note 45, at 1012-13.

47. *See supra* notes 24-29 and accompanying text.

obligation to treat even an emergency patient, the courts created fictional admissions that could produce equally arbitrary behavior on the part of hospitals.[48]

C. *Reliance On a Well Established Custom*

In *Wilmington General Hospital v. Manlove*,[49] the Delaware Supreme Court issued a landmark decision in the field of emergency hospital care. The plaintiff's infant child was stricken with diarrhea and a high fever. The family physician prescribed medicine and treatment, but after four days the child showed no signs of improvement. Knowing that their family physician was not in his office,[50] the Manloves took the child to the emergency room of defendant hospital. At the hospital the parents related the nature of the child's illness and treatment. The nurse on duty explained that there was a danger of conflicting medication, since the child was under the care of a physician. Thus, the child could not be treated. The nurse neither examined the child nor rendered any affirmative medical aid. She did attempt unsuccessfully to contact the plaintiff's family physician and recommended that the child be taken to the hospital's pediatric clinic the next day.[51] At home that same afternoon, the child died of bronchial pneumonia.

Alleging negligence in the hospital's refusal to render emergency assistance, the parents filed a wrongful death action against the hospital. The Delaware court did not approach the case on the basis of whether or not the child was a patient. Instead, the court squarely focused on whether the hospital had a duty to treat an emergency case, "one obviously demanding immediate attention."[52] The court conceded that a private hospital has no duty to maintain an emergency ward. The maintenance of such wards, however, had become a well established component of a hospital's services. The court construed the voluntary maintenance of an emergency ward as a gratuitous undertaking to render medical care. The denial of that care to a

48. Note, *supra* note 45, at 1013.

49. 54 Del. 15, 174 A.2d 135 (1961).

50. *Id.* at 16, 174 A.2d at 136. It was a Wednesday morning. *Id. See generally* E. KENNEDY, *supra* note 4, at 15.

51. Although debatable, it is unlikely that these actions would have either constituted an undertaking to render assistance or conduct sufficient to create a hospital-physician relationship. *See supra* text accompanying notes 43-45.

52. 54 Del. at 22, 174 A.2d at 139.

person relying on the hospital's custom was tantamount to the "negligent termination of gratuitous services, which creates a tort liability."[53] The court held that liability could result for failure to treat an individual in an unmistakable emergency, if that individual had relied upon the well established custom of a hospital to render aid.[54]

The *Manlove* rule expands the voluntary undertaking concept beyond that of the other cases.[55] Although still confined by the common law attitude toward nonfeasance, the Delaware court created a rule that could be applied with greater certainty. While other courts had gone to great extremes to locate conduct sufficient to establish a hospital-patient relationship,[56] under *Manlove* the plaintiff need only prove reliance on a custom of treating emergency cases.[57]

The Georgia Court of Appeals embraced *Manlove* in *Williams v. Hospital Authority of Hall County*.[58] The plaintiff arrived at a county hospital suffering from a traumatic injury, which visibly caused him great pain. The defendant hospital refused to treat him and contended in court that it had the absolute right to refuse emergency treatment. The judge stressed that the hospital was supported by public funds and maintained an emergency ward. He rejected as "repugnant" the argument that the hospital could refuse to render emergency care when emergency facilities were available.[59] While carefully limiting the opinion to the duty of public hospitals, the court held that a public hospital may not deny emergency care to an individual who sought aid from an institution that held itself out as providing such care.[60]

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53. *Id.* at 23, 174 A.2d at 139. *See* RESTATEMENT, *supra* note 10, § 323. *See also supra* notes 17-20 and accompanying text.

54. 54 Del. at 25, 174 A.2d at 140. The case is discussed in Note, *Duty of Private Hospital Maintaining Emergency Ward to Treat in Case of Unmistakable Emergency*, 40 TEX. L. REV. 732 (1962); 62 COLUM. L. REV. 730 (1962); 14 STAN. L. REV. 910 (1962). *See generally* Note, *Must a Private Hospital Be a Good Samaritan?*, 18 U. FLA. L. REV. 475 (1965); Powers, *supra* note 6.

55. *See supra* notes 38-48 and accompanying text.

56. *Id.*

57. Commentators suggest that the *Manlove* court did not clearly define what it meant by "reliance on a well established custom." Powers, *supra* note 6, at 1474-75; Note, *supra* note 45, at 1016. Nevertheless, proof of knowledge that an emergency room existed and had a practice of rendering aid is a clearer formulation than the implied admission rationale. *See supra* notes 38-48 and accompanying text.

58. 119 Ga. App. 626, 168 S.E.2d 336 (1969).

59. *Id.* at 627, 168 S.E.2d at 337.

60. *Id.*

The Missouri Supreme Court applied the same rationale to a private hospital in *Stanturf v. Sipes*.[61] The plaintiff there was suffering from frostbite. The physician who examined him determined that the patient needed emergency hospital treatment. The physician tried to arrange for the plaintiff's admission to the nearest hospital, which was private. Admission was contingent on the payment of a twenty-five dollar fee, which plaintiff could not afford. Although other individuals were willing to pay the fee in the plaintiff's behalf,[62] treatment was refused. After several days of futile effort, the plaintiff was finally admitted to an out-of-state hospital. When therapy treatments proved unsuccessful, both his feet were amputated.

In a suit against the hospital, the plaintiff alleged that the hospital's refusal to treat him had aggravated his condition and was actionable. Concluding that a jury could find that the plaintiff or his physician had relied on the hospital's practice of treating emergencies, the Missouri Supreme Court reversed a summary judgment for the hospital.[63] When viewing the evidence in a light most favorable to the plaintiff, it was also possible to find that the plaintiff's condition constituted an unmistakable emergency and that delay in treatment had worsened the condition.[64]

Courts in many jurisdictions have applied the *Manlove* rule to both public and private hospitals.[65] Some courts have rejected *Manlove* by following dicta in *Crews* indicating that a hospital which main-

61. 447 S.W.2d 558 (Mo. 1969).

62. Although the facts are unclear, the court's opinion recites that a local church group had expressed its willingness to pay the admission fee. Nevertheless, the hospital administrator declined the church group's assistance, perhaps because of a policy against admitting charity patients. *Id.* at 559.

63. *Id.* at 562.

64. *Id.*

65. *E.g.*, Carr v. St. Paul Fire & Marine Ins. Co., 384 F. Supp. 821 (W.D. Ark. 1974) (jury could properly decide that public hospital had breached its duty to plaintiff's decedent who had relied on hospital's practice of treating emergency patients); Guerro v. Copper Queen Hosp., 112 Ariz. 104, 537 P.2d 1329 (1975) (private general hospital may not refuse emergency treatment without cause); Hunt v. Palm Springs Gen. Hosp., 352 So. 2d 582 (Fla. Dist. Ct. App. 1977) (questions of whether emergency condition existed and breach of duty occurred were properly before the jury); Richard v. Adair Hosp. Found. Corp., 566 S.W.2d 791 (Ky. 1978) (jury should decide question of whether or not hospital was negligent for refusing to treat decedent who was stricken with pneumonia); Mercy Medical Center v. Winnebago County, 58 Wis. 2d 260, 206 N.W.2d 198 (1973) (private hospital maintaining emergency ward has duty to treat emergency patients who rely on hospital's holding itself out as providing such care).

tains an emergency department may refuse to treat an individual in need of immediate attention.[66] As noted earlier, this is an erroneous reading of *Crews*. *Crews* held simply that a hospital need not admit a patient after providng emergency room treatment.[67] Other courts have avoided *Manlove* by finding that the hospital had no duty to render service, because the patient's condition did not constitute an emergency.[68] Another court found *Manlove* inapposite when the plaintiff could not prove reliance on the hospital's policy of rendering emergency care.[69]

The commentators agree that *Manlove* represents the developing trend regarding a hospital's duty to treat emergency patients.[70] It is not, however, the universal position.[71] Furthermore, *Manlove* has not disturbed the principle that a hospital that treats an emergency patient is under no obligation to hospitalize that individual. Transfers to other hospitals are permissible as long as the diagnosis is not negligent and the transfer does not aggravate the patient's condition.[72] Nevertheless, *Manlove* represents a judicial landmark in imposing a duty on hospitals to treat unmistakable emergency cases when the applicant has relied on the hospital's custom of rendering

66. *E.g.*, Levin v. Sinai Hosp., 186 Md. 174, 46 A.2d 298 (1946) (in absence of statutory duty, private hospital has no obligation to serve every applicant who applies for treatment); Fjerstad v. Knutson, 271 N.W.2d 8 (S.D. 1978) (even hospital that operates emergency department may refuse to render emergency treatment). *See supra* notes 24-27 and accompanying text.

67. *See supra* notes 24-27 and accompanying text.

68. *See, e.g.*, Campbell v. Mincey, 413 F. Supp. 16 (N.D. Miss. 1975) (pregnant woman who sought treatment at county hospital so she could deliver child did not constitute an emergency case). *See also supra* notes 30-32 and accompanying text.

69. Fabian v. Matzko, 236 Pa. Super. 267, 344 A.2d 569 (1975) (plaintiff, who merely telephoned hospital and conversed with staff physician, but did not visit the hospital, did not rely to his detriment on hospital's practice of treating patients).

70. M. MANCINI & A. GALE, *supra* note 1, at 50; A. SOUTHWICK, THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION 187-88 (1978); UNIVERSITY OF PITTSBURGH HEALTH LAW CENTER, HOSPITAL LAW MANUAL, 31 (1980); D. WARREN, PROBLEMS IN HOSPITAL LAW 88-89 (3d ed) 1978); Ficarra, *The Hospital Emergency Room and the Law*, 12 CAL. W.L. REV. 223, 236 (1976); Note, *supra* note 45, at 1020.

71. *See supra* note 66 and accompanying text.

72. *E.g.*, Birmingham Baptist Hosp. v. Crews, 229 Ala. 398, 157 So. 224 (1934); Harper v. Baptist Medical Center—Princeton, 341 So. 2d 133 (Ala. 1976); Joyner v. Alton Ochsner Medical Found., 230 So. 2d 913 (La. Ct. App. 1970) (after affording plaintiff initial emergency treatment, hospital could properly transfer him rather than hospitalize him for additional treatment).

aid.[73]

IV. Statutory Duties

Coincident with these developments in judicially created law, many states have enacted statutes governing the duties of hospital emergency departments. The scope and requirements of the statutes vary from state to state. A few states require hospitals to have at least one licensed doctor or intern on duty at all times.[74] Other states have imposed more stringent requirements. Wisconsin, for example, has enacted a statute requiring that public hospitals in counties with populations of more than 250,000 persons establish and maintain emergency departments.[75] The statute imposes a duty to treat "persons in said county who may meet with accidents or suddenly be afflicted with illness not contagious."[76] The statute permits the removal of the patient to another hospital when transfer may be safely achieved. Thus, the Wisconsin statute does not require hospitalization of all emergency patients.[77]

Like the Wisconsin provision, the Texas statute applies only to public hospitals.[78] It imposes a duty on staff members at hospitals supported with public funds to treat all applicants who are seriously ill or injured, provided the hospital customarily provides such treatment.[79] The statute is a codification of the *Manlove* rule, but is restricted to public hospitals.

California, Florida and Wyoming have adopted nearly identical legislation.[80] Their statutes apply to all hospitals that maintain and operate emergency departments, whether public or private. Applicants who are in danger of loss of life or in serious condition,[81] or whose condition will deteriorate from failure to receive treatment,[82]

73. *See supra* note 64 and accompanying text.

74. *E.g.*, PA. STAT. ANN. tit. 35, § 435 (Purdon 1977); VA. CODE § 32.1-127 (1979).

75. WIS. STAT. ANN. § 46.21(8)(b) (West 1979).

76. *Id.*

77. *Id.*

78. TEX. HEALTH & SAFETY CODE ANN., § 4438a (Vernon 1976).

79. *Id.*

80. CAL. HEALTH & SAFETY CODE § 1317 (Deering 1975); FLA. STAT. ANN. § 401.45 (West 1973); WYO. STAT. § 35-2-115(a) (1977).

81. CAL. HEALTH & SAFETY CODE § 1317 (Deering 1975).

82. FLA. STAT. ANN. § 401.45 (West 1973).

must be afforded emergency care. The California statute further mandates that hospitals lacking emergency facilities must use reasonable care to facilitate the applicant's access to emergency treatment, including transportation assistance.[83]

In 1969, New York enacted a law requiring every general hospital to admit any person in need of immediate hospitalization.[84] The statute also provides that hospitals maintaining emergency departments must furnish emergency medical care to any applicant who requires such care.[85] The statute thus differentiates between hospitalization and emergency treatment, but imposes both obligations in appropriate circumstances. In 1973 the legislature added a section obligating every hospital in metropolitan areas with over one million inhabitants to provide emergency care to persons in need of such care.[86]

The Illinois and Tennessee enactments are the broadest in scope. The Illinois act provides that every licensed hospital in the state that provides general medical and surgical services must maintain an emergency department and must furnish such 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."[87] The Tennessee act applies to "every hospital, either public or private, which does business within this state and provides general medical and surgical services."[88] Such hospitals are required to operate emergency departments and may not deny treatment to applicants whose conditions are liable to result in death or severe injury or illness.[89]

Several states have enacted sanctions for failure to comply with the statutes. In New York, the penalty for noncompliance is revocation or suspension of a hospital's license.[90] More frequently, criminal penalties are imposed for refusal to furnish emergency treatment.[91] Violations of the statutes would also be grounds for civil liability in

83. CAL. HEALTH & SAFETY CODE § 1317 (Deering 1975).
84. N.Y. PUB. HEALTH LAW § 2805-b (McKinney 1977).
85. *Id.*
86. *Id.* § 2805-b(2).
87. ILL. ANN. STAT. ch. 111½ § 86 (Smith-Hurd 1977).
88. TENN. CODE ANN. § 53-5201 (1977).
89. *Id.*
90. N.Y. PUB. HEALTH LAW § 2806 (McKinney 1977).
91. Violations are usually misdemeanors, punishable by fines of up to $1000.

private actions for damages.[92]

The commentators agree that these statutes indicate a trend toward requiring hospitals to maintain emergency departments and to furnish care to those in need.[93] The trend, however, is far from universal. Several of the states that impose duties to maintain emergency departments exempt private hospitals from the statute's scope.[94] Even more states have not enacted statutory obligations at all. Over fifty years have passed since the first statute requiring a hospital to treat emergency cases was enacted,[95] and only a handful of states have followed. The trend is not only incomplete, but painstakingly slow in developing.

V. ALTERNATE RATIONALES

A. *Imposition of Other Duties Indicates High Degree of Public Responsibility*

Despite the common law attitude toward nonfeasance,[96] states have traditionally imposed duties on physicians and hospitals. Perhaps most well known are statutes requiring a physician or hospital to report cases of gunshot wounds[97] or infectious diseases.[98] Of more interest here, however, are state child abuse reporting statutes. These statutes impose broad obligations as part of comprehensive state public welfare programs.

All fifty states and the District of Columbia have enacted laws obligating physicians, hospital administrators, and others to report suspected cases of child abuse to local social welfare agencies.[99]

E.g., TENN. CODE ANN. § 53-5203 (1977); TEX. HEALTH & SAFETY CODE ANN. § 4438a(2) (Vernon 1976).

92. *See supra* notes 49-65 and accompanying text.

93. A SOUTHWICK, *supra* note 70, at 184; UNIVERSITY OF PITTSBURGH HEALTH LAW CENTER, *supra* note 70, at 28; Note, *supra* note 45, at 1020.

94. *See supra* notes 75-79 and accompanying text.

95. Illinois first enacted its statute in 1927. *See supra* note 87 and accompanying text.

96. *See supra* notes 9-20 and accompanying text.

97. *E.g.*, CAL. PENAL CODE §§ 11160-11161 (Deering 1980); MICH. STAT. ANN. § 28.643 (1972); N.Y. PENAL LAW § 265.25 (McKinney 1980).

98. *E.g.*, CONN. GEN. STAT. § 19-33 (1979); MINN. STAT. ANN. § 144.42 (West 1970); N.Y. PUB. HEALTH LAW § 2101 (McKinney 1980). *See generally* Frankel, *Criminal Omissions: A Legal Microcosm*, 11 WAYNE L. REV. 367, 402-05 (1965).

99. Fraser, *A Glance at the Past, A Gaze at the Present, A Glimpse at the Future: A*

Significantly, the statutes do not differentiate between public and private hospitals.[100] Reporting duties are imposed on all physicians or hospital administrators who suspect a child has been abused or battered. Many states have also provided criminal penalties for failure to report suspected cases, but civil liability presents a greater threat.[101]

Two California cases illustrate that the reporting statutes are not merely empty gestures. In a 1970 civil action[102] brought by a child's natural father against four hospital-based physicians, the father alleged that the doctors had violated the reporting statute. The child had been taken to the defendants on three occasions with multiple injuries inflicted by the mother's boyfriend.[103] Although one of the physicians suspected child abuse, no reports were filed. After three days of trial, a settlement was reached, whereby the defendants agreed to pay over $500,000 in damages.[104] In a similar civil case, the California Supreme Court ruled in *Landeros v. Flood*[105] that a hospital and attending physicians could be liable for failure to diagnose and report a case of child abuse. Furthermore, the physician could be held liable for subsequent damages to the child if such additional injuries were reasonably foreseeable.[106]

In addition to requiring that reports be filed, many child abuse reporting statutes have imposed other obligations on physicians and hospitals. Several states have recognized the importance of a mandatory medical examination and oblige hospitals and physicians

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Critical Analysis of the Development of Child Abuse Reporting Statutes, 54 CHI.-KENT L. REV. 641, 650 (1978). For a compilation of the statutes, see Comment, *Civil Liability for Failing to Report Child Abuse*, 1 DET. L. REV. 135, 135-36 (1977).

100. Comment, *supra* note 99, at 135-36.

101. Fraser, *supra* note 99, at 665-67; Comment, *supra* note 99, at 136.

102. Robinson v. Wical, No. 70-37607 (Cal. Super. Ct., San Luis Obispo, filed Sept. 4, 1970).

103. For a shocking description of the child's injuries, see Ramsey & Lawler, *The Battered Child Syndrome*, 1 PEPPERDINE L. REV. 372, 374-76 (1974).

104. Comment, *supra* note 99, at 136-37; TIME, Nov. 20, 1972, at 74.

105. 17 Cal. 3d 399, 551 P.2d 389, 131 Cal. Rptr. 69 (1976).

106. The court held that the jury should determine whether or not a reasonably prudent physician would have diagnosed the child as battered. In that sense, the court addressed the case on a medical malpractice theory. The court also concluded that the jury should resolve the question of the foreseeability of future abuse. *Id.* at 412, 551 P.2d at 396, 131 Cal. Rptr. at 76.

to treat battered children.[107] For example, Pennsylvania's statute provides:

> Children appearing to suffer any physical or mental trauma which may constitute child abuse, shall be admitted to and treated in appropriate facilities of private and public hospitals on the basis of medical need and shall not be refused or deprived in any way of proper medical treatment and care.[108]

The statute provides for the issuance of a court order compelling treatment if the hospital refuses to render appropriate care.[109] It also provides a civil action for damages against the hospital.[110] Other states require hospitals or physicians to render care if requested by the local social welfare agency or officer, regardless of parental consent.[111]

Recently, many states have amended their reporting statutes to include provisions for temporary protective custody of the child.[112] These provisions are designed to remove the child from home before additional injury or abuse is inflicted. The protective custody provisions also recognize that additional medical treatment may be necessary, but that parents may be unwilling to arrange for such care. Consequently, the statutes authorize hospitals and physicians to keep a child in custody under certain conditions.[113]

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107. *E.g.*, MD. ANN. CODE art. 27, § 35A(h)2 (1977); R.I. GEN. LAWS § 40-11-6(3) (1977). The Rhode Island provision states that the Department of Social and Rehabilitative Services, after receiving a report of child abuse, "shall have the child examined by a licensed physician." *Id.*

108. PA. STAT. ANN. tit. 11, § 2209(a) (Purdon 1979).

109. *Id.* § 2209(b).

110. *Id.*

111. *E.g.*, MICH. STAT. ANN. § 24.248(6) (Callaghan 1980); N.J. STAT. ANN. § 9:6-8.28 (West 1976).

112. Fraser, *supra* note 99, at 674.

113. *E.g.*, FLA. STAT. ANN. § 827.07(6) (West 1980). The Florida provision is representative of these enactments:

> Any person in charge of any hospital or similar institution or any physician treating a child may keep that child in his custody without consent of the parents, legal guardian or legal custodian, whether or not additional medical treatment is required, if the circumstances are such that continuing the child in the child's place of residence or in the care or custody of the parents, legal guardian, or legal custodian presents an imminent danger to the child's life or physical or mental health.

Id. Other enactments are nearly identical. *E.g.*, ARK. STAT. ANN. § 42-811 (1977); R.I. GEN. LAWS § 40-11-5 (1977); WASH. REV. CODE § 26.44.056 (1980). Other states empower courts to order a hospital or physician to keep a child in temporary custody.

The reporting statutes have imposed a variety of obligations on physicians and hospitals. States have imposed these duties on all hospitals, regardless of status. The imposition of these duties serves the public policy objectives of identifying, investigating and treating child abuse cases.[114] Although the common law frowned upon the imposition of affirmative obligations to act,[115] it is clear that when acceptable social policy considerations are served, such duties can and will be imposed.

The imposition of a duty to treat emergency patients would likewise serve desirable social goals. Like child abuse reporting statutes, state legislation imposing an obligation to treat emergency patients would serve public policy and humanitarian considerations. The child abuse reporting statutes, which authorize physicians or hopitals to keep a child in protective custody,[116] indicate that hospitals and physicians have a high degree of public responsibility toward the patients they treat. It is inconsistent with that degree of public responsibility to deny emergency treatment to persons who need it.

B. *Physicians and Hospitals are in a Fiduciary Relationship to the Public*

The view that hospitals and physicians are in a fiduciary relationship to the public finds support in several areas of hospital law. The public accountability of hospitals and physicians has been instrumental in the law regarding medical staff appointments and privileges.[117] The existence of the trust relationship between hospitals and the public provides a basis for imposing a duty to administer emergency medical care.

The law is settled that a physician does not have an absolute right

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See, e.g., COLO. REV. STAT. § 19-10-107 (1978); MASS. GEN. LAWS. ANN. ch. 119, § 51c (West 1975). The Massachusetts provision empowers judges to "authorize the hospital and attending physicians . . . to keep such a child in the hospital until custody is transferred" to the Department of Public Welfare. *Id.*

114. *See supra* note 99 and accompanying text.

115. *See supra* notes 9-20 and accompanying text.

116. *See supra* notes 112-13 and accompanying text.

117. *See generally*, Note, *Denial of Staff Privileges: Hearing and Judicial Review*, 56 IOWA L. REV. 1351 (1971) [hereinafter cited as Note, *Denial of Privileges*]; Note, *Hospital Medical Staff: When are Privilege Denials Judicially Reviewable?*, 11 U. MICH. J.L. REF. 95 (1977) [hereinafter cited as Note, *Hospital Medical Staff*]; Note, *The Physician's Right to Hospital Staff Membership: The Public-Private Dichotomy*, 1966 WASH. U.L.Q. 485 [hereinafter cited as Note, *Public-Private Dichotomy*].

to an appointment in either a public or private hospital.[118] It is also widely accepted, however, that a public hospital may not act arbitrarily, capriciously, or unreasonably in granting, denying, or restricting staff privileges.[119] Courts have been willing, therefore, to review public hospital board actions and decisions. Furthermore, since public hospitals are owned by the government, courts have insisted that such hospitals afford the physician procedural due process in compliance with the fourteenth amendment.[120] Physicians have attacked public hospital rules or decisions on the grounds that they are unreasonable or arbitrary,[121] or that due process requirements were not met.[122] Implicit in decisions reviewing public hospital board action is the principle that the board holds its power in public trust and may not contravene the public interest.[123]

118. Hayman v. Galveston, 273 U.S. 414 (1927) (a physician does not have a constitutional right to practice in a public hospital); Levin v. Sinai Hosp., 186 Md. 174, 46 A.2d 298 (1946) (private hospital has the right to exclude any physician from practicing therein). *Accord* Van Campen v. Olean Gen. Hosp., 210 A.D. 204, 205 N.Y.S. 554, *aff'd per curiam*, 239 N.Y. 615, 147 N.E. 219 (1924).

119. *See* Note, *Public-Private Dichotomy*, *supra* note 117, at 487-91.

120. A. SOUTHWICK, *supra* note 70, at 431; Note, *Denial of Privileges*, *supra* note 117, at 1354-56. Due process is not violated, however, by the summary suspension of a physician if the hospital acted to safeguard the welfare of its patients. The physician need only be afforded the opportunity for a hearing within a reasonable time. *See, e.g.*, Citta v. Delaware Valley Hosp., 313 F. Supp. 301 (E.D. Pa. 1970) (hospital may summarily restrict physician's privileges when his competence has been called into question, provided hospital grants him an adjudicatory hearing within a reasonable time); Duby v. Baron, 369 Mass. 614, 341 N.E.2d 870 (1976) (when the quality of care rendered by physician has been cast into doubt, summary suspension followed by prompt hearing does not offend due process).

121. *E.g.*, Ware v. Benedikt, 225 Ark. 185, 280 S.W.2d 234 (1955) (hospital by-law requiring that staff physicians be members of local medical society ruled invalid). *Accord* Hamilton County Hosp. v. Andrews, 227 Ind. 217, 84 N.E.2d 469 (1949), *cert. denied*, 338 U.S. 831 (1949). *See, e.g.*, Bronaugh v. City of Parkersburg, 148 W. Va. 568, 136 S.E.2d 783 (1964) (court invalidated a rule stating that before a physician could be appointed to a public hospital staff he must be on the staff of a private hospital); Group Health Coop. v. King County Medical Soc'y, 39 Wash. 2d 586, 237 P.2d 737 (hospital by-law excluding physicians who practiced contract medicine held arbitrary and discriminatory).

122. *E.g.*, Milford v. People's Community Hosp. Auth., 380 Mich. 49, 155 N.W.2d 835 (1968) (hospital board violated due process because suspended physician not granted hearing); Johnson v. City of Ripon, 259 Wis. 84, 47 N.W.2d 328 (1951) (due process requires that physician be afforded notice and hearing before revocation of privileges).

123. The opinions emphasized that the hospital's actions must promote "the safety, interest and welfare of patients and the general public." Ware v. Benedikt, 225

Courts traditionally afforded private hospitals a free reign in administration and operation.[124] The actions and procedures of private hospital boards were not even subject to judicial review and were left strictly to the discretion of the board. The only constraint on private hospitals was that they act in accordance with their rules and regulations.[125] This view was a product of the philosophy that private corporations should be free to conduct their business without judicial interference.

Increasingly, however, the trend is to ignore any distinction between private and public institutions.[126] One source of this development is the widespread distribution of government funds to hospitals through the Hill-Burton Act[127] or through programs like Medicare and Medicaid.[128] Several courts have held that the receipt of governmental funds and benefits, such as tax exemptions, may be sufficient

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Ark. 185, 189, 280 S.W.2d 234, 236 (1955). Language to the same effect may be found in Sosa v. Board of Managers of Val Verde Hosp., 425 F.2d 44 (5th Cir. 1970) (motion for stay granted), *aff'd*, 437 F.2d 173, 176-77 (5th Cir. 1971).

124. *E.g.*, Shulman v. Washington Hosp. Center, 222 F. Supp. 59 (D.D.C. 1963) (private hospital board had the power to appoint and remove staff physicians at will); Edson v. Griffin Hosp., 21 Conn. Supp. 55, 144 A.2d 341 (1958) (court is without authority to interfere in internal affairs of private hospital); Foote v. Community Hosp., 195 Kan. 385, 405 P.2d 423 (1965) (private hospital board's managerial powers are discretionary and not subject to judicial review). *See generally* Note, *Denial of Privileges*, *supra* note 117, at 1356-60; Note, *Public Private Dichotomy*, *supra* note 117, at 492-93.

125. Note, *Public-Private Dichotomy*, *supra* note 117, at 492. Thus, if the hospital's by-laws are silent regarding hearings before dismissal, the board need not afford the physician a hearing. *E.g.*, Natale v. Sisters of Mercy, 243 Iowa 582, 52 N.W.2d 701 (1952) (no impropriety in hospital's not even giving notice to physician that he had been dismissed); Khoury v. Community Memorial Hosp., 203 Va. 236, 123 S.E.2d 553 (1962) (physician not entitled to hearing before dismissal from private hospital).

126. *See* McMahon, *Judicial Review of Internal Policy Decisions of Private Nonprofit Hospitals: A Common Law Approach*, 3 AM. J.L. & MED. 149 (1977); Note, *Judicial Review of Private Hospital Activities*, 75 MICH. L. REV. 445 (1976).

127. 42 U.S.C. § 291 (1976). Pursuant to this Act, the federal government makes grants for the construction or modernization of hospital facilities. All recipient hospitals are obligated to provide a reasonable volume of services to persons unable to pay. *Id.* § 291c(e). *See* 42 C.F.R. § 53.111(a) (1981). *See generally* Rose, *Federal Regulation of Services to the Poor Under the Hill-Burton Act: Realities and Pitfalls*, 70 NW. U.L. REV. 168 (1975).

128. 42 U.S.C. §§ 1395, 1396 (1976). For discussions of these provisions, see Butler, *An Advocate's Guide to the Medicare Program*, 8 CLEARINGHOUSE REV. 831 (1975); Butler, *The Medicaid Program: Current Statutory Requirements and Judicial Interpretations*, 8 CLEARINGHOUSE REV. 7 (1974).

to imbue a private hospital's operations with state action.[129] The result of these decisions is to subject an increasing number of private hospitals to the requirements of the fifth and fourteenth amendments. These decisions represent the minority view, however, and for most courts, receipt of government funds is only one element in finding state action.[130]

Of far greater significance is judicial recognition of the proposition that even private hospitals are vested with a public character. The New Jersey Supreme Court has been at the forefront of this movement. In *Greisman v. Newcomb Hospital*,[131] the court held that a private hospital[132] had a duty to consider an osteopathic physician's application for staff privileges, despite its by-laws to the contrary.[133]

129. *E.g.*, Doe v. Charleston Area Medical Center, Inc., 529 F.2d 638 (4th Cir. 1975) (private hospital's receipt of Hill-Burton funds and participation in Medicare and Medicaid programs constitutes state action); Pollock v. Methodist Hosp., 392 F. Supp. 393 (E.D. La. 1975) (private hospital, which receives substantial funds through Hill-Burton Act, satisfies state action requirement of 42 U.S.C. § 1983). *Accord* Duffield v. Charleston Area Medical Center, Inc., 503 F.2d 512 (4th Cir. 1974); O'Neill v. Grayson County War Memorial Hosp., 472 F.2d 1140 (6th Cir. 1973); Don v. Okmulgee Memorial Hosp., 443 F.2d 234 (10th Cir. 1971); Sams v. Ohio Valley Gen. Hosp. Ass'n, 413 F.2d 826 (4th Cir. 1969); Simkins v. Moses H. Cone Memorial Hosp., 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1963).

130. *E.g.*, Madry v. Sorel, 558 F.2d 303 (5th Cir. 1977) (receipt of Hill-Burton funds is not sufficient by itself to transform private hospital into arm of the state); Taylor v. St. Vincent's Hosp., 523 F.2d 75 (9th Cir.) (hospital that received Hill-Burton funds and tax exemptions did not act under color of state law), *cert. denied*, 424 U.S. 948 (1975); Hodge v. Paoli Memorial Hosp., 433 F. Supp. 281 (E.D. Pa. 1977) (mere receipt of Hill-Burton funds insufficient to establish finding of state action). *Accord* Ascherman v. Presbyterian Hosp. of Pac. Medical Center, Inc., 507 F.2d 1103 (9th Cir. 1974). The courts appear to require a connection between the state involvement and the objectionable activity. If the governmental involvement does not aid, encourage, or demonstrate approval of the activity, the courts refuse to find state involvement. *E.g.*, Barrett v. United Hosp., 376 F. Supp. 791 (S.D.N.Y.), *aff'd*, 506 F.2d 1395 (2d Cir. 1974). *See generally* Cronin, *Private Hospitals that Receive Public Funds Under the Hill-Burton Program: The State Action Implications*, 12 NEW ENG. L. REV. 525 (1977).

131. 40 N.J. 389, 192 A.2d 817 (1963).

132. The court noted that despite the "private" label, the hospital's certificate of incorporation declared that the purpose of the institution was to care for "sick or injured persons as the facilities of the hospital permit." Furthermore, the hospital had solicited funds publicly and was eligible for Hill-Burton grants. *Id.* at 390-91, 192 A.2d at 818-19.

133. *Id.* at 390-91, 192 A.2d at 824-25. In so holding, the court relied on its previous decision in Falcone v. Middlesex County Medical Soc'y, 34 N.J. 582, 170 A.2d 791 (1961). In *Falcone*, the court invalidated a rule prohibiting an osteopath from membership in a local medical society, as arbitrary and discriminatory.

The court acknowledged that the hospital's administrators possessed broad managerial powers. The exercise of those powers was so imbedded with the public interest, however, that the hospital officials were in a fiduciary relationship to both the public and the medical community.[134] Therefore, the courts could overturn the exercise of that discretion if the board's actions were unreasonable or unrelated to the public good.

The *Greisman* rule is a departure from previous judicial unwillingness to review the actions of a private hospital.[135] The court persuasively indicated that numerous other activities, whose functions are less public than hospitals, have been subjected to judicial and legislative scrutiny.[136] Emphasizing the vital public interests at stake, the court concluded that private hospitals' actions should not be immune from judicial review. Several courts have followed *Greisman* and recognize the quasi-public nature of private hospitals.[137] These courts, therefore, are willing to overturn conduct that contravenes the public interest.[138]

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134. 40 N.J. at 403, 192 A.2d at 825. Judge Jacobs, writing for a unanimous court, noted:

> Hospital officials are properly vested with large measures of managing discretion and to the extent that they exert their efforts toward the elevation of hospital standards and higher medical care, they will receive broad judicial support. But they must never lose sight of the fact that the hospitals are operated not for private ends, but for the benefit of the public, and that their existence is for the purpose of faithfully furnishing facilities to the members of the medical profession in aid of their service to the public. They must recognize that their powers, particularly those relating to the selection of staff members, are powers in trust which are always to be dealt with as such.

40 N.J. at 403-04, 192 A.2d at 825.

135. *See supra* notes 124-25 and accompanying text.

136. *E.g.*, railroads, warehouses, insurance rates and the milk industry. 40 N.J. at 397-98, 192 A.2d at 821-22.

137. *E.g.*, Willis v. Santa Ana Community Hosp. Ass'n, 58 Cal. 2d 806, 376 P.2d 568, 26 Cal. Rptr. 640 (1962); Ascherman v. San Francisco Medical Soc'y, 39 Cal. App. 3d 623, 114 Cal. Rptr. 681 (1974); Hawkins v. Kinsie, 540 P.2d 345 (Colo. Ct. App. 1975); Silver v. Castle Memorial Hosp., 53 Hawaii 475, 497 P.2d 564 (1972); Bricker v. Sceva Speare Memorial Hosp., 111 N.H. 276, 281 A.2d 589 (1971); Davidson v. Youngstown Hosp. Ass'n, 19 Ohio App. 2d 246, 250 N.E.2d 892 (1969); Adler v. Montefiore Hosp. Ass'n, 453 Pa. 60, 311 A.2d 634 (1973), *cert. denied*, 414 U.S. 1131 (1974); Woodard v. Porter Hosp., Inc., 125 Vt. 419, 217 A.2d 37 (1966).

138. The language of the Colorado Court of Appeals in Hawkins v. Kinsie, 540 P.2d 345, 349 (Colo. Ct. App. 1975) is representative:

> While the governing board of a private hospital must necessarily have broad discretion in its decisions relative to renewal of staff privileges for a physi-

Similarly, a growing number of courts have inquired into the validity of the procedural process that private hospitals afford staff members and applicants. Originally, courts deferred to the discretion of private hospitals in staff related matters, even if no procedural safeguards were provided.[139] Following *Greisman*, the New Jersey Superior Court held that a private hospital could not refuse an applicant for staff privileges without giving him a fair hearing.[140] The court concluded that an inquiry of this sort was mandated by the hospital's fiduciary duty to serve the interests of the public and the individual applicant.[141] Other courts have followed New Jersey's lead and require private hospitals to grant physicians due process of law when considering applications for appointment or renewal.[142] Another New Jersey decision has upheld the right of a physician to have an attorney represent him at medical staff hearings and also permitted broad discovery of documents in the board's possession.[143]

Courts have extended the rationale that a private hospital's board members are fiduciaries with an obligation to the public beyond the

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cian, . . . this discretion must not be immune from judicial review. . . . Therefore, a physician whose staff privileges are not renewed by the governing board of a private hospital operated to serve the general public states a claim for relief in damages by alleging that the decision not to renew those privileges was arbitrary, capricious, and unreasonable.

139. *See supra* notes 124-25 and accompanying text.

140. Sussman v. Overlook Hosp. Ass'n, 95 N.J. Super. 418, 231 A.2d 389 (1967).

141. *Id.* at 424, 231 A.2d at 538.

142. *E.g.*, Ascherman v. San Francisco Medical Soc'y, 39 Cal. App. 3d 623, 114 Cal. Rptr. 681 (1974) (private hospital may not deprive physician of staff privileges without granting due process); Silver v. Castle Memorial Hosp., 53 Hawaii 475, 497 P.2d 564 (1972) (applicant for staff privileges at a private hospital is entitled to a hearing and procedural due process); Hagan v. Osteopathic Gen. Hosp., 102 R.I. 717, 232 A.2d 596 (1967) (court reviewed procedures afforded by private hospital and found them in compliance with due process).

These courts view procedural fairness as an essential check on the fiduciary power of hospital boards. Due process requirements are a means of assuring that each application will be afforded individual review and attention. The interests of the hospital board in maintaining a quality staff, the individual applicant in pursuing his profession, and the public in having access to capable physicians are all served by these processes. *See* Note, *Hospital Medical Staff*, *supra* note 117, at 109.

Contra Monyek v. Parkway Gen. Hosp., 273 So. 2d 430 (Fla. Dist. Ct. App. 1973) (private hospital could deny physician staff membership without hearing and without assigning reasons for denial); Jain v. Northwest Community Hosp., 67 Ill. App. 3d 911, 385 N.E.2d 108 (1978) (actions of private hospital not judicially reviewable). *See supra* notes 124-25 and accompanying text.

143. Garrow v. Elizabeth Gen. Hosp., 79 N.J. 549, 401 A.2d 533 (1979).

area of staff privileges. For example, courts have generally invalidated exculpatory provisions in contracts between hospitals and patients.[144] In *Tunkl v. Regents of the University of California*,[145] a contract between a patient and a private hospital releasing the hospital from liability for negligence was held to violate the public interest. The court emphasized that the private hospital's conduct was affected with the public interest and that exemption from liability was inimical to that interest.[146] Courts have also applied the *Tunkl* rationale to exculpatory contracts between individual physicians and their patients, with uniform results.[147]

In *Doe v. Bridgeton Hospital Association*,[148] the New Jersey Supreme Court utilized the public trust doctrine in holding that a private hospital could not refuse its facilities to women seeking elective abortions during the first trimester of pregnancy. The court stressed that, as fiduciaries, the hospital's directors had committed themselves to serving the public without discrimination.[149] Finding no valid reason for permitting therapeutic, but not elective abortions, the court concluded that the hospital's policy was arbitrary and unrelated to valid hospital purposes. Although some courts have rejected this holding,[150] the rationale is likely to be followed elsewhere to expand access to medical services.[151]

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144. UNIVERSITY OF PITTSBURGH HEALTH LAW CENTER, HOSPITAL LAW MANUAL, PRINCIPLES OF HOSPITAL LIABILITY 71 (1981); M. Bertolet & L. Goldsmith, *supra* note 8, at 687.

145. 60 Cal. 2d 92, 383 P.2d 441, 32 Cal. Rptr. 33 (1963).

146. *Id.* at 101-04, 383 P.2d at 447-49, 32 Cal. Rptr. at 38-41.

147. Belshaw v. Feinstein, 258 Cal. App. 2d 711, 65 Cal. Rptr. 788 (1968); Bowman v. Davis, 48 Ohio St. 2d 41, 356 N.E.2d 496 (1976); Olson v. Molzen, 558 S.W.2d 429 (Tenn. 1977).

148. 71 N.J. 478, 366 A.2d 641 (1976), *cert. denied*, 433 U.S. 914 (1977).

149. The court relied heavily on *Greisman*, as in the following passage:

> As quasi-public institutions, their actions must not contravene the public interest. They must serve the public without discrimination. Their boards of directors are managing quasi-public trusts and each has a fiduciary relationship with the public.

Id. at 487, 366 A.2d at 645.

150. *E.g.*, Jones v. Eastern Maine Medical Center, 448 F. Supp. 1156 (D. Me. 1978) (private hospital may legally withhold the use of its facilities to perform elective second trimester abortions); Greco v. Orange Memorial Hosp. Corp., 374 F. Supp. 227 (E.D. Tex. 1974), *aff'd*, 513 F.2d 873 (5th Cir.) (private hospital may bar all nontherapeutic abortions), *cert. denied*, 423 U.S. 1000 (1975).

151. *See* McMahon, *Judicial Review of Internal Policy Decisions of Private Nonprofit Hospitals: A Common Law Approach*, 3 AM. J.L. & MED. 149, 167 (1977); Price,

The principle that a hospital's board is in a fiduciary relationship to the public should guide our analysis of emergency medical care. It would be consistent with that fiduciary relationship to impose an obligation on private hospitals to render emergency care within the common law framework.[152] Private hospitals, like railroads, inns, and common carriers, are affected with the public interest. It is a judicial anomaly that patrons of an inn or owners of bailed goods are afforded greater protection than patients of a hospital. The innkeeper's performance is hardly more vital to the public than that of the hospital. The dynamism of the common law[153] should respond to this anomaly by imposing a duty to treat emergency patients upon all hospitals.

It is troubling that the common law regarding a hospital's duty to render emergency aid dates to the 1930's.[154] The entire medical field has progressed since then and social attitudes have also changed.[155]

Expanding the Public Obligation of Private Hospitals, 11 CLEARINGHOUSE REV. 119 (1977).

152. *See supra* notes 9-20 and accompanying text.

153. Chief Justice Vanderbilt of the New Jersey Supreme Court wrote over 20 years ago:

> One of the great virtues of the common law is its dynamic nature that makes it adaptable to the requirements of society at the time of its application in court. There is not a rule of the common law in force today that has not evolved from some earlier rule of common law, gradually in some instances, more suddenly in others, leaving the common law of today when compared with the common law of centuries ago as different a day is from night. The nature of the common law requires that each time a rule of law is applied it be carefully scrutinized to make sure that the conditions and needs of the times have not so changed as to make further application of it the instrument of injustice.

State v. Culver, 23 N.J. 495, 505, 129 A.2d 715, 721 (1957).

154. *Birmingham Baptist Hosp. v. Crews* was decided in 1934. *See supra* notes 24-28 and accompanying text.

155. For a brief overview of the changes in the medical profession, see J. KNOWLES, *supra* note 2, at ch. 1.

The changing social attitudes toward medical care are demonstrated by the number of commentators suggesting that health care is a right. *E.g.*, E. KENNEDY, *supra* note 4, at 17. Kennedy's book, a compilation of hearings before the Senate Health Subcommittee, is a plea for a federal health security program. Kennedy insists that "good health care should be a right for all Americans." *Id.* Victor Fuchs, another right to health advocate, equates access to health care with access to education. V. FUCHS, WHO SHALL LIVE? HEALTH, ECONOMICS, AND SOCIAL CHOICE 28 (1974). He posits:

> The assertion that medical care is (or should be) a "right" is more plausible. In a sense medical care is to health what schooling is to wisdom. No society can truthfully promise to make everyone wise, but society can make schooling freely available; it can even make it compulsory.

The common law rule emerged at a time when individual medical practitioners were the norm, rather than the exception. Today, membership on a hospital staff is crucial to the great majority of American physicians.[156] The hospital is now the major health care resource in most communities and the emergency room is the focal point for health care delivery.[157] The common law should adjust to these conditions in order to meet today's needs.

VI. CONCLUSION

It is shocking that although our country possesses highly sophisticated health care facilities and manpower, those resources are not necessarily available to emergency patients. The imposition of a duty on all hospitals that maintain emergency rooms to render emergency care is compatible with the high degree of public responsibility associated with hospitals and is consistent with developments in other areas of hospital law. Before Americans lose confidence in our system of justice,[158] the law must respond by imposing a duty to treat emergency patients. A legal system that permits hospitals to close their

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Id.

Fuchs also criticizes existing hospital practices. He is especially critical of unnecessary hospital utilization and unduly long stays. He suggests that more efficient administration and decentralization of health care delivery will improve access to medical care. *Id.* at 149-51.

Victor and Ruth Sidel contend that health care is a fundamental right, and urge a decentralized, community controlled delivery system. V. SIDEL & R. SIDEL, A HEALTHY STATE: AN INTERNATIONAL PERSPECTIVE ON THE CRISIS IN UNITED STATES MEDICAL CARE (1977). *See generally* E. BANDMAN, BIOETHICS AND HUMAN RIGHTS (1978); T. BEAUCHAMP, *supra* note 5; OATMAN, MEDICAL CARE IN THE UNITED STATES 124-32 (1978); Blackstone, *On Health Care as a Legal Right: An Exploration of Legal and Moral Grounds*, 10 GA. L. REV. 391 (1976).

156. Hirsh, *Health Care as a Business*, in LEGAL MEDICINE ANNUAL—1980 at 275 (C. Wecht ed.); A. SOUTHWICK, *supra* note 70, at 429. *See also* Comment, *Hospital Medical Staff Privileges: Recent Developments in Procedural Due Process Requirements*, 12 WILLAMETTE L.J. 137 (1975).

157. AMERICAN HOSPITAL ASSOCIATION, EMERGENCY SERVICES 7-8 (1972). *See supra* notes 1-2 and accompanying text.

158. Charles Bohlen wrote the following timeless words in 1908:

> [It] should not be forgotten that a system of justice which lags too far behind the universally received conceptions of abstract justice, in the end must lose the sympathy, the confidence, perhaps even the respect of the community.

Bohlen, *Moral Duty to Aid Others as a Basis of Tort Liability*, 56 U. PA. L. REV. 316, 337 (1908).

doors to emergency victims is barbaric, morally reprehensible, and unworthy of respect.