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Granny Dumping: The Hospital's Duty of Care to Patients Who Have Nowhere to Go

Jane Reister Conard[†]

Hospital personnel have coined the term "granny dumping" to describe the newly recognized phenomenon of abandoning the elderly in hospital emergency rooms by frustrated families who, for various reasons, can no longer continue to provide care.¹ Having come into common use in late 1991,² the term "granny dumping" is currently being tracked by the editors of *The American Heritage Dictionary* as a word that may eventually make its way into the dictionary.³ Both the phenomenon and the term seem to be spreading and gaining recognition by the press and the public.

One typical-yet-poignant reported case of granny dumping is that of a woman found sitting in a wheelchair in the Tampa General Hospital Emergency Department.⁴ A note pinned to her said, "She's sick. Please take care of her."⁵ Dr. Toni Mitchell, director of the adult emergency department at Tampa General calls cases such as this one "the positive tail-light sign. They roll them in the door and all I see is the tail-lights vanishing in the distance."⁶ Dr. Jack Allison, president of the American College of Emergency Physicians and chief of services of the Pitt County Memorial Hospital Emergency Department in Greenville, North Carolina, has also dealt with granny dumping. Referring to it as the "packed-suitcase-syndrome," he explains that family members "show up with all of granny's belongings in one or two suitcases and they say, 'Put her in the hospital and take care of her.'"⁷

In rural Newcastle, Wyoming, a family brought their aged mother in a wheelchair to the office of Weston County Memorial Hospital and simply left her there.⁸ The family refused to pick her up, and they refused to cooperate with social service agencies to investigate options for financial support. The hospital, unable to place the woman in another facility, cared for her until her

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1. Sylvia Rubin, *Boomers' Crisis: "Granny Dumping" Sandwich Generation Feeling Overwhelmed*, S.F. CHRON., Nov. 4, 1991, at D3.

2. Annette Soukhanou, *Word/Watch*, ATLANTIC MONTHLY, Apr. 1992, at 119.

3. *Id.*

4. *Elderly Abandoned at Hospitals—"Granny Dumping" is Variation of Baby-on-Doorstep*, CHI. TRIB., Nov. 29, 1991, at 27 [hereinafter *Elderly Abandoned*].

5. *Id.*

6. *Id.*

7. *Id.*

8. *Administrative Ethics in the 1990's: CEO's Confront Payment, Access Dilemmas*, HOSPITALS, Jan. 5, 1992, at 21 [hereinafter *Administrative Ethics*].

death nine months later. The unreimbursed costs of care caused the hospital to show a loss.⁹

For three months during the winter of 1989-1990, Evanston (Wyoming) Regional Medical Center hosted an older, homeless individual who had been one of the passengers on a Greyhound bus that skidded off Interstate 80 during a blizzard.¹⁰ All injured passengers received emergency care at the hospital, and although most were discharged after a short time to resume their journeys, the homeless patient lingered on, refusing to leave a warm bed and three meals a day. The hospital attempted to transfer this patient to a facility offering a lower level of care—more appropriate to the patient's needs—but no facility would accept a non-funded patient.¹¹

In St. George, Utah, the Dixie Regional Medical Center frequently experiences a patient census of 100% during the winter months due to the community's growing popularity as a winter retirement retreat.¹² Despite the hospital board's long-standing, well-publicized policy of reserving beds for those in need of acute-level hospital care and refusing admission to those in need of skilled nursing-level care, the hospital cared for an elderly patient with a chronic terminal disease—admitted through the emergency department at the family's insistence—for over two months in the winter of 1990.¹³ As these examples illustrate, American hospitals often are expected to care for frail elderly people who lack family or other support networks to assist with basic living needs. Because the scope of their duty is so ill-defined, hospitals are forced to retain elderly patients for unnecessarily long periods to the detriment of the institution and other patients with serious medical needs.

This Article will examine briefly the scope of the growing social problem of granny dumping. Next, it will trace the development of the hospital's common law and statutory duties of care to elderly individuals, examining legislative and judicial initiatives and focusing in particular on the extent or end point of the duty of care. Then, the Article will suggest, as a short-term action, a means to delimit the duty of care so that hospitals can avoid becoming the "dumping ground," or social agency of last resort for the elderly who have nowhere else to go. Finally, the Article will discuss possible means of ameliorating the problem of granny dumping through health-care delivery system reforms relating to access to care and reimbursement for care.

9. *Id.*

10. Telephone Interview with Robert Allen, Administrator of Evanston Regional Medical Center, Evanston, Wyoming (Jan. 27, 1992).

11. *Id.*

12. Interview with L. Steven Wilson, Administrator of Dixie Regional Medical Center, St. George, Utah (Jan. 31, 1992).

13. *Id.*

Granny Dumping

I. SCOPE OF THE GRANNY DUMPING PROBLEM

The scope of the granny dumping problem is not well documented; little data has been collected to provide any objective measure of the phenomenon. Until the fall of 1991, when a spate of press reports appeared using the term “granny dumping,” the problem of abandoned elderly in the hospital emergency department was not generally recognized as an issue distinct from the larger problem of people seeking care in hospitals because they have nowhere else to go.¹⁴ While public and community hospitals traditionally have provided charity care to indigent people in need of medical attention, the problem of granny dumping presents a more complex set of issues. In a case of granny dumping, the elder’s needs usually extend beyond medical care to other basic needs such as shelter and assistance with daily life activities. Granny dumping creates a burden for hospitals not only by increasing the amount of economic resources devoted to charity care, but also by extending the scope and complexity of the abandoned patient’s needs.

Some informal surveys suggest that the granny dumping problem is prevalent and growing throughout the United States. In response to its survey, the American College of Emergency Physicians received responses from 169 emergency departments across the country, reporting an average of eight abandonments a week.¹⁵ An extrapolation of this number leads to an estimate of 70,000 granny dumping cases per year. A recent survey by the Senate Aging Committee indicated that 38% of the hospitals responding had received reports of “elder abandonment.”¹⁶

Granny dumping appears to occur more frequently in Florida, California, and Texas, perhaps because of the large retirement communities in the sun belt.¹⁷ Nevertheless, incidents have been reported in Massachusetts¹⁸ and North Carolina¹⁹ as well as in western states such as Wyoming²⁰ and Utah.²¹ The American Association of Retired Persons reports that a small but “rapidly growing number” of elderly are being abandoned at hospital emergency departments.²²

From a societal perspective, granny dumping is symptomatic of overwhelming familial stress. It is frequently a reaction to the burden placed on

14. See Melinda Beck & Jeanne Gordon, *A Dumping Ground for Granny—Weary Families Drop Her in the Emergency Room*, NEWSWEEK, Dec. 23, 1991, at 64.

15. *Elderly Abandoned*, *supra* note 4, at 27.

16. Beck & Gordon, *supra* note 14, at 64.

17. *Elderly Abandoned*, *supra* note 4, at 27.

18. Phil Reaves, *When Granny Becomes Too Much, Just Dump Her; Families Are Leaving Their Cares on Hospital Doorsteps*, THE INDEPENDENT, Jan. 5, 1992, at 18.

19. *Elderly Abandoned*, *supra* note 4, at 27.

20. *Administrative Ethics*, *supra* note 8, at 21.

21. See interviews cited *supra* notes 10, 12.

22. Rubin, *supra* note 1, at D4.

adults who had children late and are caught between two dependent generations: the so-called "sandwich generation."²³ Increased granny dumping can be attributed in part to a lack of resources for geriatric care, such as supervised adult residential care, assisted living arrangements, home health care, or adult day care.²⁴ Because such health-care support resources rarely exist in the sparse continuum of health-care options, people look to the hospital—the most visible and historically most well-established institutional medical provider—for help.²⁵ Pressured family care givers turn to the hospital emergency department looking for a quick solution to relieve their burden and may, in desperation, drop off granny.

More generally, granny dumping is symptomatic of a health-care system in crisis. The American system has been described as "a paradox of excess and deprivation."²⁶ Although the United States spends a greater percentage of its gross national product on health care than any other country—perhaps as much as 15% by the year 2000—more than thirty-five million Americans have no financial protection from the expenses of medical care.²⁷ For those without health-care insurance or for those with limited coverage, the emergency departments of both public and private hospitals become the only point of access to care.²⁸

Perhaps looking for a quick fix, Congress has attempted to legislate solutions to the social problem of access to health care by mandating a duty for hospitals to provide emergency care.²⁹ But, due to ambiguities in the patchwork of federal regulatory schemes affecting hospitals,³⁰ it is the author's contention that hospitals now have the burden of an open-ended duty to provide care for all who seek it, regardless of ability to pay and regardless of the patients' continuing need (or lack thereof) for acute-level hospital care. Consequently, hospitals often are forced to wastefully appropriate their limited resources or risk tremendous exposure to liability.

23. *Id.*

24. *See id.*

25. *See generally* PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 145-79 (1982) (providing a discussion of the history and development of hospitals from almshouses to "centers of active medical treatment").

26. Alain Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990s*, *Universal Health Insurance in a System Designed to Promote Quality and Economy*, *NEW ENG. J. MED.*, Jan. 5, 1989, at 29.

27. *Id.*

28. Peggy McNamara, *New AHA Survey: Emergency Departments in Gridlock*, *HOSPITALS*, Feb. 20, 1992, at 38.

29. *See Consolidated Omnibus Budget Reconciliation Act of 1985*, Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164-67 (1986) [hereinafter *COBRA*] (codified at 42 U.S.C. § 1395dd (1988)).

30. *See, e.g.*, Phillip Green, Note, *COBRA: Another New Patch on an Old Garment*, 33 *ST. LOUIS U. L.J.* 743 (1989) (focusing on the various federal programs that attempt to ensure access to care, including the Hill-Burton Act, Medicare, Medicaid, and *COBRA*).

II. THE HOSPITAL'S ILL-DEFINED DUTY OF CARE

A. Judicial Attempts to Increase Access: Development of a Common Law Duty to Treat

Common law imposes no explicit duty upon physicians or hospitals to rescue or treat those in need of emergency care.³¹ The “no-duty” rule arises from tort theory which distinguishes between nonfeasance and malfeasance.³² Nonfeasance, or failure to provide care, normally will not trigger liability. However, if there is an actual or implied consensual agreement creating a physician/patient relationship, then once treatment has begun, and absent any limiting agreement, the physician/hospital has a duty to continue treatment so long as the case requires attention.³³ The obligation of continuing attention can be terminated in only three ways: by the cessation of the necessity that gave rise to the relationship, by the discharge of the physician by the patient, or by the withdrawal from the case by the physician after giving the patient reasonable notice so as to enable the patient to secure other medical attention.³⁴

Beginning in the 1960s, several state courts began to search for a basis on which to impose a duty on hospitals to provide emergency treatment.³⁵ *Wilmington General Hospital v. Manlove*, one of the first cases to impose such a duty, grounded its holding on a reliance theory, opining that when a hospital customarily renders emergency care service, and such undertaking is relied upon by a person in need of emergency care, then the hospital has a duty to provide such care.³⁶ The *Manlove* decision by the Supreme Court of Delaware has been described as “a turning point in the search for a common-law duty to treat, representing the first time that a court went beyond the constraints of both the traditional tort misfeasance-nonfeasance theory and the requirement of a hospital-patient relationship to find a new basis of liability.”³⁷ Nevertheless, courts did not widely adopt the *Manlove* reliance theory; in fact, by 1989, fewer than twenty-five court decisions had cited the decision and only a few had followed it.³⁸ Difficulties in application and proof of the elements of the *Manlove* theory—e.g., proof of “unmistakable emergency” and “a well-established custom” to render care in such circumstances—may explain

31. Karen H. Rothenberg, *Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care*, 26 HOUS. L. REV. 21, 22 (1989).

32. *Id.*

33. See *Ricks v. Budge*, 64 P.2d 208 (Utah 1937); *Childs v. Weis*, 440 S.W.2d 104 (Tex. Civ. App. 1969).

34. *Ricks*, 64 P.2d at 211-12.

35. Rothenberg, *supra* note 31, at 23.

36. 174 A.2d 135 (Del. 1961).

37. Rothenberg, *supra* note 31, at 36.

38. *Id.* at 38.

the limited following the case has received.³⁹ Although one legal commentator viewed *Manlove* as “a recognition of new public attitudes toward the issues of health, hospitals, and emergency rooms,” and possibly “the first step toward the establishment of health care as a right, legally guaranteed to all Americans,” these great expectations have not been met as other state courts have declined to follow *Manlove*.⁴⁰

In 1975, after rejecting *Manlove* and in search of a different rationale, the Supreme Court of Arizona held in *Guerrero v. Copper Queen Hospital* that it was the “public policy of this state” that a “hospital may not deny emergency care to any patient without cause.”⁴¹ The *Guerrero* court found the public policy in the Arizona health facility licensing laws, which required that hospitals maintain emergency services for the benefit of the public without regard to ability to pay.⁴² Since the duty to treat derived from a statute, the *Guerrero* decision, like *Manlove*, had little direct impact outside the borders of the state where it was decided.⁴³ Whether based on a reliance theory or on licensing statutes, a common law duty of care has not been recognized widely and has met with only limited success in assuring access to emergency care.⁴⁴

In recent years, twenty-one states have enacted statutes similar to that of Arizona. The statutes impose some sort of access to emergency care or prohibit inappropriate transfer of patients—commonly referred to as “dumping”—from private to public hospitals.⁴⁵ Most of these statutes, however, simply state a prohibition against transfer and contain no enforcement provisions.⁴⁶ Furthermore, most of these state laws fail to include a private cause of action allowing an injured individual to sue the hospital for failure to comply.⁴⁷ In the absence of explicit statutory authority, courts are reluctant to create a private cause of action.⁴⁸ Thus, while the beginnings of a duty to treat can be found in limited case law and some state statutes, the duty to treat is not widely or uniformly recognized.

39. *Id.* at 40.

40. *Id.* at 38; Barry Gold, *Emergency Room Medical Treatment: Right or Privilege?*, 36 ALB. L. REV. 526, 535 (1972).

41. 537 P.2d 1329, 1331.

42. Rothenberg, *supra* note 31, at 51.

43. *Id.* at 53.

44. *Id.*

45. See, e.g., CAL. HEALTH & SAFETY CODE § 1317 (West 1990). Twenty-one states have passed laws which attempt to regulate the problem of patient dumping by imposing some type of duty on hospitals. See also James P. McHugh, Note, *Emergency Medical Care for Indigents: All Hospitals Must Provide Stabilizing Treatment or Pay the Price*, 93 W. VA. L. REV. 165, 189 (1990). Eight of these statutes were passed after COBRA was enacted in 1985.

46. McHugh, *supra* note 45, at 190.

47. Rothenberg, *supra* note 31, at 56.

48. *Id.*

Granny Dumping

B. *Congressional Initiatives to Increase Access to Care: Development of a Statutory Duty to Treat*

Simultaneous with the limited development of case and state law to establish a duty to provide emergency care, federal legislative initiatives to increase accessibility to care took effect. Congress developed and passed programs, beginning with the Hill-Burton Act in 1946⁴⁹ through the establishment of Medicare⁵⁰ and Medicaid⁵¹ in 1965, that sought to assure availability of care to the elderly and the indigent. Unfortunately, weaknesses in each statutory scheme have frustrated the goal of guaranteed access to care and, simultaneously, have placed administrative burdens on health-care providers.

More recently, in 1986, Congress passed a new section to the Medicare provisions entitled, "Examination and Treatment for Emergency Medical Conditions and Women in Labor." Established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (effective August 1, 1986), the emergency care requirements have become popularly known as "COBRA."⁵²

Even the explicit duty to provide emergency care which COBRA imposes on hospitals has shortcomings that inhibit realization of access to care. Among other problems, COBRA has created ambiguities and an administrative compliance burden for hospitals. The following sections will examine these statutory initiatives and the subsequent failed attempts of the federal courts to establish a workable legal duty for hospitals in hopes of increasing accessibility to care.

1. *The Hill-Burton Program*

The federal government first established a duty of care for hospitals in the 1946 Hospital Survey and Construction Act, popularly known as the Hill-Burton Act.⁵³ Congress created this program in response to President Truman's call for legislation that would ensure adequate health care for all Americans.⁵⁴ In return for federal assistance for the construction and modernization of hospitals, the recipient facility assumed both the obligation of

49. Hospital Survey and Construction Act, Pub L. No. 79-725, 60 Stat. 1040 (1946) [hereinafter Hill-Burton Act] (codified at 42 U.S.C. §§ 291-291o (1988)).

50. Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a), 79 Stat. 286, 291-332 [hereinafter Medicare] (codified at 42 U.S.C. §§ 1395-1395ccc (1988)).

51. Social Security Amendments of 1965, Pub. L. No. 89-97, §§ 121(a), 79 Stat. 286, 343-53 [hereinafter Medicaid] (codified at 42 U.S.C. §§ 1396-1396s (1988)).

52. COBRA, *supra* note 29.

53. Hill-Burton Act, *supra* note 49.

54. President Truman's Message to Congress on Health Legislation, U. S. CODE CONG. SERV. 1143 (1945).

providing a reasonable volume of services to persons unable to pay and a community service obligation.⁵⁵

The subsequent Hill-Burton regulations (issued from 1947 to 1972) to implement the statutory assurances of uncompensated care and community service, merely tracked the statutory language and did not attempt to quantify or elaborate upon the obligations.⁵⁶ Finally, in 1974, as a result of lawsuits seeking to enforce the Hill-Burton assurances, the Department of Health and Human Services began to issue regulations that set standards for compliance with the statute's goals.⁵⁷

The 1979 regulations set specific charity care amounts, denied credit for any Medicaid "shortfall,"⁵⁸ and prohibited exclusionary admissions policies.⁵⁹ The last provision, relating to admissions policies, attempted to remedy the problem of a lack of physicians with "admitting privileges" who would accept Medicaid patients at a particular hospital.⁶⁰ The regulations suggest various alternatives to hospitals, such as setting up a clinic or otherwise directing patients to Medicaid provider physicians.⁶¹ Nevertheless, the burden of assuring access to care remains with the hospital, which can provide a bed, furnishings, nursing care, and equipment, but cannot supply medical diagnosis, medication, or treatment without a cooperative physician. The statutory scheme unfortunately overlooked an essential element—the physician's involvement—in its encouragement of uncompensated community service. To remedy the oversight, hospitals are required to procure and pay for physician services, if they are needed.

This lack of a physician obligation of care is but one of the weaknesses of the Hill-Burton scheme. Commentators also have criticized Hill-Burton for its failure to define "emergency" in setting forth a duty to provide emergency care; its failure to require states to develop eligibility standards, hospital guidelines, or complaint monitoring systems; its failure to prescribe punitive measures for violations or to establish a private cause of action; and the absence of any requirement to inform potentially eligible patients of free or

55. 42 U.S.C. § 291c(e) (1988).

56. See *American Hosp. Ass'n v. Schweiker*, 721 F.2d 170 (7th Cir. 1983), *cert. denied*, 466 U.S. 958 (1984) (reviewing the legislative intent and regulatory history of the Hill-Burton Act and holding that the 1979 regulations, setting specific, quantifiable charity care compliance levels, were within the Secretary's statutory authority to promulgate regulations).

57. See *Cook v. Ochsner Found. Hosp.*, 61 F.R.D. 354 (E.D. La. 1972) (ordering an injunction requiring the Secretary of the Department of Health and Human Services to effect compliance with the community service obligation and directing the Secretary to take action assuring that Hill-Burton hospitals "terminate their practices and/or policies of excluding substantially all Medicaid beneficiaries").

58. 42 C.F.R. § 124.509(b) (1991). Hospitals are not allowed to credit against the uncompensated care obligation the difference between the cost of care of a patient and the Medicaid reimbursement for such care received by the hospital, which can be substantially less.

59. 42 C.F.R. § 124.603(d) (1991).

60. *American Hosp. Ass'n*, 721 F.2d at 181.

61. 42 C.F.R. § 124.603(d) (1991).

Granny Dumping

below-cost care.⁶² Although *American Hospital Association v. Schweiker* has corrected some of the problems of Hill-Burton by affirming the regulations mandating continuing obligation of community service—including the provision of emergency services without regard to ability to pay (as opposed to the twenty-year limit on the uncompensated care obligations)—so many faults remain that the statute cannot be viewed as a successful health-care access program.⁶³

2. Medicare and Medicaid Programs

In 1965, after much public debate, Congress enacted Medicare as the federal government's health insurance system for the elderly and disabled.⁶⁴ At the same time, Congress established Medicaid, to provide free government health insurance for welfare recipients and certain other indigent groups, to be funded by a combination of federal and state monies.⁶⁵ As initially implemented, Medicare and Medicaid did not impose a duty to provide emergency treatment on hospital and physician providers within the programs. Rather, the legislation aimed to ensure access to care to the elderly and indigent by providing government funds to pay for such care.

Unfortunately, the Medicare and Medicaid programs have not fulfilled the promise of assuring access to health care. Health-care costs skyrocketed during the 1970s and 1980s, with expenditures increasing from 8% of the gross national product to nearly 12%.⁶⁶ Inflation, larger numbers of indigent, an increasingly elderly population, and increased use of health-care services all have contributed to the steep rise in costs.⁶⁷ In response, state Medicaid programs have instituted cost-cutting measures that have reduced eligibility and reimbursement levels. Medicaid covered 70% of the poor in 1965, but by 1984, it covered only 40%.⁶⁸ Similarly, Medicaid programs have dropped their reimbursement levels. In 1989, the national average Medicaid hospital reimbursement was only 78% of Medicaid costs.⁶⁹ As a result, many hospitals have attempted to transfer Medicaid patients to other facilities to avoid the financial shortfall.

62. See, e.g., Karen Treiger, Note, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. REV. 1186, 1199-1200 (1986); Green, *supra* note 30.

63. See Treiger, *supra* note 62, at 1200; Helene Hoffman, *Does COBRA Work? The Problem of Patient Dumping and Possible Solutions*, J. HEALTH & HOSP. L., Jan. 1992, at 3; Rothenberg, *supra* note 31, at 59.

64. Medicare, *supra* note 50.

65. Medicaid, *supra* note 51.

66. Treiger, *supra* note 62, at 1193 n.46.

67. *Id.* at 1192-93.

68. *Id.* at 1194.

69. Hoffman, *supra* note 63, at 11 n.17.

Changes in the Medicare reimbursement system also have created incentives for hospitals to avoid treating indigent Medicare recipients. In 1983, Medicare switched from cost-based reimbursement to a prospective payment system.⁷⁰ Medicare reimburses hospitals a fixed amount for specified illnesses that are categorized by "diagnosis-related groups" (DRG's). Theoretically, an efficient hospital can make money by holding the costs of a patient's care at or below the DRG fixed payment levels. But those hospitals with higher costs due to poor management or a high level of charity care may not be able to cover their costs because of an inability to cost-shift or cross-subsidize indigent care.⁷¹

The net result of the changes, which have reduced eligibility and payment in Medicare and Medicaid, has been to create economic pressures on hospitals that mitigate against voluntary adherence to any implied duty to provide emergency medical care without regard to ability to pay.

3. COBRA

a. *COBRA's Statutory Provisions.* In response to the continuing problem of indigents' access to emergency care, Congress in 1986 enacted the emergency care provision of COBRA, which requires hospitals to provide medical screenings and stabilization of all patients with emergency medical conditions without regard to ability to pay.⁷² The emergency care provision was amended by OBRA in 1989 and 1990 in order to provide effective notice of availability of care, to strengthen documentation requirements, to demonstrate compliance, and to enhance enforcement.⁷³

COBRA applies to any hospital that has a provider agreement with Medicare, which includes almost all hospitals.⁷⁴ It also imposes a duty on any physician who provides on-call services at a hospital that is required to comply with COBRA and who is in a position to examine, treat, or transfer patients protected by the act.⁷⁵

The scope of the duty imposed on the hospital and the physician extends to any individual who comes to the hospital with a medical complaint.⁷⁶ This

70. Social Security Amendments of 1983, Pub. L. No. 98-21, § 601, 97 Stat. 65, 149-63 (codified at 42 U.S.C. § 1395ww (1988)).

71. See Andrew J. McClurg, *Your Money or Your Life: Interpreting the Federal Act Against Patient Dumping*, 24 WAKE FOREST L. REV. 173, 181 (1989); Treiger, *supra* note 62, at 1194.

72. COBRA, *supra* note 29.

73. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106; Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388.

74. COBRA, *supra* note 29. Ninety-eight percent of hospitals are participating providers for patients enrolled in Medicare, according to BUREAU OF MANAGEMENT & STATISTICS, HEALTH CARE FIN. ADMIN., HCFA STATISTICS (1989).

75. 42 U.S.C. § 1395dd(d)(1)(c) (1988).

76. 42 U.S.C. § 1395dd(a) (1988).

Granny Dumping

screening examination to determine the existence of an emergency medical condition may not be delayed to determine the individual's insurance coverage, method of payment, or financial status.⁷⁷

If an emergency medical condition exists, the hospital must either treat the individual so as to stabilize the emergency condition or transfer the patient to another facility or to home following specific requirements.⁷⁸ The statute defines "to stabilize" as the provision of necessary medical treatment to assure that within reasonable medical probability the condition would not materially deteriorate as a result of or during transfer.⁷⁹ It is important to note that "transfer" is defined as the movement or discharge of an individual outside the hospital's facilities at the direction of any person employed by (or affiliated or associated with) the hospital.⁸⁰ This definition sweeps broadly to raise issues of authority to transfer or discharge and the illusion of a guarantee of medical condition post-discharge maintenance. In the landmark *Burditt* case, a federal appeals court discussed the transfer provisions of the COBRA statute and imposed a penalty on a doctor for the first time. The physician, who was on-call to the emergency department by virtue of his obligation under hospital medical staff bylaws, ordered the transfer of a patient contrary to a written, COBRA-based hospital policy provided to him by a nurse.⁸¹ The Fifth Circuit determined that the transfer was inappropriate, and in penalizing both the physician and the hospital, held that because a hospital can act only vicariously through individuals, any COBRA violation by a physician is also a violation by a hospital.⁸² Further, since the definition of "transfer" extends to discharge to the home, the hospital potentially could be liable if a physician discharged a frail elderly person whose condition subsequently deteriorated due to lack of support care at home.

Hospitals may transfer unstable patients in only two situations: either the patient must request a transfer, or the physician must sign a certification which states that she has determined that the medical benefits reasonably expected at the receiving facility outweigh any increased risks to the patient from transfer.⁸³ In addition, the transfer must be an appropriate transfer, and a transfer is appropriate only if a number of conditions are satisfied. First, the emergency department must assure that it has provided, within its capacities, sufficient medical care to reduce risks to the individual. Then, an agreement to accept the transfer patient must be reached with the new facility. This new facility must assure that it has available space and qualified personnel to treat

77. 42 U.S.C. § 1395dd(h) (1988).

78. 42 U.S.C. § 1395dd(b) (1988).

79. 42 U.S.C. § 1395dd(e)(3)(A) (1988).

80. 42 U.S.C. § 1395dd(e)(4) (1988).

81. *Burditt v. Department of Health and Human Serv.*, 934 F.2d 1362, 1366-77 (5th Cir. 1991).

82. *Id.* at 1374.

83. 42 U.S.C. § 1395dd(c)(1) (1988).

the individual to be transferred. The emergency department must then send all available medical records relating the patient's emergency medical condition, including a record of the identity of any physician who was on-call yet refused or failed to appear within a reasonable time to provide stabilizing treatment to the patient. The actual transfer must be accomplished with use of qualified personnel and appropriate transportation equipment, including life support equipment as medically necessary. Finally, other requirements for transfer may be imposed in regulations by the Secretary of Health and Human Services.⁸⁴

These statutory requirements effectively extend the hospital's duty to provide emergency treatment beyond the emergency department both to all physicians who practice in hospitals and to the provision of all medical care necessary to avoid deterioration of the patient's condition. The COBRA amendments, effective July 1, 1990, impose liability on both the hospital and any on-call physician who refuses or fails to appear within a reasonable period of time.⁸⁵ The penalties do not apply to a physician who orders the transfer of a patient because she determines that without the services of the on-call physician the benefits of a transfer outweigh the risks of transfer. As discussed in the *Burditt* case, this provision in effect exposes the hospital to potential liability for the acts of both its agents and independently practicing medical staff physicians through whom it carries out its duties, even if the hospital itself does not knowingly violate the provisions of COBRA.⁸⁶

Subsequent COBRA amendments further broadened the scope of medical treatment the hospital is obligated to provide.⁸⁷ Now, all resources available, including ancillary services routinely available—e.g. diagnostic testing, such as electrocardiograms and diagnostic imaging, computerized tomography, or magnetic resonance imaging—must be accessible and used, as medically indicated, in the medical screening process.⁸⁸ In some cases, the hospital can be obligated to perform a complete diagnostic workup which could extend over a period of days.

Violations of COBRA subject a hospital to severe penalties. COBRA may be enforced by suspension or termination of a hospital's Medicare Provider Participation Agreement and the assessment of penalties by the Health Care Finance Administration (HCFA). Additionally, civil actions can be brought by other facilities that receive an improperly transferred patient or, under state law, by individuals who suffer harm as a result of the hospital's violation of

84. 42 U.S.C. § 1395dd(c)(2) (1988). There are no other requirements imposed by the Secretary at this time because no regulations have been issued.

85. 42 U.S.C. 1395dd(d)(1)(C) (1990).

86. James L. Hall, Jr., *The New Medical Staff: Legal Issues Update, COBRA/OBRA Patient Antidumping*, Address Before the National Health Lawyers Association 15 (Sept. 27, 1991).

87. See COBRA, *supra* note 29.

88. 42 U.S.C. § 1395dd(a) (1988).

Granny Dumping

COBRA.⁸⁹ Both the hospital and responsible physician may be charged a \$50,000 civil penalty for each knowing violation of the statute.⁹⁰ As a result of COBRA, the hospital has been saddled with a substantial, though poorly defined, duty to treat nearly any patient who is left in its emergency department, regardless of the patient's ability to pay or the appropriateness of hospital care for the patient's particular health problem.

b. *Significant Developments in COBRA Case Law.* The growing body of COBRA case law upholds the statutory extension of the duty of care beyond the emergency department and arguably further extends the duty by interpreting COBRA's provisions broadly. Emerging issues dealt with by the courts include whether patients to whom hospitals deny treatment for non-economic reasons may bring actions under COBRA and whether patients may bring private actions against emergency department physicians who allegedly have violated COBRA. Additionally, judges have examined these questions: does COBRA preempt state medical malpractice laws relating to medical panel review and damages limitations? Do COBRA's provisions apply beyond the emergency department in their requirements for stabilizing treatment?

The federal courts have divided on the first issue: whether plaintiffs who bring suit under COBRA must plead that care was denied to them on economic grounds. COBRA states that "any individual" who suffers personal harm as a direct result of the hospital's violation may obtain damages. Five federal courts have followed the plain language of the statute and held that COBRA applies to any individual denied treatment without regard to the person's financial condition.⁹¹ For example, in *Cleland v. Bronson Healthcare Group*, the Sixth Circuit Court of Appeals held that a broad interpretation of COBRA, consistent with the plain words of the statute extending coverage "to any individual," is certainly not contrary to Congress' concern in passing the legislation.⁹²

In direct contrast, four federal courts have disallowed COBRA claims in situations in which hospitals refused to treat plaintiff-patients based on non-economic grounds.⁹³ The cases all concerned disputes based on misdiagnosis

89. 42 U.S.C. § 1395dd(d)(2) (1988).

90. 42 U.S.C. § 1395dd(d)(1)(A)-(B). Effective May 1, 1991 the penalty was reduced to \$25,000 per violation for hospitals with less than 100 beds. These monetary penalties may be imposed by the Office of the Inspector General, and they may be imposed in addition to suspension or termination of the hospital's Medicare participation agreement.

91. *Cleland v. Bronson Health Care Group*, 917 F.2d 266 (6th Cir. 1990); *Delaney v. Cade*, 756 F. Supp. 1476 (D. Kan. 1991); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037 (D.C. Cir. 1991); *Brooker v. Desert Hosp.*, 947 F.2d 412 (9th Cir. 1991); *Wetzel v. Alleghany Regional Hosp. Corp.*, 778 F. Supp. 900 (W.D. Va. 1991).

92. *Cleland*, 917 F.2d at 270.

93. *Nichols v. Estabrook*, 741 F. Supp. 325 (D.N.H. 1989); *Evitt v. Univ. Heights Hosp.*, 727 F. Supp. 495 (S.D. Ind. 1989); *Stewart v. Myrick*, 731 F. Supp. 433 (D. Kan. 1990); *Zaikaner v. Danaher*, 1990 Medicare & Medicaid Guide (CCH) ¶ 38, 999 (D. Minn. Oct. 21, 1991).

or failure of the physician to recognize an emergency medical condition followed by subsequent worsening of the condition and death. The courts held in these cases that the plaintiffs had alternative avenues of recourse that were more appropriate than a suit under COBRA, because the facts supported bringing malpractice claims in state court. The development of contradictory case law exacerbates the problem of defining the hospital's duty of care under COBRA.

The federal courts have shown more agreement on the issue of whether plaintiffs can bring private actions against physicians who allegedly have violated COBRA. Most district court cases have decided to reject such claims.⁹⁴ Yet, the Federal District Court for the Northern District of Illinois has held that a patient does have a private cause of action against a physician.⁹⁵

The question of COBRA's effect on state medical malpractice laws and other preemption matters has been treated by the courts in a generally consistent fashion as well. The COBRA statute provides that it does not preempt any state or local law requirements unless direct conflict exists.⁹⁶ State medical malpractice laws typically require a medical review panel to evaluate all plaintiffs' medical malpractice claims as a prerequisite to filing suit and then set limits for personal injury damages. Federal district courts in Indiana and Louisiana have waived the medical review panel requirement in COBRA actions.⁹⁷ The state damage limitations have been upheld, however, by federal district courts in Illinois and Indiana.⁹⁸

In 1990, statutory amendments extended the treatment necessary to medically screen and stabilize the patient to include all routinely available ancillary services. Case law then further extended the scope of required treatment beyond the emergency department. In *Thornton v. Southwest Detroit Hospital*, the circuit court refused to restrict application of COBRA solely to the emergency room, noting that emergency care does not stop when a patient is "wheeled from the emergency room into the main hospital."⁹⁹ The Sixth Circuit panel held that once a patient is diagnosed as having an emergency medical condition in the emergency department, a hospital or physician cannot discharge the patient until the condition is stabilized, regardless of whether the

94. Verhagen v. Olarte, No. 89-0300, 1990 WL 41730 (S.D.N.Y. Nov. 21, 1989); Delaney v. Cade, 756 F. Supp. 1476 (D. Kan. 1991); Lavignette v. West Jefferson Medical Ctr., No. CIV.A.89-5495, 1990 WL 178708 (E.D. La. Nov. 7, 1990).

95. Sorrels v. Babcock, 733 F. Supp. 1189 (N.D. Ill. 1990).

96. 42 U.S.C. § 1395dd(f) (1988).

97. Reid v. Indianapolis Osteopathic Medical Hosp., 709 F. Supp. 853 (S.D. Ind. 1989); Green v. Touro Infirmary, No. CIV.A.90-4860, 1991 WL 17259 (E.D. La. Feb. 4, 1991).

98. See Reid, 709 F. Supp. at 855; Maziarka v. St. Elizabeth Hosp., Medicare & Medicaid Guide (CCH) ¶ 38,010 (N.D. Ill. 1989).

99. 895 F.2d 1131, 1135 (6th Cir. 1990).

Granny Dumping

patient remains in the emergency department.¹⁰⁰ Although the court stated that a hospital is not obligated to “bring patients to a complete recovery,” it did not provide guidance to hospitals beyond reference to the statutory definition of stabilization.¹⁰¹ The *Loss v. Song*¹⁰² court followed *Thornton* and held that Congress did not intend that the requirement to care for patients be limited to the emergency department because emergency care of necessity often goes beyond that department.

c. *The Impact of an Ill-Defined Duty of Care.* The *Thornton* case attempts to grapple with the key question of when hospitals may legally cease treatment under COBRA. COBRA requires that a patient be stabilized so that “within reasonable medical probability,” the patient’s condition will not “materially deteriorate.”¹⁰³ This definition, however, has been criticized as being highly subjective and too susceptible to reinterpretation when examining physicians’ decisions with the benefit of hindsight.¹⁰⁴ As a result, after five years of experience with COBRA, hospitals and physicians remain unclear as to the scope of their duty under the statute. As noted above, federal courts are divided as to whether or not COBRA covers patients when hospitals refuse to treat for non-economic reasons.¹⁰⁵ Further, COBRA assumes that hospitals control physicians, which simply is not always the case.¹⁰⁶ While the 1990 amendments extended the scope of COBRA to on-call physicians, many medical staffs are either unaware of this fact or resistant to it.¹⁰⁷

Finally, by imposing a duty on hospitals to provide care without establishing a funding mechanism to pay for such care, COBRA arguably has exacerbated the access problem it was designed to solve.¹⁰⁸ In practice and application, it has not created a network of legally obligated emergency care providers for the elderly and indigent. Instead, as the burden of providing this unreimbursed care has increased, so has the number of hospitals that have chosen to reduce services, close their emergency departments, or close their doors altogether.¹⁰⁹

Nor does COBRA mitigate economic realities that lead private hospitals to “dump” unstable, indigent patients on to public facilities; rather it heightens

100. *Id.* at 1134.

101. *Id.*

102. No. 89C-6952, 1990 WL 159612 (N.D. Ill. Oct. 16, 1990).

103. 42 U.S.C. § 1395dd(e)(3)(A) (1988).

104. Green, *supra* note 30, at 775.

105. See cases cited *supra* notes 91-93.

106. See, e.g., Hoffman, *supra* note 63, at 7; Rothenberg, *supra* note 31, at n.334; Burditt v. Sullivan, 934 F.2d 1362 (5th Cir. 1991).

107. See, e.g., Hoffman, *supra* note 63, at 7; Jur Strobos, *Patient Transfer Update: Part II, FORESIGHT*, Jan. 1992, at 2.

108. See Hoffman, *supra* note 63, at 7; Green, *supra* note 30, at 780-83.

109. *Id.*

them. Uncompensated care and shortfalls in reimbursement from Medicare and Medicaid create tremendous economic pressures for hospitals.¹¹⁰ One study estimates that to achieve 2% operating profit margin the average hospital, with 40% of its revenues coming from Medicare and Medicaid, must earn eight cents on the dollar treating privately insured patients to compensate for losing seven cents on the dollar treating Medicare and Medicaid patients.¹¹¹ As for cost-shifting, the American Hospital Association estimates that in 1989 hospitals charged an additional two billion dollars to private payers to cover Medicare losses alone.¹¹² More recently, the chairman-elect of the American Hospital Association presented testimony to the United States Senate Finance Committee indicating that in fiscal year 1993, 900 hospitals will lose up to 10% treating Medicare beneficiaries, another 900 hospitals will lose between 10% and 20%, and 2,000 hospitals will lose more than 20% of costs of care provided to Medicare beneficiaries that Medicare will not reimburse.¹¹³ In sum, COBRA has had a chilling effect on hospitals because it imposes a duty to provide care, enforced by severe penalties, without specifying either the financial means to comply or the scope and extent of the duty.¹¹⁴

IV. WHEN HAS THE HOSPITAL FULFILLED ITS DUTY OF CARE?

With COBRA's ambiguous scope and definition—particularly the definition of “stabilize”—hospitals face great difficulty in determining with any consistency or precision when they have fulfilled their duty of care. Questions of this nature existed prior to COBRA, but the potential liabilities under the COBRA provisions have served to magnify the problem and forced hospitals to address this urgent question more intently than before.

Thus far, only two COBRA cases have focused on the end point of the hospital's duty of care.¹¹⁵ The case of *Thornton v. Southwest Detroit Hospital*, discussed briefly above, purports to set an upper limit on how far treatment must be extended.¹¹⁶ An elderly woman who suffered a stroke gained admission to the hospital through the emergency department and received eleven days of in-patient care. At that point, the hospital attempted to transfer her to a rehabilitation facility, but the facility refused to accept her because

110. David Burda & Cathy Tokarski, *Hospitals Are Under Pressure to Justify Cost Shifting*, MODERN HEALTHCARE, Nov. 12, 1990, at 28.

111. *Id.* at 32.

112. *Id.* at 28.

113. *News at Deadline*, HOSPITALS, Mar. 5, 1992, at 10.

114. Green, *supra* note 30, at 780.

115. See *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990); *Loss v. Song*, No. 89C-6952, 1990 WL 159612 (N.D. Ill. Oct. 16, 1990).

116. *Thornton*, 895 F.2d 1131.

Granny Dumping

she was unable to pay for services. The hospital subsequently discharged her to her home where she received home health services. The women brought suit after her condition deteriorated at home. The plaintiff alleged that the hospital had violated COBRA because it failed to assure that, according to the COBRA definition of “stabilize,” reasonable medical probability existed that her condition would not materially deteriorate as a result of the transfer.¹¹⁷ The court took a more restrictive view than other courts and held that the hospital had met COBRA requirements because Congress intended the statute to guarantee only emergency treatment to indigent patients, not long-term care.¹¹⁸ The court held that it was not necessary for the hospital to “bring patients to a complete recovery.”¹¹⁹

While the *Thornton* case indicates that long-term, rehabilitative care is beyond the scope of the hospital’s duty, many questions remain. The line is not easily drawn between emergency care and continuing medical treatment after the patient has received care in the emergency department. Many patients can be treated to alleviate crises in emergency departments, but the nature of their medical conditions may be such that repeated or continuing intervention may be required. This is not long-term care, but care for chronic conditions. Suppose, for example, an elderly patient with a gall bladder attack can be treated in the emergency department, his pain alleviated and his general condition evaluated. The medical diagnosis, however, indicates surgery to remove the gall bladder. A problem arises if the hospital transfers the patient to his home and recommends that he arrange to have surgery to remove the gall bladder, but the patient cannot do so because he lacks health insurance. When the patient suffers another gall bladder attack a few days later, is the hospital liable for failing to fulfill its duty of care?¹²⁰

Another hypothetical example involves an elderly patient experiencing congestive heart failure who arrives at the emergency department. She is examined and administered medication to ease her breathing, but her family worries that her breathing difficulties will recur. She is transferred home with oxygen. She returns to the emergency department forty-eight hours later in florid congestive heart failure, suffers cardiac arrest, cannot be resuscitated, and dies. Has the hospital failed to meet its duty?¹²¹

It is ambiguous situations such as these that led the American College of Emergency Physicians to urge that physicians document in detail all factors comprising their current medical judgment as to why there is no reasonable medical probability of material deterioration either from or during the patient’s

117. *Id.* at 1132.

118. *Id.* at 1134

119. *Id.*

120. Telephone Interview with Thomas Weed, M.D., President, Utah Chapter of the American College of Emergency Physicians (Jan. 25, 1992).

121. *Id.*

transfer, particularly if the patient is going home.¹²² Even with such documentation, according to the American College of Emergency Physicians, the decision to transfer or discharge a patient against that patient's will for economic reasons "is fraught with risk of financial liability, public outcry, patient dissatisfaction, and allegations of improper care."¹²³

Having considered the extent of the hospital's duty of care under COBRA and within COBRA's economic terms, we still must answer two related and perhaps more compelling questions: At what point does the duty of care end where ability to pay is not an issue? And what if the hospital wants to discontinue treatment for non-economic reasons? Only three cases provide any guidance at this point: one predates COBRA and two are post-COBRA, although they do not contain COBRA claims.¹²⁴

The first case, *Lucy Webb Hayes National Training School v. Geohegan*, involved the quite common case of the hospital patient who no longer needs hospital care and who can be provided for adequately in a nursing home.¹²⁵ After a series of negotiations with defendants, the plaintiff-private hospital brought a trespass action to require Ellen Geohegan's removal from the hospital.¹²⁶ In finding for the hospital, the court held that hospitals have a duty not to permit their facilities to be diverted to uses for which hospitals are not intended and that "it would be a deviation from its purposes to act as a nursing home for aged persons who do not need constant medical care but ... [only] nursing care."¹²⁷

Other courts have declined to follow the holding of the 1967 *Webb* case and it is questionable whether the D.C. District Court itself would decide that case in the same manner today. Hospitals now approach such cases with extreme caution and insist on laborious documentation in view of the risks of COBRA litigation, economic sanctions, and bad publicity.¹²⁸

Payton v. Weaver, a California case involving an "obnoxious" dialysis patient, is the only post-COBRA case that deals directly with the issue of the end point of the physician's and hospital's duty of care.¹²⁹ Since Medicare covers end stage renal disease treatment,¹³⁰ lack of insurance or inability to pay played no role in the case. Instead, the *Payton* decision was controlled by

122. Strobos, *supra* note 107, at 6.

123. *Id.* at 5.

124. *Lucy Webb Hayes Training Sch. v. Geohegan*, 281 F. Supp. 116 (D.D.C. 1967); *Payton v. Weaver*, 182 Cal. Rptr. 225 (1982); *In re Wanglie*, Minn. Dist. Ct., No. PX-283, Jan. 28, 1991 (as reported in *Court Refuses to Appoint Conservator to Make Life-Support Decisions for Woman in Coma*, MENTAL HEALTH L. NEWS, May 1992, at 5).

125. *Geohegan*, 281 F. Supp. at 117.

126. *Id.*

127. *Id.*

128. See *supra* text accompanying notes 120-23.

129. 182 Cal Rptr. 225 (1982).

130. 42 U.S.C. § 1395rr (1988).

Granny Dumping

relevant provisions of the California mandatory emergency services law.¹³¹ The court analyzed the case using traditional abandonment criteria and determined that Dr. Weaver had given Ms. Payton due notice and ample opportunity to secure other medical treatment.¹³² The court held that although “end stage renal disease is an extremely serious and dangerous disease, which can create imminent danger of loss of life if not properly treated, the need for continuous treatment” is not a condition qualifying for mandatory emergency services pursuant to the California statute.¹³³ The court reasoned that:

There are any number of diseases or conditions that could be fatal to a patient if not treated on a continuing basis. If a patient suffering from such a disease or condition were to appear in the emergency room of the hospital in need of immediate life saving treatment, Section 1317 would presumably require that such treatment be provided. But it is unlikely that the legislature intended to impose upon whatever health care facility such a patient chooses the unqualified obligation to provide continuing preventive care for the patient's lifetime.¹³⁴

The court struggled, however, with the concept of the hospital as the holder of a scarce medical resource needed to preserve life and it suggested that the hospital should not be permitted to withhold its services arbitrarily or without reasonable cause.¹³⁵ The court speculated that a collective responsibility on the part of providers of scarce health resources, enforceable through equity, may exist to share the burden of difficult patients.¹³⁶ In the final analysis, the court found an alternative to assure that Ms. Payton did not die from lack of treatment as a result of her disruptive behavior: voluntary mental health conservatorship in a private psychiatric facility.¹³⁷

The *Payton* case instructs us on one issue: it sets a limit on the duty of care at “immediate lifesaving treatment” for cases of chronic medical conditions that require continuing treatment. Yet it also leaves us with an ambiguous result. The court refused to extend a duty of continuing care to a particular physician or hospital, but demonstrated its reluctance to hold that no duty existed to provide care through its discussion of “collective responsibility.”¹³⁸ Thus, *Payton* provides little meaningful guidance to hospitals attempting to conform their emergency department policies to the COBRA provisions.

The hospital's duty of emergency care is truly pushed to its furthest application with the following question: does a duty of continuing care in order to maintain life exist? The third case dealing with the end point of the hospital's duty of care grapples with this crucial issue. It presents the reverse of the

131. CAL. HEALTH & SAFETY CODE § 1317 (West 1990).

132. *Payton*, 182 Cal. Rptr. at 229.

133. *Id.* at 230.

134. *Id.*

135. *Id.*

136. *Id.*

137. *Id.* at 231.

138. *Id.* at 230.

more typical "right to die" case in which families seek to withhold treatment from a critically ill patient, and instead asks if the hospital can withhold the life-preserving treatment without the permission of the patient's family.¹³⁹

During the summer of 1991, Hennepin County Medical Center drew national attention when the hospital initiated legal action to determine whether it had a duty to continue to provide care to Helga Wanglie, an eighty-six-year-old woman in a persistent vegetative state whom the hospital kept alive by use of a ventilator.¹⁴⁰ Hospital physicians determined that continued use of the ventilator was medically inappropriate. Private insurance fully reimbursed the cost of care—over \$800,000 to care for Mrs. Wanglie from May 1990 until her death July 4, 1991. The issue focused on whether the family could require the hospital and its physicians to continue "futile" treatment.¹⁴¹

In December 1990, the hospital asked the family to find another facility capable of caring for Mrs. Wanglie, but the family refused.¹⁴² Finally, the hospital petitioned the probate court to appoint an independent conservator to make medical decisions for Mrs. Wanglie. The court denied the petition because the hospital offered no evidence that Oliver Wanglie, the patient's eighty-seven-year-old husband, was incompetent to discharge the duties as conservator for his wife.¹⁴³ The hospital medical director said the decision frustrated him because it forced his hospital to continue to provide care to Mrs. Wanglie that the medical staff believed to be inappropriate.¹⁴⁴

Dr. Arthur Caplan, Director of the Center for Biomedical Ethics at the University of Minnesota, said he believed that the *Wanglie* case would trigger a similar case where the question regarding treatment limits would be answered. But he claimed that the matter would be better handled in legislatures than in courtrooms.¹⁴⁵ In the same vein, Susan M. Wolf, an ethicist at New York's Hastings Center, commented that the case identified the need for society to decide what limits can be placed on treatment.¹⁴⁶

In summary, the cases analyzed in this section attempt to answer the question, retrospectively, of when has the hospital fulfilled its duty of care. Two cases, *Thornton* and *Geohegan*, suggest that the hospital's duty of care does not extend to rehabilitative or long-term nursing care.¹⁴⁷ The *Payton*

139. See *Cruzan v. Missouri Dep't of Health*, 110 S. Ct. 2841 (1990).

140. *Can Families Require Doctors to Continue Futile Treatment?*, AMA NEWS, July 22, 1991, at 32 [hereinafter *Futile Treatment*].

141. *Id.*

142. Tom Majeski, *Board Faces Life and Death Decision*, ST. PAUL PIONEER PRESS, Dec. 13, 1990, at A1.

143. Tom Majeski, *Judge Refuses to Let Hospital Unplug Patient*, ST. PAUL PIONEER PRESS, July 2, 1991, at A1 [hereinafter *Judge Refuses*].

144. *Id.*

145. *Id.*

146. *Futile Treatment*, *supra* note 140, at 32.

147. *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990); *Lucy Webb Hayes Training Sch. v. Geohegan* 281 F. Supp 116 (D.D.C. 1967).

Granny Dumping

case held that the hospital's duty of care does not extend to chronic medical conditions unless the patient has an acute episode and requires immediate, life-saving treatment.¹⁴⁸ Finally, although there was no court ruling on the issue, the hospital caring for Mrs. Wanglie argued that its duty should not extend to the provision of "futile" care.¹⁴⁹ These cases shed some light on the issue of when the hospital has fulfilled its duty of care, but hospitals still remain largely in the dark.

V. SHORT-TERM ACTION: A MEANS TO DELIMIT THE HOSPITAL'S DUTY OF CARE

While case law provides some assistance to hospitals in defining their duty of care and developing useful emergency room policy to deal with increasing granny dumping, hospitals need a means to delimit the duty of care more clearly and explicitly so that physicians and administrators confidently can make their medical evaluations within the parameters of the law. Hospitals need to be able to clearly formulate and communicate their policies on the extent or end point of care to their staff and to their communities. They also need coherent policies to avoid potential liability, pursuant to COBRA,¹⁵⁰ state emergency care statutes,¹⁵¹ and other common law causes of action.¹⁵²

In the short term, Congress should amend the COBRA statutory provisions to clarify the definition of stabilization. Several commentators recommend the adoption of the American College of Emergency Physicians' description of stabilization, which includes medical criteria relating to the establishment of an adequate airway, adequate ventilation, adequate fluid and/or blood replacement, and adequate vital signs.¹⁵³ This definition conforms to common medical usage of the term "stabilize," which refers to an improvement or leveling of vital signs.¹⁵⁴ It sets forth objective, measurable medical criteria in contrast to the conclusionary, hindsight element of the current COBRA definition

148. *Payton v. Weaver*, 182 Cal. Rptr. 225 (1982).

149. *Judge Refuses*, *supra* note 143, at A1.

150. 42 U.S.C. § 1395dd (1988).

151. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1317 (West 1990). Twenty-one states have passed laws which attempt to regulate the problem of patient dumping by imposing some type of duty on hospitals; *see also* McHugh, *supra* note 45, at 189.

152. *See, e.g.*, *Wanglie Legal Bills Paid*, ST. PAUL PIONEER PRESS, Dec. 19, 1991, at C3. A claim of approximately \$40,000 for costs of litigation incurred by Mr. Wanglie was presented to the Hennepin County Commissioners.

153. *See Guidelines for Transfer of Patients*, ANNALS EMERGENCY MED., Dec. 1985, at 1221; Strobos, *supra* note 107. The definition includes "establishing and assuring an adequate airway and adequate ventilation; initiating adequate fluid and/or blood replacement; and determining that the patient's vital signs are sufficient to sustain adequate perfusion."

154. Jur Strobos, *Tightening the Screw: Statutory and Legal Supervision of Interhospital Patient Transfers*, ANNALS EMERGENCY MED., Mar. 1991, at 302, 304.

which requires an advance determination that the patient likely will not deteriorate as a result of transfer.¹⁵⁵

To introduce a helpful time element to the definition of stabilization, one commentator has suggested that a definition of "stable for transfer" (or discharge) include a determination that the next step in anticipated care would not be scheduled for several hours and that any transfer/discharge would not lead to a delay or break in medical care.¹⁵⁶ These clarifications and additions to the definition of stabilization would delimit more clearly the extent of care the hospital is obligated to provide to elderly patients with chronic medical conditions or to patients in need of long-term or rehabilitative care. A definition of stabilization based on time-limited, medical criteria could help hospitals to answer—in many more cases—the question of when they have fulfilled their duty of care.

VI. LONG-TERM ACTION: NATIONAL HEALTH-CARE REFORM

Admittedly, enactment of a new definition of "stabilized" would not be a panacea. Even with a new definition of stabilization, hospitals would continue to experience granny dumping. The phenomenon of granny dumping in overcrowded hospital emergency departments is a symptom of the larger crisis in American health care.¹⁵⁷ It demonstrates compellingly the problem of lack of access to care. Although a review of national health-care reform developments is beyond the scope of this Article, the following discussion briefly sets forth two relevant criteria by which to measure or analyze national health-care reform proposals as to their impact on access to care and, in turn, their impact on granny dumping balanced against a fair and defined duty of care for hospitals.

Any health-care reform proposal first must put forth a plan for access to a continuum of health-care services, including acute, sub-acute, and primary care. Hospitals cannot and should not be the only providers of care. In the past decade, an "explosion" in emergency department visits has created a crisis due to overcrowding and limited resources.¹⁵⁸ A survey published in the *Annals of Emergency Medicine* suggested that, particularly for the poor, the emergency department has become the primary point of access to the health-care system.¹⁵⁹ Due to COBRA requirements the emergency department must treat

155. 42 U.S.C. § 1395dd(c) (1988).

156. Strobos, *supra* note 154, at 309.

157. See, e.g., *Study Cites Emergency Room Crisis*, CHI. TRIB., Aug. 27, 1991, at 15; Emily Friedman, *The Sagging Safety Net: Emergency Departments on the Brink of Crisis*, HOSPITALS, Feb. 20, 1992, at 26.

158. See, e.g., Friedman, *supra* note 157, at 26.

159. *Study Cites Emergency Room Crisis*, *supra* note 157.

Granny Dumping

all patients without regard to ability to pay.¹⁶⁰ It is not surprising then that people view the hospital emergency department as “a safety net, a lifeline for the community” in terms of access to care.¹⁶¹

Overly stressed families utilize this “safety net” when they dump granny. The problem is that granny needs a range of services, not just acute hospital care. But government initiatives to assure access to health care, e.g., the Hill-Burton program, Medicare, and COBRA, wrongly have focused attention exclusively on hospitals.

The Medicare program in many respects functions as national health-care insurance for the aged. But, it offers very little coverage for long-term care. Medicare will reimburse the beneficiary for only 100 days in a skilled nursing facility subject to a daily co-insurance payment equal to one-eighth of the applicable inpatient hospital deductible for days 21-100.¹⁶² Even this level of coverage is restricted by the requirement of a related, immediately preceding hospitalization as well as level of care requirements mandating that services must be “skilled” and result in the improvement of the patient’s condition rather than “custodial” services.¹⁶³ As a result of such restrictive coverage, Medicare occupies a very small niche in long-term care, accounting for less than 3% of total nursing home expenditures.¹⁶⁴ If an individual does not qualify for Medicare-reimbursed long-term care or exceeds the Medicare length-of-stay limit, then payment must be out of pocket. If the individual lacks private means of payment, then she must “spend-down” to qualify for Medicaid. Since Medicaid functions as a welfare program with a strict means test, the “spend-down” results in “virtual impoverishment” for most elderly.¹⁶⁵ One report claims that due to “spend-down” the average elder today spends more personal money (both in absolute dollars and as a percentage of income) on total health care than she did prior to the enactment of Medicare and Medicaid in 1965.¹⁶⁶

The American Geriatrics Society has published its view that “although there are gaps in acute care coverage under Medicare, it is the absence of coverage for long-term care that is the genuine catastrophe” for the elderly and their families.¹⁶⁷ The Medicare Catastrophic Coverage Act of 1988 attempted to expand long-term care benefits and alleviate the potentially devastating financial burden of unexpected and prolonged medical-care needs,¹⁶⁸ but Congress

160. See *supra* text accompanying notes 74-80.

161. Friedman, *supra* note 157, at 30.

162. 42 C.F.R. § 409.85 (1991).

163. *Id.*; 42 C.F.R. § 409.31 (1991).

164. Marshall B. Kapp, *Options for Long-Term Care Financing: A Look to the Future*, 42 HASTINGS L.J. 719, 723 (1991).

165. *Id.* at 724-25.

166. *Id.* at 726.

167. *Id.* at 719.

168. See Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, 102 Stat. 683.

repealed the law only sixteen months later, largely due to negative public reaction spurred by the imposition of higher "premiums" on the more well-off Social Security recipients in order to cover the poorer elderly and to support financially the expanded coverage.¹⁶⁹

An effective national health-care scheme must allow entry into the delivery system at intermediate levels of care. Once patients have gained entry, they should receive comprehensive services at each level of care in the health-care continuum. For example, after the need for skilled nursing care in a long-term care facility has been met, then patients should have access to care either in a residential care setting or in an adult day care setting. One commentator has alleged that a major weakness of public policy has been its failure to address adequately the financing of non-institutional alternatives to long-term care (e.g., adult day care, life care communities, respite care, congregate living arrangements, and hospice).¹⁷⁰ If such a range of services were accessible to the indigent elderly, then granny dumping at hospital emergency departments would be rare or non-existent.

The second criterion for health-care reform proposals relates to cost. Only adequate funding will assure universal and uniform eligibility for services. At the heart of the debate on health-care reform lies the question of whether or not national government should assume responsibility for the provision of health care to its citizens. Although there is widespread sympathy for the elderly poor as deserving of society's help, there appear to be growing tensions as the working class views itself as sacrificing to pay taxes to support federal entitlement programs like Medicare which all elderly may tap into irrespective of need.¹⁷¹ The challenge of financing comprehensive health-care services for the elderly will be how to spread costs in an "equitable, efficient, and politically acceptable way."¹⁷²

To date, the United States has taken an incremental approach to the provision of health care covering specified needs for targeted populations through Medicare and Medicaid. Any national health-care plan that perpetuates the inequalities in the types of services covered and the levels of reimbursement provided for various population groups will in turn encourage "dumping" of underfunded patients from private to public institutions. The economic pressures that promote cost-shifting on to private payers cannot be solved unless universal coverage with reasonable reimbursement levels applies throughout the health-care delivery system.

169. See Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. No. 101-234, 103 Stat. 1979; see also Lawrence A. Frolik & Alison P. Barnes, *An Aging Population: A Challenge to the Law*, 42 HASTINGS L.J. 683, 710 (1991) (discussing some of the factors that contributed to the Congressional repeal).

170. Kapp, *supra* note 164, at 727-28.

171. Frolik & Barnes, *supra* note 169, at 713.

172. Kapp, *supra* note 164, at 754.

Granny Dumping

In the long term, far more than clarification of the hospital's duty of care will be required to put an end to granny dumping. A solution to this problem necessarily involves addressing the wider issues of access to care and setting limits of care. The *Wanglie* case provides the scenario for linking the issues of duty of care, access to care, and limits to care with life or death consequences. The ultimate resolution of these complex issues must await difficult legislative and societal determinations of fundamental values within ethical and economic restraints.

VII. A CALL FOR SOLUTIONS

Reviewing the development of the hospital's legal duty to provide care establishes a context for understanding the current state of the law. COBRA now provides an affirmative duty to provide, at a minimum, and without regard to ability to pay, a medical screening examination to every individual who enters the hospital emergency department seeking care. Nevertheless, due to problems in the definitions, scope, and applications of COBRA, hospitals now stand in the unenviable position of assuming a duty without a clear end point. Having established the hospital/patient relationship, a hospital has a duty of treatment that could potentially continue as long as the patient or family demands care. Therefore, in the short term, the COBRA definition of stable to transfer or discharge should be changed to include objective, time-limited, medical criteria that would minimize potential liability to hospitals. Then hospitals would be relieved of the legal jeopardy posed by granny dumping and left only with the practical social problem of finding appropriate placement.

In the long term, we must address the fundamental issues of how much health-care assistance we owe to the elderly and how much we can afford. Meaningful policy choices about access to care and reimbursement for care will be a function of the political process. An effective solution must be fashioned as part of a comprehensive national health policy that incorporates a goal of funding some level of universal care. Until we achieve that goal however, hospitals must act cautiously to set their own limits given medical, ethical, and economic constraints.

While the short-term action of clarifying the hospital's duty of care will help institutional health-care providers cope with abandoned elderly patients, granny dumping will continue to plague our nation until there is broad-based national health-care reform. Only when every American has a right to comprehensive, uniformly reimbursed health-care services will granny dumping cease to be a grave problem for overburdened hospitals and an overburdened society.