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# The Emergency Room Admission: How Far Does the "Open Door" Go?

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News item: February 4, 1985—San Francisco. A 34 year old man with a wound from a knife which penetrated his skull was denied emergency neurosurgery at a private hospital. Though the hospital began treatment in the emergency room, the uninsured patient was refused further care. Following transfer to another facility the patient died.[1]

This may have been an isolated incident. Certainly it was unique or tragic enough to gain national media exposure, indicating that the public should find the circumstances uncommon and dramatic. Some legal commentators, however, have proposed that similar incidents are all too common, and that the law controlling hospital emergency room care is sometimes ignored or misinterpreted to the patient's harm.[2] While the law governing initial access to emergency room services has been documented reasonably well,[3] the incident above poses a narrower issue of increasing importance: what is the extent of a private hospital's legal obligation to treat a patient once emergency care has begun? The case law suggests that there are at least two situations in which the private hospital may be liable for denying extensive treatment to the emergency patient. First, when the patient cannot be transferred without unreasonable

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1. *CBS Evening News* (Feb. 5, 1985); *ABC Evening News*, (Feb. 6, 1985). The patient was an uninsured black man. Though the hospital had neurosurgical facilities, a decision was made to transfer the patient. Two other hospitals refused to take him, apparently prolonging the delay. Medical and legal commentators recently cited similar incidents, however, none has received such national attention. *See, e.g.*, Dowell, *infra* note 2; Fine, *infra* note 3; Friedman, *infra* note 17.

2. *See* Dowell, *Indigent Access to Hospital Emergency Room Services*, 18 CLEARINGHOUSE REV. 483-84 (1984). Dowell cites a number of reports of patients being denied emergency care, and notes that "numerous patients continue to be turned away from hospital emergency rooms because of confusion about the specific requirements under relevant laws and the lack of enforcement of these laws." *Id.* at 484.

3. *See, e.g.*, Fine, *Opening the Closed Doors: The Duty of Hospitals to Treat Emergency Patients*, 24 WASH. J. URB. & CONTEMP. L. 123 (1983); Powers, *Hospital Emergency Service and the Open Door*, 66 MICH. L. REV. 1455 (1968).

risk of injury, and second, when the hospital has unique or specialized capabilities which the emergency condition requires.

## I. HOSPITAL REVOLUTIONS: THE PROPRIETARY INSTITUTION AND THE EMERGENCY ROOM

"[T]he modern hospital is a revolutionary institution," wrote Professor Powers over fifteen years ago.[4] If that was true in 1968, then the 1980's launched a new offensive. Although the hospital industry has been traditionally dominated by charitable and public institutions,[5] proprietary hospitals have aggressively and rapidly captured a large share of the hospital market.[6] In addition, proprietary business techniques and marketing practices have become the trend in institutional health care for proprietary hospitals and, responding to competitive pressures, for nonprofit and some public hospitals.[7] Such hospitals credit their success to cost cutting measures such as centralized billing and economies of scale.[8] However, they have been criticized for "industrializing" health care and focusing on profit at the expense of health services.[9]

Parallelling this proprietary revolution is the demise of the traditional role of the hospital emergency room. Initially a lowly "accident room," the public now considers the emergency room as a neighborhood health center, and expects it to provide around-the-clock primary care and emergency care with equal skill and speed.[10] This may be explained in part by the loss of general practitioners to specialty medicine and the disappearance of the house call from American health care, though other factors have been cited.[11] However, the change in public expectations resulted in a staggering increase in emergency room visits since 1954. From only nine million visits in 1954, emergency rooms were expected to see 160 million patients in 1984,[12] eighty to ninety-five percent of which were not in "critical need of care."[13] This exponential growth has certainly bur-

4. Powers, *supra* note 3, at 1455.

5. In 1983, there were 5,783 community hospitals in the United States; 3,347 were non-profit, 757 were proprietary, 1679 were governmental (public). AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS 6 (1984).

6. *Medicine*, TIME, Dec. 10, 1984, at 84. Proprietary institutions such as Humana and Hospital Corporation of America have gathered a 20% share of the market, double the market share of only five years ago.

7. P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 428-44 (1982).

8. TIME, *supra* note 6.

9. *See, e.g.*, Powers, *supra* note 3, at 1476; TIME, *supra* note 6, at 85; Relman, *Economic Considerations in Emergency Care*, 312 NEW ENG. J. MED. 372 (1985).

10. M. MANCINI & A. GALE, EMERGENCY CARE AND THE LAW 43 (1981).

11. *Id.* For a more complete discussion of the forces that impact upon the public's concept of the emergency room and its use, see Fine, *supra* note 3, at 123 n.2.

12. M. MANCINI & A. GALE, *supra* note 10, at 43.

13. I. SNOOK, HOSPITALS: WHAT THEY ARE AND HOW THEY WORK 59 (1981).

dened emergency room resources, but conversely, hospitals have found that from sixteen to thirty percent of admissions come from the emergency department, making the "accident room" a potential source of both profit and goodwill in the community.[14]

Medical and legal writers have suggested that proprietary hospital practices in the emergency room may collide with the civil law.[15] Some writers have charged that many hospitals with emergency services are limiting the care that they provide to uninsured emergency patients by refusing emergency service[16] or making premature patient transfers from the emergency room.[17] Other commentators add that such proprietary "cost cutting" practices are not infrequently endangering patients. These writers forecast an inevitable increase of injuries and civil litigation.[18] Proprietary institutions also suffer criticism for cutting traditional hospital charity services to indigents and low income patients.[19] While these latter allegations pose no question of liability under the common law,[20] they are at least creating a major public policy problem and may also be contributing to a financial crisis for hospitals that provide services to the poor.[21] These hospitals, confronted with cuts in government support, strong competition for the paying patient, and recent closings of public and charitable institutions,[22] may be forced to cut services to the poor in order to survive, thus effectively rationing health care.[23]

In response, some proprietary institutions such as Humana ac-

14. *Id.* at 52, 55.

15. *See, e.g.*, Relman, *supra* note 9, at 372; Frank, *Dumping the Poor: Private Hospitals Risk Suits*, A.B.A. J., Mar. 1985, at 25.

16. *See, e.g.*, Himmelstein, Woolhandler, Harnley, Bader, Sibler, Backer & Jones, *Patient Transfers: Medical Practice as Social Triage*, 74 AM. J. PUB. HEALTH 494 (1984). The authors did a retrospective study of 458 consecutive transfers from 14 private hospitals to a public hospital in Alameda, California. Using criteria to establish patients at high risk during transfer, they found 103 patients meeting this profile. Of these patients, 33 were found to have received substandard care resulting from the transfer. *See also* Friedman, *The "Dumping" Dilemma: Finding What's Fair*, HOSPITALS, Sept. 1982, at 75.

17. *See, e.g.*, Dowell, *supra* note 2 and accompanying text.

18. Frank, *supra* note 15.

19. *See, e.g.*, Dallek, *For-Profit Hospitals and the Poor*, 17 CLEARINGHOUSE REV. 860 (1983). Dallek notes industry spokesmen do not deny some of these charges, quoting an American Medical Center spokesman: "We support indigent care through the payment of our taxes." *Id.* at 862. *See also* Dallek, *The Continuing Plight of Public Hospitals*, 16 CLEARINGHOUSE REV. 97 (1982).

20. *See infra* notes 41-54 and accompanying text.

21. *See, e.g.*, Dallek, *The Continuing Plight of Public Hospitals*, *supra* note 19.

22. *Id.*

23. *See* Feder, Hadley & Mullner, *Poor People and Poor Hospitals: Implications for Public Policy*, 9 J. HEALTH POL. & POL'Y L. 237 (1984). The authors note that "[a hospital's] chronic deficits bring chronic pressure: to cut back services, reduce quality, or give up marginal activities—which may include some care to the poor. In 1980 almost 20 percent of providers with high proportions of care to the poor

knowledge a responsibility to begin treating all emergencies. However, they vigorously defend their right to refuse to treat non-emergency charity patients and to transfer "stabilized" emergency patients to tax supported institutions if they cannot afford further care.[24]

Such statements somewhat beg the underlying legal and political questions. Clearly, some transfers can be made safely, while others risk creating liability; but there is a vast grey area in the law involving the interpretation of the traditional legal concepts of "duty" and "standard of care" within which predictions of liability cannot be easily made. In addition, if transfer policies do in fact create a burden on public or charitable hospitals, access for the transfer patient may become restricted, either through hospital closings or refusals to accept transfer patients. If so, proprietary hospital practices effectively "kill the golden goose." As other hospitals become reluctant to accept transfers, the risk of liability to the transferring institution can only increase. In short, while much will depend on the specific facts and the jurisdiction, the law may require a private institution to fully treat an emergency patient when no transfer is possible or when transfer may result in serious detriment to the patient.

## II. THE EMERGENCY ROOM

The modern hospital emergency room is a separate and distinct department, often so well staffed and equipped it resembles a "miniature hospital."[25] Patients arrive at an admitting desk, if time permits, or may go straight to "triage," where the patient is evaluated by a nurse or M.D. and directed to the appropriate emergency room physician.[26] Once a patient has been seen by a physician, the patient may be referred, treated and released, transferred, taken to emergency surgery, or admitted.[27] In most hospitals, only a physician with admitting privileges for the institution can formally admit a patient. The trend is for the emergency room to be staffed by full time salaried physicians, but there are many variations on physician staffing, ranging from compulsory or voluntary rotation of the hospital's medical staff to contract arrangements with independent emergency physician groups.[28] In fact, few emergency room physicians have admitting privileges. Generally, the emergency room physician determines whether admission is required, and then seeks

reported adoption of explicit limits on care to charity patients for financial reasons." *Id.* at 248.

24. Dallek, *For-Profit Hospitals and the Poor*, *supra* note 19, at 862.
25. I. SNOOK, *supra* note 13, at 52.
26. *See* J. GEORGE, LAW AND EMERGENCY CARE 66-70 (1980).
27. I. SNOOK, *supra* note 13, at 52-53.
28. *Id.* at 53-54.

admission for the patient through the appropriate staff physician who is usually "on call" for admissions to his or her specialty of care.[29] Each hospital's policies and regulations, whether individualized or based on national standards such as those of the Joint Commission on Accreditation of Hospitals, frequently clarify how these matters are handled for that particular institution.[30] Written hospital policies can be extremely important as evidence of "duty" or "standard of conduct" in malpractice suits.[31] Notwithstanding, such measures of liability will be made ultimately by the courts and not by the individual institution or professional associations.

## III. THE EMERGENCY: WHAT IS THE STANDARD?

The liability of a hospital for limiting or withholding emergency care may often turn on a judicial definition of "emergency," as the case law below will demonstrate. However, courts have virtually refused to provide an explicit definition of the term. Instead, courts generally let a jury find whether an emergency existed based on expert testimony and the facts of each case. Therefore, providers making emergency treatment and transfer decisions may be subject to the diverse definitions of "emergency" in the medical community, and, ultimately, to the interpretation of these definitions by a jury in malpractice litigation.[32]

The definition of "emergency" could be quite broad. One writer recently suggested that some medical clinicians might define emergency care as "that care which if not given will result in death within 24 hours."[33] Other commentators have supported a much broader definition.[34] Some courts addressing the emergency transfer issue have adopted the broader view in practice, finding that non-fatal frostbite,[35] burn,[36] or arterial[37] injuries could be "emer-

29. *See* J. GEORGE, *supra* note 26, at 79.

30. *See* A. SOUTHWICK, THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION 194 (1978).

31. *Id. See also* Fjerstad v. Knutson, 271 N.W.2d 8 (S.D. 1978), where the court noted "we find it unnecessary to evaluate the evidence in light of one of these [common-law] standards, since the evidence of the hospital's breach of its own standards is sufficient to create a jury issue." *Id.* at 12.

32. The Supreme Court of Arizona has said that "[w]hat constitutes an emergency is a matter of some disagreement. There are various definitions; the need for immediate attention seems to be the common thread. Ordinarily it is for the jury to determine the factual question of the duration of an emergency and the treatment modalities that are a necessary component of emergency care." Thompson v. Sun City Community Hosp., Inc., 141 Ariz. 597, 603, 688 P.2d 605, 611 (1984).

33. Frank, *supra* note 15, at 25.

34. Dowell, *supra* note 2, at 484-85.

35. Stanturf v. Sipes, 447 S.W.2d 558 (Mo. 1969).

36. Guerrero v. Copper Queen Hosp., 112 Ariz. 104, 537 P.2d 1329 (1975).

37. Thompson v. Sun City Community Hosp., Inc., 141 Ariz. 597, 603, 688 P.2d 605, 611 (1984).

gencies." The Mississippi Supreme Court implicitly defined emergency in broader terms by holding that emergency treatment is that which is "immediately and reasonably necessary for the preservation of the life, limb or health of the patient."[38] Medical organizations have provided their own definitions of the term, which tend to be quite broad. For instance, the American Hospital Association has defined a true emergency as "any condition *clinically determined* to require *immediate* medical care. Such conditions range from those requiring extensive immediate care and admission to the hospital to those that are diagnostic problems and may or may not require admission after work-up and observation."[39] Other organizations have developed even broader definitions.[40]

Clearly, some courts and some national organizations (including their member hospitals and physicians) have developed an expansive definition of what constitutes an "emergency." In malpractice actions, where the existence of an emergency is relevant to a provider's liability, the majority of courts may allow the jury to consider a similar range of evidence on the meaning of the term. It

38. New Biloxi Hosp. v. Frazier, 245 Miss. 185, 197, 146 So. 2d 882, 887 (1962).

39. AMERICAN HOSPITAL ASSOCIATION, EMERGENCY SERVICES vii (1972).

40. The American College of Emergency Physicians has defined emergency care in this way:

> A medical emergency includes:
> 1. any condition resulting in admission of the patient to a hospital or nursing home within 24 hours;
> 2. evaluation or repair of acute (less than 72 hours) trauma;
> 3. relief of acute or severe pain;
> 4. investigation or relief of acute infection;
> 5. protection of public health;
> 6. obstetrical crises and/or labor;
> 7. hemorrhage or threat of hemorrhage;
> 8. shock or impending shock;
> 9. investigation and management of suspected abuse or neglect of a person which, if not interrupted, could result in temporary or permanent physical or psychological harm;
> 10. congenital defects or abnormalities in a newborn infant, best managed by prompt intervention;
> 11. decompensation or threat of decompensation of vital functions, such as sensorium, respiration, circulation, excretion, mobility or sensory organs;
> 12. management of a patient suspected to be suffering from a mental illness and posing an apparent danger to the safety of himself, herself or others;
> 13. any sudden and/or serious symptom(s) which might indicate a condition which constitutes a threat to the patient's physical or psychological well-being requiring immediate medical attention to prevent possible deterioration, disability or death.

American College of Emergency Physicians, *Definition of Emergency Medicine*, 10 ANNALS OF EMERGENCY MED. 385, 385-88 (1981) (as cited in Dowell, *supra* note 2, at 484).

follows that a prospective definition is inherently speculative. A hospital using less than an expansive definition of "emergency" to determine emergency treatment and transfer policies may be exposing itself to a substantial risk of liability.

## IV. The Common Law and the "No Duty" Rule

The case law and legal principles that address a hospital's obligation to *continue* emergency treatment were largely developed to address a separate and more primary question: does the private hospital have *any* legal obligation to treat emergency patients who come to the emergency room?

Literally read, the common-law[41] answer may be shocking to the lay public: in at least some American jurisdictions, a hospital may be able to refuse emergency treatment to a patient.[42] Commentators have characterized this rule as the older and poorer view,[43] however, and have warned that when applied to emergency

41. The discussion in this article is focused entirely on the common-law obligations of private hospitals. Hospitals, both private and public, may also have obligations to accept patients arising from federal or state legislative mandates.

Hospitals that have received Hill-Burton funds (or funds under the 1974 health planning legislation) must provide both a reasonable volume of uncompensated services and a community service. For a discussion of these two distinct obligations, see Wing, *The Community Service Obligation of Hill-Burton Health Facilities*, 23 B.C.L. Rev. 577 (1982).

Various federal and state laws also prohibit discrimination on the basis of race, religion, creed, color, handicap, and age in the provision of hospital services (although these laws have been rarely interpreted with regard to hospital services). For background on one such legislative scheme, see Wing, *Title VI and Health Facilities: Forms Without Substance*, 30 Hastings L.J. 137 (1978).

It is also possible, although rarely applied or enforced, that non-profit hospitals might have either a "free care" or a "community service" obligation arising out of their exemption from federal or state taxes. For interpretations of a non-profit hospital's obligations under its federal income tax exemption, see Rev. Rul. 69-545, 1969-2 C.B. 117; Rev. Rul. 83-157, 1983-42 C.B. 94.

42. Powers noted in 1968 that "[w]e begin with the shocking proposition that present law in most American jurisdictions is said to permit a hospital to keep its doors closed to the person seeking emergency medical aid." Powers, *supra* note 3, at 1460. The most recent article to address the emergency care issue presents a state by state analysis of relevant common-law cases and applicable statutes. Though the modern trend is apparently to require a hospital to provide treatment to those emergencies which present at the emergency room, a majority of jurisdictions that have not yet addressed the issue may still permit a private hospital to refuse to provide such treatment, at least in theory. *See* Dowell, *supra* note 2, at 494-99.

43. Addressing the traditional view, Powers stated "[it may be that] the amazing potency of the dictum in *Crews* [the seminal common-law case] has evaporated. . . . The common law regurgitates what it cannot digest." Powers, *supra* note 3, at 1468. Southwick notes that "a hospital need not, by application of the early common law, employ its facilities and staff to aid the person who presents himself for treatment. Recent court cases and some statutes, however, suggest that this attitude has changed, at least with respect to hospitals which maintain emergency

treatment, the common law rarely does what the common law says. In almost every jurisdiction, courts have circumvented the rule and found some way to hold hospitals or emergency room physicians liable for negligently refusing or providing emergency treatment.[44]

The situation is complex, but it can be explained, if not justified. One longstanding principle of tort law is that a person is not legally obligated to help another person in distress.[45] There are a number of exceptions to this rule, but no exception mandates a physician to aid someone who is not already his patient. Thus a physician can refuse to aid the dying child who comes to his office, or the accident victim he encounters on the street; there is no duty to render such aid.[46] From this common-law "no duty to treat" rule evolved *Birmingham Baptist Hospital v. Crews*,[47] and the often quoted 1934 holding that a private hospital owes no duty to accept an emergency patient not desired by it.[48] However, in almost every American jurisdiction to consider the issue, either the *Crews* doctrine has been rejected,[49] or another principle of law was found controlling.[50] Some modern courts, expressly rejecting *Crews*, have held that a private hospital with an emergency room has a legal duty to at least examine every emergency patient that appears at the door.[51]

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care facilities. The public expects aid, and sound moral doctrine dictates that hospitals extend aid which they are capable of rendering." A. SOUTHWICK, *supra* note 30, at 186.

44. Analyzing these cases in detail is beyond the scope of this article. For an in depth treatment of the issue, see generally Fine, *supra* note 3; Powers *supra* note 3. Southwick concludes that:

> [a]s these cases demonstrate, in summary, patients who present themselves at the hospital emergency room should never be turned away until they have been seen and examined by a licensed physician, who thus determines the seriousness of the illness or injury and then orders admission, return home, or referral to another facility, depending on the facts and circumstances of each case.

A. SOUTHWICK, *supra* note 30, at 194.

45. For a discussion of the common-law origins of the "no duty" rule, see RESTATEMENT (SECOND) OF TORTS § 314 comment c (1965).

46. *See, e.g.*, Childs v. Weiss, 440 S.W.2d 104 (Tex. Civ. App. 1969) (leading case holding that a physician is under no duty to provide emergency services to all who request such care).

47. 229 Ala. 398, 157 So. 224 (1934).

48. See *infra* notes 60-63 and accompanying text for a detailed discussion of the *Crews* case.

49. *See, e.g.*, Wilmington Gen. Hosp., Inc. v. Manlove, 54 Del. 15, 174 A.2d 135 (1961); Richard v. Adair Hosp. Found. Corp., 566 S.W.2d 791 (Ky. Ct. App. 1978); Stanturf v. Sipes, 447 S.W.2d 558 (Mo. 1969).

50. *See, e.g.*, Fjerstad v. Knutson, 271 N.W.2d 8 (S.D. 1978); Citizens Hosp. Ass'n v. Schoulin, 48 Ala. App. 101, 262 So. 2d 303 (1972); Lejune Rd. Hosp., Inc. v. Watson, 171 So. 2d 202 (Fla. Dist. Ct. App. 1965).

51. *See, e.g.*, Mercy Medical Center, Inc. v. Winnebago County, 58 Wis. 2d 260, 206 N.W.2d 198 (1973); Guerrero v. Copper Queen Hosp., 112 Ariz. 104, 537 P.2d 1329 (1975); Hiser v. Randolph, 126 Ariz. 608, 617 P.2d 774 (Ariz. Ct. App. 1980).

Thus, at least in the emergency room setting, most courts have treated hospital and hospital-based physicians differently than private physicians by circumventing the traditional "no duty" rule. The reasons are probably based on a traditional view of hospitals as institutions of charity and compassion—institutions with a "moral duty" to treat emergencies. An explanation that also addresses the foundation of the "no duty" rule was neatly stated by Professor Powers: "the emergency room is vital to the community; it cannot be characterized as the locus of a chance encounter. A rule which evolved in the context of independent medical practitioners . . . should not be applied to hospitals automatically and without consideration."[52]

An understanding of the common law on this issue is complicated by the fact that over half the states have not addressed the point in case law or by legislation.[53] Presumably, in these states, even a court following traditional common-law principles could choose to follow the "no duty" rule, recognize an affirmative duty to treat, or hedge (the majority) and find an effective duty to treat under various exceptions to the "no duty" rule. Though a modern court *could* follow the *Crews* "no duty" rule, the weight of the precedent and modern opinion argues against it. A practical reading of the case law, contradictions and complexities admitted, is that a hospital must treat or arrange treatment for all emergency patients that appear at the emergency room, or run a palpable risk of liability.[54] In addition, many hospitals are subject to a variety of state and federal statutory requirements that essentially require that initial emergency treatment be provided.[55] Moreover, by imposing this obligation on the hospital emergency room, the law may have opened a door that cannot easily be closed.

## V. The Open Door: Where Does it Stop?

There are few cases that directly address the extent of a hospital's duty to the undesirable (*e.g.*, uninsured or Medicaid eligible) emergency patient following initial examination or treatment. In the past, many hospitals have, as a practical matter, probably followed a policy of stabilizing and transferring undesirable patients, while treating or even admitting the undesirable emergencies which would worsen during transfer. That may explain why relatively few interpretations of relevant legal principles have developed. However, if some observers are correct, emergency patients are now being transferred from hospitals having more proprietary-type

52. Powers, *supra* note 3, at 1477.
53. *See* Dowell, *supra* note 2, at 494-99.
54. *See supra* note 44 and accompanying text.
55. *See supra* note 41.

practices with alarming frequency,[56] and some researchers charge that many of these patients may be "at risk" of deteriorating during transfer.[57] If accurate, these claims suggest that unless hospitals making emergency transfers have some "immunity" from liability, courts will soon be forced to apply these critical principles with increased frequency.

The relevant case law, though neither consistent in theory nor always well reasoned, clearly provides no "immunity" to the transferring institution in these cases. On the contrary, the overwhelming majority of decisions have essentially allowed a *jury* to decide whether the hospital was responsible for injury-related emergency transfers.[58] Unfortunately, the inconsistency of the reasoning behind these decisions makes either descriptive or predictive summary of the underlying principles difficult. Nonetheless, the few cases on point and the larger body of law on the similar "duty to begin treatment" issue provide some guidelines.

### *A. Duty to Continue Emergency Care*

In a common-law negligence action, whether against a hospital or a physician, a plaintiff cannot recover without satisfying the four elements of duty, breach of the standard of conduct, causation, and injury.[59] The legal recognition of "duty" and the definition of the standard of conduct imposed by that duty are pivotal to an understanding of any obligation to continue emergency care.

In the common law, "duty" is defined as "an obligation . . . to conform to a particular standard of conduct toward another."[60] As noted earlier, the seminal *Crews* decision held that a private hospital had no duty to accept any patient it did not desire.[61] In *Crews*, a two year old girl with diptheria, though responding to antitoxin and oxygen treatment in the emergency room, was refused further treatment and sent home; she subsequently died within the hour. The court said the hospital was clearly within its rights, indicating that there was no duty to treat the patient.[62] The *Crews* court rejected an argument that the hospital had incurred a duty to treat the patient by beginning treatment. This latter concept, the common-law the-

56. Dowell reports a 500% increase in transfers from private hospitals to Chicago's Cook County General Hospital during 1982 and 1983. Dowell, *supra* note 2, at 483. Other reports note an increase in transfers to public hospitals of 200 to 375% in some cities over the last few years. Frank, *supra* note 15, at 25.

57. *See* Himmelstein, *supra* note 16 and accompanying text.

58. *See, e.g.*, *supra* notes 32, 44, 49-51 and accompanying text, and *infra* notes 79, 83, 92, 96, 106, 111, 117 and accompanying text.

59. W. PROSSER, HANDBOOK ON TORTS 143 (4th ed. 1971). *See also* M. MANCINI & A. GALE, *supra* note 10, at 15-23.

60. W. PROSSER, *supra* note 59, at 324.

61. *See supra* note 48 and accompanying text.

62. 229 Ala. 398, 399-400, 157 So. 224, 225.

ory of "gratuitous undertaking," traditionally states that, although there may be no duty to aid another, one may be liable for negligently giving or discontinuing aid if the risk of harm is increased as a result or if the other is harmed by relying on the aid.[63] The Alabama Supreme Court found that the hospital "undertook" emergency treatment, but had not affirmatively increased the risk of harm from the child's illness, and therefore was not liable for her death. The reliance issue was not addressed.[64]

A majority of courts have agreed with the initial "no duty to begin treatment" rule established in the *Crews* decision.[65] However, virtually all courts have avoided this rule, finding that a minimal undertaking may impose a duty of due care,[66] or that having the patient in the emergency room (without treating him) may make him an "admitted patient" and therefore undertake a duty,[67] or that a hospital with an emergency room must treat all emergencies as a matter of law.[68]

Further, in addressing a duty to *continue* emergency care, most modern courts have rejected the *Crews* contention that a hospital could arbitrarily *discharge* an emergency patient before emergency or necessary care was provided or arranged. As will be discussed below, various courts have found that a hospital which undertakes to treat but then transfers the patient may be liable for "increasing the risk of harm,"[69] or that a hospital cannot make a transfer to avoid

63. *See* RESTATEMENT (SECOND) OF TORTS § 323 (1965).

64. The *Crews* court went beyond the facts presented in that case to state the applicable law. One commentator notes: "On the lack of duty to render emergency treatment, the principle for which it has been so often cited, the *Crews* case contains only dicta." Powers, *supra* note 3, at 1465-66. *See also* Fine, *supra* note 3, at 130-31. This is because the hospital in *Crews* had a valid policy barring admissions of individuals with a contagious disease, which the child had. However, the dicta in *Crews* is probably consistent with the traditional common law. *See* Powers, *supra* note 3, at 1465. Further, though *Crews* is fifty years old, the Alabama Supreme Court expressly reaffirmed the decision in 1976 in Harper v. Baptist Med. Center-Princeton, 341 So. 2d 133 (Ala. 1976). Though both *Crews* and *Harper* could be criticized for supporting the traditional common-law only in dicta, *see, e.g.*, Fine, *supra* note 3, at 128, the courts tend to view the common-law "no duty" rule as binding precedent.

65. *See supra* notes 42, 43, 44 and accompanying text.

66. *See infra* note 79 and accompanying text.

67. *See, e.g.*, Methodist Hosp. v. Ball, 50 Tenn. App. 460, 362 S.W.2d 475 (1961); *see infra* note 96 and accompanying text. There may be no practical difference between finding a hospital/patient relationship and finding a hospital's "undertaking" as in O'Neill v. Montefiore Hosp., 11 A.D.2d 132, 202 N.Y.S.2d 436 (1960). Both approaches allow a jury to find a resultant duty of reasonable care. However, the former approach has overtones of a contract relationship, which may support a cause of action in abandonment. *See generally* 3 PROOF OF FACTS 2d 123 (1974); A. SOUTHWICK, *supra* note 30, at 92-100.

68. *See supra* note 51 and accompanying text.

69. *See, e.g., infra* note 111 and accompanying text.

providing necessary emergency treatment,[70] or that a hospital must provide all "medically indicated" emergency care.[71]

In avoiding or rejecting the *Crews* court's interpretation of duty on the continuing emergency treatment question, it appears that courts have been struggling to avoid a problem with the "undertaking" theory. Traditionally, this problem with the common-law theory of gratuitous undertaking has been illustrated by a "drowning man" hypothetical. Assume a man is drowning in a lake with no hope of rescue. Must a passer-by who can easily throw a rope and save the man's life do so? The common-law answer is theoretically "no." This hypothetical illustrates the "no duty to aid" theory noted earlier, as morally outrageous as it may appear.[72]

However, the concept of gratuitous undertaking arises when the hypothetical is slightly varied. Assume that the passer-by undertakes to save the drowning man and throws the rope. Will the law obligate him to complete the effort, or may he arbitrarily abandon the rescue? Under traditional common-law theory, unless the drowning man's plight is worsened by the passer-by's action, or unless the drowning man relied to his detriment on the action (for example, by foregoing other chances of rescue), the passer-by can abandon the rescue without legal sanction.[73] The reasoning is that the aborted rescue has not changed the drowning man's lot—he is still a drowning man, no better, no worse—so the passer-by has not *increased* the risk of harm. Further, there is no reliance to his detriment if no chance of rescue was lost because of the passer-by's acts.

The emergency care issue resembles the "drowning man" hypothetical. *Crews* illustrates this.[74] However, other courts addressing the emergency care question have not applied the theory of gratuitous undertaking with great deference to the traditional common-law formula. In fact, authorities have recognized a general

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70. *See, e.g., infra* notes 96, 106 and accompanying text.
71. *See infra* note 117 and accompanying text.
72. *See supra* note 46 and accompanying text.
73. *See generally* W. PROSSER, *supra* note 59, at 343-48.
74. One commentator noted:

> *Crews* is an example of rendering aid and sending the patient away with the mutual understanding that he is in no better condition than before treatment. It is completely consistent with the general tort law with respect to the duty to aid one in peril. The hospital provided aid and, although its help conferred no particular benefit, it did not make the condition worse.

Powers, *supra* note 3, at 1465. However, other commentators maintain that in *Crews* "[t]he hospital provided some treatment, but it abandoned that care before the patient's condition had stabilized. The imposition of liability would be fully consistent with the exception to the general rule that one who undertakes to aid another in peril must do so with reasonable care." Fine, *supra* note 3, at 127-28. Prosser tends to support the latter interpretation of the undertaking law. *See infra* notes 75-77 and accompanying text.

trend toward changing the law of undertaking.[75] Prosser, addressing the "drowning man" hypothetical, claimed the individual rendering aid could not let go of the rope without good reason:

> It seems very unlikely that any court will ever hold that one who has begun to pull a drowning man out of the river after he has caught hold of the rope is free, without good reason, to abandon the attempt, walk away and let him drown, merely because he was already in extremis before the effort has begun.[76]

Prosser further stated that "[w]here performance clearly has been begun, there is no doubt that there is a duty of care."[77] It appears that most courts have agreed with Prosser's analysis, and have been quite liberal both in finding what constitutes an "undertaking," and in assessing the extent of the "duty" once an undertaking is found.[78] In the fifty years since *Crews* was decided, the law of gratuitous undertaking may have acquired a new significance in hospital law, at least on the narrow issue of a duty to continue emergency care.

One of the cases most often cited in the emergency care context is *O'Neill v. Montefiore Hospital.*[79] Plaintiff's decedent complained of severe arm pains and became diaphoretic and pale. He walked to the hospital emergency room and told the nurse he thought he was having a heart attack. The hospital did not accept patients with his particular insurance policy, and the nurse refused to begin treatment. However, she did call a physician who worked with that insurance plan. He instructed the decedent to go home until the morning. After walking home, the decedent died of a heart attack. The court found that it was for the jury to determine whether the nurse undertook to provide medical attention by telephoning the physician, and if so, whether that medical attention was inadequate. A new trial was ordered to make that determination.[80]

The *O'Neill* case illustrates the quantum of action that may create a legal "undertaking." No pre-existing provider/patient relationship was found. Consequently, the hospital had no duty to accept the decedent under a literal reading of the traditional common law. However, the court found that a de minimus act by the nurse, making a phone call, could constitute an undertaking and impose a duty of care.[81] In *O'Neill,* such a duty was recognized and the jury was left to decide the extent of this duty. This decision graphi-

75. *See, e.g.,* W. PROSSER, *supra* note 59, at 346-47.
76. *Id.* at 348.
77. *Id.* at 346.
78. *See, e.g., supra* notes 65-71 and accompanying text.
79. 11 A.D.2d 132, 202 N.Y.S.2d 436 (1960).
80. *Id.* at 135-36, 202 N.Y.S.2d at 440.
81. *Id.*

cally shows how the "no duty to begin treatment" doctrine has been undermined by the law of gratuitous undertaking. It also suggests the practical implications of this judicial interpretation of this duty since, as a practical matter, emergency rooms must evaluate emergencies, and evaluation involves some degree of interaction with the patient. In *O'Neill* and similar cases,[82] *any* evaluation or attention apparently will create a duty to use reasonable care.

In *Fjerstad v. Knutson*,[83] plaintiff's decedent arrived at the emergency room after becoming ill on a family trip. An intern examined him, took a throat culture and blood test (but made no direct examination of the throat), and discharged him with a prescription for an antibiotic. The intern was unable to locate a staff physician to approve the patient's discharge as required by hospital policy. The next morning, the decedent's wife found him dead, asphyxsiated from his swollen epiglottis blocking the trachea. In ordering a new trial on the issue of the hospital's liability, the Supreme Court of South Dakota interpreted the undertaking law as follows:

> Although it has been held that a hospital, even one operating an emergency room, has no duty to accept a patient for treatment . . . once [a hospital] undertakes to render medical aid, the hospital is required to do so non-negligently. . . . The duty arose in this case, since the hospital undertook, through its nurses and intern, to render treatment to decedent. Decedent had a right to expect that the treatment rendered by a hospital which maintains and staffs an emergency room would be commensurate with that available in the same or similar communities or in hospitals generally.[84]

The *Fjerstad* court easily found an undertaking, because the patient was diagnosed and treated during a lengthy stay at the emergency room. However, in finding a duty, the court made no analysis of the traditional undertaking law criteria noted earlier. Though it presumably could have found the patient relied to his detriment on the undertaking (by foregoing other care), the court instead stated a blanket rule that in undertaking to treat an emergency, a hospital incurs a duty which is measured by the community standard for similar hospitals to treat the emergency patient. This is clearly a broad departure from the traditional law of undertaking, but the *Fjerstad* court has not been alone in adapting that law to fit the emergency care situation. In fact, most of the cases addressing the undertaking rule in the emergency room context would allow a jury to find liability if a hospital "undertakes" to treat an emergency patient by its

82. *See supra* note 67 and accompanying text.
83. 271 N.W.2d 8 (S.D. 1978).
84. *Id.* at 11-12.

conduct, giving the jury wide latitude in interpreting the reasonableness of the conduct.[85] This standard of conduct and its implications may impose more of a legal burden in the emergency transfer context than many hospitals realize.

*B. Reasonable Care under the Circumstance—the Standard of Conduct*

In a medical context, the standard of conduct requires that a provider be found negligent for failing to do what a reasonable provider would have done in similar circumstances—for not adhering to "good medical practice."[86] Under this standard of conduct, a hospital can be liable for its acts alone, such as implementing negligent hiring, admissions, or medical treatment policies.[87] In addition, a hospital can be liable for the acts of a hospital physician or hospital employee on separate legal grounds.[88] Generally, the question whether this standard of conduct has been breached is determined by the jury (based on expert testimony);[89] thus, precise definitions are elusive. However, the decisions in the emergency care context at least indicate that the extent of a hospital's obligations may be quite broad.

Courts have taken two general approaches in determining the standard of conduct for hospitals in rendering emergency treatment. Some courts have avoided lengthy discussion of the underlying legal principles or definitions such as "duty," "undertaking," or the "standard of conduct," and instead have given the jury broad discretion to find or reject liability on the facts.[90] Other courts have been more pedantic in formulating guidelines for a jury and future

85. *See, e.g., supra* notes 67, 79; *infra* notes 92, 96, 106, 111 and accompanying text.

86. W. PROSSER, *supra* note 59, at 185-93.

87. *See generally* A. SOUTHWICK, *supra* note 30, at 409-23. This is a relatively new theory of liability in hospital law termed "corporate negligence." Before the case of Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966), a hospital owed only limited duties directly to the patient. However, *Darling* found that a hospital as a separate entity could be liable for the quality of medical treatment under some circumstances.

88. *See generally* M. MANCINI & A. GALE, *supra* note 10, at 25-38. Under the doctrine of respondeat superior, hospitals as employers can be liable for the wrongful acts of their employees, even though the hospital's conduct is without fault. It must be shown that a master-servant relationship existed and that the wrongful act occurred within the scope of that relationship. This doctrine applies to physicians who are employees of the hospital as well. However, hospitals may be liable in some situations for the negligence of physicians who are independent contractors, which is a common arrangement in the emergency room. *See supra* note 28 and accompanying text. The doctrine of "ostensible agency" provides that a hospital may be liable for the actions of an individual who is not an employee if the hospital has cloaked an independent contractor with the indicia of apparent authority to act in behalf of the hospital.

89. W. PROSSER, *supra* note 59, at 161-66, 206-07.

90. *See infra* notes 92, 106 and accompanying text.

courts to use.[91] In either approach, however, courts generally have recognized that a hospital may have an extensive duty to continue treating the undesirable emergency patient. An example of the former approach is *Hunt v. Palm Springs General Hospital*,[92] where a hospital refused to admit an emergency room seizure patient because of an unpaid bill. Apparently, the patient had been without needed medication for some time and began convulsing at home. At the emergency room, he was given medication and discharged, but he later returned and his physician asked if the patient could be admitted. Because of the outstanding bill, the hospital refused to admit him unless his condition was "critical," which the physician said it was not. Thereafter, the patient was placed in a hallway where he stayed for five hours unattended, his blood pressure and pulse elevated, his body trembling. He was finally transferred to another hospital, where he died of brain damage from prolonged seizures within twenty-six hours. Expert testimony for the patient's estate stated that the hospital's treatment fell below acceptable standards of medical practice, and that these deficiencies were causually related to his death.

The court addressed the issues of "duty" and "standard of conduct," stating, "[i]f Palm Springs owed no duty to the decedent, its negligence would be immaterial to this cause."[93] However, the court *rejected* the contention that the hospital had no duty to continue treating the patient. Instead, the court held that "the questions of whether [defendant] owed [the patient] a duty of care despite his non-admitted status while he lay in its emergency room area, and whether any breach of such duty occurred which was a causative factor in [his] demise are for the jury to determine."[94]

*Hunt* is not particularly enlightening for its analysis of the facts or the common law.[95] The standards that measure the hospital's duty of care to an emergency patient are not articulated. On its facts, however, the case is consistent with the same "undertaking" and "reasonable care" approach to hospital liability as *Fjerstad* and other cases below. The case does not expressly address the question of whether the patient had to be admitted or treated in the emergency room, or whether the hospital could have simply transferred him sooner. However, the court found that the hospital had a duty to continue treating him and allowed a jury to hear evidence on the issue of whether that duty had been breached.

91. *See infra* notes 96, 111 and accompanying text.

92. 352 So. 2d 582 (Fla. 1977).

93. *Id.* at 584.

94. *Id.* at 585.

95. *Id.* at 583, 585. Whether "admitted" as opposed to "non-admitted" refers to the emergency room or the hospital proper is left unclear. In addition, the court makes no attempt to analyze the elements of liability on the facts.

Unlike *Hunt*, other cases provide more helpful guidelines to determine the extent of a hospital's duty. For example, the Mississippi Supreme Court addressed the issue in *New Biloxi Hospital, Inc. v. Frazier*,[96] in which a forty-two year old man, his brachial artery torn away by a shotgun blast, was brought to the emergency room by ambulance. Though he bled enough to soak the ambulance cot and the floor with blood, his care was limited to having his vital signs taken once. He was not bandaged. The physician on call did make arrangements for transfer to the nearest veteran's hospital, but after bleeding freely for two hours in the New Biloxi emergency room, the patient died following the transfer. In affirming a verdict against the hospital, the court first found that the man was a "patient," though he had not been treated. The court next outlined the hospital's duty to the patient:

> In an emergency, the victim should be permitted to leave the hospital only after he has been seen, examined and offered reasonable first aid. In undertaking to do so, a hospital must exercise due care. A hospital rendering emergency treatment is obligated to do that which is immediately and reasonably necessary for the preservation of the life, limb or health of the patient. It should not discharge a patient in a critical condition without furnishing or procuring suitable medical attention.[97]

Again, the undertaking issue is addressed without mention of the strictures of the traditional common law. The *New Biloxi* court, like the court in *Fjerstad*, applied a broad standard of conduct to the treatment of emergency patients, whether or not the patient was desired by the hospital. *New Biloxi* is unusual among the cases recognizing that a duty of continuing care applies to emergency patients because it expressly articulates the standard of conduct. In doing so, the decision uses an expansive definition of emergency. However, *New Biloxi* is neither extreme nor unique. Other cases have similarly recognized, either explicitly or by implication, that a duty to continue emergency care may require a hospital to provide extensive treatment to an undesirable patient if transfer would cause or allow deterioration of the patient's condition.[98]

### *C. The Emergency Transfer*

Hospital spokesmen are correct in stating that they are within their rights to stabilize emergency patients and transfer them to other hospitals.[99] However, the transfer of an emergency patient, if

96. 245 Miss. 185, 146 So. 2d 882 (1962).
97. *Id.* at 197, 146 So. 2d at 887.
98. *See infra* notes 104, 106, 111, 117 and accompanying text.
99. *See supra* note 19.

done non-negligently, is lawful *not* because the hospital has "no duty" or a "lesser duty" following initial emergency care, but because in transferring the patient it has acted as a reasonable provider and has not violated the applicable standard of conduct.

Legal commentators agree that a duty of care incurred by an undertaking can be discharged if the conduct is reasonable. Prosser has stated:

> The defendant is never required to do more than is reasonable; and he may terminate his responsibility by turning an injured man over to a doctor or to his friends, or where it is reasonable to do so he may discontinue his performance and step out of the picture upon notice of his intention and disclosure of what remains undone.[100]

It follows that a hospital may be able to discontinue performance and transfer an emergency patient when a duty is incurred through an undertaking.[101] However, the majority of jurisdictions suggest that the reasonableness of an emergency transfer decision depends upon the patient's condition and is measured by the prevailing standard of medical practice. No lesser standard controls, and surely not a standard based upon the hospital's "convenience," or an administratively determined policy to accept or refuse certain categories of patients. The *Fjerstad* court found that reasonable care meant care "commensurate with that available in . . . hospitals generally."[102] In *New Biloxi* the court held that a hospital "should not discharge a patient in a critical condition without furnishing or procuring suitable medical attention."[103] These decisions and others below suggest that reasonable treatment of a true emergency would not allow a provider to "step out of the picture" without arranging for or providing virtually any necessary medical treatment.

In *Joyner v. Alton Ochsner Medical Foundation*,[104] a Louisiana Court of Appeals addressed the "reasonableness" question when it held that an emergency patient could not recover for pain and suffering incurred in transfer after receiving initial emergency treatment. The patient came to the emergency room with facial lacerations, a possible head injury, and loss of blood. He was bandaged, x-rayed, monitored for shock, and given I.V. fluids to stabilize his blood pressure. After his blood pressure stabilized and a serious head injury was ruled out, he was given pain medication. However, the hospital refused to admit the patient in-house without a deposit on his bill and transferred him. The patient later sued for injury and

100. W. PROSSER, *supra* note 59, at 348.
101. *See infra* note 104 and accompanying text.
102. 271 N.W.2d at 11.
103. 245 Miss. at 103, 146 So. 2d at 887.
104. 230 So. 2d 913 (La. Ct. App. 1970).

pain and suffering incurred during the transfer. The court noted that the plaintiff's "condition did not require . . . admission as an emergency measure. . . . In the absence of an immediate need for emergency treatment the requirement of a deposit prior to hospital admission was neither unreasonable nor improper."[105] Thus, the court did not find that the hospital had no duty to treat the emergency patient. Rather the court determined that the hospital had not violated its standard of conduct in arranging for transfer. Under *Joyner*, if a hospital, measured by what a reasonable hospital in similar circumstances would do, determines that the emergency patient will not suffer injury during or because of the transfer, then a transfer is not negligent.

In *Jones v. City of New York Hospital for Joint Diseases*,[106] the court held a hospital liable for not providing emergency surgery to an undesirable patient. The patient came to the emergency room after being assaulted. She was diagnosed as having a stab wound penetrating the abdomen. Only private beds were available, and the hospital or intern apparently thought the patient unsuitable for a private bed. Her wound was simply cleaned and dressed. Although the hospital had appropriate surgical facilities, she was sent by ambulance to the city hospital, a one hour trip. After transfer, she died in surgery.

In court, the intern testified that he did not regard the patient's condition to be an emergency. However, he testified in deposition that there could be serious internal injury from such an abdominal stab wound. Considering the full evidence, the court said "[we are] convinced that the interne [sic] adopted the alternative of transferring the patient to the City Hospital for the convenience of his own hospital and not because he thought there was no emergency."[107] Further, the court noted that there was ample evidence that the patient required admission at the hospital regardless of its "convenience." Expert testimony showed that the patient's wound mandated exploratory surgery, and that considering the time factor for transport, the "proper" course would have been to keep her at the defendant hospital. The court held for the patient's estate, concluding that "the deceased was denied necessary treatment at the Hospital for Joint Diseases and was transferred without her consent to the City Hospital, and that such transfer was a contributing factor in her death."[108]

In *Jones*, as in *Hunt*, there was no discussion of the legal principles guiding the court's decision. The hospital, however, evaluated

105. *Id.* at 916.
106. 134 N.Y.S.2d 779 (Sup. Ct. 1954), *modified*, 286 A.D. 825, 143 N.Y.S.2d 628 (App. Div. 1955).
107. *Id.* at 781.
108. *Id.* at 784.

and undertook the responsibility of treating the patient, although it was unwilling to perform surgery. The *Jones* court implicitly found that the standard of conduct measuring the hospital's duty to treat the emergency patient was based on the patient's emergency needs, or what treatment was "necessary,"[109] basing its finding of a breach of that duty predominantly on expert testimony showing that the patient required immediate surgery.[110]

The latter two cases evaluate the decision to make the transfer entirely in terms of the patient's medical needs. The common thread binding these and the other cases above (except *Crews*) is a duty of "due" or "reasonable" care imposed on a hospital which undertakes to treat an emergency. *Jones* and *Joyner*, however, expressly recognized that this duty of reasonable care can extend beyond the confines of the emergency room and is not confined to first aid or stabilization. The decisions also suggest the limits of a hospital's duty to treat unwanted emergency patients. While *Joyner* holds that a hospital may transfer an undesirable patient when the patient requires neither immediate admission nor further treatment as an emergency measure, *Jones* holds that when a patient does require further treatment as an emergency measure, including surgery, a hospital may be liable for refusing it. According to these decisions, the immediacy of the need for emergency treatment, measured against the delay or risks involved in transfer, largely determines the extent of the hospital's obligations. Obviously the availability of other institutions willing to accept the transfer would have to be considered in this determination.

The traditional rule that a party will not be liable for undertaking aid absent increased risk or reliance was largely ignored in *Joyner*, *Jones*, and other decisions above. One recent decision may have attempted to more directly reconcile the policy of requiring a continuing duty measured by the reasonableness of the conduct with the traditional undertaking theory. In *Riddle Memorial Hospital v. Dohan*,[111] the patient came to the emergency room by ambulance, complaining of chest pain. His private physician met him there, though the physician was not on the hospitals staff and had no admitting privileges.[112] The emergency room staff (which included a physician and a nurse) performed an EKG at the private physician's request, which confirmed a diagnosis of heart attack. The patient was then transferred to another hospital, apparently at the private doctor's request. He died during the transfer. At trial, testimony

109. *Id.* at 783-84.

110. *Id.*

111. 504 Pa. 571, 475 A.2d 1314 (1984).

112. *Id.* at 574, 475 A.2d at 1315. This unusual situation occurred when the patient apparently left for the nearest hospital rather than wait for the physician at home.

showed that no one on the emergency room staff informed the patient of the risk of transfer, or that proper facilities were available without transfer. In upholding a jury verdict for the hospital, the Pennsylvania Supreme Court interpreted the law governing transfer following initial emergency examination:

> In essence, [the Restatement of Torts 2d section 323] is what the trial judge instructed the jury. If the jury found that the hospital acted unreasonably in allowing the decedent to be removed from the hospital, and it was foreseeable that such removal would aggravate or increase the danger of the existing physical condition, the hospital would be liable.[113]

As did the *Crews* court, the *Riddle* court explicitly endorsed the traditional theory of "undertaking" requiring either an increased risk of harm or detrimental reliance. However, unlike *Crews*, it is not clear what the court interpreted that theory to require under these facts. *Crews* found that a hospital undertaking emergency care is not liable for unreasonable acts when a patient dies of original injuries unless the unreasonable acts affirmatively aggravate or increase the risk of those injuries. This interpretation is the crux of the "drowning man" problem in the undertaking law. However, the *Riddle* court's emphasis on reasonableness suggests that it approved a standard of conduct determined largely by the reasonableness of the conduct, even when the undertaking does not affirmatively increase or aggravate the harm. Moreover, the *Riddle* court did what the *Crews* court refused to do: it left the ultimate decision on liability to the jury. Therefore, *Riddle* is more in line with *Fjerstad* than *Crews*. Thus, after stating the common law of undertaking set out above, the court cited with approval the following jury instruction:

> [E]ven if you find that the attending physician remained in charge of the decedent, [the hospital] nevertheless remained responsible for those services or acts which according to good medical practice it should have performed. . . . Accordingly, a jury could conclude that the decedent was not a "patient" of [the hospital], and still find [the hospital] liable for failing to act reasonably in permitting [the private physician] to remove the decedent.[114]

The court further noted that "the sole issue for the jury's consideration was whether the hospital acted reasonably once it had been determined that the hospital undertook to render services to the decedent."[115]

113. *Id.* at 557, 475 A.2d at 1317.
114. *Id.*
115. *Id.* at 578, 475 A.2d at 1317.

The *Riddle* decision may provide an inconsistent analysis of the undertaking theory. *Riddle* nonetheless may be another example of the type of decision modern litigants can expect—one that attempts to blend the traditional requirements of the common law with a modern case by case analysis of liability, and which allows a jury to be the ultimate arbitrator on that issue. Under a literal interpretation of the "undertaking" law, the *Riddle* court could have kept the decision from the jury, as did *Crews*,[116] and found for the hospital as a matter of law. Significantly, the court declined to do so.

Though the decisions above may have expanded the traditional common-law approach to emergency treatment and transfer decisions, the Arizona Supreme Court recently found a still broader duty to treat emergencies on an alternative theory. In *Thompson v. Sun City Community Hospital*,[117] a thirteen year old child was rushed to a private hospital emergency room with a full or partial femoral artery transection. Three physicians consulted and agreed immediate emergency surgery was required. The patient, however, was instead deemed "stabilized" or "medically transferable," and was transferred to the county hospital because the family could not pay. At the county hospital, the child had the femoral artery repaired. When he was left with a permanent leg injury, his mother filed suit against the physicians and the hospital claiming that an inappropriate transfer caused the harm.

The hospital admitted that the transfer was made for financial reasons only and that it was hospital policy to transfer nonpaying patients whenever medically allowed. The institution rested its defense on its right to transfer a patient who is determined to be "stabilized."[118] In addition, the defense argued that the original injury would have caused the damage regardless of where the surgery was done.[119]

The Arizona Supreme Court returned to its decision in *Guerrero v. Copper Queen Hospital*,[120] and reaffirmed an Arizona public policy requiring a private hospital to *initiate* emergency care. However, the *Thompson* court took *Copper Queen* one giant step forward. The court held that not only must a private hospital begin care for all emergency patients, but that these patients may not be transferred for economic reasons until all "medically indicated" emergency care has been completed.[121] As for the issue of causation, the court held that the plaintiff need only show that the institution may have increased the risk of harm by unreasonably transferring the plaintiff,

116. 229 Ala. 398, 157 So. 224 (1934).
117. 141 Ariz. 597, 688 P.2d 605 (1984).
118. *Id.* at 600-01, 688 P.2d at 608-09.
119. *Id.* at 605-07, 688 P.2d at 613-15.
120. 112 Ariz. 104, 537 P.2d 1329 (1975).
121. 141 Ariz. at 602, 688 P.2d at 610.

but not prove that there was a probability that the defendant's conduct was in fact a cause of the actual harm.[122] In essence, the court gave the broadest discretion to the jury in determining the hospital's liability for failing to continue treatment.

*Thompson*, like *Copper Queen*, was based on the court's construction of an Arizona statute,[123] therefore courts in other states need not consider the case as common-law precedent. The case was also decided under the umbrella of a state reimbursement scheme that paid for indigent care at private hospitals,[124] a plan that many states do not have. *Thompson*, however, expressly addresses the same public policy issues that have moved other courts to reject a strict interpretation of the common law of undertaking. While *Jones*, *New Biloxi*, *Hunt* and other decisions above may have implicitly favored access to emergency care as a policy matter, the *Thompson* decision expressly articulates a public policy approving access to emergency treatment for all true emergency patients, treatment which includes all "medically indicated" emergency care. For that matter, while *Thompson* may provide future courts with yet another approach to the emergency transfer issue, on the facts, the decision could have been reached under the analysis suggested by the common-law decisions above. In *Thompson*, the court found that the patient required emergency surgery.[125] Further, the hospital had clearly "undertaken" to care for him, thus binding itself to the "standard of reasonable care."[126] Whether the standard is violated is for a jury to decide, but the *Thompson* court cited overwhelming evidence that a reasonable hospital in the same situation would not have subjected the child to the delay in surgery.[127] Given the precedent of *Jones*, *New Biloxi*, *Fjerstad* and *Riddle*, the Arizona court, following common-law principles, could have found the hospital potentially liable. Indeed, it is likely that courts in other jurisdictions will do so, following the lead of these decisions.

122. *Id.* at 608, 688 P.2d at 616.
123. *Id.* at 601, 688 P.2d at 609.
124. *Id.* at 602, 688 P.2d at 610.
125. *Id.* at 603, 688 P.2d at 611.
126. *Id.* at 599-600, 688 P.2d at 607-08.
127. *Id.* at 601, 603-04, 688 P.2d at 609, 611-12. Evidence of negligence which the Arizona Supreme Court also considered in its analysis was the Joint Commission on the Accreditation of Hospitals (J.C.A.H.) standards for emergency services, which state: "[N]o patient [should] arbitrarily [be] transferred if the hospital where he is initially seen has the means for providing adequate care." JOINT COMMISSION ON THE ACCREDITATION OF HOSPITALS, MANUAL FOR HOSPITALS 33 (1986). As the *Thompson* court found, consideration of a patient's source of payment is "arbitrary" under the J.C.A.H. standards. 141 Ariz. at 601-02, 688 P.2d at 609-10. A hospital's breach of its own standards can clearly be evidence of negligence in court. *See supra* notes 30, 31.

## VI. CONCLUSION

In recent years many private and some public hospitals have assumed a new proprietary persona, a business-like posture that clashes with the traditional hospital goals of charity and community service. This conflict may be most acute in the emergency room where the hospital may further its financial interests by quickly transferring or discharging undesirable emergency patients. Most modern courts have avoided the traditional common law giving private hospitals an absolute right to choose their patients once they have provided initial first aid. Instead, courts have often required hospitals to continue to provide care or to arrange for transfer to another facility and have allowed juries to determine whether the conduct is reasonable under the circumstances.

This duty of continuing emergency care is measured principally by what the reasonable provider would do in similar circumstances and by the medical needs of the patient. This duty can be discharged by transferring the emergency patient, provided the transfer is reasonable. In the emergency treatment cases that have been decided thus far, the limits of this standard of reasonableness are generally based on the immediacy of the patient's emergency needs, measured against the delay and risk of transfer.

Depending upon the specific factual context, this common-law precedent may impose substantial obligations on hospitals. For example, assume a patient appears in the emergency room with a severed tendon in the wrist. The patient has no insurance; the surgical repair will be expensive. If the patient is otherwise healthy, alert, and ambulatory, and if a public facility is available to repair the severed tendon in time to prevent damage, it would be presumably reasonable to provide initial emergency care, inform the patient and the public facility, and transfer. However, assume the same patient has a severed artery in his wrist. This injury may not only require expensive repair, but also *immediate* treatment to save the hand. If permanent damage would likely occur before another hospital could repair the artery, the hospital that began initial treatment on an emergency basis may be obligated to perform the surgery. The patient could be transferred to a public facility once the danger from delay in treatment has passed. On the other hand, if there is no other hospital willing to accept the patient, the hospital may be required to provide extensive treatment, perhaps even rehabilitation, to this "emergency patient."

This analysis suggests that it is not necessarily the severity of an injury nor the risk of death that determines whether a hospital must treat an emergency. Rather, it is the risk of injury from delay in treatment, or from the transfer itself. This may mean, among other things, that hospitals in urban areas, which are closer to charitable institutions and have access to more sophisticated transfer modali-

ties, have a lesser practical obligation to treat the undesirable emergency than more distant transferring hospitals. It also means that hospitals that are the sole provider for an area, or that are in areas where there is no charitable hospital, may have a considerable obligation.

Perhaps more interesting is the question of what duty hospitals may owe to victims of a catastrophic injury. Under the analysis above, an emergency room faced with catastrophic trauma requiring immediate treatment may be liable for refusing treatment, even if it means extensive hospitalization. Given the expense of some emergency surgical procedures and post operative intensive care, this may be a difficult burden for some hospitals to bear. As a hypothetical, recall the news report that began this article in which an uninsured victim of penetrating trauma to the skull arrives at an emergency room. Although the hospital begins emergency treatment, the extensive injury requires expensive and immediate surgical intervention. In this situation, if a hospital with neurosurgical facilities elects to transfer the trauma patient, that hospital may be liable if the delay or transfer causes death or permanent injury. Further, the hospital may be liable if the attempted transfer is to a facility unable or unwilling to care for the patient.

Hospitals, of course, have a legitimate interest in their financial security and survival. Arguably, some institutions will incur a substantial financial burden arising from emergency treatment if courts continue to enforce the duty of continuing emergency care in the manner suggested by the case law. It is even conceivable that the added financial burden of emergency treatment could force closings of marginal institutions. Alternatively, some hospitals may find it preferable to simply close emergency rooms and refer emergencies to other institutions or free standing emergency rooms. A third possibility is present in the complexities of the common law. Some courts interpreting the "duty to begin treatment" issue have held that there is no duty to treat emergencies absent an undertaking. To avoid that theory, these same courts often found an "undertaking" and imposed a duty of reasonable care based on de minimus acts by the hospital. Hospitals in these jurisdictions could conceivably take advantage of a literal reading of the common law and require deposits or proof of insurance before "undertaking" *any* evaluation of the emergency patient.[128]

Whether hospitals currently conform to the duty of continuing emergency treatment suggested by the case law is not clear. The recent increase in emergency transfers has resulted in significant research and media coverage in which the validity of some emergency

128. Note, however, that these hospitals are still subject to statutory and other requirements relating to emergency room care. *See supra* note 41.

transfer policies has been questioned. As indicated earlier, whether these questionable policies are the rule or the exception is not clear, notwithstanding trends toward "industrializing" health care. It may be difficult to believe that many institutions are cavalierly denying necessary care to emergency patients, just as it is difficult to believe that they are knowingly subjecting themselves to a risk of liability given the current medical malpractice "crisis." On the other hand, it may be that some hospitals are taking a calculated risk. The paucity of case law reveals that similar suits were rarely heard by courts in the past, at least at the appellate level. This may reflect the practical difficulties of bringing a malpractice suit as much as a scarcity of negligent emergency transfers. As a practical matter, patients most likely to be transferred are probably indigents or the working uninsured with little knowledge of, or access to, the legal system. Considering the additional difficulty of proving compensable injury and causation in the already injured patient, some hospitals may assume the risk of litigation to be low, and thus, a risk worth taking.

Whether this is true or not, there are signs that the public is becoming increasingly aware of and concerned about emergency transfers. In the space of two months in early 1985, the CBS news show *60 Minutes*, the *New England Journal of Medicine*, and the *American Bar Association Journal* devoted significant time and space to the medical and legal problems associated with emergency transfers. This combination of an increase in public awareness and in the numbers of emergency transfers may suggest a flood of future litigation if hospitals are unwilling or unable to modify unreasonable transfer policies.

In the emergency transfer situation, most courts have apparently imposed a duty of continuing emergency care on the "business" of emergency treatment. Clearly, this duty restricts the autonomy of private institutions and can be expensive. However, in simplistic terms, either the hospitals or the emergency patients must bear the burden in these circumstances. The patient's burden involves human suffering and possible loss of life; it is also unforeseeable; the hospital's burden is financial and can be anticipated. Given these choices, public policy clearly favors burdening the hospital, as most common-law decisions reflect. Further, if government intervention is required (*e.g.*, further financing of indigent care or support for charitable institutions), hospitals, not patients, have the voice and the audience to effect such changes through the legislatures. In any event, hospitals may have to accept the burden of this duty as the cost of doing "business" in emergency care.