

Drexel University Thomas R. Kline School of Law

From the Selected Works of Barry R. Furrow

Spring 1993

Forcing Rescue: The Landscape of Health Care Provider Obligations to Treat Patients

Barry Furrow



Available at: https://works.bepress.com/barry_furrow/23/



Content downloaded/printed from

[HeinOnline](#)

Tue Feb 18 14:43:10 2020

Citations:

Bluebook 20th ed.

Barry R. Furrow, Forcing Rescue: The Landscape of Health Care Provider Obligations to Treat Patients, 3 Health Matrix 31 (1993).

ALWD 6th ed.

Barry R. Furrow, Forcing Rescue: The Landscape of Health Care Provider Obligations to Treat Patients, 3 Health Matrix 31 (1993).

APA 6th ed.

Furrow, B. R. (1993). Forcing rescue: The landscape of health care provider obligations to treat patients. Health Matrix: Journal of Law-Medicine, 3(1), 31-88.

Chicago 7th ed.

Barry R. Furrow, "Forcing Rescue: The Landscape of Health Care Provider Obligations to Treat Patients," Health Matrix: Journal of Law-Medicine 3, no. 1 (Spring 1993): 31-88

McGill Guide 9th ed.

Barry R. Furrow, "Forcing Rescue: The Landscape of Health Care Provider Obligations to Treat Patients" (1993) 3:1 Health Matrix: J of L-Medicine 31.

MLA 8th ed.

Furrow, Barry R. "Forcing Rescue: The Landscape of Health Care Provider Obligations to Treat Patients." Health Matrix: Journal of Law-Medicine, vol. 3, no. 1, Spring 1993, p. 31-88. HeinOnline.

OSCOLA 4th ed.

Barry R Furrow, 'Forcing Rescue: The Landscape of Health Care Provider Obligations to Treat Patients' (1993) 3 Health Matrix 31

-- Your use of this HeinOnline PDF indicates your acceptance of HeinOnline's Terms and Conditions of the license agreement available at

<https://heinonline.org/HOL/License>

-- The search text of this PDF is generated from uncorrected OCR text.

-- To obtain permission to use this article beyond the scope of your license, please use:

[Copyright Information](#)

FORCING RESCUE: THE LANDSCAPE OF HEALTH CARE PROVIDER OBLIGATIONS TO TREAT PATIENTS

Barry R. Furrow†

INTRODUCTION.

A POOR CITIZEN living in America suffers a range of indignities—poor housing and diet, limited educational opportunities, a high risk of becoming a crime victim. Restricted access to health care is another such indignity, a fatal one in the wrong circumstances. Between 1975 and 1986 the proportion of low income persons covered by Medicaid fell from 63% to 38%, primarily due to tightened eligibility requirements.¹ During this same period the number of Americans living at or above 125% of the federal poverty level increased by 27%.² Hospitals' abilities to subsidize indigent care by cost-shifting to private payers have diminished, as they are forced to negotiate discounts with insurers and employers.³ Employers now offer fewer and less extensive health care options to their employees, including reduced dependent coverage. Those who lack health insurance have trouble finding care.⁴ A 1986 study found that nearly 14 million people said they did not even seek health care because they would not be able to afford it.⁵ The situation has only deteriorated since 1986. "The uninsured are less likely to get their young children adequately immunized, less likely

† Professor of Law, Widener University School of Law. B.A. 1967 Harvard College, J.D. 1971 Harvard Law School.

1. Michael A. Dowell, *State Insurance Programs for the Uninsured Poor*, Clearing-house Rev., June 1989, at 141.

2. *Id.*

3. Richard W. Foster, *Cost-Shifting Under Cost Reimbursement and Prospective Payment*, 4 J. HEALTH ECON. 261 (1985).

4. Emily Friedman, *The Uninsured: From Dilemma to Crisis*, 265 JAMA 2491 (1991).

5. Dowell, *supra* note 1 (citing to THE ROBERT WOOD JOHNSON FOUNDATION, SPECIAL REPORT — ACCESS TO HEALTH CARE IN THE UNITED STATES: RESULTS OF A 1986 SURVEY (1987)).

to receive prenatal care, less likely to have their blood pressure checked, and less likely to see a physician even when they have serious symptoms."⁶ When uninsured patients do seek care from hospitals, they are often turned away or superficially treated and transferred to stressed and overburdened public hospitals.⁷ When they do receive health care in hospitals, indigent patients experience a higher mortality rate because they do not receive as many high-cost procedures.⁸

America has a health care access problem that makes us the embarrassment of modern industrialized societies. Yet, ironically, Americans seem to view access to health care as almost a "right", an egalitarian value that led to political passage of the Medicare and Medicaid programs.⁹ These programs consume a significant portion of state and federal budgets, in contrast to housing and food policies characterized mostly by their penuriousness. Access to health care, with government help, has become part of American political consciousness.¹⁰ A principle of egalitarianism has at times driven national health policy, fueled by public discomfort at the thought of not providing the poor and the elderly with a financial net when they face catastrophic illness and its expense. At the same time, the strong libertarian streak imbedded in the American character has often braked the ship of state, diverting impulses toward consistent funding for the poor by supporting a conception of health care as a service best provided by physicians and providers within the param-

6. Dowell, *supra* note 1, at 142. See generally Colin McCord & Harold P. Freeman, *Excess Mortality in Harlem*, 322 N. ENG. J. MED. 173 (1990).

7. Andrew B. Bindman et. al., *Consequences of Queuing for Care At a Public Hospital Emergency Department*, 266 JAMA 1091 (1991). See generally Emily Friedman, *Public Hospitals: Doing What Everyone Wants Done But Few Others Wish to Do*, 257 JAMA 1437 (1987); Andrew B. Bindman et. al., *A Public Hospital Closes: Impact on Patients' Access to Care and Health Status*, 264 JAMA 2899 (1990).

8. Jack Hadley et. al., *Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use, and Outcome*, 265 JAMA 374 (1991). For an excellent survey of research on problems caused by limited access to health care, see Karen Davis, *Inequality and Access to Health Care*, 69 MILBANK Q. 253 (1991).

9. The notion of a "right" to health care can mean many different things, from a constitutionally based guarantee like that in the Italian constitution, to a statutory claim based on eligibility thresholds such as Medicare eligibility. For a range of definitions, see Mark Kelman, *Health Care Rights: Distinct Claims, Distinct Justifications*, 3 STAN. L. & POL'Y. REV. 90 (1991). See also James F. Blumstein, *Financing Uncompensated Care: An Approach to the Issues*, 38 J. LEGAL EDUC. 511 (1988); Sarah H. Carey, *A Constitutional Right to Health Care: An Unlikely Development*, 23 CATH. U. L. REV. 492 (1974).

10. The best treatment of cultural attitudes of Americans toward welfare and toward health care services can be found in THEODORE R. MARMOR ET. AL., *AMERICA'S MISUNDERSTOOD WELFARE STATE: PERSISTENT MYTHS, ENDURING REALITIES* (1990).

eters of contract and charity.¹¹ "Trust us," resonate doctors at the frequency of libertarianism. "We are professionals, driven by our fiduciary duties to help you." "Grant us respect," chant hospitals, "for we are charities with all that implies." "Leave politics out of health care," the full chorus repeats in a basso ostinato, "for we are nonpolitical."

The realm of "rights" talk offers a useful frame of reference for discussing the current state of access to health care. Judge-made and statutory requirements imposed on health care providers—to rescue patients from a crisis, to fund free care, to mandate benefits—are "rights"-based approach to health care access. Under what circumstances, then, are physicians, health care providers, and insurers compelled to treat patients (or pay for their treatment) at the risk of some legal penalty for failure to comply? What moral vision of health care obligations, unifies these obligations imposed on providers by regulatory schemes, with insurance law obligations imposed by the courts, the handling of "bad debts" by taxing authorities, tax exemptions, and judicially imposed rules? Finally, what more can be done to promote access to necessary health care?

The current debate over national health insurance may lead to broad-based reform of the American system. Or it may not. Comprehensive reform of our expensive, and yet, inadequate, health care system awaits the commitment of a new President facing a powerful array of interest groups. Even if some system reform results from the efforts of a new administration, "rescue" obligations will still need to be explored and expanded. This article will pursue a "rights"-based approach, unfashionable in an era of efficiency, scarce resources, and sympathy for constraints on health care providers. The exquisite sensitivity to the world of scarce resources, often displayed by analysts, too readily concedes to providers their desires to retain as much autonomy as possible and to prevent further slippage away from the era of the blank check and the independent provider. Affirmative obligations by courts, tax collectors, and other agents of the state, while certainly inefficient

11. The social legislation of the sixties and seventies pushed America toward an egalitarian model of health care delivery.

A uniquely American phenomenon, however, has been the endeavor to extract an *egalitarian* distribution of health care from a delivery system still firmly grounded in *libertarian* principles . . . in no other modern society espousing egalitarian principles for the distribution of health care have physicians and hospitals been quite so free as they have in the United States to organize their facilities as they see fit, to practice medicine as they see fit, and to price their services as they see fit.

Uwe E. Reinhardt, *Uncompensated Hospital Care*, in *UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES* 8-9 (Frank A. Sloan et. al. eds., 1986).

and problematic at times, have advantages. Such obligations tighten the screws on the health care industry, force physicians to better define their professional responsibilities, and stretch the resources of providers and insurers in socially valuable directions. These pressures may speed reform of financial and structural barriers to access. More indigent individuals will ultimately receive more and better care than at present, through expanded obligations of providers to care for patients—to “rescue” them from their distress.¹² Such obligations are not imposed by agents of the state out of thin air; they are grounded in the definition of health professionalism, the images and promises projected by providers, and the concrete expectations created. They are therefore morally justifiable, and as such, not simply conscription without justification.

A. The Definition of “Rescue”

A duty to rescue is an enforceable legal obligation to help someone out of a situation of peril without a specific prior agreement to do so and without the promise of compensation. Such burdens run the gamut from a doctor treating a stranger in an emergency without the promise of payment, to a hospital providing free care and tolerating a certain level of bad debts, to an insurer paying for health care treatment without a prior agreement to do so. The phrase “uncompensated care” is often used to describe these externally imposed burdens on providers, and “mandated benefits” are those which statutes require employers to provide.¹³ These phrases have a clinical sound that obscures the real desperation of individuals presenting in distress, whether to an emergency room or a doctor’s office. I prefer to use the phrase “forced rescue” to better capture the desperation of the vulnerable, in need of rescue, and the resistance of providers to such rescue, therefore requiring the coercive power of legal institutions.

A forced rescue context involves a vulnerable person in need, someone who will suffer or die from the denial of an essential health care service,¹⁴ and a provider who is linked to the vulnerable person by one of a number of connections. These links are discovered or

12. See Robert J. Blendon et. al., *Uncompensated Care By Hospitals or Public Insurance for the Poor: Does It Make A Difference?*, 314 N. ENG. J. MED. 1160 (1986) (suggesting that growing reliance on uncompensated care may adversely affect the health care received by the poor).

13. Hawaii mandates benefits as the result of an ERISA (Employee Retirement Income Security Act) waiver. See generally BARRY FURROW ET. AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* (2nd ed. 1990).

14. For an earlier treatment of some of these issues, see George J. Annas, *Beyond the*

constructed by courts and legislatures. Some justifications for forcing rescue on providers include:

- a definition of the provider role, and the duties inherent in that role, that transcends contract limits;
- the creation of reasonable expectations by the provider and reliance by patients;
- a utilitarian justification in "easy" or cost effective rescue situations;
- recognition of the economic and technological power of providers and the reciprocal burdens such power should properly require.

B. The Role of Affirmative Duties

Is it misguided to cast social and even legal obligations on individual professionals and the medical profession collectively? Skeptics claim providers have obligations bearing on distributive justice only through "specific contractual arrangements when they enter into roles within the social system of health-care institutions."¹⁵ When existing institutional arrangements for the provision of health care fail, these skeptics contend that the full extent of provider obligations is to work toward new arrangements to achieve a just distribution of health care.

Thus, the individual physician or resident does not have an obligation to treat the underserved patients unless he has undertaken such an obligation through prior agreements and decisions. But if such patients exist, then institutional structures, such as incentives which work through reimbursement structures, have to be altered so that some physicians are drawn into undertaking the appropriate obligations.¹⁶

This is a narrow position: positing obligations created through preexisting contract relations, and expanding obligations to care for needy patients only through voluntarily accepted new distributive structures.

The customary arguments against affirmative obligations to provide care are threefold. First, provision of free health care by providers typically requires an unfair and inefficient cross subsidy from one group of patients to another.¹⁷ However, given the vagaries of hospital pricing structures generally, cross subsidization may not be

Good Samaritan: Should Doctors Be Required to Provide Essential Services?, 8 HASTINGS CENTER REP., Apr. 1978, at 16.

15. NORMAN DANIELS, *JUST HEALTH CARE* 118 (1985).

16. *Id.* at 119.

17. See Foster, *supra* note 3, at 261.

any less fair than hospital charges to paying patients.¹⁸ If such a subsidy is imposed on all providers, and external payers resist increased charges, the profession will absorb the costs through somewhat lower wages. This is hardly unfair to patients. For example, if a state were to require a certain level of annual pro bono care by each physician as a condition for receiving and retaining a medical license, this would be a subsidy internal to the profession, simply another requirement for the license. It may be objectionable to the medical profession, but it is not unfair to patients and may not be unfair to doctors if the burden is not excessive and is fairly distributed among them.

Second, critics argue that it is preferable to use the power of the government to provide rescue in a systematic way, using the power of taxation to fairly spread the cost. This assumes reducing or eliminating uncompensated care of all kinds. Such a distributional answer through government funding increases may well be preferable, assuring everyone some minimal level of necessary care. But in a world of deficits and scarce resources, a second best solution will have to suffice. Legal obligations serve a vital gap-filling role in stretching resources in such a world.

Third, libertarian critics object to any affirmative obligation not freely chosen by a provider by claiming that such an obligation is "coercive" and likely to impose excessive enforcement costs. Richard Epstein argues that in the case of moral duties to rescue, "a system of informal norms may influence behavior more effectively than a system of legal coercion."¹⁹ Self-help motivated by benevolence and altruism is preferable, he contends, and intermediate social institutions—charities, social leaders—can do the job.²⁰ "It is a mistake to think that legal bonds only reinforce social bonds. In many instances, they overpower and destroy them."²¹ On this view, altruism is stifled by obligations imposed by the state through its agents—courts and the legislature.²² Yet, this critique fails to rec-

18. "[I]f the hospital did not treat the poor, its pricing behavior for paying patients would not necessarily be any less irrational or exploitive. It would only make different use of the profits." Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 363 n.198 (1991).

19. Richard A. Epstein, *Book Review: Rights and "Rights Talk"*, 105 HARV. L. REV. 1106, 1118 (1992) (reviewing MARY ANN GLENDON, *RIGHTS TALK: THE IMPOVERISHMENT OF POLITICAL DISCOURSE* (1991)).

20. *Id.* at 1118.

21. *Id.* at 1119.

22. Ronald M. Green, *Altruism in Health Care*, in *BENEFACTENCE AND HEALTH CARE* 239 (Earl E. Shelp ed., 1982) addresses this concern.

ognize the complex new world of health care systems, professional obligations, and bureaucratic health care. Legal bonds also create social bonds that were nonexistent or weak to start with, and may bolster fading charitable impulses.

The health care industry and medical professionals have extensive affirmative obligations: hospitals as charities exist by legal policy through the tax code, massively subsidized by implicit national policy; physicians are licensed by the state, measured against a role defined by licensing boards and courts, and credentialed by hospital medical staffs in conformity with mandated institutional requirements. An abstract debate about coercion and social versus legal bonds is largely irrelevant to the more complicated issues of providing health care. Health care providers resemble public utilities in some of their characteristics: they provide basic needs, they operate within an environment in which market forces function poorly, and they require external regulation.

Beneficence is not a suitable starting point for questions of access to health care. A system of duties and rights needs to be motivated independently of beneficence.²³ An ideal health care system would not have to rely on forced rescue, but surely rescue can be demanded in the absence of the ideal. In an imperfect world where some people experience inadequate health care access all the time, and others some of the time, legal obligations serve to counter the deficiencies of voluntarism, the shortcuts induced by market pressures, and rapidly shrinking insurance coverage for millions of people. We should prefer five hundred thousand points of induced rescue to a thousand points of overburdened voluntarism.

I. PHYSICIANS ALONE

The poor are poor, and one's sorry for them, but there it is. As civilization moves forward, the shoe is bound to pinch in places, and it's absurd to pretend that anyone is responsible personally. (Mr. Wilcox)²⁴

Those in need of necessary medical care are stranded between the world of contracted-for care and government funded care. But is this justifiable? Philosophers considering the obligations of health care providers argue that "in the US at least, an individual provider, and the profession as a whole, have *no legal obligation* to distribute services except to patients to whom they already have contractual

23. JOHN P. REEDER, JR., *BENEFACTENCE, SUPEREROGATION, AND ROLE DUTY, BENEFICENCE AND HEALTH CARE* 83 (Earl E. Shelp ed., 1982).

24. E. M. FORSTER, *HOWARD'S END* 188 (Vintage Books 1973) (1910).

obligations."²⁵ This proposition is so circumscribed by judicial and other restrictions as to be false in practice. A principled framework for legal obligations to treat those in need, prior to any contractual obligation, and expanded obligations to treat them once the nexus is created, will be established below.

A. From Contract to Covenant

Health care today is most often delivered within institutions—whether hospitals, ambulatory care clinics, or HMO offices—but it is still the individual physician who sees the patient, diagnoses the problem, and prescribes the treatment. This physician also controls the consumption of more than 70% of the health care dollars spent, by directing patients to particular loci of diagnosis and treatment in laboratories and hospitals. The starting point is therefore the obligations on a physician outside an institution.

1. THE CONTRACT MODEL. Courts often assume the contract model as the starting point for their analysis of tort duties in the doctor-patient relationship.²⁶ The contract foundations of the doctor-patient relationship are often summarized, hornbook style, in tort decisions. Thus, physicians in private practice may contract their services as they see fit and retain substantial control over the extent of their contact with patients.²⁷ Physicians may limit their specialty and scope of practice, their geographic area, and the hours and conditions under which they will see patients. There is no obligation to offer services that a patient may require outside the physician's competence and training; or services outside the scope of the original physician-patient agreement, where the physician has limited the contract to a type of procedure, to an office visit, or to con-

25. Daniels, *supra* note 15, at 116.

26. Roger D. Masters, *Is Contract An Adequate Basis for Medical Ethics?* 5 HASTINGS CENTER REP., Dec. 1975, at 24.

27. When, for example, a doctor employed by an insurance company examines an individual for the purpose of qualifying him for insurance coverage, most courts considering the issue have held that a doctor owes no duty to the individual to treat or to disclose problems discovered during the examination. The justification is the lack of a doctor-patient relationship, and the rationale that there is a lack of an expectation by the person examined that he is being diagnosed for purposes of treatment. The screening function dominates over the treatment function in the relationship — the doctor is treated like a screening device, purely mechanical in nature. See *Ervin v. American Guardian Life Assurance Co.*, 545 A.2d 354 (Pa. Super. Ct. Law Div. 1988) (holding no duty owed by doctor employed by an insurance company to the plaintiff, where doctor examined the plaintiff for purposes of insurance and failed to discover or disclose his cardiac abnormalities to him; plaintiff died a month after the examination from his heart condition); *accord*, *Keene v. Wiggins*, 138 Cal. Rptr. 3 (Ca. Ct. App. 1977).

sultation only.²⁸ Physicians may transfer responsibility by referring patients to other specialists. As private practitioners, they may refuse to enter into a contract with a patient, or to treat patients, even under emergency conditions.²⁹ Both physician and patient can shape the parameters of the relationship.³⁰ This is the essence of a libertarian definition of professional contracting: the doctor sets the terms and conditions, and no external constraints on bargaining and performance exist. According to this legal summary, doctor and patient are autonomous agents, contracting freely. While the above principles have some support in law and practice *for the physician in private office practice* practicing fee-for-service medicine, they do not begin to define the nature of professional medical obligations as most physicians practice medicine.

2. THE LIMITS OF THE CONTRACT MODEL. Physician autonomy claims, as manifested in a pure contract model of health care, are based on little more than historical accident. As Daniels writes, "[i]t is the legacy of the fact, more visible in the U.S. than elsewhere, that physicians have been more independent of institutional settings for the delivery of their skills than many other workers and even than physicians in other countries."³¹ The defects of the contract model of the doctor-patient relationship are apparent.

First, the basis of the relationship bears little resemblance to the economic model of arms-length dealings between a buyer and a seller. The patient hardly consents to buy health care in the same way he consents to buy a house or to rent instead, or chooses between a Mercedes and a Ford. He would rather skip the purchase of health care forever, if his body would allow it. The professional has more latitude, since he can find more clients more easily than the patient can find professionals.³² The patient's interest in a health care service is greater than that of a VCR buyer, for when the need arises it is intense and anxiety-producing. The knowledge disparity between doctor and patient is great, and parity in informa-

28. When a patient has a reasonable expectation that a physician will disclose all relevant information to him, even though no physician-patient relationship exists, then an examining physician who fails to inform a patient of abnormal test results will be liable for resulting injury. *Daly v. U.S.*, 946 F.2d 1467 (9th Cir. 1991).

29. *Hiser v. Randolph*, 617 P.2d 774, 776 (Ariz. 1980) (holding physician on-call at hospital emergency room is obligated to treat all those who come into the emergency room).

30. *Clough v. Lively*, 387 S.E. 573 (Ga. Ct. App. 1989) (holding patient declined to enter into a physician-patient relationship any broader than necessary to accomplish the drawing of a blood sample).

31. Daniels, *supra* note 15, at 123.

32. MICHAEL D. BAYLES, PROFESSIONAL ETHICS 64 (1981).

tion may be unattainable, since the purchase of a health care service cannot usually be deferred until a market analysis has been done and comparative shopping completed. Third party payers dominate the relationship, so that any incentive by either side to bargain based on price sensitivity is diminished or eliminated by the existence of external payers. Finally, the physician is not an independent seller, but sells within social institutions—he is both a citizen of the institution and an agent of the purchaser-patient. He has a monopoly and the patient is neither a mobile nor an independent shopper. As one commentator observed, “[f]rom this point of view, the bargaining situation is more like that between an individual and a public utility.”³³

Second, other social forces and institutions impinge upon and redefine the relationship: third party payment and utilization review, tort and fiduciary law standards, peer pressure within the institution, and staff privilege constraints.³⁴ The contract model is hopelessly incomplete in the complex world of health care delivery. The terms of the contract are largely fixed in advance of any bargaining, by standard or customary practices that the physician must follow at the risk of legal penalties. The exact nature of the work to be done by the physician is usually left vaguely defined at best. The relationship is closer to quasi-contract, where we impute standard intentions and reasonable expectations to both the physician and the patient.³⁵ Professional ethics impose on physicians fiduciary obligations which courts convert into legal obligations. Courts often look outside the parameters of contract law analysis in judging the obligations of a physician to treat a patient, stressing that the physician's obligation to the patient, while having origins in contract, is governed also by fiduciary obligations and other public considerations “inseparable from the nature and exercise of his calling”³⁶ Doctors are not viewed as businesspeople, where self-interest is the expected norm.³⁷ Professionals' ability to withdraw from

33. *Id.* at 66.

34. *Id.* at 26.

35. See ROBERT E. GOODIN, PROTECTING THE VULNERABLE 63-65 (1985).

36. Norton v. Hamilton, 89 S.E.2d 809, 812 (Ga. App. 1955) (stating that patient's action was in tort rather than in contract when doctor withdrew from case at time when wife was in premature labor and wife delivered child while husband searched for substitute doctor). See Chatman v. Millis, 453 S.W.2d 504, 506 (Ark. Sup. Ct. 1975) (malpractice action requires a doctor-patient relationship, a duty owed from doctor to patients, although “[w]e do not flatly state that a cause for malpractice must be predicated upon a contractual agreement between a doctor . . . and patient . . .”).

37. “It is clear from everyday observation that the behavior expected of sellers of medical care is different from that of business people in general. These expectations

their contracts is constrained by judicial caselaw defining patient abandonment.³⁸ Implied abandonment is a negligence-based theory judged by the overall conduct of the physician.³⁹ Physicians also lose a range of legal protections when they withhold information from patients. Some states deem a doctor's withholding information about his medical error to be fraud, a distinct cause of action.⁴⁰

are relevant because medical care belongs to the category of commodities for which the product and the activity of production are identical. In all such cases, the customer cannot test the product before consuming it, and there is an element of trust in the relation. But the ethically understood restrictions on the activity of a physician are much more severe than on those of, say, a barber. His behavior is supposed to be governed by a concern for the customer's welfare which would not be expected of a salesman. In Talcott Parsons's terms, there is a "collectivity-orientation," which distinguishes medicine and other professions from business, where self-interest on the part of participants is the accepted norm."

Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 949 n.15 (1963). See also Talcott Parsons, *The Professions and Social Structure and The Motivation of Economic Activities*, in TALCOTT PARSONS, *ESSAYS IN SOCIOLOGICAL THEORY* 34-68 (Free Press 1964) (1949) (stressing the role of trust in professions as institutions).

38. As discussed *supra*, a doctor who withdraws from the physician-patient relationship before a cure is achieved or the patient is transferred to the care of another may be liable for abandonment. To escape liability, the physician must give the patient time to find alternative care. See, e.g., *Norton v. Hamilton*, 89 S.E.2d 809 (Ga. Ct. App. 1955) (holding that a cause of action for abandonment exists where a doctor withdrew from a case while a woman was in premature labor and a child was delivered before the husband could find a replacement doctor).

39. See *Meiselman v. Crown Heights Hosp.*, 34 N.E.2d 367 (N.Y. 1941); *Ascher v. Gutierrez*, 533 F.2d 1235 (D.C.Cir.1976); See Leon L. McIntire, *The Action of Abandonment in Medical Malpractice Litigation*, 36 TUL. L. REV. 834 (1962).

40. Negligent spoliation, based on a provider's failure to properly maintain records, or in the extreme cases, active destruction of records, had been recognized by a few state courts. The cause of action requires the existence of a potential civil action, a legal duty by the defendant to preserve evidence relevant to that action, destruction of that evidence, resulting impairment of the plaintiff's ability to prove the lawsuit, a causal relationship between the destruction of the evidence and the impairment of the ability to sue, and damages. *Continental Ins. Co. v. Herman*, 576 So. 2d 313 (Fla. Dist. Ct. App. 1990) (action recognized as generally valid in Florida, but plaintiff's claim dismissed for failure to show damage). See generally, P. Fritz King, *Spoilation: Civil Liability for Destruction of Evidence*, 20 U. RICH. L. REV. 191 (1986).

The party seeking to take advantage of a defendant's fraudulent concealment has the burden of proving that the defendant affirmatively concealed the facts upon which the cause of action is based. As one court noted, however, "The close relationship of trust and confidence between patient and physician gives rise to duties of disclosure which may obviate the need for a patient to prove an affirmative act of concealment." *Koppes v. Pearson*, 384 N.W.2d 381, 386 (Iowa 1986).

An action for deceit requires proof that a false representation of a material fact was made, was relied upon by the patient in ignorance, and damage resulted. The representation must be fraudulently made, since an intention to deceive by the physician is needed. See *Harris v. Penninger*, 613 S.W.2d 211, 214 (Mo. App. 1981) (dismissing cause of action based on fraud where plaintiff had failed to assert a claim for damages resulting from the fraud). In *Hart v. Browne*, 163 Cal. Rptr. 356 (Cal. Ct. App. 1980), a physician was sued for fraud when he advised the lawyer for a surgeon's patient that the surgeon's conduct was not negligent, when

The omission also tolls the statute of limitations in a malpractice suit by the patient against that doctor.⁴¹ An informed consent cause of action is based on failure to disclose information.⁴² Some newer cases are also based on a claim for a breach of a physician's fiduciary duty to disclose conflicts of interest.⁴³ The environment of providers is bounded by legal constraints and specific role requirements.

An express written contract is rarely drafted for specific physician-patient interactions. An implied contract is usually the basis of the relationship between a physician and a patient.⁴⁴ A physician who talks with a patient by telephone may be held to have an implied contractual obligation to that patient.⁴⁵ Likewise, a physician such as a pathologist, who renders services to a patient but has not

the records he had examined in fact showed abundant negligence. *See also* Henry v. Deen, 310 S.E.2d 326 (N.C. 1984) (allowing a theory of civil conspiracy and a punitive damages claim); Kreuger v. St. Joseph's Hosp., 305 N.W.2d 18 (N.D. 1981) (allowing a fraud claim based upon the physician's false representations.)

Some commentators have advocated a major development of these few cases into a new duty to disclose, requiring negligent health care providers to confess their negligence to the patients injured by it. *See* Joan Vogel & Richard Delgado, *To Tell the Truth: Physicians' Duty to Disclose Medical Mistakes*, 28 UCLA L. REV. 52 (1980) (advocating a duty to disclose malpractice to the patient); Theodore R. LeBlang & Jane L. King, *Tort Liability for Nondisclosure: The Physician's Legal Obligations to Disclose Patient Illness and Injury*, 89 DICK. L. REV. 1 (1984) (suggesting the fiduciary relationship creates a duty to disclose information concerning the patient's physical condition).

41. *See, e.g.,* Mastro v. Brodie, 682 P.2d 1162 (Colo. 1984) (defining "discovery of injury" for purposes of tolling statute of limitations).

42. *See generally* Furrow, *supra* note 13 at 338-39 (providing a list of items a physician should consider disclosing: a) diagnosis; b) the nature and purpose of the proposed treatment; c) the risks of treatment; d) the probability of success; and e) treatment alternatives).

43. *See* discussion of Moore *infra* § I(b)(3).

44. When a patient goes to a doctor's office with a particular problem, he is offering to enter into a contract with the physician. When the physician examines the patient, she accepts the offer and an implied contract is created. The physician is free to reject the offer and send the patient away, relieving herself of any duty to that patient. *See, e.g.,* Childs v. Weis, 440 S.W.2d 104 (Tex. Civ. App. 1969) (holding that a physician has no duty to treat where there is no express or implied contract creating a physician-patient relationship). Some courts state as a starting principle that:

[a]s a practical matter, health professionals cannot be required to obtain express consent before each touch or test they perform on a patient. Consent may be express or implied; implied consent may be inferred from the patient's action of seeking treatment or some other act manifesting a willingness to submit to a particular course of treatment.

Jones v. Malloy, 412 N.W.2d 837, 841 (Neb. 1987) *citing* *Banks v. Wittenberg*, 266 N.W. 2d 788 (Mich. Ct. App. 1978).

45. *See* Bienz v. Central Suffolk Hosp., 557 N.Y.S.2d 139 (1990) (holding that a telephone call for purposes of initiating treatment may create a physician-patient relationship); O'Neill v. Montefiore Hospital, 202 N.Y.S.2d 436 (1960) (holding that a jury question of negligence exists when patient was refused treatment following a telephone conversation with physician).

contracted with him, is nonetheless bound by certain implied contractual obligations. These implied obligations become part of the professional role, defined by the courts through a variety of rationales. Courts have held that workplace examinations of employees may create physician obligations to the examined person, even though he is not defined as a "patient".⁴⁶ These maintenance examinations in the workplace go beyond screening for other purposes, such as insurance, and the courts have found a duty to diagnose and inform.⁴⁷ The entanglement of the doctor with a quasi-patient has increased. One explanation could be the expectation of the employee with regard to his employer's obligations to him.⁴⁸

Once the physician-patient relationship has been created, physicians are subject to a range of obligations. They must give the patient "continuing attention."⁴⁹ Termination of the physician-patient relationship, once created, is subject in some jurisdictions to a "continuous treatment" rule to determine when the statute of limitations is tolled. Treatment obligations cease only if the physician can do nothing more for the patient, or if the physician ceases to attend the patient.⁵⁰ A physician who withdraws from the physician-patient relationship before the patient is cured or transferred to another's care may be liable for abandonment.⁵¹ The tort doctrine

46. *Daly v. Unites States*, 946 F.2d 1467 (9th Cir. 1991) (holding that under Washington law, a physician had a duty to disclose abnormal test results even if no physician-patient relationship exists).

47. *See, e.g., Cofee v. McDonnell Douglas Corp.*, 503 P.2d 1366 (1972) Plaintiff applied for a job as a pilot with the defendant aircraft manufacturer; as part of his physical, he was given a blood test, with the results received by a secretary at defendant's medical clinic, time-stamped, and filed. No doctor reviewed the result, which would have led to a diagnosis of cancer of the bone marrow. The court held that the company was negligent in its failure to establish a proper procedure for evaluation of blood test reports.

48. In *Green v. Walker*, 910 F.2d 291 (5th Cir.1990), the U.S. Court of Appeals for the Fifth Circuit, interpreting Louisiana law in a diversity action, held that the physician-patient relationship should be expanded to include employees examined by a company physician for employment purposes. The court held that:

This relationship imposes upon the examining physician a duty to conduct the requested tests and diagnose the results thereof, exercising the level of care consistent with the doctor's professional training and expertise, and to take reasonable steps to make information available timely to the examinee of any findings that pose an imminent danger to the examinee's physical or mental well-being.

Id. at 296.

49. *See Ricks v. Budge*, 64 P.2d 208, 211 (Utah 1937) (holding that the obligation of continuing attention may be terminated only when the case no longer requires attention).

50. *See Jewson v. Mayo Clinic*, 691 F.2d 405 (8th Cir. 1982) (stating that treatment ceases when a physician stops attending to the patient). *Cf., Wells v. Billars*, 391 N.W.2d 668 (S.D. 1986) (holding that an optometrist's duty continued to date when patient visited clinic to take delivery of glasses).

51. *See Norton v. Hamilton*, 89 S.E. 2d 809 (Ga. Ct. App. 1955).

of abandonment presumes an improper attempt by the physician to extricate herself from this contract, to the patient's detriment. It can be invoked by a patient-plaintiff whenever a treating physician has severed the physician-patient relationship without giving the patient a reasonable time or the opportunity to secure another equally qualified physician, and the patient then suffers injury because of delay in treatment or lack of further treatment.⁵² To avoid liability, the physician generally is required to give the patient time to find other care.⁵³ A negligence-based theory, abandonment is judged by the overall conduct of the physician.⁵⁴ While contract rules may guide the formation of a physician-patient relationship, termination of that relationship absent explicit mutual consent is evaluated by standards of reasonableness.

A duty of "necessary rescue" is imposed by the courts in situations where a person would be left helpless if the professional refuses to help.⁵⁵ The physician's right to unilaterally terminate treatment is thus particularly circumscribed in emergency situations, defined as situations where the patient has a "critical need" for that physician's attention. A provider can be "conscripted" to rescue through webs of obligation created by emergency situations. In *Urrutia v. Patino*,⁵⁶ the court stated that "a physician is never justified in withdrawing from a case that he has once undertaken *at a critical stage when his replacement cannot be supplied.*" [emphasis

52. See *Surgical Consultants, P.C. v. Ball*, 447 N.W. 2d 676, 682 (Iowa Ct. App. 1989) (stating that "There must be evidence that the physician has terminated the relationship at a critical stage of the patient's treatment, that the termination was done without reason or sufficient notice to enable the patient to procure another physician, and that the patient is injured as a result thereof.") See also *Lyons v. Grether*, 239 S.E. 2d 103 (Va. 1977) (holding that a physician may withdraw from the case only when the patient has reasonable opportunity to acquire needed services from another physician).

53. See *Norton v. Hamilton* *supra* note 38.

54. *Ascher v. Gutierrez*, 533 F.2d 1235 (D.C. Cir. 1976) (setting out proper types of evidence for abandonment cases); *Meiselman v. Crown Heights Hosp.*, 34 N.E. 2d 367 (N.Y. 1941) (setting out the types of evidence permissible in cases of physician abandonment); Leon M. McIntire, *The Action of Abandonment in Medical Malpractice Litigation*, 36 TUL. L. REV. 834 (1962) (discussing how the extent and scope of the physician-patient relationship determine duties and obligations).

55. "[A] professional ought to be held morally and professionally (if not necessarily legally) responsible to provide assistance in any situation in which, if he did not, someone would be left helpless. Consider the case of the only doctor in an isolated frontier town. Surely he should not be entitled to withdraw from the case of someone too ill to be moved, no matter how much notice he gives of this intention to do so. Neither should he be entitled to refuse to treat that patient in the first place." Goodin, *supra* note 35, at 67. See also Robert Justin Lipkin, *Beyond Good Samaritans and Moral Monsters: An Individualistic Justification of the General Legal Duty to Rescue*, 31 U.C.L.A. L. REV. 252 (1983).

56. 297 S.W. 512, 516 (Tex. Civ. App. 1927).

added]. These constraints—critical need for treatment and unavailability or lack of time to secure a replacement—define a situation considerably broader than the normal “emergency” situation.

In a nonemergency situation, the original physician need not physically replace herself with another physician before withdrawing in order to avoid a tort suit for abandonment.⁵⁷ Yet the physician must give the patient a list of possible alternative physicians to handle the patient’s condition.⁵⁸ Suppose, however, that the physician is the only specialist within the relevant geographic area, as measured by the expense or difficulty experienced by a patient when traveling to consult with another specialist. Must the physician continue to treat when the only other available specialist requires the patient to incur large transportation costs, so that the referring physician is essentially unavailable to the patient? The patient may have a critical need for treatment, with alternative care unavailable in any practical sense.

A continuing treatment obligation imposed on physicians against their wishes must withstand several arguments. First, given physician antipathy, forcing a continuation of the physician-patient relationship against the physician’s wishes hardly achieves the idealized model of the physician-patient relationship. It is even arguable that the physician might render bad care unconsciously, if not consciously, because of this anger. However, this argument overstates the problem. Physician antipathy must be counterbalanced by patient needs and a realization that the professional role carries with it continuing obligations. Lack of payment by the patient is one area in which there is an analogous body of caselaw that imposes an obligation on physicians even when physicians feel hostile to the patient. The caselaw has consistently declared that the failure of the patient to pay for the physician’s services will not justify unilateral termination of the physician-patient relationship so long as the patient still needs medical attendance.⁵⁹ These cases often involve emergency situations where the physician has not taken steps in ad-

57. *Miller v. Greater Southeast Community Hosp.*, 508 A.2d 927, 931 (D.C.C.A. 1986). See also *Wyatt v. Ford*, 363 S.E. 2d 866 (Ct. App. Ga. 1987) (trial court had denied physician’s motion for summary judgment, court held that the appeal should be dismissed as improvidently granted).

58. *Id.* (holding “[w]here a patient is not in need of immediate medical attention, supplying the patient with a list of substitute physicians to replace the attending physician is a reasonable means of severing the professional relationship.”) In this regard, direct provision of another colleague to cover the patient is sufficient to relieve the physician of further obligations to the patient.

59. See *Ricks v. Budge*, *supra* note 49.

vance to warn the patient of the termination and to find him an alternate provider, and the patient could, therefore, be said to have a legitimate expectancy of a continuing relationship.

Second, it may be argued that such a rule will create perverse obligations for physicians practicing in rural areas. The courts have not faced a situation where substantial travel costs, or even impossibility of access, may result from the remoteness of referral physicians. The rural setting involves a special case of expectations: citizen expectations that a physician who chose to relocate in their area will be available to them within reason, and the physician's expectation that he will have to provide care when needed, given the lack of backup in such areas. While a government subsidy or some kind of special program might be useful,⁶⁰ it does not seem unreasonable to obligate a physician to treat patients within his realm of expertise, particularly in emergency situations. Goodin argues for a collective duty on the medical profession to a patient, to be provided by a particular doctor who is "linked"—selected out of the general pool of professionals—by a promise, a contract, or the fiduciary bonds of a health care system.⁶¹ According to Goodin, "it is vulnerability, however engendered, that plays the crucial role in generating special responsibilities."⁶²

3. THE COVENANT TO SERVE. The implied contract expectations imposed by the courts suggest a much broader definition of role obligations in forced rescue contexts. May offers the model of a covenant as a basis for health care, rejecting contract, code, and philanthropy as alternatives.⁶³ Medical codes embody the ideal of philanthropy, that is, dedication to the service of mankind. Such codes succumb to what May calls "the conceit of philanthropy", which assumes "that the professional's commitment to his fellow-

60. A special program has existed to subsidize a student's medical education in exchange for a certain number of years of service. The National Health Service Corps Scholarship Program was established by Congress to address the maldistribution of health care manpower in the U.S. 42 U.S.C. § 254d (1988) (National Health Service Corps). Eligible students in professional health degree programs receive scholarships that cover their educational expenses and include a stipend for living expenses. U.S.C. § 254i (1988) (National Health Service Corps Scholarship Program). In exchange the student agrees to serve "in a health manpower shortage area" to which he is assigned by the Secretary. 42 U.S. § 254d(a) and 254e (1988). See also *Rendlemen v. Sullivan*, 760 F. Supp. 842 (D. Or. 1991) (holding failure to serve in area gives government right to seek repayment, but doctor's actions in starting a homeless clinic should be considered by DHHS as to whether it would make enforcement of his payment obligation unconscionable).

61. Goodin, *supra* note 33, at 126.

62. *Id.*

63. William F. May, *Code, Covenant, Contract, or Philanthropy*, 5 HASTINGS CENTER REP., Dec. 1975, at 29.

man is a gratuitous, rather than a responsive or reciprocal, act."⁶⁴ It is a model of a profession owing no duties to patients except those self chosen, much like the contract model. The contract view is also too limited; as May argues, "[t]he kind of minimalism encouraged by a contractualist understanding of the professional relationship produces a professional too grudging, too calculating, too lacking in spontaneity, too quickly exhausted to go the second mile with his patients along the road of their distress."⁶⁵

A covenant, by contrast, is an agreement between parties, a reciprocal relationship based on a gift between partners, and a covenant is a promise based on this original exchange of gifts, labors or services. This historic promissory event then defines future obligations. In medicine, the liberal state defines the obligations of this covenant, since the professions exist with the consent of the state and for its benefit.⁶⁶ The physician owes a debt to the community. He owes some group for his education, since the social investment in medicine is large. He was selected for medical school while others were not. He receives an "extraordinary social largess" in exchange for his services.⁶⁷ He learned on patients as a beginner, receiving a further subsidy through risk-taking. And he is in the debt of patients treated during his career for his existence and his ability to perform his trade competently. The relationship is therefore marked by elements of exchange and reciprocity. It is bounded by contractual protections, but more is required by the medical covenant and by the social definition of the professional role.⁶⁸

64. *Id.* at 32.

65. *Id.* at 35.

66. Bayles, *supra* note 32, at 11-12 (discussing TROYEN BRENNAN, *JUST DOCTORING: MEDICAL ETHICS IN THE LIBERAL STATE* (1991)). Brennan wants physicians to have a primary role, in contrast to Bayles' view, with medical ethics defined as a set of evolving principles by physicians and other members of the liberal state.

67. May, *supra* note 63, at 32.

68. May writes:

But the contractualist approach to professional behavior falls into the opposite error of minimalism. It reduces everything to tit-for-tat: do no more for your patients than what the contract calls for; perform specified services for certain fees and no more, But it would be wrong to reduce professional obligation to the specifics of a contract alone, . . . Professional services in the so called helping professions are directed to subjects who are in the nature of the case rather unpredictable. One deals with the sickness, ills, crimes, needs, and tragedies of humankind. These needs cannot be exhaustively specified in advance for each patient or client. The professions must be ready to cope with the contingent, the unexpected. Calls upon services may be required that exceed those anticipated in a contract or for which compensation may be available in a given case.

Id. at 34.

B. Affirmative Obligations On Physicians

A landscape of affirmative obligations, broadly defined, is constructed out of a wide spectrum of legal doctrines. A moral detective finds a legal landscape dotted with eruptions of principles that redefine medical and fiduciary obligations, demanding that providers "rescue" someone in distress. Some doctrines stretch the boundaries of contractual relationships by requiring additional burdens on the provider or creating the fiction of a contract.

1. **RESCUING PATIENTS FROM THEIR OWN IGNORANCE.** Basic informed consent doctrine in tort law requires physicians to disclose to patients all information necessary to their health care decisionmaking.⁶⁹ A patient must make an informed choice, that is, must be rescued from his own ignorance about courses of treatment. A physician must disclose to the patient not only the consequences of treatment, but also of inaction. In *Truman v. Thomas*,⁷⁰ Dr. Thomas failed to explain to his patient, Rena Truman, the consequences of her persistent refusal to undergo a Pap smear. Dr. Truman saw her as a patient for five years, and often said to her, "You should have a Pap smear."⁷¹ She always declined, either not wanting to pay for it or simply not wanting to undergo any more tests. Dr. Thomas is quoted as saying, "We are not enforcers, we are advisors," in justifying his failure to explain the purpose of the test and the consequences of cervical cancer.⁷² The California Supreme Court held that a physician has a duty to disclose to a patient the consequences of a failure to undergo a test or procedure viewed as valuable by a doctor. "If a patient indicates that he or she is going to *decline the risk-free test or treatment, then the doctor has the additional duty of advising of all material risks of which a reasonable person would want to be informed before deciding not to undergo the procedure*" (emphasis added).⁷³

This "right to an informed refusal" demands that the doctor rescue the patient from her ignorance about choices, in an attempt to ensure that a future bad result is either avoided or the tradeoff is explicitly made by the patient. It requires that the doctor spend a

69. See *Natanson v. Kline*, 354 P.2d 670, 672 (Kan. 1960) (holding doctors owed patient the duty to inform him generally of the possible serious collateral hazards of insulin treatment); and *Mitchell v. Robinson*, 334 S.W.2d 11, 19 (Mo. 1960) (holding radiologist was obligated to make a reasonable disclosure to patient of nature and probable consequences of radiation treatment).

70. 611 P.2d 902 (S.C. Cal. 1980).

71. *Id.* at 906.

72. *Id.*

73. *Id.*

valuable commodity—time—in order to maximize the patient's choices. The doctor controls information otherwise unavailable to patients; from this control flows an obligation to use that information to help patients avoid medical hazards and even to help a patient preserve a tort right to sue the physician.⁷⁴

2. RESCUING THIRD PARTIES FROM EXPOSURE TO RISKS. An example of the extension of physician obligations to those not in a contractual relationship with them is found in caselaw that requires a warning to third parties. What if doctors have information about a patient which, if disclosed, might prevent harm to others? Requirements of confidentiality of the physician-patient relationship militate against disclosure generally, and disclosure may even expose the physician to potential liability. However, physicians and other health professionals have an affirmative obligation to protect third parties against hazards created by their patients. In *DiMarco v. Lynch Homes—Chester County*,⁷⁵ the sexual partner of a patient sued the patient's physicians, who had assured her that she would not contract hepatitis. The patient-plaintiff Janet Viscichini, a blood technician, went to the Lynch Home to take a blood sample from one of the residents. During the procedure, her skin was accidentally punctured by the needle she had used to extract blood. When she learned that the patient had hepatitis, she sought treatment from Doctors Giunta and Alwine. They told her that if she remained symptom-free for six weeks, she would not be infected by the hepatitis virus. She was not told to refrain from sexual relations for any period of time following her exposure to the disease, but she practiced sexual abstinence until eight weeks after the exposure. Since she had remained symptom-free during that time, she then resumed sexual relations with the plaintiff. She was later diagnosed as suffering from hepatitis B in September; in December, the plaintiff was similarly diagnosed.

The court cited Restatement (Second) of Torts, Section 324A, which provided, in part, that one who provides services to another may be liable to a third person for harm resulting from his failure to exercise reasonable care, if "the harm is suffered because of reliance of the other or the third person upon the undertaking."⁷⁶ The court allowed the action, concluding that the class of persons at risk included any one who is physically intimate with the patient.

When a physician treats a patient who has been exposed to or

74. See case cited *supra* note 38.

75. 583 A.2d 422 (Pa. 1990).

76. *Id.* at 424.

who has contracted a communicable and/or contagious disease, it is imperative that the physician give his or her patient the proper advice about preventing the spread of the disease Physicians are the first line of defense against the spread of communicable diseases, because physicians know what measures must be taken to prevent the infection of others.⁷⁷

Contagious diseases are thus a consistent example of a physician's duty to disclose risk of real or potential harm or protect others who might be exposed to the risks of disease or infection. Physicians are conscripted into rescue; in the court's words, they "are the first line of defense."⁷⁸ Physicians have been held liable for failing to warn the daughter of a patient with scarlet fever, a wife about the danger of infection from a patient's wounds, a neighbor about a patient's smallpox.⁷⁹ Family members are foreseeable third parties, as are neighbors.⁸⁰ *DiMarco* clearly applies to the risk of contagion from the HIV virus, requiring that physicians be aware of the nature of the HIV virus, its modes of transmission, and the kind of counseling that AIDS necessitates.

Another line of cases imposes a duty on a physician to protect unknown third parties against medication side-effects that their patients might experience,⁸¹ and to warn third parties of dangers

77. *Id.* at 424. See also *Shephard v. Redford Community Hospital*, 390 N.W. 2d 239 (Mich. Ct. App. 1986) (holding that a duty was owed to child of carrier of contagious disease to properly warn of the danger of transmitting disease to a child).

78. *Id.*

79. *Lemmon v. Freese*, 210 N.W.2d 576 (Iowa 1973) (epilepsy); and *Jones v. Stanko*, 160 N.E. 456 (Ohio 1928) (smallpox).

80. *Freese v. Lemmon*, 210 N.W. 2d 576 (Iowa 1973) (holding physician may be liable for negligence in not diagnosing epilepsy in patient for injury later caused to third party because of patient's epileptic seizure); *Jones v. Stanko*, 160 N.E. 456 (Ohio 1928) (holding physician liable for failure to warn persons in close proximity to patient that patients has infectious smallpox). See *Skillings v. Allen*, 173 N.W. 663 (N.H. 1919) (physician liable for negligently advising plaintiff's wife that daughter's scarlet fever was not infectious); *Edwards v. Lamb*, 45 A.480 (1899) (surgeon liable for negligently assuring plaintiff that there was no danger of infection when plaintiff assisted surgeon in addressing plaintiff's husband's wound). See generally *Bruce A. McDonald, Ethical Problems for Physicians Raised by AIDS and HIV Infection: Conflicting Legal Obligations of Confidentiality and Disclosure*, 22 U. C. DAVIS L.REV. 557 (1989).

81. *Welke v. Kuzilla*, 375 N.W. 2d 403 (Mich. Ct. App. 1985). *Welke* is part of a line of case law requiring physicians to warn third parties about, or take steps to protect them from, patients who are taking medication. These steps might include warning the patient about the effects of medication, or even refusing to prescribe the medication if the patient might still drive. See *Meyers v. Quesenberry*, 193 Cal. Rptr. 733 (Cal. Ct. App. 1983) (physician failed to warn his patient, a diabetic, of the dangers of driving); *Gooden v. Tips*, 651 S.W.2d 364 (Tex. Ct. App. 1983) (physician failed to warn the patient of the dangers of driving while taking tranquilizers); *Watkins v. United States*, 589 F.2d 214 (5th Cir. 1979) (negligence to prescribe Valium to mentally ill patient); *Freese v. Lemmon*, 210 N.W.2d 576 (Iowa 1973) (doctor found liable for failure to warn the patient about the risk of a sudden seizure, and the

posed by psychiatric patients.⁸²

3. RESCUING PATIENTS FROM DOCTORS: DISCLOSING CONFLICTS OF INTEREST. The limits of a contract model for the doctor-patient relationship are further revealed by duties imposed by the courts to disclose conflicts of interest between the patient's best interests and a physician's interest in fame and fortune. Patients are vulnerable, and this vulnerability imposes on physicians a "trust", a fiduciary obligation justified by the physician's dominant position in the relationship. Economic conflicts of interest have been the focus of recent cases that use fiduciary concepts to define physician duties to disclose possible conflicts of interest or other information important to a patient in assessing physician motivations.

In *Moore v. Regents of the University of California*,⁸³ the plaintiff John Moore (hereinafter Moore) underwent treatment for hairy-cell leukemia at the Medical Center of the University of California at Los Angeles (hereinafter UCLA Medical Center). Moore first visited UCLA Medical Center shortly after he learned that he had hairy-cell leukemia. His physician Dr. Golde hospitalized Moore and withdrew blood and bone marrow aspirate. Dr. Golde failed to disclose his preexisting research and economic interests in the cells before obtaining consent to the medical procedures by which they were extracted. The defendants, including Dr. Golde, were aware that Moore's cell line was of great commercial value.

The court characterized the cause of action as either a breach of fiduciary duty to disclose facts material to a patient's consent, or in the alternative, as the performance of medical procedures without the patient's consent.

[A] physician who treats a patient in whom he also has a research interest has potentially conflicting loyalties. This is because medical treatment decisions are made on the basis of proportionality—weighing the benefits to the patient against the

patient then drove into the plaintiff during a fainting spell); *Kaiser v. Suburban Transport. Sys.*, 398 P.2d 14 (Wash. 1965) *amended*, 401 P.2d 350 (Wash. 1965) (doctor prescribed a drug for a patient, a bus driver, but neglected to tell him that it might make him sleepy; doctor held liable to the bus passengers and other third persons who were harmed when the driver fell asleep at the wheel).

82. *Davis v. Lhim*, 335 N.W.2d 481 (Mich. Ct. App. 1983), *remanded* 422 Mich. 875 (1985) (held that a psychiatrist owes a professional duty of care to those who could be foreseeably injured by his patient). This obligation has first appeared in the psychiatric context, beginning with *Tarasoff v. Regents of the Univ. of Cal.*, 131 Cal. Rptr. 14, 551 P.2d 334 (1976). *See also* *McIntosh v. Milano*, 403 A.2d 500 (N.J. Super 1979); *Hedlund v. Superior Court of Orange County*, 669 P.2d 41 (Cal. 1983); *Lipari v. Sears, Roebuck & Co.*, 497 F.Supp. 185 (D. Neb. 1980).

83. 793 P.2d 479 (Cal. 1990).

risks to the patient . . . [A] physician who adds his own research interests to this balance may be tempted to order a scientifically useful procedure or test that offers marginal, or no, benefits to the patient. The possibility that an interest extraneous to the patient's health has affected the physician's judgment is something that a reasonable patient would want to know in deciding whether to consent to a proposed course of treatment. It is material to the patient's decision and, thus, a prerequisite to *informed consent*.⁸⁴

In *Moore*, the court explicitly used both fiduciary duty and informed consent doctrine in order to impose an obligation on the physicians to disclose their research and economic interests.⁸⁵ The tension in the fiduciary disclosure cases is tangible—a physician must rescue a patient from the physician's own mixed motivations and conflicts of interest between the patient's good and his own. The rescuer and the person posing a danger are folded into the same person.

C. Bribe Rescue

Physicians often seem to need encouragement to be Good Samaritans. Hesitant to force rescue, state legislatures have enacted Good Samaritan Laws to encourage rescue by quieting physician

84. *Id.* at 484.

85. Physicians may at times want to try a new or innovative approach to a patient's problems. In *Estrada v. Jaques*, 321 S.E. 2d 240 (N.C. App. 1984), the plaintiff *Estrada*'s physicians neglected to tell him that the procedure they were trying on him was experimental, an innovation on him that they hoped to study.

The psychology of the doctor-patient relation, and the rewards, financial and professional, attendant upon recognition of experimental success, increase the potential for abuse and strengthen the rationale for uniform disclosure . . . Accordingly, we reaffirm our holding that reasonable standards of informed consent to an experimental procedure require disclosure to the patient that the procedure is experimental.

Id. at 255.

See generally on fiduciary obligations, Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 U. PITT. L. REV. 365 (1990); Marc. A. Rodwin, *Physicians' Conflicts of Interest: The Limitations of Disclosure*, 321 NEW ENG. J. MED. 1405 (1989); Thomas Boyd, *Cost Containment and the Physician's Fiduciary Duty to the Patient*, 39 DEPAUL L. REV. 131 (1989); EDMUND D. PELLEGRINO & DAVID C. THOMASMA, *A PHILOSOPHICAL BASIS OF MEDICAL PRACTICE* 260 (1981); Stephen R. Feldman & Thomas M. Ward, *Psychotherapeutic Injury: Reshaping the Implied Contract as an Alternative to Malpractice*, 58 N.C. L. REV. 63 (1979).

Many of the cases use the language of fiduciary obligations in discussing informed consent. See *Lambert v. Park*, 597 F.2d 236 (10th Cir. 1979) (physician's fiduciary duty is to obtain patient's informed consent); *Ostojic v. Brueckmann*, 405 F.2d 302, 304 (7th Cir. 1968) (existence of physician's fiduciary duty requires full disclosure); *Margaret S. v. Edwards*, 488 F. Supp. 181, 207 (E.D. La. 1980) (holding "informed consent involves the fiduciary nature of the doctor patient-relationship . . .").

anxiety about lawsuits. Forty-nine states and the District of Columbia have adopted Good Samaritan legislation to protect health care professionals who render emergency aid from civil liability for damages for any injury they cause or enhance in rendering such emergency aid.⁸⁶ The statutes take a variety of forms.⁸⁷ Some statutes protect health care professionals, while others protect all Good Samaritans, without regard to their profession.⁸⁸ Some states grant statutory immunity from suit to emergency medical personnel unless gross negligence is shown.⁸⁹ The majority of state statutes exclude medical services rendered in the hospital from the coverage of the statutes, either by excluding emergency services provided in the ordinary course of work or services that doctors render to those with whom they have a doctor-patient relationship or to whom they owe a preexisting duty.⁹⁰ Hospital-based emergency assistance by a physician is often protected, however, where the physician is not on duty at the time of the call for help.⁹¹

The purpose of Good Samaritan statutes is to encourage physicians and other providers to offer emergency aid, by eliminating their largely unfounded fears of malpractice suits for any negligent harm they might cause a victim that they rescue.⁹² This reduced standard of care for medical rescuers strikes a balance between pe-

86. In *McCain v. Batson*, 760 P.2d 725 (Mont. 1988), a physician on vacation sutured a hiker's wound at his condominium, using limited medical supplies on hand. The court held that this was an "emergency" within the meaning of the statute.

87. CAL.BUS. & PROF.CODE § 2395 (West 1990), for example, states, in relevant part, "No licensee, who in good faith renders emergency care at the scene of an emergency, shall be liable for any civil damages as a result of any acts or omissions by such person in rendering the emergency care."

"The scene of an emergency" as used in this section shall include, but not be limited to, the emergency rooms of hospitals in the event of a medical disaster.

88. See, e.g., FLA. STAT. ANN. § 768.13 (West Supp. 1992) ("Any person . . . who gratuitously and in good faith renders emergency care or treatment . . ."); MASS. GEN. LAWS. ANN. ch. 258A § 9 (West 1988) ("No person who in good faith . . ."), OHIO REV. CODE ANN. § 2305.23 (Anderson 1991) ("No person shall be liable . . . for administering emergency care or treatment . . .").

89. *Mallory v. City of Detroit*, 449 N.W.2d 115 (1989) (upholding grant of statutory immunity as long as act or omission of emergency medical personnel is not the result of gross negligence or willful misconduct). See generally W.R. Habeeb, Annotation, *Construction of 'Good Samaritan' Statutes Excusing from Civil Liability One Rendering Care in Emergency*, 39 A.L.R. 3d 222 (1971).

90. *Guerrero v. Copper Queen Hospital*, 537 P.2d 1329, 1331 (Ariz. 1975) (statute not applicable to services in hospital); *Colby v. Schwartz*, 144 Cal. Rptr. 624 (Cal. Ct. App. 1978) (normal course of practice not protected); *Gragg v. Neurological Associates*, 263 S.E.2d 496 (Ga. Ct. App. 1979) (crisis during operating procedure is not emergency within meaning of statute).

91. See *Gordin v. William Beaumont Hospital*, 447 N.W.2d 793 (Mich. Ct. App. 1989).

92. For an interesting discussion of the duty to rescue, see *Saul Levmore, Waiting for*

nalizing the hasty physician caught in an unexpected treatment setting and promoting risk-free additional rescues.⁹³ Some states have gone further by providing indigent care immunities, extending Good Samaritan immunity beyond emergencies to the treatment of the indigent generally, especially Medicaid patients.⁹⁴ Some states have considered implementing tort immunity for physicians who treat the indigent.⁹⁵

II. PHYSICIANS IN INSTITUTIONS: THROWING OUT LIFELINES

Ethical and legal discussions tend to focus on the individual physician and her obligations to her patients, whether by agreement or externally expanded by courts and fiduciary concepts. But most health care is delivered by physicians within institutional frameworks — hospitals, health maintenance organizations (hereinafter HMO), group practices. Physicians who practice in institutions, either as employees or members of the medical staff, must provide health care within the limits of the health plan's coverage or their employment contracts with the institution. In this case, the contact between the physician and the patient is preceded by an express contract spelling out the details of the relationship. Physicians who are members of a health maintenance organization have a duty to treat plan members, as part of their contractual obligation

Rescue: An Essay on the Evolution and Incentive Structure of the Law of Affirmative Obligations, 72 VA. L. REV. 879 (1986).

93. MARSHALL SHAPO, *THE DUTY TO ACT: TORT LAW, POWER, & PUBLIC POLICY* 28 (1977).

94. See American Medical Association, 16 State Health Legislation Report (May 1988). See also ARIZ. REV. STAT. ANN. § 12-571 (1992); FLA. STAT. ANN. § 768.13 (West Supp. 1992); GA. CODE ANN. § 51-1-29 (Michie Supp. 1992); ILL. ANN. STAT. ch. 111, § 4404 (Smith-Hurd 1978); ME REV. STAT. ANN. tit. 24, § 2904 (West 1990); S.C. CODE ANN. § 33-55-210 (Law Co-op. 1977); VA. CODE ANN. §§ 8.01-225 to 8.01-225.1 (Michie 1992).

95. While the threat that a poor patient will sue a physician is quite low, Molly McNulty, *Are Poor Patients Likely to Sue for Malpractice?*, 262 JAMA 1391 (1980); Sara Rosenbaum & Dana Hughes, *The Medical Malpractice Crisis and Poor Women*, in *PRENATAL CARE, REACHING MOTHERS, REACHING INFANTS* (1988), the concept of a mandate for free care at some level in exchange for the tort subsidy is a direct step beyond the Good Samaritan statutes, which simply hope for more provider willingness to help someone in distress in exchange for a qualified immunity from suit. The District of Columbia has amended its Good Samaritan Act to provide immunity for volunteer physicians, nurse-midwives and nurses providing obstetrical care. D.C. CODE ANN. § 2-1345 (Supp. 1992). For a discussion and critique of this act, see generally Bridget A. Burke, *Using Good Samaritan Acts to Provide Access to Health Care for the Poor: A Modest Proposal*, 1 ANNALS HEALTH L. 139 (1992). This emphasis on volunteerism in exchange for tort immunity raises troubling questions. It is not particularly fair to force the indigent as a group to trade off their right to sue, with its deterrence potential in exchange for care.

to the HMO. The express contracts are between the physician and the HMO, and the subscriber and the HMO, with an implied contract between the subscriber and the treating physician.⁹⁶ Members of a hospital staff may also be expressly bound to treat patients, particularly in the emergency room when they are on call.⁹⁷ They have waived their rights to refuse to treat particular patients, as a result of their contractual obligations to the hospital. Contractual obligations flow from the employment setting, binding physicians to treat individual subscribers.⁹⁸ Professional autonomy is traded for the security of income stability.

The traditional malpractice standard of care applies to hospitals and to individual physicians. Malpractice is usually defined as unskillful practice resulting in injury to the patient, a failure to exercise the "required degree of care, skill and diligence" under the circumstances.⁹⁹ A physician is not a guarantor of good results, nor is he required to exercise the highest degree of care possible. However, modern courts grant less leeway to providers than in the past, for example, rejecting "error in judgment" instructions as unduly favorable to defendants.¹⁰⁰

The standard of care by which the conduct of providers is measured is a national one, requiring the provider to render care consistent with a reasonable level of medical skill and knowledge, based on the adept use of available medical facilities and equipment.¹⁰¹ Most courts also allow evidence describing the practice limitations under which the defendant labors.¹⁰²

96. See generally Louis D. Rodgers et. al., *The HMO Contract and Quality of Care*, 78 IOWA MED. 466 (1988); Comment, *Contractual Theories of Recovery in the HMO Provider—Subscriber Relationship: Prospective Litigation for Breach of Contract*, 36 BUFF. L. REV. 119, 124-25 (1987).

97. Hiser, *supra* note 29.

98. The traditional scope of the contractual relationship may even include obligations such as completing benefit forms for a patient. See *Chew v. Meyer*, 527 A.2d 828 (Mich App. 1987) (recognizing a cause of action in negligence where a physician's failure to complete plaintiff's insurance form led to plaintiff losing a job).

99. *Bardessono v. Michels*, 478 P.2d 480, 484 (Cal. 1970) (holding negligence can be found from the fact that the accident itself occurred where an injection renders a patient partially paralyzed).

100. See *Deyo v. Kinley*, 565 A.2d 1286, 1293 (Vt. 1989) (rejecting "error in judgement" instruction in medical malpractice action due to ambiguous language and subjectivity).

101. *Hall v. Hilbun*, 466 So. 2d 856 (S.C. Miss. 1985) (allowing expert testimony from other localities to be entered into the record to help determine national standard in malpractice action).

102. *Id.* at 972. Hall's "resource component" allows the trier of fact to consider the facilities, staff and other equipment available to the practitioner in the institution, following the general rule that courts should take into account the locality, proximity of specialists and special facilities for diagnosis and treatment. See also *Blair v. Eblen*, 461 S.W.2d 370, 373

The law has imposed obligations on physicians, often when they have done something to create reliance or a generalized sense of security.¹⁰³ A judicial move from contract to negligence is typically most evident in emergency settings, particularly in hospitals, as courts search for a nexus between doctor and individual in crisis. A case illustrates the point. In *Noble v. Sartori*,¹⁰⁴ two brothers took their third brother, Amel, who was having a "heart attack", to the emergency room at Knox County General. One brother went to Dr. Sartori, who was dressed "like a doctor" in a white coat, with a stethoscope around his neck. He pleaded with the doctor three times to help his brother. Dr. Sartori did not help, but told him to get in line and sign in. They then left and drove to another hospital; the next day Amel died. Dr. Sartori argued that he had not agreed to treat the patient, so no physician-patient relationship existed. The court noted that it was an emergency situation, the physician was obviously a staff physician, and he told the brother to get in line three times. The court however went beyond this: "[T]he question here becomes whether the actions of the physician were negligent in the circumstances, and if so, whether the jury could infer what he did was a substantial factor contributing to Noble's death."¹⁰⁵ Dr. Sartori was the only doctor on duty who could have handled the problem, and he was available. The court quoted *Rockhill v. Pollard*,¹⁰⁶ to the effect that "a physician who is consulted in an emergency has a duty to respect that interest, at least to the extent of making a good-faith attempt to provide adequate treatment or advice."¹⁰⁷ The court in *Noble* then seemed to define a utilitarian duty to rescue where it was efficient to do so, even if no contract existed

(Ky. Ct. App. 1970) (allowing standard of care to "include elements of locality, availability of facilities, specialization in general practice, proximity of specialist and special facilities as well as other relevant consideration."); Restatement (Second) of Torts, § 299A, Comment g. ("Allowance must be made also for the type of community in which the actor carries on his practice. A country doctor cannot be expected to have the equipment, facilities, experience, knowledge or opportunity to obtain it, afforded him by a large city.")

103. See Shapo, *supra* note 103, at pt. 1 (discussing methods by which a power holder may engender reliance on the part of the injured party).

Often the solution for a particular case will depend principally on the fact that a power holder already has done something in a way that engenders reliance on the part of the injured party or has created a generalized sense of security with reference to the latter's physical integrity.

Id. at 4.

104. 799 S.W.2d 8 (Ky. 1990).

105. *Id.* at 4.

106. 485 P.2d 28 (Or. 1971) (holding that in order to ensure physician liability, plaintiff must show physician's conduct was outrageous in the extreme and that he suffered emotional distress as a result).

107. *Id.* at 63.

or could be constructed: "Thus, although we recognize that in the usual situation a doctor is under no obligation to treat a person, we also recognize [that] the law implies a duty wherever circumstances put parties in a relationship to each other where when one acts negligently and it causes injury to the other."¹⁰⁸ This sounds like a judicial summary of a vulnerable plaintiff, susceptible to a physician's failure to act.¹⁰⁹ It was an emergency rescue, and the physician's refusal to act breached his legal obligation to rescue the vulnerable plaintiff. The plaintiffs had expectations as to the doctor's treatment of the ill brother; by agreeing to serve in the hospital emergency room the physician had traded some autonomy for income. The web of obligations entangled Dr. Sartori fairly.

The myth of the independent and freely contracting physician has thus been undermined in many ways. The courts have been willing to stretch contract and fiduciary principles to snag physicians and impose obligations on them. Courts have also imposed duties on physicians to "rescue" patients and third parties—from their own ignorance, from external risks, from the physician's own conflicts of interest.

The complexity of reimbursement under Medicare and Medicaid and the multiple sources of funding for patient care have pushed courts toward imposing new duties to rescue on providers. As physicians increasingly practice within managed care frameworks and under utilization review constraints in hospitals, they have an emerging duty to learn how the reimbursement mechanisms work.

One emerging duty to rescue is the obligation to throw a financial lifeline to a patient. A physician may have a duty to assist patients in obtaining payment for health care.¹¹⁰ This is an obligation of financial rescue, using insider information to open channels of reimbursement for a patient in a crisis. At a minimum, this means that the doctor must be aware of reimbursement constraints so that he can promptly advise the patient or direct him to an appropriate institutional office for further information. Federal and state payment systems are designed to control healthcare cost inflation. Medicare's prospective payment system, the Diagnosis-Related Groups (hereinafter DRG) system, approved in 1982 by Congress,

108. *Noble*, *supra* note 104, at 9-10.

109. See also *Richard v. Adair Hospital Foundation Corp.*, 566 S.W.2d 791 (1978) (examining what constitutes an emergency situation which may render a physician or hospital liable for failing to treat a patient); and *RESTATEMENT (SECOND) OF TORTS* § 323 (1965).

110. See discussion of *Wickline*, *Wilson*, and other case *infra*.

creates a complex administered price system for hospital services.¹¹¹ Many states also have implemented prospective payment hospital reimbursement systems,¹¹² and private insurers are also piggy-backing on the system.¹¹³ Such approaches, aimed at controlling escalating health care costs, create tensions between cost control and quality of care. The pressure is to reduce diagnostic tests, control lengths of stay in hospitals, and trim the fat out of medical practice.¹¹⁴

Physicians have affirmative obligations to treat their patients in conformity with recognized standards of care, to inform them of the risks of treatments, and to advise them of conflicts of interest. But must a physician actively assist a patient in obtaining funding for a procedure that the physician feels is necessary? No court would require a physician to pay out of his own pocket for a treatment that a patient needs—there is no “duty to rescue” in the sense of a physician’s financial obligation to support his patient.¹¹⁵ However, *Wickline* and other cases may support the argument that a physician operating within a reimbursement structure and bureaucracy is expected to be familiar with the mechanisms of payment.

A. The Duty to Understand Reimbursement: *Wickline*

*Wickline v. State*¹¹⁶ considered physician obligations to use their special position to rescue patients from reimbursement limits. The case involved the release of a patient from the hospital post-operatively in less time than the treating physician thought ideal (four

111. See Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 101, 96 Stat. 324, 331 (codified as amended at 26 U.S.C. § 1 (1986)).

112. See generally Furrow, *supra* note 13 at 694-95.

113. Barry R. Furrow, *The Ethics of Cost Containment: Bureaucratic Medicine & the Doctor as Patient Advocate*, NOTRE DAME J. L., ETHICS, & PUB. POL’Y 189 (1988).

114. See William R. Roper, *Balancing Efficiency and Quality—Toward Market-Based Health Care*, 3 NOTRE DAME J. L., ETHICS & PUB. POL’Y 169 (1988) (analyzing the past and future course for Medicare and its effects on health care cost and quality). See generally Barry R. Furrow, *Medical Malpractice and Cost Containment: Tightening the Screws*, 36 CASE W. RES. L. REV. 985 (1986) (proposing four strategies for physician advocacy in refining the beneficence principle in the world of cost containment); Furrow, *The Ethics of Cost-Containment*, *supra* note 113 at 216-17 (1988) (examining the role and benefit of interacting health care cost containment with traditional tort law doctrine).

115. One could argue on this point that the abandonment cases require a direct subsidy by the doctor, in cases where the doctor must continue to treat even though the patient owes the doctor money on a past bill. See *Ricks v. Budge*, *supra* note 49 (holding that it is a question for the jury whether plaintiff suffered damages by a physician’s refusal to continue treatment of plaintiff unless plaintiff satisfied an old account).

116. 228 Cal. Rptr. 661 (Cal. App. Ct. 1986), *published at* 741 P.2d 613 (Cal. 1987) (debating whether the physician or health care payor bears responsibility for allowing a patient to be discharged prematurely).

days instead of eight). The physician had applied for an extension of hospitalization time from Medi-Cal (California's Medicaid program), had been refused, and had not filed an appeal. Dicta in the case suggests that the court expected treating physicians to be aware of the reimbursement structure and to engage in bureaucratic infighting when necessary, exhausting procedural rights when the utilization review process has rejected a recommendation.

The patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the deprivation of such care, including, when appropriate, health care payors . . . [The] physician who complies without protest with the limitations imposed by a third-party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour.¹¹⁷

If further payment was available dependent upon following an appeals procedure, and the provider was ignorant of this procedure, he might be liable for patient harm attributable to his ignorance. If a patient is discharged against the better judgment of a treating physician when reimbursement is denied, he risks liability for malpractice. He has not made a good faith effort to "rescue" the patient from further bad outcomes.

B. Joint Liability for Treatment Denied: *Wilson I*

The case of *Wilson v. Blue Cross of Southern California*¹¹⁸ qualified and limited *Wickline* but also expanded potential liability of outside reviewers. It held that a physician could be jointly and severally liable with a utilization review body for a patient's bad outcome.

Howard Wilson suffered from major depression, drug dependency, and anorexia. He entered College Hospital on March 1, 1983. An Alabama Blue Cross policy which covered Wilson had no provision for concurrent utilization review. In 1983, Alabama Blue Cross had delegated authority to California Blue Cross to do reviews. In 1983 California Blue Cross contracted with Western Medical, a third party utilization review organization, to make determinations of medical necessity. Western applied federal Medicare utilization review standards to private insurance patients. On

117. *Id.* at 670-71.

118. 222 Cal. App. 3d 660 (1990).

March 11, Western Medical decided that Wilson's hospital stay was not justified or approved. Although Dr. Taff, the treating physician, felt that Wilson would require three to four weeks of care. Dr. Taff did not appeal the utilization review determination made by Western Medical. Wilson was discharged, and on March 31 he killed himself. Dr. Taff felt that Wilson would have lived if he had remained in hospital. The court refused to follow the *Wickline* dicta, which had suggested that civil liability for a discharge decision rested solely within the responsibility of a treating physician.¹¹⁹ The court instead applied the test of joint liability for tortious conduct, Restatement (Second) of Torts Section 431: "[An] actor's negligent conduct is legal cause of harm to another if (a) his conduct is a substantial factor in bringing about the harm, and (b) there is no rule of law relieving the actor from liability because of the manner in which his negligence has resulted in harm."¹²⁰ The court concluded that it was a triable issue of material fact as to whether Western's conduct was a substantial factor in causing the suicide.

The relevant points of *Wilson* from the perspective of a duty to rescue analysis are that (1) after denying further payment, the payer or utilization reviewer cannot pass the buck to the treating physician for a discharge decision: they may be jointly liable for a "bad" decision; (2) a doctor does not have to pursue appeal channels if they are not clearly spelled out or well understood; the negative implication is a doctor must appeal if the appeals process is clear.¹²¹

Wilson means that a physician may be held to affirmative obligations to demand further reimbursement for a ready patient.

C. The Duty to Coordinate Financing: *Wilson II*

One ongoing case based in part on an expansive view of physician obligations is *Wilson v. Chesapeake Health Plan, Inc.*¹²² The plaintiff Hugh Wilson, a thirty-one-year-old black employee of the city of Baltimore, developed liver disease. He was a member of a prepaid health plan, the Chesapeake Health Plan, Inc. (Chesapeake). Dr. Cooper, a specialist to whom Wilson was referred by his primary care physician, repeatedly reassured Wilson that a liver transplant would be covered under his HMO coverage.

119. *Wickline*, *supra* note 116, at 672.

120. RESTATEMENT (SECOND) OF TORTS § 431 (1965).

121. The jury in *Wilson II* (see footnote 122) used a clear and convincing standard to reject liability for the utilization review body.

122. Plaintiff's amended complaint, *Wilson v. Chesapeake Health Plan, Inc.*, (4th Cir.) (No. 88019032/CL76201) (complaint is in the possession of the author).

Dr. Cooper made arrangements with Presbyterian Hospital in Pittsburgh, Pennsylvania, to put him on the list of donor liver recipients and to perform the transplant. In August of 1985 Wilson arrived at Presbyterian Hospital. At that time Chesapeake advised the hospital that they were not certain that the plan would cover the transplant. Wilson's admission was delayed, and a demand for full payment was made. Wilson's wife Joyce worked to obtain financing. On August 28, a suitable liver was available but because Mr. Wilson lacked evidence of financial coverage of the procedure, the hospital threw the liver away. Between August 29 and September 4 Wilson deteriorated further. His wife returned to Baltimore to work further on the financing problem, and learned that the Maryland Medical Assistance Program would pay for the procedure once the Wilsons had spent down their savings. During this period a second liver became available, but it was also thrown away. By September 4, Wilson had deteriorated further. On September 5 Joyce Wilson returned to find Wilson in a coma. He died on September 6.

The plaintiffs pleaded a variety of theories. Count 16, Negligence, alleged that Dr. Cooper and the health plan

knew or should have known that staff and resources existed . . . to assist the Wilsons in determining the scope of coverage provided by their HMO, other insurers, and alternative funding sources, but they failed to utilize such resources, alert plaintiffs to the existence of such resources or advise them of the need to identify a funding source.¹²³

The *Wilson II* duty means that providers, including outside specialists, should at a minimum know enough to refer patients to experts with a managed care organization or hospital when they need information as to possible sources of funding for a medically necessary procedure. The bundle of services offered by the health care provider, in these times of limited resources, now includes not only medically correct diagnosis and treatment that complies with the standard of care, but also information as to how to fund such care.

III. INSTITUTIONAL CARE: EXPANDED ACCOUNTABILITY

Hospitals began as the doctor's workshop, little more than a shell within which health care services were provided.¹²⁴ As they

123. *Id.* at 33. This count in the complaint withstood both a motion to dismiss and a motion for summary judgment.

124. ROSEMARY STEVENS, IN SICKNESS AND IN WEALTH: AMERICAN HOSPITALS IN

have grown in complexity, their obligations to patients have also grown. The health care institution provides support, equipment, and administration to physicians, and is, therefore, responsible for sloppy or careful practice within its walls. The notion of a covenant is central to the role of the institution as well as the physician; covenant

reminds the professional community that it is not good enough for the individual doctor to be a good friend or parent to the patient; that it is important also for whole institutions—the hospital, the clinic, the professional group—to keep covenant with those who seek their assistance and sanctuary. Thus the concept permits a certain broadening of accountability beyond personal agency.¹²⁵

A. The Expansion of Tort Duties

Hospitals have a duty to provide adequate staff and services to deal with expected medical problems.¹²⁶ Hospitals, like physicians, are expected to keep up with with an evolving standard of medical practice. In *Washington v. Washington Hospital Center*,¹²⁷ the court considered whether the defendant hospital should have had end-tidal carbon dioxide monitors in place in 1987. This was a new technology that many hospitals had installed by 1986. The defendant hospital argued that use by teaching hospitals was not a fair standard of care, since “[i]nstitutions with significantly enhanced financial resources and/or government grants which accelerate their testing and implementation of new and improved technologies would naturally have available to them items which, inherently, were not yet required for the general populace of hospitals.”¹²⁸ The court rejected the argument, noting the effectiveness of the new technology and its relatively low cost.

The failure of a hospital to maintain adequate services to deal with medical emergencies can create liability.¹²⁹ Hospital responsibility goes beyond supplying up-to-date equipment. The power of

THE TWENTIETH CENTURY (1989); PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982); CHARLES E. ROSENBERG, *THE CARE OF STRANGERS: THE RISE OF AMERICA'S HOSPITAL SYSTEM* (1987).

125. May, *supra* note 63, at 36.

126. *Douglas v. Freeman*, 814 P.2d 1160 (Wash. 1991) (recognizing hospital has duty to provide necessary medical hospital assistance to a doctor and to supervise all those who practice medicine within its facilities).

127. 579 A.2d 177 (D.C. Cir. 1990).

128. *Id.* at 183, n.5.

129. See *Herrington v. Miller*, 883 F.2d 411 (5th Cir. 1989) (failure to provide adequate 24-hour anesthesia service).

the institution in managing hundreds of personnel and setting up systems for smooth operation has led to judicial recognition of a duty to design proper systems. For example, institutional providers are increasingly expected to implement protocols that address difficult treatment and ethical issues.¹³⁰ Doctors have often used such protocols to guide nurses in decisionmaking in their absence,¹³¹ and such protocols are used to guide physician performance.¹³² Standardized approaches to a particular clinical or treatment problem or approach are manifested in a health care institution through written policies, bylaws, personnel directives, or educational programs.¹³³ Internal manuals, including emergency room policy and procedure manuals, are admissible at trial when they contain information concerning general industry standards or evidence that an institutional defendant violated its own policy. Liability will result from institutional failure to study and take action, rather than from action that, although reasonable when implemented, later proves to be ineffective. Florida, for example, has incorporated by statute "institutional liability" or "corporate negligence" in its regulation of hospitals. Hospitals and other providers will be liable for injuries caused by inadequacies in the internal programs that are mandated by the statute.¹³⁴

A hospital and its contracting physicians may be liable for damages caused by defects in systems they develop and implement. In the Florida case of *Marks v. Mandel*,¹³⁵ the plaintiff brought a wrongful death action against the hospital, alleging negligence and failure of the on-call system to produce a thoracic surgeon and fail-

130. An algorithm or protocol is "a set of instructions that describes how a patient who comes with a given set of signs or symptoms should be managed, step by step, so that the findings at each step influence which next step is to be taken, until the patient is successfully diagnosed and treated." AVEDIS DONABEDIAN, *THE METHODS AND FINDINGS OF QUALITY ASSESSMENT AND MONITORING* 38 (1985) (Vol. III of AVEDIS DONABEDIAN, *EXPLORATIONS IN QUALITY ASSESSMENT AND MONITORING*).

131. See *Hall v. Hilbun*, 466 So. 2d 856 (Miss. 1985) (stating the real negligence of Dr. Hilbun, according to the plaintiff's expert from the Cleveland Clinic, was that he failed to leave detailed protocols for the nursing staff describing what danger signs to watch out for post-operatively).

132. Clinical algorithms have been converted to protocol charts and computerized algorithms that both define clearly how the clinician should make a decision and provide him with appropriate feedback." Margolis, *Uses of Clinical Algorithms*, 249 JAMA, 627, 629 (1983).

133. For a study of unjustifiable costs using such algorithmic criteria as a quality audit, see Michael P. Corder et. al., *A Financial Analysis of Hodgkin Lymphoma Staging* 71 AM. J. PUB. HEALTH 376 (1981). For a lawyer's discussion of protocols in the hospital, see Barbara R. Pankau, *AIDS: Responding to the Issues*, 3 HEALTH LAW. 1, 10 (1987).

134. FLA. STAT. ANN. § 768.60 (West 1986).

135. 477 So. 2d 1036 (Fla. 1985).

ure of the hospital staff to send the patient to a hospital with a trauma center. The Florida Supreme Court held that the trial court erred in excluding from evidence the hospital's emergency room policy and procedure manual. This manual set out in detail how the on-call system should operate and itemized procedures for responding to calls made from ambulances. The court held that evidence was sufficient to go to the jury on the issue of liability of the hospital and the emergency room supervisor for the failure of the on-call system to produce a thoracic surgeon in a timely fashion.

Support systems must also be adequate to handle the range of problems the hospital purports to treat. Short staffing has thus been rejected as a defense where the available staff could have been juggled to achieve closer supervision of a problem patient.¹³⁶ Courts are less tolerant of excuses for failures by institutions when patient injury results. Institutions must run a well-managed system of care.

The fundamental principle of agency law is vicarious liability, i.e., the master (employer) is responsible for the torts of his servant (employee) even though the master was not negligent. It is a nonfault rule of liability. In the medical setting, physicians have traditionally been treated as independent contractors rather than employees; as a result, the hospital is relieved of any agency-based liability for their negligent acts. As the courts have considered the range of situations in which physicians provide care in the hospital setting, they have extended agency principles to limit the independent contractor defense and thereby circumvent vicarious liability limitations.¹³⁷ An expanded notion of accountability is apparent in the judicial treatment of agency law and independent contractor defenses.

The control test was first used by the courts to test whether the doctor was an employee or subject to the control of the hospital. The courts apply a number of standard criteria for evaluating the existence of a master-servant relationship. If the contract gives the hospital substantial control over the doctor's choice of patients or if the hospital furnishes equipment, then an master-servant relation-

136. *Horton v. Niagara Falls Memorial Medical Ctr.*, 51 A.D.2d 152 (N.Y. Sup. Ct. 1976) (holding hospital guilty of negligence in connection with a patient's fall from window where hospital could have but failed to provide continuous supervision for the short time before patient's mother-in-law arrived).

137. See generally ARTHUR F. SOUTHWICK, *THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION*, ch. XIV (2d ed. 1988); Note, *Theories for Imposing Liability Upon Hospitals for Medical Malpractice: Ostensible Agency and Corporate Liability*, 11 WM. MITCHELL L. REV. 561 (1985).

ship can be found.¹³⁸ The control test looks to the terms of the contract and the actual relationship between the hospital and the physician.

The inherent function test takes the inquiry one step further, looking at those functions of a hospital which are essential to its operation. Radiology labs and emergency rooms are two such functions.¹³⁹ This notion of "inherent function" overlaps substantially with the "non-delegable duty" rule in agency law, as expressed in corporate negligence cases. Where a function is considered to be an inherent part of the functioning of the health care institution, the courts have held that the institution cannot escape liability because of the status of the physician. Vicarious liability applies in spite of a physician's independent contractor status.

The ostensible agency or apparent authority test is also commonly used to channel liability from the negligent physician to the health care institution. In some settings, such as the emergency room or the radiology laboratory, the institution is held to offer services to the patient through a doctor, even though the doctor who renders the service is not an employee. The ostensible agency or apparent authority test then looks to the patient and his expectations as to treatment.¹⁴⁰ Several jurisdictions have allowed cases to

138. The caselaw reflects divergent applications of the "control" test, because of the breadth of the factors involved. See *Mduba v. Benedictine Hospital*, 52 A.D.2d 450 (N.Y. 1976) (doctor failed to give blood to patient, resulting in his death; hospital in the contract between doctor and hospital had guaranteed doctor's salary and controlled his activities. Court held doctor to be an employee); *Kober v. Stewart*, 417 P.2d 476 (Mont. 1966) (finding contract establishes the method by which hospital hired a doctor as supervisor).

139. See, e.g., *Adamski v. Tacoma Gen. Hosp.*, 579 P.2d 970 (Wash. Ct. App. 1978).

140. See, e.g., *Porter v. Sisters of St. Mary*, 756 F.2d 669 (8th Cir. 1985) (holding the plaintiff failed to prove, under RESTATEMENT (SECOND) OF AGENCY § 267, that he relied upon representations that the physician was an agent of the hospital). When the plaintiff entered the emergency room with a collapsed lung, an employee of the hospital said that he had called Dr. Schneider, "... and he's our best person for the job." The court held that statement was insufficient to satisfy the requirements to prove apparent authority because plaintiff had then deliberated for several days before selecting Dr. Schneider to perform further surgery which gave rise to his injuries.

Apparent authority is governed by two alternative Restatement Sections. RESTATEMENT (SECOND) OF AGENCY § 267 provides:

One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.

RESTATEMENT (SECOND) OF TORTS § 429 (1965) provides:

One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.

proceed past summary judgment motions, or to go to the jury, on agency-based theories of ostensible agency or apparent authority. The courts use agency principles to hold a hospital liable for negligent acts of independent contractors such as radiologists or emergency room physicians. Hospitals have thus been held liable for the acts of radiologists, residents, emergency room physicians, and surgeons, even though these persons were not hospital employees.¹⁴¹ Courts hold hospitals liable for the malpractice of their independent contractor physicians where there is evidence that the hospital allowed or encouraged patients to believe that the physicians were authorized agents of the hospital.

Other institutional forms have developed over the past decade. Managed care networks are one example. Squeezed by reimbursement limitations and rising health care costs, employers and medical providers have turned to managed care to control costs. The Director of the Federation of American Health Systems, Michael Bromberg, describes managed care as "the hottest growth area in health care delivery today."¹⁴² In one decade, the change from fee-for-service care to managed care has become a stampede.¹⁴³ Health care is increasingly delivered through large managed care systems, with health maintenance organizations and preferred provider organizations (hereinafter PPOs) growing rapidly. About 60% of the

141. The number of courts that have adopted exceptions to vicarious liability, including ostensible agency, include *Shepard v. Sisters of Providence*, 750 P.2d 500 (Or. Ct. App. 1988) (resident clothed in ostensible authority when he assisted private surgeon in an operation with a private patient, in the hospital); *Pamperin v. Trinity Memorial Hospital*, 423 N.W.2d 848 (Wisc. 1988) (radiologists); *Thompson v. Nason Hospital*, 535 A.2d 1177 (Pa. Super Ct. 1988) (surgeons); *Richmond County Hospital Authority v. Brown*, 361 S.E.2d 164 (Ga. 1987) (holding hospital liable for emergency room physicians under doctrine of ostensible or apparent authority); *Martell v. St. Charles Hospital*, 523 N.Y.S. 2d 342 (N.Y. Sup. Ct.) (holding hospital vicariously liable for emergency room physician's actions even if hospital emergency room where actions occurred was run by an independent contractor); *Strach v. St. John Hospital Assoc.*, 408 N.W.2d 441 (Mich. Ct. App. 1987) (physicians referred to surgery unit as part of hospital's team and surgery team doctors exercised direct authority over hospital employees); *Barrett v. Samaritan Health Services, Inc.*, 735 P.2d 460 (Ariz. Ct. App. 1987) (physician's organization vicariously liable for physician's actions).

142. Michael D. Bromberg, *Managed Care — Who Reviews the Reviewers?* 21 *FED'N AM. HEALTH SYS. REV.*, July/Aug. 1988, at 6; see also Glenn Kramon, *'Managed Care' is Top Plan Now*, N.Y. TIMES, June 14, 1988, at D2, c.1.

143. The escalation in medical spending by both the Medicare program and private health insurers has led to an intensified focus on managing health care costs. Traditional fee-for-service insurance, which pays medical charges without question, has declined sharply over the past few years. For example, Aetna Life and Casualty Company now covers only 22% of the 11 million people covered for health benefits, compared with 64% in 1988. Employees are offered the chance to join an HMO or other discount network more and more frequently. Milt Freudenheim, *Health Insurers' Changing Role*, N.Y. TIMES, Jan. 16, 1990, at D2, c.1.

160 million Americans with employer-sponsored health insurance were enrolled in a managed care plan in 1987; in 1980 only 5 to 10% were enrolled in such plans.¹⁴⁴ HMOs and PPOs (excluding managed fee-for-service plans) enrolled over 27% of employees with group health insurance in 1987. This contrasts with 1981 figures of 4% enrollment.¹⁴⁵

Managed care organizations (hereinafter MCOs) create a new set of relationships between payers, subscribers and providers. These new relationships create new liability risks. The subscriber typically pays his fee to the MCO rather than the provider, giving up control over his treatment and choice of his treating physician. The payer, in turn, shifts some of its financial risk to its approved providers, who must also accept certain controls over their practice. The physician, traditionally the patient's agent and advocate, as a *quid pro quo*, now receives many patients from the payer.¹⁴⁶

Medical practice is therefore firmly embedded within a variety of health care delivery structures. Doctors are affiliated with PPOs or group practices with staff privileges at least at one hospital. The physician without institutional linkages is a fading breed. The logic of institutional responsibility has been readily extended to managed care organizations. The relationship of the MCO to its member physicians is more varied than that of the hospital with its medical staff, and this relationship will determine the source of liability. Staff model HMOs, employing physicians on a salaried basis in its own medical facilities, satisfy the master-servant requirements of agency law. In *Sloan v. Metropolitan Health Council of Indianapolis, Inc.*,¹⁴⁷ the Sloans sued Metro, a health maintenance organization, alleging a negligent failure to diagnose. Metro claimed that its physicians were independent in their practice of medicine, and that Metro did not control their judgment in diagnosis or treatment decisions. It therefore invoked the "corporate practice of medicine"

144. Jon Gabel et. al., *The Changing World of Group Health Insurance*, 7 HEALTH AFF., Summer 1988, at 48, 53.

145. *Id.* at 52. See also Kramon, *supra* note 117.

146. Ernest W. Seward & E.K. Gallagher, *Reflections on Change in Medical Practice: The Current Trend To Large-Scale Medical Organizations*, 250 JAMA 2820 (1983); Starr, *supra* note 124.

Young doctors want to work in these new settings, to gain the advantages of free time and control over work load. One survey found that more than 50% of the young doctors polled preferred a guaranteed salary to traditional fee-for-service compensation, and 81% preferred a group practice or HMO, while just 11% favored solo practice. Physicians want more time for families and personal interests. Ron Winslow, *Debt-Burdened Doctors Seek Financial Security*, WALL ST. J., Oct. 10, 1989, at B1.

147. 516 N.E.2d 1104 (Ind. Ct. App. 1987).

doctrine, which makes it unlawful for a corporation to practice medicine. The defendant argued that a physician may not accept directions in diagnosing and treating ailments from a corporation, and is therefore an independent contractor. The court rejected this defense, finding it to be a "non sequitur to conclude that because a hospital cannot practice medicine or psychiatry, it cannot be liable for the actions of its employed agents and servants who may be so licensed."¹⁴⁸ An HMO, likewise, should not be insulated from liability. The court noted that Metro's staff physicians were under the control of its medical director, a physician, and "[t]he circumstances establish an employment relationship where the employee performed acts within the scope of his employment."¹⁴⁹ Independent practice association (hereinafter IPA) model HMOs that become "the institution", "hold out" the independent contractor as an employee, and restrict provider selection are vulnerable to ostensible agency arguments. The development of complex cost and quality controls, which strengthen the supervisory role of the HMO, together with the managed care industry's preference for the capitation method of physician compensation, are likely to lead the courts to hold the IPA model HMO-physician relationship to respondeat superior liability.

Malpractice cases have also extended the non-delegable duty doctrine of agency law to impose obligations on hospitals as quasi-utilities to maintain responsibility for emergency rooms.¹⁵⁰ In *Jack-*

148. *Id.* at 1108.

149. *Id.* at 1109. In *Schleier v. Kaiser Found. Health Plan*, 876 F.2d 174 (D.C. Cir. 1989) a staff model HMO was held vicariously liable for physician malpractice, not of its employee-physician, but of an independent consulting physician. The court found grounds to hold the HMO vicariously liable: (1) the consultant physician had been engaged by an HMO-employed physician, (2) the HMO had the right to discharge the consultant, (3) services provided by the consultant were part of the regular business of the HMO, and (4) the HMO had some ability to control the consultant's behavior, since he answered to an HMO doctor, the plaintiff's primary care physician. This judicial willingness to impose respondeat superior liability for the negligence of a consulting, non-employee physician clearly applies to the IPA model HMOs and even PPOs. In *Boyd v. Albert Einstein Medical Ctr.*, 547 A.2d 1229 (Pa. Super. Ct. 1988) another ostensible agency case involving an HMO, the court asked whether the HMO through its agents created the appearance that an agency relationship existed between the HMO and the negligent physician; and whether the patient reasonably relied upon the appearance to his detriment or injury.

150. A non-delegable duty is an exception to the rule that an employer is not liable for the negligence of an independent contractor. *W. PAGE KEETON ET. AL., PROSSER AND KEETON ON THE LAW OF TORTS*, § 71, at 511-12 (5th ed. 1984). The court in *Jackson v. Power*, 743 P.2d 1376, 1383 (Alaska 1987) observed that a non-delegable duty analysis is based upon a judicial assessment that "*. . . the responsibility is so important to the community that the employer should not be permitted to transfer it to another.*" *Id.* at 512 (emphasis added). *Accord*, *Alaska Airlines v. Sweat*, 568 P.2d 916, 925-26 (Alaska 1977).

son v. Power,¹⁵¹ the Alaska Supreme Court held that a hospital had a "non-delegable duty to provide non-negligent physician care in its emergency room." It could not shift liability onto independent contractors, once it determined that it had a duty to provide that emergency room care. The hospital, licensed as a "general acute care hospital," was required to comply with state regulations designed to promote "safe and adequate treatment of individuals in hospitals in the interest of public health, safety and welfare," including the provision of a physician at all times to respond to emergencies.¹⁵² It had also voluntarily assumed a broader duty, as a result of its accreditation by the Joint Committee on the Accreditation of Healthcare Organizations (hereinafter JCAHO).

The *Jackson* court analogized hospital emergency services to the operation of an airline. Patients, like passengers, deserve protection. The court then noted the pervasive regulation of the hospital industry in Alaska, as in other states, and the "close parallel between the regulatory scheme of airlines and hospitals. Undoubtedly, the operation of a hospital is one of the most regulated activities in this state." The court gave a number of justifications for its quasi-utility analysis: the implication from pervasive legislative regulation that the hospital is the ultimate repository of responsibility; public expectations of hospitals as responsible for the quality of care rendered by physicians and finally, the commercialization of medicine.¹⁵³

A hospital as a public utility may capture the reality of today's health care system. The health care industry is pervasively regulated, particularly by the federal government. Health care generally is viewed as an inappropriate industry for free market principles. Health care at least in the emergency room in a crisis is considered a necessity by most people, an expectation created by hospitals over the years.¹⁵⁴ The halo effect of nonprofit status, and

151. 743 P.2d 1376, 1377 (Alaska 1987).

152. *Id.* at 1382.

153. *Jackson*, *supra* note 151. Not all courts have found the *Jackson* position compatible. The application of the non-delegable duty doctrine to hospitals was rejected in *Estates of Milliron v. Francke*, 793 P.2d 824, 827-28 (Mo. 1990) (distinguishing *Jackson* since it involved radiology, not emergency room practice) and *Albain v. Flower Hosp.*, 553 N.E.2d 1038 (Ohio 1990) (noting that the normal application of nondelegable duty doctrine is premised on peculiar risks and special precautions attendant to the work itself, "The practice of medicine in a hospital by an independent physician with staff privileges does not involve the type of risks and precautions required . . .") *Id.* at 1048.

154. For an intriguing discussion of the role of expectations in generating claims, see Leslie Pickering Francis, *Consumer Expectations and Access to Health Care*, 140 U. Pa. L. Rev. 1881 (1992). Francis argues that expectations are based on beliefs about the future. The

the willingness of hospital administrators to draw on this line of credit in their marketing, supports obligations derived from public expectations as to emergency care.¹⁵⁵ Given the extent of government regulation and the special status of health care, the argument that hospitals approach the status of public utilities is a supportable position.¹⁵⁶ It justifies imposing rescue obligations on institutions, and requires that they meet a heavy burden of proof to avoid responsibility for such care.

B. Hospitals and Indigent Care: From Charity to Obligation

Hospitals and other institutions have extensive obligations to properly treat their patients, once they enter the hospital. But what are the obligations of institutions to "rescue" distressed individuals who present themselves at the hospital door? Emergency rooms are a visible combat zone in the American health care system—overburdened, understaffed and underfinanced. They have become the gateway to the health care system for the uninsured and the indigent, a safety net of last resort to replace the shrinking government net.¹⁵⁷ Yet trauma centers and emergency rooms have been eliminated in the past few years to stem financial losses.¹⁵⁸ From

more unreasonable the beliefs, the less moral weight they carry, and context determines the reasonableness of the beliefs.

Francis proposes "encouragement" as a second feature of expectations that deserve moral weight. "Without the acknowledgement that it is sometimes reasonable to rely on assurances that expectations will be fulfilled, much planning would be undercut." *Id.* at 1892.

155. The mission of a hospital, and its projection to the community at large, creates expectations. "Voluntarism, community, and cooperation are potent values for hospitals, which deliver care. Hospitals sit in one place and render intimate, caring human services to people who often feel a personal identification with the institutions' histories, staffs, and corporate identities. None of this applies to health insurance, whose tasks are actuarial, technical, impersonal, and bureaucratic." Laurence D. Brown, *Capture and Culture: Organizational Identity in New York Blue Cross*, 16 J. HEALTH POL. POL'Y & L. 651, 669 (1991).

156. See William F. Corley, *Hospitals as a Public Utility: or "Work with Us Now or Work for Us Later*, 2 J. HEALTH POL. POL'Y & L. 304 (1978); A.J. Priest, *Possible Adaptation of Public Utility Concepts in the Health Care Field*, 35 L. & CONTEMP. PROB. 839 (1970).

157. Robert Stern et. al., *The Emergency Department as a Pathway to Admission for Poor and High-Cost Patients*, 266 JAMA 2238, 2243 (1991):

In summary, our study has shown that certain patient groups often thought to be disadvantaged — the elderly, nonwhites, the poor — are more likely than other patient groups to be admitted through the emergency department, and admission through the emergency department is associated with higher costs of care Some system to compensate hospitals for these additional costs may be worthwhile to preserve access to care for disadvantaged patients and to ensure the financial viability of institutions that serve the disadvantaged.

158. Melinda Bech et. al., *State of Emergency: Hospitals are seeking radical solutions to ease walk-in patient overload*, NEWSWEEK, Oct. 14, 1991 at 52 (discussing the means hospitals have pursued to deal with the walk-in overload).

the hospital's viewpoint, undesirable patients enter through the emergency room, stressing hospital budgets.¹⁵⁹ The goal has often been to transfer them as soon as possible to public hospitals. Where treatment is given, hospitals tend to undertreat patients if their insurance coverage is inadequate.¹⁶⁰ A 1988 study of a publicly subsidized hospital in Memphis found that during one 92-day study, private hospitals made 190 requests to transfer patients to the public facility. Almost all patients transferred (91%) were sent for primarily economic reasons. One fourth of these patients were unstable, according to explicit clinical criteria, upon arrival at the public hospital.¹⁶¹ But most hospitals are still trying to reduce bad debts by avoiding nonpaying patients.¹⁶²

1. SOURCES OF OBLIGATIONS TO RENDER CARE. The sources and limits of obligations on hospitals to render emergency care have

159. James M. Perrin, *High Technology and Uncompensated Hospital Care* in UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES (Frank Sloan et. al., eds., 1986).

Much uncompensated hospital care does not involve high-technology services. Nevertheless, a sizeable proportion does arise from the intensive care of sick and premature newborns, accident victims, and people suffering from certain malignancies. In one private academic teaching hospital, newborn care accounts for almost 25 percent of uncompensated care.

Id. at 70.

160. Paula A. Braveman et. al., *Differences in Hospital Resource Allocation Among Sick Newborns According to Insurance Coverage*, 266 JAMA 3300 (1991). The study examined the relationship between health insurance coverage and utilization of hospital inpatient services by sick newborns. It concluded that similar pressures were found on providers across all hospital ownership types.

The observed pattern of hospital resource suggests strongly that allocation of hospital services to sick newborns was influenced significantly by expected reimbursement rather than determined strictly by medical need.

Id. at 3307.

Comparisons between newborns without insurance and those with prepaid private coverage also contribute to the ability of this study to indicate the far greater likelihood of too little care for some groups than too much care for others. It is known that care provided in the first days of life can have a significant impact on a high-risk newborn's chances for long-term survival and optimal health and development. The concept of equity suggests that treatment provided to sick newborns should be based on clinical criteria alone. *The finding of allocation of fewer hospital services to vulnerable groups likely to be at higher risk during the first days of life constitutes prima facie evidence of serious inequity and suggests the need for intensive and systematic public surveillance of the pressures on institutions, providers, and patients under current health care financing systems.* (emphasis added)

Id. at 3308.

161. See Arthur L. Kellerman & Bela B. Hackman, *Emergency Department Patient 'Dumping': An Analysis of Interhospital Transfers to the Regional Medical Center at Memphis, Tennessee*, 78 AM. J. PUB. HEALTH 1287 (1988). See also Robert L. Schiff et al., *Transfer to a Public Hospital: A Prospective Study of 467 Patients*, 314 NEW ENG. J. MED. 552 (1986).

162. See George J. Annas, *Your Money or Your Life: 'Dumping' Uninsured Patients from Hospital Emergency Wards*, 76 AM. J. PUB. HEALTH 74 (1986).

been well described by other commentators.¹⁶³ The Joint Commission on Accreditation of Healthcare Organizations' *Accreditation Manual for Hospitals* states: "Unless extenuating circumstances are documented in the patient's record, no patient is arbitrarily transferred to another hospital if the hospital where he is initially seen has the means for providing adequate care."¹⁶⁴

State courts have developed common law doctrinal bases for a duty on hospitals to care for patients who could not pay, but the duty has not been contagious.¹⁶⁵ A hospital's emergency department is presumed to have a duty to provide care to all who seek it.¹⁶⁶ Courts have adopted a number of different strategies to this end. They have stretched the facts to find an admission, so that the doctor-patient relationship exists.¹⁶⁷ A nurse who examines a patient and calls a doctor has thus created a provider-patient relationship with a facility.¹⁶⁸ A second strategy has been to find a duty to treat based on public reliance or established custom.¹⁶⁹ This approach has not found much support, and raises difficult issues regarding the definition of "emergency" and the nature and extent of care to be provided.¹⁷⁰ A third approach, one that the Alaska Supreme Court in *Jackson* articulated in its vicarious liability analy-

163. Karen H. Rothenberg, *Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care*, 26 HOUS. L. REV. 21 (1989).

164. JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, AMH ACCREDITATION MANUAL FOR HOSPITALS § 1.33 (1990).

165. *Wilmington Gen. Hospital v. Manlove*, 174 A.2d 135 (Del. 1961) (finding that where a hospital refuses service to a patient in case of an unmistakable emergency, liability is on the hospital if the patient has relied on a well-established custom of the hospital to render aid in such a case).

166. J. Koeze, *Access to Treatment*, in HEALTHCARE FACILITIES LAW: CRITICAL ISSUES FOR HOSPITALS, HMOs, AND EXTENDED CARE FACILITIES § 6.2.1, 424 (Anne M. Dellinger ed., 1991).

167. See discussion of *Noble v. Sartori*, text at § II.

168. *O'Neill v. Montefiore Hosp.*, (N.Y. App. Div. 1960) (reversing a lower court decision to dismiss the case in favor of the hospital where the plaintiff's proof was sufficient to permit the inference that the nurse in charge of the emergency ward undertook to provide medical attention for the deceased).

169. *Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 135 (Del. 1961) (holding private hospital may be liable for refusal of service to a patient in case of emergency if the patient has relied upon a well-established custom of the hospital to render care in such a case) is the leading case for a reliance approach. See also *Williams v. Hospital Auth. of Hall County*, 168 S.E.2d 336 (Ga. Ct. App. 1969) (holding public hospital which assumes the duty of furnishing emergency first-aid facilities to injured persons cannot arbitrarily refuse its facilities to a member of the public in need of such treatment); *Mercy Medical Ctr. of Oshkosh v. Winnebago County*, 206 N.W.2d 198 (Wis. 1973) (discussing the social policy that private hospitals with emergency rooms have a duty to admit those in need of such service because the public expects such service).

170. *Supra*, note 139, at 425-27.

sis, is to hold hospitals to be public utilities, with a fiduciary duty owed to the public for emergency care.¹⁷¹

State and federal legislation has reduced the significance of common law duties by offering explicit mandates for emergency care.¹⁷² The most powerful current statutory source of obligations is The Consolidated Omnibus Budget Reconciliation Act (hereinafter COBRA),¹⁷³ the Emergency Medical Treatment and Women in Active Labor Act, enacted to counter the emerging scandal of patient dumping. It mandates that patients be medically stable for transfer, imposes stiff penalties for inappropriate transfers, and creates a civil cause of action for damages. COBRA has been used to impose sanctions on physicians and hospitals,¹⁷⁴ although it provides statu-

171. See, e.g., *Doe v. Bridgeton Hosp. Assn.*, 366 A.2d 641, 644-646 (N.J. 1976) (holding private, non-profit hospitals could not refuse to permit their facilities to be used for elective abortions during first trimester pregnancy where hospitals had facilities for such abortions and permitted use of facilities for therapeutic abortions), *cert denied*, 433 U.S. 914 (1977); Jeffrey E. Fine, *Opening the Closed Doors: The Duty of Hospitals to Treat Emergency Patients*, 24 WASH. U. J. URB. & CONTEMP. L. 123 (1983).

172. Over twenty states have some kind of regulation or statute that prohibits facilities from denying emergency care based on ability to pay, although remedies are often deficient. See Koeze, *supra* note 166, at 428. See also Dowell, *supra* note 1.

173. Consolidated Omnibus Budget Reconciliation Act, 42 USC § 1395dd (1988) (examination and treatment for emergency medical conditions and women in labor).

174. *Owens v. Nacogdoches County Hospital District*, 741 F. Supp. 1269 (E.D.Tex. 1990):

Plaintiff's [a 16 year old pregnant woman] evidence demonstrates a long-standing pattern of patient dumping, caused by staffing policies that in the opinion of a series of medical experts would inevitably lead to standards of care at Memorial Hospital that patently did not meet state or federal statutory requirements. Bluntly stated, Memorial Hospital has callously and negligently allowed a situation to develop in which all emergency obstetric and gynecological services to indigent patients—an enormous and ever-increasing load—have been left to on-call private physicians like Dr. Thompson, and the dumping of pregnant women has been the inevitable result.

Id. at 1280.

Abercrombie v. Osteopathic Hosp. Founders Ass'n, 950 F.2d 676 (10th Cir. 1991) (sixty-eight-year-old woman with chest pains, went to an Osteopathic, court held that either of the following violations is sufficient because hospital has a strict liability standard to provide screening: (1) hospital must provide a proper screening examination, and/or (2) patient may not be discharged if the emergency medical condition has not stabilized).

Courts split over whether indigency must be established. See *Nichols v. Estabrook, M.D.*, 741 F. Supp. 325 (D.N.H. 1989) (holding liability cannot be based on COBRA, absent allegation by plaintiffs that their financial condition or lack of health insurance contributed to defendant's decision not to treat their son and to send him to another hospital, where family pediatrician would be in attendance). *Contra*, *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037 (D.C. Cir. 1991) (holding act draws no distinction between patients with and without health insurance yet it does not create simply another malpractice cause of action). *Accord*, *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990) (holding act is not limited to indigent or uninsured persons who seek treatment or examination at hospital emergency rooms and hospital met its duty to stabilize patient in emergency room and thus did not violate the act even though patient was misdiagnosed).

tory escape clauses for providers who want to avoid caring for indigents who enter through the emergency room.¹⁷⁵ COBRA has attracted much analysis and worry on the part of providers, given its explicit demand for forced rescue under the specific circumstances of the Act. It is the most recent expression of our political willingness to conscript hospitals to rescue patients they would otherwise try to avoid.

2. **THE TAX COLLECTOR.** Prior to 1950, most nonprofit institutions were donatively supported, providing services that served the public good—they were traditional charities, easily distinguishable from business firms. By 1950, however, hospitals had evolved from donative institutions to commercial nonprofits.¹⁷⁶ With the growth of technological medicine and of health care financing through the Medicare and Medicaid programs,

hospitals have become mainstream service institutions providing medical care on a fee-for-service basis to the public at large, while performing little or no role in subsidizing care for the poor. Nevertheless, seventy-five percent of general hospitals remain nonprofit today, presumably in large part as a consequence of institutional inertia. They are anachronistic and perhaps also a bit opportunistic, continuing to trade on whatever goodwill attaches to the image of a nonprofit organization, and enjoying as well the benefits of tax exemption and other fiscal and regulatory privileges that nonprofit status continues to bring.¹⁷⁷

The tax exemption granted to nonprofit hospitals by the federal, state, and local governments has been a continuing and massive subsidy.¹⁷⁸ Comprising less than 3% of all nonprofit organizations, hospitals account for more than half of nonprofit sector expenditures.¹⁷⁹ But charitable giving to hospitals has dropped considerably since 1968.¹⁸⁰

The federal government, through Internal Revenue Service (hereinafter IRS) tax exemptions for hospitals and other providers,

175. See Rothenberg, *supra* note 164.

176. Henry Hansmann, *The Evolving Law of Nonprofit Organizations: Do Current Trends Make Good Policy?* 39 CASE W. RES. L. REV. 807, 813 (1988-89).

177. *Id.* at 813-14.

178. Hall & Colombo, *supra* note 18, at 314 n.18.

179. JAMES T. BENNETT & THOMAS J. DiLORENZO, UNFAIR COMPETITION: THE PROFITS OF NONPROFITS 73 (1989).

180. The nonprofits have become similar, and one commentator writes that "[b]y the mid-1960s . . . the notion of an institution closely connected to its community seemed like a romantic remnant of a 'pre-scientific' era." David Rosner, *Heterogeneity and Uniformity: Historical Perspectives on the Voluntary Hospital*, in SICKNESS AND IN HEALTH: THE MISSION OF VOLUNTARY HEALTH CARE INSTITUTIONS 122 (1988).

has made health policy by indirection since 1969.¹⁸¹ In that year the IRS ruled that hospitals do not have to provide free or below-cost care to those unable to pay in order to retain their federal charitable tax exemption.¹⁸² This ruling removed an important barrier to "dumping" indigent patients by allowing voluntary nonprofit hospitals to refuse to treat uninsured patients.¹⁸³ The ruling described a hospital which "limits admissions to those who can pay the cost of their hospitalization, either themselves or through private health insurance, or with the aid of the public programs such as Medicare." A hospital is charitable, since "by providing hospital care for all those persons in the community able to pay the cost thereof either directly or through third-party reimbursement, [the] hospital . . . is promoting the health of a class of persons that is broad enough to benefit the community." This explanation left open the argument that a hospital that accepted Medicare and Medicaid patients and had an emergency room open to all was one way to get the exemption, but not the only way. The IRS position, based on a staffer's research, was that Medicare and Medicaid had eliminated the need for free care for patients, and the demand for such care was disappearing.¹⁸⁴

For the next twenty years, the IRS neither clarified nor enforced its rulings.¹⁸⁵ "There is no record of a nonprofit hospital losing its charitable status for turning away patients from its emergency room for inability to pay, for transferring such a patient to a public hospital even though the transfer was medically sound, or for refusing patients enrolled in Medicaid."¹⁸⁶

181. Daniel M. Fox & Daniel C. Schaffer, *Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts*, 16 J. HEALTH POL. POL'Y & L. 251 (1991).

182. Rev. Rul. 69-545, 1969-2 C.B. 117, also released as T.I.R. 1022, dated Oct. 28, 1969.

183. Fox and Schaffer, *supra* note 181, argue that the IRS made policy without admitting it.

In our interpretation of events, the Internal Revenue Service, thinking that it was merely reasoning from legal principles, in effect accepted the hospital industry's view of the history and purpose of hospitals . . . The Internal Revenue Service accepted the hospital industry's argument, to a large extent, as the result of research by a junior member of its staff . . . They accepted without verification that hospitals are primarily places where sophisticated medical procedures are carried out for the benefit of entire communities, most of whose residents had or would shortly have an insurer or public agency willing to pay their bills. In this formulation, an appropriate use of any surplus revenue of nonprofit hospitals would be to purchase new technology rather than to subsidize the cost of care.

Id. at 252-53.

184. *Id.* at 260.

185. UNITED STATES, INTERNAL REVENUE SERVICE, EXEMPT ORGANIZATION HANDBOOK, § 349.2 (May 18, 1988).

186. Fox & Schaffer, *supra* note 181, at 273.

The current IRS stance is intensified scrutiny of not-for-profit hospitals' operations. Hospital audits have stepped up, and the IRS is exploring a "Closing Agreement" policy with facilities, allowing hospitals to keep tax-exempt status while correcting problems.¹⁸⁷

Some states have taken a more aggressive position, administering the exemption on a hospital-specific, annual basis, requiring each hospital to demonstrate yearly its delivery of free care in an increment sufficient to earn the subsidy.¹⁸⁸ Other state taxing authorities have moved aggressively to compel uncompensated care in exchange for tax exemptions of health care providers. The most famous of these actions, in *Utah County v. Intermountain Health Care, Inc.*,¹⁸⁹ required a level of free care beyond that provided by Intermountain, leading to the revocation of their tax-exempt status. Most other states have been satisfied with mere availability of indigent care, without more, while others simply presume that provision of health care is a charitable purpose.¹⁹⁰ Pennsylvania and a few other states have been pockets of aggressive scrutiny of hospitals.¹⁹¹ As the IRS position toughens, the states are more likely to follow suit, in search of revenue, with increased skepticism toward the claims of charity so readily accepted by taxing authorities from hospitals in the past.¹⁹²

187. Jeffrey M. Green, *IRS to explore closing agreement with hospitals*, AHA NEWS, May 4, 1992, at 1; Ron Winslow, *IRS Reviews Nonprofit Hospitals For Abuses of Tax-Exempt Status*, Wall St. J., Apr. 3, 1992, at B1.

188. Hall and Colombo, *supra* note 18, at 325-36. Alabama allows a tax exemption only if the hospital demonstrates that 15% of its business constitutes treatment of charity patients, or free care. Each hospital must certify annually to the tax commissioner that this test is met. ALA. CODE ANN. § 40-9-1(2) to -1(3) (Supp. 1992).

189. 709 P.2d 265 (Utah 1985) (holding that hospital was not exempt from property tax because it did not meet the definition of a charity).

190. See, e.g., *Medical Center Hosp. of Vermont v. City of Burlington*, 566 A.2d 1352 (Vt. 1989) (hospital was not required to prove it dispensed free care; fact that it made health care available was sufficient to allow tax-exempt status).

191. Terese Hudson, *Not-for-profit Hospitals Fight Tax-Exempt Challenges*, HOSPITALS, Oct. 20, 1990, at 32-37.

192. See *Evangelical Lutheran Good Samaritan Soc'y Board of Equalization of Latah County*, 804 P.2d 299 (Idaho 1990) (denying tax-exempt status to independent living facility division of multi-level care facility while granting tax-exempt status to skilled nursing division); *Chicago Health Servs. v. Commissioner of Revenue*, 462 N.W.2d 386 (Minn. 1990) (holding that hospital's auxiliary outpatient facility did not meet the definition of institution of public charity and was not entitled to property tax exemption); *Hospital Utilization Project v. Commonwealth*, 507 Pa. 1, 487 A.2d 1306 (1985) (holding that organization which is a provider of statistical analysis of patient treatment and cost data to hospitals was not a charitable organization and was not exempt from sales and use tax); *Cape Retirement Community, Inc. v. Kuehle*, 798 S.W.2d 201 (Mo. Ct.App. 1990) (holding retirement home was not exempt from taxes because its application procedure did not provide equal access to both rich and poor).

IV. INSURER RESPONSIBILITIES

Experimental treatments that promise rescue from certain death for desperate individuals are often at the heart of insurance litigation. Third party payers often refuse reimbursement of "experimental" treatment under insurance policies covering only "accepted" medical treatments. These disputes raise two issues: (1) Is the treatment in fact experimental? (2) Is it excludable under the policy language?¹⁹³ Distinguishing experimental from accepted treatments is difficult, since medical professionals often disagree. The need to control costs and avoid quack remedies justifies payer sensitivity to wasting resources on useless rescue attempts by providers and patients.¹⁹⁴ However, the history of insurance regulation suggests the need to tip the balance toward subscribers and patients when the therapy has some admitted efficacy.¹⁹⁵ Mandated rescue by insurers through compelled payment of treatment has been achieved by the courts in several cases, where the insurer could not justify its refusals except on the basis of saving money.

Courts interpret ambiguity in favor of subscribers in close cases, demanding coverage exclusions that leave no room for doubt, recognizing the imbalance of power between insurer and insured.¹⁹⁶ Courts require that contracts disclose relevant information and use clear language that the layman can understand. Courts construe

193. Paul J. Molino, *Reimbursement Disputes Involving Experimental Medical Treatment*, 24 J. HEALTH & HOSP. L. 329 (1991); Jennifer Belk, *Undefined Experimental Treatment Exclusions in Health Insurance Contracts: A Proposal for Judicial Response*, 66 WASH. L. REV. 809 (1991); Lee N. Newcomer, *Defining Experimental Therapy — A Third party Payer's Dilemma*, 323 N. ENG. J. MED. 1702 (1990).

194. Grace P. Monaco & Rebecca L. Burke, *Insurer as Gatekeeper — Part Two: Policy Obstacles in Unproven Methods Litigation*, 20 FORUM 400 (1985).

195. See *Reilly v. Blue Cross & Blue Shield United of Wis.*, 846 F.2d 416 (7th Cir. 1988) (holding the coverage denial based on a treatment's success rate of less than 50% may be an unreasonable application of an experimental treatment exclusion); *Doza v. Crum & Forster Ins. Co.*, 716 F. Supp. 131 (D. N.J. 1989) (stating insurer abused its discretion in evaluating a treatment with criteria used to assess whether a treatment was investigational when the contract excluded experimental treatment), *cert. denied*, 488 U.S. 856 (1988).

196. *Baucci v. Blue Cross-Blue Shield of Conn., Inc.*, 764 F. Supp. 728 (D. Conn. 1991) (chemotherapy with autologous bone marrow transplant covered for treatment of breast cancer); *Adams v. Blue Cross/Blue Shield of Md., Inc.*, 757 F. Supp. 661 (D. Md. 1991) (holding if treatment not experimental for other forms of cancer, it is not experimental for breast cancer); *Pirozzi v. Blue Cross-Blue Shield of Va.*, 741 F. Supp. 586 (E.D. Va. 1990) (holding high dose chemotherapy with autologous bone marrow transplant was covered under the specific language of the policy); *Fasio v. Montana Physicians' Serv.*, 553 P.2d 998 (Mont. 1976) (holding treatment prescribed by a licensed physician was covered notwithstanding insured's contention that services performed were "experimental" and "unacceptable medical practice"; also holding that failure to notify plaintiff's of policy change excluding certain types of treatment bars insurer from taking advantage of the exclusion).

coverage clauses broadly and exclusions narrowly.¹⁹⁷ Insurers bemoan the difficulty in drafting adequate exclusions for experimental therapy, since courts subject any restrictive attempts to careful scrutiny. Their concerns may be legitimate, but the courts still demand a fair evaluation of the usefulness of treatments and full disclosure to subscribers of any exclusions. Otherwise, a duty to rescue through reimbursement will be enforced. "Say what you mean, or you pay" is the maxim of contract interpretation in the courts. Contracts, health care advertising, and a past history of insurance coverage create expectations in the public, so insurers cannot get a free ride on those expectations while avoiding responsibility when the bill comes due.¹⁹⁸

The pressure from the courts, through application of rules of contract interpretation in favor of subscribers, has motivated insurers to fund definitive experiments to resolve the issues over accepted versus experimental therapies. Blue Cross and Blue Shield's support for a clinical trial of the drug HDCT-ABMT in the treatment of advanced staged breast cancer is a recent example.¹⁹⁹ The incentive effect of the courts' interpretive rules is evident, driving insurers toward a form of rescue of subscribers by covering experimental therapies that may prolong life, until a clinical resolution of efficacy is established. Insurers are caught in a web of equity issues and can only extricate themselves by proving that the evidence does not justify payment.

V. PROFESSIONAL GROUPINGS AND OBLIGATIONS: MANDATING COORDINATION OF CARE

Physicians as part of a professional group may have an obligation to coordinate care in some fashion for discrete groups of patients in distress. Ethicists often articulate this as a moral obligation, which does not bind any one physician.²⁰⁰ But can it be

197. *McLaughlin v. Connecticut Gen. Life Ins. Co.*, 565 F. Supp. 434, 440 (N. D. Cal. 1983) (holding the proper interpretation of the insurance policy clauses is broad for coverage clauses and narrow for exclusion clauses).

198. See Kenneth S. Abraham, *Judge-Made Law and Judge-Made Insurance: Honoring the Reasonable Expectations of the Insured*, 67 VA. L. REV. 1151, 1192 (1981) (creation by insurers of a misleading impression about coverage explains use by courts of equitable principles to find for insureds).

199. Ron Winslow, *Blue Cross to Help Pay for Clinical Test on Controversial Breast Cancer Therapy*, WALL ST. J., Oct. 30, 1990, at B4, c.1.

200. "[P]rofessionals recognize a responsibility to establish equal opportunity for or equal access to their services . . . This obligation belongs to professions as a whole and cannot be directly reduced to a similar obligation on the part of individual professionals." Bayles, *supra*

a binding legal obligation at the group level, without penalizing any one physician? Patients may be too poor to pay for care, may refuse to comply with a prescribed course of treatment, may have a contagious disease that terrifies the provider,²⁰¹ or may interfere with a provider's care of other patients. Yet they all are patients needing treatment and demanding a Good Samaritan for their rescue. Consider the problem of Brenda Payton. In *Payton v. Weaver*,²⁰² Brenda Payton, a black woman with end stage renal disease, sued her physician to force him to continue treating her. She needed hemodialysis two or three times a week to stay alive. She was a poor woman living on Social Security in a housing project, addicted to heroin and barbiturates for over 15 years, overweight, with emotional, and alcohol problems. Reluctantly, Dr. Weaver finally decided to stop giving her dialysis in his outpatient clinic, since she had failed to abide by the treatment regimen and was sometimes abusive during dialysis when several patients were hooked up to the single dialysis machine. Dr. Weaver finally told Brenda that he could no longer treat her. However, he did supply her with a list of the names and telephone numbers of all dialysis providers in San Francisco and the East Bay.

The court focused on the ability of the patient to control her disruptive conduct. "Absent such control or modification her conduct was of such a nature as to justify respondent hospitals in refusing to permit her access to their facilities. Whatever collective responsibility may exist . . . it is clearly not absolute, or independent of the patients' responsibility."²⁰³

Physicians who refuse to treat a difficult patient can create severe financial and treatment problems for that patient. In another case, a patient, Jeanie Joshua, suffered from kidney disfunction. She suffered further injury when a home dialysis unit malfunctioned. She then sued the physician in charge of her care, the

note 32, at 27. See also Michael D. Bayles, *A Problem of Clean Hands: Refusal to Provide Professional Services*, 5 SOC. THEORY & PRAC. 165-81 (1979).

201. Oscar W. Clarke & Robert B. Conley in *The Duty to 'Attend Upon the Sick'*, 266 JAMA 2876 (1991), express concern about the willingness of doctors to care for patients with AIDS. The First Code of Ethics adopted by the AMA in 1847 defined an ethical duty to treat patients in "times of pestilence". In 1912, the AMA asserted that doctors have the freedom to choose which patients they will serve. In the 1957 Code of Ethics, the duty to treat patients described in 1847 was eliminated. See Walter J. Friedlander, *On the Obligation of Physicians to Treat AIDS: Is There a Historical Basis?* 12 REV. INFECTIOUS DISEASES 191 (1990). See WIS. STAT. ANN. § 146.024 (Supp. 1992) (prohibiting individual health care providers from refusing to treat patients because they have AIDS).

202. 182 Cal. Rptr. 225 (Cal. Ct. App. 1982).

203. *Id.* at 231.

maker of the machine, the home nurse, and others. She was forced to seek conventional dialysis. None of the kidney specialists nor six kidney centers in Santa Barbara and Ventura Counties would accept her for dialysis. She was, therefore, required to drive three times a week to Los Angeles, a round trip of 150 miles.²⁰⁴ The physicians who refused to treat her maintained simply that she was a difficult, noncompliant patient.²⁰⁵

The court in *Payton v. Weaver* noted that health care providers might have to find a way to share the responsibility for difficult patients:

[W]hile disruptive conduct on the part of a patient may constitute good cause for an individual hospital to refuse continued treatment, since it would be unfair to impose serious inconvenience upon a hospital simply because such a patient selected it, it may be that there exists a *collective* responsibility on the part of the providers of scarce health resources in a community, *enforceable through equity* [italics added], to *share* the burden of difficult patients over time, through an appropriately devised contingency plan.²⁰⁶

This novel suggestion rests on a judicial assumption of a legal obligation for providers to treat a patient, thereby sharing the burden. The courts are capable of developing principles of group responsibility, using existing powers in equity. Where a group of providers has a special responsibility to persons with a concrete need for coordinated care, these providers should be able to be obligated to work out among themselves a method for providing that care.²⁰⁷

The government is the best coordinator of any rescue situation involving large numbers. But if the government, i.e., the legislature or the administrative agencies with authority, does not act, can a court exercising its equitable powers, so called "public action" powers, force providers collectively (if they are subject to the courts'

204. Ms. Joshua was quoted as saying, "The tragedy is that I am forced to make this my total preoccupation. When you are left without life support in the area where you live, it takes over your whole life. So granted I'm a big pain in the butt. What's that got to do with denying me life support?" Robert Reinhold, *When Doctors Shun Difficult Patients*, N.Y. Times, Nov. 14, 1988, at A16.

205. *Id.*

206. *Payton*, *supra* note 175, at 230.

207. If A's interests are vulnerable to the actions and choices of a group of individuals, either disjunctively or conjunctively, then that group has a special responsibility, to (a) organize (formally or informally) and (b) implement a scheme for coordinated action by members of the group such that A's interests will be protected as well as they can be by that group, consistently with the group's other responsibilities. Goodin, *supra* note 35, at 136. Goodin further observes that "[t]he more realistic the case, the greater the need for coordination." *Id.* at 137.

powers jurisdictionally) to find a way to treat indigents? Why not derive individual duties from collective duties imposed by the courts, legislature, ethics of professional organizations?

One collective duty that can be found in caselaw is a duty of institutions and groups within institutions to monitor the workings of the scheme to make sure that everyone who is vulnerable is protected. Such groups and their members are occasionally assigned responsibility in cases of failure to rescue. Suppose a patient is left paralyzed through some failure during surgery and no one claims to be able to reconstruct the causal factors that led to the injury. Tort doctrines such as *res ipsa loquitur* reconstruct negligence by dispensing with a plaintiff's need to prove fault of any one particular defendant with specificity.²⁰⁸ This relaxation is based in some situations on assumptions of group responsibility.²⁰⁹ The doctrine of joint and several liability then imposes the obligation to pay the injured patient upon each health care provider causally implicated in the patient's injury.²¹⁰ Hospital corporate negligence has likewise imposed a new burden on hospitals to account for the behavior of physicians and other staff who are purportedly independent contractors.²¹¹ Hospitals have been held to a duty to supervise the medical care given to patients by staff physicians. Providers must detect physician incompetence or take steps to correct problems upon learning information raising concerns of patient risk. Hospitals must have proper procedures developed to detect impostors.²¹² They should also properly restrict the clinical privileges of staff physicians who are incompetent to handle certain procedures; they also need methods to divine a staff doctor's concealment of medical errors.²¹³ A failure to implement proper procedures to detect physi-

208. See generally DAN B. DOBBS, *TORTS AND COMPENSATION: PERSONAL ACCOUNTABILITY AND SOCIAL RESPONSIBILITY FOR INJURY* 173-74 (1985).

209. The classic case recognizing the team practice of medicine in a hospital, and the need for collective responsibility to prevent patient injury is *Ybarra v. Spangard*, 154 P.2d 687 (Cal. 1944) (holding all members of operating room liable for negligence during surgery); see also *Anderson v. Somberg*, 338 A.2d 1 (N.J. 1975) (holding defendant must prove lack of liability in case where foreign object left in patient's body after surgery).

210. As to joint and several liability generally, see W. Prosser & P. Keeton, *Torts* § 50 (5th ed. 1984).

211. For a good description of the justification for corporate negligence on hospitals, with a full citation of cases, see *Pedroza v. Bryant*, 677 P.2d 166 (Wash. 1984).

212. See, e.g., *Insinga v. LaBella*, 543 So. 2d 209 (Fla. 1989) (holding non physician fraudulently obtained an appointment to the medical staff, after having assumed the name of a deceased Italian physician; the court applied corporate negligence, noting that at least seventeen jurisdictions had adopted the doctrine.); *Hendrickson v. Hodkin*, 11 N.E.2d 899 (N.Y. 1937) (hospital held liable for allowing a quack to treat a patient on its premises).

213. See *Cronic v. Doud*, 523 N.E.2d 176 (Ill. App. Ct. 1988) (holding hospital can be

cian problems leads to direct liability for patient injury.

The obligation of a health care institution to protect patients has been considerably expanded by both courts and legislatures. The next step should be to impose upon professional groups a duty to rescue individuals in desperate situations. The AIDS epidemic is one recent example of a crisis that has left many patients without access to health care, as dentists and physicians in some communities have refused patients, or have set up waiting lists to indirectly avoid treating such patients.²¹⁴ Dental and medical associations in such situations have sometimes been slow to react to patient need, in spite of their self-proclaimed ethical obligations. Should not a legal duty be imposed at the professional group level, to find professionals to provide care? Such a duty could be tort- or fiduciary-based, derived from standards set forth in the ethical rules of that association. Ideally, injunctive relief beyond damages would be desirable to motivate proper rescue in such distress circumstances. Or it could be made a condition of licensure, with a system set up that would allow buying out of such service in special cases, so long as coverage was available.

VI. REDRAWING THE MAP

[I]deals of private charity and voluntarism . . . act as the opiate of the American public, deluding a basically decent people into believing that . . . deeply troubling social problems requiring whole dollars for their solution [can] be adequately addressed with just two bits' worth of trickle-down generosity. . . ."²¹⁵

liable for breaching duty to know qualifications and standard of performance of the physicians who practice on its premises); *Corleto v. Shore Memorial Hospital*, 350 A.2d 535 (N.J. Super. Ct. Law Div. 1975) (holding hospital could be held liable to patient for permitting known incompetent physician to perform abdominal surgery and in allowing him to remain on the case when the situation was obviously beyond his control).

Under the Health Care Quality Improvement Act of 1986 (HCQIA), hospitals must check a central registry, a national database maintained by the Unisys Corporation under contract with the Department of Health and Human Services, before a new staff appointment is made. This database contains information on individual physicians who have been disciplined, had malpractice claims filed against them, or had privileges revoked or limited. If the hospital fails to check the registry, it is held constructively to have knowledge of any information it might have gotten from the inquiry.

214. In Wilmington, Delaware, in 1986 and 1987, for example, persons with AIDS (PWAs) were unable to get dental care. Local dentists were unwilling to treat such patients, in spite of the rhetoric of professional dental ethics. Moral suasion was at first unsuccessful, and a legally enforceable duty upon the professional group, to come up with an access solution, would have been extremely valuable.

215. Uwe E. Reinhardt, *Charity at a Price*, N.Y. TIMES BOOK REV., Aug 20, 1989, at 14.

A. The Ideal: Redistribution in the Liberal State

State and federal governments provide direct subsidies through Medicaid, as do some counties and municipalities, for indigent health care. In all but three states, state or local governments are obligated by statute or constitution to provide some medically indigent health care.²¹⁶ The cost totalled 3.9 billion dollars in 1982. Rate regulation at the state level also allows for subsidies for the provision of indigent care. State or county hospitals provided 11.6 billion dollars worth of indigent care in 1988. In other states, general assistance or general relief covers some care, as do Aid to Medically Indigent programs.²¹⁷ Some states have adopted catastrophic illness programs, or risk-sharing pools. For example, Hawaii has required employers to provide employees with insurance. Other states have focused on helping institutions that provide uncompensated care. States with all-payer rate setting systems have managed to permit charge-shifting, or setting up special pools of uncompensated care funds. Other states have tried revenue pools. These efforts are not enough—they are scattered, uncoordinated, unrelated to the distribution of the worst cases, and grossly inefficient.²¹⁸

Mandated care of the indigent has been criticized as inefficient and inequitable. Critics note that choice and access depend upon proximity to providers that offer such care and upon accessing it before the provider has offered all it is required to for that year. If emergency room care is the only way to gain access, patients will use it although ambulatory care would be far more efficient and cost-effective. Mandated care may also impose perverse incentives on providers to simply meet a quota of care, regardless of which patients are in fact the neediest.²¹⁹ Such forced rescue may be attractive to government, allowing it to dodge responsibility, since its cost does not appear as a line item in the budget, and leaves both the revenue side and the expenditure side unaffected.²²⁰ Population

216. See Blendon, *supra* note 12, at 1160. For an example of how such a statute functions, see *Sioux Valley Hosp. Ass'n v. Yankton County*, 424 N.W.2d 379 (S.D. 1988) (county pays for emergency hospitalization of indigent.).

217. State and county hospitals contributed up to \$11.6 billion in 1988. In other states, state general assistance or general relief covers some care, as do Aid to Medically Indigent programs. Michael Dowell, *State and Local Government Legal Responsibilities to Provide Medical Care for the Poor*, 3 J. L. & HEALTH 1 (1988-89). See also Hall & Colombo, *supra* note 18, at 307; Blendon, *supra* note 12.

218. Peter H. Schuck, *Designing Hospital Care Subsidies for the Poor*, in UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 69 (Frank A. Sloan et. al. eds., 1986).

219. *Id.* at 77-78.

220. *Id.* at 78. "Especially in times of budgetary stringency, the temptation to achieve

mobility and competition between states for low tax rates to attract businesses may also have perverse effects upon state level efforts to subsidize the poor.

A national solution to the problem of forced rescue is undoubtedly the best approach, particularly to subsidizing hospital care. Government is a superior mechanism to private charity for collecting and redistributing income to the poor, achieving economies of scale, and lowering overhead.²²¹ Several social programs—Medicare, even Medicaid with its minimum coverage requirements—demonstrate some evidence of a political desire to provide a uniform minimum with respect to health care for the poor.²²² But that desire does not translate into adequate access for many citizens.

B. The Hybrid Ideal: Government Plus Collective Responsibility

A national solution to problems of indigent care in cases of emergency or traumatic injury, while ideal, may come only in a piecemeal fashion. The law should continue to articulate and expand affirmative obligations on health care professionals and their institutions. These role or collective obligations flow from the special power and expertise of health care professionals. Such duties plug the holes in the social net left by deficient social programs and a lack of national or state political will.

Principled justifications for imposing affirmative duties to treat can be derived from many sources. Health care institutions receive large sums of federal money for treating Medicare and Medicaid patients. These sums are conditioned on compliance with a variety of federal obligations. Private parties such as employers, insurers, and other providers also impose contractual demands through their reimbursement agreements.²²³ History plays a part, since hospitals

important social objectives such as subsidization of hospital care for the poor through mandated private expenditures rather than by raising taxes may prove nearly irresistible." *Id.*

221. It's a fine thing that our elected leaders have decided to use the bully pulpit to encourage private charity. As a taxpayer, I don't even mind seeing a few of my dollars going to pay for the propaganda. The trouble is that these same elected leaders have used the same bully pulpit to poison the minds of citizens against the mechanism of selflessness and social generosity that is at these leaders' actual disposal: the government. A free society deciding to tax itself to make itself a better society—that's the real united way.

Michael Kinsley, *Charity Begins With Government*, TIME, Apr. 6, 1992, at 74.

222. *Id.* at 80.

223. It is well accepted that the government may condition the receipt of federal moneys upon reasonable conditions, so long as such conditions are clearly expressed. See *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981) ("... if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously.")

have taken on burdens of care that now can be dropped only with the greatest effort. This is so because of public expectations, created in part by institutions and used by them to their advantage. A concept of stabilized expectations is at the heart of many such affirmative duties. Such expectations as to the availability of rescue allow individuals to exist on a day-to-day basis free of the overriding anxiety that if they are hit by a car, or struck by a catastrophic illness, they are doomed by lack of access to health care. For the poor, a lack of access to health care can reduce life to a desperate Hobbesian terror that the liberal state promised to banish from our conception of a moral Republic.

Expectations evolve as the capabilities of the health care system evolve, so that what was unrealistic, or simply not even contemplated in 1880, is now within the range of the possible. The power of technology can mandate efficient rescue. Given the high costs of accidents, a general legal duty to rescue would save lives and reduce the cost of rescue operations.²²⁴ Relationships also create duties, both through explicit contract terms and implied obligations.²²⁵

Finally, the fundamental nature of powerful institutions with unique access to technologies, personnel, and information creates obligations to treat all patients consistently.²²⁶ In cases involving hospitals the language of the courts is full of the language of power and responsibility, showing a judicial recognition of the resources now commanded by modern health care institutions.²²⁷

The affirmative obligations that this article has either discovered in the legal landscape or argued as desirable can be summed up in four propositions:

1. **Nexus Demands Rescue.** Individual providers face strong claims by patients for care under difficult, quasi- or actual emergency circumstances. When a provider says, "Why me? Why should I be forced to help?", we respond, "You are here and therefore in a position to help this victim. Is there a stronger claim upon you now?"²²⁸ Has the role of physician created a covenant with expectations legitimately felt by the public at large? Is there a nexus

224. See generally Lipkin, *supra* note 55.

225. See Shapo, *supra* note 93, at pt. I and pt. II.

226. *Id.*

227. See *Pedroza v. Bryant*, 677 P.2d 166, 169 (Wash. 1984) (adopting the doctrine of hospital corporate negligence justified by hospitals superior position to control physicians and public's perception of hospital as a "multifaceted health care facility responsible for the quality of medical care and treatment rendered").

228. Goodin, *supra* note 35, at 126, asks this question.

between provider and patient created by the facts of the specific situation?

2. **Institutions Owe Rescue.** Institutional providers are visible emblems of rescue in trauma crises, not easily disengaged once a life in peril presents. As nonprofits are forced into competition to survive with for-profits, outpatient clinics, and franchised operations, they have in many cases narrowed or dropped their traditional offerings of service, while expanding into money-making ventures. The demands of taxing authorities, the mandates of COBRA, and the duties of the common law are useful counterpressures to competitive pressures on hospitals to cut back on indigent care. At the institutional level, the pressures of competition are likely to limit indigent care unless countervailing pressures are created. Institutions are constructs, and the state, through its agents the courts and the legislatures, may reconstitute these constructs in more productive ways.

3. **Coordination of Rescue Should be Fostered.** Collegial and professional groupings have a duty to share and distribute burdens where people are in need of rescue. The covenant binds the group as well as the physician to figure out ways to provide care for those in distress, those who are unpleasant or contagious, those too poor to gain easy access. Hospital collaboration can sometimes be found in sharing emergency cases and providing backups when centers are overloaded. Other institutions have set up primary care clinics to provide alternative services and systems of care,²²⁹ or screening and treatment programs for the homeless.²³⁰ Local professional groups have struggled to find "volunteers" to deal with risky patients. Co-operative efforts occur, but all too rarely. The development of affirmative obligations is a worthwhile project for courts or legislatures, to extract from the professional group a level of rescue that their ethical codes promise but often fail to deliver.

4. The liberal state owes the vulnerable access to necessary care. The rights and privileges of citizenship support a strong argument that government should protect the vulnerable by setting a threshold point of deserved care and funding it fairly.²³¹ Regional planning or state resource reallocation, such as the Oregon Medi-

229. *Id.*

230. Frank Cerne, *California hospital hits the road to care for the homeless*, AHA News, May 4, 1992, at 5.

231. I leave for another discussion the problem of defined "deserved care", and the arguments for and against treating health care as a "right". However, at the level of emergency care, for vulnerable and distressed individuals, a rights-based analysis is easily justifiable.

caid experiment, might distribute certain health care more fairly;²³² access to emergency care, to prenatal and obstetric care, in situations where emergencies can be real and life-threatening, should be assured.²³³ The liberal state has an obligation at a minimum to protect vulnerable citizens from medical emergencies.²³⁴ Rights-based obligations to rescue vulnerable patients in need of care will always be needed in a world of scarce resources. In fairness we can demand that our health care providers fill in the gaps in the reimbursement net where a person will suffer serious harm without rescue.

232. The attempts by the states to better allocate their scarce health resources is chronicled in John J. Kitzhaber & Mark M. Gibson, *The Crisis in Health Care — The Oregon Health Plan as a Strategy for Change*, 3 STAN. L. & POL'Y REV. 64 (1991).

233. For a discussion of the role of the non-poor in welfare and redistribution, with benefits also usually accruing to them, see ROBERT E. GOODIN ET. AL., NOT ONLY THE POOR: THE MIDDLE CLASSES AND THE WELFARE STATE (1987); ROBERT HAVEMAN, STARTING EVEN: AN EQUAL OPPORTUNITY PROGRAM TO COMBAT THE NATION'S NEW POVERTY (1988).

234. See generally ROBERT E. GOODIN, REASONS FOR WELFARE: THE POLITICAL THEORY OF THE WELFARE STATE, (1988). Goodin makes a powerful argument for the welfare state.

We individually and collectively have a strong moral responsibility to protect those whose interests are especially vulnerable to our actions and choices. [It is an adjunct to a market economy.] Both the market and the welfare state aim at essentially the same end, after all. Both are basically mechanisms for promoting public welfare.

Id. at 153-54. He rejects the position that the function of the welfare state is to coordinate people's charitable impulses, that it is primarily "a means of eliminating those individual acts of charity which are designed to mitigate poverty, by centralizing them in the hands of the state." *Id.* at 155, quoting ANDREW SHONFIELD, MODERN CAPITALISM 93 (1965). He notes that charity is not generally susceptible to problems of free-riding, nor does it require public intervention. *Id.* at 157.

The problem that the welfare state is designed to answer, according to Goodin, is the problem of dependency.

