DEDICATIONS
Dedication to the Honorable Odis W. Bertelsman
Tribute to James Culbertson Ware

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In tribute to their contributions to
the study of law and the legal profession,
the editors and staff respectfully dedicate this issue to
the late Honorable Odis W. Bertelsman and James C. Ware.
DEDICATION
TO THE
HONORABLE ODIS W. BERTELSMAN
(1900-1991)

Give the things which are yours
whilst they are yours,
after death they are not yours.
-The Triangle (1929)

During a career that spanned over sixty years, Judge Odis W. Bertelsman served his community and his profession eminently well. A lifelong resident of Campbell County, he held office as interim Circuit Judge, County Judge, and County Attorney. A Republican in a Democratic county, his ability to be elected spoke highly of his popularity and competence.

Judge Bertelsman was born in Newport, Kentucky, in 1900. He graduated in 1929 from the Young Men's Christian Association Night Law School, the predecessor to the Salmon P. Chase College of Law. While in law school, he was a member of Iota Lambda Pi, Order of Curia, and the 1926 winner of the First Bettman Prize. He was President of his sophomore law school class and, as reflected in the Class History in the 1929 Triangle, "The class was organized in the first month of school with Odis Bertelsman as its president." Certainly all of his later friends in life would agree that the following biographical statement about Judge Bertelsman in the 1929 Triangle was a premonition of the character attributes he would carry throughout his sixty plus years of practice: "If the entire class were as well prepared at all times, and enunciated its legal doctrines as masterfully as Odis, then truly would our professors have achieved an instructor's Utopia."

In those days, one could be admitted to the bar as soon as he or she felt ready to sit for the bar examination. So, Judge Bertelsman was admitted two years before his graduation from law school.

Upon admission to the Kentucky bar in 1927, Judge Bertelsman opened an office in Newport as a sole practitioner. He later formed the firm of Bertelsman & Bertelsman with his son William O. Bertelsman, who is currently Chief Judge of the United States District Court for the Eastern District of Kentucky. His practice
was busy and varied; he rendered legal services for railroads, banks, buildings and loans, and numerous individual clients in times when it was not always so easy to do so, such as during the Great Depression. Judge Bertelsman represented the CSX Railroad for over sixty years, and always had an interesting story to tell about a railroad case or trial. His dedication to the practice of law and to his clients was evidenced by the fact that, despite his age, he continued to work his regular schedule until two weeks before his death. At the time of his death, Judge Bertelsman was the senior member of the firm of Bertelsman, Kaufmann, Seidenfaden & Kolentse.

The true measure of a man’s life, though, is not adequately expressed by a mere listing of career accomplishments, but rather by the recollections of those whose lives he touched and influenced. His friends and colleagues remember him as kind, dedicated, fair — a true gentleman. Younger lawyers particularly recall that he was patient and always willing to offer advice drawn from a wealth of experience. He always had a ready smile and a fantastic memory for names and faces.

Older members of the bar compliment Judge Bertelsman on his standard of integrity, ethics, honesty, dedication to the law and to the legal profession, and an unselfishness that young lawyers would do well to emulate. They describe how, in years long past, Judge Bertelsman was one of a group of lawyers who regularly ate lunch together and exchanged stories of interesting cases or discussed current legal issues. A student of the law, Judge Bertelsman could be counted on to provide an invaluable answer to most legal questions by reference to his famous index card system in which he recorded significant Kentucky case decisions.

Although he enjoyed traveling with his wife Dorothy, Judge Bertelsman was dedicated to the law and his law practice. As a lawyer, his primary concern was to represent the interests of his clients to the best of his ability. As a judge, he was committed to the efficient and fair administration of justice. One friend and former courtroom adversary observed that Judge Bertelsman should serve as an example for all lawyers to follow.

Perhaps the most poignant remark offered in memory of him came from a fellow lawyer who noted that, in over forty years, he had never heard anyone utter a disparaging word about Judge Bertelsman. Certainly, in such an adversarial profession as the law, this is the highest tribute to a fine gentleman.
Many thanks to the following individuals whose contributions were used in the compilation of this dedication, and who are but a few among the many friends and colleagues of Judge Odis Bertelsman:

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TRIBUTE
TO
JAMES CULBERTSON WARE
(1913-1991)

On November 16, 1991, Northern Kentucky lost an outstanding legal, civic and political leader with the passing of James C. Ware. He is survived by his wife, Jo Kummer Ware, and his two children, Mary W. McBrayer and James O. Ware. At the time of his death, Jim was the senior member of the law firm of Ware, Bryson, West & Bartlett of Edgewood, Kentucky. The law firm had been founded by his father, the late Orie S. Ware.

After graduating from Centre College, Jim attended the Salmon P. Chase Law School when it was located in Cincinnati, Ohio. He was admitted to the Bar in Kentucky in 1940. Thereafter, he was employed in the Trust Department with the Central Trust Company of Cincinnati. He served as a special agent with the Federal Bureau of Investigation between 1943 and 1946. Upon leaving the Bureau, he joined his father and brother, William O. Ware, in the practice of law in Covington, Kentucky.

Throughout his career, Jim was active in politics. He served as Kentucky State Senator from 1958 to 1966. During that time, he was Majority Leader from 1960 to 1964 and Senate President Pro Tem from 1964 to 1966. While holding the position as President Pro Tem of the Senate, he served as acting Governor of the Commonwealth of Kentucky on two occasions in 1964 and 1965.

In addition to holding public office, Jim served his community in numerous ways. For many years, he was on the Advisory Committee of the William Booth Memorial Hospital. He also served on the Board of Trustees for the Covington Protestant Children's Home and on the Board of Trustees for the Baptist Convalescent Home in Newport, Kentucky. At the time of his death, he was Chairman of the Board of the Convalescent Home. He also acted as Trustee for the Linden Grove Cemetery in Covington. To all of these civic endeavors, he devoted consider-
able time and energy without compensation. Jim held the sincere conviction that a lawyer is under an obligation to serve the community.

Jim was also a deeply religious man and was an active member of the Ft. Mitchell Baptist Church, serving as a Deacon and Trustee. For thirty-five years, he taught a men’s bible class at his church.

Having been his law partner for over thirty years, I can personally attest to the fact that Jim was an excellent lawyer as well as a fine gentleman. He was one of a rare breed from what some call the old school. He was an inspiration to me and to every attorney who had the pleasure of working with him.

Jim’s kindness, fairness, and courtesy to his clients was returned by their loyalty to him over many years. To the mild consternation of his law partners, Jim rarely charged a fee equal to the value of his considerable experience and expertise, especially if the clients were elderly or lacking in funds to pay a lawyer. He would frequently spend many hours with a client discussing legal problems and concerns and, on more than one occasion, his fee from a client might be in the form of fresh produce which he generously divided among his co-workers. He was considered by his clients to be a trusted friend as well as a legal advisor.

All lawyers, young and old, would do well to follow his example in their personal and professional lives. Our community, and our Bar Association in particular, have been diminished by his passing.

Larry C. West, Esq.
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PATIENT AUTONOMY AND STATE INTERVENTION: REEXAMINING THE STATE'S PURPORTED INTEREST

Dr. G. Steven Neeley*

Prevention of suicide — There exists a right by which we take a man's life but none by which we take from him his death: this is mere cruelty.
—Nietzsche, Human, All Too Human

There is nothing in the world a man has a more incontestable right to than his own life and person.
—Schopenhauer, "On Suicide"

I. INTRODUCTION

The decision of the Supreme Court of the United States in Cruzan v. Director, Missouri Department of Health1 centered upon the right of a legal guardian to order the termination of nutrition and hydration from an incompetent ward who was in a persistent vegetative state but was neither legally dead nor terminally ill.2 The Cruzan decision marks the latest skirmish in an ongoing debate regarding the right of an individual to refuse or disemploy artificial life support.

Since the seminal decision of In re Quinlan3 in 1976, over fifty appellate decisions have turned on this issue.4 The opinions of the courts often have conflicted and, faced with a dearth of controlling precedent, the judiciary has been forced to make far-reaching decisions in murky waters. In keeping with its policy

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2. Id. See also Cruzan v. Harmon, 760 S.W.2d 408, 410-12 (Mo. 1988) (en banc).
of judicial restraint, the Supreme Court decided *Cruzan* as narrowly as possible and avoided sweeping pronouncements regarding the constitutionality of elective death. But even if the highest court, sometime soon, were to give a more express and definitive ruling on a general right to disemploy life support, this pronouncement would be no more dispositive of all future right-to-die scenarios than *Roe v. Wade* was dispositive of the abortion question. This article will examine what interests are implicated and what interests should be implicated when a person declines or seeks to stop life support measures.

II. INTERESTS IMPLICATED IN RIGHT-TO-DIE CASES

The current dilemma in the law on the issue of an individual's right to refuse or disemploy life support results from the clash of two ancient canons. Historically, the common law has recog-

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5. In *Cruzan*, guardians of a patient in a persistent vegetative state sought a declaratory judgement sanctioning the termination of hydration and nutrition for the patient. The Circuit Court of Jasper County, Probate Division, granted the request. Upon appeal, the Supreme Court of Missouri reversed, holding that: (1) the guardians did not have authority to compel the withdraw of hydration and nutrition, and (2) evidence of the patient's wishes was inherently unreliable and insufficient to support the guardian's claim for substituted judgement. *Cruzan v. Harmon*, 760 S.W.2d 408, 409 (Mo. 1988) (en banc), cert. granted, 109 S. Ct. 3240 (1989). At the highest court level the question was:

simply and starkly whether the United States Constitution prohibits Missouri from choosing the rule of decision which it did. This is the first case in which we have been squarely presented with the issue of whether the United States Constitution grants what is in common parlance referred to as a "right to die." We follow the judicious counsel of our decision in *Twin City Bank v. Nebeker*, 167 U.S. 196, 202, 17 S. Ct. 766, 769, 42 L. Ed. 134 (1897), where we said that in deciding "a question of such magnitude and importance ... it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject."


Although the Supreme Court assumed "for purposes of this case ... that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition," *id.* at 2852, the real focus of the decision centered upon the point that "Missouri requires that evidence of the incompetent's wishes as to the withdrawal of treatment be proved by clear and convincing evidence. The question, then, is whether the United States Constitution forbids the establishment of this procedural requirement by the State. We hold that it does not." *Id.*

Justice O'Connor wrote separately, further emphasizing the limited scope of the holding:

"Today we decide only that one State's practice does not violate the Constitution; the more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the 'laboratory' of the States, *New State Ice Co. v. Leibmann*, 285 U.S. 262, 311, 52 S. Ct. 371, 386-87, 76 L. Ed. 747 (1932) (Brandeis, J., dissenting), in the first instance." *Id.* at 2859 (O'Connor, J., concurring).

nized the right of the individual to be free from nonconsensual invasions of bodily integrity. This right has been extended to include the freedom to refuse necessary lifesaving medical treatment. Yet, for an equally long time, the law has been anathematic to suicide. For centuries, these doctrines were able to peacefully coexist. It is only with the advent of invasive medical technology that such tenets are forced to do combat within the medical arena.

Twenty-six states and the Commonwealth of Puerto Rico presently have laws which prohibit assisting a suicide. Yet, decisions to disemploy life-support are often swept into the same rubric. Indeed, the accepted legal definitions of suicide include "[s]elf-destruction; the deliberate termination of one's own life," and "the act of self-destruction by a person sound in mind and capable of measuring his moral responsibility." Decisions to remove life-support are, in turn, deliberate acts which are likely—perhaps even certain—to result in death. As a result, health care personnel or other third persons who might otherwise be willing to facilitate a patient's removal of life-support are hindered by the threat of criminal sanctions. This is because such assistance might be construed as facilitating a deliberate act of self-destruction.

This uneasy state of affairs has led to situations in which even seriously ill competent adults have found it nearly impossible to compel the removal of invasive life-support apparatus. As a reaction to this expanding problem, a number of legal scholars have addressed the concept of a constitutional right to suicide which, at least under certain circumstances, would protect the right of the individual to terminate his own existence. Judicial

11. WEBSTER'S NEW TWENTIETH CENTURY DICTIONARY 1822 (2d ed. 1979).
13. Alan Sullivan, A Constitutional Right to Suicide, in SUICIDE: THE PHILOSOPHICAL ISSUES 133, 133-50 (M. Pabst Battin & David J. Mayo eds., 1980); David A.J. Richards,
recognition of a fundamental right to suicide would mandate that state legislation infringing this right must be necessary to advance some compelling state interest and be narrowly drawn so as to constitute the least restrictive means available to sustain its compelling state interest.

A. Individual Interests

Historically, the common law has recognized the right of persons to peace of mind and to be free from nonconsensual invasions of bodily integrity. These rights have been extended to include the freedom to refuse necessary lifesaving medical treatment. One court has observed:

Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of lifesaving surgery, or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary, but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception.

Indeed, "[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law .... 'T]he right to one's person may be said to be a right of complete immunity: to be let alone.'"

The "right to be let alone" is also considered a fundamental precept of "the principles underlying the Constitution's guarantee of personal liberty [which] hold the right to privacy to be among the most precious and cherished of all human rights."


14. See generally Palko v. Connecticut, 302 U.S. 319, 325 (1937); Snyder v. Massachusetts, 291 U.S. 97, 105 (1933) (Fundamental rights are those explicitly guaranteed by the Bill of Rights or which are implicit in the concept of "ordered liberty.").


of privacy.” 19 Brandeis’ immortal dissent in Olmstead v. United States20 is frequently cited in this regard:

The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man’s spiritual nature, of his feelings and of his intellect. They knew that only a part of the pain, pleasure and satisfaction of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized men.21

Moreover, this protection of personal autonomy and bodily integrity includes the right of the individual to make decisions regarding his own welfare even if such choices appear unsound or even foolish to others.22 Reflecting upon Brandeis’ articulation of the right of self-sovereignty, Justice Burger suggested that this principle must be held inviolate against the claims of paternalistic third persons who wish to deprive the individual of personal choice under the broad rubric of acting “in his own best interests”:

Nothing in this utterance suggests that Justice Brandeis thought an individual possessed these rights only as to sensible beliefs, valid thoughts, reasonable emotions, or well-founded sensations. I suggest he intended to include a great many foolish, unreasonable

20. 277 U.S. 438 (1928).
21. Id. (citing Olmstead v. United States, 277 U.S. 438 (1928) (Brandeis, J., dissenting)).


22. “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without the patient’s consent commits an assault, for which he is liable in damages.” Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914).
and even absurd ideas which do not conform, such as refusing medical treatment even at great risk.\textsuperscript{23}

\textbf{B. State Interests}

The right to refuse medical treatment is counterbalanced by the interest of the state in protecting its citizens from unwarranted acts of self-destruction.\textsuperscript{24} Thus, "\textit{"[w]hether based on common law doctrines or on constitutional theory, the right to decline life-saving medical treatment is not absolute. In some cases, it may yield to countervailing societal interests in sustaining the person's life."}\textsuperscript{25} The courts and commentators have commonly identified four state interests that may limit a person's right to refuse medical treatment: preserving life, preventing suicide, safeguarding the integrity of the medical profession, and protecting innocent third parties.\textsuperscript{26}

This article endeavors to show that when these interests are carefully examined, it becomes clear that the state's concern in the welfare of its citizens is marginal compared to the stake that the individual has in his own life. Further, in situations regarding the refusal of termination of life support for a mentally competent adult, these traditional considerations alone will rarely, if ever, justify overriding a patient's decision. From this perspective, there appears to be even less justification for the perpetuation of archaic and overly broad proscriptions of all deliberate acts of self-destruction, and an even greater urgency in the call for the judicial recognition of a constitutional right to suicide.

\textsuperscript{23} \textit{In re President and Directors of Georgetown College}, 331 F.2d 1010, 1017 (D.C. Cir. 1964) (reh'g denied en banc) (Burger, J., dissenting) \textit{cert. denied}, 377 U.S. 978 (1964).

\textsuperscript{24} \textit{Bartling v. Superior Court}, 209 Cal. Rptr. 220, 226 (Ct. App. 1984); \textit{In re Conroy}, 486 A.2d 1209 (N.J. 1985); \textit{See also Bouvia v. Superior Court}, 225 Cal. Rptr. 297 (Ct. App. 1986).

\textsuperscript{25} \textit{In re Conroy}, 486 A.2d 1209, 1223 (N.J. 1985).

III. EXAMINING THE STATE INTERESTS

A. Preservation of Life

The interest in preserving life is commonly considered the most significant of the four state interests and embraces two separate but related concerns: an interest in preserving the life of the particular patient and an interest in preserving the sanctity of all life. It is virtually axiomatic that a state should have a legitimate concern in the welfare of its citizens and should seek to prevent an unwarranted loss of life. Yet, as aptly stated by the court in In re Conroy, neither of these allied concerns will generally foreclose a competent adult from declining lifesaving medical treatment for himself. The life that the state is seeking to protect in such situations is the life of the same person who has competently decided to forego medical intervention. Furthermore,

In cases that do not involve the protection of the actual or potential life of someone other than the decisionmaker, the state's indirect and abstract interest in preserving the life of the competent patient generally gives way to the patient's much stronger personal interest in directing the course of his own life. Indeed, insofar as the 'sanctity of individual free choice and self-determination [are] fundamental constituents of life,' the value of life may be lessened rather than increased 'by the failure to allow a competent human being the right of choice.'

The general concept of a "state interest in preserving life" is analytically imprecise. As a broad statement of direction the

31. Id.
32. Id. at 1223-24 (citations omitted) (quoting Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 426 (Mass. 1977)).
state indeed should concern itself with the preservation of life. Yet the state never should seek to compel a competent adult to remain alive against his will and best interests. The proper statement of governmental purpose should be to reflect an interest in preserving the lives of individuals for whom the loss of life would be infelicitous. A wealth of recent right-to-die cases attest to scenarios in which the loss of life would actually prove a blessing to the patient involved. Broad proscriptions of suicide or assisted suicide which seemingly serve a general state interest in the preservation of life can extend too far and may unduly usurp fundamental rights of self-determination.

The issue here really centers upon answering the question of who should decide whether a particular life ought to be preserved, the state or the individual. If we confine our discussion to cases involving mentally competent adults, then the individual, rather than the state, occupies the more favorable vantage point from which to correctly assess whether that life should continue. As courts are beginning to recognize, the quality of life cannot be discounted in any balancing of interests. Undeniably, we would


34. See generally Bouvia v. Superior Court, 225 Cal. Rptr. 297 (Ct. App. 1986). A 28-year-old quadriplegic suffering from severe cerebral palsy and degenerative arthritis sought to compel the removal of a nasogastric feeding tube. The appellate court wrote:

At bench the trial court concluded that with sufficient feeding petitioner could live an additional 15 to 20 years; therefore, the preservation of petitioner's life for that period outweighed her right to decide. In so holding the trial court mistakenly attached undue importance to the amount of time possibly available to petitioner, and failed to give equal weight and consideration for the quality of that life; an equal, if not more significant, consideration.

All decisions permitting cessation of medical treatment or life-support procedures to some degree hasten the arrival of death. In part, at least, this was permitted because the quality of life during the time remaining in those cases had been terribly diminished. In Elizabeth Bouvia's view, the quality of her life has been diminished to the point of hopelessness, uselessness, unenjoyability and frustration. She, as the patient, lying helplessly in bed, unable to care for herself may consider her existence meaningless. She cannot be faulted for so concluding. If her right to choose may not be exercised because there remains to her, in the opinion of a
be loathe to sanction something on the order of a state-imposed “quality of life index” in which anyone below a certain quality level “Q” would be allowed to die while anyone above such a level would not be permitted to die. (Or, extending to include the worst-case scenario, anyone below level “X” would be made to die.) Rather, the state’s goal should be aimed toward allowing the individual to assess the quality and value of his or her own life. When properly understood, the interest in life which the state should promote in right-to-die situations is not some generic and abstract conception of life per se, but the lives of individuals; lives which derive meaning and consequent value from the ends and aspirations established by autonomous persons instead of the balancing of sweeping social policies. If a competent adult has deliberated over his or her life and has determined that within the scope of his or her situation, aspirations and ends that life is no longer worth living, the state should not interfere.

B. Prevention of Suicide

In close conjunction with the state’s general interest in preserving life, a number of courts have recognized the more particular interest of preventing suicide.35 Proscriptions of suicide have ancient roots.36 The present controversy at issue is engendered by the fact that a majority of states have laws which

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prohibit the assistance of suicide. Yet, at least one court has observed that "[t]his state interest in protecting people from direct and purposeful self-destruction is motivated by, if not encompassed within, the state's more basic interest in preserving life. Thus, it is questionable whether it is a distinct state interest worthy of independent consideration."  

Assuming, arguendo, that the prevention of suicide ought to be treated as a state interest distinct from the more general interest in the preservation of life, it is questionable whether the actual grounds of this concern would pass constitutional muster as a sufficiently "compelling" or even "legitimate" state purpose. The rationale advanced at common law for an absolute and unyielding proscription of "self-slaughter" is based almost exclusively upon dubious theological dogma. It will neither compel the assent of those who do not accept the traditional eschatology, nor successfully scale the wall of separation between church and state.  

Moreover, since the term "suicide" does not admit of ready or precise definition, it is difficult to ascertain exactly which types of self-destructive acts the state really wants to, or ought to, concern itself with. In standard usage, the term "suicide" denotes "the act of killing oneself intentionally" and carries "extremely negative connotations." Yet attempts to formulate a more phil-

39. See Alan Sullivan, A Constitutional Right to Suicide, in Suicide: The Philosophical Issues 229, 229-53 (M. Pabst Battin & David J. Mayo eds., 1980). Interests which are not entitled to strict-scrutiny analysis (see cases cited supra note 14) may nevertheless be protected by the less rigorous "rational basis test." Under this standard, only if the state's regulation is so unrelated to legitimate state interests as to be arbitrary will the individual's conduct be protected by the guarantees of personal liberty afforded through the Fifth and Fourteenth Amendments. The Supreme Court's rulings under the "rational basis test" suggest that courts will generally accept at face value the state's conclusion that its proscription rests upon a legitimate interest. Id. at 232.  
40. The rationale advanced at common law for the prohibition of suicide is based almost exclusively upon theological dogma. See Norman St. John-Stevas, Life, Death and the Law 233-61 (2d prtg. 1961); Glanville Williams, The Sanctity of Life and the Criminal Law 248-310 (5th prtg. 1972). But the establishment clause of the First Amendment has erected a "wall of separation between church and state" which estops parochial concerns from intruding upon the auspices of secular institutions. See Everson v. Board of Educ., 330 U.S. 1, 16 (1947).  
42. Margaret Pabst Battin, Ethical Issues in Suicide 22 (Prentice-Hall Series in the Philosophy of Medicine, 1982).
osophically rigorous definition are legion and have proven unsuccessful.

The refusal or disemployment of artificial life-support is an intentional act which is likely to result in death. But should such a decision be classified as a species of suicide? The courts and commentators have elicited a variety of conceptual niceties in an effort to preserve a general prohibition of suicide while, nevertheless, excusing certain specific instances of self-destruction. Thus, the courts have considered, inter alia, the competence and specific intent of the actor and whether the patient could be classified as terminally ill. Differences have been sought based upon: the "distinction between the self-infliction of deadly harm and a self-determination against artificial life support or radical surgery in the face of irreversible painful and certain imminent death"; "the distinction ... between actively hastening death by terminating treatment and passively allowing a person to die of a disease"; the "distinction between withholding and withdrawing life-sustaining treatment"; the difference "between

43. Id. at 21.
44. See, e.g., Bartling v. Superior Court, 209 Cal. Rptr. 220 (Ct. App. 1984):
   In the case of a competent adult's refusing medical treatment such an act does not necessarily constitute suicide since (1) in refusing treatment the patient may not have the specific intent to die, and (2) even if he did, to the extent that the cause of death was from natural causes the patient did not set the death producing agent in motion with the intent of causing his own death.

Id. at 226 (quoting Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 426 n.11 (Mass. 1977)). But see Bouvia v. Superior Court, 225 Cal. Rptr. 297, 306 (Ct. App. 1986), which held that
   [i]f a right exists, it matters not what "motivates" its exercise. We find nothing in the law to suggest the right to refuse medical treatment may be exercised only if the patient's motives meet someone else's approval. It is certainly not illegal or immoral to prefer a natural, albeit sooner, death than a drugged life attached to a mechanical device.

Id. at 306 (emphasis in original).
47. In re Conroy, 486 A.2d 1209, 1234 (N.J. 1985) (explicitly rejecting "this distinction that some have made ... as one of limited use in a legal analysis of such a decision making situation" Id.).
48. Id. at 1234 (rejecting such a distinction made by commentators).
‘ordinary’ treatment . . . and ‘extraordinary’ treatment,”; 49 and even the difference between “the termination of artificial feedings and the termination of other forms of life-sustaining medical treatment.” 50

But even a blanket proscription which is riddled with holes is sufficient to smother the right of choice for seriously ill patients. Because the law always lags behind the most advanced thinking in any area, 51 and because the law of death and dying is particularly inept at keeping pace with the rapid advance of medical technology, 52 no set of conceptual or terminological qualifications augmenting the term “suicide” is ever likely to be complete. Restricting the broad reach of general proscriptions of suicide on such a piecemeal basis not only fails to be optimally expedient, but injures to the detriment of seriously ill patients who find themselves at the mercy of circumstances until they can become the next “test case.” 53

C. Safeguarding The Integrity of the Medical Profession

The third state interest asserted as a limitation on a patient’s right to command the circumstances of his death is the interest in safeguarding the integrity of the medical profession. 54 It is agreed that society as a whole benefits by its association with and respect for the medical community. Yet, this interest does not appear to be particularly threatened by allowing competent patients to determine the moment of their own death. As long ago as 1624, Francis Bacon wrote: “I esteem it the office of a physician not only to restore health, but to mitigate pain and

49. Id. (finding this distinction “unpersuasive”).
53. The common law method of adjudication necessarily involves decision making on a case-by-case basis. However, where the law is clear, fewer “hard cases” develop. If the Supreme Court were to expressly rule on the issue of a constitutional right to suicide, state courts would have applicable precedent to guide them. Similarly, state legislatures would have a better appreciation of the limits of their reach (it is clear that they must have some limit) and would be forced to draft carefully tailored statutes accordingly.
dolours; and not only when such mitigation may conduce to recovery, but when it may serve to make a fair and easy passage." 55 Recently, courts have recognized that modern-day "physicians distinguish between curing the ill and comforting and easing the dying; that they refuse to treat the curable as if they were dying or ought to die, and they have sometimes refused to treat the hopeless and dying as if they were curable." 56 Accordingly:

Prevailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances. Rather, as indicated in Quinlan, the prevailing ethical practice seems to be to recognize that the dying are more often in need of comfort than treatment . . . .

"[R]ecent surveys have suggested that a majority of practicing doctors now approve of passive euthanasia and believe that it is being practiced by members of the profession." 58 It might still be asserted, however, that the province of medicine is to cure, not to kill, and that all forms of active euthanasia violate the most basic tenets of the profession. Yet both medicine and the law are becoming increasingly critical of the tenuous distinction between "active" and "passive" conduct in the context of medical decisions. 59 Furthermore, at least within the context of seriously

59. See In re Conroy, 486 A.2d 1209, 1234 (N.J. 1985). See also supra note 42. While this may not dispose of the distinction between active and passive conduct within the context of medical decision making, it does at least signal that both medicine and the law are becoming increasingly aware that such a distinction is problematic.
ill, competent adults confined to life support, there is considerable momentum toward revamping the view of the proper role of the medical profession. As eloquently stated by Associate Justice Compton in Bouvia v. Superior Court:

The right to die is an integral part of our right to control our own destinies so long as the rights of others are not affected. That right should, in my opinion, include the ability to enlist assistance from others, including the medical profession, in making death as painless and quick as possible.

That ability should not be hampered by the state's threat to impose penal sanctions on those who might be disposed to lend assistance.

The medical profession, freed of the threat of governmental or legal reprisal, would, I am sure, have no difficulty in accommodating an individual in Elizabeth's situation.

The Hippocratic Oath reads in pertinent part: "... I will follow the method of treatment which, according to my ability and judgment, I consider for the benefit of my patients.... I will give no deadly medicine to anyone if asked ..." Surely, adherence to that oath would yet admit of a reasonable balancing between the doctor's obligation to alleviate suffering and his obligation to preserve life, remembering that the term 'life' has itself recently undergone substantial redefinition.

It is also worth noting that the original oath also contained the phrase "... I will not give to a woman an instrument to produce an abortion ...." Obviously, the profession has already accommodated a deviation from that part of the oath.

D. Protecting Innocent Third Parties

The fourth state interest involved in limiting an individual's right to hasten or ordain his own destruction is the interest in protecting relevant third parties who may be harmed by the actor's decision. The right to self-determination is not absolute,

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62. See Roe v. Wade, 410 U.S. 113 (1973) (the privacy right involved in the abortion decision "cannot be said to be absolute. In fact, it is not clear to us that the claim
and it may give way to the competing interests of third persons who could be seriously and adversely affected by the "patient's treatment decision." The principle of personal autonomy which lies at the foundation of the Bill of Rights proclaims the right of the individual to unfettered liberty over his own life and person insofar as the exercise of such liberty does not seriously encroach upon the welfare of others. Since the choice to terminate one's own life rarely occurs in a social vacuum, the right of the actor to exercise such a choice stops where the competing rights of third party claimants begins. Thus, the courts have curtailed the right of self-determination if necessary to protect public health, to prevent serious risk to prison security, or to prevent the abandonment of the patient's minor children.

The welfare of persons is undeniably a compelling state purpose, and the state has a legitimate concern in the stake of survivors who may be adversely affected by a suicide. Yet the state's interest should be directed towards a balance of welfare for all concerned, with particular regard to the best interests of the patient. When the rights of third persons come into conflict with the right of the individual to self-determination, a delicate balancing of interests should be applied to the exigency of particular situations. Prohibitions of suicide advance the interests of relevant third parties under certain circumstances, but often only at a tremendous premium to the seriously ill patient who is forced to remain alive against his will. In a conflict of interests, the state should protect individual liberties.

asserted by some amici that one has an unlimited right to do with one's body as one pleases bears a close relationship to the right of privacy previously articulated in the Court's decisions. The Court has refused to recognize an unlimited right of this kind in the past. Id. at 154 (citing Jacobson v. Massachusetts, 197 U.S. 11 (1905) (vaccination); Buck v. Bell, 274 U.S. 200 (1927) (sterilization)).


The interest a patient has in dying could well exceed the interest others have in keeping him alive. Many seriously ill patients have no one who would be significantly and adversely affected by the patient's death. Further, the interest of others may, at certain times, be on the side of the patient's choice to terminate his or her own life. Survivors of the aged, infirm, or terminally ill may have made emotional and economic adjustments in anticipation of the patient's demise. Family and friends may be benefitted by the knowledge that their loved one died peacefully and quickly rather than painfully. Moreover, it is the exception rather than the rule that society at large will suffer from the loss of one of its members.

IV. CONCLUSION: PRACTICAL CONSIDERATIONS

The scope of the implicit constitutional right to suicide is to protect the right of the competent adult to terminate his own existence. The impact of the right falls upon seriously ill patients who seek death but lack the wherewithal to effect their own desires. Judicial recognition of this right would not open social floodgates causing a wave of unwarranted suicides. Individuals who want to die and are capable of carrying out their wishes are not likely to be deterred by the threat of criminal sanctions. Thus, incompetent or distraught persons who would destroy themselves without sufficient cause or consideration will not be affected by a change in the legal status of suicide. Therefore, as a practical matter, broad proscriptions of suicide, which include in particular assisted suicide, seem to deny access to self-selected death to that specific class of persons who would actually benefit from exiting life—terminal and seriously ill patients.

As the foregoing sections have made clear, if elected self-termination were recognized as a fundamental human right under the Constitution, it would mean two things: (1) the state could not infringe this right unless the proposed abridgment were necessary to advance some compelling state interest; and, (2) the legislation in question would need to be narrowly tailored so as to constitute the least restrictive means available to sustain the state's compelling purpose.68 The four state interests commonly asserted as restrictions upon an individual's right to self-deter-

68. See cases cited supra note 15.
mination are: the preservation of life, the prevention of suicide, safeguarding the integrity of the medical profession, and protecting innocent third parties. Yet, a thorough analysis of the purported interests has revealed that the state's real concern should be with preserving the lives of those persons for whom the termination of their lives would be infelicitous and with preventing unnecessary harm to all relevant parties concerned. This statement of government interest would take into consideration the observation that life is not always worth living and that the state must not ignore or undervalue the overriding concern of the patient in effecting a balancing of interests. It reflects the understanding that the "prevention of suicide" is not an independent interest worthy of consideration, but rather is subsumed within the more general interest in the "preservation of life." It further recognizes that the integrity of the medical profession is not particularly threatened by allowing the autonomous rights of the individual to supersede institutional considerations.

Legislation which broadly proscribes all deliberate acts of self-destruction, or aiding and abetting such acts, does not constitute the least restrictive means of advancing the state's compelling purpose. Recognition of the constitutional right to self-termination would accordingly herald the demise of criminal sanctions which flatly condemn self-termination or assisted self-termination. It would not mean, however, that the state could never impose justifiable constraints upon the exercise of the right. It would

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69. See cases cited supra note 26.
70. See supra notes 27-34 and accompanying text.
71. See supra notes 61-67 and accompanying text.
72. See supra notes 29-34 and accompanying text.
73. See supra notes 35-53 and accompanying text.
74. See supra notes 54-60 and accompanying text.
75. Opponents of the constitutional right to suicide have suggested that judicial recognition of the right will have disastrous consequences for society because "the Constitution would not permit an absolute prohibition on any attempt to exercise an acknowledged constitutional right." Thomas J. Marzen, Suicide: A Constitutional Right?, 24 Duq. L. Rev. 1, 101 (1985). The implication proposed is that once suicide becomes a constitutional right, society will be impotent to prevent irrational acts of self-destruction by minors, incompetents, or the temporarily distraught. But it betrays a rather naive grasp of constitutional law to suggest that the right to suicide would not admit of regulatory safeguards. The state may regulate within the sphere of fundamental liberties provided that such restrictions satisfy the requirements of "strict scrutiny" analysis. If freedom of expression, for example, may be circumscribed by reasonable limits designed
mean only that the legislature would be forced to draft narrowly tailored laws which advance the state's compelling purpose without unnecessarily stifling the fundamental right of self-determination. The breadth of legislative abridgment of the right would be held in check by the "least restrictive means" test afforded to fundamental liberties under "strict scrutiny" analysis.

The upshot of judicial recognition of the right to self-termination would be the creation of a legal atmosphere in which the state could still promote legislation geared toward the protection of life, such as enactments seeking to protect minors or incompetents from unwarranted acts of self-destruction, but in which no competent adult could be forced to remain alive against his or her will and best interests. As a positive right, rather than simply a negative claim, the right to self-termination could be used to solicit the assistance of others in order to make death as painless and dignified as possible. Further, precisely because the right to self-termination stems from the Constitution's core commitment to personal autonomy, the right would be conceptually antithetical to the usurpation of self-sovereignty and could never be used to sanction involuntary euthanasia.

to curtail its misuse—see Feiner v. New York, 340 U.S. 315, 320 (1951); Chaplinsky v. New Hampshire, 315 U.S. 568 (1942); cf. Colten v. Kentucky, 407 U.S. 104, 111 (1972)—there is no reason to believe that the same would not hold true of the right to suicide.
I. INTRODUCTION

In July of 1980, Edna Leach entered Akron General Medical Center in Akron, Ohio, diagnosed with respiratory distress. Following her admission, she suffered a "respiratory-cardiac" arrest. Although she was resuscitated, she thereafter existed in a "chronic vegetative state."

On October 28, 1980, Mrs. Leach's husband petitioned the Summit County Probate Court for an order permitting the withdrawal of life support measures instituted by the hospital. The order was issued on December 18, 1980. Mrs. Leach died when the respirator was removed on January 6, 1981.

On July 9, 1982, Mrs. Leach's representatives filed suit seeking damages for the time that Mrs. Leach was maintained on life support systems.

Dr. Fred Plum, the creator of the term "persistent vegetative state" and renowned expert on the subject, has described the "vegetative" state in the following terms: Vegetative state describes a body which is functioning entirely in terms of its internal controls. It maintains temperature. It maintains heart beat and pulmonary ventilation. It maintains digestive activity. It maintains reflex activity of muscles and nerves for low level conditioned responses. But there is no behavioral evidence of either self-awareness or awareness of the surroundings in a learned manner.

Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2845 n.1 (1990) (citing In re Jobes, 529 A.2d 434, 438 (N.J. 1987)).

5. Leach, 469 N.E.2d at 1051 (citing Leach v. Akron Gen. Medical Ctr., 426 N.E.2d 809 (Ohio Ct. C.P. Summit County 1980)).

6. Id.

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2. Id.
3. The Leach plaintiffs did not object to the cardiopulmonary resuscitation which preceded the institution of life support systems for Mrs. Leach. Id.
4. Id.
5. Leach, 469 N.E.2d at 1051 (citing Leach v. Akron Gen. Medical Ctr., 426 N.E.2d 809 (Ohio Ct. C.P. Summit County 1980)).
6. Id.
support systems. They alleged that the life support treatment was undertaken without the consent of, and contrary to the express wishes of, Mrs. Leach. The defendants filed a motion to dismiss or in the alternative for summary judgment. The defendants argued that there could be no damage caused by keeping someone alive. Defendants' motion was granted by the trial court, and the case was dismissed for plaintiff's failure to state a claim upon which relief could be granted. The Summit County Court of Appeals then reversed, holding that "[a] cause of action exists for wrongfully placing and maintaining a patient on life-support systems contrary to the express wishes of the patient and her family." 11

The Leach decision represents the only Ohio decision involving the theory of "wrongful living." Although the Leach court established that a patient may recover damages which foreseeably flow from the institution of life support systems against the patient's wishes, the case did not address the question of recovery of damages in cases of unpermitted resuscitation. This article will explore the peculiar problem not addressed in Leach; namely, the application of the "wrongful living" theory

7. Id.
8. Id.
9. OHIO R. CIV. P. 12(B)(6) and 56. The motion was not supported by affidavits or other evidence and was therefore treated as a motion to dismiss for failure to state a claim upon which relief could be granted. Leach, 469 N.E.2d at 1051.
10. Id.
11. Id. at 1050 (syllabus of the court).
12. See A. Samuel Oddi, The Tort of Interference with the Right to Die: The Wrongful Living Cause of Action, 75 GEO. L.J. 625 (1986) (first developing the "wrongful living" cause of action). A number of states have addressed similar fact scenarios and "nearly unanimously, those courts have found a way to allow persons wishing to die, or those who seek the death of a ward, to meet the end sought." Cruzan v. Harmon, 760 S.W.2d 408, 412 n.4 (Mo. 1988) (citing, e.g., Rasmussen v. Fleming, 741 P.2d 674 (Ariz. 1987); Lovato v. District Ct., 601 P.2d 1072 (Colo. 1979); John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921 (Fla. 1984); In re L.H.R., 321 S.E.2d 716 (Ga. 1984); In re PVW, 424 So. 2d 1015 (La. 1982); In re Joseph W. Gardner, 534 A.2d 947 (Me. 1987); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977); In re Torres, 357 N.W.2d 332 (Minn. 1986); In re Quinlan, 355 A.2d 647 (N.J. 1976), cert. denied sub nom., Garger v. New Jersey, 429 U.S. 922 (1976); In re Storar, 420 N.E.2d 64 (N.Y. 1981), cert. denied, Storar v. Storar, 454 U.S. 858 (1981); In re Milton, 505 N.E.2d 255 (Ohio 1987), cert. denied by Ohio Dep't of Mental Health v. Milton, 484 U.S. 820 (1987); In re Colyer, 860 P.2d 738 (Wash. 1993), holding modified by In re Guardianship of Hamlin, 689 P.2d 1372 (Wash. 1984)). None of these cases, however, involved a "wrongful living" claim.
14. Leach, 469 N.E.2d at 1052.
when medical providers resuscitate a patient who has previously expressed a desire to avoid resuscitation in the event of impending death. This analysis includes a review of common law tort actions of wrongful life, wrongful birth, and wrongful living, as well as consideration of the recent living will statutes enacted in Ohio and Kentucky.

II. "WRONGFUL LIVING," "WRONGFUL LIFE," AND "WRONGFUL BIRTH"

Regardless of whether a patient is placed on life-support and maintained on that equipment against the patient’s will, as was Mrs. Leach,15 or resuscitated against the patient’s will, the legal dilemma remains the same: Are damages recoverable for a person who has been subjected to unwanted medical treatment when the person probably would have died without the treatment? As a first step in the analysis of this issue, it is necessary to distinguish the "wrongful living" theory from the so-called "wrongful life"16 and "wrongful birth"17 concepts, both of which have been more widely explored and debated.18

The "wrongful life" concept is typified by the 1984 case of Procanik v. Cillo.19 The plaintiff in Procanik was an infant who, by and through his mother, sought damages from his mother’s physician for negligent failure to diagnose her as suffering from

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15. See supra notes 7-8 and accompanying text.


17. "Wrongful birth" is the parent’s equivalent to a child’s wrongful life action. Tucker, supra, note 16, at 675 (citing W. PAGE KEETON ET AL., PROSSER & KEETON ON THE LAW OF TORTS § 55, at 370 (5th ed. 1984) (wrongful birth is an action brought by parents against health care professionals for failure to inform them of the increased possibility that the child would be born with birth defects, thus precluding them from an informed decision regarding continuance or termination of the pregnancy)).


German measles during her first trimester of pregnancy. As the result of this failure the infant claimed that he had been born with severe birth defects. His legal stance was that, had his mother been properly diagnosed, she would have had the choice of terminating the pregnancy, in which case he would have never been born. He sought damages for 1) the extraordinary expenses due to his condition, namely, past and future health care, and 2) the pain, suffering, and emotional distress associated with his severely impaired life.

The New Jersey Supreme Court held that “special” damages, that is, extraordinary medical expenses, were recoverable but that “general” damages, such as pain, suffering, and emotional distress, were not recoverable. The court based this distinction on the ease with which costs of medical treatment may be calculated versus the difficulty in assessing the value of impaired life versus non-life.

“Wrongful Birth,” on the other hand, refers to a claim by the parents of an impaired child. They claim that due to the negligence of a physician, they were prevented from exercising their right to avoid conception or terminate a pregnancy. These cases are typified by Berman v. Allen, where the New Jersey Supreme Court, reversing earlier precedent, allowed the parents of a

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21. Id.
22. Id.
23. Id. at 757. See also P.R. Glazebrook, Case and Comment, 50 Cambridge L.J. 241 (1991) (English view of the wrongful life issue); Kelly, supra note 19, at 513-49 (reviewing traditional damage and policy concerns).
25. Id. at 764. See infra section VI. See also Gleitman v. Cosgrove, 227 A.2d 689, 711 (N.J. 1967). In describing the struggle at hand, the Gleitman court said:

Ultimately, the infant's complaint is that he would be better off not to have been born. Man, who knows nothing of death or nothingness, cannot possibly know whether that is so. We must remember that the choice is not being born with health or being born without it .... Rather the choice is between worldly existence and none at all .... To recognize a right not to be born is to enter an area in which no one can find his way.

26. As summarized by Kelly, "In genetic counseling torts, the rightful position standard presents courts with an enigma. Plaintiffs must claim that, but for the tort, a child suffering from severe genetic defects would not have been born. Thus, the parents' rightful position is childless; the child's rightful position is lifeless, unborn." Kelly, supra note 19, at 506.
27. 404 A.2d 8 (N.J. 1979).
28. See, e.g., Gleitman v. Cosgrove, 227 A.2d 689 (N.J. 1967) (parents of child born with defects caused by intrauterine exposure to German measles could not seek recovery
Down Syndrome child to recover damages for the emotional distress involved in raising their genetically defective child. The Berman court concluded that “the monetary equivalent of this distress is an appropriate measure of the harm suffered by the parents.”

The Berman court refused, though, to allow the parents to recover damages for the “medical and other expenses that will be incurred in order to properly raise, educate and supervise the [impaired] child.” The decision was based upon the interesting rationale that to allow the parents the love and joy that they will experience as parents, while requiring the defendants to pay for the enormous expenses incurred in rearing the child, would constitute a windfall to the parents.

This inconsistency in wrongful birth cases between allowing damages for emotional distress while refusing damages for the cost to rear the child was corrected by the New Jersey Supreme Court two years later in Schroeder v. Perkel. In Schroeder, parents were granted the right to recover damages for the extraordinary medical expenses of raising a child born with cystic fibrosis.

of damages; damages were said to be unascertainable and against public policy; Cf., Gildiner v. Thomas Jefferson Univ. Hosp., 451 F. Supp. 692 (E.D. Pa. 1978) (recognizing parents’ claim of physician’s negligent failure to test for Tay-Sachs disease); Elliot v. Brown, 361 So. 2d 546 (Ala. 1978) (parental recovery allowed for failed sterilization procedure); Stills v. Gratton, 127 Cal. Rptr. 652 (Ct. App. 1976) (parental recovery for negligent performance of an abortion resulting in birth of child); Becker v. Schwartz, 386 N.E.2d 807 (N.Y. 1978) (recognizing cognizable damages for tangible costs such as medical expenses, but no recovery for psychic or emotional harm); Dumer v. St. Michael’s Hosp., 233 N.W.2d 372 (Wis. 1975) (damages to parents limited to medical and supportive costs).


30. Id. See generally Kelly, supra note 19, at 563-89 (discussing concepts of a “perfect baby” warranty, the “wrongful birth” family’s position, and emotional pain and suffering issues).

31. Id. See generally Kelly, supra note 19, at 563-89 (discussing concepts of a “perfect baby” warranty, the “wrongful birth” family’s position, and emotional pain and suffering issues).

32. 432 A.2d 834 (N.J. 1981) (the defendant physician failed to diagnose cystic fibrosis in the plaintiff’s first born in time to prevent or abort the second pregnancy. The court held that the physician had an independent duty to the parents to disclose that their first born child suffered from cystic fibrosis, id. at 838, that the physician breached his duty by failing to diagnose cystic fibrosis and to advise the parents that their child suffered from such disease, id. at 839-40, and that if the parents prevailed on the liability issue, defendants would be liable for the incremental medical costs of a subsequent child born with cystic fibrosis. Id. at 842).

33. Id.
In contrast to the "wrongful birth" concept, the "wrongful living" plaintiff does not assert a right to prevent another person's life from coming into being. Rather, the wrongful living plaintiff asserts the highly personal right to decide what medical treatment he or she will choose to accept, even if the choice to forego that treatment will almost certainly result in the individual's own death. In contrast to the "wrongful life" concept, the "wrongful living" plaintiff does not assert a right to make a retrospective decision about whether to be born, that is, to speculate about what decision the plaintiff would have made had the future been known to the plaintiff prior to conception or in utero. The "wrongful living" plaintiff weighs the effects of his medical therapy and his prognosis with and without the therapy, against the desirability of remaining alive.

Valuation of life exists as a legal problem in all three of these situations. The "wrongful living" plaintiff, though, is the one who has had the opportunity to make an informed, competent decision, before the fact, as to what risks he is willing to accept in exchange for the probability of continuing to live under particular circumstances.

34. See generally Oddi, supra note 12.
35. See Tucker, supra note 16 (defining wrongful life).
III. CRUZAN AND THE RIGHT TO DIE

Nancy Cruzan was an adult female who suffered severe brain injury in an automobile accident. Following resuscitation, Ms. Cruzan remained in a persistent vegetative state from which there was no hope of recovery. When the request of her parents and co-guardians to terminate artificial hydration and nutrition was refused by the hospital, they then filed an action with the Missouri state court for a declaratory judgment. The trial court entered an order directing the employees of the State of Missouri to "cause the request of the co-guardians to withdraw nutrition or hydration to be carried out." The State and the guardian ad litem appealed.

The Missouri Supreme Court, in reversing the decision of the trial court, held that the Missouri Constitution did not contain a right to privacy broad enough to "support the right of a person to refuse medical treatment in every circumstance." In its opinion, the court required that the wishes of Ms. Cruzan to discontinue her medical treatment had to be shown by clear and convincing evidence. The Missouri Supreme Court declined to recognize and accept the "substituted judgment" of Ms. Cruzan's close family members, namely her parents as co-guardians.

On appeal to the United States Supreme Court, the Cruzans argued that Nancy Cruzan, even as an adult incompetent acting

40. Cruzan v. Harmon, 760 S.W.2d 408, 411 (Mo. 1988) (en banc).
41. See supra note 4.
42. Cruzan, 760 S.W.2d at 411.
43. Id. at 410.
44. Id. at 411-12.
45. Id.
46. Id. at 416-17. The Missouri Supreme Court found that the state interest in preserving life outweighed the privacy interests of a patient in a persistent vegetative state, though not incurably ill. Id. at 424.
47. Id. at 426.
48. Id. at 426. When a court utilizes the "substituted judgment" test, the family member must prove what would have been the incompetent's choice regarding life sustaining treatment had the patient been competent. Varying degrees of proof and subjective/objective tests have been utilized by the states. Id. at 413-16 (discussing the standards for the "substituted judgment" doctrine utilized by other states). The "substituted judgment" doctrine would allow a close family member to make life and death decisions for an incompetent patient, conceivably "even in the absence of substantial proof that their views reflected the view of the patient." Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2855 (1990). See also Louise Harmon, Falling Off the Vine: Legal Fictions and the Doctrine of Substituted Judgment, 100 Yale L.J. 1 (1990).
through her co-guardians, had a federal constitutional right to compel withdrawal of life-sustaining medical treatment. The United States Supreme Court held that the individual state had the power to require clear and convincing evidence of the wishes of an incompetent person prior to withdrawal of such treatment, and that the United States Constitution did not require a state to accept the substituted judgment of a close family member.

While upholding the burden of proof required by the State of Missouri that the wishes of the patient must be shown by clear and convincing evidence, the Supreme Court in Cruzan acknowledged that "[an] incompetent person has a liberty interest under the Due Process Clause in refusing unwanted medical treatment." Thus, the Cruzan case brought into the national spotlight this so-called "right to die."

This is the first case in which we have been squarely presented with the issue of whether the United States Constitution grants what is in common parlance referred to as a "right to die." The Fourteenth Amendment provides that no State shall "deprive any person of life, liberty, or property, without due process of law." The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.

The above-quoted language supports the position that a plaintiff in a "wrongful living" case may proceed by asserting a liberty

50. Id. at 2853-55. The Supreme Court upheld the requirement by the State of Missouri that, because of Missouri's interest in preserving life, clear and convincing evidence of Ms. Cruzan's desire to have hydration and nutrition withdrawn had to be shown. Id. at 2855. The Court noted that many states impose a clear and convincing standard of proof, whether in the context of proving the prior express wishes of the incompetent or in the context of substituting the judgment of another close family member. Id. at 2854-55 (citing state decisions).
51. Cruzan, 110 S. Ct. at 2855.
52. Id. at 2843 (citing Jacobson v. Massachusetts, 197 U.S. 11, 24-30 (1905)).
54. Cruzan, 110 S. Ct. at 2851.
interest in the right to die. This liberty interest is thwarted and results in a wrongful living action when the health care professional fails to make himself aware of the patient's express wish to forego potentially lifesaving treatment or when the health care professional intentionally disregards those wishes.

In addition to the recognition of a cause of action for wrongful living when an individual's liberty interest in the right to die is thwarted, it is also necessary for attorneys and judges confronted with a wrongful living case to understand that "wrongful living" is, in reality, a damages concept. There is no more a "cause of action" for "wrongful living" than there is a cause of action for a "wrongful broken leg" or a "wrongful whiplash." In every such case there must be some underlying tort. Every "wrongful living" case must involve underlying negligence or battery.

IV. THEORIES OF RECOVERY: NEGLIGENCE VERSUS BATTERY

To fit within the negligence framework, a "wrongful living" plaintiff would postulate a breach of a duty owed by medical care providers to be aware of and honor the patient's previously expressed desire to forego potentially lifesaving treatment, including resuscitation. The duty, then, is owed by all medical personnel who are constructively aware of the patient's

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55. Public opinion supports recognition of this liberty interest. In a New York Times - CBS poll conducted the day after the *Cruzan* decision was rendered, 85% of participants stated that they would want tube feeding terminated if they were in a persistent vegetative state. Only 11% said they would not. See Zartman, *supra* note 53, at 13.

56. For an analogous case that concluded that the failure to comply with a competent person's wishes in the context of a request for discontinuance of life support could lead to civil liability, see *Bartling v. Superior Court*, 209 Cal. Rptr. 220 (Ct. App. 1984). In *Bartling*, a competent adult, sure to die if mechanical ventilation was removed, was said to have a common law right to be free from unconsented bodily intrusions and a constitutional right of privacy; discontinuance of life support would not impose criminal liability for assisted suicide or other criminal charges. The case was said not to be of such a nature that discontinuance of life support would result in "death by unnatural means .... Rather, they would merely have hastened his inevitable death by natural causes." (citations omitted). *Id.* at 225. See also John L. Capone, Note, *Bartling v. Superior Court: The Final Transgression of a Patient's Right to Die?*, 35 CASE W. L. REV. 764 (1985).

57. As stated in *Leach v. Shapiro*, the physician owes his patient a fiduciary duty of good faith and fair dealing which gives rise to certain specific professional obligations. These obligations include not only the duty to exercise due care and skill, but to fully inform the
wishes. A typical situation where this duty would arise is where a “Do Not Resuscitate” order is on the patient’s chart, but resuscitation is performed by someone who is unaware of the order. As noted by Oddi:

The situation where the right to die is being expressly asserted by or on behalf of a patient, for example where the hospital records indicate “do not resuscitate,” must be distinguished from the situation where the patient could have legally asserted the right to die but did not expressly do so .... The normative principle guiding medical personnel is that patients have the right to live until the contrary is established.59

The United States Supreme Court held in *Cruzan* that a state is constitutionally permitted to require “clear and convincing” evidence of the wishes of an incompetent patient in a proceeding to withhold life-sustaining medical treatment brought on behalf of the patient.60 In order to reach this conclusion it was logically necessary for the Court to first recognize the right of any competent patient to make the decision to refuse unwanted medical treatment.61

In *Cruzan* the decision to decline unwanted lifesaving or life-sustaining treatment was viewed prospectively by the Court. The question to be answered was: What would the patient’s choice be today if we could ask her? In a “wrongful living” case, though, the decision will be viewed retrospectively. The question to be answered will be: What was the patient’s choice prior to the event? It is probable that in the retrospective situation courts would require that there be written documentation of the patient’s wishes, such as a “do not resuscitate” order, before a health care provider would be held liable for wrongfully failing

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58. As stated by the court in *Leach*, “A physician who treats a patient without consent commits a battery even though the procedure is harmless or beneficial.” *Id.* at 1051 (citing *Lacey v. Laird*, 139 N.E.2d 25 (Ohio 1956)).


60. *Cruzan v. Director*, Missouri Dep’t of Health, 110 S. Ct. 2841, 2854 (1990). This clear and convincing evidence of the patient’s wishes in *Cruzan* was not demonstrated by the evidence received in the trial court, “consisting primarily of statements made to a housemate about a year before her accident that she would not want to live should she face life as a ‘vegetable’.” *Id.* at 2855.

61. See *supra* notes 49-51 and accompanying text.
to honor the wishes of the patient and rendering lifesaving or life-sustaining medical treatment. Questions still to be addressed by courts are scenarios where a patient's physician refuses to write a "do not resuscitate" order upon the patient's request, and where the physician is noncomittal following a patient's request and subsequently fails to honor the request.

The theoretical battery\textsuperscript{62} situation is much simpler, though much more unlikely. A battery will have occurred whenever a health care provider, actually aware of the patient's refusal of a particular lifesaving or life-prolonging medical therapy, proceeds to render that therapy in spite of refusal.\textsuperscript{63} Whether the cause of action is based on negligence or battery, the philosophical question remains the same: is the therapy really prolonging life or, in fact, just prolonging death?\textsuperscript{64}

\textsuperscript{62} A person commits the tort of battery if he acts with intent to cause harmful or offensive contact, and the contact occurs. See Restatement (Second) of Torts §§ 13, 18 (1965). Even the mere touching of one person by another without consent or legal justification was a battery at common law. W. Keeton et al., Prosser and Keeton on the Law of Torts § 9, at 39-42 (5th ed. 1984).

\textsuperscript{63} See supra, note 58. See also Barber v. Superior Court, 195 Cal. Rptr. 484 (Ct. App. 1983) (doctors charged criminally after stopping patient's life support at request of family; writ of prohibition granted by California court of appeal. The Barber court stated, "A long line of cases ... have held that where a doctor performs treatment in the absence of an informed consent, there is an actionable battery. The obvious corollary to this principle is that a competent adult patient has the legal right to refuse medical treatment." Id. at 489 (citation omitted)); In re Estate of Longeway, 549 N.E.2d 292 (Ill. 1989) (action by guardian of incompetent to remove nutrition and hydration; court noted that since surgery performed without a patient's consent is assault, by extension of such reasoning, a physician cannot, without consent, "force medical care upon a patient, even in life-threatening situations." Id. at 297; Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988) (en banc) ("[T]he common law developed the principle that a battery occurs when a physician performs a medical procedure without valid consent. ... If one can consent to treatment, one can also refuse it. Thus, as a necessary corollary to informed consent, the right to refuse treatment arose." Id. at 417 (citation omitted)); Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841 (1990) ("The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment." Id. at 2847); In re Joseph v. Gardner, 534 A.2d 947 (Me. 1987) (patient in persistent vegetative state following fall from truck had previously expressed desire not to be maintained on nasogastric tube; Maine Supreme Court recognized continued validity of battery analysis when treatment is rendered "against the patient's will or substantially at variance with the consent given. ... Thus when a competent patient has expressly refused to receive some form of medical care, a doctor would be acting tortiously if he insisted on providing the treatment against his patient's will." Id. at 951 (citations omitted)).

\textsuperscript{64} See Daniel D. King, Esq., et al., Where Death Begins While Life Continues, 31 S. Tex. L. Rev. 145 (1990); Edward R. Grant & Cathleen A. Cleaver, A Line Less Reasonable:
V. APPLICATION OF PRINCIPLES TO THE CLINICAL SITUATION

Obviously the only patients who would ever find themselves in a dilemma such as the one posed herein are those whose medical condition is life-threatening. With regard to such patients, it is perhaps analytically useful to identify three types of medical intervention which may give rise to a "wrongful living" fact scenario. The first clinical situation involves the employment of true emergency medical intervention, such as cardiopulmonary resuscitation65 or cardioversion,66 which clearly constitute "lifesaving" therapies. The second class of clinical encounters encompasses the "middle ground" of therapies which have the potential to promote recovery, but are highly invasive and involve inherent risks to the life and well-being of the patient. These therapies include mechanical ventilation and diagnostic surgery. The third category of clinical therapies for consideration may more properly be termed "life-sustaining." These therapies, such as hydration, nutrition, antibiotics, chemotherapy, and hemodialysis, are commonly used where clinically indicated to preserve life. They rarely have the unambiguous "lifesaving" character necessary to support a "wrongful living" claim.67

Application of the "wrongful living" theory to the middle category of medical intervention is especially problematic. It could be argued that a patient cannot at one and the same time present himself to a hospital for treatment, and simultaneously

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65. Cardiopulmonary resuscitation ("CPR") is: "The reestablishing of heart and lung action as indicated for cardiac arrest or apparent sudden death resulting from electric shock, drowning, respiratory arrest and other causes." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1145 (26th ed., 1985).

66. Cardioversion is: "The restoration of normal rhythm of the heart by electrical shock." Id. at 223.

67. Ohio's living will statute allows for an election in the living will form for or against the provision of nutrition (defined as "sustenance that is artificially or technologically administered," see OHIO REV. CODE ANN. § 2133.01(T) (Anderson 1991), and hydration (defined as "fluids that are artificially or technologically administered," id. at § (N)), when the patient is permanently unconscious. See id. § 2133.02(A)(3)(a) (Anderson 1991). However, OHIO REV. CODE ANN. § 2133.02(A)(3)(b) expressly says that § 2133.02(A)(3)(a) shall not be construed to apply to one with a terminal condition. In such circumstances hydration and nutrition is "comfort care." Id. See infra section VII.
exercise a power of election against any and all therapeutic steps which have a tendency to preserve or prolong life. It is likely that the inherent contradiction in such a course of conduct would preclude a legal cause of action where the challenged therapy would, judged in light of reasonable medical knowledge, have any prospect of promoting recovery. However, the hypothetical situation of a terminally-ill patient who only consents to hospitalization for the purpose of being made comfortable must be considered. Perhaps transfer to a hospice setting would be appropriate for such a patient. Until that could be accomplished, though, administration of any treatment against the express wishes of the patient would arguably constitute a battery. Surely the idea of restraining a competent adult patient for the nonconsensual administration of, for example, cancer chemotherapy is repugnant to any reasonable person.

Although Ohio's Living Will Act thoughtfully provides for an election with respect to nutrition and hydration, application of wrongful living analysis to these and other therapies in the third category, such as chemotherapy, dialysis, and antibiotics, is problematic. These problems extend as well to "intermediate" interventions such as mechanical ventilation and diagnostic surgery. Accordingly, just as with the obvious situation of resuscitative therapy, each patient who expresses reluctance to accept any of these therapies or therapeutic treatments must be thoroughly interviewed and the patient's wishes carefully documented. A decision must then be made jointly by the patient and the physician as to how to proceed.

68. The difficulty is greatly reduced where institutional protocols exist which mandate specific procedures to be followed in the event of impending death. See generally U.S. Congress, Office of Technology Assessment, Institutional Protocols for Decisions About Life-Sustaining Treatments - Special Report OTA-BA-389 (July 1988). Such protocols will ideally require that competent patients must be consulted and have a right to refuse treatment. Id. at 39.

69. See supra note 67.

70. In the case of mechanical ventilation the wishes of the patient should be determined by the treating physician or hospital personnel upon admission to the hospital whenever possible. This is important because situations do arise where a patient will die within minutes without ventilation. The determination of the patient's wishes regarding ventilation need not and should not be made under "emergency" circumstances. As stated in Leach v. Shapiro: "Absent an emergency, defendants had an obligation to secure consent for Mrs. Leach's treatment." Leach v. Shapiro, 469 N.E.2d 1047, 1053 (Ohio Ct. App. 1984).

71. "[T]he prospect of refusing to act in an emergency because the patient at some time voiced vague wishes not to be kept alive on machines is equally unacceptable ...."
Fortunately for both the patient and the health care provider, sufficient time will usually be available for the patient to choose an option and have it documented. Almost invariably with diagnostic surgery and all of the “third level” treatments, and frequently with mechanical ventilation, there will be some time available to investigate and document the patient’s wishes should there be any confusion or uncertainty about whether the patient has made an informed decision to refuse nonemergency lifesustaining care. Any medical intervention after discovery of the patient’s wishes would plainly constitute a battery since the element of intent would be present.

By contrast, the critical care nurse or other health care worker faced with a situation which requires resuscitation or cardioversion has no time for reflection or investigation. If the competent patient has made the decision to forego resuscitation, that information must be clearly communicated to every health care provider who may possibly come into contact with the patient. The “do not resuscitate” status of the patient may be readily communicated by placing applicable stickers on the patient’s monitor, chart, or door. Failure to take these preventative steps places the health care institution in jeopardy of facing a negligence-based “wrongful living” lawsuit.

VI. DAMAGES: ASSESSING RECOVERY FOR PROLONGATION OF LIFE

By far the most difficult element of a “wrongful living” claim is the concept of continued life as a compensable injury. In wrongful life cases courts have consistently held, either as a matter of policy or of proof, that they are unable to calculate the value of life as contrasted to the value of “non-life.” As stated by the Court in Procanik:

Before refusal of treatment can controvert the implied consent of a medical emergency ... it must satisfy the same standards of knowledge and understanding required for informed consent.” Leach v. Shapiro, 469 N.E.2d 1047, 1053 (Ohio Ct. App. 1984).

The crux of the problem is that there is no rational way to measure non-existence or to compare non-existence with the pain and suffering of [the infant plaintiff's] existence. Whatever theoretical appeal one might find in recognizing a claim for pain and suffering is outweighed by the essentially irrational and unpredictable nature of that claim. Although damages in a personal injury action need not be calculated with mathematical precision, they require at their base some modicum of rationality.73

In wrongful birth cases, courts have allowed recovery for the increased medical expenses to raise an impaired or defective child.74 However, for those courts which also use the term "wrongful birth" action for claims made by parents over the birth of an unplanned or unwanted healthy child, damages have typically been limited based on public policy considerations that the parents now have the enjoyment of a healthy, normal child.

In *Bowman v. Davis*75 a claim was made by parents for damages arising from the birth of twins following a failed sterilization.76 The court distinguished the case from those for wrongful life which are brought by children and, instead, described it as a traditional negligence action.77

Much of appellant's argument [concerning the propriety and speculative character of "wrongful pregnancy" damages] is irrelevant. This is not a suit for "wrongful life," which asks the jury to measure damages on the relative merits of *being* versus *non-being*. It is, instead, a traditional negligence action. At the trial, appellees asserted that the appellant was negligent during and after the tubal ligation, that this negligence was the proximate cause of the birth of the twins, and that the negligence cost the family the expenses of childbirth and rearing.78

The *Bowman* court did not view the case as a traditional "wrongful birth" action, perhaps in light of the fact that one of the twins was born in a normal, healthy state, and the other twin suffered from severe birth defects.79 The court affirmed the jury

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73. Procanik, 478 A.2d at 763.
74. See *supra* notes 32-33 and accompanying text.
75. 356 N.E.2d 496 (Ohio 1976) (per curiam).
76. *Id.* at 496-97.
77. *Id.* at 499.
79. *Id.* at 497 (one twin suffered from kidney and hip malformations and mental retardation). *See also* Maggard v. McKelvey, 627 S.W.2d 44 (Ky. Ct. App. 1981) (tort
verdict awarding $450,000 in general damages and $12,500 in special damages,\textsuperscript{80} and declined to review defendants' argument, made for the first time on appeal, that damages should be limited to those for the pregnancy only.\textsuperscript{81}

This question as to what limitations should be placed on the damages recoverable by the parents following the birth of an unwanted, but normal and healthy child was eventually addressed by the Ohio Supreme Court in Johnson v. University Hospitals.\textsuperscript{82} The Johnson court clarified the distinctions between causes of action for "wrongful life" and "wrongful birth" versus those for "wrongful pregnancy."\textsuperscript{83} The court recognized the difficulty involved in quantifying damages in cases involving an unwanted pregnancy that resulted from medical negligence.\textsuperscript{84} Recovery for child-rearing expenses was disallowed,\textsuperscript{85} with the court stating:

In a wrongful pregnancy action, Ohio recognizes the "limited damages" rule which limits the damages to the pregnancy itself and does not include child-rearing expenses. The extent of the recoverable damages is limited by Ohio's public policy that the birth of a normal, healthy child cannot be an injury to her parents.\textsuperscript{86}

\textsuperscript{80} Id. at 499 (special damages included loss of consortium).
\textsuperscript{81} Id. at 498 n.1.
\textsuperscript{82} 540 N.E.2d 1370 (Ohio 1980) (action for alleged negligent failure to properly perform sterilization via a tubal ligation).
\textsuperscript{83} Id. at 1372.
\textsuperscript{84} Id. at 1370 (Ohio 1980) (syllabus of the court). See generally Liza F. Cohen, Note, Recovery of Damages in Wrongful Pregnancy Action: Johnson v. University Hospitals of Cleveland, 4 J.L. & HEALTH 83 (1989). In contrast, see Russell G. Donaldson, J.D., Annotation, Recoverability of Cost of Raising Normal, Healthy Child Born as a Result of Physician's Negligence or Breach of Contract or Warranty, 89 A.L.R.4TH 632 (1991) (distinguishing between damages available for traditional wrongful birth cases involving a damaged or genetically defective child and damages in actions for wrongful pregnancy or conception).
\textsuperscript{85} Johnson v. University Hosps., 540 N.E.2d 1370, 1374-75 (Ohio 1980).
\textsuperscript{86} Johnson, 540 N.E.2d at 1370 (syllabus of the court). The limited damages concept adopted in Johnson includes recovery of out-of-pocket and direct expenses, pregnancy-
The Johnson and Bowman cases are relevant to a cause of action asserted by a competent adult for “wrongful living” to the extent that they support an award of damages at least for the medical expenses directly attributable to the plaintiff’s continued existence, without any need to assess the value of life versus non-life. The award of such damages in Johnson and Bowman was clearly warranted and should be extended to wrongful living cases, since such damages do not require an assessment by the fact finder of the relative value of “being versus non-being.”

Furthermore, because of factual circumstances which accompany the typical “wrongful living” suit, damages should generally be more readily calculable than they would be for a wrongful birth suit. Wrongful living suits necessarily involve assessment of damages for a period commencing at the time of the wrongful resuscitation or institution of life-sustaining therapy and ending at the time of the patient’s death. Wrongful birth suits, on the other hand, necessarily involve assessment of damages for the lifetime of a child born as a result of negligence or the cost of raising a healthy child versus the joy of having it. The “wrongful living” plaintiff, a competent adult, has made a conscious decision related expenses (such as lost wages, medical expenses, cost of future sterilization operation, loss of consortium, and comfort), and the pain and suffering inherent in childbirth. Child-rearing expenses are excluded. See Cohen, supra note 73, at 92.

87. See supra section II. In contrast, consider the interesting question of the relationship between “wrongful living” claims and hedonic damages. Hedonic damages have been defined in the Ohio legal literature as compensation for “the loss of life and loss of the pleasures of living.” Tabacchi, Hedonic Damages: A New Trend in Compensation?, 52 Ohio St. L. J. 331 (1991). They are said to “encompass the larger value of life ... including [the] economic ... moral ... [and] philosophical ... value with which you might hold life.” Id. at 331 (quoting Sherrod v. Berry, 629 F. Supp. 159, 164 (N.D. Ill. 1985), aff’d, 827 F.2d 195 (7th Cir. 1987)). The few Ohio cases which have discussed hedonic damages have, in general, resisted the recognition of separate claims for hedonic damages. See, e.g., Binns v. Fredendall, No. 85AP-259, 1986 WL 4939 (Ohio Ct. App. April 22, 1986) (no separate claims for loss of enjoyment and mental anguish); accord Valentine v. Walker Felback Funeral Home, C.A. No. L-80-054, 1981 WL 5506 (Ohio Ct. App. March 6, 1981). Kentucky has not expressly addressed the issue of hedonic damages by statute or case law. As a matter of logic, a “wrongful living” plaintiff would be estopped from a claim for hedonic damages where the claimed injury consists of continued life. On the other hand, it could well be argued that it is consistent with the recovery of hedonic damages that a person who is kept alive in an impaired state contrary to their wishes would be damaged by being deprived of the enjoyment of a quality life.

88. See supra notes 34-35 and accompanying text.

89. See supra notes 26-33 and accompanying text.
before the fact, rather than after, that the prospect of death was preferable to the prospect of unwanted treatment.

It is well-established that "every human being, [and thus every medical patient,] of adult years and sound mind has a right to determine what shall be done with his own body ...."90 The rule is similarly well-settled in Ohio,91 and has been recognized by the Kentucky legislature in its Living Will Act.92 An individual obviously has the right to determine what shall be done with his or her own body.93 Whenever either resuscitation or other lifesustaining treatment has been administered against the wishes of a competent, adult patient, at least technical or nominal damages should be recoverable. Consistent with Bowman, future medical expenses should also be recoverable.94 In addition, the jury should be permitted to assess damages as it would in any other case; that is, to award for pain, suffering, and emotional distress.

Arguments that jurors are not capable of assessing the value of a diminished life against no life are not persuasive.95 Consider the automobile accident victim who has lost, for example, a limb, an organ, or an eye. It would be a rare juror who could assess, from any kind of personal experience, the value of life with two legs versus life with one leg, of life with two kidneys versus life with one kidney, or of life fully sighted versus life blinded in one eye. In fact, a prospective juror who had experienced a loss similar to the loss claimed by a plaintiff in such a case would


91. Lacey v. Laird, 139 N.E.2d 25 (Ohio 1956). The syllabus reads, at paragraph 1: "Even though a surgical operation is beneficial or harmless, it is, in the absence of a proper consent to the operation, a technical assault and battery for which the patient may recover damages, but only nominal damages, and the surgeon is entitled to have the jury so instructed." Accord, Guth v. Huron Road Hosp., 539 N.E.2d 670 (Ohio Ct. App. 1987) (nonconsensual transfer of patient actionable as battery despite failure of medical malpractice claim sounding in negligence); Siegel v. Mt. Sinai Hosp., 403 N.E.2d 202 (Ohio Ct. App. 1978) (action for lack of informed consent where plaintiff having a history of asthma suffered permanent and irreversible brain damage caused by improper ventilation during surgical procedure).


93. See supra notes 39-49 and accompanying text.


95. See supra text following note 49.
almost surely be dismissed by way of a preemptory challenge. In spite of this fact, courts have almost unanimously allowed jurors to make these assessments in personal injury actions.

VII. COMPARISON: OHIO AND KENTUCKY LIVING WILL ACTS

The legislatures of Ohio and Kentucky have recently passed "living will" acts. The Ohio bill, introduced January 22, 1991, provides inter alia, that a patient, while competent, may elect against specific forms of medical treatment in the event of certification by two physicians that the patient exhibits either a "terminal condition," or is in a "permanently unconscious state." The interventions against which the patient may make an election include nutrition and hydration. A living will becomes effective when (1) it is communicated to the attending physician, (2) the attending physician and one other physician determine that the patient is either in a "terminal condition," or a "permanently unconscious state," whichever is addressed in the patient's declaration, and (3) the attending physician further determines that


97. Section 2133.01(AA) of the Ohio Revised Code provides:

'Terminal condition' means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a declarant's own or other patient's attending physician and one other physician who has examined the declarant or other patient, both of the following apply: (1) There can be no recovery. (2) Death is likely to occur within a relatively short time if life sustaining treatment is not administered.


98. Section 2133.01(U) of the Ohio Revised Code provides:

'Permanently unconscious state' means a state of permanent unconsciousness in a declarant or other patient that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by the declarant's or other patient's attending physician and one other physician who has examined the declarant or other patient, is characterized by both of the following: (1) The declarant or other patient is irreversibly unaware of himself and his environment and (2) There is a total loss of cerebral cortical functioning resulting in the declarant or other patient having no capacity to experience pain or suffering.


99. See supra note 60 and accompanying text.
“the declarant no longer is able to make informed decisions regarding the administration of life-sustaining treatment.”

Notably, the bill provides that a valid living will “supersedes any general consent to treatment form signed by or on behalf of the declarant prior to, upon, or after his admission to a health care facility to the extent there is a conflict between the declaration and the form, even if the form is signed after the declaration.” The valid living will declaration will likewise supersede a durable power of attorney for health care where both are present, to the extent that the provisions of the documents would conflict. The statute requires that, prior to the withdrawal or withholding of life-sustaining treatment, the attending physician “make a good-faith effort and use reasonable diligence” to notify person(s) designated for notification by the living will declarant, or certain enumerated other persons. Failure to provide adequate notice is defensible by appropriate documentation in the patient’s medical record of reasons regarding the “failure to provide the requisite notices and information pertaining to the nature of the good faith effort and reasonable diligence used.”

The statute also sets forth the standards and procedures required when an incompetent individual has failed to previously state his desire, and another now seeks to substitute his judgment for that of the incompetent. Although these new statutes may

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101. Id. § 2133.03(B)(1).
102. Id. § 2133.03(B)(2).
103. Id. § 2133.05(A)(2)(a)(i).
104. Id. § 2133.05(A)(2)(a)(ii) (including guardian, spouse, adult children, parents, adult sibling(s)).
105. Id. § 2133.05(A)(2)(ii)(c).
106. The statute establishes a procedure for situations whereby consent to administer, withhold or withdraw life-sustaining medical care can be obtained from a relative or a guardian who was not appointed for that specific purpose after consultation with the patient’s attending physician. In order to qualify under this section, a patient must be: 1) in a terminal condition (as defined in the statute), or 2) in a permanently unconscious state (as defined in the statute) for at least 12 months, and 3) no longer medically able to make informed health care decisions. Id. § 2133.08(A)(1)(a). The consent may be obtained from, in order of preference, a preexisting guardian, a spouse, a majority of the reasonably available adult children, the parents, a majority of the reasonably available adult siblings, or the next nearest adult relative by blood or adoption. Id. § 2133.08(B)(1). The statute also gives guidance as to the considerations to be undertaken by the person(s) making the decisions on behalf of the patient. Id. §§ 2133.08(D)(2)-(3).
be very helpful in dealing with situations involving patients who are unable to communicate their own wishes regarding life-sustaining medical care, they have no relevance or applicability to patients who are capable of making their wishes known. The Living Will Act specifically states that it does “not affect, and shall not be construed as affecting, the right of a qualified patient or other patient to make informed decisions regarding the use or continuation, or the withholding or the withdrawal, of life-sustaining treatment as long as he is able to make those decisions.”

Thus, the Ohio legislature appears to have officially recognized the constitutional principal that each competent adult has total freedom in the decision to accept or reject any medical treatment, even if the decision to reject such treatment will likely result in the individual’s own demise.

The statute provides for nonliability of any attending physician and those acting under his or her direction for good faith compliance with the dictates of a living will. This would include nonliability in a criminal proceeding, tort or other civil action, or professional disciplinary action.

The statute appears to obviate many of the concerns of medical care givers who fear that compliance with a patient’s wishes to avoid lifesaving treatment may expose them to civil or criminal liability. However, the legislation does not, by its terms, preclude a cause of action based upon noncompliance with a patient’s

Should a guardian, spouse, adult child, parent or adult sibling dispute the decision of the statutorily-designated substitute decision maker, such person may file suit in probate court after first giving the attending physician notice of the objection and the grounds for it within 48 hours of the time at which the decision is made. That person must then file suit within two business days. If the objecting party is challenging a decision to forego or discontinue life-sustaining care, the burden of proof is by a preponderance of the evidence. If the objecting party is challenging a decision to continue life-sustaining care, the burden of proof is by clear and convincing evidence. 

The statute specifically prohibits anyone except a family member or guardian from initiating or intervening in an action involving substitute decision making in the consent to or the decision to withhold or withdraw life-sustaining medical treatment. 

107. Id. § 2133.08(E)(4).
108. Id. § 2133.12(C)(2) (emphasis added).
109. Id. § 2133.11(A) (non-liability extends to consulting physicians, the health care facility, and other health care personnel).

Notably, a “competing” living will bill also introduced January 22, 1991, provided for criminal sanctions for noncompliance with the dictates of a living will. Among the crimes described therein was “Wrongful Conduct Prolonging or Hastening Another’s Death,” denominated a felony of the first degree. S.B. 17, 119th G.A.
wishes when those wishes are not embodied in a legally sufficient living will.\textsuperscript{110}

In 1990 the Commonwealth of Kentucky likewise adopted a series of statutes addressing an individual's right to self determination.\textsuperscript{111} Although similar to Ohio in terms of nonliability for compliance with personal directives\textsuperscript{112} and preservation of common law and statutory rights of autonomous decision making,\textsuperscript{113} the Living Will Act materially differs in certain respects.

The Kentucky legislature expressly recognized that:

all adults have the fundamental right to control decisions relating to their own medical care, including the decision to have medical or surgical means calculated to prolong their lives provided, withheld, or withdrawn. [And] ... that the dignity, privacy, and sanctity of adults with terminal conditions may be respected even after they are no longer able to participate actively in decisions concerning their medical care ....\textsuperscript{114}

Within this framework certain limitations have been placed on an individual's control over what constitutes life-sustaining treatment. The Act specifically limits its application to terminal conditions which are described as incurable, irreversible, and of such a nature that death will occur, "within a relatively short period of time."\textsuperscript{115} The Act goes further to define life-prolonging treatment.\textsuperscript{116} Life-prolonging treatment excludes, "the administration

\begin{itemize}
\item \textsuperscript{110} See \textit{Ohio Rev. Code Ann.} § 2133.11(D) (Anderson 1991) ("This section does not grant, and shall not be construed as granting, an immunity from criminal or civil liability or from professional disciplinary action to health care personnel for actions that are outside the scope of their authority.") See also id. § 2133.12(C)(2) ("This chapter does not affect, and shall not be construed as affecting, the right of a qualified patient or other patient to make informed decisions regarding the use or continuation, or the withholding or withdrawal, of life-sustaining treatment as long as he is able to make those decisions.")
\end{itemize}
of medication or the performance of any medical procedure deemed necessary to alleviate pain or for nutrition or hydration." 117

The Kentucky legislature distinguished between basic human needs and medical treatment. A citizen of the Commonwealth cannot opt to refuse basic human needs. 118 This obviously leaves open the debate as to how much control a patient really has and whether a directive to withhold nutrition and hydration would be valid. 119

VIII. SUMMARY AND CONCLUSIONS

Medical care in this country is arriving at a very significant crossroads. With increasingly sophisticated medical technology it will soon be theoretically possible to prevent a patient from "dying," in the traditional sense, almost indefinitely. In many situations the prolongation of "life" is of no benefit to the patient, who is either comatose or experiencing great physical pain and mental suffering. The only benefit flows to the physicians and hospitals who care for these patients and then bill their services to the patient, the patient's insurance company, and when those resources are exhausted, to the government.

A decision must be made soon as to whether the patient or the doctor has the power to say "enough is enough." It is clear that a physician is not permitted to make a decision to terminate care on a living patient without the consent of the patient and/or the patient's family. Given that fact, allowing a physician to continue care against the wishes of the patient would be a travesty. If such were the case, any patient could be subjected to any medical treatment without consent simply because a physician thought the treatment to be appropriate or "lifesaving."

If, as Cruzan strongly implies, a competent adult patient has a constitutionally grounded right to refuse lifesaving or life-

117. Id. § 311.624(5)(b). Kentucky H.R. 456, Reg. Sess. (1992), now being considered by the Kentucky House of Representatives, would also permit a person making a living will to authorize the withdrawal or withholding of artificially provided food and water.


119. See id. at 15-17. Interestingly, Ky. REV. STAT. ANN. § 311.626(2) (Baldwin 1990), expressly states that if one portion of a valid living will is not lawful, only that portion will be stricken. Thus, it appears that all wishes except the withdrawal of "basic human needs" will be upheld, if challenged.
sustaining medical therapy, the law must provide a remedy for intentional or negligent violations of that right. The courts of this country may conclude that, as a matter of policy, a person is better off alive than dead, regardless of how miserable and meaningless that person's life may be. The patients in the hospitals of this country would then be left with a theoretical right to decide to withhold consent to medical treatment, but no remedy for the foreseeable damages which might flow from a violation of that right. Such a "right" is really no right at all.
AIDS: DEALING WITH THE PLAGUE

Roger N. Braden*

I. INTRODUCTION

In 1347, a Genoese fleet made its way into the Messina harbor in northeast Sicily. Members of its crew were either dying or already dead, afflicted with a strange disease carried from The Orient. The harbor masters attempted to quarantine the fleet, but without success. It was not men, but rats and fleas that brought the sickness to the harbor in Sicily. Within days, half of the region's population had either died or fled. This scene, repeated in thousands of ports across Europe, Asia and North Africa, heralded the coming of what some consider to be the greatest natural disaster in European history—the Black Death.

The Black Death devastated the Western world from 1347 to 1351, killing twenty to fifty percent of Europe’s population, which continued to decline steadily for at least a century thereafter. This depopulation contributed to constitutional changes and the rise of bureaucratic government in Europe, and brought political and constitutional changes to the Islamic world as well.

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1. ROBERT S. GOTTFRIED, THE BLACK DEATH: NATURAL AND HUMAN DISASTER IN MEDIEVAL EUROPE xiii (1983); PHILIP ZIEGLER, THE BLACK DEATH 40 (1969) (both referencing the account of Michael of Piazza, a Franciscan Friar, who wrote down this history ten years later in Bibliotheca scriptum qui res in Sicilia gestus retulere, Vol. 1 at 562).


3. ROBERT S. GOTTFRIED, THE BLACK DEATH: NATURAL AND HUMAN DISASTER IN MEDIEVAL EUROPE 145 (1983). The plague affected all segments of society. However, the clergy which was in power at the time appeared to be affected more severely than the laity. Earlier recovery by laity and the lack of recovery by the clergy changed the power structure of society, which allowed for the change in form of government.

4. MICHAEL W. DOLS, THE BLACK DEATH IN THE MIDDLE EAST 185-92 (1977). In Egypt the plague was especially severe among the ruling class. The Turks were able to conquer the Middle East as a result.
Many scholars rank the Black Death as the greatest biological-environmental event in history, and one of the major turning points in Western Civilization.\(^5\)

Today, we are faced with another plague — AIDS. It may be just as devastating, if not more devastating, than the plague that stalked Eurasia and Northern Africa for four centuries. The Black Death and AIDS have many things in common. This article will attempt to educate its readers about the AIDS disease itself, and will examine how courts have dealt with some of the forms of actions brought by individuals or by the government when seeking to place blame on those responsible for the spread of this disease.

II. ACQUIRED IMMUNE DEFICIENCY SYNDROME

In order to appreciate fully the dilemma facing the courts, we must understand the nature of acquired immune deficiency syndrome (AIDS) and the challenges facing our legal system\(^6\) in responding to this proliferating, politically-sensitive disease.\(^7\) In June of 1981, the Centers for Disease Control (CDC) reported an "unusual" outbreak of a deadly form of pneumonia, *pneumocystis carinii pneumonia* (PCP), diagnosed in five young homosexuals in Los Angeles.\(^8\) Shortly afterwards, the CDC


6. These challenges include "balancing the need to protect the privacy of persons with AIDS against the need to protect the public from transmission of the disease; weighing the risks to the public, the defendant, and others in considering the appropriate sentence and treatment for a criminal defendant with AIDS; dealing with the fears of court personnel about being in contact with persons with AIDS in the courtroom; and new issues of discrimination in housing, schools, and the workplace." CLARK C. TORRETT, JR., AIDS AND THE COURTS xvii (1990).


The epidemic raises fundamental questions regarding the nature of individual freedom, our responsibilities to others, the always delicate balance between private rights and public interest, and society's obligation to its 'out' groups — those members it has stigmatized, discriminated against, ridiculed, and treated as less than full and equal citizens. Indeed, it requires us to ask whether society can discharge its responsibilities in this regard without discarding some of its essential myths about itself.

Id. at 5.

reported that ten more cases of the deadly pneumonia as well as a rare form of cancer, Kaposi's sarcoma, usually seen in elderly men, had appeared among the young homosexual population.9 AIDS had arrived in America.

Since 1981, there have been more than 206,392 cases of AIDS in the United States and its Territories reported by the Centers for Disease Control.10 While most AIDS victims are men, 22,823 women have contracted the disease in the last decade.11 There have been over 133,233 deaths in the United States from AIDS.12

New York is the nation's leader in AIDS cases, having 42,619.13 California has 38,329 cases.14 Ohio ranks twelfth in the nation in AIDS cases with 2,906.15 The Centers for Disease Control has reported that 455 AIDS cases have been confirmed in the Metropolitan Cincinnati area through December of 1991.16 Through December of 1991, there have been 671 reported cases of AIDS in Kentucky, ranking it thirty-second in the nation.17

AIDS is caused by a retrovirus, a virus that contains ribonucleic acid (RNA), which is used by the cell as a template for creating deoxyribonucleic acid (DNA) of infected cells.18 When originally located, the human immunodeficiency virus (HIV) was identified as the human T-Cell lymphotropic virus type III (HTLV-III) or as lymphadenopathy-associated virus (LAV).19 By
international agreement, the virus is called HIV to distinguish it as a human pathogen.\textsuperscript{20} The virus depletes white blood cells, called T4 lymphocytes, which act as inducers/helpers in the immune system. The depletion of T4 lymphocytes cripple the immune system, which makes the AIDS victim more susceptible to infection.\textsuperscript{21}

AIDS is transmitted primarily by heterosexual or homosexual intercourse; as a result of transfusion of blood or blood products; by use of unsterilized syringes and needles; or from mother to child in connection with the birth process.\textsuperscript{22} After an individual is exposed to HIV, the individual may or may not become infected with the disease.\textsuperscript{23} If the person is infected with HIV, though, there is a period of time when the person will not test positive on an HIV antibody test.\textsuperscript{24}

Many individuals are aware of the actions taken by the medical, governmental and community groups in dealing with the AIDS crisis.\textsuperscript{25} But how are the legislatures and courts responding to the challenges resulting from the AIDS epidemic? This article will examine the legislative and judicial responses to date in a few key areas — the integrity of blood and blood products,\textsuperscript{26} tort actions for sexual transmission of the disease,\textsuperscript{27} discrimination against persons with AIDS or HIV,\textsuperscript{28} and criminal remedies.\textsuperscript{29}

\textsuperscript{20.} Id.
\textsuperscript{23.} See LEVY, supra note 18, at 11-12. Some individuals have serum-neutralizing antibodies that may help in blocking initial infection. Id.
\textsuperscript{24.} See MERCK MANUAL, supra note 21, at 292. False negatives usually occur only at early stages of infection. Id. The medical researchers are not in agreement as to how long the period lasts. Id. at 290. Some believe that the "window" period lasts somewhere between six weeks to six months. Others believe it may last several years. Id.
\textsuperscript{25.} For example, actions such as establishing standardized blood testing, researching and experimenting with drugs, and setting up clinics and support groups.
\textsuperscript{26.} See infra part III.A.
\textsuperscript{27.} See infra part III.B.
\textsuperscript{28.} See infra part III.C.
\textsuperscript{29.} See infra part III.D.
III. AIDS AND THE LAW

The states and the federal government have been attempting to respond expeditiously to the myriad of legal problems created by the new phenomenon of AIDS. For example, within the last three years, states have responded legislatively by imposing criminal penalties on individuals spreading the disease, and by enacting laws that either expressly provide a civil cause of action to infected persons or by implication may afford a civil cause of action. One of the recent ways in which the federal government has legislatively addressed the issue of AIDS is the Americans with Disabilities Act. From the judicial standpoint, trial courts across the country have been faced with a glut of recent filings and have been required to interface traditional civil and criminal legal theories to this new context.

Kentucky is one of those states whose legislature has expressly acknowledged that it is being adversely affected by the modern plague of AIDS. Since this acknowledgment, the Ken-

30. See, e.g., MD. HEALTH-GEN. CODE ANN. § 18-601.1 (1990) (makes transfer of disease a misdemeanor punishable by fine of $2,500.00 or imprisonment not exceeding three years or both).
31. See, e.g., OHIO REV. CODE § 3701.244 (Baldwin 1990) (expressly provides for a civil cause of action for violation of certain consent and disclosure statutes pertaining to AIDS testing).
32. See, e.g., KY. REV. STAT. ANN. §§ 214.454 and 214.990 (Baldwin 1991) (donor of blood who knowingly gives tainted blood is guilty of a Class D felony; no express provision made for civil cause of action).
34. See Miriam Walzer, Acquired Immune Deficiency Syndrome and Infection with Immunodeficiency Virus, 36 LOY. L. REV. 55 (1990); Larry Gostain, A Decade of a Maturing Epidemic: An Assessment and Directions for Future Public Policy, 5 NOTRE DAME J. ETHICS & PUB. POL'Y 7 (1990); Lynn Weisberg, AIDS: How Some Courts are Coping, 72 JUDICATURE 60 (1988).
35. As for its legislative findings, in 1990 the General Assembly of the Commonwealth of Kentucky found:
that acquired immunodeficiency syndrome, otherwise known as AIDS, constitutes a serious and unique danger to the public health and welfare. The General Assembly finds that acquired immunodeficiency syndrome is transmitted by sexual activity, by intravenous drug use, or from an infected mother to a fetus and that public fear of contagion from casual contact is not supported by any scientific evidence. The General Assembly finds that acquired immunodeficiency syndrome is transmitted by a retrovirus which makes the possibility of a cure highly unlikely in the near future. The General Assembly finds that, once infected, there is a high probability that an individual will develop acquired
The Kentucky legislature has proceeded to enact in excess of fifty statutes to deal with the legal and policy issues implicated. Immune deficiency syndrome or a related syndrome and die a premature death as a result, but may live productively for years in a communicable state without any signs or symptoms of illness. The General Assembly finds the unique methods of transmission of this disease, and its inevitably fatal course, have raised public fears; changed the attitudes of employers, insurers, educators, law enforcement personnel, and health and medical providers about dealing with the disease; and could unexpectedly raise the medical costs of this state. The General Assembly intends to establish programs and requirements related to acquired immunodeficiency syndrome which carefully balance medical necessity, the right to privacy, and protection of the public from harm and which establish public programs for the care and treatment of persons with acquired immunodeficiency syndrome and related conditions.


36. See KY. REV. STAT. ANN. §§ 16.095 [Educational Course for State Police], 71.130 [Testing of Prisoners], 72.415 [Mandatory training on AIDS for Deputy Coroners], 164.351 [Information on preventing transmission to be provided to freshman and transfer university students], 196.171 [Corrections personnel to take education course on AIDS], 197.055 [Education and testing programs for prison inmates], 207.135 [Testing as a condition of hiring, promoting or continuing employment is prohibited unless bona fide occupational qualification], 207.150 [Prohibited employment practices], 207.160 [Prohibited discriminatory acts in labor organizations], 207.250 [No cause of action for failure to disclose HIV information in real estate transaction], 207.260 [Right of action for discrimination under Equal Opportunity Act], 211.967 [Educational course concerning AIDS required for certification of emergency medical technicians], 214.181 [HIV testing, consent, disclosure], 214.452 and 214.454 [Blood supply screening], 214.600 [Intent of General Assembly], 214.605 [Public Education Program], 214.610 [Educational Course to be completed by Health Care Workers and Social Workers], 214.615 [Required educational course on transmission control, treatment and prevention], 214.620 [Implementation of Professional education], 214.625 [Testing; consent; confidentiality], 214.635 [Impact on Spending for Health by Cabinet Human Resources], 304.14-130 [AIDS/HIV exclusion of coverage not permitted on insurance contracts in Kentucky], 304.12-013 [Prohibits unfair or deceptive practices in writing of insurance], 304.99-115 [Penalty for violation of 304.12-013], 311.281 [Testing of organs, skins, or other human tissue with informed consent], 311.450 [Podiatrists licensing requires education requirement under 311.653], 311.654 [Continuing education course for paramedics], 311.908 [Educational course requirement for athletic trainers], 311.282 [No civil or criminal penalties for disclosure by physicians under specified conditions], 311.990 [Penalties for violations of Chapter 311 statutes], 312.175 [AIDS educational course requirements for licensing of chiropractors pursuant to 214.610], 313.305 [AIDS educational course requirements for licensing of dental hygienists pursuant to 214.610], 313.080 [AIDS educational course requirements for licensing of dentists pursuant to 214.610], 315.065 [AIDS educational course requirements for licensing of nurses pursuant to 214.610], 315.065 [AIDS educational course requirements for licensing of pharmacists pursuant to 214.610], 320.280 [AIDS educational course requirements for licensing of optometrists pursuant to 214.610], 327.050 [AIDS educational course requirements for licensing of physical therapists pursuant to 214.610], 331.571 and 331.601 [AIDS educational course requirements for licensing of physicians], 333.190 [AIDS educational course requirements for licensing of medical laboratory personnel], 335.150 [AIDS educational course
Ohio has also enacted statutes in an effort to deal with the AIDS dilemma, but not to the same extent as has Kentucky.\textsuperscript{37} Let us now look in more depth to some of the primary areas in which a statutory or common law civil cause of action has been or may be recognized for victims of AIDS or HIV, and to some of the theories of criminal responsibility that have been advanced.

\textbf{A. Liability For Infection Through Blood Transfusion}

One of the first recognized means by which the AIDS virus can be transmitted is through transfusion of blood or blood products. Transfusion by blood and blood products is a particularly frightening fact since every member of our society, not just those considered to be in high risk groups, is susceptible to contracting the virus if our blood supplies are not safe. Everyone, young and old, heterosexual or homosexual, may at some time need a blood transfusion due to elective or emergency surgery.

The scientific world first became aware of the prospect that the AIDS virus could be transmitted through blood or blood products in the early 1980s.\textsuperscript{38} The earliest suspected transfusion-related case was reported in 1982.\textsuperscript{39} By March of 1983, the

\begin{itemize}
  \item requirements for licensing of social workers, 367.175 [Prohibition of self-testing kits], 441.115 [Educational course requirements for jail personnel], 529.090 [Mandatory testing following prostitution conviction].
  \item 37. \textit{See} \textit{Ohio Rev. Code} §§ 2907.27 [Examination and treatment of venereal disease in those charged with prostitution], 2927.13 [Sale or donation of blood by AIDS carrier], 3701.24 [Reporting of contagious or infectious diseases or AIDS], 3701.241 [AIDS testing; duties of health director], 3701.242 [Informed consent; counseling; anonymity], 3701.243 [Confidentiality and disclosure of information], 3701.244 [Violations; civil actions; defenses and immunities], 3701.245 [Prohibition of discriminatory acts], 3701.246 [Testing of anatomical gifts and blood donations], 3701.247 [Use of complaint to compel testing of health care worker or police officer], 3701.248 [Emergency medical services worker access to information on exposure to contagious or infectious disease], 3701.249 [Employer immunity regarding AIDS], 3901.45 [Prohibition of AIDS-related conduct regarding insurance applicants], 3901.46 [AIDS testing of insurance applicants], and 5120.16 [AIDS policy toward prison inmates].
  \item 38. The medical community's awareness and interest in the virus increased dramatically following the issuance in 1981 of the seminal reports from Los Angeles and New York involving homosexual men with pneumocystitis, pneumonia and comissicercoma. \textit{See supra} notes 8-9 and accompanying text.
\end{itemize}
Public Health Service recommended that "high risk" persons not give blood.\textsuperscript{40} By early 1984, representatives of blood banks in the United States were convinced of the association between blood products and AIDS.\textsuperscript{41}

1985 was a pivotal year because a test was finally developed which could identify the HIV virus.\textsuperscript{42} Prior to that time blood banks had to rely upon surrogate tests which could only indicate if a person was more likely to be a risk for contracting the disease.\textsuperscript{43} With the development of more sophisticated testing, combined with the increased awareness by the blood bank industry in general, the potential liability of blood banks for the testing and handling of its inventory became apparent. A few key issues emerged: first, what should be considered a reasonable time after the availability of testing to train staff in performance of the tests,\textsuperscript{44} and second, how should the current inventory be managed during the transition period during which the testing and training are implemented.\textsuperscript{45}

\begin{itemize}
  \item \textsuperscript{40} See Irving J. Sloan, AIDS Law: Implications for the Individual & Society 23 (1988).
  \item \textsuperscript{41} Office of Technology Assessment, Blood Policy and Technology at foreword (1985).
  \item \textsuperscript{42} This test was known as the HIV-1 antibody enzyme-linked immunosorbent assay (ELISA) test. See 1990 American Medical Association Archives of Pathology and Laboratory Medicine 1990; 114: 309-315 Sec.: College of American Pathologists Conference 16, AIDS and the Pathologist; Aug. 9-11, 1989.
  \item \textsuperscript{43} See Robert K. Jenner, Transfusion-Associated AIDS Cases, TRIAL, May 1990, at 31. The "surrogate" tested for was that of the hepatitis-B core antibody, since positive findings of the antibody were found in a very high percentage of persons affected with AIDS. See also generally Jan M. Bennetts, Note, AIDS: Blood Bank Liability, 27 Williamette Law Rev. 355 (1991); and Gregory N. Woods & Ann V. Thornton, Deadly Blood: Litigation of Transfusion-Associated AIDS Cases in Texas, 21 Tex. Tech. L. Rev. 667, 697 (1990).
  \item See also 21 C.F.R. § 610.11 (1986) which regulated general safety tests on biological products. Section 610.40 specifically called for the testing of blood and blood products for the hepatitis-B antigen and labeling as to the product's test reactivity. 21 C.F.R. § 610.40 (1986). These regulations were in place prior to the development of the ELISA test. See supra note 42. Following the development of that test, Subpart E - Hepatitis Requirements added a specific regulation for HIV testing. See infra note 46 and accompanying text.
  \item \textsuperscript{44} In K.W. v. Bellebonfilles Memorial Blood Bank, No. 87-CV-4127 (Colo. Denver County Dist. Ct. 1989), the jury awarded $5.5 million to a patient infected with AIDS because the blood transfused was never tested even though the blood kits had been received nine days prior to the transfusion. The issue presented to the jury for consideration was whether it was reasonable for the blood not to be tested at that time, given that the blood testing kits were available.
  \item \textsuperscript{45} In Carol v. Blood Ctr. of Southeastern Wis., No. 753-411 (Wis. Milwaukee County Cir. Ct. 1988), the jury awarded the plaintiffs a $3.9 million verdict because
\end{itemize}
Appropriate federal agencies were monitoring the evolving connection between AIDS and blood products. The Federal Food and Drug Administration, in January of 1988, added a provision to the standard regulations governing biological products generally, which required each donated unit of human blood and blood products be tested for antibody to HIV and labeled as non-reactive.\textsuperscript{46}

States have also reacted to the recognition of the connection between blood products and AIDS. For example, in 1988 the Commonwealth of Kentucky began requiring that all blood establishments within the Commonwealth perform certain specific tests on blood.\textsuperscript{47} The state of Ohio responded by making it a crime for an individual to sell or donate his blood if he knows or has reason to know that he may carry the AIDS virus.\textsuperscript{48}

Recent statistics show that claims filed for transmission of AIDS through blood products account for approximately two

\textsuperscript{46} 21 C.F.R. \textsection 610.45 (1991). All blood collection centers were thereafter required to quarantine contaminated products, keep adequate records of test results, protect the confidentiality of records, and maintain a permanent record identifying positive-testing donors so that blood products from these individuals would not be distributed in the future. \textit{Id.}

\textsuperscript{47} KY. REV. STAT. ANN. \textsection 214.452(1) (Baldwin 1991) places the duty upon the administrator of any blood establishment which collects blood for the purpose of distributing to another health service, health facility or health care provider to: (a) secure a signed written risk factor history and donor consent form for each potential paid or volunteer donor for the purpose of determining if such potential donor is at high risk for infection with HIV; or has tested positive for AIDS; or has a blood-borne communicable disease; or has a blood-borne sexually transmitted disease; (b) provide a means for a potential paid or volunteer donor to self-elect not to donate blood; (c) refuse donation or sale of blood by persons of high risk or from those persons who have tested positive for AIDS; and (d) post a sign visible to all donors that states in essence, that persons with AIDS, or who have tested positive with HIV, or who have a blood-borne communicable disease or sexually-transmitted disease or who have been exposed to one or more risk factors as established by the United States Centers for Disease Control are prohibited by Kentucky law from selling or donating blood. Additionally, the sign should inform the donors that any person who violates the law is guilty of a Class D felony.

\textsuperscript{48} OHIO REV. CODE ANN. \textsection 2927.13 (Baldwin 1990) (individual with knowledge that he is a carrier of the AIDS virus who gives or sells his blood is guilty of a felony of the third degree).
percent of the reported cases of AIDS. A person claiming to have been infected by the AIDS virus or HIV through a blood transfusion may proceed against the blood supply facility in an action based on products liability, negligence, or an intentional tort.

1. Products Liability

In a products liability action, plaintiff's complaint can be based on strict liability or breach of an implied warranty. A strict liability theory of recovery, as contemplated by section 402A of the Restatement (Second) of Torts, imposes liability on those who sell "any product in a defective condition unreasonably dangerous to the user or consumer." Section 402A requires that the seller be "engaged in the business of selling such a product" and the product "is expected to and does reach the user or consumer without substantial change in the condition in which it is sold."

Plaintiff's counsel would be required to assert that a "sale" took place in the administration of blood or the blood product. Arguably, a "sale" does occur. Hospitals pay blood banks in order to receive each unit that they supply to the patients. Patients are charged for each unit of blood that they receive. "This theory of strict liability, therefore, is premised upon the

54. Id.
55. Id.
concept that blood is a product and payment for a transfusion is a sale."

In addition, plaintiff’s counsel would be required to assert that the AIDS-contaminated blood or blood product had reached the user or consumer without substantial change in the condition in which it was sold. Because the HIV-infected blood or blood product was contaminated prior to being administered to the plaintiff, the product was previously contaminated and therefore left the defendant’s control without substantial change in its condition.

Finally, plaintiff’s counsel must allege that the defective condition of the AIDS-contaminated blood had made the product "unreasonably dangerous" and had been the cause of plaintiff’s death. If plaintiff’s counsel successfully establishes these elements, then a strict liability cause of action is established.

However, blood banks are not without a potential defense to a strict liability action. Protection may be afforded through the comment k exception to section 402A, Restatement (Second) of Torts. The exception precludes the imposition of strict liability on the grounds that the product is one which is "unavoidably unsafe." Blood fits within the exception pro-
vided by comment k.\textsuperscript{66}

Liability under an implied warranty of merchantability\textsuperscript{67} or fitness for a particular purpose\textsuperscript{68} depends upon the determination by the court to characterize blood and blood products as a product rather than a service.\textsuperscript{69} If blood is considered a product, then the sale of the product is governed by article 2 of the Uniform Commercial Code (UCC).\textsuperscript{70}

However, courts have generally refused to allow liability under a breach of implied warranty theory.\textsuperscript{71} The courts' refusal can be traced to the New York decision of \textit{Perlmutter v. Beth David Hospital}.\textsuperscript{72} In \textit{Perlmutter}, the plaintiff attempted to recover damages from the defendant hospital for contracting hepatitis from a blood transfusion administered by the hospital.\textsuperscript{73} The plaintiff's products liability theory was based upon an implied warranty imposed by the New York Sales Act that the blood was "reasonably fit for [the] purpose for which required and of merchantable quality."\textsuperscript{74} The court refused to characterize blood as a product, but rather found:

[t]he supplying of blood by the hospital was entirely subordinate to its paramount function of furnishing trained personnel and

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\textsuperscript{66} See Moore v. Underwood Memorial Hosp., 371 A.2d 105 (N.J. 1977) (holding that virally contaminated blood fits within the comment k exception); but see DeBattista v. Argonaut Southwest Ins. Co., 403 So. 2d 26 (La. 1981), \textit{cert. denied}, 459 U.S. 836 (1982) (rejecting the defendant's argument that the virally contaminated blood provided the plaintiff was not "unreasonably dangerous"). A hepatitis case sets the important precedent of placing blood within the comment k exception. In Hines v. St. Joseph's Hospital, 527 P.2d 1075 (N.M.), \textit{cert. denied}, 529 P.2d 1232 (N.M. 1974), plaintiff received blood tainted with the hepatitis virus and sued the blood supplier and hospital based on theories of strict liability and negligence. \textit{Id.} The court granted defendant's motion for summary judgment on both theories, holding that blood comes within the comment k exception to strict liability. \textit{Id.} at 1076.

\textsuperscript{67} U.C.C. § 2-314 (1987).

\textsuperscript{68} U.C.C. § 2-315 (1987).

\textsuperscript{69} \textit{Id.}

\textsuperscript{70} \textit{Id.}

\textsuperscript{71} "Most states have enacted legislation specifying that the use or transfusion of blood is a 'service,' not a sale, and therefore does not give rise to an implied warranty." Greif, \textit{supra} note 56, at 887.

\textsuperscript{72} 123 N.E.2d 792 (N.Y. 1954).

\textsuperscript{73} \textit{Id.} at 793.

\textsuperscript{74} \textit{Id.}
specialized facilities in an endeavor to restore plaintiff's health....
The conclusion is evident that the furnishing of blood was only an incidental and very secondary adjunct to the services performed by the hospital.\textsuperscript{75}

Dicta in the \textit{Perlmutter} decision indicates that the court refused to hold the hospital liable as a matter of public policy because to do so would make the hospital responsible as an insurer.\textsuperscript{76} However, several courts have rejected \textit{Perlmutter} and permitted recovery under either a strict liability or warranty claim.\textsuperscript{77}

Although the \textit{Perlmutter} decision was based on applicability of a breach of implied warranty theory to the transmission of hepatitis through tainted blood, the ramifications for the AIDS plaintiff are obvious. If blood and blood products are not a product, but rather a service, a products liability cause of action will not lie.

2. \textit{Negligence}

The most common cause of action involving the transmission of AIDS or other infection through blood or blood products is negligence.\textsuperscript{78} "It is the one cause of action that stands the greatest opportunity of withstanding summary judgment."\textsuperscript{79} Under a negligence theory, a plaintiff must demonstrate the following: (1) a duty to conform to a certain standard of conduct for the protection of others against unreasonable risk of harm; (2) breach of the duty; (3) a causal connection between the conduct and the injury; and (4) actual loss or damage.\textsuperscript{80}

\begin{itemize}
\item \textsuperscript{75} \textit{Id.} at 795 (emphasis added).
\item \textsuperscript{76} \textit{Id.}
\item \textsuperscript{77} \textit{See, e.g.,} Cunningham v. MacNeal Memorial Hosp., 266 N.E.2d 897 (Ill. 1970) (hospital engaged in selling a product consisting of hepatitis-contaminated blood stating a cause of action for strict liability); Community Blood Bank, Inc. v. Russell, 196 So. 2d 115 (Fla. 1967) (plaintiff's complaint characterized blood as a product and successfully stated a cause of action for breach of implied warranty of fitness for a particular purpose).
\item \textsuperscript{78} \textit{See Woods & Thornton, supra note 43, at 695-96; Karen Shoos Lipton, Blood Donor Services and Liability Issues Relating to Acquired Immune Deficiency Syndrome, 7 J. LEGAL MED. 131, 139 (1986).}
\item \textsuperscript{80} \textit{W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS} \textsection{30, at 164-65 (5th ed. 1984); \textit{See also generally id.} \textsection{96, at 681 and \textsection{98, at 694.}}
\end{itemize}
The potential defendants in a negligence action would include the blood supplier or blood bank, the donor whose infected blood caused plaintiff's illness, the hospital at which plaintiff received the infected blood, and the physician who prescribed the blood.

a. Negligence of Blood Suppliers or Blood Banks

In the context of blood donations and liability for the transmission of infected blood, any allegations of negligence on the part of the blood suppliers will focus on three primary negligence theories: first, negligent donor screenings; second, negligent blood testing or screening; and third, failure to provide for directed donations.

81. See Hoemke v. New York Blood Ctr., 720 F. Supp. 45 (S.D.N.Y. 1989) (plaintiff who allegedly contracted AIDS through blood transfusions received during kidney stone surgery brought action against the hospital's blood bank, as well as the physicians and the hospital); Vuono v. New York Blood Ctr., Inc., 696 F. Supp. 743 (D. Mass. 1988) (plaintiff sued the blood center when he received an infusion of a contaminated vial of blood albumin); Doe v. American Red Cross, 377 S.E.2d 323 (S.C. 1989) (plaintiff who was given a unit of HIV blood brought action in negligence against the blood supplier for failing to employ surrogate test to identify high risk donors); Hernandez v. Nueces County Medical Soc'y Community Blood Bank, 779 S.W.2d 867 (Tex. Ct. App. 1989) (plaintiff brought action against the blood bank for negligence in failing to conduct surrogate test which could indicate the presence of hepatitis).

82. For a general discussion of donor liability and the constitutional issues surrounding donor liability, see Woods & Thornton, supra note 43, at 677-78 and Lipton, supra note 78, at 160.


85. See Woods & Thornton, supra note 43, at 676.

86. See generally Stevens, supra note 79, at 226; Woods & Thornton, supra note 43, at 696; Lipton, supra note 78, at 140.

A fourth potential area establishing negligence on the part of blood suppliers is the failure to inform a donor that he has a transmittable disease before he infects
Two methods exist for establishing a blood bank's negligence in the screening of donors. First, the plaintiff can show that the blood bank's screening procedures violated federal regulations. Second, the blood bank may be negligent in failing to follow accepted donor screening practices. Though no standards for HIV blood screening or testing practices were in existence prior to 1985, four distinct high risk groups of
persons infected with AIDS were identified. As such, plaintiffs can argue that the blood supplies could have been made safer by eliminating donors in these high risk categories. For example, plaintiffs can assert that the blood banks could have used specific questioning to determine the donor's lifestyle and personal habits prior to permitting donation.

As noted previously, no test existed for the HIV antibody until 1985. If a plaintiff contracted AIDS from blood donated prior to 1985, when the FDA approved the ELISA test, a blood bank could be negligent for failing to perform one of the "surrogate tests" in existence. A cause of action against a blood center for negligence in failing to implement a surrogate test as part of its routine donor screenings process would require a plaintiff to establish "a sufficiently high correlation existed between people who were at high risk for contracting AIDS and people who tested positive to one of the surrogate tests without losing large numbers of donors who were infected with AIDS," and "that the cost of implementing the surrogate test was not prohibitive and that the test was readily available."

Since only a few banks implemented surrogate testing at all before 1985, a plaintiff would find it difficult to prove that the failure to implement testing breached the standard of care.

Lipton, supra note 78, at 144 (citing Office of Biologies, National Center for Drugs and Biologies, FDA, Recommendations to Decrease the Risk of Transmitting Acquired Immune Deficiency Syndrome (AIDS) from Blood Donors (Mar. 24, 1983); Office of Biologies, National Center for Drugs and Biologies, FDA, Recommendations to Decrease the Risk of Transmitting Acquired Immune Deficiency Syndrome (AIDS) from Plasma Donors (Mar. 24, 1983). By this time confirmed and unconfirmed AIDS-associated transfusions began to be reported.

91. Woods & Thornton, supra note 43, at 696. The four distinct high-risk groups of persons affected with the AIDS virus included: (1) homosexuals, bisexuals and their sexual partners; (2) Haitians who recently entered the United States; (3) hemophiliacs; and (4) intravenous drug users.

92. Id.

93. Id.

94. See supra note 42.

95. Bennett, supra note 43, at 365; Woods & Thornton, supra note 43, at 697 (surrogate tests could not determine if a person had AIDS but the tests did indicate if a person was more likely to be a risk for contracting AIDS). See also supra note 43.


In addition, since so few organizations implemented surrogate testing, it is difficult to find an expert to support the surrogate theory.\textsuperscript{98} Obviously, after the development of testing for HIV in 1985, a blood bank would be held liable in negligence for failure to administer the test or in improperly administering the test or misreading the results.

Another practice which might be challenged as a failure to exercise due care is the unwillingness to implement a “directed donations” program.\textsuperscript{99} Under a directed donor program, the recipient receives blood from a designated individual rather than from an anonymous donor.\textsuperscript{100} Often the donor is a friend or family member who donates prior to the recipient’s elective surgery.\textsuperscript{101} However, blood donor services have consistently opposed the establishment of a directed donation program.\textsuperscript{102} Though little or no valid evidence exists to support or to contradict the position of the blood collecting organizations, it is highly unlikely that the failure to provide a directed donation program would result in liability for these organizations.\textsuperscript{103}

\textsuperscript{98} Jenner, supra note 43, at 31.

\textsuperscript{99} Lipton, supra note 78, at 149; Woods & Thornton, supra note 43, at 698.

\textsuperscript{100} Lipton, supra note 78, at 149; Woods & Thornton, supra note 43, at 698.

\textsuperscript{101} Lipton, supra note 78, at 149; Woods & Thornton, supra note 43, at 698.

\textsuperscript{102} AMERICAN RED CROSS, AMERICAN ASSOCIATION OF BLOOD BANKS, COUNCIL OF COMMUNITY BLOOD CENTERS, JOINT STATEMENT ON DIRECTED DONATION PROGRAMS, (June 22, 1983); See Lipton, supra note 78, at 149. (Opposition was based on two arguments—that directed donation programs would seriously disrupt the nation’s blood supply and that the “pressure” from friends or family members to donate blood would compromise the single most effective screening device available to blood collecting organizations, the complete and accurate health history of the donor. It is believed by these organizations that the individual who is “pressured” into donating blood for family or friends may be reluctant to reveal an accurate medical history or current health problems.).

\textsuperscript{103} See Lipton, supra note 78, at 150. The blood donor organizations do assert valid arguments against the establishment of a directed donor program. First, their as-
Moreover, a potential plaintiff alleging negligence for failure to provide a directed donation program has the additional difficult burden of proving that such a failure, in fact, directly caused the transmission of the AIDS virus.\textsuperscript{104}

\textit{b. Negligence of the Hospital and/or Physician}

In addition to the blood banks, potential defendants in a negligence cause of action may include the hospital and/or the physician. Three basic negligence theories exist which could lead to recovery from hospitals and/or the physician.\textsuperscript{105} First, a negligent determination may have created the need for a blood transfusion that ultimately leads to contraction of the AIDS virus by the plaintiff.\textsuperscript{106} Second, negligent medical treatment by the hospital or physician may have created the need for the transfusion.\textsuperscript{107} Finally, there may have been a failure to use the patient's own blood rather than a transfusion from an anonymous donor.\textsuperscript{108}

Since a physician has little control over blood quality, negligence may be limited to the physician's conduct with regard to informed consent;\textsuperscript{109} the physician's control over the use of the
and the physician's conduct related to directed donations. As for negligence liability against a hospital, if the hospital maintains its own blood supply and possesses blood testing equipment, like the blood bank it may be negligent for improper handling of the supply or improper testing. However, if it does not, the hospital's negligence will likely be limited to the selection of a blood supplier and/or the failure to monitor the use of the blood in the hospital. Some additional areas for possible negligence actions against hospitals include the failure to get informed consent and the hospital's failure to use directed donations.

Courts differ as to the applicable standard of care in a negligence action. The opposing views are that either an "ordinary" standard of care or a "professional" standard of care should apply. Under the ordinary standard of care, the de-
fendant's liability is premised upon a showing that the defendant failed to do what the reasonably prudent physician, blood supplier, hospital, et cetera should have done in the same or similar circumstances.\textsuperscript{117} Under the professional standard of care, a less stringent standard, the defendant need only meet the standard of care prevalent in the applicable industry.\textsuperscript{118} In other words, under the professional standard, a defendant could rely upon the fact that the industry's practices are less than what a reasonably prudent defendant would do.

Certain statutory and common law defenses to contaminated blood actions developed during the mid-1960s and 1970s as a response to the transmission of the hepatitis virus.\textsuperscript{119} State courts and legislatures feared that the threat of liability without fault would drive the suppliers of blood out of business.\textsuperscript{120}

Statutory protection for the suppliers of blood and blood products is known as a "blood shield statute." These statutes reflect a balancing of basic policy considerations, balancing public benefit against public risk, and recognizing that blood, although absolutely needed, cannot be made absolutely safe.\textsuperscript{121}

\begin{quote}
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\textsuperscript{117} Woods & Thornton, \textit{supra} note 43, at 702.
\textsuperscript{118} Id. at 708.
\textsuperscript{119} Greif, \textit{supra} note 56, at 885.
\textsuperscript{120} Id. at 885-86.
\end{quote}

For example, in Doe v. Travenol Laboratories, Inc., 698 F. Supp. 780 (D. Minn. 1988), a patient who had acquired AIDS from an antihemophilic factor manufactured by the defendant brought suit alleging breach of warranty, strict products liability, and negligence. \textit{Id.} at 781. The court examined the Minnesota blood shield statute, which states,

\begin{quote}
The use of any part of a body for the purpose of transplantation in the human body shall be construed, for all purposes whatsoever, as a rendition of a service by each and every person participating therein and shall not be construed as a sale of such part for any purpose whatsoever.
\end{quote}

\textit{Minn. Stat.} § 525.928, and determined that the antihemophilic factor was squarely within the meaning of the statute. \textit{Travenol}, 698 F. Supp. at 782. The court held that
Blood shield statutes fall into one of four categories. The first type of statute bars claims based in strict liability and implied warranties of merchantability or fitness for a particular purpose. These causes of actions are barred because blood is defined as a service rather than the sale of product. This type of statute may specifically adopt a negligence standard which imposes liability only if "negligence on the part of the hospital or blood donor service can be established." The second group of the blood shield statutes bar application of the implied warranties of merchantability and fitness for a particular purpose, but make no mention of strict liability or negligence. The third category limits the protection of the statute to the transmission of hepatitis. The fourth type specifically states that blood "‘procurement,’ ‘processing,’ ‘distribution,’ ‘transfusion,’ ‘donation,’ or ‘preparation’" constitutes a service and not a sale.

the commercial processor of the antihemophilic factor could not be held liable on the breach of warranty or strict products liabilities theory based on the blood shield statute, id. at 784, although the decision did not foreclose recovery upon a showing of negligence. Id.

122. See Lipton, supra note 78, at 135-39.


124. "In 47 jurisdictions, blood and blood components are, by statute, defined as a service and not as a sale subject to implied warranty or strict liability." Id. at 135-36.

125. Id. at 135.


3. Intentional Tort

Finally, a person who has received contaminated blood may have a cause of action based on the intentional tort of battery. The action may be brought against either the donor or the physician. While there are no reported cases of battery actions against a donor of contaminated blood, this may simply be the result of the "anonymous donor" system implemented by many hospitals and laboratories. If the plaintiff knows who the donor is, however, that donor could be sued if the plaintiff can show that (1) the donor knew he was a member of a high risk group, or (2) the donor knew he had the AIDS virus and nevertheless chose to donate blood.

Generally, one who gives consent to surgery cannot recover under a theory of battery for any harm suffered as a result of the surgery. However, if the plaintiff placed conditions on the consent and the surgeon exceeded those conditions, the consent given by the plaintiff would not immunize the surgeon from liability for exceeding those stated conditions. For example, one court has held that a surgeon could be liable for battery as a result of transfusing AIDS-contaminated blood into the patient, if patient's consent to the operation was conditioned upon the use of only family-donated blood, the surgeon intentionally violated that condition, and the patient was harmed as a result of the violation.


Courts that have interpreted these last two types of statutes have ruled that the language in these statutes does not preclude the application of strict liability. Lipton, supra note 78, at 136; see, e.g., Fogo v. Cutter Labs., Inc., 137 Cal. Rptr. 417 (Ct. App. 1977) (statutory language characterizing the distribution of blood and blood products as a service and not a sale precluded application of strict liability and breach of implied warranty theories).

129. See Woods & Thornton, supra note 43, at 694.
131. See supra notes 99-104 and accompanying text.
133. See Ashcraft v. King, 278 Cal. Rptr. 900, 902 (Ct. App. 1991); see also Restatement (Second) of Torts § 892(A) (1965).
134. Ashcraft, 278 Cal. Rptr. at 902; see also Restatement (Second) of Torts §§ 892(A)(3), (4) cmt. h (1965).
135. Ashcraft, 278 Cal. Rptr. at 903-04.
Thus, one of the early forms in which AIDS was reportedly being detected in the United States was through transfusion of contaminated blood and blood products. Although a negligence action is the most common form in which a cause of action is brought for transmission of AIDS through blood products, other important theories for recovery include intentional battery and products liability. Yet another predictable means of contracting AIDS or HIV is through sexual transmission. Courts are only recently beginning to deal with the legal issues arising in this new arena.

B. Tort Liability for Sexual Transmission of AIDS

There are three potential avenues of recovery in tort for the sexual transmission of the AIDS virus: (1) negligence, (2) sexual battery, and (3) fraud or misrepresentation. To date, these theories have generally not been well developed in the context of AIDS infection by sexual contact. However, numerous commentators have drawn an analogy to other sexually-transmitted diseases such as gonorrhea and genital herpes, and to exposure to cancer causing agents. 136

1. Negligence

In any action based on negligence it must be shown that the defendant had a duty which defendant breached, that there was a causal relationship between defendant’s conduct and plaintiff’s injury, and that plaintiff suffered a loss or damage as a result. 137


With regard to the virus causing AIDS, this would require a plaintiff to show that defendant had a duty to protect his sexual partner from sexually-transmitted diseases, and that defendant failed to take precautions, resulting in plaintiff contracting the virus.

In the absence of cases charging negligence for the sexual transmission of AIDS, one can draw an analogy to those cases involving the transmission of other venereal diseases. One commentator suggests that a reasonable person who is part of a group that is at high risk for carrying the AIDS virus, such as intravenous drug users, homosexual contacts, or multiple sexual partners, should know that sexual relations would be a risk for contracting the virus. 138

As in any action based on negligence, causation must be proven. 140 In an AIDS case, as in any case based on the sexual transmission of disease, it may be sufficient to establish that the defendant had sexual relations with the plaintiff during the time frame in which the plaintiff contracted the disease. 141

138. In Long v. Adams, 333 S.E.2d 852 (Ga. 1985), a sexual partner who transmitted genital herpes was found liable under a theory of negligence. The court declined to find that defendant had a specific duty to warn of genital herpes, but did find that the sexual partner had a legal duty not to injure others. Id. at 854. A breach of a legal duty occurs when a defendant knew or should have known of the potential for injury to another and fails to adequately warn of this danger. Kathleen K. v. Robert B., 198 Cal. Rptr. 273 (Ct. App. 1984). In Kathleen K., summary judgment for defendant was reversed and the cause of action against defendant for, inter alia, negligent transmission of genital herpes to plaintiff, at a time when defendant should have known that he was infected and that sexual intercourse with plaintiff was likely to transmit the infection, was upheld. Id. at 276-77.


140. See W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 30, at 164 (5th ed. 1984) (causation in a negligence action can be established either by showing that defendant's actions were in fact what caused plaintiff's injury or that defendant's actions were the proximate cause of plaintiff's injury).

141. The court in Long v. Adams, 333 S.E.2d 852 (Ga. 1985), found that the causation element of a negligence claim involving transmission of genital herpes was satisfied when plaintiff showed simply that during the timeframe in question defendant had sexual relations with plaintiff and plaintiff contracted genital herpes. Id. at 855. By analogy to Long, a plaintiff would need only prove that sexual relations occurred with defendant and that defendant was HIV positive in order to substantiate a causal connection between defendant's actions and plaintiff's contraction of the virus.
The injury element\(^{142}\) of an AIDS sexual transmission tort raises some unique and interesting issues. In the first place, would the plaintiff sustain injury merely by testing positive for the virus, or would the injury have occurred only when the disease manifested itself?\(^ {143}\) Likewise, can the fear of contracting the disease when the plaintiff has tested positive for HIV,\(^ {144}\) or even where the plaintiff has tested negative,\(^ {145}\) satisfy the

\(^{142}\) See W. Page Keeton et al., Prosser and Keeton on the Law of Torts § 30, at 165 (5th ed. 1984) (plaintiff must prove injury in the form of loss or damage in order to have a cause of action in negligence).

\(^{143}\) In Plummer v. United States, 580 F.2d 72 (3d Cir. 1978), plaintiff was incarcerated with a cellmate who was infected with the bacteria that causes tuberculosis, resulting in plaintiff contracting the bacteria. The court held that infection with the dormant bacteria satisfied the physical injury requirement for a negligence claim. Id. at 73. Under this reasoning, a plaintiff infected with the HIV virus who has not yet developed AIDS would satisfy the injury-in-fact requirement for negligence.

\(^{144}\) Should a plaintiff be able to recover for prospective AIDS? At least one commentator has urged the courts to consider an analogy to recovery for prospective cancer for a plaintiff who has been exposed to carcinogens. See John P. Darby, Tort Liability for the Transmission of the AIDS Virus: Damages for Fear of AIDS and Prospective AIDS, 45 Wash. & Lee L. Rev. 185 (1988) (discussing recovery for fear of developing AIDS based on lines of cases that awarded damages to plaintiffs for fear of developing cancer and other diseases).

Courts have allowed recovery for mental anguish based on fear of developing cancer where the fear is reasonable and genuine and the fear is related to defendant's negligence. See Hagerty v. L&L Marine, 788 F.2d 315, 317 (5th Cir. 1986) (plaintiff who was soaked with toxic chemicals was entitled to recover damages for serious mental distress arising from fear of developing cancer where his fear is reasonable and causally related to defendant's negligence; the injury was discernible on occasion when he was drenched with chemicals; plaintiff presented sufficient indicia of genuineness so as to make summary judgment of his cancerphobia claim improper).

Applying this logic to the HIV-positive plaintiff, the plaintiff would need to prove, based on facts, that he has a reasonable and genuine fear of contracting AIDS from his status of testing positive for the HIV. One court allowed recovery for prospective cancer since plaintiff had been exposed to asbestos due to defendant's negligence and plaintiff could show that odds were greater than 50% that he would develop cancer as a result of this exposure. See Gideon v. Johns Manville Sales Corp., 761 F.2d 1129 (5th Cir. 1985) (plaintiff had contracted asbestos but did not yet suffer from any form of cancer; Fifth Circuit ruled that district court did not err in refusing to charge jury that plaintiff could not recover for his fear of future injury and death). Should the courts follow either of these theories, a plaintiff seeking recovery for prospective AIDS would need to prove that he has a high degree of likelihood of developing AIDS as a result of defendant's actions.

\(^{145}\) Should a plaintiff be able to recover in tort for emotional distress from fear of contracting AIDS when the plaintiff has not tested positive for HIV? In Doe v. Doe, 519 N.Y.S.2d 595 (Sup. Ct. 1987), a wife sued her husband for AIDS phobia after husband disclosed to wife that he had had a homosexual encounter. The court dismissed the claim for AIDS phobia, holding that there was no physical injury since defendant
injury requirement so as to support a cause of action? Finally, when would the injury be sustained for purposes of calculating the period of limitations?

2. Sexual Battery

A battery is an intentional and nonconsensual contact with the person of another which is harmful or offensive. Sexual activity satisfies the contact requirement for a cause of action for battery. The transmission of HIV by an infected person or one who has contracted AIDS will likely satisfy the requirement that the contact was harmful or offensive. To establish battery, it is often necessary to show that the defendant intended to cause the unprivileged contact — that is, the transmission of the virus. It may be enough to show, though, that the defendant knew that he was infected with HIV, or had contracted AIDS, and intended to cause the sexual contact which, in turn, caused transmission of the virus.

had tested negative for HIV and plaintiff had refused to be tested. \textit{Id.} The plaintiff sought recovery based on \textit{Ferrara v. Galluchio}, 17 N.E.2d 996 (N.Y. 1958), where a claim was allowed for cancer phobia based on improper irradiation of plaintiff's shoulder even though plaintiff in \textit{Ferrara} did not contract cancer. The court in \textit{Doe} distinguished \textit{Ferrara}, noting that Ferrara's cancer phobia was reasonable since Ferrara's doctor recommended regular cancer check-ups after the improper irradiation, and because the emotional distress claim was part of a larger claim where actual physical injury occurred. The court in \textit{Doe} went on to liken that allowing a claim for AIDS phobia based on the facts presented would be to open a Pandora's box, giving a cause of action to any plaintiff whose sexual partner was a member of a high-risk group. \textit{Doe}, 519 N.Y.S.2d at 598.

146. W. PAGE \textsc{Keeton} \textsc{et al.}, PROSSER AND KEETON ON THE LAW OF TORTS § 9, at 39 (5th ed. 1984).

147. \textit{See Tennessee v. Schimpf}, 782 S.W.2d 186 (Tenn. Crim. App. 1989) (Tennessee statutes that defined aggravated sexual battery as unlawful sexual contact, where sexual contact was defined as intentional touching if that intentional touching can reasonably be construed as being for purpose of sexual arousal or gratification, were not so overbroad and vague as to violate due process).

148. \textit{See, by analogy}, Barlow v. Superior Ct., 236 Cal. Rptr. 134 (Ct. App. 1987) (affidavit for search warrant did not support finding of probable cause for taking and testing blood of defendant five months after incident in question to support the intent element of asserted crime. Court stated must show biting motivated by the intent; intent to kill and physical act of biting the officers must concur. Testing five months later is not sufficient to support probable cause because affidavit did not allege that plaintiff had killed or inflicted great bodily harm. In addition, state statute prevented disclosure of testing information.).

149. Cooper v. Florida, 539 So. 2d 508 (Fla. Ct. App. 1989) (sentences in excess of sentencing guidelines upheld because of defendant's lifestyle, he knew or should have
3. Fraudulent Misrepresentation

If an AIDS-infected individual makes either an express or implied statement to another that he does not have AIDS prior to engaging in sexual intercourse, and then transmits the disease to his partner, he may be held liable under a theory of fraudulent misrepresentation.\textsuperscript{150} In those circumstances where the defendant does not knowingly misrepresent his freedom from the virus, by analogy to other sexually-transmitted disease cases, he may nevertheless be liable under a theory of negligent misrepresentation.\textsuperscript{151}

Determining whether to recognize tort liability for fraudulent misrepresentation when an intimate sexual relationship is involved requires the courts to address public policy considerations.\textsuperscript{152} Although it may be argued that such intimate personal


\textsuperscript{151} For cases involving fraudulent misrepresentation, see Barbara A. v. John G., 193 Cal. Rptr. 422 (Ct. App. 1983) (citing De Vall v. Strunk, 96 S.W.2d 245 (Tex. Civ. App. 1936); Crowell v. Crowell, 105 S.E. 206 (N.C. 1920); and State v. Lankford, 102 A. 63 (Del. 1917)).

\textsuperscript{152} See generally Gainor, supra note 139.
relationships should be free from governmental intrusion, cases have held that this governmental intrusion is warranted in the interests of public health, welfare and safety.

A more difficult situation is presented where the defendant, rather than lying, fails to disclose his condition to a sexual partner and remains silent. While in some relationships there is no duty of disclosure, concealment or silence has been found to be the basis of liability in a fiduciary relationship, including the relationship between a married couple and even unmarried lovers.

It appears therefore that an action for fraudulent or negligent misrepresentation for transmission of AIDS is viable. Nevertheless, in order to successfully pursue such a case, the plaintiff must still be able to prove that the defendant knew or had reasonable grounds to believe that he was infected with the virus at the time of the alleged transmission.

C. Discrimination

In addition to the forms of action for AIDS or HIV from blood transfusions, and the progressively evolving forms of action in tort, discrimination against persons with AIDS or HIV is also an area of primary concern to courts and legislatures.

153. See Stephen K. v. Roni L., 164 Cal. Rptr. 618 (Ct. App. 1980) (Defendant in paternity action cross-claimed, alleging that the child's mother falsely represented that she had been taking birth control pills. Court refused to recognize his cause of action, noting that circumstances of such private relations should be best left to the individual.).

154. See Kathleen K. v. Robert B., 198 Cal. Rptr. 273 (Ct. App. 1984) (Kathleen K., another California case decided after Stephen K. v. Roni L., where the court recognized a cause of action brought by a woman who contracted genital herpes from the defendant. Citing another California case, Barbara A. v. John G., 193 Cal. Rptr. 422 (Ct. App. 1983), the court in Kathleen K. distinguished Stephen K. by observing that the latter case did not involve any personal injury to the plaintiff. Moreover, the government had an interest in rejecting the claim in Stephen K. to protect the rights of an innocent child.).

155. See Christian v. Estate of Rock Hudson, No. 574153 (Cal. Super. Ct. Los Angeles County Feb., 1989) (plaintiff alleged that he was never informed of his sexual partner's AIDS status; jury returned a multimillion dollar verdict for plaintiff).


157. Id. § 7.14, at 473.


159. See C.A.U. v. R.L., 438 N.W.2d 441 (Minn. App. 1989) (court held defendant had no duty to warn plaintiff that he had AIDS when, at the time of his relationship, he had no reasonable foreseeability that he had AIDS and could cause plaintiff harm).
There are several forms of discrimination against persons with AIDS or HIV.

1. Discrimination in Employment

In the employment setting the rights of the person infected with AIDS must be balanced with the rights of the persons seeking protection from exposure to the disease. Kentucky has attempted to deal with AIDS-related occupational discrimination through the Kentucky Equal Opportunities Act (the Act). The Act prohibits employers from failing or refusing to hire individuals who have AIDS, or who have tested HIV positive, unless the absence of HIV is a bona fide occupational qualification for the job in question. The Act also prohibits employment discrimination against health care professionals who provide treatment or care to persons infected with human immunodeficiency virus.

In addition, under the Kentucky Equal Opportunity Act, no labor organization is permitted to exclude or expel persons from its membership, or otherwise discriminate against them, because of a human immunodeficiency virus-related test. A labor organization may not limit, segregate, or classify its membership in any way that would deprive an individual with AIDS of employment opportunities, or adversely affect that person's wages, hours, or conditions of employment.

There have been no reported Kentucky cases involving the AIDS and HIV provisions of the Kentucky Equal Opportunity Act. The Kentucky legislature, though, as part of the Act, specifically provided a statutory cause of action for individuals who experience discrimination in the employment setting because they are infected with AIDS. The statutory remedy provides the right to enjoin further violations and enables the

161. KY. REV. STAT. ANN. § 207.150 (Baldwin 1991).
162. KY. REV. STAT. ANN. § 207.135(d) (Baldwin 1991).
163. KY. REV. STAT. ANN. § 207.150 (Baldwin 1991).
164. KY. REV. STAT. ANN. § 207.160 (Baldwin 1991).
165. KY. REV. STAT. ANN. § 207.260 (Baldwin 1991).
aggrieved party to recover attorney fees, court costs, and actual damages. 166

When counsel perceives that employment discrimination has occurred, the first step would be to check the applicable state statutes, such as employment discrimination laws or laws dealing specifically with discrimination against those with AIDS or HIV. Some states, like Kentucky, have statutes which expressly prohibit at least some discriminatory employment practices with respect to AIDS or HIV infection. 167 On the other hand, some states exclude illness in general, or AIDS or HIV infection in particular, from their definition of “disability” or “handicap” in the context of employment discrimination. 168 Other states have employment discrimination statutes that fail to address specifically whether AIDS is included in the definition of “hand-

166. Id. Section 207.260 provides an aggrieved person with a right of action for each violation and enables the person to recover liquidated damages of $1,000 or actual damages, whichever is greater. In addition, in the event the person intentionally or recklessly violates a provision of the Act, liquidated damages of $5,000 or actual damages, whichever is greater, and attorney fees may be awarded to the aggrieved party. Ky. REV. STAT. ANN. § 207.260 (Baldwin 1991). See also Ky. REV. STAT. ANN. § 207.230 (Baldwin 1991) (citizen suit provisions).

167. See, e.g., FLA. STAT. ANN. § 760.50 (West 1991) (specifically prohibiting employment discrimination on the basis of acquired immune deficiency syndrome, acquired immune deficiency syndrome-related complex, and human immunodeficiency virus); IOWA CODE ANN. § 601A.2 (West 1991) (defining “disability” to include a positive HIV test result, a diagnosis of acquired immune deficiency syndrome, a diagnosis of acquired immune deficiency syndrome-related complex, or other condition related to acquired immune deficiency syndrome) and IOWA CODE ANN. § 601A.6 (West 1991) (prohibiting employment discrimination based on HIV testing unless the state epidemiologist determines that a person with AIDS poses a significant risk of transmission to other persons in a specific occupation); KAN. STAT. ANN. § 65.6002 (1990) (setting reporting guidelines for physicians having information indicating that a person has AIDS and prohibiting use of such reports to discriminate in employment); Neb. REV. STAT. § 20-168(1) (1990) (prohibiting discrimination in hiring or discharging an individual on the basis that the individual is suffering or is suspected of suffering from AIDS or HIV infection); and N.C. GEN. STAT. § 130A-148(1) (1989) (prohibiting discrimination against any person with AIDS or HIV infection in determining continued employment, but expressly not prohibiting employers from requiring or using tests for AIDS in screening job applicants).

168. See, e.g., TEX. REV. CIV. STAT. ANN. art. 5221k § 2.01(4) (West 1991) (stating that the term “disability” does not include a person with acquired immune deficiency syndrome or HIV infection that constitutes a direct threat to the health or safety of other persons or makes the person unable to perform his job); N.H. REV. STAT. ANN. § 354-A:3, -A:8 (1991) (which prohibits employment discrimination based on physical disability and defines the term “physical disability” to mean other than illness).
icapped” or “disabled.” In such states administrative agencies and courts may be called upon to determine the scope of terms such as “handicapped” or “disabled.” For example, in Benjamin R. v. Orkin Exterminating Co., the Supreme Court of Appeals of West Virginia held that persons testing positive for HIV are handicapped with respect to the West Virginia employment discrimination laws. In addition, in Raytheon Co. v.

169. See Burgess v. Your House of Raleigh, Inc., 388 S.E.2d 134, 138 (N.C. 1990) (noting that to date 47 states and the District of Columbia have enacted statutes prohibiting employment discrimination on the basis of disability or handicap. Few of these statutes have specifically addressed whether HIV or communicable diseases are to be included in the definition.).


172. Id. The court stated that a person “at any stage of infection with the human immunodeficiency virus . . . is a person with a ‘handicap . . . .’” Id. at 819. The court stressed that infected employees are hesitant to have HIV tests performed due to employment discrimination fears, and that public health concerns make legal protection of infected employees a key factor in encouraging early testing and diagnosis of the disease. Id. at 818-19.
Fair Employment & Housing Commission, a California court held that an employee suffering from AIDS was “physically handicapped” within the meaning of California’s Fair Employment and Housing Act.

In Raytheon, the court recognized the public fear engendered by AIDS and that widespread lack of knowledge about AIDS produces deep anxieties and considerable hysteria. The court emphasized, though, that while there is a critical need to protect co-workers and others from contracting AIDS, there was no bona fide reason to justify Raytheon’s refusal to allow the employee to return to work. Thus, according to Raytheon, mere fear is insufficient to justify discriminatory actions by an employer.

The rising awareness and fear of the AIDS virus has resulted in two heavily debated issues in the field of employment law: the right of employers to test employees for the presence of the virus and the right or duty to disclose positive test results. This latter right or duty of the employer must be balanced against the employee’s right of privacy. Before a person can suffer discrimination, he must first be identified as having AIDS or HIV. Thus, in the employment area, the preclude to a charge of discrimination may be a dispute over the employer’s right to identify those employees who have HIV or AIDS.

Recent state legislative enactments and courts decisions have restricted the right of employers to test employees for AIDS

174. Id. at 201. In Raytheon, an employee diagnosed with AIDS was not permitted by his employer to return to his job, and civil suit was filed based upon the California Fair Employment and Housing Act. Id. at 200. The California Fair Employment and Housing Commission had determined that Raytheon had discriminated against the employee based upon a physical handicap. Id. This finding was upheld on appeal. Id.
175. Id. at 203.
176. Id.
177. Id.
178. See also Cain v. Hyatt, 734 F. Supp. 671, 681-83 (E.D. Pa. 1990) (holding that an employer’s apprehension that co-workers would fear working with an infected employee did not make the handicap a job-related handicap, and that a legal service had a duty to accommodate a regional partner during his first hospitalization for AIDS until the employee’s condition constituted an undue hardship on the employer).
or HIV. Two reasons can be advanced for these restrictions. First, there is little risk that AIDS will be transmitted in most employment situations; consequently, there is no perceived need for testing.\textsuperscript{180} Second, some believe that the consequences of a positive AIDS blood test in its disclosure to third persons would have a devastating impact on the infected person's life.\textsuperscript{181} Some states, such as California, Florida, Massachusetts, and Wisconsin, have passed laws that prohibit employers from testing employees for AIDS or from using the results of any such test in making employment decisions.\textsuperscript{182}

Courts which have addressed the right of the employer to test employees have, under a Fourth Amendment search and seizure analysis, considered the reasonableness of the intrusion to test balanced against the need for the testing in order to protect others.\textsuperscript{183} Moreover, a distinction has been made be-

\begin{enumerate}
\item \textsuperscript{180} Howe, supra note 179, at 364-71.
\item \textsuperscript{181} Id.
\item \textsuperscript{183} See Glover v. Eastern Neb. Community Office of Retardation, 867 F.2d 461 (8th Cir.), cert. denied, 493 U.S. 932 (1989). In Glover, employees of a multi-county health services agency brought suit to enjoin enforcement of a chronic infectious disease policy. Id. at 463. The Agency's policy required that certain employees submit to mandatory testing for hepatitis B and AIDS, inform the employer if they knew or suspected that they had the disease, and disclose to the employer if and when they were hospitalized or treated for AIDS. Id. at 462. The district court ordered a permanent injunction prohibiting the testing and the court of appeals affirmed. Id. at 464. The district court reasoned that the mandatory testing required by the policy constituted an "involuntary intrusion into the body." See Glover v. Eastern Neb. Community Office of Retardation, 686 F. Supp. 243, 251 (D. Neb. 1988), aff'd, 867 F.2d 461 (8th Cir.), cert. denied, 493 U.S. 932 (1989).

In defense of the policy, the employer argued that the employees worked for a highly regulated state agency and thus had only a diminished expectation of privacy. Glover, 867 F.2d at 464. The employer further argued that the court should analyze the blood testing policy as an administrative search, and therefore find that the proposed testing procedures were reliable methods of detecting the disease. Id. The appeals court disagreed, finding that the testing policy was not reasonable at its inception because the risk of transmitting AIDS was negligible, even in the agency's work environment. See Howe, supra note 179, at 365. It therefore concluded that the testing policy violated the Fourth Amendment. Glover, 867 F.2d at 464.

In Plowman v. United States Army, 698 F. Supp. 627 (E.D. Va. 1988), a federal district court examined the privacy question of whether the nonconsensual HIV testing of a civilian employee of the Army violated his Fourth Amendment rights with respect to searches and seizures. Id. at 628. The plaintiff also claimed that he was a victim of the intentional infliction of severe emotional distress by the defendant who ratified the AIDS test and improperly disclosed the results. Id. at 637.
tween testing that is required as a condition of employment as opposed to AIDS testing that is merely nonconsensual. 184

In the event the employer discovers through testing that an employee has AIDS, what should or must the employer do? There are those who advocate that disclosure would do more harm than good unless the employee receives counseling. 185 Others believe that if the employer required the test in the first place, failure to disclose the employee is infected and failure to take precautionary measures constitutes negligence. 186 It is reasonable to assume that the courts will perform a

The employee had been badly injured in a fight and the Army doctor ordered tests, including a HIV test, because surgery might be required. The HIV test revealed that the employee had been exposed to the AIDS virus. Id. at 629. The court dismissed the employee's privacy claims, stating that the constitutional protection against unreasonable searches and seizures did not necessarily extend to an AIDS test on a blood sample that had already been extracted for the purposes of other consensual diagnostic tests. Id. at 636 (citing United States v. City & County of San Francisco, No. 84-7089 (N.D. Cal. Aug. 28, 1987) (unpublished opinion) (the use of a person's blood sample for an HIV test was reasonable when that sample was already required for a series of other diagnostic tests)). Additionally, the Plowman court noted that the reason for testing was compelling, since the Army physician needed to know whether the patient was HIV positive in the event that surgery was necessary. Plowman, 698 F. Supp. at 635.

184. See supra note 183 (discussing the Glover v. Eastern Neb. Community Office of Retardation and Plowman v. United States Army decisions). The holdings of the Glover and Plowman cases can be harmonized by the fact that Glover dealt with a mandatory testing circumstance, while Plowman dealt with a nonconsensual HIV testing of blood already drawn for other testing.

See also Leckelt v. Board of Comm'rs, 714 F. Supp. 1377 (E.D. La. 1989), aff'd, 909 F.2d 820 (5th Cir. 1990). In Leckelt, the court found that the employer had a legitimate need to test one of its employees. Id. at 1392. The court upheld a hospital's discharge of a homosexual nurse who refused to disclose the results of an HIV test after his roommate had died of AIDS. Id. at 1391. There were several specific considerations that were of significance to the court. It was general knowledge that the nurse lived with a male friend and that he was homosexual. Id. at 1383. He was also assigned to a surgical/medical floor of the hospital. Id. at 1382. The hospital had learned that the plaintiff was a hepatitis B carrier and had been treated on two occasions for syphilis during the past two years, none of which he had disclosed to the hospital as required. Id. at 1390. The plaintiff was discharged by the hospital for failing to follow its infectious disease policy and for gross insubordination for failing to provide the HIV test results. Id. at 1379. It is significant to note the defendants only asked for the results of a test that the plaintiff had voluntarily taken. Id. at 1391.


186. Union Carbide & Carbon Corp. v. Stapleton, 237 F.2d 229, 232 (6th Cir. 1956) (employer was found negligent for failing to inform employee of tubercular condition discovered during employee's medical examination).
balancing of interests of the employer's need to disclose to others against the extent of intrusion upon the individual's privacy.\textsuperscript{187}

2. Discrimination in Child Custody and Visitation

Though there are few reported cases on the subject, courts which have considered the question have found that the alleged or documented fact of a parent's infection with the AIDS virus or HIV, alone and of itself, is not determinative of custodial rights.\textsuperscript{188} Such was the holding in the case of \textit{Steven L. v. Dawn J.},\textsuperscript{189} which involved a custody proceeding where the

\textsuperscript{187} In Cronan v. New England Tele., 41 F.E.P. 1273 (Mass. Sup. Ct. 1986), an employee requested permission to take a third medical absence. \textit{Id.} His employer insisted the employee reveal the reason for the needed absences and promised to keep the information confidential. \textit{Id.} When the employee told his supervisor that he had AIDS-related complex (ARC), the supervisor disclosed the information to his managers. \textit{Id.} at 1274. The management subsequently informed the employees in large group meetings that the employee had AIDS rather than ARC. \textit{Id.} The employee later received threatening telephone calls from fellow employees insisting that he not return to work. \textit{Id.} The employee sued New England Telephone for handicap discrimination, violation of his civil rights, and violation of the Massachusetts privacy statute. \textit{Id.} (The Massachusetts Privacy Act, Mass. Gen. L. ch. 214, § 1B (1989) provides: "A person shall have a right against unreasonable, substantial or serious interference with his privacy. The Superior Court shall have jurisdiction in equity to enforce such right and in connection therewith to award damages.").

The \textit{Cronan} court applied the standard set forth in Bratt v. International Business Machs. Corp., 467 N.E.2d 126 (Mass. 1984), a case which also involved disclosure of medical information under the privacy statute. \textit{Cronan}, 41 F.E.P. at 1274. The \textit{Cronan} court opined that it was necessary to balance the employer's legitimate business interest in obtaining and publishing the information against the substantiality of the intrusion on the employee's privacy. \textit{Id.} The court concluded that there was sufficient evidence to send to the jury fact questions as to the legitimacy of the defendant's business interest and the substantiality of the intrusion of Cronan's privacy. \textit{Id.}

Employers faced with potential privacy right claims can obtain guidance by looking not only to cases analyzing employee privacy rights under common law theories in the private sector, but also to cases brought by inmates in prisons. \textit{See} Howe, \textit{supra} note 179, at 368. (In Woods v. White, 689 F. Supp. 874 (W.D. Wis. 1988), \textit{aff'd}, 899 F.2d 17 (7th Cir. 1990), an inmate alleged that medical services personnel at the prison had discussed with prison staff and other inmates the fact that he tested positive for AIDS virus. \textit{Id.} The inmate maintained that these actions violated his constitutional right of privacy. \textit{Id.} at 875. The court denied the defendant's motion for summary judgment, \textit{id.} at 877, and acknowledged that even inmates have a constitutional right of privacy. \textit{Id.} at 875. The court balanced the individual's right to confidentiality against the government's interest in limited disclosure. \textit{Id.} at 876.).


\textsuperscript{189} 561 N.Y.S.2d 322, 323 (Fam. Ct. 1991).
father sought a modification of a voluntarily entered custody order.\textsuperscript{190} Likewise, in \textit{Anne D. v. Raymond D.},\textsuperscript{191} a husband sought an order compelling his wife to undergo a physical examination and HIV blood test.\textsuperscript{192} He alleged that she had engaged in a series of extramarital affairs.\textsuperscript{193} The court rejected the husband's assertion that a positive test result for HIV would automatically be a determinative factor with respect to the wife's ability to be a custodial parent.\textsuperscript{194}

Courts will weigh additional factors other than the presence of AIDS or HIV in making child custody determinations. For example, in \textit{Doe v. Roe},\textsuperscript{195} a New York court refused to order a custodial father to submit to an involuntary blood test for the HIV antibody on the motion of the maternal grandparents.\textsuperscript{196} The court found no compelling need for such a test, since it was the opinion of the court-appointed psychiatrist that, even if the father had AIDS, it would not justify the removal of the children from their loving long-term custodial parent.\textsuperscript{197}

Similar reasoning has been used by the courts in determining visitation rights for those infected with AIDS or HIV. In \textit{Stewart v. Stewart},\textsuperscript{198} an Indiana appellate court ruled that a father's infection with the HIV virus alone did not support the trial court's complete termination of his visitation rights.\textsuperscript{199} The case was remanded for presentation of further evidence with respect to current information on AIDS, together with other evidence, in support of a modification of visitation rights.\textsuperscript{200}

\textsuperscript{190.} Id. at 323.
\textsuperscript{191.} 528 N.Y.S.2d 775 (Sup. Ct. 1988).
\textsuperscript{192.} Id.
\textsuperscript{193.} Id.
\textsuperscript{194.} Id. at 777.
\textsuperscript{195.} 526 N.Y.S.2d 718 (Sup. Ct. 1988).
\textsuperscript{196.} Id. at 728.
\textsuperscript{197.} Id.
\textsuperscript{198.} 521 N.E.2d 956 (Ind. App. 1988).
\textsuperscript{199.} Id. at 958. The court relied on medical evidence presented at trial by two doctors, which showed that AIDS is not transmitted through everyday household contact, in finding that contraction of the virus alone did not support termination of visitation rights. See also \textit{Conkel v. Conkel}, 509 N.E.2d 983, 987 (Ohio Ct. App. 1987) (noting that HIV-associated diseases are not contracted by casual household contact).
\textsuperscript{200.} Stewart, 521 N.E.2d at 966. The court apparently was specifically interested in any new medical information which might be presented by either party on issues relating to contraction of AIDS. The court also ordered remand to obtain a visitation order which was not to be based solely on the issue of appellant's infection with the AIDS virus.
Jane W. v. John W. involved an application for visitation pendente lite by a father diagnosed as having AIDS. The court ruled that there were no exceptional circumstances to require limitation of such visitation with his child and ordered unsupervised visitation. The court relied heavily on the fact that the father was a health care provider intimately aware of the precautions he must take to protect his family and friends.

Thus, in the custody and visitation settings, the few reported cases indicate the courts will perform a balancing of the affected parents' rights against the potential harm to the child by a denial of visitation or custody. This appears to be similar to the determination of what would be in the best interests of the child made by courts when faced with other less controversial issues concerning custody and visitation.

3. Discrimination Against AIDS Children in School

Children of school age are also victims of the AIDS plague. Historically, courts have allowed school authorities, in the interest of protecting public health under the state police power, to exclude children who were infected with or who had been exposed to contagious diseases. The fact that children of school age are now being diagnosed with AIDS has revitalized the debate over the right of schools to exclude such infected children. While one case has held that the state had no

201. 519 N.Y.S.2d 603 (Sup. Ct. 1987).
202. Id.
203. Id. at 605.
204. Id.
206. See Hammett, supra note 205, at 1373.
207. See, e.g., Thomas v. Atascadero Unified Sch. Dist., 662 F. Supp. 376, 380 (C.D. Cal. 1987) (school district had adopted a policy for admission of students who were
rational basis to support exclusion of a child where the risk of transmission of the disease to others was small, courts, in the past, have rarely interfered with exercise of local police power in connection with the public health, safety and welfare.

While state and local school boards may retain the right to regulate and exclude AIDS-infected children, such students may be afforded protection by the Education of the Handicapped Act and section 504 of the Rehabilitation Act of 1973. In

infected with communicable diseases); Board of Educ. v. Cooperman, 523 A.2d 655 (N.J. 1987) (state commissioners of health and education adopted policy guidelines for admission to school of children with AIDS, AIDS-related complex or HTLV-III antibodies).


211. Pub. L. No. 93-112, 87 Stat. 394 (1973) (codified as amended at 29 U.S.C. § 794). The section provides: "No otherwise qualified individual with handicaps in the United States, . . . shall, solely by reason of her or his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . ." 29 U.S.C. § 794 (1988). The regulations promulgated pursuant to that statute further provide that a handicapped person is "any person who (i) has a physical or mental impairment which substantially limits one or more major life activities . . ." 45 C.F.R. § 83.3(j) (1991).


Child v. Spillane, 866 F.2d 691 (4th Cir. 1989), was a case brought under the Rehabilitation Act. The issue under the Rehabilitation Act is whether the person is an otherwise qualified handicapped individual. Id. at 692. If the person fits this test, the individual cannot be "discriminatorily excluded from activities receiving federal financial assistance." The court did not reach the issue in Spillane since the case was dismissed without prejudice when the AIDS-infected child was allowed to return to school upon a determination that she was not a significant risk to others. Id. See also Doe v. Dolton Elementary Sch. Dist. No. 148, 694 F. Supp. 440 (N.D. Ill. 1988) (student brought suit under the Rehabilitation Act for the purpose of requesting a preliminary injunction to allow him to return to school; court granted the injunction, reasoning
Martinez v. School Board,\textsuperscript{212} the Eleventh Circuit Court of Appeals found that a neurologically handicapped child in the late stages of AIDS was entitled to a free, appropriate public education in the least restrictive environment if the risk of transmission was not significant.\textsuperscript{213} The court found that the student fell within the protections afforded by the Education of the Handicapped Act,\textsuperscript{214} and section 504 of the Rehabilitation Act of 1973,\textsuperscript{215} the statutes under which these types of actions are most commonly brought.\textsuperscript{216} In Ray v. School District of DeSoto County,\textsuperscript{217} the court granted an injunction against the school district to the parents of three hemophiliac children infected with HIV.\textsuperscript{218} The injunction required the school district to admit the children to a normal integrated classroom setting, unless and until it could be established that the children posed a real and valid threat to the school population.\textsuperscript{219}

The right of an innocent child to a public education is fundamental. When a child who has AIDS or HIV is excluded from school due to this disease, through the Education of the Handicapped Act and section 504 of the Rehabilitation Act of 1973, the federal government has taken steps to ensure that an innocent child who happens to have contracted AIDS is not prohibited from enjoying the right to a public education.

\textsuperscript{212} Martinez, 861 F.2d at 1506.
\textsuperscript{213} Id. at 1506.
\textsuperscript{214} Id. at 1504.
\textsuperscript{216} Martinez, 861 F.2d at 1506.
\textsuperscript{217} 666 F. Supp. 1524 (M.D. Fla. 1987).
\textsuperscript{218} Id.
\textsuperscript{219} Id. at 1538.
4. Discrimination in Real Estate Transactions

Many states have enacted statutes in the area of real estate and housing which protect individuals who have been infected with human immunodeficiency virus or diagnosed with acquired immunodeficiency syndrome. Some of these statutes provide that brokers or salespersons have no duty to disclose that an occupant of real property has been infected with HIV or diagnosed with AIDS. The fact that a former occupant of real property is infected with HIV or diagnosed with AIDS is not considered a material fact and, therefore, it is not necessary for a salesperson to disclose to a new buyer that the previous owner was infected. Other statutes make it unlawful for a person to discriminate by refusing to sell or lease to a person who is suffering or is suspected of suffering from human immunodeficiency virus. Still other state

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220. See infra notes 221, 223, 224 and accompanying text.
222. See supra statutes cited in note 221.

For example, in *Poff v. Caro*, 549 A.2d 900 (N.J. Super. 1987), a state statute enabled the court to issue a preliminary injunction restraining a landlord from refusing to rent an apartment to homosexual men because they might contract acquired immune deficiency syndrome. See id. The court held that under the New Jersey civil rights statute, a person suffering from AIDS had a handicap within the meaning of the law prohibiting discrimination against handicapped individuals. The New Jersey statute protects the individuals who are discriminated against because they may be potential victims of AIDS or they are perceived to have AIDS. Id. See N.J. Stat. Ann. § 10:5-4 (West 1991).

See also *Barton v. New York City Comm'n on Human Rights*, 531 N.Y.S.2d 979 (Sup. Ct. 1988) (A dentist engaged in discriminatory rental practices under section 8-108 of the Administrative Code of New York City when he refused to sublease space to another dentist because the subtenant treated patients with AIDS. The court held that individuals with AIDS are entitled to the protection given to handicapped persons. The dentist whose sublease was terminated had standing to sue even though he himself was not handicapped); *Seitzman v. Hudson River Assocs.*, 542 N.Y.S.2d 104 (Sup. Ct. 1989) (punitive damages were available due to defendant's alleged willful and malicious conduct in violation of the Human Rights law when plaintiff physicians were
laws protect AIDS-infected persons in community living arrangements.224

AIDS and HIV victims who believe that they are subject to housing discrimination may also seek relief provided by the federal government in the Fair Housing Act (FHA).225 The FHA gives private litigants the right to challenge discriminatory housing practices.226 The Fair Housing Amendments Act of 1988 prohibits discrimination based on handicap.227 These amend-

denied the opportunity to buy a cooperative apartment because defendant refused to take the necessary steps to change the apartment into a medical office when defendant learned that the physicians would be treating patients with AIDS. See N.Y. Exec. Law § 296(5)(b)(1) (McKinney 1991)).

224. See, e.g., WIS. STAT. ANN. § 62.23 (West 1991). This statute provides in relevant part:

The fact that an individual with acquired immuno-deficiency syndrome or a positive test for the presence of HIV ... antigen or nonantigenic products of HIV or an antibody to HIV resides in a community living arrangement with a capacity for 8 or fewer persons may not be used ... to assert or prove that the existence of the community living arrangement in the city poses a threat to the health, safety or welfare of the residents of the City.

Id. See also Mixon v. Grinker, 556 N.Y.S.2d 855 (App. Div. 1990) (action to compel a municipality to provide special housing for homeless individuals infected with AIDS; the Coalition for Homeless was granted standing to sue on the behalf of AIDS homeless individuals to seek special housing for such persons). See generally Patti E. Phillips, Comment, Adding Insult to Injury: The Lack of Medically-Appropriate Housing for the Homeless HIV-ILL, 45 U. MIAMI L. REV. 567 (1990-91).


226. See id. The stated purposes of these sections were “the Congressional interest in expanding the Act to allow private litigants the right to challenge alleged discriminatory housing practices, and including handicapped persons among those protected by the Act.” Baxter v. City of Belleville, 720 F. Supp. 720, 728 (S.D. Ill. 1989) (citing H.R. REP. No. 100-711, 100th Cong. 2d Sess. 5 (1988)). In Baxter, the plaintiff sought injunctive relief against the city requiring the city to allow Baxter to open a residence where he intended to house persons infected with AIDS. Baxter claimed his rights under the Fair Housing Act were violated when the city refused to allow him to open the home. The court stated that it was clear that “Congress intended to include among handicapped persons those who are HIV positive,” Baxter, 720 F. Supp. at 729. The court in Baxter granted plaintiff’s motion for preliminary injunction to enjoin the city from refusing to issue Baxter a special use permit for a residence for HIV-infected persons. Id. at 735.

227. Pub. L. No. 100-430, 102 Stat. 1619 (codified in scattered sections of 28 U.S.C. and 42 U.S.C.). The amendments state in relevant part that it is unlawful to discriminate in the sale or rental, or to otherwise make unavailable to any buyer or renter because of a handicap of (A) that person; or (B) a person residing in or intending to reside in that dwelling after it is so sold, rented, or made available; or (C) any person associated with that person.

ments are a "clear pronouncement of a national commitment to end the unnecessary exclusion of persons with handicaps from the American mainstream." Unfounded threats to safety and misconceived perceptions about handicapped individuals are not grounds for which people may be excluded. People with AIDS cannot be discriminated against in real estate transactions because of the erroneous belief that they pose a health risk to others.

5. Discrimination in Insurance

One of the most emotional issues involving the civil rights of individuals with HIV or the AIDS virus concerns their access to health care. Several states have enacted legislation ensuring the rights of those who test positive for HIV to receive health care and health insurance coverage. However, some courts


229. See, e.g., CAL. INS. CODE § 11512.193(a) (West 1990) (nonprofit hospital plan may not discriminate based on sexual orientation); FLA. STAT. ANN. § 381.609(11)(a) (West 1988) (HIV test as a prerequisite to hospital admission is prohibited); FLA. STAT. ANN. § 641.31(3)(b)(7) (West 1991) (department will disapprove any HMO contract that excludes coverage for HIV infection that is different from exclusions that apply to other conditions); MD. CODE ANN., HEALTH OCC. § 14-404(a)(30) (1990) (physicians' license can be revoked or suspended for refusal to treat an HIV-infected individual); OHIO REV. CODE ANN. § 3701.245(A) (Baldwin 1989) (no private nonprofit hospital that receives state funds shall refuse to admit as a patient an HIV-infected individual); TEX. INS. CODE ANN. § 11.107(j)(1) (West 1991) (employee uniform group insurance act amended to prohibit the trustee from contracting for HMO coverage that excludes or limits HIV-infected individuals). See generally Troyen A. Brennan, Ensuring Adequate Health Care for the Sick: The Challenge of the Acquired Immunodeficiency Syndrome as an Occupational Disease, 1988 DUKE L.J. 29 (1988) (discusses the ethical and legal questions of restricting health care to HIV positive individuals).

230. See, e.g., D.C. CODE ANN. § 35-223(c) (1989) (no health insurance policy shall include an exclusion or reduction in coverage for HIV infection unless the provisions apply generally to all benefits under the policy); FLA. STAT. ANN. § 627.429(5) (West 1989) (an insurer may not use a positive HIV test to exclude a person from coverage except where individual underwriting is otherwise allowed by law, i.e., specified disease policy); HAW. REV. STAT. § 431:13-103(7)(G) (1989) (it is an unfair trade practice to refuse to issue an individual a policy solely on the basis of a positive HIV test); KY. REV. STAT. ANN. § 304.14-130(1)(e) (Baldwin 1990) (the commissioner of insurance will disapprove a form policy if it excludes coverage or limits benefits based on HIV infection); ME. REV. STAT. ANN. tit. 24-A § 2159(3) (West 1989) (it is an unfair trade practice for insurers to discriminate unfairly against an HIV-infected individual); WIS. STAT. ANN. § 631.93(2)(b) (West 1990) (insurer may not condition coverage on whether an individual has had an HIV test).
and legislatures have not ruled as favorably with regard to restrictions on insurance benefits. In many cases courts have even cleared the way for insurers to consider a person's HIV status in deciding whether to approve a policy.


Individuals with the AIDS virus or HIV have gained additional protection against discrimination with the passage of the Americans with Disabilities Act of 1990. The Act was signed into law on July 26, 1990, and is effective on July 26, 1992. The purpose of the Act is to provide a national mandate for the elimination of discrimination against individuals with disabilities. The Americans with Disabilities Act prohibits dis-
A threshold question is what is a "physical or mental impairment"? The regulations provide that a physical or mental impairment means "[a]ny physiological disorder, or condition, cosmetic disfigurement or anatomical loss affecting one or more of the following body systems: neurological, muscular, skeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine,["] 55 Fed. Reg. 35734, 35735 (1991) (to be codified at 29 C.F.R. § 1602.2(h)(ii)). The definition of physical or mental impairment also includes "[a]ny mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities." 55 Fed. Reg. 35734, 35735 (1991) (to be codified at 29 C.F.R. § 1630.2(h)(2)).

The Act reiterates specific exclusions from the definition of physical or mental impairment. While AIDS and HIV are considered impairments under the Act, homosexuality and bisexuality are not considered impairments. 55 Fed. Reg. 35734, 35736 (1991) (to be codified at 29 C.F.R. § 1630.3(e)).

241. An impairment is not a disability under the Americans with Disabilities Act unless it results in a substantial limitation of one or more major life activities. 55
garded as having such an impairment. Thus, a person infected with AIDS, a lymphatic disorder, would fall within the regulatory definition of "physical or mental impairment." The manifestation of the disease would also substantially limit the individual's major life activities.

In addition to having a disability, the individual must be "qualified." A qualified individual with a disability is a disabled person who can perform all the essential functions of the job with or without reasonable accommodation. Thus, an employer can still insist that the employee be able to fully perform the job. However, in making this determination, the employer must evaluate that person's abilities using the assumption that all necessary, reasonable accommodations are made.

Based on the provisions of the Americans with Disabilities Act which are scheduled to go into effect on July 26, 1992, it will be illegal for most companies to fire or even reassign an employee solely because the person is HIV-positive. On the other hand, many states have had similar laws for years, and HIV positive employees still face job discrimination. Similar federal laws have been enacted but have had limited success.

Fed. Reg. 35734, 35735 (1991) (to be codified at 29 C.F.R. § 1630.2(g)(1)). Major life activities are those basic activities that the average person in the general population can perform with little or no difficulty. 55 Fed. Reg. 35734, 35735 (1991) (to be codified at 29 C.F.R. § 1630.2(i), (j)). The Act provides that the following factors should be considered in whether an individual is substantially limited in a major life activity: "[the nature and severity of the impairment," id. at (j)(2)(i); "[the duration or expected duration of the impairment," id. at (j)(2)(ii); and "[the expected permanent or long term impact of or resulting from the impairment," id. at (j)(2)(iii). In a nutshell, the Act prohibits discrimination against an individual who has been treated as if he has a disability.

243. See 55 Fed. Reg. 35734, 35735 (1991) (to be codified at 29 C.F.R. §§ 1630.2(g)(1), (h)(1), (i) and (j)).
244. Pub. L. No. 101-336, § 102(a), 104 Stat. 327, 331 (to be codified at 42 U.S.C. § 12112(a)).
248. Id. (noting that under federal law, housing discrimination has been banned against people with HIV since 1989, but has apparently had little deterrent effect since complaints of illegal evictions are still on the rise).
D. Criminal Remedies

In addition to AIDS law in the context of blood and blood products, tort, and discrimination, the final area in AIDS law of current major focus and public attention is criminal remedies. Twenty-four states have statutes making the communication of a venereal disease a crime.249 AIDS, however, has prompted a few state legislatures to enact statutes which specifically address the virus.250 These statutes criminalize certain behavior by persons who are HIV positive or have AIDS.251 Most states, however, seek to criminalize specific conduct by persons with AIDS through general state criminal statutes regulating offenses against the person.252 In particular, state prosecutors are charging persons with murder, attempted murder, assault and reckless endangerment.253 There are, though, several inherent difficulties in imposing criminal liability for the transmission of AIDS under these statutes. This section will address these

250. Id. In 1987, 29 bills containing criminal sanctions specifically dealing with AIDS were introduced in state legislatures. Id. Several states have adopted AIDS-specific statutes. See, e.g., Florida, FLA. STAT. ANN. § 796.08 (1992); Georgia, GA. CODE ANN. § 16-5-60 (Michie 1988); Idaho, IDAHO CODE § 39-608 (1991); and Oklahoma, OKLA. STAT. ANN. tit. 21, § 1192.01 (West 1992).
251. For example, the Oklahoma Statute states:
A. It shall be unlawful for any person knowing that he or she has Acquired Immune Deficiency Syndrome (AIDS) or is a carrier of the human immunodeficiency virus (HIV) and with intent to infect another, to engage in conduct reasonably likely to result in the transfer of a person's own blood, bodily fluids containing visible blood, semen, or vaginal secretions into the bloodstream of another, or through the skin or other membranes of another person, except during in utero transmission of blood or bodily fluids, and:
1. the other person did not consent to the transfer of blood, bodily fluids containing blood, semen or vaginal secretions; or
2. the other person consented to the transfer but at the time of giving consent had not been informed by the person that the person transferring such blood or fluids had AIDS or was a carrier of HIV.
B. Any person convicted of violating the provisions of this section shall be guilty of a felony, punishable by imprisonment in the custody of the Department of Corrections for not more than five (5) years.
OKLA. STAT. ANN. tit. 21, § 1192.01 (West 1992).
253. See supra authorities cited in note 252.
difficulties by first looking at the American Model Penal Code and then looking at the various court decisions in this area.

1. *American Model Penal Code*
   a. *Murder*

   At first glance, it seems reasonable to conclude that if a person with AIDS or an AIDS carrier is found to have transmitted the disease to another with the effect of causing that person's death, he might be charged with murder. However, upon considering the definition of murder it becomes apparent that a murder conviction lies only in extremely unusual cases.\(^{254}\)

   An element of murder is the death of the victim.\(^{255}\) In the HIV context, the victim is unlikely to die for a considerable period of time after the actual transmission of HIV.\(^{256}\) Thus, the charge of murder is only appropriate after the victim has died. Furthermore, for a murder conviction, the HIV transmitter must be aware that he carries the virus and he must engage in conduct calculated to transmit the virus with the intent to cause the death of another.\(^{257}\) Considering that the HIV transmitter must engage in conduct aimed at infecting the victim for the purpose of killing him, a murder charge is only available in extreme situations.\(^{258}\)

   b. *Assault*

   Under the Model Penal Code a person transmitting the AIDS virus could be guilty of either aggravated assault or simple assault.\(^{259}\) Assault can be committed by a person: (1) purpose-

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\(^{254}\) Murder is defined as the killing of another human being either purposely, knowingly, or recklessly under circumstances manifesting extreme indifference to the value of human life. *Model Penal Code* § 210.1 and § 210.2 (1974).

\(^{255}\) Id.


\(^{258}\) For example, in order to sustain a murder conviction the state must prove that the HIV transmitter engaged in sexual activity aimed at infecting the victim for the purpose of killing him or shared intravenous needles with another with the purpose of killing him.

\(^{259}\) *Model Penal Code* § 211.1 (1974). Aggravated assault is defined as an attempt to cause serious bodily injury to another, or causes such injury purposely, knowingly or recklessly under circumstances manifesting extreme indifference to the value of
fully causing serious bodily injury, (2) knowingly causing serious bodily injury, (3) recklessly causing serious bodily injury or (4) negligently causing serious bodily injury. Each will be addressed separately.

In order to prove purposefully causing serious bodily injury, one must show that the HIV transmitter: (1) knew or believed that he was infected, (2) knew or believed that he could transmit the virus by the kind of conduct in question, and (3) desired to injure another person by his conduct. Most of the court decisions in this area discuss the second and third elements of proof and will be addressed later in this section.261

"Knowingly" means that the HIV transmitter is "aware that it is practically certain that this conduct will cause such result." This standard would be difficult to meet since the risk of transmitting the AIDS virus is not "practically certain."264

"Recklessly" requires proof that the HIV transmitter "consciously disregarded a substantial and unjustifiable risk." Thus, to prove criminal recklessness, the state must show that the HIV transmitter knew that his conduct involved a "substantial and unjustifiable risk" of transmission.266

Negligently causing bodily injury involves culpability which is greater than tortious liability. It requires proof that the HIV

human life or an attempt to cause or purposely or knowingly cause bodily injury to another with a deadly weapon. Id. Simple assault is an attempt to cause or purposely, knowingly or recklessly causing bodily injury to another or negligently causes bodily injury to another with a deadly weapon. Id. 260.

261. Id. See also Schultz, supra note 252, at 82.


264. United States v. Stewart, 29 M.J. 92 (C.M.A. 1989). In Stewart, a physician testified that whenever a person is exposed to AIDS through sexual contact, there is a 30-50% chance that the exposed person will become infected with the virus. Id.


266. Id. Different conduct may present different degrees of risk which may or may not be considered by the courts to be substantial and unjustifiable. For example, the risk from a human bite which does not break the skin would probably be classified as insubstantial. Schultz, supra note 252, at 88. The degree of risk varies depending on the type of sexual activity involved - anal and vaginal intercourse versus oral intercourse. Id. at 90. Sharing needles poses a relatively high risk and would probably easily be characterized as substantial and unjustifiable. Id. at 92.
transmitter should have known or been aware of the risk of transmitting the virus through his conduct. The negligent standard also requires an evaluation of the risk of the HIV transmitter's conduct as previously discussed. In addition, the HIV transmitter must use a dangerous weapon. What is a dangerous weapon in the context of the transmission of AIDS is a question which the courts have and will continue to address.

c. Attempt

A viable alternative for state prosecutors to assault and murder is charging HIV transmitters with attempt. Attempt requires that the HIV transmitter act with the purpose of causing or with the belief that his conduct will cause serious bodily injury without the AIDS virus being transmitted. The prosecutor must only show that the HIV transmitter believed that his conduct would cause serious bodily injury or acted with the purpose of causing serious bodily injury. Therefore, even if the AIDS virus is not transmitted by the HIV transmitter's conduct, and even if it was not his purpose to transmit the virus and cause serious bodily injury or death, a HIV transmitter may be charged with attempted assault or murder. Consequently, under attempt a much broader class of possible HIV transmitters may be successfully prosecuted.

d. Recklessly Endangering Another Person

It is a misdemeanor for a person to recklessly engage in conduct which places or may place another person in danger of

267. Model Penal Code § 2.02(2)(d) (1974). The HIV transmitter should have been aware of the risk if his “failure to perceive it, considering the nature and purpose of his conduct and the circumstances known to him, involves a gross deviation from the standard of care that a reasonable person would observe in the HIV transmitter’s situation.” Id.

268. Model Penal Code § 211.1 (1974). Deadly weapon is defined as “any firearm, or other weapon, device, instrument, material or substance, whether animate or inanimate, which in the manner it is used or is intended to be used is known to be capable of producing death or serious bodily injury. Model Penal Code § 210.00(4) (1974).

269. See Brock v. State, 555 So. 2d 285 (Ala. Crim. App. 1989) (Court found the mouth and teeth of an AIDS-infected person were not deadly weapons under the state assault statute), and United States v. Moore, 669 F. Supp. 289 (D. Minn. 1987), aff’d, 846 F.2d 1163 (8th Cir. 1988) (Court found the mouth and teeth of an AIDS-infected person were deadly weapons under the state assault statute).

death or serious bodily injury. 271 Under this section, the state must prove only that the HIV transmitter consciously disregarded a substantial risk of infecting a person with the AIDS virus by his conduct. 272

2. Case Law

Three court systems have addressed the issue of AIDS from a criminal standpoint: the United States military courts, federal courts and state courts. These cases center around three areas of conduct of the HIV transmitters: (1) biting, (2) spitting, scratching and throwing blood and (3) sexual activities.

a. Biting

In United States v. Moore273 and Brock v. State274 the Eighth Circuit Court of Appeals and the Alabama Criminal Court of Appeals addressed whether the mouth and teeth could be considered “deadly and dangerous” when used as a weapon by a person who has tested HIV positive. At first glance, it appears that the courts came to opposite conclusions on the issue. However, after reading the opinions carefully they are in fact consistent.

In Moore, the defendant bit two correctional officers during a struggle. 275 The defendant had previously tested positive for HIV. 276 During the struggle, the defendant said he hoped to kill the guards. 277 The defendant was subsequently charged with assault with a deadly weapon and convicted by a jury. 278 The medical evidence presented at trial established that there was no case known in which a human bite had resulted in the transmission of the HIV virus. 279 However, evidence was presented which established that a human bite had the capacity

272. Id.
275. Moore, 846 F.2d at 1164. Moore bit one officer on the knee and hip without breaking the skin. Id. at 1165.
276. Id.
277. Id.
278. Id. at 1164.
279. Id. at 1165.
to inflict serious bodily harm. Based on the later evidence, the court held that the defendant's mouth and teeth were a deadly weapon because under the circumstances, the defendant used his teeth in a manner likely to inflict serious bodily harm. The court's decision, however, was not based on the fact that the defendant had the HIV virus. The court stated that the evidence was sufficient to support the finding regardless of the presence or absence of AIDS.

In *Brock*, the defendant bit a correctional officer on the arm. The defendant had previously tested positive for HIV. The defendant was charged with attempted murder, but the jury found him guilty of the lesser-included offense of first degree assault. The court held that the evidence failed to establish that the defendant's mouth and teeth were deadly weapons or dangerous instruments.

In reaching this conclusion, the Alabama court distinguished *Moore*. The court pointed out that in *Moore* a medical expert testified that a human bite could cause a serious infection, which is a serious bodily injury. The State in *Brock*, however, presented no such evidence as to the medical consequences of a human bite.

Although the actual findings on the two cases are diametrically opposed, the Eighth Circuit Court of Appeals and the Alabama Criminal Court of Appeals did agree that the possi-
bility of AIDS transmission by means of a [human] bite was too remote to support a finding that the mouth and teeth may be considered a deadly and dangerous weapon.”

b. Spitting, Scratching and Throwing Blood

The courts have reacted differently to the conduct of spitting, scratching and throwing blood. The reason is that unlike a human bite, there is a chance that such conduct may transmit the HIV virus. In a local case in Hamilton County, Ohio, prosecutors charged a defendant, who had AIDS, with attempted murder and felonious assault after he spit on police officers. In State v. Haines, the defendant slashed his wrists and sprayed blood into police officers' mouths, eyes and skin. After a struggle, one of the officers was covered with the defendant's blood and had scrapes and scratches on his arms. The defendant was charged with attempted murder. During the trial, a medical expert testified that the HIV virus could be transmitted through blood, tears and saliva. Although the trial judge set aside the jury's conviction, the court of appeals reversed and remanded the case. The court held that the defendant was aware he had the HIV virus, he intended to kill the police officers by infecting them with AIDS, and he took a substantial step towards killing them by his conduct and his belief that he could kill them.

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292. See State v. O'Banion, Case No. B-917012 (Ohio Ct. Com. Pleas Ham. County 1992). (O'Banion pled guilty to reduced charges in municipal court and was found guilty of three assault charges in the court of common pleas. The charges of attempted murder and felonious assault were later dropped).

293. 545 N.E.2d 834 (Ind. App. 1989).

294. Id. at 835.

295. Id.

296. Id.

297. Id.

298. Id. at 837. Issue raised by the defendant was whether his conduct constituted a substantial step toward murder. The trial judge found that normally spitting, biting and throwing blood did not constitute a substantial step in causing the death of another person, and the state failed to establish otherwise. Id. at 836.

299. Id. at 841. The court reasoned that the state did not have to prove that the defendant's conduct could actually have killed the officers. Id. at 839. According to
The United States military has become the forerunner in setting a standard with regard to the criminal consequences of the sexual transmission of the AIDS virus. The military has dealt with such conduct in three ways. First, the military, through its military courts, has punished informed AIDS carriers who have engaged in sexual intercourse with another person who did not know of the presence of the virus under Article 134 of the Uniform Code of Military Justice, 10 U.S.C. § 934. Second, the military has found servicemen guilty of aggravated assault for such conduct under Article 128 of the Uniform Code of Military Justice, 10 U.S.C. § 928. The military appeals courts in United States v. Stewart, United States v. Johnson, the court, it was only necessary to establish that the defendant did all that he believed necessary to bring about an intended result, regardless of what was actually possible. \textit{Id.} Additionally, the court found that the defendant’s beliefs were not unsubstantiated speculation, but, in fact, medically possible. \textit{Id.} at 841.

300. Article 134 states: “Though not specifically mentioned in this chapter, all disorders and neglects to the prejudice of good order and discipline in the armed forces, all conduct of a nature to bring discredit upon the armed forces, and crimes and offenses not capital of which persons subject to this chapter may be guilty, shall be taken cognizance of by a general, special or summary court-martial according to the nature and degree of the offense and shall be punished at the discretion of that court.” 10 U.S.C. § 934 (1988). \textit{See} United States v. Wood, 28 M.J. 318 (C.M.A. 1989) (a serviceman had sexual intercourse knowing that he had the AIDS virus without notifying his partner. The military appeals court held that his conduct was an inherently dangerous act likely leading to death or great bodily injury and in violation of Article 134.).

301. 10 U.S.C. § 928 (1988). Any person who “attempts or offers with unlawful force or violence to do bodily harm to another person, whether or not the attempt or offer is consummated is guilty of assault.” \textit{Id.} Any person who “commits an assault with a dangerous weapon or other means or force likely to produce death or grievous bodily harm; or commits an assault and intentionally inflicts grievous bodily harm with or without a weapon is guilty of aggravated assault. \textit{Id.} Both assault and aggravated assault are punished as a court-martial may direct. \textit{Id.}

302. 29 M.J. 92 (C.M.A. 1989). A serviceman, on numerous occasions, had unprotected sexual intercourse with a female soldier knowing he was infected with the AIDS virus. \textit{Id.} The Court of Military Appeals affirmed the Army Court of Military Review’s decision that the defendant was guilty of aggravated assault. \textit{Id.}

303. 30 M.J. 53 (C.M.A. 1990). A serviceman attempted to have anal intercourse with another person knowing that he was infected with the AIDS virus. \textit{Id.} The Court of Military Appeals found the defendant guilty of aggravated assault. \textit{Id.} The court stated that “if the circumstances surrounding the sexual contact are such that HIV is likely to be transmitted, then the virus is a means likely to produce death or grievous bodily harm.” \textit{Id.}
and United States v. Joseph\textsuperscript{304} all held that sexual intercourse involving HIV-infected semen is a means capable of producing death or grievous bodily harm under the assault statute.\textsuperscript{305}

Third, the military has punished servicemen who have violated "safe-sex orders" under Article 134 of the Uniform Code of Military Justice, 10 U.S.C. § 934.\textsuperscript{306}

Outside of the military, courts have begun to tackle the issue of criminal prosecution for the sexual transmission of the AIDS virus. In Florida v. Sherouse,\textsuperscript{307} a prostitute had tested positive for the AIDS virus.\textsuperscript{308} She was informed that the deadly virus could be transmitted through sexual intercourse.\textsuperscript{309} However, she disregarded the warning and had sexual intercourse with two persons.\textsuperscript{310} She was later charged with attempted manslaughter.\textsuperscript{311} The court held that although the defendant was negligent, she did not have the requisite intent to support the charge.\textsuperscript{312}

In addition to criminal prosecutions, the courts have considered the potential sexual transmission of the AIDS virus when sentencing sex offenders who have tested positive for HIV.\textsuperscript{313} These courts have held that the fact that a sex offender had sexual intercourse with an innocent nonconsensual party know-

\begin{itemize}
\item \textsuperscript{304} 33 M.J. 960 (C.M.A. 1991). A serviceman had protected sexual intercourse using a condom with another military person knowing he was infected with the AIDS virus. \textit{Id.} The Court of Military Appeals affirmed the Navy Court of Military Review's decision that the defendant was guilty of aggravated assault. \textit{Id.} The court refused to make a distinction between unprotected and protected sexual conduct. \textit{Id.} The court found that the use of condoms was not a surety against the nontransfer of the HIV. \textit{Id.} The risk of transmission is still present with both protected and unprotected sexual intercourse. \textit{Id.}

\item \textsuperscript{305} Stewart, 29 M.J. 92 (C.M.A. 1989); Johnson, 30 M.J. 53 (C.M.A. 1990); and Joseph, 33 M.J. 960 (C.M.A. 1991).

\item \textsuperscript{306} United States v. Womack, 29 M.J. 88 (C.M.A. 1989). The court upheld the constitutional validity of a "safe-sex order." \textit{Id.} The "safe-sex order" provided, in part, that a person with the HIV virus will inform all sexual partners of their infection and avoid transmitting the infection to other persons by taking the requisite precautions. \textit{Id.}

\item \textsuperscript{307} 536 So. 2d 1194 (Fla. Dist. Ct. App. 1989).

\item \textsuperscript{308} \textit{Id.}

\item \textsuperscript{309} \textit{Id.}

\item \textsuperscript{310} \textit{Id.}

\item \textsuperscript{311} \textit{Id.}

\item \textsuperscript{312} \textit{Id.} at 1195.

\item \textsuperscript{313} Cooper v. State, 539 So. 2d 508 (Fla. Dist. Ct. App. 1989); State v. Guayante, 783 P.2d 1030 (Or. App. 1989).
\end{itemize}
ing he had the AIDS virus is an aggravating factor which the trial court may consider in imposing maximum sentences.314

IV. CONCLUSION

“We stand nakedly in front of a pandemic as mortal as any pandemic there has ever been.”

Halfdan Mahler315

AIDS is not a disease that just affects homosexuals, it affects all of us. If you get AIDS, you will die. The major routes of transmission include blood, blood products, and semen. An infected person may remain asymptomatic for years, then develop the classic symptoms—lymphadenopathy, weight loss, profound fatigue, night sweats, thrush, fever, bowel irregularities, and skin irritations.

Initially, different governments reacted to the AIDS plague by blaming other countries.316 More recently, the federal gov-

314. Cooper, 539 So. 2d at 511; Guayante, 783 P.2d at 1031.
315. WORLD HEALTH ORGANIZATION, SPECIAL PROGRAMME ON AIDS: PROGRESS REPORT, No. 1 (Apr. 1987).
316. C. JENNINGS, UNDERSTANDING AND PREVENTING AIDS 143 (2d ed. 1988). While the federal government and the individual states have been somewhat slow to respond to the crisis, and their legal response is still in the neophyte stage, the international response has been similar to the overall response taken by the United States.

One of the initial responses across the world was to try to find someone on which to place the blame for the AIDS pandemic by tracking down the origin of the disease. The various theories as to the origin of AIDS tend to vary depending on the geographic location of the theorist. In the United States, the popular belief is that AIDS originated in Africa. A popular belief throughout the European countries is that AIDS originated in the United States. The prevailing theory among Africans is that Europeans brought the disease to Africa.

Many believe that Zaire is the country where AIDS originated. Zaire was the first African nation to invite researchers to study AIDS and, in return, received much bad publicity. In response to the negative international reaction, Zaire, for a long time, did not report AIDS cases to the World Health Organization. The first Africans reported to have AIDS were Zairians, diagnosed in Belgium where they lived. These individuals were heterosexual men, and their wives and children. Zaire used to be called the Belgium Congo, and was once a colony of Belgium. It still has close economic and educational ties to Belgium. Reports of “African AIDS” gradually filtered through medical literature until 1983, when researchers were invited to go to Zaire to study the problem. The researchers found 38 cases within a matter of weeks and, since no blood tests were available, diagnosed the individuals on clinical symptoms. Based on these findings, the researchers concluded that the research suggested that Zaire had an AIDS rate of 170 cases per one million people. Extrapolating further, it was predicted that millions of Africans would die of AIDS over the next few years.
ernment and some state legislatures have passed legislation in an effort to protect HIV-infected individuals from discrimination. Courts have generally ruled that an infected person has a legitimate right of privacy in employment situations and should not be required to reveal that he has the disease.

Civil remedies as well as criminal penalties have been created to deal with the various situations in efforts to protect persons wrongfully infected with HIV, and persons wrongfully exposed to the AIDS virus. As with all other legal cases, AIDS cases will be decided on a case-by-case basis. The difference is that if the projections set forth by the World Health Organization regarding increases in the number of cases are true, (40,000,000 cases by the year 2000), the number of AIDS cases in our court system will eventually be staggering.

While a majority of states have enacted some form of AIDS-related legislation and courts have attempted to deal with the crisis, it should be obvious by the disarray of results that there is no uniformity among the states in dealing with this very serious dilemma. Furthermore, there is much that needs to be done on the federal level. While the Americans with Disabilities Act deals with the discrimination aspect associated with AIDS, other federal programs are still needed to help us deal more effectively with AIDS—the disease that may prove to be just as deadly as, if not more deadly than, the Black Plague.317

When the presence of AIDS was discovered in Haitians who had immigrated to the United States, Haiti was blamed as the possible origin of AIDS. Alternatively, it was cited as a stepping stone for AIDS as it travelled from Africa to America. This theory has lost some of its "sex appeal" since many of the Haitian men have now reported bisexual behavior. Although the United States has tended to blame other countries for the origin of AIDS, as of 1985, the United States had 80% of the world's reported AIDS cases, according to the World Health Organization.

Obviously, the researchers of these different countries have not been able to agree on the origin of the disease. However, one thing that researchers in all of the countries have tended to agree on is that the AIDS pandemic appeared suddenly and seemingly out of nowhere.

317. Assistance in researching and drafting this article provided by Tim Hatfield, Dawn Middlebrooks, Dana Quesinberry, and Sue Massie.
THE LIABILITY OF PHYSICIANS WHO EXAMINE FOR THIRD PARTIES

Dr. Malcolm A. Meyn, Jr.*

I. INTRODUCTION

A young jeweler injures himself while working. He develops an infection in his groin resulting in a penial discharge. The draining wound is shown to a boarding house roommate, who afterward develops a sense of duty. He promptly informs the father of the jeweler's bride-to-be of this problem. The father, not wanting his daughter to marry someone with venereal disease, hires a physician to examine the young man. The doctor performs the examination and declares the jeweler to be suffering from gonorrhea. Encouraged by the angry father, the daughter quickly calls off the engagement. The young jeweler sues the father and the friend for libel, and the physician for medical malpractice.¹

A physician is hired to examine a young infant for symptoms of congenital abnormalities for the purpose of advising a husband and wife prior to adoption. The physician is subsequently sued by the couple, who allege medical malpractice when it is discovered sometime after the adoption that the child does indeed have a congenital condition.²

A man is sent to a physician by an insurance company for the sole purpose of determining his physical condition and to make a report of disability. The man and his wife sue the physician when a brain tumor is later discovered to be the cause of his disability.³

These cases illustrate the potential liability of the physician who places himself outside of the traditional physician-patient

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relationship by performing examinations and evaluations at the request of, and for the benefit of third parties. Medical malpractice claims traditionally rely on this physician-patient relationship, which arises out of contract,\(^4\) as the basis of establishing the duty owed to the patient by the physician. The absence of this traditional physician-patient relationship creates potential liability exposure that may be unrecognized or misunderstood by examining physicians. A physician may believe he is protected by his professional liability policy for negligent acts. However, unless such acts are considered to be medical malpractice, the negligence may lie outside the scope of his insurance.\(^5\)

An individual may be required to undergo a physical examination at the request or insistence of a third party for a number of reasons. These include examinations for preemployment,\(^6\) continued employment,\(^7\) life insurance,\(^8\) Social Security Administration benefits,\(^9\) workers compensation benefit determination,\(^10\) continued disability benefits,\(^11\) defendants in personal injury

\(^4\) See infra note 18.

\(^5\) "Such a doctor would have few or no patients in the usual sense to whom he might be liable for malpractice, and arguably the only entity intended to be covered by the policy might be the employer. Unless intended to cover the employer the policy might be illusory." McFarling v. Azar, 519 F.2d 1075, 1077 n.3 (6th Cir. 1975).

\(^6\) Beadling v. Sirotta, 197 A.2d 857 (N.J. 1964) (plaintiff was unsuccessful in suit against physician for misreading chest x-ray as showing active tuberculosis, thereby causing loss of employment); Lotspeich v. Chance Vought Aircraft, 369 S.W.2d 705 (Tex. Ct. App. 1963) (plaintiff was unsuccessful in suit against employer's examining physician for failing to diagnose tuberculosis on preemployment examination).

\(^7\) Hoover v. Williamson, 203 A.2d 861 (Md. 1964) (plaintiff successful in suit against physician who failed to disclose lung disease discovered during employment examination); Wilcox v. Salt Lake City Corp., 484 P.2d 1200 (Utah 1971) (waitress sued physician hired by city for finding and reporting tubercular lesion on chest x-ray; suit failed as there was no physician-patient relationship).


\(^9\) Beaman v. Helton, 573 So. 2d 776 (Miss. 1990) (physician held not liable for failure to disclose presence of lung tumor to plaintiff even though it had been included in report to Social Security Administration); Peace v. Weisman, 368 S.E.2d 319 (Ga. Ct. App. 1988) (medical malpractice case in which physician found not liable for failing to inform plaintiff of presence of lung tumor found on examination for disability benefits).


\(^11\) Tompkins v. Pacific Mutual Life Ins. Co., 44 S.E. 439 (W. Va. 1903) (physician held liable for medical malpractice when he failed to replace a cast which had been removed
cases,\textsuperscript{12} preinduction into the Armed Service,\textsuperscript{13} casual medical consultation regarding a patient’s diagnosis between two physicians,\textsuperscript{14} and examinations requested by private individuals.\textsuperscript{15}

This burgeoning number of medical examinations occupies an increasing part of the average physician’s daily practice and can soon lead to interference with normal patient care. A certain amount of patient report preparation for third parties is expected of all physicians, especially orthopedic surgeons, rehabilitation specialists, and others who treat injuries or disabling diseases. However, most of the examinations listed above do not involve the physician’s own patients, but are usually adversarial evaluations of persons sent by third parties. These third parties usually request specific information regarding the examinee, the details of which may be beyond the knowledge of the average practitioner who has not acquired the knowledge or special training necessary to determine impairment and disability.

This need for specialized education has led to the formation of at least one national organization\textsuperscript{16} dedicated to this objective. It has also prompted some physicians to suspend their usual practice during an examination for continued disability benefits; Rogers v. Horvath, 237 N.W.2d 595 (Mich. Ct. App. 1975) (worker’s compensation claimant filed action for medical malpractice, fraud, and libel against examining physician who said claimant was a malingerer; court held there was no medical malpractice as there was no physician-patient relationship, but remanded on claim of libel); LoDico v. Caputi, 517 N.Y.S.2d 640 (App. Div. 1987) (plaintiff sued examining physician for failure to diagnose brain tumor during disability examination; lower court held physician liable; appellate court reversed based on no physician-patient relationship).

12. Pearl v. West End Street Ry. Co., 57 N.E.2d 339 (Mass. 1900) (plaintiff claimed injury when directed by examining physician to stand on injured leg during examination; directed verdict for physician as plaintiff had no obligation to follow orders to his detriment); Coss v. Spaulding, 126 P. 468 (Utah 1912) (physician held liable for medical malpractice when, after examining child for extent of injuries, physician gave advice to mother on care of child).


15. Harriott v. Plimpton, 44 N.E. 992 (Mass. 1896); Greenwald v. Grayson, 189 So. 2d 204 (Fla. Dist. Ct. App. 1966) (plaintiff sued for medical malpractice when physician failed to diagnose congenital condition in plaintiff’s child before adoption; physician not liable as there was only contractual relationship between plaintiff and physician).

and specialize in performing these examinations for third parties. The reasons for changing from the usual practice of medicine are many and go beyond the scope of this paper. They do, however, include secure income outside of the usual payment/reimbursement system, as well as an opportunity for a physician to continue practice even though physical disability or advancing age may have interrupted a more traditional medical career.

This "different" type of medical practice, not involving the usual physician-patient relationship, has led some physician examiners to abandon their traditional medical malpractice liability insurance. The exposure to liability that these and other physicians incur while doing these examinations is the topic of this article.

II. THE PHYSICIAN-PATIENT RELATIONSHIP

The physician-patient relationship is a necessary element for the action of medical malpractice against a physician. 17 Although founded in negligence, medical malpractice denotes a breach of the duty owed by the physician in rendering professional services to a person who has contracted for those services. Thus medical malpractice arises from this physician-patient relationship. 18 A physician who examines for a third party does not, in principle, create such a relationship. Theoretically, therefore, medical malpractice cannot be committed by such a physician. 19 This is not to say that a physician who examines a person for reasons other than diagnosis and treatment owes no duty of care to that person. Rather the physician in such case does not owe such a duty of care so that he or she is liable for malpractice. 20 On the other

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19. Hoover v. Williamson, 203 A.2d 861, 863 (Md. 1964); J. P. Ludington, Annotation, Physician's Duties and Liabilities to Person Examined Pursuant to Physician's Contract with Such Person's Prospective or Actual Employer or Insurer, 10 A.L.R.3D 1071 (1966); Keene v. Wiggins, 138 Cal. Rptr. 3 (Ct. App. 1977) (worker obtained copy of examination report and relied on it to his detriment; suit for medical malpractice failed as there was no physician-patient relationship); Beaman v. Helton, 573 So. 2d 776 (Miss. 1990).
hand, the courts have construed many different acts of the physician as establishing a physician-patient relationship. These include, in part, any treatment or advice given by the physician to the person being examined, or any reliance by the patient on anything said or done during or as a result of the examination. For the moment, though, only those circumstances where no physician-patient relationship is thought to exist will be considered.

III. EXAMINATIONS WHERE NO PHYSICIAN-PATIENT RELATIONSHIP EXISTS

In doing examinations for a third party where no physician-patient relationship exists, the physician still owes to the examinee some duty of care. Although the examiner does not owe the same duty that is owed patients who pay for the services they receive, the physician must still perform the examination with reasonable care. This reasonable care standard requires that no harm be done to the examinee. Harm in this instance includes both physical injury and nonphysical damages such as loss of employment, or harm to a person's social status which would occur after wrongfully being diagnosed as having venereal disease. Suits against physicians for claims of negligence when a physician-patient relationship exists are pursued under the medical malpractice statutes in effect in that jurisdiction. Suits for

25. Harriott v. Plimpton, 44 N.E. 992, 993 (Mass. 1896) (young man wrongly diagnosed by physician as having venereal disease following examination ordered by future father-in-law. The Harriott court stated: "In our opinion, the fact that the purpose of the examination was information (sic), and not medical treatment, is immaterial, and the breaking of the plaintiff's marriage engagement in consequence of the wrong diagnosis was not too remote a damage to sustain the action.").
26. Most jurisdictions have recently legislated revisions of their medical malpractice statutes. An attempt to reiterate these statutes is beyond the scope or meaning of this paper.
violation of the standard of reasonable care when no physician-patient relationship is found are brought forth under the theory of common law negligence. Statutes of limitations for common law negligence are usually longer than they are for medical malpractice claims. Physicians therefore have a longer exposure to claims of negligence from people they examine without intent to treat.

In addition to establishing a duty on the part of a defendant and the breach thereof, claims for damages pursued through the theory of common law negligence, unlike medical malpractice claims, do not require the use of expert medical witnesses to establish causation and deviations from accepted standards of care. The plaintiff in such cause of action must only show damages and establish a causal relationship between the examination and the harm done.

The person being examined also incurs some responsibility during an examination ordered by a third party. The physician performing the examination is not liable for merely directing the examinee to do a thing, which when done, actually causes injury. The person being examined is under no obligation to comply with the physician's improper request if he or she knows it will cause harm. The examinee should realize that the request or direction comes from one who has an adverse interest and has no authority of any kind.

In addition to the physician's duty to exercise reasonable care, a second common law duty owed by physicians in the absence of a physician-patient relationship is to disclose to the examinee any life threatening or serious medical problem discovered during the course of the examination. There is, however, no duty of the

29. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 32, at 189 (5th ed. 1984) (where the matter is within the common knowledge of laymen).
30. Id. § 42, at 272.
31. 61 AM. JUR. 2D Physicians, Surgeons, and Other Healers § 297 (1981).
32. Id.
physician to discover unknown conditions. In the context of third-party examinations, that duty of the physician is to the party who, by a contractual agreement, has hired that physician to determine the physical status of the individual. Although this might seem harsh, the person being examined does not normally go into such an examination believing he is to be treated for illness or injury; no suggestions or advice are given after the examination; and no payment is made directly by the examinee for his evaluation. The adversarial nature of the examination is usually well appreciated by the examinee, with no expectations for treatment.

If such a life threatening or serious condition is discovered during the examination, then even in the situation of evaluations for third parties, the physician must disclose the condition directly to the examinee with instructions to seek treatment. Reporting to the examinee's treating physician has also been found sufficient. Communication of the existence of the problem through reports to the examinee's attorney has been found to fulfill this duty. This duty to disclose has been extended to include previously unknown conditions revealed after reviewing the examinee's confidential medical records.

Some governmental agencies have reporting instructions for the examining physician should an abnormality be discovered during an evaluation of their claimants. Following these instructions, however, does not relieve the examiner of direct disclosure to the examinee or his treating physician. Disclosure of the

35. See LoDico v. Caputi, 517 N.Y.S.2d 640 (App. Div. 1987) ("Where a doctor conducts an examination of an injured employee solely for the employer's insurance carrier in a workers' compensation proceeding, neither offers nor intends to treat, care for or otherwise benefit the person examined and has no reason to believe the person being examined will rely on his report, the doctor is not liable to the person being examined for failure to properly diagnosis a latent brain tumor.") Id. at 642; Lotspeich v. Chance Vought Aircraft, 369 S.W.2d 705, 710 (Tex. Ct. App. 1963).
40. Id. at 174.
41. Id. at 173-74.
42. DISABILITY EVALUATION UNDER SOCIAL SECURITY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, SSA Publication No. 05-10089, at 6 (1986) ("...contact Chief Medical Consultant of DDS in your State").
problem, if done by report, must be in clearly understood language, not in obscure medical terminology that might be overlooked or misunderstood by an untrained clerk in a governmental agency.\textsuperscript{44} Thus, by disclosing previously unknown serious medical conditions to the person being examined, the physician discharges this common law duty. The examining physician is under no duty to intervene directly in the patient's care whenever the physician opines that treatment is inadequate or thinks there are better ways of treating a particular medical condition.\textsuperscript{45} Moreover, such actions go beyond the duty to disclose. While these opinions may be of interest to the third party who ordered the examination, they are more properly included in the physician's report of the examination. Such opinions may not be correct and, if communicated to the examinee, could jeopardize the physician-patient relationship that does exist between the examinee and the treating physician. Such advice could also be construed as establishing a physician-patient relationship between the examiner and examinee, thus exposing the physician to possible medical malpractice liability.\textsuperscript{46}

There is some indication, at least in dicta, that a physician who performs examinations for a governmental body or agency on its employees may be immune from liability. In \textit{Wilcox v. Salt Lake City Corp.},\textsuperscript{47} the Utah Supreme Court, although dismissing the case on other grounds, left open the question of whether a governmental body performing a nonproprietary function could shield the physician.\textsuperscript{48} Similarly, in \textit{Lotspeich v. Chance Vought Aircraft},\textsuperscript{49} there is dicta for immunity of physicians who perform disability examinations on employees at the request of employers through a workers' compensation insurance company.\textsuperscript{50} The theory presented by the defendant physician, not ruled upon by the court, was that both the injured worker and the physician were employees of the same company, and that under workers' compensation rules an individual employee cannot receive damages

\textsuperscript{44} Id.
\textsuperscript{46} See infra part IV.
\textsuperscript{47} 484 P.2d 1200 (Utah 1971).
\textsuperscript{48} Id. at 1202.
\textsuperscript{49} 369 S.W.2d 705 (Tex. Ct. App. 1963).
\textsuperscript{50} Id. at 710.
outside of workers' compensation for injuries sustained as a result of a co-worker's negligence.\footnote{1}

The physician's report to the third party ordering the examination, even though independent and theoretically unbiased, often conflicts with the diagnosis, treatment, and opinions of the treating practitioner.\footnote{2} This happens for understandable reasons. The examinee's physician usually has a longer professional relationship with the person and often relies heavily on the subjective complaints of the person when giving opinions regarding physical impairment and disability. This is not a flaw of the physician but is a result of the mutual trust established by the physician-patient relationship. The examining physician has no such relationship and must depend solely on the objective findings of the examination and diagnostic studies in making his determinations and recommendations. This, along with the adversarial nature of the examination, often produces opinions that are adverse to the interests of the person being examined.

These opinions of nontreating physicians have, on occasion, led to lawsuits not only for medical malpractice, but also causes of action for fraud and/or libel when the examinee believed the physician was unjustly biased in reporting the findings of the evaluation.\footnote{3} Although the medical malpractice claims in both Dunbar and Rogers were dismissed because there was no physician-patient relationship, both courts indicated that the libel action would be sustained.\footnote{4} It is thus in the interest of the physician, as well as the examinee, to be truthful in reporting the findings of the evaluation.

IV. ESTABLISHING A PHYSICIAN-PATIENT RELATIONSHIP

If an examining physician does nothing more than direct or supervise an examination at the request of a third party, no

\footnote{1} Id.
\footnote{2} See Keene v. Wiggins, 138 Cal. Rptr. 3 (Ct. App., 1977) ("[I]t is common knowledge there are claimant's doctors and insurance company doctors and the claimant cannot assume the insurance company's physician will be as generous as his own physician when assessing the injury to be rated." Id. at 7).
\footnote{3} Dunbar v. Greenlaw, 128 A.2d 218 (Me. 1956) (plaintiff sued physician after detainment in state mental institution based on erroneous certification; case failed as there was no physician-patient relationship); Rogers v. Horvath, 237 N.W.2d 595 (Mich. Ct. App. 1975).
\footnote{4} Dunbar, 128 A.2d 218 (Me. 1956); Rogers, 237 N.W.2d 595 (Mich. Ct. App. 1975).
physician-patient relationship is established. The physician's only
duty is to the party who hired him. If, however, the physician
goes beyond this and in some way offers advice to the examinee
regarding diagnosis and/or treatment, or in fact begins to treat
the examinee, then a physician-patient relationship is estab-
ished. Under these circumstances, the physician is no longer a
disinterested observer but has become involved in the patient's
care. The examining physician now becomes a treating physician
even though there is no contractual agreement, either expressed
or implied. The physician, therefore, assumes the duties and
obligations of a reasonable physician and becomes subject to the
laws of medical malpractice, and not common law negligence.
This is based on the general rule that

[There is, however a broader, a more fundamental rule of long
standing under which a physician may incur a tort obligation which
is nonconsensual and independent of contract. This is the general
rule that one who assumes to act, even though gratuitously, may
thereby become subject to the duty of acting carefully, if he acts
at all.]

This physician-patient relationship established by direct inter-
vention into the examinee's medical care can ensue by several
courses of action. If during or after the examination the physician
begins treatment, it is clear that such relationship exists. For
example, in Tompkins v. Pacific Mutual Life Insurance Co. a
physician removed a cast to inspect an injured ankle and then
told the examinee to his detriment that recasting was unneces-
sary. Such intervention by the examining physician undoubtedly
falls into this category.

It is also apparent that offering the examinee advice concerning
the injury or illness creates a physician-patient relationship. In

medical malpractice held valid against examining physician who had given plaintiff advice
about illness); see James L. Rigelhaupt, Jr., J.D., Annotation, What Constitutes Physician-
Patient Relationship For Malpractice Purposes, 17 A.L.R.4TH 132 (1982), for general
discussion of physician-patient relationship.
57. RESTATEMENT (SECOND) OF TORTS § 323 (1965); c.f. Krieger v. J.E. Greiner Co., Inc.,
382 A.2d 1069, 1081 (Md. 1978); Hoover v. Williamson, 203 A.2d 861, 863 (Md. 1964);
58. 44 S.E. 439 (W. Va. 1903).
59. Id.
60. Miller v. Dumon, 64 P. 804 (Wash. 1901); Coss v. Spaulding, 126 P. 468 (Utah 1912).
Hickey v. Travelers Insurance Co. 61 a New York court of appeals said, "that the doctor’s advice was, in fact, incorrect, [and] that the issuance of such advice constituted professional malpractice."62 The advice must be affirmative in nature,63 and there must be reliance upon the advice by the examinee.64

What may not be so obvious are cases where a physician-patient relationship has been found to exist when the physician has had no personal contact with the examinee. In Betesh v. United States 65 the physician was a radiologist examining chest x-rays of inductees;66 he had no personal contact with the examinees.67 An abnormality was noted and reported to the Selective Service Board. The physician, however, failed to notify the examinee but did make arrangements for a follow-up x-ray six months later.68 The court in that case said, "The court finds reliance present in this case ... notwithstanding the fact that it was the doctor’s silence that misled the examinee."69

Based on the foregoing authorities, it is clear that if a physician doing examinations for third parties chooses not to establish a physician-patient relationship he must not treat the examinee, nor can he offer any advice. This first requirement is easily met, but it is difficult to avoid the second. The examination is usually adversarial in nature. The physician usually will try to develop some rapport with the examinee in an attempt to lessen the apprehension that almost always exists when someone meets a new physician for the first time, especially one from "the other side." If rapport is established the examinee will frequently ask questions of the physician concerning the illness or accident. Declining to answer these queries destroys any trust established by the physician. This can cause the examinee to become hostile and mistrustful, making the remainder of the examination extremely arduous.

62. Id. at 555.
63. Id. at 556.
64. Id. at 555; Betesh v. United States, 400 F. Supp. 238, 246 (D.D.C. 1974) (applying Maryland law).
66. Id. at 241.
67. Id.
68. Id. at 242.
69. Id. at 246.
V. ESTABLISHING A LIMITED PHYSICIAN-PATIENT RELATIONSHIP

A recent Louisiana case, *Green v. Walker*, has departed from the commonly accepted rule that no physician-patient relationship exists between physicians and those examined at the request of third parties. The Fifth Circuit, applying Louisiana law, established that in that state such a relationship does exist, at least to the extent of the examination.

In *Green* a physician during an examination failed to diagnose and report a lung tumor that later proved to be fatal to the examinee. During the trial for medical malpractice the defendant-physician relied on a very similar Louisiana case that held there was no physician-patient relationship and therefore no duty was owed to that plaintiff. The *Green* court noted, however, that "[t]he Louisiana Supreme Court has taken great pains to plainly state that, particularly in the changing field of delictual responsibility, the notion of stare decisis, derived as it is from the common law, should not be thought of as controlling in this state.'"

The court found for the plaintiff and proceeded to set forth a new standard under Louisiana law: "We therefore now hold that when an individual is required as a condition of future or continued employment, to submit to a medical examination, that examination creates a relationship between the examining physician and the examinee at least to the extent of the tests conducted." The Fifth Circuit considered its decision to be fully consistent with the Louisiana Civil Code.

The Fifth Circuit has therefore established that in Louisiana, the examiner will be held to the standards of a reasonable physician in similar circumstances of third party examinations. The court was careful, however, not to equate this duty to that...
owed to the physician's traditional patients; that duty which extends beyond the mere examination of those patients.\textsuperscript{77}  

This opinion of the Fifth Circuit in \textit{Green v. Walker} is a wide departure from the traditionally held view of physician duty during third party examinations. It has not been sustained in other jurisdictions.\textsuperscript{78} There are, though, two cases, \textit{Peace v. Weisman}\textsuperscript{79} and \textit{Beaman v. Helton},\textsuperscript{80} in which strong dissents were written in opposition to the traditionally held opinions of the courts' majorities.\textsuperscript{81} Both cases involved examinations done at the request of the Social Security Administration for determining disability subsequent to application for benefits.\textsuperscript{82} Both courts held in favor of the defendants based on lack of a physician-patient relationship.\textsuperscript{83}  

In \textit{Peace v. Weisman}, Judge Benham, writing in dissent, listed three essential elements for imposing liability upon a physician in a medical malpractice case, "(1) the duty inherent in the doctor-patient relationship; (2) the breach of that duty by failing to exercise the requisite degree of skill and care; and (3) that this failure be the proximal cause of the injury sustained."\textsuperscript{84} Judge Benham would have found for the plaintiff in the case, stating that the elements applied to third party examinations and had been breached by the defendant.\textsuperscript{85}  

Justice Sullivan, dissenting in \textit{Beaman v. Helton}, would also have found in the plaintiff's favor.\textsuperscript{86} He stated, "It is unconscionable to deny recovery for damages caused to an examinee by a physician's negligence when the physician has acted positively in examining an individual at the request of and for payment by a third party."\textsuperscript{87} He also agreed with the Louisiana court in \textit{Green v. Walker}.\textsuperscript{77}  

\begin{itemize}
  \item \textsuperscript{77} \textit{Id.}
  \item \textsuperscript{79} 368 S.E.2d 319 (Ga. Ct. App. 1988).
  \item \textsuperscript{80} 573 So. 2d 776 (Miss. 1990).
  \item \textsuperscript{81} \textit{Peace}, 368 S.E.2d at 323 (Benham, J., dissenting); \textit{Beaman}, 573 So. 2d at 779 (Sullivan, J., dissenting).
  \item \textsuperscript{82} \textit{Peace}, 368 S.E.2d at 319; \textit{Beaman}, 573 So. 2d at 776.
  \item \textsuperscript{83} \textit{Peace}, 368 S.E.2d at 321; \textit{Beaman}, 573 So. 2d at 778.
  \item \textsuperscript{84} \textit{Peace}, 368 S.E.2d at 323 (Banhas, J., dissenting).
  \item \textsuperscript{85} \textit{Id.} (by implication).
  \item \textsuperscript{86} \textit{Beamon}, 573 So. 2d at 778 (by implication).
  \item \textsuperscript{87} \textit{Id.} at 779.
\end{itemize}
that this duty of care is not coextensive with that of the physician's own patients, but should be limited to the extent of the examination.88

VI. THE EXAMINEE'S RELATIONSHIP TO THE THIRD PARTY

Because of the traditional view that no physician-patient relationship exists in examinations performed at the request of third parties, some examinees have taken a different path to recover for injury by bringing causes of action against the third party through the theory of agency.89 The physician in such examinations is either a full-time employee of the third party90 or an independent contractor hired specifically for the purpose of performing evaluations.91 In either case, it is not the examinee who pays the physician, but the third party who orders the examination.

There are few cases where persons injured during examinations brought suit for damages against the third party ordering the examination under the theory of agency.92 In addition, the written opinions in those cases are not consistent in their holdings.93 In Pearl v. Street Railway Co.,94 a case where a physician caused injury during an examination,95 Chief Justice Holmes, writing for the court, held the employer not liable for damages.96 He stated,

88. Id.

89. For opinions where the third party has been held liable, see Marachek v. Sunshine Biscuit Inc., 123 N.E.2d 801 (N.Y. 1954) (employer held liable for injury of employee that occurred during the drawing of blood by employer's physician); Tompkins v. Pacific Mut. Life Ins. Co., 44 S.E. 439 (W. Va. 1903); Jones v. Tri-State Tel. & Tel. Co., 136 N.W. 741 (Minn. 1912) (employer held liable for burn injury of employee caused by x-ray unit of company physician).

For opinions not imposing liability, see Pearl v. Street Ry. Co., 57 N.E. 339 (Mass. 1900); McMurdo v. Getter, 10 N.E.2d 139 (Mass. 1937).


92. Beamon, 573 So. 2d at 778.

93. Id.

94. 57 N.E. 339 (Mass. 1900).

95. Id. (plaintiff sued railroad for additional injury to leg caused by examining physician's request that he stand on the extremity).

96. Id.
The doctor was not an agent or servant of the defendant in making his examination; he was an independent contractor.... We must assume, in the absence of other evidence than his profession and his purpose, that what he should do and how he should do it was left wholly to him.97

The Supreme Court of West Virginia, in Thompkins v. Pacific Mutual Life Insurance Co.,98 held a different view in a case where the examinee was injured by the physician. The court in that case stated, "The relation of master and servant subsists between the company and its medical adviser in the exercise of such right of examination and the company must answer for injuries resulting from the negligence or misconduct of its agent in the premises."99 The distinguishing facts between these divergent opinions appear to be whether the plaintiffs in the cases received physical injury, with those receiving physical harm recovering against the third party.100

VII. OTHER CAUSES OF ACTION AGAINST EXAMINING PHYSICIANS

In contrast to the examinee, can the third party who hires a physician to perform an examination of a person, for the benefit of the third party, recover through a medical malpractice action against the physician for negligence or fraud committed during the examination? In Greenwald v. Grayson101 such a medical malpractice suit was brought against a physician by a husband and wife for failing to recognize symptoms of congenital disease in a child being considered for adoption.102 The Greenwald court held that, since a physician-patient relationship did not exist between the parents of the child and the physician, they could recover only in contract.103

97. Id.
98. 44 S.E. 439 (W. Va. 1903).
99. Id. at 444.
102. Id. at 205.
103. "A physician-patient relationship did not exist between the parties to this action. Appellants' relationship with the doctor was exclusively in contract. Therefore, the appellants, as plaintiffs, could have recovered only in contract." Id.
Likewise, in *McFarling v. Azar*\(^\text{104}\) an insurance company brought a medical malpractice suit against its examining physician for falsifying an examination of an applicant. Using different reasoning, the *McFarling* court found that the physician’s liability policy covered only acts of medical malpractice and refused to broaden the scope of that policy to include the fraudulent act of the physician.\(^\text{105}\)

Thus, a physician is bound to the third party employing the physician by contract alone, not by a professional relationship. Any grievance of the employer against his employee physician is held within the bounds of that contract. Recovery for damages cannot be made through a medical malpractice action which requires a physician-patient relationship.

A cause of action not available to a person who agrees to be examined by a physician at the request of a third party is that the person cannot later claim that the information obtained during that examination is protected by physician-patient privilege. In an interesting case, *Metropolitan Life Insurance Co. v. Evans*,\(^\text{106}\) the plaintiff was examined by a physician who found nothing of consequence on the evaluation.\(^\text{107}\) The defendant insurance company asked for a continuance when the physician became suddenly unavailable for testifying at trial.\(^\text{108}\) Plaintiff pleaded that the physician could not in any case testify because the information derived from the examination was privileged and protected by statute.\(^\text{109}\) The court said the privilege communication statute did not apply as the plaintiff had presented himself voluntarily for an examination solely for the purpose of determining disability and not for diagnosis or treatment.\(^\text{110}\)

Lastly, in contrast to an attending physician, an examining physician has no duty to fill out forms at the request of the examinee.\(^\text{111}\) In refusing to allow a claim made by a person denied

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\(^{104}\) 519 F.2d 1075 (5th Cir. 1975).
\(^{105}\) *Id.* at 1077.
\(^{106}\) 184 So. 426 (Miss. 1938).
\(^{107}\) *Id.* at 427.
\(^{108}\) *Id.*
\(^{109}\) *Id.*
\(^{110}\) *Id.* The insurance company then suggested that in lieu of a continuance the plaintiff be examined on the witness stand by any other physician appointed by the court. The court said the plaintiff had not exposed himself on the stand during testimony and therefore had not “waived the inviolability of his person.” *Id.*
disability benefits because of delay in receiving the necessary forms, the court said, "No case has gone so far as to saddle an examining physician with such a burden. And neither do we."\textsuperscript{112}

VIII. CONCLUSIONS

The physician who does evaluations at the request of third parties encounters greater exposure to liability in performing these examinations than when caring for his or her own patients. In the traditional practice of medicine there is an established physician-patient relationship. Acts of negligence that occur during the diagnosis and treatment of patients are considered to be acts of medical malpractice, the basis of which is the breach of some duty owed to the patient, created by this professional relationship. The physician is provided protection in such medical malpractice actions by professional liability insurance purchased by the physician or by his or her employer. The personal assets of the physician are thus afforded some protection in damage claims.

When a physician acts outside of this traditional relationship by performing examinations at the request of, and on behalf of third parties, theoretically medical malpractice cannot occur. Recovery for physical or economic injuries caused by acts of negligence on part of the physician during, or as a result of, the examination can be sought under the legal theory of common law negligence. Unless specifically covered by rider in a medical malpractice policy, the physician performing these examinations, if sued, may not have this, or any other liability protection securing his or her personal assets.

Courts have, however, found that a physician-patient relationship may in fact exist if anything the physician says or does during the examination can be construed to be treatment. This includes answering questions concerning the subject matter of the examination, or any spontaneous comments about the health or injury of the examinee.

A recent opinion has established in Louisiana that a physician-patient relationship is formed in a limited fashion whenever such an examination is performed for a third party.\textsuperscript{113} This makes it difficult for a physician to avoid exposure to professional liability.

\textsuperscript{112} Id. at 1187.

\textsuperscript{113} Green v. Walker, 910 F.2d 291 (5th Cir. 1990) (applying Louisiana law).
A physician without insurance who wishes to avoid professional liability in these encounters with examinees must therefore be extremely careful during the examination not to establish a physician-patient relationship. Questions of the examinee concerning medical or surgical problems cannot be answered. Nor can questions be acknowledged about any other health matters of the person being evaluated.

In addition, the physician must avoid common law negligence, being extremely careful not to cause physical harm to the examinee during the examination. There is also a common law duty to disclose serious or dangerous conditions previously unknown to the examinee that are discovered during the evaluation. This disclosure must be made directly to the person being evaluated, not merely mentioned in the physician's report. The physician however, has no duty to, and in fact should not, interject opinions regarding current or ongoing treatment by other practitioners with which he or she disagrees. To do so would not only establish a physician-patient relationship with the examining physician, but could easily erode the relationship already established between the examinee and the treating practitioner.

It is therefore very difficult for a physician to perform examinations on behalf of third parties and not run the risk of some liability. It is the opinion of this writer that these physicians review and acknowledge the protection given to them in the form of traditional medical malpractice insurance and then obtain such protection if at all possible. Instead of denying the existence of a physician-patient relationship, the physician should assume that such a relationship does exist, at least to the extent of the examination. By doing so, not only will the physician's assets be protected, but the examination can be carried out in a professional manner with a minimum of adversarial conflict inherent in such evaluations.
COMMENTS

ANTITRUST AND THE CREDENTIALING AND DECredentialing OF PHYSICIANS

Diane Ruder*

I. INTRODUCTION

During the past fifteen years, the courts have dramatically changed the way hospitals must view themselves. From a ruling in 19751 that all "learned professions" (presumably including the medical profession) were subject to antitrust considerations under the Sherman Act,2 to the recent Summit Health, Ltd. v. Pinhas3 ruling, the courts have imposed increasing restraints on the methods hospitals use to conduct their businesses. This most recent ruling means that even 200-bed small-town hospitals with only one specialist in each medical discipline are subject to antitrust rules and regulations just like big business. Hospitals are now forced to deal with the financial and practical burdens imposed upon them in order to avoid any semblance of antitrust violation.

During the 1980s hospitals were challenged by almost overwhelming odds. Decreasing utilization of hospital services4 with

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2. Valerie S. Biebuyck, Comment, Antitrust Law, Immunity, and Medical Peer Review Boards, 37 BUFF. L. REV. 831, 834 n.13 (1982). ("Such suits may also be brought under Section 2, which states that 'every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce' is guilty of a felony." Id., citing 15 U.S.C. § 2 (1982)).
4. Kopit, Hospital Antitrust Risks: The Legal Fallout of the Market Imperative, 1990 HEALTH L. HANDBOOK 241 (1990) (during the 1980s, patient admissions decreased and inpatient lengths of stay declined resulting in fewer patients spending fewer days in the hospital; this led to a steady decline in hospital revenue margins) (citing hospitalization and utilization data taken from annual compilations of the AMERICAN HOSPITAL ASSOCIATION during the 1980s, which are published each year in Hospital Statistics (AHA) and the May issue of Hospitals).
a corresponding decline in hospital revenue margins, changes in the federal Medicare program and other third party payors' methods of reimbursement, and increased exposure to medical malpractice suits have fueled these problems.

In response to these challenges, many hospitals in a growing number of communities have closed or consolidated their resources. In fact, by the year 2000 it is estimated that the currently available acute care bed capacity will be reduced by twenty percent. Truly, this is the most challenging environment facing hospitals in years.

Hospitals have begun to fight back with cooperative or regionalized arrangements designed to consolidate resources, cut costs, increase efficiency, and maximize profits. But the courts have frequently seen these efforts "through the lens of antitrust, to be a conspiracy to engage in the highly anticompetitive and illegal act of dividing markets."

Pinhas, an ophthalmologist practicing in a Los Angeles hospital, alleged that the hospital and its staff conspired to exclude him from hospital privileges. He further alleged that the hospital and its staff conspired to report his subsequent suspension to hospitals throughout the country, which gave competing surgeons a greater share of the ophthalmic surgery market. The Supreme Court found that his exclusion from practicing in a Los Angeles hospital had sufficient effect on interstate commerce to establish federal jurisdiction. It found further that this exclusion of a single doctor from the market should be evaluated by measuring

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5. Id. at 242.
6. Id. (Medicare only pays a set sum for each patient's illness regardless of the actual cost to the hospital; it has limited the number of services that can be performed inpatient; and its payments have not kept pace with inflation. These changes have the net effect of increasing the number of patients handled on an outpatient basis, and decreasing the length of hospital stays for those patients treated on an inpatient basis) (citation omitted).
8. Kopit, supra note 4, at 242.
9. Id. at n.8.
10. Id. at 241.
13. Id.
14. Id. at 1849 (Scalia, J., dissenting).
the potential impact of the restraint on other market practitioners and potential practitioners, and not solely by evaluating the actual harm that occurred by excluding that particular physician from the market.\footnote{Id. at 1848.}

Now, with the \textit{Pinhas} ruling, hospitals are presented with another conundrum. They must rid themselves of unqualified medical practitioners who not only increase their exposure to malpractice liability, but also make hospitals less attractive to potential patients.\footnote{Kopit, \textit{supra} note 4, at 243.} However, they must do so while avoiding the risk of antitrust conspiracy charges brought by decredentialled, sub-par physicians who have been refused privileges through the medical staff peer review process mandated by Congress.\footnote{Biebuyck, \textit{supra} note 2, at 854. In 1986 Congress passed the Health Care Quality Improvement Act (HCQIA) "'to improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior.'" (quoting H.R. REP. No. 903, 99th Cong., 2d Sess., pt. 1, at 2 (1986)).}

There is, though, still another part to the puzzle. Hospitals in small towns have, by necessity, peer review committees made up of doctors who are in competition with each other. These circumstances alone make them more vulnerable to allegations of antitrust violations. Now, as Justice Scalia stated in his dissenting opinion in \textit{Pinhas}, the common disputes over denial of hospital staff privileges have become issues with a federal forum.\footnote{Summit Health, Ltd. v. Pinhas, 111 S. Ct. 1842, 1849 (1991) (Scalia, J., dissenting).} This fact has exposed the industry to an even greater risk of antitrust claims for termination of physicians' staff privileges, as well as to the payment of treble damages that accompany the loss of federal antitrust cases.\footnote{Id.}

This comment will examine the Supreme Court's application of antitrust doctrine in one particular area of the health care industry—the peer review process and the credentialing and de-credentialing of physicians. It will give a brief overview of the history of that process, discuss the immunity from damages provided by Congress and some states to help protect those who serve on peer review committees, and review recent Supreme Court antitrust rulings which have impacted on this immunity.
Finally, ways for hospitals to help lessen federal antitrust liability will be discussed.

II. THE HISTORY OF PEER REVIEW

In 1952, the Joint Commission on Accreditation of Hospitals, now known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), was formed by the American Medical Association in conjunction with the American College of Surgeons, the American Hospital Association, and the American College of Physicians. Since its formation, JCAHO has required, as a part of its standards for hospital accreditation, that physicians at a hospital organize autonomously as a medical staff.20

JCAHO standards require a hospital’s medical staff to establish uniform criteria to be used in determining eligibility for membership on the medical staff.21 Although JCAHO standards are designed to provide patients with a positive assurance that they are receiving quality care from physicians,22 there are some negative features about this process of physician evaluation.

The most potentially negative aspect of hospital-based peer review in relationship to quality assurance is that medical staff peer reviewers have an ongoing relationship with each other. There is, generally, no incentive for a medical staff peer reviewer to challenge the actions of a colleague because, one day, that colleague may be reviewing the reviewer.23

From an antitrust perspective, the most potentially damaging aspect of this evaluation process is that medical staff peer reviewers are frequently competitors with each other and with

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20. Blumstein & Sloan, supra note 7, at 11 (JCAH[O] accreditation is very important to hospitals: some states required accreditation through JCAHO while others permit such accreditation to replace state licensure; furthermore, JCAHO-accredited hospitals may be automatically eligible to receive reimbursement under the medicare program) (citation omitted).
21. Id. (citing JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, AMH 88/ACCREDITATION MANUAL FOR HOSPITALS 112 (1987)).
22. Id. (“Judgment as to the quality of individual physicians may be made on the basis of current licensure, relevant training, experience, current competence, and health status. The JCAH[O] recommends that hospitals collect such information from a physician applicant as the following: involvement in any professional liability action; previously successful or pending challenges to any licensure or registration; and loss of staff privileges at any other hospital.”).
23. See id.
prospective applicants. There is a danger of being charged with anticompetitive conduct “any time members of a particular profession collectively decide whether a colleague—who is also a competitor of the decision makers—may be a part of that group, or whether he should be excluded.” This unenviable position is exactly where many medical peer reviewers find themselves each time they sit as a peer review committee.

III. IMMUNITY FROM DAMAGES

As the application of antitrust laws to the medical profession evolved, a proliferation of suits resulted. In response, many states enacted laws that created immunities from liability for damages for good faith involvement in medical staff privileges terminations.

Even though many hospitals have believed that their state laws governing peer review activities provide an exemption to antitrust laws, such “state action,” or “Parker v. Brown” defense, is very limited. In order for this defense to be successful, it is necessary that peer review activities be actively

24. Cf. id.
27. Kopit, supra note 4, at 268.
28. Id.
29. Blumstein & Sloan, supra note 7 (“The Parker v. Brown state action defense is premised on the belief that the Sherman Act was not designed to bar states from imposing restraints on competition.” Id., citing 317 U.S. 341 (1943). “Parker immunity is inferred by the courts. It assumes, on grounds of federalism, that Congress ‘did not intend to compromise the States’ ability to regulate their domestic commerce.” Id. (citing Southern Motor Carriers Rate Conference, Inc. v. United States, 471 U.S. 48, 56 (1985)). “Parker immunity extends to antitrust actions against states and state officials,” id. (citing Hoover v. Ronwin, 466 U.S. 588 (1984)), “and in proper cases, extends to suits against private parties as well.” See Southern Motor Carriers, 471 U.S. at 57.).
30. Kopit, supra note 4, at 268.
31. Id. (“Specifically, the immunity provides for an exemption to the antitrust laws only if there is state regulation that is based on an affirmative state policy and involves the ‘active supervision’ of a state agency.”).
supervised by the state based on an affirmative state peer review policy.\textsuperscript{32}

In 1986, Congress enacted the Health Care Quality Improvement Act (HCQIA)\textsuperscript{33} as a response to a fear that the risks associated with antitrust enforcement "unreasonably discour-age[d] physicians from participating in effective professional peer review."\textsuperscript{34} Peer review doctors, who monitor the performance of other medical doctors and report medical malpractice payments to a nationwide network,\textsuperscript{35} were given limited immunity by this Act. The Act was intended to ensure that incompetent physicians are identified and precluded from the practice of medicine without the identifiers being hesitant for fear of suit.\textsuperscript{36}

Under HCQIA, states were given the choice of either adopting the Act itself, or enacting their own legislation to provide peer review immunity.\textsuperscript{37}

The guidelines for professional review actions [under HCQIA] are grounded in a "reasonable belief" standard ... which "will be satisfied if the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients." ... However, it is important to note that the statute does not provide absolute immunity. If a jury concludes that a peer review body had disciplined a doctor in order to eliminate a competitor, it can award antitrust damages.\textsuperscript{38}

Through the HCQIA, Congress and those adopting states have attempted to provide a safety net for physicians who engage in peer review. Despite the HCQIA, the courts in the past decade have brought pressure on the medical industry through rulings

\textsuperscript{32} See California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980); Kopit, supra note 4, at 268.


\textsuperscript{34} 42 U.S.C. § 11101(4) (1988).

\textsuperscript{35} Id. §§ 11131, 11134.

\textsuperscript{36} Biebuyck, supra note 2, at 855.

\textsuperscript{37} Id. (citing 42 U.S.C. § 11111(c) (1988); also citing HCQIA: CA Doctors Decide to Opt Out, HOSPITALS, July 5, 1988, at 56).

\textsuperscript{38} Id. at 855-56 (quoting H.R. REP. No. 903, 99th Cong., 2d Sess., pt. 1 (1986)). See also, Tim A. Thomas, J.D., Annotation, Denial by Hospital of Staff Privileges or Referrals to Physician or Other Health Care Practitioner as Violation of Sherman Act (15 U.S.C.S. §§ 1 et seq.), 89 A.L.R. FED. 419, 429 (1988) [hereinafter Sherman Act—Hospital Privileges].
that have linked hospitals to antitrust activities, which are not protected under the HCQIA. These rulings\textsuperscript{39} have placed the medical industry on notice that it must adopt the same codes regarding interstate commerce activities as other businesses or suffer the consequences in court.

IV. PEER REVIEW AND ANTITRUST

Today, the most common antitrust claims brought against hospitals are medical staff privilege claims brought by physicians or allied health professionals who have been denied privileges or whose privileges have been terminated or restricted.\textsuperscript{40} Most such claims are brought under sections 1 or 2 of the Sherman Act.\textsuperscript{41} The provisions of the Sherman Act “prohibit[] hospitals and/or members of medical staff from using medical staff privileges decisions to eliminate competing practitioners from the market so that prices can be increased or output decreased.”\textsuperscript{42} Because peer review committees make only a recommendation and do not actually decredential, suits are brought against the hospital since it makes the ultimate decision about staff privileges.\textsuperscript{43}

Since reports from peer review proceedings are routinely distributed throughout the United States,\textsuperscript{44} the barring of a physician from use of a local hospital is tantamount to excluding the physician from the profession as a whole. Sometimes a denial of an application for privileges may adversely affect competition.\textsuperscript{45}

\begin{itemize}
  \item \textsuperscript{40} Kopit, supra note 4, at 264.
  \item \textsuperscript{41} Id. at 241 (“Section 1 prohibits conspiracies, contract and combinations in restraint of trade, and] Section 2 prohibits monopolization, attempted monopolization and conspiracies to monopolize.”) (citing 15 U.S.C. §§ 1-2).
  \item \textsuperscript{42} Id. at 264. The Sherman Act also allows the cases to be heard in federal courts with the possibility of treble damages and attorney’s fees being awarded. See also 42 U.S.C. § 11101(4).
  \item \textsuperscript{43} Interview with Keith Trumbo, J.D., Risk Manager, Middletown Regional Hospital, in Middletown, Ohio (Aug. 6, 1991).
  \item \textsuperscript{44} See Summit Health, Ltd. v. Pinhas, 111 S. Ct. 1833, 1849 (1991).
  \item \textsuperscript{45} Cf. Biebuyck, supra note 2, at 833 (citing Snow, Trust versus (sic) Antitrust, THE ATLANTIC, Sept. 1986, at 26). (In other cases, a physician may receive a low rating but is not barred from hospital privileges. Instead, he is forced to live with that rating even though it may have been given him by a competitor. Interview with Keith Trumbo, J.D., Risk Manager, Middletown Regional Hospital, in Middletown, Ohio (Aug. 6, 1991)).
\end{itemize}
thus leaving the peer review committee and the hospital at risk of being charged with antitrust violations.

To establish the applicability of the Sherman Act to a defendant’s conduct, the Supreme Court ruled in McLain v. Real Estate Board of New Orleans, Inc.\(^{46}\) that the plaintiff must show that the defendant’s conduct itself is a part of, or, if local in nature, has a substantial effect on interstate commerce.\(^{47}\) Justice Scalia noted in his dissenting opinion in Pinhas\(^{48}\) that, with this ruling, the Court began “to shift the focus of the inquiry away from the effects of the restraint itself, asking instead whether the [defendants’] activities which allegedly have been infected by a price-fixing conspiracy ... have a not insubstantial effect on the interstate commerce involved.”\(^{48}\)

In Arizona v. Maricopa County Medical Society,\(^{49}\) two “foundations for care”\(^{50}\) were made up of individual practitioners who agreed to act in concert with one another for patients by establishing maximum fees that could be charged to policyholders of specific insurance plans.\(^{51}\) The Court rejected that the foundations had formed a joint venture.\(^{52}\) It asserted they were guilty of horizontal price-fixing agreements in their patients’ fee arrangements\(^{53}\) and were subject to the per se rule of conspiring together to the detriment of their patients.\(^{54}\)

The Maricopa County analysis is applicable in the hospital peer review context because typical peer reviewers are merely individual practitioners engaged in competition with one another. They cannot be viewed as a single entity which would allow them to escape the proscriptions of section 1 of the Sherman Act.\(^{55}\)

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47. Id. See also Sherman Act—Hospital Privileges, supra note 38, at 429 (citing cases where the physician-plaintiff need only show “an effect on interstate commerce resulting from the defendant's activities generally, as distinguished from the particular activities which are alleged to violate the Sherman Act”).
50. Id. at 336.
51. Id. at 356.
52. Id.
53. Id. at 357.
54. Id. at 355.
55. See supra text accompanying note 41; see also Weiss v. York Hosp., 745 F.2d 786 (3d Cir. 1984) (the actions of a hospital's medical staff—under the traditional hospital structure—should be seen as the "actions of a combination of the individual doctors who make it up." Id. at 816).
Two cases, in particular, highlight the courts' position regarding peer review as it is currently practiced in most hospitals: Weiss v. York Hospital and Smith v. Northern Michigan Hospitals, Inc. In Weiss the Third Circuit said that a medical staff could not, as a matter of law, conspire with the hospital because the staff as an entity had no interest in competition with the hospital. It said, however, that the medical staff members were capable of conspiracy with each other, in violation of section 1 of the Sherman Act, because the staff was made up of individual doctors who were in competition with each other.

In Smith, the Sixth Circuit emphasized that members of a hospital clinic were members of a group practice and that "the interest of each clinic physician is one and the same as the enterprise of which he or she forms a part." The court observed that when participating physicians maintain "the actual practice of their profession independent of that corporate body, ... the independent personal stake ... is apparent." That is the same situation as the case of physicians who are part of the hospital peer review team.

In Patrick v. Burget the Court acknowledged the potential conflict between the peer review process and the effective enforcement of antitrust laws. The Court considered the argument that "effective peer review is essential to the provision of quality medical care and that any threat of antitrust liability will prevent physicians from participating openly and actively in peer-review proceedings." However, since that argument "essentially challenges the wisdom of applying the antitrust laws to the sphere of medical care," it was more properly the role of Congress to remedy the problem. The Court also recognized that Congress...
had "insulated certain medical peer-review activities from antitrust liability in the Health Care Quality Improvement Act of 1986" which was a response by Congress to a "concern that the possibility of antitrust liability will discourage effective peer review."  

Justice Marshall, speaking for the unanimous Court in Patrick, said antitrust laws remain fully applicable to the peer review process "[t]o the extent that Congress has declined to exempt medical peer review from the reach of antitrust laws" unless the state action doctrine applies. If physicians were not in agreement with this ruling, he said, they should "take that matter up with Congress."

Historically, federal courts have dismissed most antitrust lawsuits filed against hospitals by injured physicians because they have been unable to show any effect of their cases on interstate commerce. However, in Pinhas, the Court moved to add another "candidate to the field, one that no court or commentator has ever suggested, let alone endorsed."

Pinhas, an ophthalmologist, claimed that a hospital and several doctors had abused the peer review process and conspired to exclude him from practicing in the Los Angeles area and to report the suspension and termination to hospitals throughout the United States. This, he asserted, gave a greater share of his business to competing surgeons.

In a 5-4 decision, the Supreme Court ruled that Pinhas had met the necessary jurisdictional requirements to bring suit under section 1 of the Sherman Act. The majority opinion applied the "general business activities" jurisdictional test from McLain v. Real Estate Board of New Orleans, Inc. to the peer review process. The Court stated that Pinhas need not demonstrate an

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67. Id. at n.8 (the immunities of the Health Care Quality Improvement Act were not applicable to the case at bar since the Act was enacted after the events of this case and the Act is not retroactive).
68. Id.
69. Id. at 105.
70. Id. For a discussion of the "state action doctrine," see supra note 29.
71. Id. at 105-06 n.8.
73. Id. at 1850.
74. Id. at 1844.
75. Id. at 1849.
actual effect on interstate commerce to establish federal jurisdiction since civil liability under the Sherman Act "may be established by proof of either an unlawful purpose or anticompetitive effect," and because there would be a reduction of ophthalmological services in the Los Angeles area "as a matter of practical economics." According to the dissenting opinion, the Court did not look at the restraint's effect on interstate commerce, nor at the "infected activity's" effect on restraint of commerce, the two areas which the Court has traditionally evaluated. Instead, the Court looked at the action's effect on the commerce from which the plaintiff had been excluded. Justice Scalia noted that disputes over denial of hospital practice privileges are common: "We have today made them available for routine business torts, needlessly destroying a sensible statutory allocation of federal-state responsibility and contributing to the trivialization of the federal courts."

V. SOLUTIONS TO AVOIDANCE OF ANTITRUST LIABILITY

In a few short years, the Supreme Court has dramatically broadened the reach of federal antitrust laws. From its earliest opinion about professional antitrust liability in 1943, until the 1970s, the Court has consistently refused to hold that professions were liable for antitrust action. Then, in Goldfarb v. Virginia State Bar, the Court ruled that the activities of professionals, presumably including those in medicine, can subject them to liability for antitrust violations. In the 1980s the Court quickly erased legal barriers that had previously stopped many physicians from filing successful antitrust claims against hospitals that had terminated their staff privileges.

78. Id.
80. Id.
81. Id. at 1854.
83. Id.
84. 421 U.S. 773 (1975).
85. Sherman Act—Hospital Privileges, supra note 38, at 425.
86. See supra text accompanying note 21. See generally Biebuyck, supra note 2; Blumstein & Sloan, supra note 7.
Now, in 1991, the *Pinhas* ruling has opened the door even further to greater exposure of hospitals to antitrust action. Increasing numbers of physicians harmed by the peer review process may opt to seek treble damage awards in federal courts knowing that now they have only to show that a peer review proceeding has potentially interfered with interstate commerce. This action will ultimately prove costly to hospitals who choose to revamp their peer review proceedings by using outside consultants to review their medical staffs in an attempt to eliminate the potential for antitrust violations.

The *Patrick v. Burget* decision is useful because it conveys the degree of state supervision of the peer review process that the courts expect in order to effectuate the state action immunity doctrine. A state should ensure that its laws reflect "standards of evidence and burdens of proof" that are strong enough to adequately protect the activities of peer reviewers. Additionally, the state legislature should mandate the creation of peer review boards and make sure that they are adequately supervised.

Those states which hope to achieve immunity for their peer review process must realize that the HCQIA provides only partial federal statutory immunity for certain specific acts of a hospital and/or its medical staff relating to medical-staff privileges. For this reason it is particularly important that hospitals and physicians carefully follow the procedural requirements for "due process" regarding notice and hearings and comply with the reporting requirements that HCQIA has established.

"Hospitals have a large degree of latitude in medical staff privileges decisions under the antitrust laws if the decisions are unilateral, rather than as a result of an agreement, either express or implied, particularly if the hospital itself is not a competitor of

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88. Id.
89. Interview with Keith Trumbo, J.D., Risk Manager, Middletown Regional Hospital, in Middletown, Ohio (Aug. 6, 1991).
90. Biebuyck, supra note 2, at 857. These due process safeguards "include[e] the right to adequate notice, a written record of the proceedings, counsel, and confrontation and cross-examination of adverse witnesses, among others." Id.
91. Id. at 857-58.
92. Cf. id.
93. Kopit, supra note 4, at 269 (citing 42 U.S.C. §§ 11101 et seq.).
94. Id.
the terminated practitioner. As long as a hospital denies [medical staff privilege] decisions based on its own independent judgment rather than at the insistence of competing members of the medical staff, plaintiffs will not be able to show that a [medical staff privilege] decision resulted from an agreement.\textsuperscript{95}

Hospitals can also begin a proctoring system\textsuperscript{96} with a monitor who represents and is responsible to the medical staff for giving an objective evaluation of a physician's clinical competence. Monitors are particularly appropriate in evaluating new applicants for hospital privilege.\textsuperscript{97}

If the medical industry is to come to grips with the economic problems of the nineties, it is imperative for hospitals to take all actions necessary to reduce risks. Administrators must be knowledgeable about antitrust, and they must become more involved in seeking legislative relief from the possibility of liability under the Sherman Act.

A highly publicized case in Dayton, Ohio, involved the so-called "love doctor," Dr. James Burt.\textsuperscript{98} Dr. Burt performed numerous operations on unsuspecting women to "improve their love life." More importantly for purposes of this comment, Dr. Burt had a long history of poor peer reviews.\textsuperscript{99} St. Elizabeth Hospital looked the other way, even though it had adequate warning from the evaluations Dr. Burt had received during several peer reviews.\textsuperscript{100} Perhaps the hospital feared a lawsuit from Dr. Burt, should the medical center dare to deny him privileges, more than it feared malpractice suits from Dr. Burt's patients.\textsuperscript{101}

This case is an example of what can happen when hospitals become more conscious of the liabilities associated with decre-

\textsuperscript{95} Id. at 269-70.

\textsuperscript{96} Biebuyck, supra note 2, at 860 (citing Baker, Taking Care of the Doctors: The Hospital's Duty to "Evaluate, Monitor, and Discipline its Medical Staff, 13 JOURNAL OF QUALITY ASSURANCE—QUALITY REVIEW BULLETIN 88 (1987); Is There a Proctor in the House?, HOSPITALS 65 [June 20, 1988] [hereinafter Proctor in the House].

\textsuperscript{97} Id. (citing Proctor in the House, supra note 96, at 65).


\textsuperscript{100} Id.

\textsuperscript{101} Id.
dentiaing than with the quality assurance programs that will enable all patients to be assured of sound medical practice by competent doctors. It is imperative that hospitals take a stand about peer review proceedings. The medical profession must police itself and it must do so effectively if it is to continue to have the confidence of its patients. Given the courts' current tendency to regard the medical profession as a business that must operate under federal antitrust laws, it is urgent that hospitals, physicians, and legislators work together to establish an effective peer review process that is fair to all concerned.

VI. CONCLUSION

The Pinhas decision has largely eliminated the jurisdictional argument as a defense for hospitals at the start of litigation and has left defendants in decedentialing cases with few remaining legal weapons.\textsuperscript{102} Additionally, it has made it more difficult and more expensive for many hospitals to revoke the privileges of those physicians who are incompetent.

Pinhas has hastened the need for procedures that will lead to greater compliance with the HCQIA in order to obtain immunity from damages under state laws and antitrust.\textsuperscript{103} State legislatures and health care administrators must make certain that their state laws will decrease the possibility of lengthy and expensive legal battles. They must work together to increase the likelihood that the peer review process will continue to serve the purpose for which it was intended—to help assure that all patients in all hospitals are treated by competent physicians who are dedicated to the "furtherance of quality healthcare."\textsuperscript{104}

\textsuperscript{102} Id. at 5.
\textsuperscript{103} Busey, supra note 77, at 1.
DECISIONS UNDER THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT: A JUDICIAL CURE FOR PATIENT DUMPING

Diana K. Falstrom

INTRODUCTION

In 1986 Congress passed the Emergency Medical Treatment and Active Labor Act¹ (the Act) as part of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA).² The Act was a federal legislative response to the problem of "patient dumping."³ This term refers to a hospital's refusal to treat an emergency patient, where the hospital is physically capable of doing so, simply because the patient does not have adequate medical insurance and is unable to pay for the costs of treatment, or is considered undesirable as a long-term patient for some other reason.⁴


⁴. See Preventing Patient Dumping, supra note 2, at 174.

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Commentators\textsuperscript{5} have outlined potential problem areas in applying the specific provision of the Act which creates a private cause of action for individuals who suffer harm as a direct result of its violation.\textsuperscript{6} This Comment will review the judicial decisions rendered under the Act which have addressed the expected problems, as well as those not anticipated. Part I of the Comment summarizes the legislative and judicial history which led to the enactment of the Emergency Medical Treatment and Active Labor Act. Part II describes the provisions of the Act, as amended, and its anticipated applications. Part III briefly examines some of the expected problem areas as they have been treated by the courts. Part IV presents two unforeseen controversies in the case law, and focuses on the more significant, that is, whether the Act's protection extends beyond patients who are indigent and uninsured. Part IV also discusses the Sixth Circuit's resolution of this controversy in \textit{Cleland v. Bronson Health Care Group, Inc.}\textsuperscript{7} and the impact of \textit{Cleland} upon subsequent decisions on this issue.

I. THE PROBLEM OF PATIENT DUMPING

The evolution of the patient dumping problem can be traced from its origins in the common law treatment of hospital liability. Patient dumping has been exacerbated by the failure of federal and state remedies to adequately address the problem and by the impact of changes in the health care industry in the mid-twentieth century.

At common law, a hospital had no duty to render services to a person who requested treatment.\textsuperscript{8} The general absence of a duty was grounded in the traditional common law distinction

\textsuperscript{5} Preventing Patient Dumping, supra note 2; McClurg, supra note 2. Additional potential problems beyond those associated with the private cause of action were also identified, but these are beyond the scope of this Comment.


\textsuperscript{7} 917 F.2d 266 (6th Cir. 1990).

\textsuperscript{8} The no-duty rule was first established in Birmingham Baptist Hosp. v. Crews, 157 So. 224 (Ala. 1934) (a private hospital may refuse treatment and need not explain that refusal). For a more recent discussion of the no-duty rule, see Johnson v. University of Chicago Hosp., 774 F. Supp. 510 (N.D. Ill. 1991), and Dade County v. American Hosp. of Miami, Inc., 502 So. 2d 1230 (Fla. 1987).
between nonfeasance and malfeasance.\textsuperscript{9} Dissatisfied with the effect of the no-duty rule, courts found ways to impose liability. In some cases liability was based on an individual's reliance on a hospital's custom or policy of furnishing emergency services.\textsuperscript{10} In other cases courts held that a hospital assumed a duty of care by undertaking to render treatment.\textsuperscript{11} These theories of liability, however, were not applied consistently and left the law in a state of disarray.\textsuperscript{12}

Statutory attempts to address the patient dumping problem have, for the most part, been unsuccessful. In 1946, Congress passed the Hill-Burton Act\textsuperscript{13} which required hospitals receiving federal funds to agree to furnish a reasonable amount of uncompensated or reduced-cost care for a period of twenty years.\textsuperscript{14} It was not until thirty-three years later, however, that regulations were adopted establishing the specific dollar amounts of care required.\textsuperscript{15} The statute also lacked an express cause of action under which individuals could seek relief from offending hospitals. Congressional hearings and litigation in the 1970s showed widespread noncompliance with Hill-Burton.\textsuperscript{16}

\textsuperscript{9} See W. Keeton Et A\textsubscript{L}, Prosser And Keeton On The Law Of Torts § 56, at 373-75 (5th ed. 1984). See also Restatement (Second) of Torts § 314 (1965) ("The fact that the actor realizes or should realize that an action on his part is necessary for another's aid or protection does not of itself impose upon him a duty to take such action.").

\textsuperscript{10} Wilmington Gen. Hosp. v. Manlove, 174 A.2d 135 (Del. 1961) (patient relied on hospital's established custom of rendering emergency treatment); Stanturf v. Sipes, 447 S.W.2d 558 (Mo. 1969) (hospital had well-established policy to accept all patients upon payment of admission fee).

\textsuperscript{11} See, e.g., Riddle Memorial Hosp. v. Dohan, 475 A.2d 1314 (Pa. 1984) (relying on the undertaking exception to the nonfeasance rule of Restatement (Second) of Torts § 323 (1965)). The lengths to which a court will go to find an undertaking is illustrated by O'Neill v. Montefiore Hosp., 202 N.Y.S.2d 436 (App. Div. 1960). In O'Neill, a nurse refused to treat a heart attack victim because the hospital did not treat patients who belonged to his insurance plan. She did, however, place a phone call to a doctor who was a participant in the patient's insurance plan. The court held that the phone call was sufficient to allow the jury to conclude that the hospital had "undertaken" to provide medical care for the decedent. Id. at 440.

\textsuperscript{12} See, e.g., Harper v. Baptist Medical Ctr.-Princeton, 341 So. 2d 133 (Ala. 1976) (confirming the no-duty rule of Birmingham Baptist Hosp. v. Crews, 157 So. 2d (Ala. 1964)).


\textsuperscript{14} Id. at §§ 291(e)(2), 291(a)(2) (1988).


\textsuperscript{16} Id. at 156-58.
Although at least one-half of the states enacted statutes imposing an emergency care duty on hospitals, these have been similarly ineffective. All but a few fail to expressly provide for a private cause of action. Some impose fines or criminal penalties for violations, but even these are plagued by definitional ambiguities and regulatory deficiencies.

The inadequacy of state statutory remedies for patient dumping is illustrated by Owens v. Nacogdoches County Hospital District, a case decided under Texas law. Texas is one of the few states which had both a statute concerning emergency medical or health care for the uninsured and regulations for transferring patients from one hospital to another. The Texas statute had been in effect since 1975 and was used by congressional staff members in developing the Emergency Medical Treatment and Active Labor Act. Yet in the Owens case, the plaintiff was granted declaratory and injunctive relief against the offending hospital because the court found that "for at least five years, 


19. Georgia and Kentucky impose fines ranging from $100 to $500 on violating hospitals. GA. CODE ANN. § 31-8-46 (1991); KY. REV. STAT. ANN. § 216B.9903 (Baldwin 1991). Prior to its repeal in 1989, the Texas statute provided that violators could be punished with up to ten years imprisonment and $5,000 in fines. TEX. HEALTH & SAFETY CODE ANN. § 4438(a)(2) (Vernon Supp. 1988).

20. See McClurg, supra note 2, at 190-97.


24. See generally Preventing Patient Dumping, supra note 2.
The hospital ha[d] flagrantly been engaged in patient dumping."

The patient dumping problem has been exacerbated by a fundamental change in the provision of institutional health care in this country. Hospitals were originally built primarily to care for the poor. As hospitals began treating more paying patients, new hospitals were established as business enterprises in the late nineteenth century. In the twentieth century, hospitals have become as competitive as any commercial enterprise.

In addition to this shift in the mission of hospitals, changes in the availability of health insurance also contributed to a rise in patient dumping. The current system of offering health insurance through employment developed during the Great Depression when most people were unable to pay for their own health care. Tying health insurance to employment, however, necessarily results in high numbers of uninsured during periods of increased unemployment. The rising costs of health care in the 1970s and the changes in federal health insurance programs in the 1980s provided additional incentive for hospitals to ignore the needs of uninsured or minimally insured patients, and set the stage for congressional action in 1986.

II. THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT

The Emergency Medical Treatment and Active Labor Act requires that hospitals which participate in the Medicare program

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25. 741 F. Supp. 1269, 1281 (E.D. Tex. 1990). The facts in Owens exemplify the egregious conduct of many hospitals and physicians. A pregnant sixteen-year-old in the onset of labor was briefly examined at the defendant hospital and then instructed to travel two hundred miles to another hospital to deliver her baby. Id. at 1271. See also Burditt v. United States Dept. of Health & Human Servs., 934 F.2d 1362 (5th Cir. 1991) discussed infra notes 57-106 and accompanying text.


27. Id. at 235-334.

28. Id.

29. See generally Preventing Patient Dumping, supra note 2, at 1192.

30. See generally McClurg, supra note 2, at 179-82; Preventing Patient Dumping, supra note 2, at 1191-96.

31. Medicare, enacted in 1965, is a national health insurance program for disabled Americans in which 98% of the hospitals in this country participate. Health Care Financing Admin., Bureau of Management & Strategy, HCFA Statistics 13 (1986). Medicare must be distinguished from Medicaid, the federally-aided, state-operated health care program for the poor.
and which have emergency departments\textsuperscript{32} provide an "appropriate medical screening examination" within the capability of the hospital's emergency department to any individual requesting one.\textsuperscript{33} The purpose of the examination is to determine whether the person is suffering from an "emergency medical condition" as that term is defined in the Act.\textsuperscript{34} The term "emergency medical condition" means:

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.\textsuperscript{35}

A person determined to be in an emergency medical condition must either be provided with further medical examination and treatment or be transferred to another medical facility in accordance with the transfer provisions of the Act.\textsuperscript{36} The duty to treat or transfer only arises if an "emergency medical condition" is found. Where no such condition is diagnosed, the Act is wholly inapplicable.\textsuperscript{37}

\textsuperscript{32} The 1989 amendments expanded the Act's definition of services "within the capability of the hospital's emergency department" to include "ancillary services routinely available to the emergency department." Pub. L. No. 101-239, § 6211(i), 103 Stat. 2245.


\textsuperscript{34} Id. at § 1395dd(e)(1) (Law. Co-op. Supp. 1991). As originally enacted, the Act included a definition of "active labor" in § 1395dd(e)(2). That definition was eliminated by the 1989 amendments, Pub. L. No. 101-239, § 6211(i), 103 Stat. 2245, and the definitional requirements of "active labor" were incorporated into § 1395dd(e)(1). The current definition of "emergency medical condition" limits the Act's application for pregnant women to one who is "having contractions." Id.

\textsuperscript{35} Id.

\textsuperscript{36} Id. at § 1395dd(b)(1) (Law. Co-op. Supp. 1991).

The hospital is relieved of its duty to provide treatment if the individual refuses to consent to the examination and treatment. If the person refuses to consent to a transfer, the hospital is relieved of its duty to transfer. In its original form, the Act did not require the hospital to inform the individual of the consequences of refusing treatment or transfer. This omission was corrected by the 1989 amendments to the Act. The Act now provides that the hospital must inform the individual, or a person acting on the individual's behalf, of the risks and benefits to the individual of examination and treatment or transfer. The hospital must also “take all reasonable steps to secure the individual's ... written informed consent to refuse” such treatment or transfer.

A person who is in an emergency medical condition may be transferred without the restrictions of the Act once the person is stabilized. The term “stabilized” is defined in the Act as:

with respect to an emergency medical condition ... that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or with respect to [a pregnant woman having contractions], that the woman has delivered (including the placenta).

If the patient has not been stabilized, the hospital may not transfer unless one of the following has taken place:

1. the patient requests transfer in writing after having been informed of the hospital's obligations under the Act and the risk of transfer;

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41. The term “person acting on the individual’s behalf” is not defined in the act.
43. Or the consent of the person acting on the individual's behalf. Id.
44. Id.
(2) the physician certifies in writing that based on the information available at the time of transfer, the medical benefits reasonably expected from the transfer outweigh the increased risks to the individual and, in the case of labor, to the unborn child;\(^{48}\) or

(3) where the physician is not present in the emergency department at the time of the transfer, a qualified medical person signs a certification of transfer which is then countersigned by the physician who made the determination described in the certification.\(^{49}\)

Additionally, the transfer must be an "appropriate transfer" as specified in the Act.\(^{50}\) An "appropriate transfer" is subject to a variety of restrictions. First, the transferring hospital must provide appropriate preliminary treatment to minimize the risks to the individual and, where appropriate, to the health of the unborn child.\(^{51}\) Also, the receiving hospital must have available space and qualified personnel and agree to accept the transfer and provide appropriate treatment.\(^{52}\) The transferring hospital must also send all medical records related to the emergency condition, including observation of symptoms, diagnosis, treatment provided, test results, written consent by the patient or hospital certification recommending transfer, and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide stabilizing treatment.\(^{53}\) Finally, the transfer must be effected through qualified personnel and transportation equipment, including the use of life-support measures where necessary and medically appropriate.\(^{54}\)

The Act includes specific enforcement provisions.\(^{55}\) For violations of the Act, civil monetary penalties up to $50,000 can be

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54. Id. at § 1395dd(c)(2)(D) (Law. Co-op. Supp. 1991). The Act also provides that the transfer must meet any other requirements that the Secretary of Health & Human Services may find necessary in the interest of the health and safety of the individuals transferred. Id. at § 1395dd(c)(2)(E) (Law. Co-op. Supp. 1991). To date, the Secretary has not placed any additional restrictions on transfer. The rules proposed in 1988 largely track the language of the Act, adding little guidance as to how the operative provisions should be construed. See 53 Fed. Reg. 22,513 (1990).
55. Id. at § 1395dd(d) (Law. Co-op. Supp. 1991). Originally the Act provided that Medicare participation may be suspended or barred for hospitals which knowingly and
levied upon both the hospital and the responsible physician. In 1988 the civil penalty provisions were enforced against a Texas physician. The physician appealed this enforcement to the Court of Appeals for the Fifth Circuit. The case, Burditt v. United States Department of Health & Human Services, is instructive in that the court interpreted many of the key provisions of the Act.

The facts in Burditt exemplify the kind of patient-dumping activity the Act was designed to discourage. The patient, Mrs. Rosa Rivera, arrived at DeTar Hospital in Victoria, Texas, in the onset of labor and with extremely high blood pressure. The nurses on duty telephoned Dr. Burditt, the head of DeTar’s obstetrics and gynecology department, because he was the next physician in the hospital’s rotating call-list. Upon hearing that Mrs. Rivera had received no prenatal care, had no doctor, and had no means of payment for medical services, Dr. Burditt told the nurse that he “didn’t want to take care of this lady.” Dr. Burditt then asked the nurses to prepare Mrs. Rivera for transfer to John Sealy Hospital which was about 170 miles away.

Following this telephone conversation, the nurses contacted their supervisor and DeTar’s administrator because they believed the transfer would be unsafe. Based on this conversation, the nurses informed Dr. Burditt that according to hospital regulations and federal law, he would have to examine Mrs. Rivera and personally arrange for the transfer. Dr. Burditt arrived at the hospital and examined Mrs. Rivera approximately fifty minutes

willfully, or negligently violate the statute. This provision was eliminated in the 1990 amendments to the Act. Pub. L. No. 101-508, § 4028(b)(4), 104 Stat. 1388-118. The 1990 amendments apply to actions occurring on or after May 1, 1991. Id. Consequently, actions arising prior to that date may still be subject to that provision. There are no reported cases on the Medicare termination provision.


58. Id.

59. Id.

60. Id. at 1366.

61. Id.

62. Id.

63. Id.
after her arrival at the hospital. He confirmed her condition as
the nurses had described it but then went on to arrange for the
transfer. The nursing supervisor showed him the hospital's guide-
lines regarding the Act but he refused to read them. He then
signed the required certification authorizing transfer, listing no
basis for his conclusion that the medical benefits reasonably
expected from treatment at the transferee hospital outweighed
the increased risks of transfer. Dr. Burditt remarked to the
nursing supervisor at that time that "until DeTar Hospital pays
my malpractice insurance, I will pick and choose those patients
that I want to treat."

Dr. Burditt did not examine Mrs. Rivera again or ask about
her medical condition. Another obstetrical nurse accompanied
Mrs. Rivera in the ambulance which left for John Sealy Hospital
about two and one-half hours after her arrival at DeTar. The
accompanying nurse delivered Mrs. Rivera's baby approximately
forty miles into the 170-mile trip to John Sealy. Following the
birth, Dr. Burditt by telephone ordered the nurse to continue to
John Sealy despite Mrs. Rivera's bleeding. Instead, per Mrs.
Rivera's wishes, the nurse brought her back to DeTar where Dr.
Burditt refused to see her. After examination by another doctor,
Mrs. Rivera remained at DeTar for three days. She was then
discharged with her baby, both in good health.

In upholding the decision to impose the Act's civil monetary
penalty, the Fifth Circuit clarified many of the provisions of the
Act. The court first determined that Mrs. Rivera's hypertension
constituted an emergency medical condition as defined in the
Act. While Mrs. Rivera's blood pressure had gone down some-

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64. Id.
65. Id. at 1367.
66. Id.
67. Id.
68. Id.
69. Id.
70. Id.
71. Id.
72. Id.
73. As the actions in question occurred prior to the effective date of the 1989
amendments, Pub. L. No. 101-239, § 6211(i), 103 Stat. 2245, the "active labor" definition
eliminated by those amendments was still in effect. Under the current definition of
what during the two hours prior to the attempted transfer, it was still at a level which placed her at a high risk of serious complications. The court found this to be "substantial, if not conclusive evidence" that her condition had not been stabilized by the time she left DeTar Hospital for transfer to John Sealy.

In applying the "active labor" definition in effect at the time, the court clarified the Congressional intent to extend the Act's treatment and transfer provisions to "only a subset of all women in labor." That subset includes women in labor who have any complication with their pregnancies regardless of whether delivery is imminent. Thus, the court concluded that "hospitals may transfer at will women in uncomplicated labor who, within reasonable medical probability, will arrive at another hospital before they deliver their babies." In the court's view, the record "overwhelmingly confirm[ed]" that Mrs. Rivera did not fall within this class; thus, she was entitled to the "treat or transfer" protection of the Act.

"emergency medical condition," the fact that Rivera was experiencing contractions satisfies the threshold requirement for pregnant women. To constitute an emergency medical condition, however, it must also be shown that there is inadequate time to effect a safe transfer before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child. 42 U.S.C.S. § 1395dd(e)(1)(B)(i), (ii) (Law. Co-op. Supp. 1991). The court found that both conditions were met. Burditt, 934 F.2d at 1370.

74. Id. at 1368.
75. Id. ("Rivera entered and exited DeTar with an emergency medical condition.").
76. Id. Active labor was defined as labor at a time when (B) there is inadequate time to effect safe transfer to another hospital prior to delivery, or (C) a transfer may pose a threat [to] the health and safety of the patient or the unborn child.


77. Burditt, 934 F.2d at 1369. While this definition has been eliminated by the 1989 amendments, Pub. L. No. 101-239, § 6211(i), 103 Stat. 2245, this discussion is still instructive as the significant elements of the definition have been retained. See 42 U.S.C.S. § 1395dd(e)(1) (Law. Co-op. Supp. 1991).


79. Burditt, 934 F.2d at 1369.
80. Id. at 1370.
81. Id.
The court then considered the Act’s two restrictions on transfer: certification of transfer and appropriateness of transfer.\(^{82}\) According to the \textit{Burditt} court, the certification requirement may be violated in four ways. First, the hospital may fail to secure the required signature from the proper medical personnel. Second, the certification may have been signed without a determination that the medical benefits reasonably expected from the transfer outweigh the increased risks. Third, the certification will fail under the Act if the person signing makes an improper consideration a significant factor in the certification decision. Finally, the Act is violated if the signing physician actually concludes that the medical risks outweigh the benefits of transfer, but signs a certification indicating the opposite is true.\(^{83}\)

In analyzing Dr. Burditt’s actions, the court found that there was some evidence that he signed the certification for improper reasons.\(^{84}\) His statements to the obstetrical nurses\(^{85}\) and the nursing supervisor\(^{86}\) indicated that his primary concern was to avoid a malpractice suit, a financial and nonmedical consideration, and therefore improper. The court, however, did not rule conclusively on this question\(^{87}\) because it found a clear violation of the duty to deliberately and meaningfully weigh the risks and benefits of the transfer.\(^{88}\)

Dr. Burditt also failed to meet the “appropriateness of transfer” requirement.\(^{89}\) The statutory definition of “appropriate transfer” requires that it be “effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer.”\(^{90}\) The court noted that while the Act establishes a standard for the screening and treatment requirements,\(^{91}\) no

\(^{83}\) \textit{Burditt}, 934 F.2d at 1371.
\(^{84}\) \textit{Id.}
\(^{85}\) See \textit{supra} note 62 and accompanying text.
\(^{86}\) See \textit{supra} note 67 and accompanying text.
\(^{87}\) \textit{Burditt}, 934 F.2d at 1371 n.10.
\(^{88}\) \textit{Id.} at 1372 (“Burditt’s indifference to Rivera’s condition for two hours after he conducted his single examination demonstrates not that he unreasonably weighed the medical risks and benefits of transfer, but that he never made such a judgment.”).
\(^{89}\) \textit{Id.} at 1373.
comparable standard is included in the appropriate transfer provision. The court then adopted a “reasonable physician” standard, requiring only “personnel and ... equipment that a reasonable physician would consider appropriate to safely transport the patient in question.” Thus, the Act does not require the physician to correctly ascertain all the risks and benefits associated with transfer. The scope of inquiry is limited to those conditions known to the transferring physician.

The court found Dr. Burditt in violation of the Act in two respects. First, neither the obstetrical nurse assigned to the transfer nor the emergency medical technicians present in the ambulance were qualified to treat the complications that “could reasonably be expected to develop given [Mrs.] Rivera’s hypertension.” Second, a reasonable physician would have ordered a fetal heart monitor for Mrs. Rivera’s ambulance. Dr. Burditt’s failure to do so contravened the appropriate transfer provision.

The court rejected Burditt’s argument that the transfer was appropriate because the ambulance met state licensing requirements. In the court’s view, the state statute only ensures safe transfer when transfer is required; the Act, on the other hand, limits when a transfer is allowed. “The purposes of these two laws do not coincide; fulfillment of one ... does not necessarily satisfy ... the other.”

In affirming the civil money penalty against Dr. Burditt, the court confirmed the constitutionality of the Act. In his final attempt to avoid the fine, Dr. Burditt argued that the Act

92. Burditt, 934 F.2d at 1372.
93. Id.
94. Id.
95. Id. at 1373.
96. Id.
97. Id.
99. Burditt, 934 F.2d at 1372.
100. Dr. Burditt raised several objections to the assessment of the fine which were based on provisions of the Act which have been subsequently amended. Id. at 1373. In rejecting these arguments the court discussed the definition of “responsible physician,” which was eliminated in the 1989 amendments to the Act, Pub. L. No. 101-239, § 6211(b), 103 Stat. 2245; the requisite mental state of the physician, which was changed from “knowingly” to “negligently” by the 1990 amendments, Pub. L. No. 101-508, § 4028(b)(4), 104 Stat. 1388-118; and the effect of aggravating and mitigating circumstances on the amount of the fine. Burditt, 934 F.2d at 1373-76.
effects a public taking of his services without just compensation in contravention of the Fifth Amendment. The court was unpersuaded. Citing Whitney v. Heckler, the court noted that there can be no taking of a group's property interest where the group is not required to participate in the regulated industry. The court found Dr. Burditt's participation to be voluntary at two levels. First, participation of a hospital in the Medicare program, which subjects it and its physicians to the Act, is voluntary. Second, a physician is free to negotiate with a hospital regarding his or her responsibility to facilitate the hospital's compliance with the Act. Thus, physicians only voluntarily accept responsibilities under the Act where they consider it in their best interests to do so.

In addition to imposing civil monetary penalties upon both the hospital and the responsible physician, the Act creates a private right of action against the hospital (but not the physician) for damages and equitable relief for any individual who suffers personal harm as a direct result of a violation. The damages recoverable are those available for personal injury under the law of the state in which the hospital is located. The Act also allows a medical facility which receives a patient who is transferred in violation of the Act to sue the transferring hospital for both monetary damages and equitable relief. The Act's two-year statute of limitations begins to run on the date of the violation. Finally, the Act includes a provision stating that it does not preempt any state or local law, except to the extent that any such law directly conflicts with one of the Act's requirements.

101. Burditt, 934 F.2d at 1376.
102. 780 F.2d 963 (11th Cir. 1986).
103. Burditt, 934 F.2d at 1376.
104. Id.
105. Id.
106. Id. There is also some question as to whether professional services constitute compensable property protected by the Takings Clause of the Fifth Amendment. See White v. United States Pipe Foundry Co., 646 F.2d 203, 205 n.3 (5th Cir. 1981).
107. For a discussion of whether the Act allows a cause of action against the treating physician, see infra notes 168-76 and accompanying text.
109. Id. For a discussion of the interplay between state and federal law on the question of damages, see infra notes 138-67 and accompanying text.
112. Id. at § 1395dd(f). For a discussion on the preemption provision, see infra notes 146-67 and accompanying text.
Hence, it is possible for the Act to be violated in a variety of ways. An individual may be refused treatment upon arrival at the emergency room.\textsuperscript{113} She may receive initial emergency room treatment and then be discharged before her medical condition is stabilized.\textsuperscript{114} She may be admitted to the hospital or taken to another department for examination or treatment and then discharged before having been stabilized.\textsuperscript{115} She may be examined or treated in the emergency room and then transferred to another hospital before her condition is stabilized.\textsuperscript{116} She may be transferred in an inappropriate manner.\textsuperscript{117} Finally, the inappropriate or unstabilized transfer may follow an examination, treatment or admission which took place at some location in the hospital other than the emergency room.\textsuperscript{118} Parts III and IV of this article will discuss the decisions rendered under the Act in the context of the violations alleged.

III. ANTICIPATED PROBLEMS WITH THE PRIVATE CAUSE OF ACTION PROVISION OF THE ACT\textsuperscript{119}

After passage of the Emergency Medical Treatment and Active Labor Act, commentators speculated as to particular problems


\textsuperscript{119} One commentator predicted problems with the provision for enforcement by civil monetary penalties. See Preventing Patient Dumping, supra note 2, at 1218. The Burditt decision discusses this provision. See supra notes 57-106 and accompanying text.
courts would face in applying the private cause of action provision. One area of concern about the application of the Act was its ambiguous language.\textsuperscript{120} While the Act expressly defines "emergency medical condition,"\textsuperscript{121} "participating hospital,"\textsuperscript{122} "to stabilize,"\textsuperscript{123} "stabilized,"\textsuperscript{124} "transfer,"\textsuperscript{125} and "hospital,"\textsuperscript{126} other terms were left unclarified.\textsuperscript{127}

In addition to definitional ambiguities, other concerns about the Act include (1) the effect of the patient's comparative fault; (2) the appropriate standard of care, that is, strict liability or negligence; (3) the available damage remedies, for example, punitive damages or damages for injuries to persons other than the patient; and (4) the interplay between federal law and state law as manifested in the preemption provision of the Act\textsuperscript{128} and the damages clause\textsuperscript{129} of the private cause of action provision.\textsuperscript{130}

A review of the cases decided in federal courts under the Act reveals that only a few of the anticipated problems have surfaced. Only the Tenth Circuit has construed the standard of care. In \textit{Stevison v. Enid Health Systems, Inc.},\textsuperscript{131} the appellate court reversed the jury verdict in favor of the defendant hospital because the jury instructions placed the burden of proof on the plaintiff to show that her request for treatment had not been withdrawn.\textsuperscript{132} \textit{Stevison} concerned the provision of the Act which required an appropriate medical screening examination of any individual who requests treatment.\textsuperscript{133} The court held that the Act imposed strict

\textsuperscript{120} \textit{Preventing Patient Dumping}, supra note 2, at 1209-17.
\textsuperscript{122} Id. at § 1395dd(e)(2) (Law. Co-op. Supp. 1991).
\textsuperscript{123} Id. at § 1395dd(e)(3)(A) (Law. Co-op. Supp. 1991).
\textsuperscript{124} Id. at § 1395dd(e)(3)(B) (Law. Co-op. Supp. 1991).
\textsuperscript{125} Id. at § 1395dd(e)(4) (Law. Co-op. Supp. 1991).
\textsuperscript{126} Id. at § 1395dd(e)(5) (Law. Co-op. Supp. 1991).
\textsuperscript{127} One commentator found a lack of precision in such terms as "emergency," "serious," "imminent," "active labor," "reasonable" risks and benefits, "medical records," and "appropriate medical screening." \textit{Preventing Patient Dumping}, supra note 2, at 1209-17.
\textsuperscript{129} Id. at § 1395dd(d)(3)(A) (Law. Co-op. Supp. 1991). The damages an individual may recover are those available for personal injury under the law of the state in which the hospital is located.
\textsuperscript{130} \textit{See} McClurg, supra note 2, at 197-223.
\textsuperscript{131} 920 F.2d 710 (10th Cir. 1990). \textit{See also} Reid v. Indianapolis Osteopathic Medical Hosp., 709 F. Supp. 853, 855 (S.D. Ind. 1989) (defendant conceded that the Act is based on a strict liability standard).
\textsuperscript{132} Id.
liability on the defendant hospital. As the plaintiff had met her initial burden of showing that she had been denied treatment, the case was remanded for a new trial.\textsuperscript{134}

Boyle v. Lauengco,\textsuperscript{135} the only state court case rendered under the Act, also held that a strict liability standard is applicable to the medical screening provision.\textsuperscript{136} The Ohio Court of Appeals for the Third Appellate District went on to state, however, that once the hospital had performed the screening examination, strict liability no longer applies. Regarding the treatment required, the negligence standard of reasonable care would determine whether the Act had been violated.\textsuperscript{137}

While no reported case to date has involved the issue of comparative fault of the patient or the availability of a damage remedy for injuries to persons other than the patient, the question of punitive damages has been raised.\textsuperscript{138} In construing the clause providing the available damages as those determined by state law, the court in Maziarka v. St. Elizabeth Hospital\textsuperscript{139} held that punitive damages were not recoverable because Illinois law did not allow punitive damages in medical malpractice cases.\textsuperscript{140} The "damage remedy pursuant to state law" clause was also at issue in Owens v. Nacogdoches County Hospital District.\textsuperscript{141} Under Texas law, it is not necessary to show a physical injury to recover for negligent infliction of emotional distress.\textsuperscript{142} As substantive state law governs the damage remedy provided by the Act, the court found that the severe mental anguish suffered by the plaintiff constituted personal injury within the meaning of the Act.\textsuperscript{143}

In Reid v. Indianapolis Osteopathic Medical Hospital, Inc.,\textsuperscript{144} the court addressed the application of federal and state law as they relate to not only the damage clause of the private cause of

\begin{footnotesize}
\begin{enumerate}
\item Stewison, 920 F.2d at 714.

\item Id.

\item Id.


\item Id.

\item Id.


\item Id. at 1280.

\item Id.

\item 709 F. Supp. 853 (S.D. Ind. 1989).
\end{enumerate}
\end{footnotesize}
action provision but also to the preemption provision. Reid was rendered under Indiana law. Indiana medical malpractice actions are statutorily limited in two ways. They are limited procedurally in that no action can be brought against a health care provider before the complaint has been presented to a medical review panel. Medical malpractice actions are also limited substantively in that each health care provider is subject to a maximum damage amount of $100,000 per occurrence. The defendant hospital moved to dismiss the complaint as failing to state a claim upon which relief could be granted because the plaintiff's allegation fell within the malpractice statute and the plaintiff had not sought the requisite medical panel review.

The plaintiff argued that section 1395dd established federal question jurisdiction over his claim and that the federal standard of strict liability was in direct conflict with the negligence standard of the malpractice statute. Thus, according to the plaintiff, the federal statute must preempt the state law both procedurally (the review panel requirement) and substantively (the damage amount limitation). The court ruled that a federal statute does not incorporate state procedural limitations on a federal cause of action brought in a state court, absent express language in the statute. Even if the federal statute could be read as calling for the general incorporation of state procedural restrictions, such a reading would place the state review panel requirement in direct conflict with the Act's provision for a cause of action accruing immediately upon a violation of the statute.

146. Id. at § 1395dd(f) (Law. Co-op. Supp. 1991). This section provides that the Act's provisions do not preempt any state or local law requirement, except to the extent that the requirements directly conflict with a requirement of this section. Id.
147. Reid, 709 F. Supp. at 853.
148. Id. at 854.
149. Id.
150. Id.
151. While the Act is silent on whether it creates a federal cause of action, the courts which have addressed this question have found that the legislative intent of the Act was to allow a claim to be brought in either state or federal court. Thornton v. Southwest Detroit Hosp., 895 F.2d 1131 (6th Cir. 1990); Sorrells v. Babcock, 733 F. Supp. 1189 (N.D. Ill. 1990); Loss v. Song, 1990 U.S. Dist. LEXIS 14812 (N.D. Ill. Oct. 31, 1990); Bryant v. Riddle Memorial Hosp., 689 F. Supp. 490 (E.D. Pa. 1988).
152. Reid, 709 F. Supp. at 854.
153. Id.
154. Id.
155. Id. at 855.
Substantively, however, there was no direct conflict as the Act is silent on the amount of damages available.\textsuperscript{106} Thus, the court ruled that the Act did not incorporate Indiana's procedural limitations on medical malpractice actions but did incorporate the state's substantive limit on the amount of damages recoverable.\textsuperscript{107}

The preemption provision was also addressed in \textit{Green v. Touro Infirmary}\textsuperscript{156} and \textit{Draper v. Chiapuzio}.\textsuperscript{159} Like \textit{Reid}, \textit{Green} concerned a state requirement that medical malpractice claims be reviewed by a medical panel.\textsuperscript{160} The defendant medical facility moved for dismissal on grounds that the plaintiffs were required to bring their section 1395dd complaint before the state review board prior to filing an action under the Act.\textsuperscript{161} The court held otherwise, citing \textit{Reid} as authority for its holding that the Act does not incorporate state procedural limitations.\textsuperscript{162}

The state law at issue in \textit{Draper v. Chiapuzio}\textsuperscript{163} provided that notice of claim of wrongful death against a public body must be filed within one year after the alleged loss or injury.\textsuperscript{164} In \textit{Draper} the estate of the decedent brought an action under the Act against the defendant county hospital for an improper transfer.\textsuperscript{165} The estate argued that the state notice requirement did not apply as it was a procedural requirement that directly conflicted with the right of action created by section 1395dd.\textsuperscript{166} The district court did not find such a conflict with any provision of the Act;

\textsuperscript{156} \textit{Id.}
\textsuperscript{157} \textit{Id.} at 855-56. A medical review panel requirement was also at issue in \textit{LaVignette v. West Jefferson Medical Center}, 1990 U.S. Dist. LEXIS 14966 (E.D. La. Nov. 7, 1990). The court reached the same conclusion as in \textit{Reid}. (The court was persuaded by the plaintiff to retain subject matter jurisdiction over the physician on the basis of "federal pendent party jurisdiction." \textit{Id.} For a discussion of the viability of a private cause of action against the physician, see notes 168-76 and accompanying text. In 1989, the United States Supreme Court held that federal pendent party jurisdiction does not exist in the absence of an express statutory grant of jurisdiction. \textit{Finley v. United States}, 490 U.S. 545 (1989)).
\textsuperscript{159} 755 F. Supp. 331 (D. Or. 1991).
\textsuperscript{161} \textit{Id.}
\textsuperscript{162} \textit{Id.} (citing \textit{Reid v. Indianapolis Osteopathic Medical Hosp.}, 709 F. Supp. 853 (S.D. Ind. 1989)).
\textsuperscript{164} OR. REV. STAT. § 30.275(2).
\textsuperscript{165} 755 F. Supp. at 332.
\textsuperscript{166} \textit{Id.}
thus the notice of claim required under Oregon law was not preempted under section 1395dd.167

IV. UNANTICIPATED PROBLEMS IN APPLYING THE PRIVATE CAUSE OF ACTION PROVISION OF THE ACT

In addition to the problems anticipated by commentators, actions brought under the Act also revealed two problems of interpretation not initially predicted: first, whether the Act allows a private cause of action against responsible physicians, and second, whether the application of the Act’s protection is limited to persons who are either indigent or uninsured.

A. Application To Physicians

While the Act expressly allows a private cause of action by an individual against a hospital for a violation of the Act,168 several decisions have also allowed a claim against the responsible physician.169 Sorrells v. Babcock170 dealt with this question directly. Ignoring the express language of the Act, the court in Sorrells looked to the enforcement provision which subjects the physician to a maximum $50,000 civil penalty,171 and to the legislative history of the Act,172 and held that a “federal cause of action can be brought against a responsible physician.”173

Other courts have restricted their analyses to the statutory language, construing the Act to exclude a civil action by an individual against a treating physician.174 The most recent decision on this question, Delaney v. Cade,175 acknowledged Sorrells, but found that the statute clearly creates a private cause of action only against the hospital.176

167. Id. at 333.
172. 733 F. Supp. at 1193.
173. Id.
176. Id. at 1486-87 (citing LaVignette, 1990 U.S. Dist. LEXIS 14966).
B. Restriction of The Act to Indigent or Uninsured Persons

1. Pre-Cleland Decisions

The conflict between statutory language and legislative intent is at the heart of the most significant controversy in the cases decided under the Act, that is, whether individuals who are not uninsured or indigent can bring a claim under section 1395dd. While the Act provides that any individual who suffers personal harm may bring an action, at least three jurisdictions have held that an individual has no claim under the Act unless he was refused treatment or discharged or transferred inappropriately because of his inability to pay for treatment.

In Nichols v. Estabrook, the plaintiff sued on a negligence per se theory based on the physician’s failure to satisfy the standard of care required by the Act. The court held that liability could not be based on the Act because the plaintiff did not allege that the patient’s financial condition or lack of insurance contributed to the doctor’s decision not to treat or to send to another hospital. A Seventh Circuit court reached a similar conclusion in Evitt v. University Heights Hospital. The patient in Evitt was “unable to present evidence which could prove that she was turned away from the hospital for economic reasons, in violation of 43 U.S.C. § 1395dd.” The court granted summary judgment in favor of the defendant hospital.

Evitt was cited with approval by the Kansas District Court in Stewart v. Myrick. Relying on the congressional intent evidenced by the legislative history of the Act, the court dismissed the claim in Stewart because the patient was not denied treatment.

180. Id. at 329.
181. Id. at 330.
183. Id. at 498.
184. Id.
or discharged from the medical center due to a lack of insurance.\(^\text{186}\)

The history of the Act clearly indicates that Congress intended it to alleviate the problem of patient dumping.\(^\text{187}\) The Stewart case contains a comprehensive discussion of the congressional committee reports which preceded the enactment of section 1395dd.\(^\text{188}\) In DeBerry v. Sherman Hospital Ass’n,\(^\text{189}\) however, the District Court for the Northern District of Illinois found the Evitt and Stewart decisions unpersuasive on the question of the applicability of the Act.\(^\text{190}\) The court noted that the statute “nowhere mentions either indigency, or an inability to pay”\(^\text{191}\) as a prerequisite to statutory coverage. Consequently, according to the DeBerry court, the Stewart and Evitt courts were in error on this question.\(^\text{192}\) The DeBerry court recognized that “inquiries into such peripheral matters as policy and legislative intent are relevant only when ... a statute has a hiatus that must be filled or there are ambiguities in the legislative language that must be resolved.”\(^\text{193}\)

2. Cleland v. Bronson Health Care Group, Inc.

In Cleland v. Bronson Health Care Group, Inc.\(^\text{194}\) the Sixth Circuit Court of Appeals cited with approval the DeBerry decision in its discussion of the scope of the private right of action created

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186. Id. at 434-35. The court in Stewart misinterpreted an earlier patient dumping case, Bryant v. Riddle Memorial Hospital, citing Bryant for the proposition that “indigent persons denied emergency medical care possess a private federal cause of action under the Act.” Id. (citing Bryant, 689 F. Supp. 490, 493 (E.D. Pa. 1988)). Bryant’s holding was limited to the question of whether claims under the Act could be brought in federal court. Bryant, 689 F. Supp. at 490. The court in Bryant actually stated that individuals, not indigent persons, who allege violations of the Act could seek redress in federal court. Id. at 493.


188. Id. The House Ways and Means Committee in its report on the House bill which was the basis for the Act was “greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance.” Id. (quoting Ways and Means Rep., supra note 3, at 605).


190. Id.

191. Id. at 1306.

192. Id.

193. Id.

194. 917 F.2d 266 (6th Cir. 1990).
by the Act. In *Cleland* the parents of a fifteen-year-old boy brought both a state medical malpractice action and a claim under section 1395dd. 195 The boy was diagnosed with influenza, treated in the emergency room of the defendant medical facility, and discharged. Less than twenty-four hours later he suffered cardiac arrest and died. 196 The United States District Court for the Western District of Michigan dismissed the suit for failure to state a claim upon which relief could be granted because the boy was neither indigent nor uninsured. 197 Noting the legislative history of the Act, the district court found it unlikely that Congress intended for section 1395dd to be used as a general malpractice action because the Act addresses concerns about indigent patients rather than all the unfortunate consequences that befall any and all patients. 198 The Sixth Circuit Court of Appeals affirmed the dismissal, but did so on grounds other than the district court’s interpretation that the Act applied only to indigent and uninsured patients. 199

In an insightful, well-reasoned opinion, Circuit Judge Boggs noted that while most of the cases up to that time had indicated, in dicta, that the Act was meant to apply only to the indigent and uninsured, 200 “Congress wrote a statute that plainly has no such limitation on its coverage.” 201 Judge Boggs went on to say, "Just as the Supreme Court has frequently held that the existence of a widespread evil does not mean that Congress must address it all at once, but may address it piecemeal, see Williamson v. Lee Optical of Oklahoma, 348 U.S. 483, 489 (1955), there is no principle of construction that Congress may not similarly write a statute that is far broader than any area of concern that it has conceived of or has had brought to its attention." 202

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195. *Id.*  
196. *Id.*  
197. *Id.* at 268.  
198. *Id.* at 267.  
199. *Id.* The court held that no allegations had been made that would allow a finding that the physician’s statutory duties had been breached. Thus, there was no violation of the Act. *Id.*  
200. *Id.* Among the cases cited was a 1990 Sixth Circuit case, Thornton v. Southwest Detroit Hosp., 895 F.2d 1131 (6th Cir. 1990) (“[t]he Act requires hospitals to give emergency aid to indigent patients”). As this statement was merely dicta, Judge Boggs did not find this interpretation controlling. 917 F.2d at 270.  
201. *Id.* at 267.  
202. *Id.* at 270. *See also* United States v. Oregon, 366 U.S. 643 (1961) (courts should follow the plain words of the statute); Wilderness Society v. Morton, 479 F.2d 842 (D.C.
Judge Boggs recognized that courts should not follow the plain words of a statute if to do so would lead to an absurd result.\footnote{203} The Act plainly states that the private cause of action is available to "any individual."\footnote{204} While applying the Act's express language to claimants who are not indigent or uninsured may very well lead to a result considerably broader than Congress intended, that result is not an absurd one. It in no way vitiates or is contrary to Congress's indicated concern in passing the legislation. Recognizing that it is not the place of the courts to rewrite statutes, Judge Boggs acknowledged that the \emph{Cleland} result "may go further than what Congress contemplated, but that is not a reason to distort or excise the words Congress wrote."\footnote{205} Thus, in Judge Boggs's view, the text of the statute must control over the legislative history in this case.\footnote{206}

The \emph{Cleland} decision identifies a number of reasons other than financial condition or lack of insurance that might lead hospital personnel to give substandard attention to persons who seek emergency room treatment: prejudice against the patient's race, sex or ethnic group; distaste for the person's infirmity (e.g., AIDS patients); disapproval of the patient's occupation; or political or cultural opposition.\footnote{207} Allegations of race and religious discrimination were the basis of a section 1395dd claim in \emph{Verhagen v. Olarte}.\footnote{208} The plaintiff also brought her claim under several provisions of the civil rights statutes.\footnote{209} The \emph{Verhagen} court found

\begin{footnotesize}
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\item \footnote{203}{\emph{Cleland}}, 917 F.2d at 269.
\item \footnote{204}{42 U.S.C.S. \S 1395dd(d)(2) (Law. Co-op. Supp. 1991).}
\item \footnote{205}{\emph{Cleland}}, 917 F.2d at 269.
\item \footnote{206}{The judicial use of legislative history as an aid in the interpretation of statutes has recently come under fire. \textit{See}, e.g., Robert Pear, \textit{With Rights Act Comes Fight to Clarify Congress's Intent}, \textit{N.Y. Times}, Nov. 18, 1991, at A1. Supreme Court Justice Antonin Scalia is among the more outspoken advocates of disregarding legislative "intent" as it may be reflected in Congressional committee reports, hearings, and statements in the Senate and House of Representatives. \textit{See} Wisconsin Public Intervenor v. Mortier, 111 S. Ct. 2476, 2487-91 (1991) (Scalia, J., concurring) ("[W]e are a Government of laws not of committee reports."). For a recent example of the use of legislative history to support all sides of a controversial issue, \textit{see} Board of Edu. v. Mergens, 496 U.S. 226 (1990) (construing the Equal Access Act as it applies to after-school bible clubs).}
\item \footnote{207}{\emph{Cleland}}, 917 F.2d at 269.
\item \footnote{208}{1989 U.S. Dist. LEXIS 13881 (S.D.N.Y. Nov. 17, 1989).}
\item \footnote{209}{\textit{Id.}}
\end{itemize}
\end{footnotesize}
that she had a viable cause of action under the Act "without recourse to the civil rights statutes" and granted her leave to amend her complaint to conform with the specific requirements of the Act. While Judge Boggs did not cite the Verhagen case in his opinion in Cleland, Verhagen is consistent with the reasoning utilized in Cleland.

3. Post-Cleland Decisions

Four decisions rendered subsequent to Cleland found Judge Boggs's reasoning equally persuasive. The first of these cases, Delaney v. Cade, was decided in the same jurisdiction as Stewart v. Myrick. Like Stewart, the Delaney plaintiff did not contend that she was transferred for economic reasons. Delaney was treated at the emergency department for injuries incurred in an automobile accident, and then transferred twice the same day to other medical facilities. She received treatment at each hospital. As the third facility she underwent an operation to repair a transected aorta. As a result of her injuries she suffered permanent paraplegia. She sued all three hospitals and the attending physicians at each under theories of state medical malpractice and section 1395dd. The hospitals defended against her claim under the Act on the ground that the Act only applies to patients who are "dumped" for indigency.

The court acknowledged that the holding in Stewart v. Myrick supported the defendants' claim, but also recognized that DeBerry v. Sherman Hospital Ass'n held to the contrary. In the Delaney

210. Id.
211. In two additional cases, medical facilities defended on the basis, inter alia, that the Act did not apply because the plaintiff was neither indigent nor uninsured. Neither court reached this issue as the cases were disposed of on other grounds. Petrovics v. Prince William Hosp., 764 F. Supp. 415 (E.D. La. 1991); Draper v. Chiapuzio, 755 F. Supp. 331 (D. Or. 1991).
215. Id.
216. Id. at 1477.
217. Id. at 1478.
218. Id.
219. Id. at 1477.
220. Id. at 1485.
court's view, the analysis of the Sixth Circuit in Cleland\textsuperscript{224} resolved the question. Where the words of the statute are "quite plain and interpreting as such does not lead to an absurd result," the law must be applied as written.\textsuperscript{225} Like Cleland, the court in Delaney ultimately held that the facts of the case failed to show any violation of the Act.\textsuperscript{226}

In the second case, Burrows v. Turner Memorial Hospital,\textsuperscript{227} the facts were seemingly more favorable to the plaintiff,\textsuperscript{228} but the court ultimately held that his section 1395dd claim was time barred.\textsuperscript{229} The defendant hospital moved to dismiss the action on the basis that section 1395dd only allows a claim where the plaintiff alleges that the hospital discharged him because he was indigent.\textsuperscript{230} There was no such allegation in the complaint. In refusing to grant the motion, the court reviewed the purpose of the Act as indicated by its legislative history and acknowledged that Stewart,\textsuperscript{231} Evitt,\textsuperscript{232} and Nichols\textsuperscript{233} supported the hospital's position. The court, however, found the reasoning of Cleland more persuasive, noting that "[t]he statute as written ... contains no reference to indigency".\textsuperscript{234}

\begin{quotation}
[The] words of the statute on basic eligibility are quite plain, and interpreting them as such does not lead to an absurd result.... It is not our place to rewrite statutes to conform with our notions of efficacy or rationality. That is the job of Congress. It is only where the language that Congress uses admits of varying interpretations that secondary means of interpretation come into play. Here, the result we reach in no way vitiates or is contrary to Congress's indicated concern in passing the legislation.\textsuperscript{235}
\end{quotation}

\begin{flushright}
224. 917 F.2d 266 (6th Cir. 1990).
226. Id.
228. Burrows displayed "symptoms of shock and present or impending myocardial infarction, including shortness of breath, chest pain, extreme dizziness or loss of consciousness, chills, perspiration and skin discoloration," id. at 841; yet he was discharged from the emergency room the same day he arrived. He died of a heart attack shortly after discharge. Id.
229. Id. at 843.
230. Id.
235. Id. at 842-43 (quoting Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 272 (6th Cir. 1990)).
\end{flushright}
In the third decision, *Gatewood v. Washington Healthcare Corp.*, the Court of Appeals for the District of Columbia Circuit also adopted the *Cleland* construction of the Act. The court acknowledged that the legislative history "reflects an unmistakable concern with the treatment of uninsured patients," but concluded that it was bound by the plain language of the Act "which unambiguously extends its protection to 'any individual' who seeks emergency room assistance."

Both *Gatewood* and *Cleland* were cited with approval by the Ninth Circuit Court of Appeals in *Brooker v. Desert Hospital Corp.*, the most recent statement on this question. In *Brooker*, the defendant hospital used the Act's legislative history to support its assertion that the Act only applied where "economic considerations motivated the alleged denial of treatment or wrongful transfer." The court disagreed. As the language of the Act does not establish any "specific economic status criteria" for its protection, the court determined that it need not resort to the Act's legislative history. The Ninth Circuit elected to follow the lead of the Sixth Circuit in *Cleland* and the District of Columbia Circuit in *Gatewood* in ruling that "any discrepancies between the language of the Act and its legislative history are overshadowed by the clarity of the Act." Thus, the district court's exercise of jurisdiction over the claim was proper.

**CONCLUSION**

In the decisions rendered under the Emergency Medical Treatment and Active Labor Act, courts have been confronted with a
number of problems in the effective enforcement of the Act. These problems have generally been resolved in favor of the plain language of the statute where that language was clear and unambiguous. As the Act explicitly provides that a hospital must provide for a medical screening where one is requested, strict liability is the appropriate standard for that provision of the Act. The Act also expressly allows for the application of substantive state law to govern the damage remedy. The preemption clause, however, requires that in case of conflict, federal procedural limitations apply rather than those of the forum state. These provisions were correctly construed in the cases where such controversies arose. While some courts interpreted the Act to allow a private cause of action against the responsible physician, the better approach is to limit the Act's protection to its express language. Congress included the physician in the Act's provision for civil monetary penalties for violations; had it intended to do so for the private cause of action, the Act would have so stated.

Perhaps the most significant controversy the decisions have addressed to date is the overall scope of the private cause of action afforded by the Act. As its legislative history indicates, the Act was intended to provide a cure for an epidemic of ignoring the medical needs and abusing the status of people who have no medical insurance and cannot afford the ever-escalating costs of adequate health care. In drafting the statute, however, Congress did not limit the Act's protection to only indigent and uninsured individuals. Several jurisdictions have restricted the Act's application to just that class of persons.

The Sixth Circuit in Cleland v. Bronson Health Care Group, Inc., however, based its application of the Act on the first principle of statutory interpretation, that the plain legislative language controls in the absence of ambiguity or an obviously absurd result. The Cleland court recognized that there are other ills in this country besides poverty — racism, as well as religious, political and social discrimination — and there has been at least some indication that people have been denied emergency health care for reasons relating to these prejudices. By enacting the Emergency Medical Treatment and Active Labor Act, Congress may have inadvertently created an opportunity for judicially alleviating some of these diseases by literally taking Congress at its word. It remains to be seen whether all courts will follow the lead of the Sixth Circuit and apply the Act's protection as broadly as its language dictates.
I. INTRODUCTION

Employment relationships are central to many claims of hospital liability for negligence of physicians. While some physicians such as residents and interns may be employees of the hospitals in which they practice, most are nonemployee staff physicians or otherwise independent contractors. Agency law holds an employer vicariously liable for negligent acts of agents and employees. Employers, however, are generally not held liable under the doctrine of respondeat superior for the negligence of independent contractors.

Physicians with hospital staff privileges have generally been considered independent contractors and courts have traditionally held that hospitals are not liable for the malpractice of such physicians. However, in Albain v. Flower Hospital, the court in Ohio held that a hospital is liable for the negligence of its employees, including physicians with hospital staff privileges.

5. See Restatement (Second) of Agency § 223 cmt. a (1958):

The fact that the law requires an examination and a certain standard of skill does not prevent the relation of master and servant from arising; it may, however, indicate, as in any other case in which skill is involved, that such a relation is not contemplated, as in the case of attorneys and surgeons, whereas in other cases, as in the case of chauffeurs, the fact that some skill is required has little bearing upon the inference to be drawn. Even in the case of attorneys and physicians there may be the master and servant relation, as where a firm of attorneys employs an attorney as a member of the office staff. So likewise, while the physician employed by a hospital to conduct operations is not, in the normal case, a servant of the hospital, yet it may be found that the house physician or the interns, if subject to directions as to the manner in which their work is performed, are servants of the hospital while in performance of their ordinary duties.
physicians. However, there is a trend by courts not to rely solely on the employee-independent contractor distinction in assessing hospital liability. Today, many courts will not permit a hospital to avoid liability merely because a physician is not an employee or agent, and instead will expand hospital liability using exceptions to the doctrine of respondeat superior. These exceptions may include corporate negligence, apparent or ostensible agency, or agency by estoppel.

The trend of expanding hospital liability for negligence of non-employee physicians gained momentum in Ohio with the 1980 Cuyahoga County Court of Appeals decision in Hannola v. City of Lakewood. Hannola applied an apparent agency theory to hold that a hospital making emergency room treatment available to the public is estopped to deny that physicians on duty are the hospital's agents, regardless of any contractual arrangements between the physicians and hospital. The Hannola court further held that a hospital has an independent duty to prevent non-employee physician malpractice. Moreover, the plaintiff in Hannola was permitted to present facts showing control of a non-employee physician by the hospital to justify imposition of hospital liability based on the doctrine of respondeat superior.

Hannola and subsequent Ohio appellate court decisions have been viewed by some commentators as opening the door to

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7. WERTHMANN, supra note 1, at 11.


10. PEGALIS & WACHSMAN, supra note 8, § 3:28. Under the theory of apparent authority, courts may hold a hospital liable where the hospital holds out a physician as an employee of the hospital, regardless of the actual employment relationship. See also Arthur v. St. Peters Hosp., 405 A.2d 443 (N.J. Super. Ct. 1979) (holding there could be a permissible inference that hospital held out emergency room independent contractor physicians as employees where the patient was unaware of the status of the doctors and was not put on notice of their independent status).


12. Id. at 1190.

13. Id. at 1192.

14. Id.
virtually unlimited hospital liability.\textsuperscript{15} However, the expansion of hospital liability for the negligence of physicians has been halted, if not reversed, by the Ohio Supreme Court’s first detailed look at hospital liability in \textit{Albain v. Flower Hospital}.\textsuperscript{16} “In a decision giving hospitals a level of comfort in malpractice suits,”\textsuperscript{17} the court in \textit{Albain} held that a hospital’s granting of staff privileges to an independent physician does not establish the control required to justify hospital liability based on the doctrine of \textit{respondeat superior}.\textsuperscript{18} Further, the court listed three exceptions to the independent contractor rule, but explicitly restricted the application of each exception to persons seeking to hold a hospital liable for the negligence of a staff physician.\textsuperscript{19}

This note addresses the impact of \textit{Albain} on hospital liability for physician malpractice in Ohio. First, hospital liability in Ohio prior to \textit{Albain} is reviewed. Second, the case history and the Ohio Supreme Court’s analysis of the three exceptions to the independent contractor rule are summarized. Finally, this note discusses the court’s holdings in light of the case facts, public policy, and hospital liability law of other jurisdictions. This note concludes that the court’s narrow interpretation of the three


A review of \textit{Hannola} and post \textit{Hannola} decisions reveals the depth of the new expansion in hospital liability for physician malpractice. Hospitals have now been held liable for malpractice of emergency room physicians hired by third parties under theories of \textit{respondeat superior}, agency by estoppel, and independent duty.... Perhaps this confusion concerning the appropriate theories for hospital liability in Ohio, and their proper application, will encourage the Ohio Supreme Court to certify the record of future cases addressing these issues.

The \textit{Hannola} court’s extensive surgery on the medical malpractice liability relationship of hospitals, physicians, and patients in Ohio has set an unprecedented standard for expanding hospital liability for physician malpractice. Since \textit{Hannola}, hospitals are liable for what they do not and cannot control, namely, the independent medical decisions and actions of physicians that result in malpractice.


\textsuperscript{16} \textit{Albain v. Flower Hosp.}, 553 N.E.2d 1038 (Ohio 1990).

\textsuperscript{17} Joe Hallett, \textit{Flower Hospital Held Not Liable in Lawsuit}, \textsc{The Toledo Blade}, Apr. 26, 1990, at 7.

\textsuperscript{18} \textit{Albain}, 553 N.E.2d at 1044.

\textsuperscript{19} \textit{Id.} at 1044-45, 1048-49.
exceptions to the independent contractor rule will make it extremely difficult for future plaintiffs to prevail against hospitals in suits based on staff physician negligence.

II. HOSPITAL LIABILITY UNDER OHIO COMMON LAW

The charitable immunity defense afforded nonprofit hospitals some protections against vicarious liability at the beginning of this century.\textsuperscript{20} \textit{Taylor v. Protestant Hospital Ass'n}\textsuperscript{21} held that a hospital could not be vicariously liable for the negligence of an employee nurse.\textsuperscript{22} The Ohio Supreme Court reasoned, in part, that holding a nonprofit hospital liable for the negligence of its servants would undermine the public policy encouraging charitable enterprises.\textsuperscript{23}

The charitable immunity defense was limited in 1922, when the court held that a nonprofit hospital could be held liable for failure to use ordinary care in the selection and retention of an employee nurse.\textsuperscript{24} In 1956, the Ohio Supreme Court completely rejected the charitable immunity defense in \textit{Avellone v. St. John's Hospital},\textsuperscript{25} and held that a nonprofit hospital is liable for the torts of its servants under the doctrine of \textit{respondeat superior}.\textsuperscript{26} The court, however, expressly stated that it was not deciding the issue of whether a hospital could be liable for the negligent acts of physicians and nurses over whom the hospital has no right of control.\textsuperscript{27} Ohio has also waived the government immunity defense for all hospitals owned or operated by the state\textsuperscript{28} or municipalities.\textsuperscript{29}

\begin{itemize}
  \item \textsuperscript{21} \textit{Taylor}, 96 N.E. at 1092.
  \item \textsuperscript{22} Id.
  \item \textsuperscript{23} Id.
  \item \textsuperscript{24} \textit{Taylor v. Flower Deaconess Home & Hosp.}, 135 N.E. 287, 291 (Ohio 1922).
  \item \textsuperscript{25} \textit{Avellone v. St. John's Hosp.}, 135 N.E.2d 410 (Ohio 1956).
  \item \textsuperscript{26} Id. at 417.
  \item \textsuperscript{27} Id. at 417.
  \item \textsuperscript{28} \textit{Ohio Rev. Code Ann.} § 2743.02(A) (Baldwin 1991).
  \item \textsuperscript{29} \textit{Ohio Rev. Code Ann.} § 2743.02(B) (Baldwin 1991):

    The state hereby waives the immunity from liability of all hospitals owned or operated by one or more political subdivisions and consents for them to be sued, and to have their liability determined, in the court of common pleas, in accordance with the same rules of law applicable to suits between private parties, subject to the limitations set forth in this chapter.
\end{itemize}
In 1960, the holding of *Avellone* was reaffirmed by the Ohio Supreme Court in *Klema v. St. Elizabeth's Hospital*,\(^\text{30}\) where the court affirmed the defendant hospital's liability for the negligence of a resident physician *employed* by the hospital.\(^\text{31}\) The court held that hospitals are vicariously liable for both medical and administrative acts of a hospital employee when the employee's acts are within the scope of his employment.\(^\text{32}\) However, the Ohio Supreme Court again reserved the question of hospital liability for acts of physicians and nurses over whom the hospital has no right of control.\(^\text{33}\)

Hospital liability for the negligence of a *nonemployee* physician and hospital liability based on agency by estoppel were addressed by the court in 1971 in *Cooper v. Sisters of Charity of Cincinnati, Inc.*\(^\text{34}\) In *Cooper*, the plaintiff sued the hospital, the professional group controlling the hospital's emergency room, and the emergency room physician, who was an employee of the professional group, for the wrongful death of her son.\(^\text{35}\) The plaintiff further alleged that the hospital represented to the public that the physicians in the emergency room were acting on behalf of the hospital.\(^\text{36}\)

After affirming the lower court's directed verdict for the defendants on the issue of proximate cause,\(^\text{37}\) the *Cooper* court added, in dicta, that the hospital was not liable for any negligence of the emergency room physician where the physician was an employee of the professional group, and therefore not under the control of the hospital.\(^\text{38}\) Noting that the practice of medicine by a physician in a hospital is not sufficient to create an agency by estoppel, the court stated that a plaintiff must show an induced reliance to establish such agency by estoppel.\(^\text{39}\)


\(^{31}\) *Id.* at 767, 771. The court in *Klema* noted that the resident was not licensed to practice medicine in Ohio, but considered him a physician in its holding in order to address the question of hospital liability for negligency of a medical employee. *Id.* at 767.

\(^{32}\) *Id.* at 767.

\(^{33}\) *Id.* at 770.

\(^{34}\) *Cooper v. Sisters of Charity of Cincinnati, Inc.*, 272 N.E.2d 97, 104 (Ohio 1971).

\(^{35}\) *Id.* at 100-01.

\(^{36}\) *Id.* at 101.

\(^{37}\) *Id.* at 104.

\(^{38}\) *Id.*

\(^{39}\) *Id.* (citing *Johnson v. Wagner Provision Co.*, 49 N.E.2d 925 (Ohio 1943), requiring that, in order to establish a defendant's liability based on an agency by estoppel, a
In 1972, the Ohio Supreme Court addressed a hospital's independent duty of care owed to its patients in following an attending physician's orders.40 Johnson v. Grant Hospital41 exonerated a hospital from liability where the hospital staff had followed the attending physician's orders for protecting the patient from self harm.42 The attending physician was the patient's private physician, rather than an employee of the hospital,43 and the patient jumped from a hospital window after the hospital staff had stopped earlier repeated suicide attempts.44 While acknowledging that a hospital owes a duty of reasonable care to its patients, the court held that the hospital exercised this required standard by caring for the patient in a manner directed by the patient's attending physician.45

In comparison with the preceding Ohio Supreme Court cases, the Ohio appellate courts have taken an expansive view of hospital liability under theories of vicarious liability, agency by estoppel, and independent duty.46 Beginning with Hannola v. City of Lakewood47 in 1980, the appellate courts have increasingly found hospitals liable for the negligence of independent physicians.

In Hannola, the plaintiff sued the City of Lakewood and Lakewood Hospital, alleging that her husband died as a result of malpractice in the hospital emergency room.48 Emergency room operations were run by a private medical foundation pursuant to contract. The contract provided that the foundation would hire all emergency room physicians and bill all patients directly, and that the hospital would not be liable for acts of physicians employed by the foundation.49 The plaintiff alleged that the hospital had the right to control the emergency room physicians and

plaintiff must show the defendant induced the plaintiff to believe an actor is the defendant's agent, and that the plaintiff must show reliance on that inducement to his detriment).

42. Johnson, 291 N.E.2d at 440.
43. Id. at 440-41.
44. Id.
45. Id. at 445-46.
47. Id.
48. Id. at 1188.
49. Id. at 1188-89.
that she and her husband were induced to rely upon the appearance of the emergency room physician as an agent of the hospital. 50

Summary judgment was granted for the hospital on the issues of control and apparent agency. 51 The trial court accepted the hospital's argument that physicians, not hospitals, practice medicine, and that any malpractice was the act of nonemployee independent contractors hired by the foundation. 52 The plaintiff argued on appeal that there were issues of fact as to: (1) whether the hospital controlled or had a right to control the emergency room physician and the foundation; (2) whether the hospital had an independent duty to prevent physician malpractice; and (3) whether she and her husband were induced to rely on the appearance of the emergency room physician as an apparent agent of the hospital. 53

On the issue of apparent agency, the court of appeals looked to the plaintiff's claim in her affidavit that she and her husband sought treatment in the hospital's emergency room because of the hospital's reputation for high quality emergency room care. Plaintiff claimed she was induced to rely on the emergency room physician due to the hospital's reputation and the appearance that the emergency room physician was an employee of the hospital. 54 Noting that the hospital held itself out as a full-service hospital, and that the public was not aware that the emergency room was operated by an independent contractor, 55 the court concluded that a broad agency by estoppel is established by the statement a full-service hospital makes when it opens its emergency room to the public. 56 Further, the court held that such a hospital is estopped from denying the physicians on duty in its emergency room are its agents, regardless of any contracts the hospital has with such physicians. 57 For these reasons the court held the trial court erred in granting a directed verdict. 58

50. Id. at 1188.
51. Id.
52. Id.
53. Id. at 1189.
54. Id.
55. Id. at 1190-91.
56. Id. at 1190.
57. Id.
58. Id. at 1191.
In support of its broad application of agency by estoppel to emergency room malpractice, the court noted that a person has no meaningful choice in a time of crisis, and will turn to the local hospital regardless of notice that the emergency room physicians are independent contractors. Further, public policy would not permit a hospital to hold itself out as a full-service hospital, yet contractually insulate itself from liability for malpractice committed in the emergency room, an integral part of a full-service hospital. The court emphasized that “[t]he public assumes, correctly or not, that the hospital exerts some measure of control over the medical activities taking place there.”

The Hannola court also broadly interpreted the doctrine of respondeat superior as applied to the emergency room physician. According to the court, the key test in applying the doctrine is whether the employer retained “control” of the mode and manner of doing the work. Rather than interpreting control narrowly as pertaining only to diagnosis and treatment, the court broadly interpreted control to pertain to personnel and patient care policy. The plaintiff presented evidence from the agreement between the foundation and the hospital showing that the hospital was required to approve patient care policy and permitted to influence emergency room physician employment. These were viewed as sufficient facts to raise an issue of a hospital’s liability under the doctrine of respondeat superior.

On the third issue of a hospital’s independent duty of care to prevent physician malpractice, the Hannola court found a special duty exists with regard to emergency room care which extends beyond a hospital’s duty to use reasonable care in granting and reviewing staff privileges. Finding there was a question of fact as to whether the hospital breached a “higher independent duty of monitoring the patient care offered in its emergency room,” the court reversed the trial court’s grant of summary judgment.

59. Id. at 1190-91.
60. Id.
61. Id. at 1191.
62. Id.
63. Id. (citing Councell v. Douglas, 126 N.E.2d 597, 599 (Ohio 1955)).
64. Id. at 1192.
65. Id.
66. Id.
67. Id.
for the hospital. Further, the court stated that such a duty to monitor may arise given the nature of the emergency room and the public's lack of choice in selecting a hospital in medical emergencies.

The expansion of hospital liability begun by Hannola was continued by the 1984 Ohio Court of Appeals decision in Stratso v. Song. In Stratso, the plaintiff sued a hospital for the malpractice of physician anesthesiologists in the hospital's operating room. The anesthesiologists were employed by an independent physician corporation which provided all anesthesia coverage to the hospital. Stratso reversed the trial court's directed verdict for the hospital and found there were issues of fact of (1) whether the hospital assumed a nondelegable duty of care in providing an operating room, and (2) whether the anesthesiologists were the hospital's agents by estoppel.

The court noted that the plaintiff testified she relied on the hospital to provide the anesthesiologist's services, and had no choice in the selection of the anesthesiologists. Citing the Hannola court's comments on the public policy against allowing hospitals to contractually isolate themselves from liability, the Stratso court emphasized those comments were even more compelling with regard to anesthesiologists in operating rooms.

The Ohio Court of Appeals in Fayette County relied on the Hannola and Stratso decisions in applying agency by estoppel principles to claims of hospital liability for the acts of a non-employee staff physician. In Funk v. Hancock, the plaintiff sued the hospital and a staff physician for alleged negligence in the hospital emergency room. There was no agreement or contract between the staff physician and the hospital.

The court relied on the Cooper, Hannola, and Stratso decisions for the principle that apparent agency is applicable to physicians.

68. Id.
69. Id.
71. Id. at 1185.
72. Id. at 1185-87.
73. Id.
74. Id. at 1187.
77. Id. at 492.
78. Id. at 493.
practicing in hospital emergency rooms, and that the hospital may be prevented from denying the apparent agency if patients are encouraged to rely on a presumed agency between the physician and the hospital.\textsuperscript{79} In reversing the trial court's summary judgment for the hospital, the court relied on the plaintiff's statement in her affidavit that she believed the staff physician was working for the hospital.\textsuperscript{80} The court also noted that it was the hospital, and not the plaintiff, who contacted the physician for treatment, that the physician had staff privileges at the hospital, and that the physician was on the hospital's board of directors.\textsuperscript{81}

Hospital liability for negligence of independent contractors in emergency room situations was further expanded in \textit{Griffin v. Matthews},\textsuperscript{82} a 1987 decision by the Ohio Court of Appeals of Butler County. In \textit{Griffin}, the plaintiff sued the hospital, an emergency room physician corporation, and an emergency room physician for malpractice in failing to diagnose a heart attack that resulted in the death of the plaintiff's husband.\textsuperscript{83} The physician was an employee of the emergency room physician corporation, which in turn had a contractual agreement to furnish physicians for the hospital's emergency room.\textsuperscript{84} The trial court granted summary judgment for the hospital on the issue of agency by estoppel, holding there was nothing to indicate the decedent was induced to rely on an apparent agency between the physician and hospital.\textsuperscript{85}

Relying on \textit{Hannola} and \textit{Stratso}, the appellate court reversed.\textsuperscript{86} A malpractice plaintiff need not prove induced reliance to establish an agency relationship where "the full service hospital assumes a nondelegable duty such as the operation of an emergency room facility."\textsuperscript{87} The \textit{Griffin} court reasoned that if induced reli-

\begin{footnotesize}
\begin{enumerate}
\item Id. at 495.
\item Id.
\item Id.
\item See Griffin v. Matthews, 522 N.E.2d 1100, 1104 (Ohio Ct. App. 1987).
\item Id. at 1101-02.
\item Id.
\item Id. at 1102.
\item Id. at 1104.
\item Id.
\end{enumerate}
\end{footnotesize}
ance were required, an unconscious plaintiff admitted to an emergency room would never be successful under the theory of agency by estoppel.\textsuperscript{88}

Hospital liability on the theory of apparent agency was next expanded to encompass malpractice by a nonemployee physician in a hospital's outpatient clinic.\textsuperscript{89} In \textit{Whitlow v. Good Samaritan Hospital},\textsuperscript{90} the physician prescribed medication in the hospital's clinic which resulted in injury to the plaintiff.\textsuperscript{91} The hospital argued the agency by estoppel doctrine applies only where the patient has no opportunity to select a treating physician, such as in an emergency room situation.\textsuperscript{92}

Once again, a summary judgment for the hospital was reversed. The appellate court refused to limit the application of agency by estoppel to emergency cases, holding that the doctrine is applied any time a patient is induced to rely upon the hospital's representation to the public of a relationship between the hospital and physician.\textsuperscript{93} The court found there was an issue of apparent agency based on plaintiff's affidavits stating that he believed the hospital to be a full service hospital which selected the treating physician, that he was unaware that the physician was not an employee of the hospital, and that he received bills from the hospital for the physician's treatment.\textsuperscript{94}

The Ohio appellate courts have generally not expanded hospital liability for physician malpractice where the patient was under the care of his own physician when admitted to the hospital. In \textit{Smith v. Timken Mercy Medical Center},\textsuperscript{95} the patient was admitted to the defendant-hospital by his own private physician, and was subsequently treated by other physicians.\textsuperscript{96} The court found no evidence to indicate that the hospital held itself out to the plaintiff's decedent as the provider of medical care sufficient to

\textsuperscript{88} \textit{Id.}
\textsuperscript{90} \textit{Id.}
\textsuperscript{91} \textit{Id.} at 660.
\textsuperscript{92} \textit{Id.} at 662.
\textsuperscript{93} \textit{Id.} at 662-63.
\textsuperscript{94} \textit{Id.} at 663.
\textsuperscript{95} \textit{Smith v. Timken Mercy Medical Ctr.}, No. CA-6006 (Ohio 5th App. Dist. Stark County Feb. 8, 1983).
\textsuperscript{96} \textit{Id.}, slip op. at 1-4.
raise an issue of agency by estoppel.\textsuperscript{97} In Goodman v. Mercy Hospital,\textsuperscript{98} the decedent had been under the care of a surgeon throughout her pregnancy, and entered the hospital in anticipation of a normal delivery.\textsuperscript{99} The court of appeals upheld the trial court's summary judgment for the defendant-hospital, holding that there was no evidence to create an issue of apparent agency between the physician and the hospital.\textsuperscript{100}

Thus, with the exception of cases like Timken and Goodman, Ohio appellate courts since 1980 have generally expanded hospital liability for independent physician malpractice. The decision in Albain, however, effectively halts this trend of expanding liability in Ohio.

III. ALBAIN V. FLOWER HOSPITAL

A. Factual Background

Sharon Albain, who was visiting out-of-town friends during her eighth month of pregnancy, was taken by ambulance to Flower Hospital, the closest hospital, after she began to discharge blood.\textsuperscript{101} She was admitted to the obstetrical ward at around 2:00 p.m., and her private physician was contacted by the hospital's on-call resident.\textsuperscript{102} Since Albain's private physician had no staff privileges at Flower Hospital, he instructed the hospital resident to put Albain in the care of Dr. Abbo, Flower Hospital's on-call staff obstetrician.\textsuperscript{103} Dr. Abbo, an independent staff physician, maintained a private practice and billed patients directly rather than through the hospital.\textsuperscript{104}

The hospital resident phoned Dr. Abbo at 2:30 p.m. to inform her of Albain's condition, and Dr. Abbo gave orders for Albain's care from her office.\textsuperscript{105} At 3:50 p.m., Dr. Abbo was telephoned

\textsuperscript{97}Id.


\textsuperscript{99}Id., slip op. at 7.

\textsuperscript{100}Id.

\textsuperscript{101}Albain v. Flower Hosp., 553 N.E.2d 1038, 1040-41 (Ohio 1990); Albain v. Flower Hosp., No. 85-0847, slip op. at 1-3 (Ohio C.P. Lucas County Aug. 12, 1987).

\textsuperscript{102}Albain v. Flower Hosp., 553 N.E.2d 1038, 1040-41 (Ohio 1990); Albain v. Flower Hosp., No. 85-0847, slip op. at 1-3 (Ohio C.P. Lucas County Aug. 12, 1987).

\textsuperscript{103}Albain v. Flower Hosp., 553 N.E.2d 1038, 1040-41 (Ohio 1990); Albain v. Flower Hosp., No. 85-0847, slip op. at 1-3 (Ohio C.P. Lucas County Aug. 12, 1987).

\textsuperscript{104}Albain v. Flower Hosp., 553 N.E.2d 1038, 1043-44 (Ohio 1990).

\textsuperscript{105}Id. at 1040-41; Albain v. Flower Hosp., No. 85-0847, slip op. at 1-3 (Ohio C.P. Lucas County Aug. 12, 1987).
again by a hospital nurse, who gave Dr. Abbo various test results. The results included an echogram which did not indicate a rupture of the placenta; however, there was conflicting evidence that the nurse told Dr. Abbo that Albain was still bleeding. Dr. Abbo reported that she would be in to see Albain at about 5:30 p.m. after she completed her office hours.

By 7:00 p.m. Dr. Abbo had still not arrived. The nurse called Dr. Abbo at home, and Dr. Abbo reached the hospital at 8:00 p.m. After examining Albain and consulting with the resident physician, Dr. Abbo transferred Albain to a hospital which could care for a pre-term baby. Physicians at the hospital concluded a possible rupture of the placenta had occurred, and delivered the baby by cesarean section that night. The baby was born severely retarded and brain damaged, and died two months later. Albain and her husband filed wrongful death and survivorship claims against Dr. Abbo and Flower Hospital, alleging that individually or through their agents they failed to monitor and diagnose her condition.

B. Lower Court Decisions

The trial court ruled as a matter of law that Flower Hospital could not be held liable for the acts of Dr. Abbo under the doctrine of respondeat superior, and summary judgment was granted. Mrs. Albain argued that Dr. Abbo, acting as staff physician, was an agent of the hospital, and that Flower Hospital was liable under the doctrine of respondeat superior for Dr. Abbo's acts. The trial court, however, held that there was

111. Albain v. Flower Hosp., No. 85-0847, slip op. at 7-9 (Ohio C.P. Lucas County Aug. 12, 1987).
113. Id. at 7.
insufficient evidence of an induced reliance to create an issue of agency by estoppel.\textsuperscript{114} The trial court distinguished the case at bar from \textit{Hannola} by stating that \textit{Hannola} rested on a patient's need for emergency treatment and a corresponding lack of meaningful choice in selecting a physician, whereas no such lack of choice existed in Mrs. Albain's case.\textsuperscript{115}

The court of appeals reversed the trial court's grant of summary judgment for Flower Hospital on the issue of liability for the acts of Dr. Abbo.\textsuperscript{116} It did so on the basis of two errors. First, there was an issue of fact as to whether Flower breached an independent duty of care to Sharon Albain under a theory of corporate negligence in failing to monitor the care provided by Dr. Abbo.\textsuperscript{117} Second, there was an issue of fact as to whether agency by estoppel applied where Mrs. Albain claimed that she believed the hospital would provide a physician, and where no one informed her that Dr. Abbo was not an employee of Flower.\textsuperscript{118} Relying on \textit{Hannola}, the court reasoned that hospitals make a statement to the public by maintaining emergency medical facilities, and that Mrs. Albain had no realistic choice as to who would treat her at Flower due to her emergency situation.\textsuperscript{119}

\textbf{C. The Ohio Supreme Court Decision}

There were two issues before the Ohio Supreme Court when it granted certiorari. First, under what circumstances may a hospital be liable for the negligence of physicians to which it grants staff privileges?\textsuperscript{120} Second, can a hospital be vicariously liable for failure of its employees' to keep a staff physician informed?\textsuperscript{121} Only the court's holding with respect to the first issue will be discussed in this note.\textsuperscript{122} The court addressed hospital liability for the negligence of staff physicians from two vantage points: (1) with respect to the doctrine of \textit{respondeat...
superior and (2) with regard to three exceptions to the general rule of nonliability for the acts of independent contractors.

1. *Respondeat Superior*

According to the Ohio Supreme Court, the key test in determining liability under the doctrine of *respondeat superior* is one of control over the work performed.\(^\text{123}\) If the employer retains the right to control the manner of doing the contracted work, then there is a principal-agent relationship. Otherwise, if the employer is only interested in the end result, the relationship is that of an employer-independent contractor.\(^\text{124}\)

The court noted in the *Albain* case that both parties acknowledged Dr. Abbo had a private practice, enjoyed staff privileges at other hospitals, billed her patients directly, and was an independent contractor.\(^\text{125}\) Further, it found that actions such as granting and revoking staff privileges and making patient care policies do not establish the required control to impose liability on the basis of *respondeat superior*.\(^\text{126}\) The court "specifically reject[ed] any inclusion within the holding of the court of appeals in *Hannola* . . . to the contrary."\(^\text{127}\) Instead, the justices looked to three exceptions to the general rule of non-liability for the acts of independent contractors as possible sources of hospital liability: (1) negligent granting of staff privileges to independent physicians, (2) nondelegable duties, and (3) agency by estoppel.\(^\text{128}\)

2. *Exceptions to the Independent Contractor Rule*

a. *Independent Duty and Corporate Negligence*

The court of appeals held that Flower Hospital owed an independent duty of care based on a theory of corporate negligence, not only in selecting staff physicians, *but also in supervising and monitoring the competence of its staff physicians.*\(^\text{129}\) The Ohio


\(^{124}\) *Id.* (citing *Miller v. Metropolitan Life Ins. Co.*, 16 N.E.2d 447, 448 (Ohio 1938)).

\(^{125}\) *Id.* at 1043.

\(^{126}\) *Id.* at 1044.

\(^{127}\) *Id.*

\(^{128}\) *Id.*

Supreme Court refused to adopt this "unduly broad theory of corporate negligence"\textsuperscript{130} endorsed by the court of appeals.

Instead, the Ohio Supreme Court held that the duty of care in selecting and retaining staff physicians hinges on foreseeability of risk to hospital patients.\textsuperscript{131} The plaintiff must show the physician would not have been granted staff privileges but for the hospital's lack of care, or that the hospital had reason to know that an act of malpractice would likely take place.\textsuperscript{132} The court unequivocally held that a hospital's independent duty with respect to staff physician negligence is limited to exercising due care in granting and continuing staff physician privileges. A staff physician's negligence does not automatically mean that the hospital is liable, nor raise a presumption that the hospital was negligent.\textsuperscript{133}

Further, the court emphasized that a hospital is not an insurer of its staff physicians' skills and is not required to supervise or monitor the activities of staff physicians, since only physicians, and not hospitals, are permitted to practice medicine in Ohio.\textsuperscript{134} Though recognizing that other jurisdictions have imposed an expanded independent duty on hospitals, the Ohio Supreme Court refused to follow, stating:

\begin{quote}
We are aware that a number of our sister jurisdictions have expanded the independent duty of hospitals so as to require them to totally ensure the patient's safety while at the hospital. ... We are not convinced of the wisdom of such expansive liability and, accordingly, we hold that a hospital may be held directly liable for the malpractice of an independent physician with staff privileges only to the extent discussed above.\textsuperscript{135}
\end{quote}

Mrs. Albain presented no evidence that Dr. Abbo was incompetent, or that the hospital breached a duty of care in reviewing Dr. Abbo's credentials.\textsuperscript{136} A nurse testified that Dr. Abbo had been late in arriving at the hospital on a number of occasions, but the court concluded this did not raise an issue of whether

\begin{itemize}
\item \textsuperscript{130} Albain v. Flower Hosp., 553 N.E.2d 1038, 1045 (Ohio 1990).
\item \textsuperscript{131} \textit{Id.} (quoting Johnson v. Misericordia Community Hosp. Auth., 301 N.W.2d 156, 164 (Wis. 1981)).
\item \textsuperscript{132} \textit{Id.}
\item \textsuperscript{133} \textit{Id.} at 1046.
\item \textsuperscript{134} \textit{Id.} (referring to OHIO REV. CODE ANN. § 4731.41 (Baldwin 1989)).
\item \textsuperscript{135} \textit{Id.} at 1046.
\item \textsuperscript{136} \textit{Id.}
\end{itemize}
Flower Hospital had a reason to know that malpractice would take place.\textsuperscript{137} Therefore, the court held that summary judgment for the hospital was proper on the issue of the hospital's independent duty in granting and maintaining Dr. Abbo's staff privileges.\textsuperscript{138}

\textbf{b. Nondelegable Duties}

In addressing the nondelegable duty theory\textsuperscript{139} as an exception to the general rule that an employer is not liable for the negligence of an independent contractor, the court acknowledged that other jurisdictions have applied a nondelegable duty exception to hospitals.\textsuperscript{140} However, the Ohio Supreme Court noted that Ohio has recognized the nondelegable duty exception only in traditional areas, such as the duty to keep premises safe and a landlord's duty in making repairs.\textsuperscript{141} Further, the court characterized the court of appeals' decisions in \textit{Stratso v. Song}\textsuperscript{142} and \textit{Griffin v. Matthews}\textsuperscript{143} as "represent[ing] misdirected attempts to circumvent the necessity of proving agency by estoppel, and confus[ing] the proper scope of a hospital's duty in selecting competent physicians."\textsuperscript{144}

The \textit{Restatement (Second) of Torts} establishes that the nondelegable duty exception applies where the nature of the work contracted requires specific precautions, or involves inherently dangerous activities.\textsuperscript{145} The supreme court concluded that liability is not established under the Restatement standard by an em-

\begin{itemize}
\item \textsuperscript{137} Id.
\item \textsuperscript{138} Id. at 1047.
\item \textsuperscript{139} See generally W. PAGE KEETON, ET AL., PROSSER AND KEETON ON THE LAW OF TORTS \textsection{} 71 (5th ed. 1984) (discussing the theory of nondelegable duty as an exception to the general rule that there is no vicarious liability of an employer for the acts of an independent contractor, and noting that an employer may be liable for the negligence of an independent contractor, although he has himself done everything that could reasonably be required of him).
\item \textsuperscript{140} Albain v. Flower Hosp., 553 N.E.2d 1038, 1047 (Ohio 1990) (citing Jackson v. Power, 743 P.2d 1376, 1383-84 (Alaska 1987)).
\item \textsuperscript{141} Id. (citing Richman Bros. Co. v. Miller, 3 N.E.2d 360 (Ohio 1936) and Strayer v. Lindeman, 427 N.E.2d 781 (Ohio 1981)).
\item \textsuperscript{142} Stratso v. Song, 477 N.E.2d 1176 (Ohio Ct. App. 1984).
\item \textsuperscript{143} Griffin v. Matthews, 552 N.E.2d 1100 (Ohio Ct. App. 1987).
\item \textsuperscript{144} Albain v. Flower Hosp., 553 N.E.2d 1038, 1047-48 (Ohio 1990).
\item \textsuperscript{145} Id. at 1048 (citing \textit{RESTATEMENT (SECOND) OF TORTS} \textsection{} 416 cmt. a (1965)).
\end{itemize}
ployer merely holding out that it has assumed a duty.\textsuperscript{146} Reasoning that the practice of medicine by a staff physician does not involve the risks and precautions required by the nondelegable duty exception, the court held a hospital does not have a nondelegable duty to prevent negligence by granting staff privileges to an independent contractor physician.\textsuperscript{147} The plaintiff, therefore, could not attempt to establish liability of Flower Hospital on the basis of a nondelegable duty theory.\textsuperscript{148}

c. Agency By Estoppel

Of the three exceptions to the independent contractor rule, the court considered the application of agency by estoppel in the greatest detail. The court examined two theories of apparent authority. The first theory, described in section 429 of the Restatement (Second) of Torts, requires only that the employer "hold out" the independent contractor as his own employee, and that the third party reasonably believed the contractor was an employee or agent.\textsuperscript{149} The second theory, described in section 267 of the Restatement (Second) of Agency, requires that the employer made representations of agency or employment, and that the third party relied on such representations.\textsuperscript{150}

The Albain court adopted the stricter theory of agency by estoppel, citing prior Ohio Supreme Court decisions requiring an induced reliance to establish agency by estoppel.\textsuperscript{151} A plaintiff in Ohio must therefore satisfy a two-part test in order to hold a hospital liable by agency by estoppel. First, the plaintiff must show the hospital made representations leading the plaintiff to believe the independent physician was acting as an agent of the hospital.\textsuperscript{152} Second, the plaintiff must show that he was induced

\textsuperscript{146} Id. (citing Restatement (Second) of Torts § 416 cmt. b (1965), which states that an employer may always anticipate that if the independent contractor is negligent some harm may result, and that the exception is not concerned with the taking of routine precautions which any careful independent contractor could reasonably be expected to take against the ordinary and customary dangers which may arise in the course of work).

\textsuperscript{147} Albain, 553 N.E.2d at 1048.

\textsuperscript{148} See id. at 1047-48.

\textsuperscript{149} Id. at 1048-49 (citing Restatement (Second) of Torts § 429 (1965)).

\textsuperscript{150} Id. (citing Restatement (Second) of Agency § 267 (1958)).

\textsuperscript{151} Id. (citing Cooper v. Sisters of Charity of Cincinnati, Inc., 272 N.E.2d 97, 104 (Ohio 1971)).

\textsuperscript{152} Id. at 1049.
to rely upon the ostensible agency. The reliance must be upon the apparent agency relationship, and not merely upon the reputation of the hospital. Further, the court specifically rejected the holding in the Hannola decision that an implied inducement is automatically created whenever a hospital opens emergency room facilities to the public.

Applying the two-part test to the facts of the case, the court found no factual issue as to either inducement by the hospital or reliance by Mrs. Albain. The court noted that Mrs. Albain was taken to Flower Hospital by ambulance simply because Flower Hospital was the closest hospital. Although Mrs. Albain stated in her affidavit that she believed Flower Hospital would provide her with a physician, the court emphasized that there were insufficient facts showing inducements by the hospital which would have led Mrs. Albain to believe Dr. Abbo was Flower's employee. More importantly, the court reasoned that there was no issue of reliance by Mrs. Albain, because there was no indication in the record that she would have refused Dr. Abbo's care if she had known Dr. Abbo was not an employee of the hospital. Therefore, the court upheld summary judgment for the hospital on the issue of agency by estoppel.

IV. HOSPITAL LIABILITY AFTER ALBAIN

In Albain, the Ohio Supreme Court stated it did "not hold ... that a hospital may never be held liable for the negligence of a physician with staff privileges." However, unless the plaintiff can establish the control required for application of the doctrine of respondeat superior, the court's narrow interpretations of the three exceptions to the independent contractor

153. Id.
154. Id. at 1049-50.
155. Id. at 1049.
156. Id. at 1050.
157. Id.
158. Id.
159. Id.
160. Id. See also id. at 1050 n.12 (the court in footnote 12 states that the element of reliance is rarely present in emergency situations, such as in the present case, and quotes a law review article for the proposition that even in situations involving no emergency, patients rely on the expertise of the doctor, not the doctor's employment status).
161. Id. at 1044.
rule leave little opportunity for a potential plaintiff to take his case to the jury.

A. Respondeat Superior

The Ohio Supreme Court’s holding that the granting of staff privileges to a private physician alone does not establish liability under the doctrine of respondeat superior is the general rule followed by most jurisdictions.162 In Albain, Dr. Abbo billed her patients directly, and had a private practice with an independent contractor arrangement with the hospital.163 A different factual background might permit an application of respondeat superior.

A potential plaintiff might look to relationships between the hospital and the staff physician’s source of income, source of patients, or billing practices in an attempt to establish the required level of control.164 For instance, contact through a hospital’s physician referral service might be used to establish a link between the defendant-hospital and the negligent physician. A contractual relationship probably forms the most convincing indicator of control. The Albain court cites with approval a law review article defining a full-time salaried hospital physician as including a physician who contracts to provide services to the hospital for a set fee.165 In addition, courts in other jurisdictions have held that a hospital cannot escape liability through the independent contractor rule by merely delegating medical services by contract to independent physicians.166

An alternative method of showing control by a defendant hospital may arise from trends in hospital marketing. Hospitals may actively recruit private physicians to commu-

162. See Classen, supra note 2, at 480 (citing Runyan v. Goodrum, 228 S.W. 397 (Ark. 1921)); see also John D. Hodson, Annotation, Liability of Hospital or Sanitarium for Negligence of Physician or Surgeon, 51 A.L.R.4th 235, 244 (1987); 67 OHIO JUR. 3D, Malpractice § 48 (1986); see also Ellen B. Gwynn, Hospital Liability in Florida: The Nondelegable Duty Doctrine, 64 FLA. B.J. 14, 16 (Feb. 1990).


164. See Gwynn, supra note 162.


166. See Irving v. Doctors Hosp. of Lake Worth, Inc., 415 So. 2d 55, 59-62 (Fla. Dist. Ct. App. 1982) (holding jury in a case involving the liability of a hospital for negligence of an emergency room physician should be given instruction that one may not escape his liability by delegating performance by contract with an independent contractor, where the independent contractor doctor worked only for the hospital at an hourly rate, and was governed by detailed hospital rules controlling medical staff in the emergency room. The hospital withheld no income or social security tax from payments to the doctor. Id.
ties. Hospital recruiting of staff physicians to local communities is on the rise in almost every region of the country. Hospitals may recruit physicians for solo practices, where the recruitment can include putting money into equipping the new solo practice or providing income guarantees. Hospital recruiting may also include attracting new physicians to existing partnerships, so that the hospital will keep patients it would otherwise lose when a physician in the partnership retires. Where these recruitment relationships exist, a malpractice plaintiff might argue that the hospital is not just acting as a center for the practice of medicine by independent staff physicians, but is actively controlling and coordinating the choice and quality of physicians available to the plaintiff, so that the hospital should be liable under the doctrine of respondeat superior.

B. Independent Duty

The Albain court's interpretation of the first exception to the independent contractor rule, a hospital's independent duty to its patients, requires evidence that the hospital knew or should have known of a developing pattern of incompetence through physician review, or evidence that the hospital was negligent in reviewing the physician's records in hiring. This requirement seems to

at 56.). See also Mduba v. Benedictine Hosp., 52 A.D.2d 450, 452 (N.Y. App. Div. 1976) (holding that hospital could be liable for emergency room physician negligence despite contract provision that physician was not a hospital employee. The court looked to the control of the physician as evidenced by the doctor being bound to follow hospital rules and regulations while working in the emergency room, and by the doctor being guaranteed $25,000 annually by the hospital. Id.).

167. Jane Harriman, Hospitals Use the M Word: Marketing, WILMINGTON, DELAWARE NEWS JOURNAL, Aug. 6, 1990, at D1 (reporting that a hospital in Delaware has recruited to the community osteopathic doctors in specialties that have not been heavy users of the hospital's facilities).

168. Id. Mary Koska, Survey: Hospitals Abandoning Searches for Solo Practitioners, HOSPITALS, Sept. 20, 1990, at 42-43 (citing a 1990 survey of 654 hospitals performed by HOSPITALS magazine. According to the survey results, 61% of the hospitals responding reported increased recruiting, 35% reported no change, and 4% reported a decrease. By region, 85% of respondents in the mid-Atlantic states reported they were recruiting, as compared to 82% in the Midwest, 81% in the Southeast, 70% in the Northwest, 66% in the West, and 59% in the Southwest. Id.).

169. Koska, supra note 168 (citing a survey that the trend is away from hospitals recruiting for solo practices and toward recruiting for private physician partnership practices).

170. Id.

limit application of the exception to cases where there has been some prior malpractice by the treating physician, or where the physician lacks some technical qualification. While there was testimony by a nurse that Dr. Abbo was late in arriving at the hospital on several other occasions, the court concluded that this testimony alone was not enough to raise an issue as to whether Flower Hospital had reason to know that malpractice would take place.\textsuperscript{172}

This conclusion implies either that the court does not consider repeated physician tardiness as potentially dangerous to patients, or that the court does not consider repeated physician tardiness a matter hospitals are expected to review. In either case, the court seems to focus on technical incompetence, and seems to disregard repeated physician behavior that has a potential to cause harm as a basis for hospital liability. As a result, a plaintiff who is the victim of a physician's first instance of malpractice will probably have no claim against the hospital under this exception, unless the plaintiff can show the physician was not technically qualified when hired.

The \textit{Albain} court refused to broadly define a hospital's independent duty to include a duty to supervise the treatment provided by its staff physicians, noting that hospital administrators often have no medical training,\textsuperscript{173} and that, in any case, hospitals cannot practice medicine under section 4731.41 of the Ohio Revised Code.\textsuperscript{174} This rationale seems inconsistent for at least two reasons.

First, hospitals are liable for the treatment administered by employee physicians, yet administrators are no more qualified to supervise employee physicians than they are to supervise non-employee physicians. Second, a hospital may be held liable for the negligence of an employee nurse, yet a hospital cannot be licensed as a registered nurse any more than it can be licensed as a medical doctor.

The Supreme Court of Mississippi recognized this inconsistency in \textit{Hardy v. Brantley}.\textsuperscript{175} In \textit{Hardy}, the defendant-hospital argued that a decision to hold it liable for the negligence of an emergency

\begin{itemize}
\item \textsuperscript{172} \textit{Id.} at 1046.
\item \textsuperscript{173} \textit{Id.}
\item \textsuperscript{174} \textit{Id.} (citing \textsc{Ohio Rev. Code Ann.}, § 4731.41 (Baldwin 1989)).
\item \textsuperscript{175} Hardy v. Brantley, 471 So. 2d 358 (Miss. 1985).
\end{itemize}
room physician would necessarily require that the hospital practice medicine. The court reasoned that if a hospital may be held liable for the actions of a nurse, there is no rational basis for not holding a hospital liable for the actions of a staff physician merely because the hospital cannot be licensed to practice medicine. The reasoning relied upon by the Ohio Supreme Court seems to be founded on arbitrary distinctions between physicians and nonphysicians and employee physicians and nonemployee physicians.

The Ohio Supreme Court also takes a simplistic view of hospital liability when a developing pattern of physician incompetence is involved. The court states that the hospital must stand ready to answer for its retention of a physician who develops such a pattern of incompetence which the hospital should be aware of through its peer review process, citing a law review article dealing with hospital administration. Yet that same law review article emphasizes that there is a "mountain of political, administrative, and personal problems," in a hospital administrator's dealings with the medical staff, and that the administrator is "the expendable party" when insisting that medical staff officials take corrective action with respect to incidents involving patients' safety.

176. Id. at 372-73.
177. Id. at 373.
179. Id. (citing K.J. Williams, The Quandary of the Hospital Administrator in Dealing with the Medical Malpractice Problem, 55 Neb. L. Rev. 401, 406-07 (1976)).
180. K.J. Williams, The Quandary of the Hospital Administrator in Dealing with the Medical Malpractice Problem, 55 Neb. L. Rev. 401, 404-05 (1976).
181. Id. at 406:

With respect to incidents involving patient safety and quality control, such as the physician's refusing to adhere to hospital policy or professional standards agreed to by his conferees or practicing beyond his skill level, or physicians with drinking problems, some pertinent questions arise. Can the administrator insist that medical staff officials take corrective action? The answer is that he can, but only to the extent that he does not come into confrontation with the medical staff, because when he does, he is automatically in a win-lose situation, and he is the expendable party. Should the administrator report the incident to the board? He can (and should), but here too, there is a tolerance level. If the members of the board are not tuned in to the extent of their corporate responsibility, as many trustees are not, then they will not be receptive to such problems because correcting them means conflict with the whole medical staff or with those officials who are thought to have the responsibility for this kind of problem. Because of the pressures applied to the board by the staff, coupled with the customary charges leveled
The same article also notes that there can be a time-honored tradition of frequent changes in the medical staff leadership which prevents staff leaders from seeing developing patterns of medical incompetence.\(182\) Assuming these conditions exist, a plaintiff would have a great deal of difficulty finding witnesses able or willing to testify that a hospital was aware of a pattern of incompetence. The hospital, and not the plaintiff, has control of relationships between the medical staff and the hospital administration. Further, the governing body of every hospital has the responsibility to set standards and procedures in granting staff privileges.\(183\) For these reasons, the Albain court's holding that physician negligence does not raise a presumption that the hospital was negligent in granting the physician staff privileges seems unrealistic and unfair to injured plaintiffs.

A few courts in other jurisdictions have been more willing to expand the independent duty of hospitals under theories of corporate liability.\(184\) In the landmark case of Darling v. Charleston Community Memorial Hospital,\(185\) the Supreme Court of Illinois concluded that a hospital could be liable where it failed to monitor the treatment provided by a private physician in the hospital's emergency room.\(186\) A cast applied by the physician restricted circulation, and the plaintiff's leg had to be amputated.\(187\) That court held a jury could find that the hospital was negligent in failing to check the patient's condition, in failing to review the physician's work, or in failing to require other consultation.\(188\)

\[182\] Id. at 407.
\[183\] OHIO REV. CODE ANN. § 3701.351(A) (Baldwin 1991): "The governing body of every hospital shall set standards and procedures to be applied by the hospital and its medical staff in considering and acting upon applications for staff membership or professional privileges . . . ."

\[184\] Darling v. Charleston Community Memorial Hosp., 211 N.E.2d 253 (Ill. 1965), cert. denied, 383 U.S. 946 (1966); see also Fridena v. Evans, 622 P.2d 463 (Ariz. 1980) (holding the hospital could be liable though there was no evidence of previous negligence or incompetency, where the negligent physician had administrative posts at the hospital); Bost v. Riley, 262 S.E.2d 391, 397 (N.C. Ct. App.), cert. denied, 269 S.E.2d 621 (N.C. 1980) (a hospital breached a duty to monitor patient's medical care).


\[186\] Id. at 258.

\[187\] Id.

\[188\] Id.
However, most courts applying a theory of corporate liability to hospitals for negligence of physicians have done so with respect to a duty to use care in selecting and retaining physicians.\textsuperscript{189}

C. Nondelegable Duty

The second exception to the independent contractor rule, that of nondelegable duties, will also be of little benefit to future malpractice plaintiffs. The \textit{Albain} court noted that liability based on nondelegable duty is recognized on the basis of a need for specific precautions, such as a railing around an excavation, or on the basis of inherently dangerous work.\textsuperscript{190} Yet the court held that the nondelegable duty exception does not apply to malpractice by physicians in hospitals by concluding that the practice of medicine does not involve the degree of risk or require the necessary precautions for application of the exception.\textsuperscript{191}

Most disturbing is the \textit{Albain} court's failure to recognize any variation in the degree of risk associated with physicians' work in a hospital. Certainly a routine physical performed in a hospital does not involve peculiar risks or special precautions. However, the same may not be true of emergency treatment of a critically injured patient, or of performance of high risk surgical procedures.

In \textit{Albain}, the plaintiff, eight months pregnant and bleeding, was rushed to the nearest hospital. Conceivably, two lives were at risk. The court's holding on these facts make it unlikely that any emergency medical situation, no matter how serious, will ever expose a hospital to liability under the nondelegable duty exception.

Though courts today do not generally consider medical care provided in hospitals an inherently dangerous activity,\textsuperscript{192} a dissenting judge in a New Mexico case has suggested that the


\textsuperscript{190} Albain v. Flower Hosp., 553 N.E.2d 1038, 1047-48 (Ohio 1990).

\textsuperscript{191} Id.

\textsuperscript{192} See Gwynn, supra note 162.
inherently dangerous exception should be applied for surgery performed in the hospital. Judge Sutin noted that when a hospital admits a patient for surgery "it knows that the procedures are inherently dangerous to the life and health of the patient," and that the hospital should not be able to escape liability by delegation of all duty of care to the surgeon.

Considering the wide range of medical treatments and attending risks that can be provided by hospitals, the question of whether a particular treatment should place a nondelegable duty on the hospital would be better determined on a case-by-case basis, rather than being subjected to the blanket exception of the Albain court.

The Supreme Court of Alaska has recognized that a hospital's duty to provide emergency room care may be nondelegable as a matter of law, due in part to the importance of the quality of the service to the community. In Jackson v. Power, the plaintiff was treated in a hospital emergency room by a physician employed by an independent emergency room service corporation. The physician's failure to order tests resulted in the plaintiff losing his kidneys. The court acknowledged the well-known nondelegable duty of common carriers to provide for the safety of their passengers. Noting that the importance to the community of a hospital's duty to provide emergency room physicians rivals the importance of the duty of common carriers, the court stated that it could not "fathom why liability should depend upon the technical employment status of the emergency room physician who treats the patient."

Further, that court explained that imposition of a nondelegable duty as a matter of law was consistent with the public perception of hospitals as health care facilities, and consistent with the

194. Id.
195. Jackson v. Power, 743 P.2d 1376, 1384 (Alaska 1987). See also Marek v. Professional Health Servs., Inc., 432 A.2d 538 (N.J. Super. Ct. App. Div. 1981) (concluding that the provision of radiological services is a nondelegable duty). But see Pamperin v. Trinity Memorial Hosp., 423 N.W.2d 846, 857-58 (Wis. 1988) (holding that there were no reasons why the duty to have a radiologist available is so important that a hospital may not avoid liability on the basis of the nondelegable duty doctrine).
197. Id. at 1377.
198. Id. at 1384.
199. Id. at 1385.
The commercialization of medicine. The court, though, was careful to point out that its holding of a nondelegable duty did not apply to patients treated by their own physician in a hospital emergency room, but instead was limited to cases where a patient goes to a hospital for emergency room services and is treated by a physician provided by the hospital.

D. Agency By Estoppel

Of the three exceptions to nonliability of independent contractors, the Albain court’s analysis of agency by estoppel is probably the most important in preventing future plaintiffs from getting their case to a jury. The court’s application of a two-part test of inducement and reliance to the facts of the case seem to make the doctrine of agency by estoppel an exception with no meaningful application to hospital liability.

With regard to inducement, the Albain court noted that though Mrs. Albain stated she believed the hospital would provide her with a physician, she did not show that she believed a physician who was an employee of the hospital would be provided to her, or provide evidence that the hospital led her to believe Dr. Abbo was an employee of the hospital. This court’s interpretation of inducement requires that a plaintiff show evidence of belief in, or an express representation by the hospital of, an actual employment status. Under any set of facts it is difficult to imagine how the actual employment status of the treating physician would arise, especially in a emergency situation. In fact, it seems more likely that if any express representation is made by a hospital it would be a form or posted sign disclaiming the employee/employer status of independent contractor physicians.

A future plaintiff might try to establish an implied representation by the hospital by relying on the hospital’s marketing activities. Hospital advertising is increasing across the country.

200. Id.
201. Id.
203. See Jackson v. Power, 743 P.2d 1376, 1381 (Alaska 1987) (where the court noted that the hospital posted a sign at the emergency room admissions desk stating that emergency room physicians were from an independent emergency room service).
The nation's hospitals spent 1.54 billion dollars on advertising in 1989, up by a factor of four from the level of advertising in 1984.\textsuperscript{205} A hospital's marketing activities may include hospital mail letters, sponsored seminars, physician referral services, and newspaper ads.\textsuperscript{206} In \textit{Albain}, the plaintiff was taken to an out-of-town hospital, but a future plaintiff treated at an advertising community hospital might be able to argue that he was induced to believe that the services advertised would be provided by the hospital's employees.

However, even if the plaintiff can establish an issue of induce-
ment, the \textit{Albain} court's interpretation of the requirement of reliance is almost certain to keep the plaintiff from getting to the jury on the issue of agency by estoppel. The court held that reliance must be on the ostensible agency relationship, and concluded that \textit{since Mrs. Albain could not provide evidence that she would have refused treatment had she known Dr. Abbo was not an employee}, a directed verdict for the hospital was proper.\textsuperscript{207} Indeed, it is hard to imagine any situation where a seriously injured person would refuse treatment on the basis of employment status. Further, as the court notes, even in nonemergency cases patients generally rely on the expertise of the physician, and not the physician's employment status.\textsuperscript{208} The holding is especially harsh, since the more a seriously injured patient relies on the services of a hospital, the less likely it is that he will be able to show necessary reliance for agency by estoppel.

Other courts have not been so strict in applying doctrines of apparent authority.\textsuperscript{209} In \textit{Paintsville Hospital v. Rose},\textsuperscript{210} the Kentucky Supreme Court held there was an issue of apparent agency where the decedent was taken to the hospital emergency room unconscious.\textsuperscript{211} The treating physician on call was a private phy-

\textsuperscript{205} Id.
\textsuperscript{206} Id. at A16.
\textsuperscript{207} Albain v. Flower Hosp., 553 N.E.2d 1038, 1050 (Ohio 1990).
\textsuperscript{208} Id. (citing Ruth B. Dangel, \textit{Hospital Liability for Physician Malpractice: The Impact of Hannola v. City of Lakewood}, 47 \textit{Ohio St. L.J.} 1077, 1086 (1986)).
\textsuperscript{210} Paintsville Hosp. Co. v. Rose, 683 S.W.2d 255 (Ky. 1985).
\textsuperscript{211} Id. at 256. \textit{But see id.} (Vance, J., dissenting: The deceased could not, in an unconscious state, rely "upon a belief that the emergency room physician was in fact an agent of the hospital.").
sician on the staff of the hospital, and she was called by the hospital to attend the decedent upon his arrival.\textsuperscript{212}

The Kentucky Supreme Court acknowledged the principles of apparent agency in section 267 of the \textit{Restatement (Second) of Agency} as adopted by the Albain court, but went on to say that the "realities of the situation" required the court to interpret ostensible agency as it has been interpreted by the court's sister states.\textsuperscript{213} Quoting the Michigan Supreme Court, the court noted it would be unreasonable to put a duty on a patient to inquire of each person providing treatment whether the person was a hospital employee.\textsuperscript{214} Rather, the critical question in applying the doctrine is whether the plaintiff looked to the hospital for treatment, or merely viewed the hospital as a shell where his own physician would treat him.\textsuperscript{215} The Kentucky Supreme Court also quoted the New Jersey Superior Court for the proposition that, absent notice, a plaintiff has a right to assume emergency treatment is being rendered through hospital employees for which the hospital will be liable.\textsuperscript{216}

In \textit{Jackson v. Power}, the Alaska Supreme Court noted the theoretical difference between ostensible agency based on section 429 of the \textit{Restatement (Second) of Torts} and agency by estoppel based on section 267 of the \textit{Restatement (Second) of Agency}.\textsuperscript{217} However, unlike Albain, the Jackson court used the less strict section 429 test and held there was a jury question of apparent authority based upon whether the hospital held itself out as providing emergency care services to the public, and whether the plaintiff reasonably believed the physician was employed by the hospital.\textsuperscript{218}

Similarly, in \textit{Capan v. Divine Providence Hospital},\textsuperscript{219} the Superior Court of Pennsylvania relied on section 429. The court concluded that where a patient entered a hospital through the emergency room and was treated by an on-call physician, a jury could conclude that the hospital held the physician out as an

\textsuperscript{212} Id.
\textsuperscript{213} Id. at 257-58.
\textsuperscript{214} Id. at 258 (citing Grewe v. Mt. Clemens Gen. Hosp., 273 N.W.2d 429 (Mich. 1978)).
\textsuperscript{215} Id.
\textsuperscript{216} Id. at 257-58 (citing Arthur v. St. Peters Hosp., 405 A.2d 443, 447 (N.J. 1979)).
\textsuperscript{218} Id. at 1382.
employee by providing his services to the public, and that the patient relied upon the hospital rather than the physician himself for treatment. 220

A broad interpretation of apparent agency requiring only a holding out by the hospital and a reasonable belief by the patient that the treating physician is employed by the hospital is justified by a number of considerations. First, patients look to hospitals as the providers of care: "Patients entering a hospital believe that the hospital will care for them.... Patients going to a hospital emergency department also believe the hospital is accountable."221 Second, the modern role of hospitals in society makes it likely that patients will look to the hospital, rather than to individual physicians,222 especially in light of the increase in hospital marketing activity.223 Further, it would be unfair and unreasonable to require a patient to be familiar with the law of respondeat superior, or to require him to check the employee status of each physician rendering treatment.224

V. CONCLUSION

The Ohio Supreme Court's decision in Albain will have a significant impact on hospital liability in future malpractice cases, and reverses a trend of broadening hospital liability in the Ohio appellate courts. The court clearly holds that a hospital's granting of staff privileges to an independent contractor, alone, is not enough to establish hospital liability under the doctrine of respondeat superior. In addition, the court narrowly construes exceptions to the general rule of nonliability of independent contractors as applied to hospital liability.

The court totally rejects application of the nondelegable duty theory to hospitals, and seems to restrict the application of the theory of corporate negligence to those cases where a hospital has been negligent in reviewing a physician's technical qualifications. Similarly, the court renders the theory of agency by estoppel useless to seriously injured plaintiffs by requiring that

220. Id. at 649-50.
223. Gwynn, supra note 162.
a plaintiff show he would not have undergone treatment had he known a physician's actual employment status. As a result, future malpractice plaintiffs will find it difficult to prevail on the issue of hospital liability for the negligence of independent staff physicians.
INTERNATIONAL UNION, UAW V. JOHNSON CONTROLS, INC.: CAN SCIENCE EVER JUSTIFY GENDER DISCRIMINATION?

Maria A. Longi

I. INTRODUCTION

As many as twenty million jobs may involve exposure to workplace reproductive hazards.1 A "reproductive hazard" has been defined on a gender neutral basis as "any worker exposure that is capable of (a) harming the fetus or prospective child of the exposed worker and/or (b) harming the reproductive system or sexual capacity of the exposed worker."2 Such hazards could cause, among other things, spontaneous abortions, premature birth, reduced birth weight, physical or mental deformities, damage to the child's immune system, and chromosomal aberrations.3 With these grave consequences, the important social, political, and private interests to be addressed by Congress, the courts, and the individual must be delicately balanced when determining the scope of an employer's ability to restrict access to jobs involving reproductive hazards.

The role that science plays in defining how much hazard is too much hazard cannot be ignored. The Occupational Safety and Health Act (OSH Act)4 and the Toxic Substances Control Act (TSCA)5 provide some guidance for defining the risk of exposure, as do independent researchers, scientists, and companies. Despite the apparent role that scientific data would seem to play, the

3. See id. at 527.
Supreme Court's recent decision in *International Union, UAW v. Johnson Controls, Inc.* indicates that gender discrimination as analyzed under Title VII of the Civil Rights Act of 1964 (Title VII) will not tolerate even scientifically sound fetal protection policies.

In *International Union, UAW v. Johnson Controls, Inc.*, a group of employees adversely affected by the Johnson Controls exclusionary fetal protection policy instituted a Title VII challenge. The policy barred all women capable of bearing children from working in certain areas of the battery manufacturing plant where the potential for high lead exposure existed. The district court and court of appeals, in accord with other courts of appeal, upheld the policy based on the company's showing of a business necessity in protecting the health of the fetus; summary judgment was granted to Johnson Controls. The Supreme Court reversed, holding that the lower courts analyzed the case under an incorrect Title VII framework. Since they held that the policy facially discriminated on the basis of gender, it could only be defended by a bona fide occupational qualification (BFOQ) defense, not a business necessity. The more stringent BFOQ standard required an actual interference with safe and efficient job performance, which Johnson Controls was not successful in establishing.

This note will first examine the treatment of fetal protection policies before and after the enactment of the Pregnancy Discrimination Act of 1978. Under this background, the *Interna-
tional Union, UAW v. Johnson Controls, Inc. decision will be reviewed, and its potential impact on fetal protection in the future will be analyzed.

II. BACKGROUND

A. Title VII Sex Discrimination

Prior to the enactment of Title VII, women in America were essentially powerless to defend themselves against sex discrimination in the workplace. Indeed, women's working hours could lawfully be restricted under the auspices of a state's police power to "preserve the strength and vigor of the race." An employer could have personnel policies based on assumptions "about the differences between men and women, whether or not the assumptions were valid." With time, though, more women began entering the traditionally male workplace and demanding equal treatment.

In 1964, Congress finally established a statutory redress for sex discrimination by enacting Title VII. The purpose of Title VII was to "remove barriers that have operated in the past to be treated the same for all employment-related purposes, including receipt of benefits under fringe benefits programs, as other persons not so affected but similar in their ability or inability to work, and nothing in section 2000e-2(h) of this title shall be interpreted to permit otherwise.

Id.

17. In pertinent part, Title VII of the Civil Rights Act of 1964 reads:
(a) Employer practices
   It shall be unlawful employment practice for an employer -
   (1) to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin; or
   (2) to limit, segregate, or classify his employees or applicants for employment in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual's race, color, religion, sex, or national origin.
18. Muller v. Oregon, 208 U.S. 412, 421 (1908). In Muller, a woman's natural dependency on men and protection of the race were among the reasons cited by the court for "preferential" treatment of women in the workplace.
21. See supra note 7.
favor an identifiable group" over other employees. No longer could employers rely on stereotypes or societal whims to treat similarly situated women differently than men.

Since its enactment, case law has distinguished two types of discrimination warranting protection under Title VII: disparate treatment and disparate impact. Disparate treatment requires a discriminatory motive and is the easier type of discrimination to recognize. Disparate impact, on the other hand, does not require an employer's subjective discriminatory intent. If a policy, although neutral, has a disparate impact on a protected class, then a Title VII disparate impact argument can be raised.

The distinction between these two types of Title VII discrimination, and consequently the defenses available to the employer under each, has been a pivotal issue in the federal courts' analyses concerning gender-based fetal protection policies. As seen in the treatment of Johnson Controls's policy by the district court, the Seventh Circuit Court of Appeals, and the United States Supreme Court, classifying a case as one or the other type of discrimination can produce a polar opposite result.

1. Disparate Treatment

Disparate treatment can occur either as facial discrimination or pretextual discrimination. Facial discrimination occurs when an employer adopts a policy that explicitly treats some employees differently from others on the basis of race, religion, national


24. See Griggs v. Duke Power Co., 401 U.S. 424 (1971). This decision was the first instance where the court recognized disparate impact as a form of Title VII discrimination. Id. at 431-32.


The only affirmative defense to facial discrimination is the bona fide occupational qualification (BFOQ) defense set out in the Civil Rights Act of 1964 itself.\(^2\)

In order to successfully use this defense in a gender discrimination case, an employer must show three basic elements:\(^2\) (1) members of the excluded class could not safely and effectively perform "essential" job duties;\(^3\) (2) there exists "a factual basis for believing that all or substantially all women would be unable to perform safely and efficiently the duties of the job involved";\(^3\) and (3) the classification is "reasonably necessary" to the normal operation of the business, that is, there are no reasonable alternatives.\(^3\)

A leading case applying the BFOQ defense in the gender discrimination context is *Dothard v. Rawlinson*.\(^3\) This challenge alleged, *inter alia*, that a state regulation establishing gender criteria for assigning prison guards to "contact" positions in a male maximum security prison violated Title VII.\(^3\) The Court held that the regulation, since it facially discriminated on the basis of gender, could only be permitted if it met the Title VII BFOQ standard.\(^3\) The "essential" job duty of a correctional counselor, stated the Court, was to "maintain prison security."\(^3\)

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27. *See* Weeks v. Southern Bell Tel. & Tel. Co., 408 F.2d 228 (5th Cir. 1969). A female employee alleged a Title VII violation by her employer in refusing to consider her application for a position for which the company "decided not to assign women." *Id.* at 230. The Court said a BFOQ must be shown in order to validate the company's facially discriminatory position. *Id.* at 232. They found that the BFOQ was not successfully shown here, and therefore the firm violated Title VII. *Id.* at 236. *See also* Los Angeles Dep't of Water & Power v. Manhart, 435 U.S. 702 (1978). This class action suit challenged a department policy which required female employees to make larger contributions to its pension fund than male employees, based on the Department's evaluation of mortality tables. Since the practice on its face discriminated against every individual woman on the basis of stereotypes, the Court found a Title VII violation. *Id.* at 716.

28. 42 U.S.C. § 2000e-2(e)(1) (1988). An employer may discriminate on the basis of "religion, sex or national origin in those certain instances where religion, sex or national origin is a bona fide occupational qualification reasonably necessary to the normal operation of that particular business or enterprise."

29. MACK A. PLAYER, EMPLOYMENT DISCRIMINATION LAW HORNBOOK SERIES, PRACTITIONER'S EDITION 281-82 (West 1988).


34. *Id.* at 324-26.

35. *Id.* at 332-33.

36. *Id.* at 335.
The Court concluded that "a woman's ability to maintain order ... could be directly reduced by her womanhood," reasoning that there was a "real risk" that with the type of prisoners in the facility, women guards would be assaulted more than men by the very fact that they were women.37

A significant finding in the Dothard decision was that of an exception to the second BFOQ element listed above, the existence of facts to believe most women would be unable to safely and efficiently perform the job duties.38 The Dothard case recognized an exception in that the safety of the employer and third parties could be a critical factor in determining whether the class could lawfully be excluded by a BFOQ.39 This is sometimes referred to as the "safety exception" to the BFOQ and has been applied, although not often successfully, in other cases.40 The BFOQ defense was successfully established in Dothard, though, and the state regulation was upheld.41

Although the court in Dothard found that a gender classification affected the "essence" of the job, this element of the BFOQ defense has been given a limited construction by the courts, indicating the difficulty that employers have had in justifying

37. Id.
38. See supra note 31 and accompanying text.
39. 433 U.S. at 336. Significantly, the Court said:
The likelihood that inmates would assault a woman because she was a woman would pose a real threat not only to the victim of the assault but also the basic control of the penitentiary and protection of its inmates and other security personnel. The employee's very womanhood would thus directly undermine her capacity to provide the security that is the essence of a correctional counselor's responsibility.

Id.
40. See, e.g., Western Air Lines, Inc. v. Criswell, 472 U.S. 400 (1985). The Court, in an age discrimination context, recognized that safety to third parties (in that case airline passengers) was properly considered in a BFOQ context. They reached this conclusion by holding that safety considerations went to the "essence" of a flight engineer's job (safe transportation of passengers). Id. at 413-14. Although recognizing the safety exception, the Court found that it did not justify a BFOQ in that case. Id. at 423. In Burwell v. Eastern Air Lines, Inc., 633 F.2d 361 (4th Cir. 1980), cert. denied, 450 U.S. 965 (1981), the Fourth Circuit declared the airline's mandatory pregnancy leave policy for the first 13 weeks of pregnancy invalid under Title VII. Id. at 368. They reasoned that the policy was not necessary for the safe transport of passengers. Id. at 372. The policies for leave from the thirteenth week on, though, were recognized as valid safety exceptions. Id. While the court noted this exception under the business necessity standard, id. at 369, they did say that safety considerations for the pregnant woman and her unborn child should be left to individuals and not to corporate policy. Id. at 371.
facially discriminatory policies. For instance, women could not be excluded from night work, work requiring travel, or work in tough locations because of the mere possibility of embarrassment, harassment or sexual attacks,42 and black employees could not be excluded from jobs for fear of racist attacks.43 Generally, where the primary concern is for the safety of the excluded class, the "essence" of the job is not jeopardized, and this will not be enough to sustain a BFOQ.44 The narrow application of the BFOQ defense is consistent with general Title VII objectives to provide women with employment choices and opportunities on equal terms with their male counterparts.45

In addition to facial discrimination, the other recognized type of disparate treatment is pretextual discrimination. This occurs when the policy is facially neutral, yet is in reality a pretext, or cover-up, for a discriminatory motive.46 The framework for analysis of this type of discrimination was set forth in McDonnell Douglas Corp. v. Green.47 The allocated burdens set out in this case are as follows: (1) the complainant must show a prima facie case of discrimination,48 (2) the employer must then show some legitimate, nondiscriminatory reason for the employee's rejection,49 and (3) the complainant must then have the opportunity to show that the employer's stated reason for the employee's rejection was in fact pretext.50 Again, a facial or pretextual

42. See Weeks v. Southern Bell Tel. & Tel. Co., 408 F.2d 228 (5th Cir. 1969).
44. See Player, supra note 29, at 287.
45. See Weeks v. Southern Bell Tel. & Tel. Co., 408 F.2d 228, 235 (5th Cir. 1969).
47. 411 U.S. 792 (1973). In that case, a black employee of McDonnell Douglas Corp. was laid off in the course of a general reduction in the company's work force. In protest, the employee and others illegally stalled their cars in the road to the company plant. A "lock in" of the working employees followed. Upon advertising that a position like employee's was to open up, the employee applied for the position and was rejected. The stated reason for his rejection was the illegal "stall-in" and subsequent "lock-in." Id. at 794-96. He subsequently sued for a Title VII violation based on racial discrimination. Id.
48. As for this first requirement:
This may be done by showing (i) that he belongs to a racial minority; (ii) that he applied and was qualified for a job for which the employer was seeking applicants; (iii) that, despite his qualifications, he was rejected; and (iv) that, after his rejection, the position remained open and the employer continued to seek applicants from persons of complainant's qualifications.
Id. at 802.
49. Id.
50. Id. at 804.
discriminatory motive is required for either disparate treatment analysis.

2. Disparate Impact

In contrast to a disparate treatment case, a disparate impact argument can be made when the employer's policy is concededly neutral, yet operates disproportionately on a group protected from discrimination under Title VII.51 An affirmative defense for an employer under this Title VII theory is business necessity.52 As originally established in Griggs v. Duke Power Co.,53 this defense requires an employer to show that any given requirement must have a manifest relationship to the employment in question.54 The business necessity defense recognizes that Title VII violations do not require discriminatory intent, in accord with Congress' objective in enacting Title VII.55

Recently, the Supreme Court has revamped the business necessity defense by assigning the burden of persuasion in all aspects of the case to the party challenging the allegedly discriminatory policy,56 making this defense "conform to the rule in disparate-treatment cases."57 In Wards Cove Packing Co. v. Atonio,58 nonwhite Alaskan cannery workers alleged that the Wards Cove Packing Company's hiring practices violated Title VII.59 The Court, in reversing the ruling of the court of appeals,60 stated that in a disparate impact case such as this, the employee must establish a prima facie case demonstrating that the challenged practice has a disparate impact on employment opportunities.61 The burden of production of a legitimate business justification

52. Id.
53. Id. at 424.
54. Id. at 432. Griggs involved general intelligence tests which effectively excluded blacks. The Court held that an employer's discriminatory intent is not required to constitute a Title VII violation. Id. An employment practice that operates to invidiously discriminate on the basis of race which is not related to job performance is prohibited under Title VII. Id. at 431. The court of appeals' requirement of discriminatory intent for such testing or measuring procedures was reversed. Id. at 436.
55. Id. at 431.
57. Id. at 660.
59. Id. at 648.
60. Wards Cove Packing Co. v. Atonio, 827 F.2d 439 (9th Cir. 1987).
61. Wards Cove Packing Co., 490 U.S. at 656.
shifts to the employer, yet the employee still bears the burden of disproving the employer's assertion. If business necessity is established, then the employee can still come forward with alternatives that would decrease the discriminatory impact of the employer's practices. The alternatives must be equally effective in achieving the employer's goals in light of the cost of the alternatives and other burdens. The burden of persuasion is, therefore, with the employee in all aspects of a disparate impact challenge.

This overview of Title VII theories reveals that different degrees of justification are required by an employer when charged with a Title VII violation depending on whether the employer's policy is classified as one resulting in "disparate treatment" or "disparate impact." This Title VII framework will now be viewed in the context of employer fetal protection programs. Pre-Pregnancy Discrimination Act fetal protection policies will be overviewed, followed by a discussion of the effect of the Pregnancy Discrimination Act on such policies. The Equal Employment Opportunity Commission's (EEOC's) policies will also be discussed, as these policies have changed with the courts' different rulings.

B. Early Fetal Protection Programs

During the 1970s, as women began to enter traditionally male, unionized, blue collar jobs, many companies established very restrictive fetal protection policies. These policies typically either excluded all women of childbearing capacity from working with reproductive hazards or prohibited specifically defined groups from working with these hazards. The real purpose or basis of these programs has been speculated to be: an employer's altruistic motives to protect the health of the next generation;

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62. Id. at 658.
63. Id. at 660-61.
64. Id.
65. See Becker, supra note 20, at 1225-26. Among the companies with such policies were Olin, American Cyanamid, Allied Chemical, B.F. Goodrich, Monsanto, Sun Oil, Gulf Oil, Union Carbide, General Motors, Delco-Remy, St. Joe's Minerals, Bunker Hill, and ASARCO.
66. See Sherri Evans-Stanton, Gender Specific Regulations in the Chemical Workplace, 27 SANTA CLARA L. REV. 353, 362-63 (1987). See also Ashfort & Caldart supra note 2, at 524, for the definition of a reproductive hazard.
67. See Becker, supra note 20, at 1229.
protection from toxic tort liability claims by the mother and future child; monetary savings from providing insurance coverage to injured fetuses and mothers; and the unwillingness of administrative agencies to act aggressively against reproductive hazards. Commentators have characterized these programs as underinclusive, overinclusive, ineffective, demeaning to women, and not necessarily scientifically sound.

In 1976, the Supreme Court ruled in General Electric Co. v. Gilbert that a company's exclusion of pregnancy from a disability benefits plan is not gender-based discrimination and is, therefore, not protected under Title VII. Congress quickly responded to the Court's interpretation of Title VII by amending it through the enactment of the Pregnancy Discrimination Act. This amendment says that discrimination on the basis of pregnancy is discrimination on the basis of sex, which, in essence, overrules the Court's decision in Gilbert.

C. Fetal Protection Programs Post-Pregnancy Discrimination Act

Since the Pregnancy Discrimination Act was added in 1978, there has been very little case law regarding fetal protection policies. Two major cases have emerged which established some semblance of guidance for the lower courts in International Union, UAW v. Johnson Controls, Inc.

In 1982 the Fourth Circuit, in Wright v. Olin Corp., a case of first impression, found that a company's fetal protection policy excluding females from certain jobs could be upheld under Title VII. The court announced that since the fetal vulnerability

68. See Becker, supra note 20, at 1227-28.
69. See Evans-Stanton, supra note 66, at 361-62.
70. See Ashford & Caldart, supra note 2, at 562.
71. See Evans-Stanton, supra note 66, at 362.
72. See Becker, supra note 20, at 1232-33.
73. See Blanco, supra note 1, at 759.
74. 429 U.S. 125 (1976).
75. Id. at 145-46.
77. Id.
78. 697 F.2d 1172 (4th Cir. 1982).
79. Id.
program did not fit into any appropriate Title VII theory, the disparate impact/business necessity theory was best suited for such cases. It identified the disparate treatment/BFOQ theory as inappropriate because the employer would be unable to assert a defense which it is entitled to present under developed Title VII doctrine.

The Fourth Circuit was faced with defining the business necessity defense in the context of a fetal protection policy. It found that, under such circumstances, there must be a showing that "significant risks of harm to the unborn children of women workers from their exposure during pregnancy to toxic hazards in the workplace make necessary, for the safety of the unborn children, that fertile women workers, though not men workers, be appropriately restricted from exposure to those hazards." This significant risk of harm to the fetus caused by the exposure of fertile women workers must be shown by the employer through independent, objective evidence. The scientific proof necessary to show the risk was not required to be absolute. The employee could then rebut the employer's defense by providing acceptable alternatives to the policy.

Two years later, in Hayes v. Shelby Memorial Hospital, the Eleventh Circuit was confronted with the fetal protection issue. The Hayes court took a slightly different approach than the Fourth Circuit by saying at the outset that there is a presumption of facial discrimination if an employer's policy by its terms applies only to women or pregnant women; pregnancy-based rules can never be neutral. According to the Hayes court, an employer is

80. Id. at 1185.
81. Id. at 1185 n.21.
82. Id. at 1190.
83. Id. The court stated that, with respect to scientific evidence, it suffices to show that within [the] community there is so considerable a body of opinion that significant risk exists, and that it is substantially confined to women workers, that an informed employer could not responsibly fail to act on the assumption that this opinion might be the accurate one.
84. Id. at 1191.
85. Id.
86. 726 F.2d 1543 (11th Cir. 1984). In this case, the hospital did not have a formal fetal protection policy, yet fired an x-ray technician upon learning of her pregnancy.
87. Id.
88. Id. at 1549.
able to rebut this presumption by showing that the policy is facially neutral, that is, that the policy equally protects the offspring of all employees.\textsuperscript{89} If it is not found to be neutral, a BFOQ is the only available defense.\textsuperscript{90} If the policy is neutral, then it is automatically treated as a disparate impact case and will be subject to the business necessity defense as detailed in Wright.\textsuperscript{91} While the court in Hayes found that the hospital's practices violated Title VII, they reiterated that the business necessity defense is a reliable defense to a Title VII attack on fetal protection programs.\textsuperscript{92}

The Equal Employment Opportunity Commission (EEOC), the agency responsible for administering Title VII, issued a policy statement in 1988. This statement in effect endorsed the business necessity approach to fetal protection cases.\textsuperscript{93} It was against this sparse background that the Supreme Court would eventually be confronted with the Johnson Controls case.

III. FACTUAL SUMMATION

A. Facts and Procedure Below

Johnson Controls, Inc. (Johnson Controls) has fourteen battery manufacturing plants in which lead is the principal active material.\textsuperscript{94} The company adopted its current fetal protection policy in 1982 following its determination, based on scientific research, that it was medically necessary to bar women from working in high lead exposure positions in the battery manufacturing division.\textsuperscript{95} A group of employees who had been affected by the policy,

\textsuperscript{89.} Id. at 1548.
\textsuperscript{90.} Id. at 1549.
\textsuperscript{91.} Id. at 1552. See Wright v. Olin Corp., 697 F.2d 1172, 1187-92 (4th Cir. 1982).
\textsuperscript{92.} Id.
\textsuperscript{95.} Id. The policy excluded women capable of bearing children from working in jobs where their blood lead level will rise above 30 micrograms, the critical level noted by the Occupational Safety and Health Administration (OSHA) for a woman who was planning to have a family. See 29 C.F.R. § 1910.1025 (k)(ii) (1990). Under Johnson Controls's policy, women were presumed capable of bearing children until they medically proved to the contrary. Johnson Controls, 680 F. Supp. 309, 310 (E.D. Wis. 1988).
including one male who was denied a request for a leave of absence for the purpose of lowering his lead level because he intended to become a father, brought a class action suit challenging the policy's validity under Title VII.96

The district court reasoned, pursuant to the Hayes v. Shelby Memorial Hospital method of analysis,97 that Johnson Controls's policy was facially neutral, and therefore the company would not be required to prove the demanding BFOQ defense.98 The district court concluded that Johnson Controls successfully rebutted the presumption that their gender-based policy was facially discriminatory.99 The court's first step in making this determination was to evaluate whether Johnson Controls showed the presence of a significant risk of harm to the fetus through women workers exposed to toxic hazards during pregnancy.100 The court held that,

The expert opinions in this case demonstrate that there is a considerable body of opinion which holds that lead is hazardous to the fetus through embryo exposure, and a fetus that is exposed to lead carries the significant risk that the central nervous system will be damaged. Further, a significant opinion exists which holds that the fetus cannot be protected when it is overexposed to lead from the mother’s blood.101

This conclusion was reached after the court carefully evaluated the testimony of numerous experts provided by both parties.102

97. See supra notes 86-92 and accompanying text.
98. 680 F. Supp. at 314-16.
99. Id. at 315.
100. Id.
101. Id.
102. Id. at 310-12. The experts testifying or providing affidavits for this case included: Dr. Anthony R. Scialli (practicing physician and director of the Reproductive Toxicology Center); Dr. J. Julian Chisolm (pediatrician and director of the Lead Program at the John F. Kennedy Institute); Paul B. Hammon (professor of environmental health at the University of Cincinnati); Seymore Legator (professor and director of the Division of Environmental Toxicology); Dr. M. Donel Whortin (occupational physician/epidermologist for a company that conducts research in the areas of occupational and environmental health, and primary medical consultant for a number of companies); Dr. Charles W. Fishburn (physician and assistant clinical professor at the University of Wisconsin, and certified in occupational medicine); Dr. Michael Silverstein (occupational health physician in the Health and Safety Department of the United Auto Workers); Kelly Ann Brix (assistant professor of occupational medicine at the University of Michigan School of Public Health); and Ellen Silbergeld (toxicologist and senior scientist for the Environmental Defense Funds).
The district court’s next step in analyzing the policy’s facial neutrality was to determine whether the hazard applied to offspring of male employees. The experts’ testimony amplifying the effect of lead on male reproductive abilities did not impress the district court. It led the district court to refer to a statement in Hayes that “[i]n those instances in which scientific evidence points to a hazard to women, but no scientific evidence exists regarding men, an employer may be allowed to adopt a suitable policy aimed only at women.” Again relying on the “great body of experts,” the court concluded that “fetuses are subject to a greater risk because the fetuses central nervous system is developing, and further, a fetus could be exposed to lead without the mother’s knowledge.” Thus, the exposure of the developing fetus to lead was the critical inquiry made by the court, not the effects on the reproductive abilities of the male and female workers.

Finally, the district court’s inquiry into the neutral nature of the policy was completed by the fact that the employees challenging the policy had not offered any acceptable alternatives to the policy. The declaration of the policy’s facial neutrality led the court, pursuant to Hayes, to analyze the case under the disparate impact theory, providing business necessity as Johnson Controls’s only defense.

Under the business necessity framework established in Wright v. Olin Corp., the court found that there was a business necessity and general societal interest in protecting fetuses; that the fetus, from exposure to lead, faces a substantial risk of harm; and that this exposure exists only for pregnant women. Since the plaintiffs did not show acceptable alternatives to the policy,

103. Id. at 315.
104. Id. at 317 (citing Hayes v. Shelby Memorial Hosp., 726 F.2d 1543, 1549 (7th Cir. 1984)).
105. Id. at 315.
106. Id. at 316.
107. 697 F.2d 1172 (4th Cir. 1972); see also supra notes 78-85 and accompanying text.
108. This “substantial risk of harm” to the fetus was established by the court in their evaluation of the disparate treatment theory. See supra note 81 and accompanying text. The expert scientific and medical opinions were heavily relied on by the court in meeting the scientific proof standard set out in Wright. Johnson Controls, 680 F. Supp. at 310-12 (citing Wright, 697 F.2d at 1190-91).
the district court granted Johnson Controls's motion for summary judgment, finding no Title VII violation.\textsuperscript{110}

The court's opinion devoted a section to respond to the plaintiff's argument that the United States Environmental Protection Agency (EPA), through the TSCA,\textsuperscript{111} is responsible for protecting society's interest in fetal safety.\textsuperscript{112} They concluded, though, that "because the TSCA is gender neutral, it would fail to protect the fetus which faces a significant risk from lead exposure because male and female are treated equally under the Act."\textsuperscript{113}

On appeal, the Seventh Circuit affirmed the judgment of the district court, approving their analysis under the disparate impact/business necessity theory.\textsuperscript{114} The court of appeals highlighted the efforts and monies spent by Johnson Controls in controlling and regulating lead exposure in their plants.\textsuperscript{115} The justification provided by Johnson Controls for establishing their exclusionary policy was their reliance on persuasive, recent medical research results and consultation with medical and scientific experts.\textsuperscript{116} Johnson Controls reportedly evaluated alternatives prior to instituting the policy at issue in the case,\textsuperscript{117} and found that none of them would sufficiently protect the fetus from lead exposure.\textsuperscript{118}

The parties in this appeal agreed that there was significant evidence in the record to say that lead exposure causes substantial risks to the fetus.\textsuperscript{119} The Seventh Circuit made its own evaluation of the expert opinions presented to the district court and reached the same conclusion:

\begin{itemize}
\item 110. \textit{Id.} at 317.
\item 112. 680 F. Supp. at 317.
\item 113. \textit{Id.}
\item 114. International Union, UAW v. Johnson Controls, 886 F.2d 871, 893 (7th Cir. 1989).
\item 115. \textit{Id.} at 874-76. These efforts included: monitoring employee lead levels; implementing a lead hygiene program, a respiratory program, a biological monitoring program, a medical surveillance program, and a program regulating the type, use and disposal of employee work clothing and footwear to minimize lead exposure; and installing laminar flow pumps, central vacuum systems, and powered floor scrubbers and sweepers to reduce worker lead exposure. \textit{Id.} at 875. Approximately $15 million was reportedly spent by Johnson Controls on environmental engineering controls at the battery plants. \textit{Id.}
\item 116. \textit{Id.} at 876-78.
\item 117. \textit{Id.} at 878. Among these alternatives were: excluding women on a voluntary basis, limiting the exclusion to pregnant women, limiting the exclusion to women planning pregnancy, and measuring lead levels more carefully. \textit{Id.}
\item 118. \textit{Id.}
\item 119. \textit{Id.} at 888.
\end{itemize}
The overwhelming evidence in the record establishes that an unborn child's exposure to lead creates a substantial health risk involving a danger of permanent harm. This evidence clearly approaches a "general consensus within the scientific community," and certainly "suffices to show that within that community there is [a] considerable body of opinion that significant risk exists to the unborn child from the exposure to lead."\(^{120}\)

The appellate court also recognized that OSHA research was consistent with this conclusion.\(^{121}\)

With the "substantial risk" element met, the Seventh Circuit proceeded to find that this risk was confined only to fertile female employees. It pointed out that the plaintiff did not present "any medical evidence of any human study scientifically documenting genetic defects in human beings resulting from male lead exposures"; the animal research evidence on the record was deemed "speculative and unconvincing" at best.\(^{122}\) This lack of sufficient scientific evidence on the record, coupled with the real physical differences between men and women relating to childbearing capacity, allowed the appellate court to conclude that the risk of fetal harm "is confined to fertile female employees."\(^{123}\)

Finally, the employees, as required by the burdens allocated in *Wards Cove Packing Co. v. Atonio*,\(^{124}\) did not even attempt to present adequate alternatives to the policy.\(^{125}\) Having met the Wright business necessity criteria, the court of appeals affirmed that the defense was successfully sustained by Johnson Controls.\(^{126}\) They relied as well on the 1988 EEOC Policy Statement approving of the business necessity defense.\(^{127}\)

After its discussion of approval of the lower court decision, the Seventh Circuit analyzed the case under the BFOQ defense to add weight to its conclusion that the policy should be upheld.\(^{128}\) Using this defense, the court held that health and safety is part of the "essence" of Johnson Controls's business and that the

120. *Id.* at 883 (citing Wright v. Olin Corp., 697 F.2d 1172, 1191 (4th Cir. 1982)).
121. *Id.* at 882.
122. *Id.* at 889.
123. *Id.* at 890.
124. 490 U.S. 642 (1989); see also *supra* notes 56-64 and accompanying text.
125. 886 F.2d at 891 (citing *Wards Cove*, 490 U.S. 642, 660 (1989)).
126. *Id.* at 893.
127. *Id.* at 885-86 (citing *Policy Statement, supra* note 93).
128. *Id.* at 893.
policy is "directly related" to industrial safety.\textsuperscript{129} Therefore, according to the Seventh Circuit, the policy was not only lawful under the business necessity defense, but also survived the more stringent BFOQ defense.\textsuperscript{130} With this decision, the Seventh Circuit was the first court of appeals to hold that "a fetal protection policy directed exclusively at women could qualify as a BFOQ."\textsuperscript{131}

It is interesting to note that, in response to this court's decision, the EEOC, on January 24, 1990, issued a new policy guidance stating that the BFOQ defense is now the better approach for addressing facially discriminatory fetal protection policies.\textsuperscript{132} In July of 1990 the Sixth Circuit in \textit{Grant v. General Motors Corp.}\textsuperscript{133} followed these new EEOC guidelines and applied the BFOQ defense.\textsuperscript{134} The \textit{Grant} court did recognize, however, that an inordinate risk to the fetus could qualify as a BFOQ.\textsuperscript{135}

\textbf{B. The Court's Decision}

With the grant of certiorari,\textsuperscript{136} the Supreme Court decided to confront the issue of whether an employer, seeking to protect potential fetuses, may discriminate against women simply because of their ability to become pregnant. The Court, unanimous in its judgment, flatly rejected the reasoning of both lower courts and reversed their summary judgment award to Johnson Controls.\textsuperscript{137} The Court held that Title VII explicitly forbids sex-specific fetal protection policies such as the one established by Johnson Con-

\textsuperscript{129} \textit{Id.} at 896 (citing \textit{Torres v. Wisconsin Dep't of Health & Social Servs.}, 859 F.2d 1523, 1530 (7th Cir. 1988), citing \textit{Dothard v. Rawlinson}, 433 U.S. 321, 333 (1977)).

\textsuperscript{130} \textit{Id.} at 901.


\textsuperscript{133} 908 F.2d 1303 (6th Cir. 1990).

\textsuperscript{134} \textit{Id.} at 1310-11. Female employees brought a Title VII challenge against the employer's fetal protection policy excluding all fertile women employees from jobs involving exposure to specified concentrations of airborne lead. The Sixth Circuit agreed with the dissenting opinions in \textit{Johnson Controls}, 886 F.2d 871, 901-21 (7th Cir. 1989), that such policies can only be defended under the BFOQ standard. \textit{Grant}, 908 F.2d at 1310. The \textit{Grant} court would allow an employer the opportunity to prove the BFOQ safety exception, recognizing that the unconceived fetus can qualify as a third party warranting safety protection. \textit{Id.} at 1311.

\textsuperscript{135} \textit{Id.} at 1311 (citing \textit{Johnson Controls}, 886 F.2d at 902 n.1 (Cudahy, J., dissenting)).

\textsuperscript{136} 110 S. Ct. 1522 (1990).

controls.\textsuperscript{138} Since the company's policy used the words "capable of bearing children" as the criterion for exclusion, it plainly classified on the basis of potential for pregnancy.\textsuperscript{139} It therefore could not, even with a "malevolent motive," be classified as neutral.\textsuperscript{140}

The only possible defense available to Johnson Controls's facially discriminatory policy, then, was a BFOQ.\textsuperscript{141} Justice Blackmun, in writing the opinion for the Court, acknowledged the narrowness of the BFOQ exception.\textsuperscript{142} The majority held that the employer may not discriminate based on a woman's capacity to become pregnant unless it prevents her from safely and efficiently performing activities which are within the "essence" of the particular business.\textsuperscript{143} Johnson Controls's policy failed to constitute a BFOQ because fertile women participate in the manufacture of batteries as efficiently as anyone else; concerns about the next generation were held to not be part of the "essence" of battery manufacturing.\textsuperscript{144}

The Court also concluded that "Johnson Controls is concerned about a small minority of women,"\textsuperscript{145} and therefore did not meet the \textit{Weeks v. Southern Bell Telephone & Telegraph Co.}\textsuperscript{146} requirement that "all or substantially all" women would be unable to perform the duties of the job.\textsuperscript{147} In response to Johnson Controls's contention that the policy qualifies as a safety exception to this element of the BFOQ, the Court held that the exception does not apply.\textsuperscript{148} After discussing the various cases where safety exceptions were recognized,\textsuperscript{149} the Court concluded that the exception

\begin{itemize}
  \item \textsuperscript{138} \textit{Id.} at 1209-10.
  \item \textsuperscript{139} \textit{Id.} at 1203.
  \item \textsuperscript{140} \textit{Id.} at 1203-04.
  \item \textsuperscript{141} \textit{Id.} at 1204.
  \item \textsuperscript{142} \textit{Id.} (citing \textit{Dothard}, 433 U.S. 321, 332-37 (1977)). As additional support for his narrow reading of the BFOQ, Justice Blackmun focused on the word "occupational" in the wording of Title VII. The Court interpreted Congress' use of this word as indicating that the objective requirements of the employer must concern job-related skills and aptitudes. \textit{Id.} "By modifying 'qualification' with 'occupational,' Congress narrowed the term to qualifications that affect an employee's ability to do the job." \textit{Id.} at 1205.
  \item \textsuperscript{143} \textit{Id.} at 1207.
  \item \textsuperscript{144} \textit{Id.}
  \item \textsuperscript{145} \textit{Id.} at 1208.
  \item \textsuperscript{146} 408 F.2d 228 (5th Cir. 1969).
  \item \textsuperscript{147} \textit{Johnson Controls}, 111 S. Ct. at 1208 (citing \textit{Weeks v. Southern Bell Tel. & Tel. Co.}, 408 P.2d 228, 235 (5th Cir. 1969)).
  \item \textsuperscript{148} \textit{Id.} at 1205.
  \item \textsuperscript{149} \textit{Id.} at 1205-06. \textit{See also supra} notes 38-40 and accompanying text.
\end{itemize}
to the BFOQ was limited to cases where sex or pregnancy actually interferes with an employee's ability to perform the job. Special safety standards for pregnant or fertile women would not be permitted under Title VII.

Legislative history of the Pregnancy Discrimination Act was also relied on to justify not expanding the BFOQ to allow fetal protection policies. Justice Blackmun opined that this decision manifests Congress' intent in amending Title VII with the Pregnancy Discrimination Act, by leaving decisions about the welfare of future children to the parents who conceive, bear, support, and raise them, and by letting women choose the relative importance of their reproductive and economic roles.

Threats of potential tort liability for a prenatal injury based on either negligence or wrongful death were briefly mentioned in the Court's opinion. These threats were disregarded essentially as non-issues, in part because Johnson Controls did not sufficiently set forth the argument.

The Court gave little, if any, emphasis to the medical and scientific evidence that was so heavily relied on by the lower courts. The Court did reference the OSHA lead standards, stating that a company's compliance with these standards, coupled with fully informing women of the dangers and acting non-negligently, would make successful toxic tort claims "remote at best." Although not argued by Johnson Controls, the Court also articulated the principle that federal law (Title VII) preempts state law (state tort liability) if a conflict between them should arise. Thus, if a state tort law furthers discrimination in the workplace in violation of Title VII, the Title VII result would prevail.

There were concurring opinions written by Justice White and Justice Scalia. Justice White voiced concern about the

150. Johnson Controls, 111 S. Ct. at 1206.
151. Id.
152. Id. at 1206-07.
153. Id. at 1207.
154. Id. at 1210.
155. Id. at 1208-09.
156. Id.
157. Id. at 1208.
158. Id.
159. Id. at 1209.
160. Id.
161. Id. at 1210.
162. Id.
extremely narrow interpretation given the BFOQ defense by the majority.\textsuperscript{163} He expressed that potential tort liability could constitute a BFOQ defense;\textsuperscript{164} after all, in \textit{Dothard} the court included safety to third parties in the "essence" of a job.\textsuperscript{165} Justice Scalia's concurrence, at the other extreme, proposed a much stricter BFOQ analysis that would disregard all scientific data as irrelevant, since the facial classification overtly violated Title VII.\textsuperscript{166}

\section*{IV. ANALYSIS}

The Supreme Court's decision in \textit{Johnson Controls} clearly states that sex-based fetal protection policies violate Title VII. According to the opinion, they will only be tolerated in the most extreme instances where the condition of pregnancy actually interferes with the mechanics of performing a job.\textsuperscript{167} Working in areas having lead exposure scientifically proven to cause fetal harm does not "actually" interfere with the "essence" of the job as defined by the Court.\textsuperscript{168} This holding, coupled with the Court's recognition that an unconceived fetus does not qualify as a third party warranting safety considerations,\textsuperscript{169} makes the outlook for any scientifically sound fetal protection policy appear bleak.

This decision replaces the business necessity standard analysis of fetal protection policies utilized by the Fourth, Eleventh, and Seventh Circuits\textsuperscript{170} with a more difficult BFOQ test. A BFOQ is a strong barrier for employers to overcome. As an alternative to such a policy, the \textit{Johnson Controls} Court suggested that a policy based on fertility alone, and not just gender and childbearing capacity, would be permitted under Title VII.\textsuperscript{171} This suggestion, though, does little more than provide a neutral, overinclusive warning which may have no scientific justification.

\begin{footnotesize}
\begin{itemize}
  \item 163. \textit{Id.}
  \item 164. \textit{Id.}
  \item 165. \textit{Id.} at 1213 n.5.
  \item 166. \textit{Id.} at 1216.
  \item 167. \textit{Id.} at 1210.
  \item 168. \textit{Id.} at 1205-07.
  \item 169. \textit{Id.} at 1206.
  \item 170. \textit{See} Wright v. Olin Corp., 697 F.2d 1172 (4th Cir. 1982); Hayes v. Shelby Memorial Hosp., 726 F.2d 1543 (11th Cir. 1984); International Union, UAW v. Johnson Controls, Inc., 886 F.2d 871 (7th Cir. 1989).
  \item 171. 111 S. Ct. at 1203.
\end{itemize}
\end{footnotesize}
The Court referenced the evidence from the district court discussing the effect of lead on the male reproductive system, yet did not give deference to the district court's weighing of this evidence in their summary judgment decree.\footnote{172}

With the Supreme Court's holding in \textit{Johnson Controls}, a company is not even permitted to establish gender-specific policies which are based on conclusive evidence showing reproductive hazards to fetuses through the mother alone. This is evidenced by the Court's clear statement that Title VII forbids sex-specific fetal protection policies.\footnote{173} By not recognizing the unborn fetus as a third party warranting protection,\footnote{174} it appears that no amount of scientific evidence will be able to overcome the BFOQ standard the Court has set forth. Justice White's concurrence posits a broader, more realistic, interpretation of the BFOQ; that an employer's showing that a policy of exclusion was reasonably necessary to avoid substantial tort liability should be able to qualify as a BFOQ.\footnote{175} If an employer has gathered enough data to show that a workplace hazard affects the reproductive potential of only men or only women or only the developing fetus, should they not be able to construct their policies upon that knowledge with the ability to rely on a BFOQ?

With regard to potential tort liability, the majority indicated that, absent an employer's negligence, complying with OSHA standards and warning employees of potential hazards should be sufficient to protect the fetus and to protect the employer from tort liability.\footnote{176} The speculative nature of this message to employers was recognized and contested by Justice White in his concurrence.\footnote{177} He articulated four basic reasons for disagreeing with the majority's treatment of potential tort liability.

First, Justice White found it unclear that compliance with Title VII will preempt state tort liability.\footnote{178} Second, warnings by em-

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\begin{itemize}
\item \footnote{172. Id.}
\item \footnote{173. Id. at 1209-10.}
\item \footnote{174. Id. at 1206.}
\item \footnote{175. Id. at 1210. Justice White relied on Dothard v. Rawlinson, 433 U.S. 321 (1977), and Western Air Lines, Inc. v. Criewell, 472 U.S. 400 (1985), for the argument that "safety risks to third parties is [sic] inherently part of both an employee's ability to perform a job and an employer's 'normal operation' of its business." 111 S. Ct. at 1213.}
\item \footnote{176. Id. at 1208.}
\item \footnote{177. Id. at 1211.}
\item \footnote{178. See id. at 1211 n.2.}
\end{itemize}
ployers will not necessarily preclude claims by injured children. This is so because of the general rule that parents cannot waive causes of action on behalf of their children, and parents' negligence will not be imputed to their children. Third, employers will have difficulty determining in advance what will be considered negligence for prenatal injuries, especially since compliance with OSHA standards has been held not to be a defense to state tort or criminal liability. Finally, employers could be strictly liable if their manufacturing process is considered "abnormally dangerous," thereby not precluding potential tort claims. With all of these possible implications, the prospect of tort liability, which was dismissed by the Court as being insignificant, may not, in reality, be so insignificant.

In light of this ban on gender-based fetal protection policies by the Court, two extreme consequences of this decision can be hypothesized. Industrial enterprises could respond by being more protective and eliminating all workplace reproductive hazards in order to avoid future tort liability. Or, industrial enterprises could place total reliance on OSHA and EPA regulations to provide sufficient protection to their employees.

Overprotectiveness in order to be "altruistic" and avoid discriminating on the basis of sex could prove to be the last act of a successful company. The likelihood and practicality of this type of program is next to impossible, since it is not likely to be economically or technically feasible to eliminate all industrial hazards. It is not at all obvious that Congress intended such an inflexible application of Title VII which could potentially have such a harsh impact on business.

More likely, though, the Court is sending a message to Congress and the regulatory agencies; their workplace standards and regulations must acknowledge that unborn fetuses are ever-present in the workplace, and safety and health standards must be established accordingly. In the wake of this decision, Title VII is not going to allow any gender-based fetal protection policies,

179. See id. at 1211 n.3.
180. Id.
181. Id. at 1211 (referencing National Solid Wastes Management Ass'n v. Killian, 918 F.2d 671, 680 n.9 (7th Cir. 1990), and 29 U.S.C. § 653(b)(4) (1970)).
182. Id. (referencing RESTATEMENT (SECOND) OF TORTS § 869 cmt. b (1979)).
183. See Evans-Stanton, supra note 66, at 367.
even if established under solid scientific proof. We must now wait and see if Congress will remedy the problem, because by its opinion the Supreme Court does not think it should be involved in the matter.

Administrative agencies such as EEOC and EPA may be the appropriate experts to address protection of the unborn fetus. Yet such an ambiguous message from the Court to these agencies to establish that level of protection raises a concern that no one will affirmatively address the issue. The Court said that employers cannot discriminate on the basis of gender to prevent risk of harm to the fetus. The fact that the Court does not deem the courtroom an appropriate arena for debate among scientific experts over reproductive hazards to men, women, and fetuses is evident by its refusal to allow scientific findings to justify BFOQ defenses, even in the context of safety to third parties. What is not evident from the decision is what arena is appropriate. Unless someone, either Congress or an administrative agency, actively establishes and enforces regulations protecting men and women from reproductive hazards, the fate of the unborn fetus could be dismal.

V. CONCLUSION

The paramount significance of allowing a woman to decide her employment and reproductive future was manifestly expressed by Congress when it enacted Title VII and amended it with the Pregnancy Discrimination Act. Prior to the Supreme Court's Johnson Controls decision, the circuit courts analyzed fetal protection cases on the basis of business necessity, finding that this sufficiently balanced the interests of the employer, the employee, and the unborn child in a manner consistent with Title VII. The United States Supreme Court, in Johnson Controls, rejected this method of analysis and held that such facially discriminatory policies could only be upheld under the BFOQ defense, a much more difficult hurdle for an employer to jump.

Title VII will not tolerate gender-based fetal protection policies. The Court is transmitting a strong message to someone, either

Congress, OSHA, EPA, or the general scientific community, that it is their responsibility to establish protection from reproductive hazards for males, females, and fetuses, and that it is not the responsibility of employers with exclusionary fetal protection policies. The Johnson Controls decision tells employers what their limits are with respect to such policies, and leaves unsaid precisely whose role it is to protect the next generation from reproductive hazards. So, when confronted with the question, "Can science ever justify gender discrimination?," an employer must answer that his science cannot justify it, but the science of OSHA, EPA, et cetera, may possibly protect the next generation. We can only hope that it will.
BOOK REVIEW

Vultures: Doctors, Lawyers, Hospitals, and Insurance Companies: What’s Wrong, and What to Do About It
by Farid A. Khavari, Ph.D.

Reviewed by Glenn P. Fette

I. INTRODUCTION

There are certain instances each of us will always remember. A lesson for me came early in my legal education, when two young men were senselessly killed in a bizarre accident. The victims' names and faces were displayed daily in all the local newspapers. The firm, where I worked as a law clerk, was representing the decedents' estates and families. I was asked to prepare the initial probate forms which required signatures from various family members of the victims. The misery and despair on the faces of the people with whom I met were unmistakable, and I could only hope that my discomfort with the situation was not so obvious.

Suddenly, I found myself thrust into one of the most personal and intimate of all family affairs: the tragic death of a child. Names and faces which had been mere newspaper clippings on my desk were now staring back at me, and all I could muster were the usual condolences and, of course, my request for their signatures, in triplicate. My uneasiness came not only from the their despair and misery, but also from the fact that from their misery would come the firm's prosperity. They knew it, and I had always known it. Until staring into their faces, though, it had never been quite so clear or quite so disturbing.

II. REVIEW

For this reader, Farid Khavari's Vultures: Doctors, Lawyers, Hospitals, and Insurance Companies: What's Wrong and What to

1. Khavari is an economist who lives in Miami, Florida.
Do About It\(^2\) rings true. While this book must be read in light of the strong but justifiable bitterness that Khavari admittedly possesses, it portrays a reality that is not at all pleasant to contemplate but which must be acknowledged. Khavari wrote his book to alarm us.\(^3\)

The book begins with a tragic automobile accident in which Khavari and his wife Louise were critically injured. Khavari's best friend and business partner, Ed, who was also in the car, was killed instantly. "Ed was the lucky one."\(^4\) The car accident, however, was just the beginning. Because Khavari had just begun a business and was without insurance, he and his wife lay in a hospital corridor bleeding severely for over three hours until his brother arrived to sign a payment guarantee. The following days presented an array of doctors, all of whom charged a considerable sum for not much more than assurances that the two were under the best possible care. Those initial days also saw the first of many attorneys who were about to become a permanent part of Khavari's life. Khavari was shocked when he was required to sign a contract promising to pay his attorney one-third of the money he received from his own automobile insurance company.\(^5\) This, he soon learned, was just the beginning.

His wife Louise had broken her nose, cheeks, palate, jaw, chin and various other facial bones.\(^6\) She required a series of reconstructive surgeries. Her second surgery required her nose to be packed with vaseline covered gauze and her mouth to be wired shut.\(^7\) Unfortunately, her surgeons forgot to provide her with an airway through which to breathe.\(^8\) While she lay in her room after a premature discharge from the post-operative ward, she suffered cardiac arrest and irreversible brain damage from lack of oxygen.\(^9\) There were also problems with the dosage of Fentanyl\(^{10}\)

\(^2\) FARID A. KHAVARI, PH.D., VULTURES: DOCTORS, LAWYERS, HOSPITALS AND INSURANCE COMPANIES: WHAT'S WRONG AND WHAT TO DO ABOUT IT (1990) [hereinafter cited as VULTURES].
\(^3\) VULTURES, at IX.
\(^4\) Id. at 7.
\(^5\) Id. at 9.
\(^6\) Id. at 8.
\(^7\) Id. at 23.
\(^8\) Id.
\(^9\) Id. at 13-16.
\(^10\) A drug used to anesthetize patients during surgery. Louise was given 800 micrograms where 200 micrograms would have sufficed.
given to Louise to anesthetize her. While Khavari watched his wife struggle to breathe, it took three nurses and thirty minutes before a "code blue" was called to indicate there was an emergency. The "code blue" was called too late; Louise died.

The rest of the book focuses on Khavari's dealings with the "vultures," and the medical malpractice suit he filed. The "vultures" were the doctors, lawyers, hospitals and insurance companies which preyed upon Khavari and his wife from the time of the accident. The dealings and treatments by each were reprehensible, yet almost predictable because the "system" was, and still is, tolerated.

Khavari writes on how the "system" forced him to continually relive his tragedy. His view as a victim of the system is unique. He sat in on every deposition taken, and with each one was forced to remember the senseless death of his wife. At the same time he became friends with his attorney, and the two often had dinner together. On his birthday, he was treated to a $160 lunch by his attorney. Throughout the process, he was continuously amazed at the amount of money being generated and spent from what began as a one car accident.

Ultimately, after one year and two months of discovery and after waiting for a trial date, Khavari's case was settled for $755,000, a record amount for an out-of-court settlement at the time. After costs, Khavari walked away with approximately $400,000 while his lawyers took $300,000. He realized that justice was only measured in dollars, and that there was no real justice. No doctors had lost their licenses or hospital privileges, no nurses were fired, the insurance companies made money by stalling to pay the money they owed him and collecting interest off the capital, and his own attorneys ran up his expenses with $500 dinners. Yes, even his $160 birthday lunch was included on his bill. He ultimately concluded that, although he had technically "won," there is no winning in the world of the "vultures." He was left with $400,000 for the loss of his wife, and a disdain for

11. VULTURES, at 14.
12. Id. at 15.
13. Id. at 148.
14. Id. at 150.
15. Khavari believed it was cheaper for the insurance companies to pay lawyers to fight him for a year than to settle because of the interest they could earn off of the $755,000 in capital that was ultimately paid. Id. at 206.
the "system." But his experiences also inspired some innovative and thought-provoking suggestions on how the "system" could be improved.

Khavari first asserts that, unless changes are made, modern medicine will ultimately destroy the economy, if it does not kill us first. To support this premise, the book is filled with alarming statistics concerning the medical profession. For example, Khavari states that "six percent of hospital patients get hospital-induced infections, which are often drug resistant, and 20,000 to 80,000 people die from these infections each year in the United States." Still more alarming is that hospitals only operate at sixty-five percent of capacity, and Khavari believes that "every empty hospital bed is a potential disaster just looking for someone to happen to."

The book is even more critical of lawyers, who, according to Khavari, "are the Vultures who most purely epitomize the species." Yet, Khavari acknowledges that without the contingency fee arrangements used by plaintiffs' attorneys, very little litigation could be brought at all. Defense lawyers, on the other hand, since they get paid by the hour, essentially win their case as soon as it is filed. They have little motivation to settle a case, since the more complex and lengthy the litigation, the more money the defense attorney will make. In short, Khavari views attorneys as individuals who thrive on conflict, suffering and

16. "Estimates from such conservative sources as a congressional subcommittee say that 2.4 to 3 million unnecessary operations are performed each year." Id. at 163.
17. Id. at 161-81.
18. Id. at 177.
19. Id.
20. Khavari ranks attorneys (vultures) on a scale from "Hatchlings," young attorneys learning the system, to "Golden Beaks," premier plaintiffs' attorneys who work on a contingency fee basis. Khavari's attorney worked on a contingency fee basis. Khavari considered his counsel as belonging to the "coveted Order of the Golden Beak."
"Silver Beak" attorneys are high priced defense attorneys; they typically go up against "Golden Beak" attorneys but are ranked lower because they do not make as much money. "Brass Beak" attorneys are not of the prominence of other attorneys, but they make up for their shortcomings in volume. A "Brass Beak" attorney, for example, would advertise and handle a very large caseload. Khavari notes, "many aspire, but few achieve, membership in the coveted Order of the Golden Beak." Id. at 189.
21. Id. at 183.
22. Id. at 185.
23. Id.
misery. Worst of all, they are regulated only by the American Bar Association — more attorneys.24

Insurance companies fare no better under Khavari's sharp criticism. "Insurance companies are an essential part of the Vulture Crises, because they are the reservoirs of money which are tapped by the process."25 According to Khavari, insurance companies are not losing money as they claim, but rather making billions of dollars each year from corporate investments. In other words, Khavari asserts that the American public is not being told the truth and, in fact, is being led astray by the insurance companies.26

While perhaps most of Khavari's criticisms are nothing new, his suggestions for improvements are interesting and noteworthy. He proposes what he calls the "McDonaldization" of health care.27 He advocates a health care delivery system where the product (health care) is consistent, the procedures structured and efficient, the facilities clean, and each individual outlet profitable.28 He calls his proposed enterprise General Health Care (GHC), but is quick to point out that he does not favor socialized medicine and that each "outlet" would be privately owned.29

To begin, GHC would assemble a board of practitioners from every field of health care and write a book establishing detailed standards of care that each GHC outlet would maintain.30 Khavari believes the following principles should be followed to ensure the quality of health care: it must be of the highest standards possible given the state of the art today with emphasis on preventative care; it must be provided at the lowest possible cost; it must be easily accessible and convenient; and it must be provided through doctors and other personnel that are salaried with a profit sharing bonus.31

24. Id. at 190.
25. Id. at 201.
26. Insurance companies continuously raise premiums for, among other reasons, the so-called litigation explosion. However, although tort/malpractice lawsuits have increased, once adjusted for population growth, the increase is less than three percent. Id. at 207. And, although the average verdict has increased significantly, that statistic is skewed by a few spectacular awards, and the median verdict has increased only slightly. Id.
27. Id. at 240.
28. Id.
29. Id. at 238.
30. Id. at 241.
31. Id. at 241-42.
Once GHC prototypes were operating successfully in a variety of demographic circumstances, franchises would be offered nationwide.\textsuperscript{32} GHC would initially accept current health care insurance plans, but would ultimately offer its own monthly payment plan directly to the public.\textsuperscript{33} Costs would be further reduced by patients agreeing, at the time of enrollment, to submit any malpractice claims to independent arbitration and to accept prescribed limitations on damages.\textsuperscript{34} "GHC would make safe and affordable health care accessible to everyone, drastically reduce costs in the present, and hold them down in the future."\textsuperscript{35} Khavari estimates this system would take $100 million to implement and take about a decade to be established nationwide.\textsuperscript{36} He does not, however, state how he arrived at these estimations.

Until the GHC program could be implemented, Khavari would utilize remedial measures which have been previously considered. For example, in order to cut down on neglect and malpractice, he suggests improving the working conditions, treatment, and salaries of nurses. He believes that nurses are greatly underpaid and overworked, which leads to negligent mistakes.\textsuperscript{37} Additionally, in his view, doctors should be salaried and not paid on a fee-for-service basis, since this leads to needless testing and operating. Finally, he would also require that hospitals be limited to a fixed charge and that they be required to disclose prior and pending malpractice complaints.\textsuperscript{38}

Lawyers, according to Khavari, should be regulated by reducing contingency fee percentages and adopting a sliding scale concept for contingency fees.\textsuperscript{39} Defense lawyers should also have their fees reduced. The incentive to stall cases would be removed by requiring insurance companies represented by defense attorneys to pay interest at one percent over prime rate on any awards ultimately obtained by the plaintiff. This interest would

\begin{enumerate}
\item \textit{Id.} at 242.
\item \textit{Id.}
\item \textit{Id.}
\item \textit{Id.} at 243.
\item \textit{Id.} at 241-43.
\item \textit{Id.} at 242-43.
\item \textit{Id.} at 244.
\item \textit{Id.} at 245. For example, the lawyer would get forty percent of the first $50,000 collected, one-third of the next $50,000, one-fourth of the second $100,000, and ten percent of anything over this sum.
\end{enumerate}
be calculated from one month after the claim is filed.\textsuperscript{40} His additional suggestions include the traditional loser-pays-fee concept, a structured system of compensation, and monetary limits on awards for pain and suffering.\textsuperscript{41} Khavari advocates that increased regulation of the insurance industry is also warranted. He opines that insurance companies should be prohibited from making risky investments with corporate cash, insuring bad doctors, and doing business with hospitals that overcharge.\textsuperscript{42}

While all of Khavari's interim ideas are good ones, most are not realistic. There have been no voluntary changes to date, and it is difficult to believe there will be any in the future. Mandatory imposition of his suggestions by the state or federal government would create administrative burdens and certainly invoke vehement opposition from the legal, medical and insurance communities. The General Health Care concept, though, has merit or is at least worthy of further thought considering the current national attention given to the inability of many citizens to obtain affordable health care.\textsuperscript{43} If prototype outlets could prove profitable, it is not unrealistic to believe that this approach is the answer to our current crises. The plan is innovative and perhaps worthy of further development.

\textbf{III. CONCLUSION}

The lesson I mentioned earlier at the beginning of this review was one that came quickly and awkwardly. There are many lessons to be learned by reading Khavari's book, most importantly, that active reform of the current system is preferable to its inevitable self-collapse.

\textsuperscript{40} Id. at 245.
\textsuperscript{41} Id. at 247-49.
\textsuperscript{42} Id. at 249-50.
\textsuperscript{43} The national preoccupation with and attention to the health care issue is evidenced by the February 6, 1992, announcement by President Bush of his plan to provide Americans with affordable and accessible health care.