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HOSPITAL EMERGENCY SERVICE AND THE OPEN DOOR

Leonard S. Powers*

I. INTRODUCTION

COMPARED to its antecedents, the modern hospital is a revolutionary institution. Until this century the community hospital was little more than a rooming house to which the transient sick were taken and from which most never left. It served to isolate, with minimum care, those who could not afford medical treatment at home, especially those with contagious diseases who could be a burden and threat to the well. Today, the hospital is a complex center of activity—a vast assemblage of superbly trained and highly specialized talent and expensive equipment devoted to healing those suffering from accident or disease. No longer is it only for the impoverished sick; all strata of our society come to it and all demand that the very best in medical technology and skill be available to them.¹ And as the complexity and expense of operating the hospitals increased, they began to take on a distinctly business-like appearance much unlike that of the earlier charity-oriented organizations. One significant aspect of this development was the eventual demise of the charitable immunity doctrine as applied to hospitals.²

One department of the hospital subjected to especially rapid change in recent years has been the emergency service. Every section of the country notes a tremendous increase in public demand for emergency room services.³ That “the public has taken to the emer-

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1. See HOSPITALS, DOCTORS, AND THE PUBLIC INTEREST 293 (J. Knowles ed. 1965); Davis, *The Hospital's Position in American Society*, in MODERN CONCEPTS OF HOSPITAL ADMINISTRATION 7-16 (J. Owen ed. 1962).

2. For a detailed analysis of the status of the doctrine in the various states see Annot., 25 A.L.R.2d 29 (1952); 3 A.L.R.2d Later Case Service 741 (1965). The reasons for the change undoubtedly arise from the changing pattern of financial support for hospitals. See *Haynes v. Presbyterian Hosp. Ass'n*, 241 Iowa 1269, 45 N.W.2d 151, 154 (1950); *President and Directors of Georgetown College v. Hughes*, 130 F.2d 810, 824 (D.C. Cir. 1942); Davis, *supra* note 1, at 11.

3. In an Ohio study over an eight-year period, the increase per year ranged from 10% to almost 20%. See Seifert & Johnstone, *Meeting the Emergency Department Crisis*, 40 HOSPITALS 55 (1966). The American Hospital Association found a 175% increase in emergency room visits between 1954 and 1964. A.M.A. Department of Hospitals and Medical Facilities, *The Emergency Department Problem—An Overview*, 198 J.A.M.A. 380 (1966) [hereinafter 198 J.A.M.A.]. The increase for some hospitals

gency department like a duck to water"⁴ is certainly no exaggeration; it may be an understatement. While the propriety of such a magnified role for the emergency room in the total treatment context is far from clear, and, indeed, is the subject of a continuing dialogue within the medical profession,⁵ the increased emphasis is already with us. Like the shift in hospital practices which led to the rapid demise of the charitable immunity doctrine, so will this development force changes in the law. This Article will focus on the emerging duty of hospital emergency rooms to treat patients seeking their aid.⁶

Before discussing that question, it is helpful to examine the changes in emergency room practices in greater detail. The emergency room was originally what its name implies—a place for the treatment of severe injuries and diseases demanding immediate attention.⁷ Its location was usually in some remote part of the hospital. It had no organizational status as a department, and the quality of care rendered there was usually below the general standard for the hospital.⁸ The emergency room of a modern hospital is a drastically different place.⁹ Now the public goes to the emergency room for

has been as high as 600% in six years. See Stichter, *Medical Staffing of Emergency Rooms: Legal and Ethical Considerations*, 62 THE OHIO STATE MEDICAL J. 600 (1966); Foster, *Public Discovers Where Care Is: Emergency Rooms*, 106 THE MODERN HOSPITAL 77 (1966).

4. Blalock, *Emergency Care*, 40 HOSPITALS at 51 (1966).

5. For example, see Bergen, *Legal Aspects of Emergency Departments*, in EMERGENCY DEPARTMENT 109 (1966): "Emergency medical care might be defined as care necessary to sustain life or maintain health that cannot be delayed"; Letourneau, *Legal Aspects of the Hospital Emergency Room*, 16 CLEV.-MAR. L. REV. 50 (1967).

6. "Private Hospital" as used herein means any hospital which is not a public hospital. A public hospital is one owned, operated, and supported by government. *Van Campen v. Olean Gen. Hosp.*, 210 App. Div. 204, 205 N.Y.S. 554, *aff'd*, 239 N.Y. 615, 147 N.E. 219 (1924). The responsibility of public hospitals will be treated to the extent not governed by statute since the common-law duties are, in general, the same for both public and private hospitals except where changed by statute. While some statutes creating public hospitals do not specifically grant persons the right to be admitted, they do state requirements that may by implication create rights of admission to such hospitals. Such admission requirements typically relate to residence and financial status of the person seeking admission. An occasional statute provides that governmental hospitals are for "the benefit of the inhabitants of such county and of any person falling sick or being injured or maimed within its limits." FLA. STAT. § 155.16 (1965). Under such provisions, hospitals may be under a duty to admit persons for emergency treatment.

7. Stichter, *supra* note 3, at 600.

8. Meyer, *The Hospital Emergency Department—New Functions and Responsibilities*, 40 POSTGRAD. MEDICINE 374 (1966). For many years it has been the weakest and most neglected department in the hospital. 198 J.A.M.A. 380. For a comparison of inpatient and outpatient services see Seifert & Johnstone, *supra* note 3, at 57.

9. The change has been expressed as follows: "From a single room with one or two treatment tables, a few intravenous stands, and perhaps a cabinet of drugs, the 'emergency room' has now expanded into a many-chambered area with facilities for many types of examination and treatment." Noer, *Critical Surgery Belongs in O.R., Not E.R.*, 106 THE MOD. HOSP. 92 (1966).

treatment of all kinds of injuries and illnesses.¹⁰ The number and volume of services demanded have resulted in some emergency rooms becoming, in effect, complete miniature hospitals.¹¹ The United States Public Health Service predicts 49.3 million annual emergency room visits by 1970 compared to only 32.1 million ordinary hospital admissions. This is a 79 per cent increase, per 1,000 population, in the use of the emergency room compared to an 8 per cent increase in ordinary admissions over the 1960 figures.¹²

It is quite clear, then, that the public considers the emergency room to be a community medical center.¹³ It is the only place where the best equipment and facilities and at least some care are available on any day, at any hour, and without appointment. It does not require the presence of the sometimes unavailable family doctor.¹⁴ In fact, one explanation for this development is undoubtedly the concurrent disappearance of the traditional family doctor and the house call, and the advent of the clinic, regular office hours, and doctors' days off.

Yielding to the demands of the public and to the changing structure of their profession, some physicians and hospital administrators have challenged the profession to bring about a wholesale expansion of emergency facilities and organization.¹⁵ There are those who feel that no one who comes to the emergency room desiring treatment should be turned away—even if no true emergency exists. There is a feeling that what may not be an "emergency" to the physician may nevertheless be one for the patient and that hospitals must accept

10. Blalock, *supra* note 4, at 51-52.

11. Noer, *supra* note 9, at 92.

12. U.S. DEP'T. OF HEALTH, EDUCATION, AND WELFARE, HOSPITAL OUTPATIENT SERVICES: FACTS AND TRENDS, PUBLIC HEALTH SERVICE 14-15 (No. 930-C-6 1964).

13. This development has caused some to characterize the emergency room as a "neighborhood drop-in clinic." Stichter, *supra* note 3, at 600.

14. Many explanations for the new pattern of emergency room use are given. Stichter feels the major reason is "the public's general acceptance . . . of the idea that hospital facilities . . . should be available for all kinds of illnesses and injuries—the idea that the hospital emergency room should be a sort of community medical center." Stichter, *supra* note 3, at 601. For other explanations, see MODERN CONCEPTS OF HOSPITAL ADMINISTRATION, *supra* note 1, at 330; Vaughan & Gamester, *Why Patients Use Hospital Emergency Departments*, 40 HOSPS. 59 (1966); 198 J.A.M.A. 380; Seifert & Johnstone, *supra* note 3, at 58.

15. Foster, *supra* note 3, at 78. Faced with overwhelming demand, many hospitals have been modifying their emergency room physical plants, staff arrangements, and technical services. While the quality of care has been improved, there is as yet no generally accepted procedure for rendering emergency care. The immediate concern of the patient centers on the competency, efficiency, and speed of the service rendered to him, particularly if he has a true emergency. His welfare depends directly upon the emergency room procedure, *i.e.*, whether it calls for care or evaluation by a nurse, intern, or licensed physician and whether it provides for rapid and efficient rendition of service.

the public's conception of the emergency room as a place to get medical aid rapidly with a minimum of administrative complication. Others, resisting extension into nonemergency cases, admonish their colleagues to return the emergency room to its original function. Attempts have been made to re-educate the public concerning the true function of the emergency room,¹⁶ but the public, now accustomed to relying on the hospital emergency room for these vital services, has not been willing to be re-educated.¹⁷

There is some agreement, however, on what an ideal emergency room should be. First, if there is reasonable doubt whether medical care beyond "first-aid" is required, this judgment should be made by a licensed physician.¹⁸ Some cases are obviously not emergencies and are not presented or claimed to be such. These "first-aid" cases do not require treatment by a licensed physician; anyone can give such aid within the limits of his competency. Whether these cases will be treated by the emergency staff or redirected to more suitable sources of assistance depends on the defined role of that particular center. But where an "emergency" is claimed, at least the determination should never be made by a nurse, orderly, aide, or clerk. Many hospitals in practice go beyond this minimal requirement and require treatment of emergency room cases by a licensed physician.¹⁹ There is general agreement that a patient presenting himself to the emergency room should not be dismissed, discharged, or transferred without the approval of a licensed physician.²⁰

Yet it is clear from scattered comments and some reported cases that many emergency rooms do not provide the services of a licensed

16. A Maryland hospital used radio announcements, newspaper stories, and brochures. Foster, *supra* note 3, at 78. For an account of another attempt to cope with the problem see *How One Small Hospital Enlarged Emergency Room*, 106 THE MOD. HOSP. 87 (1966); T. FLINT, EMERGENCY TREATMENT AND MANAGEMENT 3 (3d ed. 1964); the ratio between urgent and nonurgent cases is as high as ten to one. . . . As a result, facilities designed, equipped and staffed for handling emergency conditions have been swamped with nonurgent patients at times when care of true emergencies suddenly and unexpectedly has become imperative.

17. The reason for the public's attitude has been compared to the thief's reply to why he robbed banks: "Because that's where the money is." Foster, *supra* note 3, at 78.

18. See Bergen, *supra* note 5, at 110.

19. Stichter, *supra* note 3, at 604; MODERN CONCEPTS OF HOSPITAL ADMINISTRATION, *supra* note 1, at 333; Letourneau, *supra* note 5, at 57; T. Flint, *supra* note 16, at 88.

20. E. HAYT, LAW OF HOSPITAL AND NURSE 112 (1958); MODERN CONCEPTS OF HOSPITAL ADMINISTRATION, *supra* note 1, at 333. One emergency treatment system development is the type instituted in the Yale-New Haven Hospital in 1963. This "medical triage" system emphasizes the screening of true emergencies from cases in which time is not of the essence by physicians. This system appears successful in increasing efficiency and the quality of patient care, [Weiner, Rutzen, & Pearson, *Effects of Medical "Triage" in Hospital Emergency Service*, 80 PUB. HEALTH REP. 389 (1965)] but it has not been adopted as standard procedure on a national scale by hospitals nor has it been required by law.

physician.²¹ In three cases that resulted in death, nurses turned people away from the emergency room without being seen by an intern, resident, or staff physician.²² In other cases, patients were transferred²³ or discharged²⁴ by interns without examination or approval by a physician. Where a physician was summoned for treatment or decision, there may have been undue delay.²⁵ Even where a physician ordered discharge, there have been instances in which he was ignorant of the patient's condition.²⁶

The most shocking aspect of the emergency room situation, however, is not the inadequate procedure or substandard quality of care provided, but the fact that these vital services are not necessarily available to the stricken patient who presents himself for emergency care. Following the traditional common-law rule that there is no affirmative duty to render emergency aid to another human being who is in peril, private and most public hospitals may legally refuse aid in an emergency case.²⁷ This rule, rather surprising in this context, is mitigated by the stated standards of the medical profession which are directed toward providing prompt and effective aid to *all* emergency patients.²⁸

Surely no emergency treatment has even been denied solely because of the legal right of the hospital to refuse treatment. It is to be

21. Seifert & Johnstone, *supra* note 3, at 58: "[T]he physical presence of competent, licensed physicians in hospital emergency departments currently is in the process of changing the community standards of emergency medical service in hospitals."

22. *Wilmington Gen. Hosp. v. Manlove*, 53 Del. 338, 169 A.2d 18, *aff'd on other grounds*, 54 Del. 15, 174 A.2d 135 (1961); *Ruvio v. North Broward Hosp. Dist.*, 186 S.2d 45 (4th Dist. Ct. App. Fla. 1966); *O'Neill v. Montefiore Hosp.*, 11 App. Div. 2d 132, 202 N.Y.S.2d 436 (1960).

23. *Jones v. City of New York*, 134 N.Y.S.2d 779 (Sup. Ct. 1954), *modified*, 286 App. Div. 825, 143 N.Y.S.2d 628 (1955); *Methodist Hosp. v. Ball*, 50 Tenn. App. 460, 362 S.W.2d 475 (1961).

24. *Bourgeois v. Dade County*, 99 S.2d 575 (Fla. 1957).

25. The standard established by the American College of Surgeons calls for treatment by a physician within 15 minutes after arrival in the emergency room. *Standards for Emergency Department in Hospital*, 48 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS 112 (1963). In *Huffman v. Lindquist*, 37 Cal. 2d 465, 234 P.2d 34 (1951), nine hours elapsed before the physician first saw the patient who had suffered a fractured skull in an automobile wreck.

26. *Reeves v. North Broward Hosp. Dist.*, 191 S.2d 307, 308 (4th Dist. Ct. App. Fla. 1966): "Dr. Moorhead . . . did not see or treat Eddie but signed his discharge slip."

27. *Birmingham Baptist Hosp. v. Crews*, 229 Ala. 398, 157 S. 224 (1934); *Olander v. Johnson*, 258 Ill. App. 89 (1930); *McDonald v. Massachusetts Gen. Hosp.*, 120 Mass. 432, 21 Am. R. 529 (1876).

28. Letourneau, *supra* note 5, at 51, notes that all statements of standards seem to agree that emergency room arrangements should insure promptness or immediacy of care. The standards of The Joint Commission on Accreditation of Hospitals require that the emergency service provide "adequate medical and nursing personnel available at all times." AMERICAN HOSPITAL ASSOCIATION, *HOSPITAL ACCREDITATION REFERENCES* 137 (1964).

expected, on the other hand, that treatment might be refused if the case is nonemergent or if the emergency facilities are full. There have, however, been other reasons given for failure to give emergency room treatment which do not comport so readily with the physician's creed: lack of referral to the hospital, membership in a disfavored medical insurance group,²⁹ pre-emergency care by another doctor,³⁰ or contagious disease.³¹ Other grounds of refusal to treat include discrimination on grounds of race, emergency room personnel being unable to locate a physician, or simply that the facility is closed.³²

Whatever the emergency room's status as part of the hospital organization, the quality of care given, or the procedures followed, most of those charged with the operation of hospitals are aware of the new role thrust upon the emergency room. Many administrators and physicians are motivated by a recognition that the public is entitled to better service than is presently available.³³ Our question concerns how the law will cope with the expectations of the public and the generally sympathetic response of hospital officials and the healing professions. What should the law require as a minimum, with a tort action against the hospital becoming available if that minimum is not met? We 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.

II. PRESENT STATE OF THE LAW

A. *The General Common-Law Rule and its Exceptions*

Whether a hospital must render emergency medical services to the sick and injured is a question residing in that branch of tort law relating to coming to the aid of someone in peril. It will be helpful, therefore, to examine briefly some of the general principles that have emerged in this area.

Basic to the older common law was the distinction between action and inaction—between misfeasance and nonfeasance. Liability was

29. *O'Neill v. Montefiore Hosp.*, 11 App. Div. 2d 132, 202 N.Y.S.2d 436 (1960).

30. *Wilmington Gen. Hosp. v. Manlove*, 53 Del. 338, 169 A.2d 18, *aff'd on other grounds*, 54 Del. 15, 174 A.2d 135 (1961).

31. *Birmingham Baptist Hosp. v. Crews*, 229 Ala. 398, 157 S. 224 (1934).

32. Harty, *Emergency Care—or Lack of It—Can Make a General Hospital Liable*, 96 THE MOD. HOSP. 106 (1961). Statutory prohibitions against racial and religious discrimination prohibit exclusion from admission on such criteria, but do not in themselves create a right to be admitted.

33. Churchill, *The Development of the Hospital*, in THE HOSPITAL IN CONTEMPORARY LIFE 68 (N. Faxon ed. 1949); Stichter, *supra* note 3, at 601.

imposed for intentional or negligent misfeasance but not for nonfeasance or failure to act. Affirmative action resulting in harm to another was a breach of duty resulting in liability but mere failure to intervene to benefit another—even to save him from serious harm—was not considered actionable since there was no duty to act in the first instance.³⁴ Justification for this distinction has been found in the individualistic philosophy of the traditional common law; it refused to restrict a man's freedom by imposing a sort of forced labor in the form of a duty to be helpful to those in distress.³⁵ Charity began and ended at home, and even there, as evidenced by the family immunities, there was very little.

As social institutions and relationships became more complex, the courts were required to reconsider the subtle problem of inaction. Liability slowly developed for nonfeasance under some circumstances; where warranted, judicial exceptions developed to the general rule of no liability for nonfeasance.

One exception developed in cases in which the defendant engaged in some sort of prior affirmative action placing the plaintiff in peril.³⁶ There had long been a duty to come to the aid of another if one tortiously put another person in peril, but this, of course, could be characterized as misfeasance. The duty has been significantly extended to those who innocently cause such bodily harm to another as to leave him helpless and in danger of further harm.³⁷ Further, if by one's prior affirmative act a force is innocently set in motion which threatens peril, then he must act to prevent the risk from taking effect.³⁸ The common thread that knits these situations together is the defendant's connection with the risk that has thrust the plaintiff into a position of peril.

A second exception to the no duty to act rule developed where the defendant undertook to confer a benefit upon another, and that person suffered harm because of his reliance upon the undertaking.³⁹ Even when there is no prior contractual duty to engage in the undertaking, certain duties are assumed when such a voluntary undertaking begins. To take a well-known example, a railroad which undertakes to maintain a traffic signalman at a street crossing takes on the

34. W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* 334 (3d ed. 1964); *RESTATEMENT (SECOND) OF TORTS* § 314 (1965).

35. Note, *The Failure To Rescue: A Comparative Study*, 52 COLUM. L. REV. 631 (1952.)

36. For a classification similar to that presented here see 2 F. HARPER & F. JAMES, *THE LAW OF TORTS* § 18.6 (1956).

37. *RESTATEMENT (SECOND) OF TORTS* § 322 (1965).

38. *Id.* § 321; W. PROSSER, *supra* note 34, at 338.

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

duty to perform that function with due care.⁴⁰ Liability extends beyond misfeasance in affirmative acts undertaken to include liability for negligent failure to perform the undertaking at all when performance was reasonably to be expected. The duty to continue to aid another who is helpless when a discontinuance would leave the other in a worse position than when the defendant took charge of him is within this exception.⁴¹

A third exception bases a duty to act upon some special relationship—some special dependence—between the defendant and the person in peril. There are duties to aid and protect imposed upon employers,⁴² common carriers, innkeepers, and inviters,⁴³ but other relationships of dependence may also impose a similar duty as, for example, public utility and customer. Most of these special relationships are found where there is a contractual relationship between the parties, or at least a potentiality of contract.

The residual applicability of the general rule after these exceptions have taken their due may be illustrated by the hypothetical familiar to all first-year law students: a man walking along a river bank sees a small child drowning in shallow water but ignores its calls for help even though he is a competent swimmer. This may be cruel and morally wrong, but there is no legal duty to rescue. Here, there is a completely fortuitous chain of events which places one person in a situation where he has the power to alleviate the distress of another. This is the factual situation where the courts and commentators still assert that there is no legal duty to assist the one in peril.

Liability for failure to aid another in peril, then, cannot today be determined without full appreciation of the factual context. Slight variations in facts bring important exceptions into operation; these exceptions, in turn, permit recovery where the general rule would deny it. Therefore, it is important to know how the courts have categorized the encounters between persons suffering medical emergencies and the hospitals maintaining emergency services.

B. *Recent Hospital Cases—An Overview*

The general rule has been stated to be that persons do not possess any right to be admitted to a hospital and that a hospital is

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

41. RESTATEMENT (SECOND) OF TORTS § 324 (1965).

42. RESTATEMENT (SECOND) OF TORTS § 314(b) (1965).

43. RESTATEMENT (SECOND) OF TORTS § 314A (1965).

not obliged to accept a patient not desired by it nor even to assign a reason for refusal to admit.⁴⁴ As the rule is stated, there is no exception for medical emergencies or emergency rooms. This rule is said to apply to all private hospitals and to public hospitals in the absence of a statutory duty.

Most of the statutes creating rights to treatment apply only to public hospitals. One exception is the Illinois statute, which imposes a duty—applicable both to public and private hospitals where surgical operations are performed—to give emergency medical treatment or first aid to any person who applies.⁴⁵ Most statutes authorizing the creation of governmental hospitals limit hospital use to persons with some defined relationship to the governmental unit supporting the institution.⁴⁶ A person coming within the statutory class probably has an implied right to admission although the statutes create no express right. Some statutes provide for waiver of the normal admission requirements for treatment in emergency cases.⁴⁷

If this is so, then absent some statute, it would seem to follow that a hospital cannot be held civilly liable for nonadmittance and consequent nontreatment. Yet, in nine out of eleven recent cases to be discussed below the courts held the hospital liable. Although in three of the nine cases the hospital may have done something it should not have done,⁴⁸ in at least six of the cases it appears that the courts found that the hospital should have done something which it failed to do.⁴⁹ On one theory or another, exceptions to the general rule were found to exist. The theory most frequently used has been the concept of a voluntary undertaking to render aid. The opinions, unfortunately, generally fail to specify the essential elements which amount to an undertaking or the extent of the duty assumed once

44. *Birmingham Baptist Hosp. v. Crews*, 229 Ala. 398, 157 S. 224 (1934). Opinions in other emergency room cases usually begin with a statement that this is a general rule.

45. ILL. REV. STAT. ch. 111½ §§ 86-87 (1966). Although the statute contains only a criminal penalty for failure to comply, a duty to provide care could be based upon it so as to result in civil liability on a defendant hospital violating it.

46. COLO. REV. STAT. ANN. § 124-4-3 (1953); FLA. STAT. ANN. § 155.16 (1965).

47. ARIZ. REV. STAT. ANN. § 11-297A (1956); N.Y. UNCONSOL. LAWS § 7301 (McKinney 1961). This type of statutory provision may imply that the public hospital should treat all emergency cases without screening for the statutory requirements.

48. *Bourgeois v. Dade County*, 99 S.2d 575 (Fla. 1957); *Reeves v. North Broward Hospital District*, 191 S.2d 307 (4th Dist. Ct. App. Fla. 1966); *Barcia v. Society of New York Hospital*, 39 Misc. 2d 526, 241 N.Y.S.2d 373 (Sup. Ct. 1963).

49. *Wilmington Gen. Hospital v. Manlove*, 53 Del. 338, 169 A.2d 18, *aff'd on other grounds*, 54 Del. 15, 174 A.2d 135 (1961); *Le Jeune Road Hospital, Inc. v. Watson*, 171 S.2d 202 (Ct. App. Fla. 1965); *New Biloxi Hospital, Inc. v. Frazier*, 245 Miss. 185, 146 S.2d 882 (1962); *O'Neill v. Montefiore Hospital*, 11 App. Div.2d 132, 202 N.Y.S.2d 436 (1960); *Jones v. City of New York*, 134 N.Y.S.2d 779 (Sup. Ct. 1954), *modified*, 143 N.Y.S.2d 628 (App. Div. 1955); *Methodist Hospital v. Ball*, 50 Tenn. App. 460, 362 S.W.2d 475 (1961).

an undertaking is found to have occurred. The legal obligations of the hospital confronting a medical emergency, then, have not been adequately formulated.

This sort of conceptual uncertainty is not uncommon where the courts are confronted with seriously conflicting policies. The urge to deny any duty to render aid springs from the individualistic notion that one should be able to set one's own policies for rendering a gratuitous service. The existence of a duty might also impose a tremendous burden on smaller hospitals, draining financial and manpower resources to the point of forcing some of these institutions to abandon the emergency service altogether. While liability insurance might soften the financial blow, the adverse publicity generated by allowing such suits could be equally damaging. On the other hand, ethical and moral pressures to assist another human being in an emergency have strong appeal in such cases. The result of a hospital's lack of treatment is often serious: in all but one of the eleven cases death ensued.

Conceptual difficulties aside, it appears that the general rule of no duty to render aid is not actually shielding hospitals from civil liability in emergency room cases, and this is a reliable indication of judicial dissatisfaction with that rule. A narrow path must be walked if hospital liability is to be avoided. Indeed, there may be no reliable path. In at least one jurisdiction the only sure way to avoid liability is apparently to accept the person in distress who appears at the emergency room and render with due care whatever emergency assistance is necessary.⁵⁰ On similar facts one other jurisdiction has reached the same result in substance if not in theory.⁵¹ How close other courts will come to imposing liability for turning patients away at the door is uncertain because few of these cases arise. Hospitals do not ordinarily turn away summarily those who appear asking for emergency aid; thus there are no modern cases for the general rule to operate upon. Each case seems to fit an exception.

C. *Recent Hospital Cases—A Factual Analysis*

The eleven recent cases mentioned earlier comprise much of the authority on the subject of hospital liability for nontreatment. Since the facts of each case are critical in determining whether some exception to the general rule is applicable, each case will be discussed in some detail. Certain factual patterns, however, are discernible and

50. See *Wilmington Gen. Hosp. v. Manlove*, 53 Del. 338, 169 A.2d 18, *aff'd on other grounds*, 54 Del. 15, 174 A.2d 135 (1961).

51. *O'Neill v. Montefiore Hosp.*, 11 App. Div. 2d 132, 202 N.Y.S.2d 436 (1960).

form a framework for analysis. The eleven cases, then, fit into five factual patterns.

1. *After the hospital exercised control, it gave some aid to the applicant and then released him with the mutual understanding that he was in no better condition than before.*

Birmingham Baptist Hospital v. Crews.⁵² A child suffering from diphtheria was taken to a private hospital. The house physician rendered treatment, consisting of a throat swab, oxygen, and two injections of antitoxin. There was a dispute concerning whether the antitoxin temporarily weakened the child's condition. After this treatment the superintendent required the family to take the child home because hospital regulations forbade accepting patients with contagious diseases. Within fifteen minutes after returning home the child died.

Crews, which denied recovery to the plaintiff, was the first important case on the question in the recent past. It is usually cited as the leading case for the general rule that there is no right to be admitted to a private hospital. Because it did not deal with the failure to give emergency aid to a person coming to the emergency room, it is precise authority only on the question of the duty of a hospital to admit a person for ordinary hospital services. In fact, the court found that emergency treatment had been provided by the hospital; the issue was whether the hospital had a duty to provide more than that. While recognizing that a hospital may create a duty to provide even ordinary hospital services by undertaking to act, the court provided no guidelines as to how or when such a duty comes into existence. It merely held that rendering emergency care alone will not create a duty to render ordinary, nonemergency, hospital services, especially when the patient is suffering from a contagious disease.

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. *Crews* cannot be regarded as a case of failure to admit or failure to render emergency aid; if a wrong was committed, it would be wrongful discharge or abandonment. On the lack of duty to render emergency treatment, the

52. 229 Ala. 398, 157 S. 224 (1934).

principle for which it has so often been cited, the *Crews* case contains only dicta. Furthermore, in an age of rapidly expanding medical facilities and changing socio-institutional attitudes, *Crews* is thirty-four years old.

It may be, however, that the *Crews* rule of no duty to accept a prospective patient for ordinary hospital services has been extended by other courts to emergency room services. This is not to say that such a rule has been applied to limit hospital liability; rather, it is inferred from the many judicial efforts in emergency room cases to find some exception to the "general rule." In other words, courts have generally dealt with emergency room cases as though the *Crews* dictum were settled law. One reason for this assumption, of course, was that it fit into the lack-of-duty position of nonfeasance cases generally.

2. *After the hospital exercised control, it kept the applicant for some period of time without giving aid and then sent him elsewhere for aid.*

*Methodist Hospital v. Ball.*⁵³ A young automobile accident victim was carried to the emergency room of the hospital at 11:45 p.m. Another person, not involved in the accident, was considered by an intern to be more in need of immediate attention and was given the only available bed in the hospital. The intern in charge examined the boy's abdomen and checked his pulse and blood pressure but gave no further medical attention. No licensed physician was called. When the boy attempted to leave his stretcher, several hospital employees assisted in holding him down, with one person applying pressure to his back. After forty-five minutes at the defendant hospital, the boy was taken to another hospital where he died at 1:00 a.m. from a ruptured liver and internal bleeding.

*New Biloxi Hospital, Inc. v. Frazier.*⁵⁴ A man, bleeding profusely from a gunshot wound in the arm, was taken to the emergency room of the hospital. Three nurses saw his condition but did nothing to stop the bleeding. The head nurse called a doctor but did not inform him of the extent of the bleeding. The doctor examined the man but did not stop the bleeding. On learning that the patient was a veteran, the doctor made arrangements for his transfer to a veteran's hospital and left him with the head nurse. The nurse was to advise the doctor of changes in the patient's condition. In spite of shock

53. 50 Tenn. App. 460, 362 S.W.2d 475 (Ct. App. 1961).

54. 245 Miss. 185, 146 S.2d 882 (1962).

symptoms, however, she made no report to the doctor. After two hours in the emergency room, the patient was transferred to the veteran's hospital where he died within a half hour from hemorrhage and shock.

Tacit adherence to the *Crews* Draconian principle probably accounts for the conclusion in these two cases that the deceased had been legally accepted as a "patient."⁵⁵ Neither opinion, however, offers a satisfactory explanation of how one becomes a patient or why a patient deserves better treatment in a medical emergency than one who, though a nonpatient, is nevertheless physically present. Hospital personnel in both cases exercised control over the patient by accepting him into the emergency room with the obvious intention of rendering some aid, but none was, in fact, rendered. A voluntary undertaking to render service, standing alone, has not been sufficient for other courts to find patient status, or it has not been necessary in order to hold the hospital liable. The only significant difference between these cases and other emergency cases is that here the persons were kept in the emergency room for a substantial time without receiving any aid and were later transferred somewhere else to receive the necessary attention. Except for these two cases, the law appears to be that a person does not achieve patient status until *treatment* starts, except in cases of formal admission for general hospital services.

Perhaps *Ball* and *Frazier* represent attempts to come within the exception of voluntary undertaking-assumed duty. The courts may have been seeking added assurance for their result by finding a hospital-patient relationship, which means a special dependence contract and another possible exception to the general nonfeasance rule. These cases may mean that, if the hospital-patient relationship exists, the hospital has a duty to render whatever treatment the condition requires and that admission may occur without any formalities or any treatment. Consider the following language from the *Frazier* case:

In an emergency, the victim should be permitted to leave the hospital only after he has been seen, examined and offered reasonable first aid. 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 critical condition without furnishing or procuring suitable medical attention.⁵⁶

55. Cases cited in notes 53 and 54 *supra*.

56. 245 Miss. 185 at 197, 146 S.2d 882 at 887 (1962).

In neither case was the injured person formally admitted: in *Ball* the deceased received only a superficial examination upon entering the emergency room and was kept forty-five minutes before being transferred; in *Frazier* a doctor was summoned and the injured man's name was recorded, but he remained for two hours. Whether anything less than forty-five minutes would create the hospital-patient relationship is unclear, but if this is enough, then practically anyone in distress who gets through the emergency room door may be a "patient." This may mean that the amazing potency of the dictum in *Crews* has evaporated, just as privity of contract in defective products negligence cases disappeared when Judge Cardozo began to write the opinion in *MacPherson v. Buick Motor Co.*,⁵⁷ and for very similar reasons. The common law regurgitates what it cannot digest.

The results of *Ball* and *Frazier* could be rationalized under other tort rules. If an individual undertakes to aid another and should recognize that the aid is necessary for the other's protection, he will be liable for harm resulting from failure to use due care to perform his undertaking if his failure increases the risk of harm to the other.⁵⁸ The hospitals in both cases materially increased the time before aid was received. This delay itself might have been a significant factor in causing death; surely it increased the risk of harm. On this theory of liability, however, the existence of a hospital-patient relationship would be unnecessary to liability. Injecting the hospital-patient relationship into the cases makes them appear to be breach of contract or wrongful discharge cases, and this compounds confusion.

3. *After the hospital exercised control, it gave some aid, but then released the applicant giving him reason to believe the emergency had passed, when in fact his condition was the same or had been worsened by the treatment.*

Barcia v. Society of New York Hospital.⁵⁹ On the advice of a family physician, the parents of a two-year old girl took her to the hospital. A physician employed by the hospital gave her an examination, including a chest X-ray, blood count, and throat culture. He decided that her condition was not critical enough to require hospitalization. The child's condition deteriorated after she returned to her home. Again she was taken to the hospital on the family phy-

57. 217 N.Y. 382, 111 N.E. 1050 (1916).

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

59. 39 Misc. 2d 526, 241 N.Y.S.2d 373 (Sup. Ct. 1963).

sician's advice. This time she was formally admitted but died several hours later. Another physician at the hospital asked the parents "why didn't you bring her sooner, I might have been able to save her."⁶⁰

*Reeves v. North Broward Hospital District.*⁶¹ The patient was given a urine test and a blood pressure check by a hospital resident physician. He diagnosed the case as hypertension and gave the man sedatives. A relief doctor came on and signed the release of the patient into the custody of two brothers without seeing or treating the patient. Eleven hours later the man died of a subdural hematoma en route back to the hospital.

*Bourgeois v. Dade County.*⁶² A man was found unconscious in his underwear on the lawn in front of a hotel and was taken by police to the emergency room of the hospital. An intern found his pulse and chest sounds normal. The man was unable to give his name or a history of his condition, and the intern made no other effort to obtain a history. No X-rays were taken. There was conflicting testimony about alcohol on the patient's breath. After a superficial examination, the intern released the patient to the police as a drunk. Several hours later he died in a jail cell from punctures of the thoracic cavity by broken ribs.

*Ruvio v. North Broward Hospital District.*⁶³ plaintiff's husband was taken to the hospital emergency room on a Sunday. Under normal practice the resident physician on duty in the emergency room screened emergency cases. On Sundays, however, although a physician was on call, the emergency room nurses screened patients and called the physician only if there was a question in their minds about the existence of an emergency. Two nurses refused the applicant admission or any treatment without a doctor's order on the ground that no emergency existed. A friend took him directly to an outside physician who found him to be an emergency case and had him admitted to the same hospital. He died two days later of a coronary infarction.

Barcia involves both an undertaking to treat and a negligent diagnosis,⁶⁴ but judgment for the plaintiff was rendered simply on the basis of negligence—without any discussion of duty to treat. The case is an example of aid given without due care which unreasonably

60. 39 Misc. 2d at 527, 241 N.Y.S.2d at 375.

61. 191 S.2d 307 (4th Dist. Ct. App. Fla. 1966).

62. 99 S.2d 575 (Fla. 1957).

63. 186 S.2d 45 (4th Dist. Ct. App. Fla. 1966), *cert. denied*, 195 S.2d 567 (Fla. 1966).

64. *Barcia v. Society of N.Y. Hosp.*, 39 Misc. 2d 526, 241 N.Y.S.2d 373 (Sup. Ct. 1963).

increases the risk of harm to another by creating a false sense of security and preventing the person from seeking aid elsewhere. The delayed admittance due to the initial inaccurate diagnosis was apparently crucial to the patient's chances.

In *Reeves* there was both negligent diagnosis and negligent treatment.⁶⁵ The Florida appellate court reversed a directed verdict for the defendant on the grounds that the evidence presented a jury question as to whether the hospital "did not exercise such reasonable care toward the deceased as his known condition required."⁶⁶ Perhaps this means that a hospital taking a patient into the emergency room may not terminate treatment until it does whatever the patient's true condition reasonably requires. Reading the case more narrowly, it may mean that the treatment and diagnosis constitute actionable neglect only because they created a false sense of security in the patient and deterred him from seeking other aid. As in *Barcia*, the hospital's intervention may have left the patient in a worse condition than he was before. Had the hospital given no aid, he would perhaps have received the necessary and proper care at another facility.

*Bourgeois*⁶⁷ was also a case of negligent diagnosis. In fact, the staff pathologist and emergency room supervising physician testified that improper procedures were followed. Again, recovery for the plaintiff may be rationalized on the basis of an intervenor who puts his potential beneficiary in worse condition than he was before. The hospital personnel not only caused movement and handling by the police which aggravated the patient's condition, but they also prevented other proper care. In *Ruvio*,⁶⁸ however, a directed verdict for defendant was affirmed on appeal. Here the time period before death was substantially longer than in the cases previously discussed. Affirmance was on the grounds that plaintiff failed to prove that any action or inaction by the hospital staff was the proximate cause of death or that the hospital staff had breached any duty. There was no indication, however, that the court thought that no duty to the deceased existed.

4. *After the hospital exercised control, it gave some aid to applicant and sent him elsewhere for further treatment.*

65. 191 S.2d 307 (4th Dist. Ct. App. Fla. 1966).

66. 191 S.2d at 309.

67. 99 S.2d 575 (Fla. 1957).

68. *Ruvio v. North Broward Hosp. Dist.*, 186 S.2d 45 (4th D. Ct. App. Fla. 1966), *cert. denied*, 195 S.2d 567 (1966).

LeJuene Road Hospital, Inc. v. Watson.⁶⁹ A mother took her son to the hospital for a scheduled appendicitis operation. The boy was examined, given medication, and dressed in a hospital gown. After waiting two hours the boy and his mother were required to leave because the mother could not produce 200 dollars in cash. Although there was evidence that the boy was violently ill at the time of leaving the hospital, they were obliged to go to another hospital where the operation was performed.

Jones v. City of New York.⁷⁰ The patient suffered an abdominal stab wound. After examining her and cleaning and dressing the wound, an emergency room intern arranged for her transfer from the charitable hospital to a city hospital for further treatment. She died there during an exploratory operation.

In this factual pattern, unless the examination and treatment given are negligent, it seems more difficult in legal theory to hold the hospital liable than in the prior three factual categories. The voluntary undertaking-assumed duty rule in nonhospital contexts is that the intervenor may terminate his services at any time as long as he does not leave his intended beneficiary in a worse position. He is neither required to continue his assistance indefinitely or to do everything it is within his power to do.⁷¹ Both of these cases, nevertheless, held the hospital liable.

Watson, which is relevant even though not an emergency room case, avoided the rule of no duty to continue treatment by finding that the plaintiff had been accepted as a patient. Once patient status is achieved, a dependent contractual relationship exists and the patient may not be discharged if the removal aggravates his condition or increases the risk of harm. The extent of control by the hospital necessary to create the hospital-patient relationship was not discussed.

In *Jones* the hospital was held liable on the theory that the deceased was denied necessary treatment at the emergency stage and that the transfer contributed to her death. The court did not find that the deceased was a patient. Perhaps the court was saying that after exercising some control the hospital should have done everything within its power to minister to the person's needs and that it did not successfully shift that duty to the second hospital. Again, this seems to be a different voluntary-undertaking rule than that which applies in the nonhospital context.

69. 171 S.2d 202 (3d Dist. Ct. App. Fla. 1965).

70. 134 N.Y.S.2d 779 (Sup. Ct. 1954), *modified*, 143 N.Y.S.2d 628 (App. Div. 1955).

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

5. *The hospital refused to exercise control over the applicant and did not give any aid. The applicant was turned away at the door.*

*O'Neill v. Montefiore Hospital.*⁷² Plaintiff's husband awoke at 5:00 a.m. experiencing severe chest and arm pains and breathing difficulties. He dressed and walked with his wife three blocks to the hospital emergency room. The wife explained to the nurse in charge that he was very ill, and she thought he was suffering from a heart attack. Upon discovering that the applicants were members of a particular insurance plan group, the nurse explained that the hospital did not treat members of that group but offered to call a physician who was associated with the plan. The husband spoke with that doctor. Exactly what transpired is unknown, but the doctor did not come to check him or seek his admission to the hospital. At this point plaintiff requested that her husband be treated by a hospital doctor since it was an emergency. The nurse disregarded the request with the explanation that he could see his own physician later in the morning. The husband died while undressing after returning home.

*Wilmington General Hospital v. Manlove.*⁷³ Plaintiff's child had been under a doctor's care for three days. By the fourth day the child had not begun to improve. Knowing their physician was not in his office on that day, the parents took the child to the hospital emergency room. They explained to the nurse that the child had had a continuously high temperature, diarrhea, and two sleepless nights. The nurse responded that the hospital could not give any treatment because of the danger of conflict with the attending physician's medication. The nurse did not examine the child in any way, but did make an unsuccessful effort to reach the family physician. She suggested that they return the next day when the pediatric clinic opened. The child died from bronchial pneumonia that afternoon at home.

In these cases, the hospital, rather than exercising any control or giving any treatment, refused to treat the applicant. One might think that the argument still open under the general rule of no duty to act would permit the hospital to escape liability in such circumstances. None of the general exceptions is applicable here. First, no innocent or negligent conduct of the hospital has caused the peril to the sick person, and no force threatening peril is under the hospital's

72. 11 App. Div. 132, 202 N.Y.S.2d 436 (1960).

73. 53 Del. 338, 169 A.2d 18, *aff'd on other grounds*, 54 Del. 15, 174 A.2d 135 (1961).

control. Second, there has been no undertaking to aid the person in peril. Third, there is no special relationship of dependence between the hospital and prospective patient since by all the tests there is no patient. In both *O'Neill* and *Manlove*, as may be guessed from this elaborate preface, the courts found the hospitals liable.

Both cases had these facts in common: (1) the person seeking aid was refused examination as well as treatment; (2) the nurse called a physician for the person; and (3) the individual died shortly after leaving the hospital. The intermediate New York appellate court in *O'Neill* split three to two in reversing a dismissal of plaintiff's claim. The court found that the evidence was sufficient to create two issues which should have been submitted to the jury: Did the nurse's actions amount to a voluntary undertaking-assumed duty by the hospital to provide medical care, or did she merely perform a personal favor? And, if the hospital assumed such an obligation, was it reasonably fulfilled? An effort was thus made to bring the case within the orthodox voluntary undertaking principles. The plaintiff's case cannot be made to fit this bed, however, without changing the requirements for this exception as established in nonhospital contexts. The opinion maintained that after exercising *any* control the hospital must do everything within its power to minister to the needs of the person. If any control was exercised, it was certainly minimal.

The *Manlove* case more squarely presents the question at issue here.⁷⁴ The complaint itself was based on the hospital's refusal to treat in an emergency case. The Delaware court did not find that the sick child was a "patient." The court emphasized that it was not treating the case as one in which the hospital "assumed" to treat the applicant. It treated the issue as being whether the hospital had a duty to treat the person at all, and not whether the hospital was negligent in the treatment it gave. Making its views quite clear, the court held that a hospital cannot refuse aid in a medical emergency and remanded for a determination of whether an unmistakable emergency existed.

74. *Manlove* is discussed in Recent Development, *Duty To Admit Emergency Patients Imposed on Private Hospital Maintaining Emergency Ward*, 62 COLUM. L. REV. 730 (1962); Recent Development, *Private Hospital Must Admit Unmistakable Emergency Cases*, 14 STAN. L. REV. 910 (1962); Note, *Torts—Hospitals—Undertakings—Duty of Private Hospital Maintaining Emergency Ward To Treat in Case of Unmistakable Emergency*, 40 TEXAS L. REV. 732 (1962); Recent Case, *Torts—Liability of Private Hospital—Refusal of Treatment in Emergency Ward*, 31 U. CINC. L. REV. 183 (1962); Case Comment, *Torts—Private Hospitals—Liability for Refusal To Provide Emergency Treatment*, 64 W. VA. L. REV. 234 (1962). For a general discussion of this issue see Note, *Must a Private Hospital Be a Good Samaritan?*, 18 U. FLA. L. REV. 475 (1965).

In taking this position, the Supreme Court of Delaware rejected the holding of the lower court which held for plaintiff on the theory that receipt of public funds and an exemption from taxation converted the defendant private hospital into a public hospital. Clearly then, in Delaware the *Crews* rule is limited to provide only that a hospital owes no duty to accept patients to cases of acceptance for ordinary hospital services. In emergency cases, the applicant seeking medical aid in reliance upon a well-established custom of the hospital to render emergency care has a right to receive such aid and the hospital a corresponding duty. Duty and the resulting liability, according to the Delaware court, rests on the existence of an unmistakable emergency and reliance by the prospective patient on the hospital's custom to treat emergency cases.

This formulation may present difficulties in proving reliance upon a custom. Perhaps fewer doctrinal difficulties would be encountered if *Manlove* were regarded as an expanded voluntary undertaking case. Though the court initially rejected this approach—no doubt to emphasize its rejection of prior cases—it later admitted the analogy of the facts to cases of negligent termination of gratuitous undertakings, citing the predecessor of section 323 of the *Restatement (Second) of Torts*. Such a rationale involves an expansion of the voluntary undertaking concept as applied in prior cases. Prior cases, especially the *O'Neill* case, went to great lengths to find an undertaking to provide aid to the particular prospective patient. In *Manlove*, the term means an undertaking to provide aid in all emergency cases in general for which a refusal in any particular case would constitute a breach of duty. There could be no reliance on an undertaking under the prior cases until the particular prospective patient presented himself for treatment and the hospital in some way indicated an intention to treat him. This explains the attempts of courts to find that the hospital exercised some kind of control over the person or that the person had legally become a patient. Clearly, *Manlove* goes further.

Such an expanded concept of undertaking may be a step other courts would be reluctant to take, but it is also true that few cases have arisen that could not be neatly fitted within an orthodox exception to the old rule of no duty. The *Manlove* court's emphasis upon an established custom is most likely an attempt to state a requirement of reasonable reliance by the prospective patient upon the general undertaking. The *Restatement (Second) of Torts* makes liability for harm caused by an undertaking to provide aid depend

upon increased risk or reliance.⁷⁵ And, reasonable reliance must be based upon a sufficient undertaking by the defendant. Reliance may be thought reasonable in a case like *Manlove*, because the expense required to open an emergency room is sufficient indication of serious intent to undertake to render aid in medical emergencies. Opening an emergency facility, however, hardly amounts to either contract or a gratuitous promise when viewed from the position of the hospital, and it is certainly not an "undertaking" as that term is used in the *Restatement*.

III. THE LAW AND SOCIETAL ATTITUDES

There is a striking divergence between the general rules of law relating to the provision of emergency medical service by hospitals and the general consensus of lay and professional opinion. The rationale supporting the general rule that there is no duty to act is in conflict with the generally accepted conception of the role of the modern hospital. Further, the result permitted by the rule is felt to be shocking and morally reprehensible by all, apparently, except the legally trained. We have already noted that some courts, reflecting this dissatisfaction, have been able to permit recovery by skirting but still rendering homage to the rule.

The most convincing justification for the general rule is the protection of individualism. The common-law courts, following their highly individualistic philosophy, refused to force men to be unselfish or to require them to be Good Samaritans.⁷⁶ Individualistic values are undeniably basic to Anglo-American law, but more important to contemporary American society is the value and worth of human life. The development of modern American hospitals has been spurred more by this human concern than by selfishness or profit.⁷⁷

75. RESTATEMENT (SECOND) OF TORTS § 323 (1965). If reliance is the basis of the duty and consequent recovery, some nasty complications may be lurking as to the amount of damages recoverable. Awards may be limited to the harm actually caused by the reliance only. A similar problem is presented when a promise is enforced under § 90 of the *Restatement of Contracts*, where a recovery may be limited to the reliance damage. 14 STAN. L. REV. 910, 915 (1962).

76. See Note, *The Failure To Rescue: A Comparative Study*, 52 COLUM. L. REV. 631 (1952).

77. M. MACEachern, *HOSPITAL ORGANIZATION AND MANAGEMENT* ch. 1 (1957); MODERN CONCEPTS OF HOSPITAL ADMINISTRATION ch. 1 (J. Owen ed. 1962); Faxon, *The Place of the Hospital in the Social Order*, in *THE HOSPITAL IN CONTEMPORARY LIFE* ch. 8 (N. Faxon ed. 1949); Goldwater, *Concerning Hospital Origins*, in *THE HOSPITAL IN MODERN SOCIETY* ch. 1, § 1 (A. Bachmeyer & G. Hartman eds. 1943).

Such motives as philanthropy, sympathy, charity, and compassion are almost universally accepted as underlying the founding and operation of hospitals. The hint of a profit motive in hospital operation has been particularly subject to criticism from members of the medical profession.⁷⁸ Considering hospitals as created for service to society, one doctor wrote that "(t)he public servant, institutional or individual, who reveals for an instant a selfish aim is instantly discredited. . . . Surely we may look forward to the day when all hospitals shall present to society harmonious, united service, adopted with the greatest care and in absolute unselfishness to the needs of the time."⁷⁹ If most hospitals are motivated by such ideals, as experience would suggest, it is peculiarly inappropriate to attribute to them a desire to refuse emergency medical aid to those in need of care.

There are factual differences between hospitals and other business institutions which may support a different legal rule in medical emergency situations. The profit motive—incorporating a notion of absolute managerial discretion to deal with all parties so as to maximize profits—is at the heart of private enterprise and is the great stimulus to efficiency and improved service. When a business enterprise ceases to be profitable, it generally liquidates and retires from the business scene. A hospital cannot quit so easily. Its worth to the community is not measured by net earnings, but by the quantity and quality of services which it renders.⁸⁰ While some would argue that profit seeking would force hospitals to be more efficient, it has been deplored as an organizational objective for hospitals and criticized as an obstacle to improvement in the quality of medical care.⁸¹ The plain fact is that not even the private hospital operates or is regarded as an ordinary private business where unfettered managerial discretion is required. If unable to support itself with income from patients who pay for their services, even the private hospital does not usually close; it is supported by the community through private and public assistance. With the profit motive and its concomitant need for managerial discretion inapplicable, then, the way is open to impose upon hospitals some sort of duty to act in emergency situations.

More indicative of the special role which the hospital plays in the community is the position of many members of the medical profession who speak in terms of the public's *right* to a coordinated, com-

78. See HOSPITALS, DOCTORS, AND THE PUBLIC INTEREST 293-94 (J. Knowles ed. 1965).

79. *The Hospital in Modern Society*, *supra* note 77, at 17.

80. *Id.*, ch. 1, § 4.

81. HOSPITALS, DOCTORS, AND THE PUBLIC INTEREST, *supra* note 79, at 293-94.

munity-wide program for the best possible medical services, including adequate provision for emergency patients.⁸² To speak in these terms is to recognize the overwhelming importance to our society of emergency medical services. Indeed, because of this important role, there has been some consideration given to the suggestion that hospitals be regulated as public utilities.⁸³ Hospitals certainly possess some of the characteristics of public utilities: they characteristically enjoy monopolistic positions in many communities and provide services in which the public has a tremendous interest. A recent sociological study of community hospitals concluded that effective hospital medical care and treatment is possible only with the mobilization of total community effort.⁸⁴ As the authors suggest, this effort may be better mobilized in the form of public-utility-style regulation of striking practical differences.

It appears, then, that the values associated with the origin of hospitals as well as the best principles of their operation are in conflict with the values traditionally thought appropriate in the context of a fortuitous encounter between two men, one in need of emergency aid and the other having power to give it. Today, the hospital, particularly 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—and which today is criticized even in that context—should not be applied to hospitals automatically and without consideration.

Beyond these criticisms of the no-duty rule's rational underpinnings, many, especially those without legal training, feel that the rule permits a morally reprehensible result. It permits hospitals arbitrarily to refuse aid in emergency cases, even though the hospital personnel recognize that they have a moral duty to provide facilities and care in such cases.⁸⁵ Surely it is the general recognition and discharge of this duty by the hospitals that accounts for the relatively few reported cases on denial of treatment. Hospital officials and administrators are acutely aware of the censure they face if their doors are closed to those in need. Aside from the risk of potential litiga-

82. Compare Stichter, *Medical Staffing of Emergency Rooms: Legal and Ethical Considerations*, 62 THE OHIO STATE MEDICAL J. 600-601, and Faxon, *supra* note 77, ch. 8, with HOSPITALS, DOCTORS, AND THE PUBLIC INTEREST, *supra* note 78, at 293.

83. Harty, *When Hospital Has Emergency Room It May Be Required To Give Treatment*, 96 THE MODERN HOSPITAL, 103 (1961).

84. I. BELKNAP & J. STEINLE, *THE COMMUNITY AND ITS HOSPITALS* (1963).

85. MODERN CONCEPTS OF HOSPITAL ADMINISTRATION 330 (J. Owen ed. 1962).

tion,⁸⁶ any such denial of emergency service may have a substantial adverse effect on the hospital's public image.⁸⁷

More than half a century ago, Professor Bohlen wrote that "it should not be forgotten that a system of law 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."⁸⁸ The fact that not only the public, but also those most intimately concerned with the operation of hospitals, feel that hospitals should provide emergency aid to those in distress argues eloquently for imposing a legal duty. At times, it seems the only ones who have anything to say for the no-duty principle are the lawyers and judges. Further, if it is true, as Holmes wrote, that the law is a prediction of what judges will do, then the no-duty rule may no longer be the law in the hospital emergency room context. All modern cases fall into the exceptions, and the only support for the no-duty principles is in dicta and secondary authorities.

IV. SOME ALTERNATIVE PROPOSALS

Many years ago, one of the great men of American law proposed a general rule—to be enforced by criminal penalties as well as civil liability—requiring that aid be given to those in peril.⁸⁹ The liability would attach to anyone failing to interfere to save another from imminent death or great bodily harm when he might do so with little or no inconvenience to himself, if death or great harm did follow as a consequence of his inaction. Although American jurisdictions have failed to adopt this proposal,⁹⁰ it is significant that other countries, especially in Europe, have created such statutory duties, generally enforceable by criminal penalties.⁹¹

86. 2 UNIVERSITY OF PITTSBURGH HEALTH LAW CENTER, HOSPITAL LAW MANUAL 7-8 (1961):

Since the risk of incurring liability is much greater than the inconvenience or cost of furnishing such treatment, it is suggested that the hospital furnish the necessary care routinely so as to insure the exercise of reasonable conduct and not aggravate the condition. . . . It is in the hospital's interest to prevent suits from arising out of emergency room situations by furnishing routine care to minimize injury and prevent harm.

87. Davis, *Hospitals Neglect Public Relations Aspects of Emergency Department*, 102 THE MODERN HOSPITAL 10 (1964); Harty, *supra* note 83, at 106, 159; Seifert & Johnstone, *Meeting the Emergency Department Crisis*, 40 HOSPITALS 55, 57 (1966).

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

89. Ames, *Law and Morals*, 22 HARV. L. REV. 97, 113 (1902).

90. W. PROSSER, HANDBOOK OF THE LAW OF TORTS 336; Seavey, *I Am Not My Guest's Keeper*, 13 VAND. L. REV. 699 (1960).

91. Criminal penalties in the form of a fine or imprisonment are the normal sanction, though in some instances civil remedies are available. *See Note, Failure To*

In the United States, only Illinois has imposed a specific statutory obligation on both public and private hospitals to render emergency aid.⁹² The Illinois statute imposes a fine on the defendant hospital for each offense.⁹³ The selection of criminal over civil sanctions reflects the strong policy considerations favoring such a duty to render aid. The duty created is specifically and narrowly limited to hospitals where surgical operations are performed; it arises only when emergency treatment or first aid is needed in case of injury or acute medical conditions. This limitation deserves special note.

Unlike Professor Ames' proposal—discussed at the outset of this section—or the European laws, the Illinois statute does not create a general affirmative duty upon all citizens to aid those in peril. The duty to aid created by this statute avoids some of the objections that have been raised to a general affirmative duty: (1) that it is too difficult to single out which person should be liable when many people could have assisted; (2) that it is too difficult to delineate all the circumstances in which a duty to aid would arise; (3) that the law should not enforce unselfishness; and (4) that such a duty would impose a form of slavery and infringe on individual freedom, which is fundamental in our society.⁹⁴

The first objection is obviously inapplicable to the Illinois statute. There is only one possible defendant: a hospital which refuses emer-

Rescue: A Comparative Study, 52 COLUM. L. REV. 631 (1952); Note, *Must a Private Hospital Be a Good Samaritan?*, 18 U. FLA. L. REV. 475 (1965). Belgian, Danish, Dutch, French, German, Italian, Norwegian, Polish, Portuguese, Rumanian, Swiss, and Turkish codes contain or have contained such statutes. See Dawson, *Negotiorum Gestio: The Altruistic Intermeddler*, 74 HARV. L. REV. 1073 (1961).

92. ILL. REV. STAT. ch. 111½, §§ 86-87 (1966). Section 86 reads as follows:

No hospital, either public or private, where surgical operations are performed, operating in this State shall refuse to give emergency medical treatment or first aid 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.

It was first enacted in 1927 and amended in 1963. A Pennsylvania statute requires all hospitals to have at least one licensed physician or resident intern on call at all times, but neither emergencies nor any duty to render aid is mentioned. The sanction is the withholding of funds by the Department of Public Welfare. PA. STAT. ANN. tit. 35, §§ 435-36 (1964).

93. The fine is small: "not less than \$50.00 nor more than \$200.00." ILL. REV. STAT. ch. 111½, § 87 (1966). Presumably civil liability could also be founded upon a breach of the duty. The only case citing this section was a civil case in which a hospital successfully sued a township for services provided an indigent, the court citing this statute as creating a duty to provide the services, thereby making prompt payment by the governmental unit proper under another statute. *St. John's Hosp. v. Town of Capitol*, 75 Ill. App. 2d 222, 226, 220 N.E.2d 333, 335 (App. Ct. 1966).

94. The arguments are summarized in Note, *Moral Challenge to the Legal Doctrine of Rescue*, 14 CLEV.-MAR. L. REV. 334, 350 (1965). For a discussion of arguments for and against general affirmative duties see Note, *Must a Private Hospital Be a Good Samaritan?*, 18 U. FLA. L. REV. 475, 486 (1965).

gency aid. The second objection is similarly inapplicable. The concern is not with all circumstances in which a duty may arise, but only with a "medical emergency" in the hospital emergency room. It is no real objection that this will require the courts to distinguish between emergencies and nonemergencies: courts make analogous distinctions in almost every case on the docket. In fact, medical evidence should make performance of this task more precise than in many other types of cases and the traditional reasonable man standard so familiar to the courts in so many other negligence situations would seem apt. The third and fourth objections seem inappropriate as applied to corporate or governmental enterprises, which most hospitals are. In the hospital context these two objections amount to a claim of the right to absolute managerial discretion that is certainly open to dispute.

The general rule that the hospital owes no duty to aid in a medical emergency undoubtedly emanated from the companion principle that a physician is under no duty to give medical aid even in an emergency.⁹⁵ The third and fourth objections are more tenable when directed to the question of whether an individual physician is to be regarded by the law as a public utility who must enter into contracts and render his services irrespective of his own wishes. There are many distinctions that may properly be made between a hospital that maintains an emergency room and the typical physician, even when he is in his own office. We need not enslave practicing physicians in order to require hospitals to be the Good Samaritans their emergency room signs and public image proclaim them to be.

Such a narrowly limited statute, then, seems to stand up well against the traditional arguments and has a good deal to recommend it. In the absence of this sort of statute, however, can the hospital be found liable within the rubrics of common-law tort? To hold a hospital liable for failure to confer a benefit may seem to violate the generally accepted definition of tort: an injury inflicted upon one person by the act of another, which act was intended or could reasonably be calculated to result in harm.⁹⁶ This definition, however, is today not exclusive; the law of torts already requires that some

95. *E.g.*, *Butterworth v. Swint*, 53 Ga. App. 602, 186 S.E. 770 (1936); *Hurley v. Eddingfield*, 156 Ind. 416, 59 N.E. 1058 (1901); *Childers v. Frye*, 201 N.C. 42, 158 S.E. 744 (1931); *McCoid, The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549 (1959).

96. Prof. Bohlen suggested that the term "tort" should have been limited to acts of this nature. Bohlen, *The Moral Duty To Aid Others As a Basis of Tort Liability*, 56 U. PA. L. REV. 217, 221-22 (1908).

acts be done. Because of this dual nature of tort law, it is important to review the relationship between affirmative legal duties and misfeasance torts in considering whether the law should require hospitals to render emergency treatment.

The early English common law had no logical classification of legal rights and obligations. Litigants were compelled to fit their claims into the procedural forms of trespass or trespass on the case. Many rights and duties with logically different attributes were, consequently, indiscriminately classified as torts. Only because of their commercial importance did the affirmative duties today classified as contracts become a distinct branch of law. Bohlen felt that many other affirmative duties should likewise have been separated from the body of tort law.⁹⁷ This would have avoided the confusion and unfortunate decisions resulting from the failure to identify the salient features of different legal rights and obligations and the considerations underlying them. Professor Bohlen proposed that at least the duties to take positive action be given the status of a distinct class within tort law. This class would be subdivided into four groups: (1) obligations created by statute; (2) obligations arising from family relationships; (3) obligations attached by custom as an incident to tenure of real estate, or incumbency of office; and (4) obligations "annexed by the policy of the law as necessary incidents to a relation voluntarily assumed"⁹⁸ Any common-law duty upon hospitals to provide medical aid in emergencies must be "annexed by the policy of the law," and, therefore, falls in Bohlen's last category.

Affirmative duties created by legal policy share important characteristics that serve to distinguish the group and to limit its expansion. First, they are similar to contract duties. Although not specifically agreed to by the parties, volition at some stage on the part of the obligated party is essential to the creation of the duty. The voluntary relationship of master and servant, for example, imposes upon the master an obligation to provide a safe place to work and safe equipment to use.⁹⁹ Significantly, the employer is also obliged to render emergency medical assistance to employees injured on the job and unable to care for themselves.¹⁰⁰ Similarly, a voluntary intervention to render emergency aid may impose a duty to render all the aid needed by the imperiled victim, as where the intervention causes

97. *Id.* at 222-226.

98. *Id.* at 226.

99. *E.g.*, *Palmer v. Julian*, 161 Kan. 619, 170 P.2d 813 (1946).

100. *E.g.*, *Szabo v. Pennsylvania R.R.*, 132 N.J.L. 331, 40 A.2d 562 (Ct. Err. & App. 1945).

the victim to forgo other sources of aid.¹⁰¹ Second, a necessary basis for the duty is always the ability of one to afford the protection and the helpless inability of the other to protect himself.¹⁰² Consequently, the potential beneficiary of the duty necessarily relies upon the obliged party—"necessarily" either as a result of the beneficiary's inability to help himself or of his failure to help himself because of ignorance of facts known to or controlled by the party obliged.¹⁰³

The relation of hospital and emergency patient seems "voluntarily assumed" by the hospital when one considers the total context. The hospital has voluntarily established an emergency facility and voluntarily made its existence known to the public. While this may not be the degree of specific volition required in some other relationships, it is done with the knowledge of the common understanding and growing belief that the emergency room is there for the benefit of the public—that there may be a *right* to such care. Further, the "policy of the law" would be served by creating a legal obligation for hospitals with emergency rooms to care for those who seek aid. It translates into law a moral obligation that is almost unanimously recognized. It would give legal support to the importance of the individual human being by preventing needless loss of life or needless impairment of productive capacity.

It seems altogether appropriate, then, to propose that a duty should be imposed by law upon hospitals that maintain emergency rooms to render treatment to all persons seeking emergency aid. Any hospital negligently failing in this duty should incur civil liability to the extent of the damage caused by the failure to treat. The standard for this negligence liability ought to be that emergency aid which ordinary, reasonable, and prudent hospital employees would have provided.¹⁰⁴

101. RESTATEMENT (SECOND) OF TORTS § 323, comment c, at 137 (1965).

102. Bohlen referred to the obliged party as the one "having exclusive control of the cause of harm." Bohlen, *supra* note 96 at 233. In a strict sense the hospital has no relation to the cause of harm in a typical emergency room case. As in other cases of detrimental reliance, however, there is a refined sense in which the hospital does have control over harm from aggravation: but for the hospital's false inducement of reliance the harm from aggravation might have been avoided.

103. The two characteristics mentioned here are discussed by Bohlen. *Id.* at 228-29.

104. The tort liability of hospitals ordinarily depends on agency principles, with the employee being primarily liable for his breach of duty, and the hospital being secondarily liable. In many hospitals the physician in the emergency room may be a member of the medical staff who is not an employee of the hospital and whose tortious conduct may not be imputed to the hospital. This may mean in such cases that the physician alone and not the hospital will be liable for breaching the proposed duty. If the governing board of the hospital had adopted a policy resulting in violations of the proposed duty then this would be a so-called "corporate" tort, though the distinc-

Lawyers, however, require a theory acceptable under common-law principles that will accommodate this duty. The absence of the duty at the present time only reflects the traditional inertia of the law and not a lack of legal theories to supply an acceptable solution.¹⁰⁵ Indeed, *Manlove* suggests two theories which could support the duty to treat: the public utility theory and the reliance theory.¹⁰⁶

The lower court in *Manlove* followed the first approach, basing a quasi-public character upon tax exemptions and state subsidies to the private hospital. The public character would obviously be present in a public hospital. Once this status is conferred, it is an easy step to find a duty to serve all members of the public desiring their public or private hospital emergency room services.¹⁰⁷ But there are several problems with this theory. The test for "public utility" status generally has not been dependent upon public financial support but upon whether or not the business is sufficiently impressed with a public interest.¹⁰⁸ While there is some correlation between public support and public interest, many subsidized groups such as farmers, churches, and charities are not public utilities, and some public utilities are not subsidized, such as telephone and telegraph companies. More important, however, is the objection that the public utility theory would create conceptual difficulties in the application of other rules of hospital law; these difficulties could be avoided by alternative theories.¹⁰⁹

Probably the most appropriate legal theory is reliance upon a voluntary undertaking. The Delaware Supreme Court in *Manlove* used this theory, expanding it in the process to permit mere reliance upon a custom of treating all emergencies. Perhaps the element of custom was included because the early case of *Erie R.R. Co. v. Stewart*¹¹⁰ indicated that reliance must be upon an established

tion seems meaningless when it is considered that the principal (hospital corporation) is still being held liable for the acts of its agents (directors or trustees) on the basis of what must be an imputation.

105. It was suggested earlier that nearly all emergency room cases can be explained by the rule imposing liability upon one who negligently performs a voluntary undertaking to provide emergency care and thereby increases the harm or risk of harm to the patient.

106. *Wilmington Gen. Hosp. v. Manlove*, 53 Del. 338, 169 A.2d 18, *aff'd on other grounds*, 54 Del. 15, 174 A.2d 135 (1961).

107. *Cf. Town of Wickenburg v. Sabin*, 68 Ariz. 75, 200 P.2d 342 (1948).

108. *E.g., Austin Bros. Transfer Co. v. Bloom*, 316 Ill. 435, 147 N.E. 387 (1925).

109. For example, why should the duty to treat be limited to the emergency room under this theory? Other matters of policy now controlled by the hospital board of trustees would be subject to the same analysis.

110. 40 F.2d 855 (6th Cir. 1930), *cert. denied*, 282 U.S. 843 (1930).

custom. A more desirable formulation, however, would require only "reasonable reliance."¹¹¹ In the hospital emergency room context reasonable reliance should not require proof of a custom of treating *all* emergencies. The allocation of scarce hospital resources to an emergency service should be sufficient to induce any prudent man reasonably to believe that the emergency room would perform and not refuse the service for which it was established.

Other theories which might appear to be appropriate, such as the invitor-invitee principles of tort law¹¹² or the contract doctrine of promissory estoppel, have significant conceptual limitations. The former requires the occupier of land to come to the aid of a business invitee needing emergency assistance.¹¹³ This duty to an invitee is usually justified on the basis of the economic benefit that the occupier expects to gain from the association.¹¹⁴ The overriding aspect of the relationship between emergency room and prospective patient that calls for a similar rule, however, is not the probable benefit to the hospital, but the potential detriment to the patient growing out of his reasonable reliance. Not many emergency services can be regarded as a potential bonanza of economic benefit. On the other hand, it might be argued that a hospital with medical facilities should be under no less an obligation than a department store with little or none.

The promissory estoppel theory has even less appeal. It is essentially a contractual mechanism for shifting the burden of loss.¹¹⁵ When invoked, promissory estoppel functions as a substitute for consideration, not as a substitute for a promise. Thus, it holds a promisor to an actual promise and is not used to imply a promise for

111. Requiring emergency room to treat all emergencies should not cause undue concern among hospital administrators over their normal operating practices. With a reasonable reliance limitation it would be permissible to operate an emergency room on a limited schedule if limited resources prohibit twenty-four hour coverage. Harty, *When a Hospital Starts Emergency Care It Must Provide the Best Service It Can*, 96 THE MODERN HOSPITAL 116, 165 (1961). The hospital, however, would be responsible for informing the public of its limited operation by posting emergency room hours on entrance signs, in telephone listings, and in other public advertisements. Any restrictions on the type of emergency service provided should be clearly publicized to prevent the public from relying upon the hospital for general emergency room services. A specialty hospital providing emergency service only in its medical specialty, for example, should take reasonable steps to make this known to the public. Harty, *supra* note 83, at 105.

112. This approach has been mentioned in 2 UNIVERSITY OF PITTSBURGH HEALTH LAW CENTER, HOSPITAL LAW MANUAL 7 (1961) and Note, *Must a Private Hospital Be a Good Samaritan?*, 18 U. FLA. L. REV. 475, 482 (1965).

113. *L. S. Ayres & Co. v. Hicks*, 220 Ind. 86, 40 N.E.2d 334 (1942); RESTATEMENT (SECOND) OF TORTS § 314(A)(3) (1965); W. PROSSER, *supra* note 90, at 337.

114. W. PROSSER, *supra* note 90, at 396.

115. RESTATEMENT OF CONTRACTS § 90, illustration 2, at 111 (1932).

the sake of creating liability.¹¹⁶ In emergency room situations like those in *O'Neill* and *Manlove*, the need to imply a promise to give the service negates the applicability of this doctrine.

Selecting the appropriate theory does not, however, answer all the questions. Should there be strict liability for failure to treat an emergency? This would mark a radical shift from the present state of the law. If not strict liability, what kind of effort will satisfy the duty and avoid liability based on negligence principles? The proposed duty involves the treatment of medical emergencies only. If there is no duty to treat nonemergencies, there must be some legally acceptable procedure for distinguishing emergency from non-emergency cases. Another legal problem is to decide what due care requires to satisfy the duty to identify and treat the emergency cases. Obviously, the large general hospital in an urban center is in a different situation than a small local hospital, but how much should the law take individual circumstances into account? Are there not minimum requirements that due care demands from all hospitals maintaining emergency rooms?

Because of the tremendous importance emergency medical care has among the total array of medical services, the law should not sanction any degree of care below that generally prevailing for other medical services. Perhaps hospitals should be required to adopt that procedure which will assure that emergency cases are handled with the degree of care and skill which an ordinary, reasonable, and prudent licensed physician would exercise under similar circumstances. The standards for emergency departments formulated by the medical profession itself call for diagnosis of emergency room cases by licensed physicians only.¹¹⁷ It would be entirely appropriate for the courts to apply this as a legal standard.¹¹⁸ There is also much to be said for creating this proposed duty by statute. The process of adjudication is too slow, and the uncertainties need to be removed.

V. CONCLUSION

There is no longer any basis for failing to require that emergency medical aid be rendered by hospitals with emergency facilities to

116. *Bard v. Kent*, 19 Cal. 2d 449, 112 P.2d 8 (1942); 1A A. CORBIN, CORBIN ON CONTRACTS § 200 (1963).

117. *Standards for Emergency Department in Hospital*, 48 BULL. OF AM. COLLEGE OF SURGEONS 112 (May-June 1963). The same standard is clearly implied in T. FLINT, EMERGENCY TREATMENT AND MANAGEMENT 88 (3d ed. 1964).

118. In *Darling v. Charleston Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), the Illinois Supreme Court gave legal recognition to the Standards of the Joint Commission on Accreditation of Hospitals.

those in need of such care. Not even the old cases cited in support of a lack of duty really support that position, and all the newer cases have found detours around the obstacle easily. Hospital personnel quite generally assume that there is a duty, and the public makes the same assumption. The law should not continue to honor such an outworn, unpopular, and barbaric dictum as the one permitting the professional "Good Samaritan" to keep its doors closed to the victim of a medical emergency.