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FOREWORD

Law Review service constitutes an extremely unique and unparalleled opportunity. Nowhere else in the world is the task of gathering, assembling and disseminating critical scholarly material vested exclusively in the hands of students. In a wholly independent student-run publication, such as the Northern Kentucky Law Review, editorial judgments as to the quality, form and content of the work of scholars are made entirely by student editors. In many ways this represents the perfect irony.

The value of the Law Review is often understated. It enables students to develop skills, such as discipline, craftsmanship, critical analysis, clarity and precision, all of which are requisite to future success in the legal profession. Law Review, as it attempts to achieve a balance between the academic and pragmatic, provides the Bar with an invaluable source of information. Furthermore, Law Review serves as a beacon to the legal and judicial communities, bringing to light newly developing theories and changes within the law and their effect on our ever mutable society. This continuing commitment to the promotion of such legal scholarship through publication fulfills a vital and necessary role in the evolution of jurisprudence.

The student serving as members of Law Review bear a particularly heavy burden. It is they who are responsible for setting a standard of intellectual scholarship and industry for the entire student body. Moreover, of all those trained in the law, it is the students who are shackled the least by the rigors and responsibilities commonly associated with courtroom, classroom and clientele. Thus, the duty befalls them to maintain a level of intellectual detachment and disinterestedness in their appraisal and analysis of the structure, integrity and social responsiveness of the legal system under which we live, and upon which future society, order and progress all depend. As members of the law review, it is our duty to understand and perform this small yet special role we play in the service of law and society.

This edition marks the Silver Anniversary of the Northern Kentucky Law Review. For twenty-five years members of this legal periodical have

3. Id.
4. Id.
5. Id.
excelled in fulfilling their obligation to school, community and one another. They have, with great diligence, discharged each of those aforementioned duties, inherent in their association with the Law Review. I have every confidence that the Northern Kentucky Law Review will continue to strive for legal excellence, remaining true to its tradition and to those who have worked so hard to make the Law Review what it is today.

In recognition of twenty-five years of growth, development and continued excellence, the 1998 Editorial Board and Staff would like to honor all those members who have, in some way, contributed to the success of the Northern Kentucky Law Review. We thank you.

Jeffrey M. Hines
Healthcare Issue Editor
Northern Kentucky Law Review
ARTICLES

THE RIGHT TO REFUSE MEDICAL TREATMENT
WHERE THERE IS A RIGHT, THERE OUGHT TO BE A REMEDY

by S. Elizabeth Wilborn

Edward Winter saw his wife suffer through a prolonged terminal illness, and was particularly upset by the intrusiveness of the efforts to keep her alive in the end. He determined not to go through the same experience himself, and gave written instructions to his physician to that effect. Incredibly, Mr. Winter experienced the exact same treatment as his wife. His estate sought compensation for his suffering, but the Ohio Supreme Court held that Mr. Winter had no recourse, because life, even an undesired extension thereof, is not a compensable injury. 2

This scenario is likely to occur more frequently in the future as advanced medical technology has increased dramatically the average life expectancy. 3 Today, medical technology has made it possible for people to live longer than ever. 4 Although modern medicine has successfully permitted individuals to survive what were previously fatal diseases, it often does not cure many chronic and degenerative illnesses entirely, and consequently does not return the individual to a fully functioning life. 5 As

1. Assistant Professor, University of Cincinnati College of Law. J.D. Duke University 1991. I am grateful for the invaluable assistance of Matthew Malloy, Esq., and for the helpful contributions of Amy Hale Mitchell.
5. As Justice Scalia stated, The timing of death -- once a matter of fate -- is now a matter of human choice. Of the approximately two million people who die each year, eighty percent die in hospitals and long-term care institutions, perhaps seventy percent of those after a decision to forego life-sustaining treatment has been made. Nearly every death involves a decision whether to undertake some medical procedure that could prolong
a result, many patients have found their physical and psychological existence to be unsatisfactory. Beginning in the 1970s, some began to assert a right to refuse treatment, to allow them to die a natural death without undue dependence on medical technology -- the right to "die with dignity." Since that time, a legal consensus has developed that competent patients and the legal surrogates of incompetent parents have a right to refuse medical treatment.

As the right to refuse treatment has gained in acceptance and notoriety, more individuals have begun to exercise this right. Considerable evidence indicates, however, that a gap exists between the individual's right to refuse medical treatment and the actual practice of physicians. The evidence suggests that many physicians still consider it to prolong life at any cost in the best interest of the patient. The fear of liability and the process of dying.


6. Both public opinion polls and scientific studies show that many people prefer not to be placed on life-support systems. James Lindgren, Death by Default, LAW & CONTEMP. PROBS., Summer 1993, at 185, 197-99 (reviewing over 200 questions from public opinion polls conducted between 1973 and 1991).


9. See Robert L. Jayes et al., Do-Not-Resuscitate Orders in Intensive Care Units: Current Practices and Recent Changes, 270 JAMA 2213, 2215 (1993) (discussing the increases in the frequency of do not resuscitate orders); see also Areen, supra note 7, at 449 (commenting that the emergence of a patient's rights movement over the past few decades has reduced the traditional autonomy of the medical profession). A recent study reported that, from 1988 to 1990, almost twice as many intensive care unit patients had DNR orders as did patients from 1979 to 1982.


availability of new technology also play a role,\textsuperscript{12} driving some physicians to employ advanced procedures to the fullest extent possible.\textsuperscript{13}

Due to the failure of the medical profession to honor the right to refuse medical treatment, several patients and their estates have filed complaints, alleging that patients who received this unwanted life-sustaining treatment suffered a compensable injury.\textsuperscript{14} In a recent case, an estate filed an action based on the tort theories of battery, negligence and wrongful living in \textit{Anderson v. St. Francis-St. George Hospital}.\textsuperscript{15} The cause of action essentially claimed that the patient suffered a diminished quality of life during and after receiving treatment which contravened his decision to forego lifesaving medical care.\textsuperscript{16} The Ohio Supreme Court held that the decedent had not suffered any injury or damages due to from the health care provider's failure to abide by his wishes.\textsuperscript{17}

Like the \textit{Anderson} court, other courts have refused to permit recovery for violation of the right to refuse treatment, and many often do not even permit such cases to proceed. Current jurisprudence tends to focus on metaphysical notions concerning life and death and fails to provide a remedy because of a fear that to do so will require a balancing of the value of life and death. The courts emphasize traditional tort rules that make sense only when applied to the living. Failure to respect the right can have an impact beyond the patient, as heroic lifesaving measures often carry severe economic consequences for the patients family and estate.

\textsuperscript{12} See Marion Danis et al., \textit{A Prospective Study of Advance Directives for Life-Sustaining Care}, 324 NEW ENGL. J. MED. 882, 887 (1991). An advance directive study tried to discover why living wills are sometimes disregarded by physicians. \textit{See id.} at 882-87. Researchers concluded that physicians override advance directives when they disagree with the patient's choices and feel that the undesired treatment is appropriate. \textit{Id.}

\textsuperscript{13} \textit{See, e.g.}, D. Callahan, \textit{Setting Limits: Medical Goals in an Aging Society} 1-62 (1987).


\textsuperscript{16} \textit{Id.} at 227-229.

\textsuperscript{17} \textit{Id.} at 229. For a further discussion of the difficulties plaintiffs have had asserting their various causes of action for a violation of the right to refuse treatment, \textit{see} M. Rose Gasner, \textit{Financial Penalties for Failing to Honor Patient Wishes to Refuse Treatment,} 11 ST. LOUIS U. PUB. L. REV. 499, 504-12 (1992) (discussing theories advanced in cases seeking damages for failure to honor patients' refusal of treatment); Steven I. Addestone, \textit{Note, Liability for Improper Maintenance of Life Support: Balancing Patient and Physician Autonomy,} 46 VAND. L. REV 1255, 1267-73 (1993) (same).
Despite this unwillingness of the courts to honor the right, the number of lawsuits filed for failure to recognize an individual's right to refuse medical treatment will likely increase. The growing popularity of living wills, durable powers of attorney, and other instruments memorializing patients' wishes to refuse treatment, will pressure courts to craft a remedy for the violation of this important right. Failure to do so will ensure the right to refuse treatment remains a nullity.

This article argues that legislatures and courts should recognize a cause of action and a remedy for violation of this important right. In making this argument, the article first highlights the importance of individual autonomy in making certain medical decisions. Part II of the article examines the Anderson case and explores the Ohio Supreme Court's holding therein that no remedy exists for violation of the right to refuse medical treatment. The article concludes with an examination of some potential for ways to provide a remedy violation of this important right.

I. THE IMPORTANCE OF PERSONAL AUTONOMY AND THE RIGHT TO REFUSE TREATMENT

A. The Common Law Development

Individuality and autonomy have long been central values in American society and law. Respect for autonomy requires recognition of another person's rights to hold certain views, to make her own choices, and act on the basis of her personal values and beliefs, even when it is thought that the person is mistaken. In general, the more intense and personal the

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consequences of a choice and the less direct or significant the impact of that choice on others, the more compelling the claim to autonomy in the making of a given decision.\textsuperscript{21} Under this criterion, the case for respecting patient autonomy in decisions about health and bodily fate is very strong.\textsuperscript{22} Indeed, the United States Supreme Court has stated about the interest of self-determination that "[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 by others, unless by clear and unquestionable authority by law."\textsuperscript{23}

The informed consent doctrine,\textsuperscript{24} which requires the physician to obtain consent\textsuperscript{25} prior to invading the patient's bodily integrity,\textsuperscript{26} was devel-

\textsuperscript{21} The claim to autonomy was most compellingly expressed by John Stuart Mill:

\begin{quote}
[T]he only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. . . . [T]he conduct from which it is desired to deter him must be calculated to produce evil to someone else. The only part of the conduct of any one for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his mind and the body, the individual is sovereign.
\end{quote}


\textsuperscript{22} The classic statement of this value in the medical context is that of Judge Cardozo in \textit{Scholendorff v. Society of New York Hospitals}: "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 his patient's consent, commits an assault. . . ." 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914). A more recent statement of the importance of patient autonomy is found in 1 President's Comm'n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions 2-4 (1982). See generally, Goldstein, Harold Laswell, \textit{Some Reflections on Human Dignity, Entrapment, Informed Consent, and the Plea Bargain}, 84 YALE L.J. 683 (1975) (critiquing inadequate protection of self-determination in three disparate process, including informed consent to medical intervention).

\textsuperscript{23} Union Pacific Railroad Co. v. Botsford, 141 U.S. 250, 251 (1891) (refusing to compel personal injury plaintiff to undergo pretrial medical examination).

\textsuperscript{24} Within the patient-physician relationship, autonomy is protected by allowing the patient to make her own decisions, despite the greater training and expertise of her physician. \textit{See id.} Informed consent also protects the autonomy of each member of society by protecting against institutional violations of autonomy, fostering trust in medical professionals and encouraging self-scrutiny by physicians and researchers. Mary A. Bobinski, \textit{Autonomy and Privacy: Protecting Patients From Their Physicians}, 55 U. PIT. L. REV. 291 (1994).

oped to protect bodily integrity and personal autonomy. The doctrine of informed consent protects the patient's right to determine his own destiny in medical matters; it promotes his status as an autonomous human being; it guards against overreaching on the part of the physician; it protects his physical and psychic integrity and thus his privacy; and it compensates him both from affronts to his dignity and from the untoward consequences of medical care. The doctrine of informed consent therefore establishes an obligation of health care professionals to respect patient's rights to make their own treatment decisions. These common law background principles provided the foundation for courts that faced the task of addressing and defining an individual's right to refuse medical treatment, including life sustaining treatment. That the doctrine of informed consent includes the patient's choice to refuse life sustaining medical treatment today is well accepted. The jurisprudence that has developed is a


28. Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 277 (1990). Some state constitutions also recognize a right to refuse treatment based on a liberty or privacy interest. See, e.g., Rasmussen v. Fleming, 741 P.2d 674, 682 (Ariz. 1984) (privacy interest); In re Barry, 445 So. 2d 356, 370 (Fla. Dist. Ct. App. 1984) (privacy interest); In re Lawrence, 579 N.E.2d 32, 38 (Ind. Ct. App. 1991) (liberty interest). The Supreme Court has recognized that a competent person has a constitutionally protected liberty interest, grounded in the Fourteenth Amendment, in refusing unwanted medical treatment, including life-sustaining treatment. Cruzan, 497 U.S. at 261. Thus, following Cruzan, it is clear that patients have a liberty interest in refusing resuscitation. Whether this liberty interest is violated, however, is determined by weighing the liberty interest against the relevant state interests. Id. at 278-79.


30. There were at least eighty-four appellate decisions addressing the right to die issued prior to the Supreme Court's decision in Cruzan. George J. Annas, The "Right to Die" in America: Sloganeering from Quinlan and Cruzan to Quill and Keownikian, 34 DUQ. L. REV. 875, 882 (1996); see also Cruzan v. Harmon, 760 S.W.2d 408, 412 n.4 (Mo. 1988)
mixture of common law, statutes, and federal and state constitutional glosses.\textsuperscript{31} From these sources of law, culminating with \textit{Cruzan v. Director, of Missouri Department of Health}, the first "right to die" case to come before the United States Supreme Court, the existence of a fundamental legal right to make choices about one's medical treatment is now firmly established.\textsuperscript{32}

\textbf{B. Further Recognition of the Right toRefuse Medical Treatment – The Legislative Response}

The publicity and concern generated by the \textit{Cruzan} case brought public focus on the inadequacy of protection for the right to refuse treatment. In response, Congress and state legislatures passed a variety of laws.\textsuperscript{33} Congress enacted the Patient Self Determination Act ("PSDA"),\textsuperscript{34} a federal law requiring every hospital and nursing home to provide information about advance directives to all patients upon admission. It further required institutions to develop policies addressing advance directives and to notify patients of the substance of these policies.\textsuperscript{35}

\begin{itemize}
  \item Some state constitutions recognize a right to refuse treatment based on a liberty or privacy interest. \textit{See supra note 28; see also Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 271 (1990) (citing Laurence H. Tribe, \textit{AMERICAN CONSTITUTIONAL LAW} 15-11, at 1365 (2d ed. 1988)). Thus, following \textit{Cruzan}, it is clear that patients have a liberty interest in refusing resuscitation. Whether this liberty interest is violated, however, is determined by weighing the liberty interest against the relevant state interests. \textit{Id.} at 278-79.
  \item For a comprehensive account of practices and laws governing the forgoing of life-sustaining treatment and surrogate decision making, \textit{see Alan Meisel, \textit{THE RIGHT TO DIE}} (2d ed. 1995).
  \item Specifically, the PSDA requires that health care providers "maintain written poli-
State legislatures also began passing laws to help protect the right to refuse medical treatment. Today, all states and the District of Columbia have recognized the right to refuse treatment, through the enactment of a variety of natural death statutes, including living-will laws, durable power of attorney for health care laws, do not resuscitate order laws, the right to formulate advance directives and procedures applicable to "all adult individuals receiving medical care" concerning "an individual's rights under State [statutory and case-] law ... to make decisions concerning [their] medical care, including the right to accept or refuse treatment ... and the right to formulate advance directives. ..." 42 U.S.C. §§ 1395cc(b)(1), 1396a(w)(1) (West 1992 & Supp. 1995). Furthermore, at the time of admission to the health care facility, providers must give patients written information about their state law rights to make decisions concerning their medical care, the right to accept or refuse treatment, the right to formulate advance directives, and "the written policies of the provider or organization respecting the implementation of such rights." Id. Although the PSDA does not create any substantive rights concerning medical decisionmaking, it recognizes that such rights exist independent of the Act, and more specifically that state law has created and acknowledged the existence of such rights. See Kelly C. Mulholland, Protecting the Right to Die: The Patient Self Determination Act, 28 HARV. J. ON LEGIS. 609 (1991); Susan Wolf, et. al., Sources of Concern About the Patient Self Determination Act, 325 NEW ENGL. J. MED. 1666 (1991).


37. Living wills are documents in which individuals state whether they desire life-sustaining treatment during the final stages of life, and if so, which treatments can be provided and under what circumstances. David Orentlicher, Trends in Health Care Decisionmaking: The Limits of Legislation, 53 MD. L. REV. 1255, 1258 (1994). Generally these statutes apply only to patients who are terminally ill or permanently unconscious and limit the patients' treatment withdrawal orders to artificial nutrition and hydration. Id.

38. The durable power of attorney for health care statutes allow patients to appoint an individual to make medical decisions on the patients' behalf in the event that the patients are unable to make medical decisions themselves. David Orentlicher, Advance Medical Directives, 263 JAMA 2365, 2366 (1990). Patients can combine a living will and a durable power of attorney appointment. Id. The patient instructs the appointed surrogate to follow the patient's instructions regarding treatment. Id. If the instructions in the living will fail to give enough guidance to the surrogate, the surrogate has the authority to make the best judgment concerning the patient's preferences. Id. These statutes often apply to patients with any medical condition and are less likely to restrict the types of treatments that the surrogate can order to be withdrawn. Id. at 1260. See generally Colleen M. O'Connor, Statutory Surrogate Consent Provisions: An Overview and Analysis, 20 MENTAL & PHYSICAL DISABILITY L. REP. 128 (1996).

39. Do not resuscitate ("DNR") order statutes allow patients to state that they do not want to receive cardiopulmonary resuscitation ("CPR") if they suffer cardiac arrest. Orentlicher, supra note 37, at 1260. CPR can be defined as measures to restore cardiac function or to support ventilation in the event of a cardiac or respiratory arrest. See, e.g., N.Y. Pub. Health Law § 2961(4) (McKinney 1993). These statutes limit the patient's treatment withdrawal orders to one kind of treatment, CPR. Orentlicher, supra note 37,
and health care surrogate laws. In addition, medical organizations, such as the Joint Commission on Accreditation of Health Care Organizations ("JCAHO"), now require that health care facilities create a mechanism to assist patients in the development of advance directives. The JCAHO designed directives, such as living wills, to give physicians information about an individual's treatment preferences. All of these statutes and regulations demonstrate acceptance by a majority of the public of the right to refuse treatment.

One primary failing of these statutes is that most people, for understandable reasons, fail to complete formal advance directives. A recent study estimates that the number of individuals completing formal advance directives varies between ten and twenty-five percent (with some estimates as low as five percent) of the adult population. And as noted earlier,

at 1260.

40. See Orentlicher, supra note 37 at 1258. See also Gregory Gelfand, Living Will Statutes: The First Decade, 1987 Wis. L. REV. 737, 796-97 (1987) (stating that many such statutes were enacted in states that already created the same rights by judicial decision and the statutes merely provided a procedure for channeling these rights); Sabatino, supra note 34, at 313, 330 (1991-92).

41. Joint Commission on Accreditation of Hospitals, 1993 ACCREDITATION MANUAL FOR HOSPITALS, 1 JOINT ACCREDITATION OF HOSP. 106 (1992). See also, American Hosp. Ass'n, POLICY AND STATEMENT OF PATIENTS' CHOICES OF TREATMENT OPTIONS (Feb. 1985) ("Whenever possible, however, the authority to determine the course of treatment, if any, should rest with the patients" and "the right to choose treatment includes the right to refuse a specific treatment or all treatment. . ."); American Med. Ass'n, Council of Ethical and Judicial Affairs, WITHHOLDING OR WITHDRAWING LIFE PROLONGING MEDICAL TREATMENT (Mar. 15, 1986) ("The social commitment of the physician to sustain life and relieve suffering where the performance of one duty conflicts with the other, the choice of the patient . . . should prevail.").

42. See Ezekiel J. Emanuel & L.L. Emanuel, Living Wills: Past, Present, and Future, 1 J. CLINICAL ETHICS 9, 9-19 (1990). To be accredited by the JCAHO, a health care institution must have a mechanism for facilitating the family's or legal guardian's participation in making decisions for the patient throughout the course of treatment. See JCAHO Requires Hospitals to Address Ethical Issues, 7 MED. ETHICS ADVISOR 121, 123 (1991) (citing Joint Comm'n on Accreditation of Healthcare Orgs., Accreditation Manual for Hospitals (1992)). This mechanism might be an ethics committee or an ethics consultant. See id. at 122. This requirement applies to long-term care facilities as well as to hospitals, but whereas most hospitals seek accreditation, most long-term care facilities do not. See Danis, Southerland & Garrett, A Prospective Study of Advance Directives for Life Sustaining Care, 324 NEW ENG. J. MED. 881, 886 (1991) (presence of advance directive did not increase likelihood that an individual's treatment wishes would be followed); Rhoden, supra note 18, at 430 ("The judiciary's reaction to those few cases in which patients or their families have sued for damages for nonconsensual treatment represents another instance of the legal system's uncritical endorsement of the medical profession's activist approach.").

43. See D. Meyers, MEDICO-LEGAL IMPLICATIONS OF DEATH AND DYING 277-78 (1981) (noting that most persons do not like to dwell on the prospect of their own death).

even if a patient is one of the few that has completed an advance directive, no guarantee exists that the doctor will obey that directive. Indeed, some commentators have noted that a financial incentive may exist to keep certain people, (those with health insurance) alive despite their wishes. Finally, many of these statutes actually provide immunity to the physician who fails to obey an individual's living will or advance directive. Thus,

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45. See Orentlicher, supra note 37, at 1281 (citation omitted). To support his thesis that legislation has not changed physician behavior, Orentlicher cites several studies that conclude that physicians often overrode living wills when they disagreed with the patients' choices, including providing undesired treatment when they felt that the treatment was appropriate. Id. at 1281-82; see also Marion Danis et al., A Prospective Study of Advance Directives for Life-Sustaining Care, 324 NEW ENG. J. MED. 882, 886-87 (1991); Panagiota v. Caralis & Jeffrey S. Hammond, Attitudes of Medical Students, Housestaff and Faculty Physicians Toward Euthanasia and Termination of Life-Sustaining Treatment, 20 CRITICAL CARE MED. 683, 686-89 (1992) (noting that a continuing problem with 'living wills' has been the unwillingness of many physicians to honor them). The existence of physician resistance to living wills has also been a source of concern for the nurses who work with them. Two nursing journals have discussed nurses' responsibilities when physicians fail to honor patient wishes. Barbara Springer Edwards, When a Living Will Is Ignored, AM. J. NURSING, July 1994, at 64; Cindy Hylton Rushton, What Can a Nurse Do When the Patient Has an Advance Directive and the Physician Disregards It?, CRITICAL CARE NURSE, Feb. 1993, at 61.


47. See Gelfand, supra note 40, at 771-72 (noting that legislation providing for living wills frequently contain no penalty for physicians who do not honor them); Maggie J. Randall Robb, Living Wills: The Right to Refuse Life-Sustaining Medical Treatment - A Right Without A Remedy? 23 U. DAYTON L. REV. 169, 173-77 (1998) (discussing the various types of immunity provided to physicians who fail to obey a patient's living will). In addition, all state living will and health care proxy statutes confer some sort of immunity from civil or criminal liability or both on health care providers who in good faith comply with a properly executed living will or the instructions of a proxy acting in accordance with the patient's wishes or in the patient's best interest. See id.
although these statutes buttress the ideal of patient autonomy, they do not adequately protect the patient’s right to refuse treatment, and fail to provide an incentive for the medical profession to respect a patient’s considered exercise of the right to refuse treatment. Thus, the statutes fail to address the real problem; the physicians ability to ignore a patient’s wishes.

C. Physician Responses to the Right to Refuse Medical Treatment

Despite the acceptance of the right to refuse medical treatment by the public, and in the courts and legislatures, a large disjunction exists between what the law requires and the actual practice in the health care community. Commentators examining this have provided several reasons to explain why physicians are so reluctant to obey a patient’s decision to exercise her right to refuse medical treatment. Some have argued that fear of liability affects physicians' willingness to follow advance direc-


49. See Zinberg, supra note 48, at 452. The author, a physician/attorney, interviewed eighteen physicians in Vermont and thirty-nine physicians in and around Los Angeles concerning their experiences with and understanding of advance directives and identified three reasons for physician failure to honor patients' advance directives regarding the withholding of treatment: "(1) fear of liability; (2) the perception that directives interpose an unnecessary additional control over, and interfere with, the physicians' professional actions; and (3) the perception that directives implicitly question the physicians' judgment of the patients' best interest." Id. at 482.

50. See Renee M. Goetzler & Mark A. Moskowitz, Changes in Physician Attitudes Toward Limiting Care of Critically Ill Patients, 151 ARCHIVES INTERNAL MED. 1537, 1538 (1991) (finding that physicians were concerned about malpractice liability in deciding how to treat critically ill patients). The courts have been clear that liability should not be a serious concern for physicians and others who participate in a decision to forgo life-sustaining treatment if they act reasonably and in good faith. See, e.g., In re Farrell, 529 A.2d 404, 415-16 (N.J. 1987) (“no civil or criminal liability will be incurred by any person who, in good faith reliance on the procedures established in this opinion, withdraws life-sustaining treatment at the request of an informed and competent patient who has undergone the required independent medical examination described above”).
tives which ask that life-sustaining treatment be withheld. Others note, some commentators have noted that while physicians fear liability for failing to provide sufficient treatment, non-existent sanctions or, mild sanctions, apply to a physician who fails to abide by a patient’s treatment decision. Other commentators have further speculated that physicians’ failure to abide by refusal of treatment decisions reflects a basic reluctance to abandon the paternalistic model of decision making. They state that

51. Physicians fear liability from withdrawing treatment even though there has never been a successful suit or prosecution against a physician or faculty for removing treatment in accordance with the instructions of the patient or the instruction of the family. See S. Van McCrary, Jeffrey W. Swanson, et al. Treatment Decisions for Terminally Ill Patients: Physicians’ Legal Defensiveness and Knowledge of Medical Law, 20 LAW, MED. & HEALTH CARE 364 (1992); Alan Meisel, Legal Myths About Terminating Life Support, 161 ARCHIVES INTERNAL MED. 1497, 1497-98 (1991); See also Robert F. Weir & Larry Gostin, Decisions to Abate Life-Sustaining Treatment for Nonautonomous Patients, 264 JAMA 1846, 1852 (1990) (“Every court of final decision in every jurisdiction that has addressed the question of physician liability... has found physicians participating in the cases to be free from civil or criminal sanctions.”); David Orentlicher, The Right to Die After Cruzan, 264 JAMA 2444-46 (1990); Alexander Morgan Capron, Legal and Ethical Problems in Decision for Death, 14 LAW MED. & HEALTH CARE 142 (1986) (noting that “If patients behaved as irrationally about treatment as physicians do about liability, the patients would be labeled incompetent”).

52. See Ben A. Rich, The Values History: A New Standard of Care, 40 EMORY L.J. 1109, 1117 (1991); Orentlicher, supra note 37, at 1293. For example, many advance directive statutes have severe penalties including felony convictions for those who might falsify or destroy a living will. However, the actions of a physician who refuses to follow the terms of a patient’s living will or to refer the patient to another physician who is willing to comply with the directive are only designated to be unprofessional conduct potentially subject to sanction by the State Medical Board. See, e.g., COLO. REV. STAT. ANN. § 15-18-113 (West 1987 & Supp. 1995). Although each state and the District of Columbia have enacted Natural Death Acts, only approximately seventeen states have any sanctions against physicians for a violation of a Natural Death Act, and of those, approximately six provide that the physician may be civilly or criminally liable. See, e.g., ALASKA STAT. §18.12.070(a) (1994); ARK. CODE ANN. § 20-17-209(a) (Michie 1991 & Supp. 1993); MONT. CODE ANN. § 50-9-206(1) (1994); TENN. CODE ANN. § 32-11-106(a) (Supp. 1995).

53. See Jay Katz, supra note 9, at 11 (explaining that hard paternalism is causing resistance to patient efforts to exercise some degree of autonomy in decisions abut their medical treatment). Hard paternalism accepts the proposition that it is morally justifiable for others to protect competent adults, against their will, from the harmful consequences of their fully voluntary choices. Rich, supra note 52, at 1119 n.34. Zinberg also reports: “One interviewee volunteered that a substantial number of his colleagues dislike directives because they believe directives would curtail doctors’ control of treatment.” See Zinberg supra note 48, at 445. This observation is partially confirmed by the fact that many interviewees strongly opposed the interposition of formal ethics committees. Only three interviewees in each state agreed that other physicians or an ethics committee should be consulted. Id. at 482-83 (citations omitted). For a detailed analysis of this type of physician behavior and the implications for patient autonomy, see David Orentlicher, The Illusion of Patient Choice in End-of-Life Decisions, 267 JAMA 2101, 2101-04 (1992) (stating that there is “increasing evidence that physician value may be a more decisive factor than patient values in [life-sustaining treatment] decisions”).
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many physicians simply do not want to allow their patients to share actively in the decision making process, or do not trust them to make these choices because they believe that medical training and expertise should be required for every treatment decision. In addition, many physicians believe that morally they should not be tacit facilitators of death. However,

54. Research studies have concluded that a significant number of physicians question the ability of patients to make decisions at the end of life. See, e.g., Kent W. Davidson et al., Physicians' Attitudes on Advance Directives, 262 JAMA 2415, 2416 Table 3 (1989) (indicating that over fifty-eight percent of responding doctors strongly agreed that "a potential problem with advance directives is that patients could change their minds about 'heroic' treatment after becoming terminally ill," and over thirty-two percent strongly agreed that "the training and experience of physicians gives them greater authority than patients' own decisions about withholding 'heroic' treatment").

55. Certain members of society receive less respect for their decisions about medical treatment than others. Specifically, in assessing terminally ill patients' wishes to die, women's views are considered less credible. See Lisa C. Ikemoto, Furthering the Inquiry: Race, Class, and Culture in the Forced Medical Treatment of Pregnant Women, 59 TENN. L. REV. 487, 507 & n.112 (1992) (referring to a finding that men's moral preferences are given more weight than women's choices). Professor Ikemoto quotes a study of appellate decisions in right-to-die cases that uncovered the following differences in the treatment of men and women: The first difference is the courts' view that a man's opinions are rational and a woman's remarks are unreflective, emotional, or immature. See id. at 507 (quoting Steven H. Miles & Allison August, Courts, Gender and 'The Right to Die,' 18 LAW MED. & HEALTH CARE 85, 87 (1989)). Second, women's moral agency in relation to medical decision is often not recognized. Id. Third, courts apply evidentiary standards differently to evidence about men's and women's preferences. Id. Fourth, life-support dependent men are seen as subjected to medical assault; women are seen as vulnerable to medical neglect. Id. See also Lisa Napoli, The Doctrine of Informed Consent and Women: The Achievement of Equal Value and Equal Exercise of Autonomy, 4 AM. U. J. GENDER & L. REV. 335, 338-39 (1996) (finding that "[h]istorically, experiments and operations have been performed on women without their consent," and even "[w]hen consent is sought, women must often overcome gender-based stereotypes that impact on a doctor's decision to perform a procedure"); Sylvia A. Law, Silent No More: Physicians' Legal and Ethical Obligations to Patients Seeking Abortions, 21 N.Y.U. REV. L. & SOC. CHANGE 279, 295 (1994-95) (finding that "the tradition of medical paternalism is particularly strong in relation to women patients; doctors often assume authority to determine what is in women's best interest without soliciting their view"); John M. Smith, M.D., WOMEN AND DOCTORS 9 (1992) (observing that whether it is unnecessary surgeries, inappropriate treatment or testing, lack of preventive care, lack of consideration in research, allocation of dollars, or simply being milked for dollars by physicians, women, regardless of their race, wealth, or career, are abused by doctors more often than similarly situated men).

as several legal commentators have observed, life-sustaining treatment decisions are value-based and do not require medical knowledge.57

Thus, from the viewpoint of a patient or the patient's family, the right to refuse medical treatment is easily ignored.58 Broad judicial proclamations and state statutory protections have failed to guarantee patients this right to medical self-determination.

II. ASSESSING THE FAILURE TO REMEDY BREACHES OF PATIENT'S REFUSALS

Due to the medical profession's failure to implement the right to refuse treatment, patients have been kept alive against their wishes. However, it has been very difficult for patients to recover damages for this non-consensual provision of medical treatment. As noted earlier, a major incentive for doctors to comply with patients' rights to decisional autonomy has been the fear that failure to do so will result in litigation.59 The law of torts, including battery actions, medical malpractice actions and the doctrine of informed consent, has been protectively employed rather than administrative enforcement.60

57. See Orentlicher, supra note 37, at 1293; Bouvia v. Superior Court, 225 Cal. Rptr. 297 (1986).

Elizabeth Bouvia's decision to forego medical treatment or life-support through a mechanical means belongs to her. It is not a medical decision for her physicians to make. Neither is it a legal question whose soundness is to be resolved by lawyers or judges. It is not a conditional right subject to approval by ethics committees or courts of law. It is a moral and philosophical decision that, being a competent adult, is hers alone. Id. at 304.

58. Realizing the difficulty of having their right to refuse treatment respected, some commentators have suggested some rather creative measures so that physicians will be unable to ignore their request. See Marian Haglund Juhl, A Tattoo in Time: I Want My Last Wish to be Clearly Visible so it Will be Honored by the Doctor Who Treats Me, NEWSWEEK, Oct. 13, 1997, at 19 (stating that she will have a DNR tattoo placed on her body so that physicians cannot ignore her wishes).

59. See, e.g., Hackelman, supra note 18, at 1355; Rhoden, supra note 18, at 430; Oddi, supra note 18, at 625. Indeed, one prominent commentator suggested that "a successful [tort] suit of this type might be more effective than legislation in encouraging physicians to take 'living wills' seriously." George A. Annas, Reconciling Quinlan and Sakewicz: Decision Making for the Terminally Ill Incompetent, 4 Am. J.L. & Med. 367, 386 n.48 (1979).

60. See Cruzan v. Director, Mo. Dept. of Health, 497 U.S. 261, 269 (1990) (finding that the "notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment" and informed consent is a component of American tort law). In his dissent, Justice Brennan also remarks that the right "to determine what shall be done with one's own body is grounded in American tort law." Id. at 305 (Brennan, J., dissenting).
Although actions against health care providers for failure to terminate life sustaining treatment are ordinary tort actions, they pose a somewhat problematic issue with regard to the elements of injury and damages. Courts believe that any damages in tort actions for failure to terminate life sustaining treatment must be based on the premise, still unacceptable to many, that death is preferable to continued life under some circumstances. A recent case demonstrates some of the difficulties that patients and their estates have had in obtaining the court’s implementation of the right to refuse treatment.

In *Anderson v. St. Francis-St. George Hospital*, the Ohio Supreme Court ruled that a hospital cannot be held liable for damages for wrongful life resulting from its failure to follow a DNR requested by a patient. Mr. Edward Winter was admitted to St. Francis-St. George Hospital complaining of chest pain in 1988. While in the hospital, Mr. Winter discussed the type of treatment he was to receive with his family doctor, Dr. Russo, and stated that "he wanted no extraordinary life-saving measures

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61. See *Gasner*, supra note 17, at 504-12 (discussing theories advanced in cases seeking damages for failure to honor patients' refusal of treatment); Addlestone, supra note 17 at 1267-72 (same).

62. In denying wrongful living suits, courts have cited problems with two primary issues, those of injury and damages. On the issue of damages, the plaintiff must allege that had the health care provided not been negligent or willful, the plaintiff's right to refuse treatment would have been respected and the plaintiff would have died. Thus, the person’s injury is found in the fact that she is living. To conclude that the plaintiff had suffered an injury cognizable in tort, the fact finder would have to compare the relative benefits of nonexistence to a life with disabilities, a task courts have labeled “impossible.” Courts have also held that the issue of damages also poses troubling questions. The compensatory measure of damages required by tort actions would theoretically require a determination of the value of life with disabilities versus the value of no life at all. Many courts have refused to make such calculations of injury and the resulting valuations of life with and without disabilities and thus, have denied the availability of wrongful living suits to plaintiffs. See *Gasner*, supra note 17 at 504-12 Addlestone, supra note 15, at 1267-72.

63. See, e.g., Liniger v. Eisenbaum, 764 P.2d 1202, 1212 (Colo. 1988) (concluding that "life, however impaired and regardless of any attendant expenses, cannot rationally be said to be a detriment" when compared to the alternative of nonexistence); Cockrum v. Baumgartner, 447 N.E.2d 385, 389 (Ill. 1983) (finding that human life cannot be a compensable harm, and stating that "the benefit of life should not be outweighed by the expense of supporting it"); Becker v. Schwartz, 386 N.E.2d 807, 812 (N.Y. 1978) (finding courts not equipped to handle the task of comparing the value of life in an impaired state and nonexistence).


65. *Id.*

in the event of further illness." Although Dr. Russo recorded, "no code blue" on his chart, a nurse revived him with the use of a cardiac defibrillator after his heart went into a potentially fatal rhythm. Mr. Winter survived the ventricular fibrillation, but two days later, he suffered a stroke that left him paralyzed on the right side until his death in 1990. Mr. Winter's estate alleged battery, negligence, and wrongful living claims, asserting that by keeping Mr. Winter alive, the hospital caused him pain, suffering, emotional distress, disability, and medical damages, as well as other expenses.

Chief Justice Moyer, writing for a majority of the Ohio Supreme Court, concluded from the facts that Mr. Winter had not suffered a compensable injury from the hospital’s failure to follow his treatment request. In his decision, Justice Moyer did not question Mr. Winter’s right to make the treatment decision or his competency to do so. On the contrary, the Court noted the constitutional significance of his right to make such a decision.

The plaintiff asserts a right to enforce an informed, competent decision to reject life-saving treatment. This claim is inextricably linked to, and arises directly out of, the right to die recognized in Cruzan. . . . Thus, in a “wrongful life” action, the plaintiff is asserting a liberty interest in refusing unwanted medical treatment. It is the denial of this liberty interest, when the medical profes-

67. Id. During his conversation with Dr. Russo, Mr. Winter was competent and alert. Id. In addition, Winter's daughter told Dr. Russo of a conversation with her father concerning life-saving measures that had been performed on Winter's wife and resulted in "great misery and suffering for the remainder of her life." Id. During Mrs. Winter's hospital stay, her heart was shocked and her chest beaten while in intensive care, and Winter's daughter told Dr. Russo that Winter was very upset about these actions. Id. at *1, n.1. Winter subsequently told his daughter "never to let anybody do that to him." Id.

68. Anderson, 1995 WL 109128 at * 1. Dr. Russo defined a "no code blue" order in his deposition testimony:

Well, in my mind, a no code blue order is an organized process of resuscitating a patient and anything that would initiate that or any procedure that would be, that would occur during that process would be a resuscitative procedure, whether you whap them on the chest or whether you give medicine or whether you give an I.V.

69. Id.

70. Id. After his stroke, Mr. Winter "was unable to walk, was incontinent of urine, had difficulty speaking, and needed assistance in bathing and dressing." Id. Winter required constant medical care until his death.

71. See Anderson, 614 N.E.2d at 843.


73. See Anderson, 671 N.E.2d at 227-28.

74. Id. at 226 (noting that in a wrongful living action the plaintiff is asserting a constitutional liberty interest in refusing medical treatment).
sional either negligently or intentionally disregards the express
wishes of a patient, that gives rise to the wrongful living cause of
action.\textsuperscript{75}

The court, however, concluded that Ohio did not recognize a claim for
wrongful living.\textsuperscript{76} In its analysis, rather than focus on Mr. Winter’s auton-
omy interest, the court instead focused on the difficulty of determining
damages under a wrongful living cause of action for the harm of prolonga-
tion of life, stating that "[t]here is perhaps no issue that better demonstrates
the outer bounds of liability in the American civil justice system than this
issue."\textsuperscript{77}

Focusing on the potential of awarding damages for life-prolonging
treatment, Justice Moyer stated that the issue presented was whether
"‘continued living’ [is] a compensable injury?"\textsuperscript{78} The Court held that, “life

\textsuperscript{75.} Id.

\textsuperscript{76.} Id. The wrongful living cause of action was first coined by Samuel Oddi. See Oddi, supra note 18, at 625. The tort is essentially a battery or negligence claim associated with doctors that perform life sustaining treatment against the wishes of a patient. Id. The wrongful living claim should be distinguished from claims for wrongful life, wrongful birth and wrongful pregnancy, and wrongful conception. A wrongful life claim is brought by a child seeking damages against a health care provider for negligently failing to in-
form parents of a possible hereditary defect, or for failure to properly sterilize a parent. Turpin v. Sortini, 643 P.2d 954 (Cal. 1982) (granting special damages to a child in a
wrongful birth action where the physician failed to inform the mother of hereditary de-
ful pregnancy and wrongful conception deal specially with the failure of either a birth
control method or a sterilization procedure that led to the birth of an unwanted, albeit
healthy child. See id. at 434-435. For a discussion of the relationship between these
theories and the courts’ reluctance to award damages, see Philip G. Peters, Jr., The Illu-
sion of Autonomy At the End of Life: Unconsented Life Support and the Wrongful Life

\textsuperscript{77.} Anderson, 671 N.E.2d at 228 (noting that “damages, if any, must be based strictly
on the theory of negligence or battery”). In rejecting the wrongful living tort, the Ohio
Supreme Court reversed the appellate court’s decision to allow recovery for all foresee-
able consequences of the treatment, including pain, suffering, and emotional distress
beyond that which Winter would have suffered had he not been resuscitated. Id. Courts
have relied on the difficulties in comparing death to a life with disabilities in rejecting
the “wrongful life” suits as well. See generally, Brown, ‘Wrongful Life’ A Misconceived
Tort: An Introduction, 15 U.C. DAVIS L. REV. 445 (1981); Barry R. Furrow; Impaired
Children and Tort Remedies: The Emergence of a Consensus, 11 LAW MED. & HEALTH
CARE 148 (1983); Robertson, Toward Rational Boundaries of Tort Liability for Injury to
1401 (1978).

\textsuperscript{78.} Anderson, 671 N.E.2d at 227. In Justice Douglas’ concurring opinion, he firmly
stated his view:

[iif] [one] [appl[ied] the positive connotation to an act which continues
life, where death would have occurred without intervention, what dam-
age could possibly ensue? . . . Assuming, for purposes of argument only,
is not a compensable injury." 79 The court held that this was true even if the plaintiff could show a breach of a duty and the resulting prolongation of life. 80 It noted that it had previously recognized the "impossibility of a jury placing a price on the benefit of life" 81 and concluded that: "[t]here are some mistakes, indeed even breaches of duty or technical assaults, that people make in this life that affect the lives of others for which there simply should be no monetary compensation." 82

Justice Moyer then examined the possibility that Mr. Winter might have a claim in this case on theories of negligence or battery. 83 Justice Moyer concluded that causation was lacking for either a negligence or battery claim. 84 The court applied an extremely narrow version of the "but for" test 85 and found that the defibrillation did not cause Mr. Winter's subsequent stroke. Even though the record indicated that Mr. Winter would have died without resuscitation, 86 and that a stroke is a foreseeable medical

that the action of the hospital through its staff was negligence, and assuming further that "damages" should be assessed as a result of the negligence, how could they be computed? Can the preservation of life (furthering life) even be amenable to the "damages" concept. I think not! Id. at 229-30 (Douglas, J., concurring).

79. Id. Overall, it appears that the court did not believe that Mr. Winter had suffered any recognizable injury from the wrongful resuscitation. The court specifically noted that after his resuscitation and paralyzing stroke, "Winter enjoyed numerous visits and outings with his family." Id. at 226.

80. See Id. at 228-29.

81. Id. (citing Heiner v. Moretuzzo, 652 N.E.2d 664, 670 (Ohio 1995) (finding "that 'not every wrong is deserving of a legal remedy.'"). For a critique of the view that an individual does not suffer harm by being kept alive against his will, see Joel Feinberg, THE MORAL LIMITS OF THE CRIMINAL LAW: HARM TO OTHERS 91 (1984) (It is perfectly reasonable to believe that a person may be harmed or burdened by something even if he is unaware of it. An example is the man who does not know his wife is having an affair).

82. See Anderson, 671 N.E.2d at 228-29.

83. See Anderson, 671 N.E.2d at 226. For a discussion of how courts will often confuse the concepts of valuation and causation in tort cases involving preexisting conditions, see King, Causation, Valuation and chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences, 90 YALE L. J. 1353 (1983).

84. Id. at 226. For an ordinary tort analysis, Application of the "but for" test in a case where a doctor ignores a DNR order is straightforward. The plaintiff must demonstrate that the doctor's actions proximately caused the subsequent injury. The appropriate test should be, but for the resuscitation, the injury would not have occurred. Without intervention from the doctors, the patient would have died and not been subjected to the pain and loss of dignity associated with her medical condition. These conditions are foreseeable. See Anderson v. St. Francis St. George Hosp., 1995 WL 109128 at * 5 (holding that a patient is entitled to compensation for foreseeable injuries proximately caused by the unwanted medical treatment), rev'd, 671 N.E.2d 225 (Ohio 1996).

86. See Anderson, 1995 WL 109128 at * 1.
condition if one survives resuscitation of the heart, the court held that "the record is devoid of any evidence that the administering of the resuscitative measures caused the stroke." 

Not surprisingly, the Court also interpreted the battery claim very narrowly to provide compensatory damages only if the patient had suffered physical harm. Because Mr. Winter had suffered no physical damages due to defibrillation, "i.e., no tissue burns or broken bones," and that because his estate had conceded that it was not seeking nominal damages, the court concluded that there was no issue for the trial court to decide on remand and entered judgment for the hospital.

Addressing the fact that Mr. Winter's failure to recover might have a detrimental impact on the important right to refuse medical treatment, Justice Moyer stated that this decision should not encourage unwanted life saving treatment, "where a patient clearly delimits the medical measure he or she is willing to undergo, and the health care provider disregards such instruction, the consequences for that breach would include the damages arising from any battery inflicted on the patient, as well as appropriate licensing sanctions against the medical professionals." 

Three judges dissented and argued that Winter's estate should have been given an opportunity to prove that the hospital was negligent and that the health care providers violated Mr. Winter's constitutional rights. The dissenters specifically argued that, "[c]ontrary to the assertion of the majority, the plaintiff was not seeking to recover because Winter's life was prolonged. He was seeking to recover because the hospital failed to follow the instructions Winter gave them." The dissent stated that Mr. Winter's estate could most likely prove that the hospital's negligence increased the

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87. See Anderson, 671 N.E.2d at 228.
88. Id. ("Winter suffered the stroke because the nurse enabled him to survive the ventricular tachycardia. Because the nurse prolonged Winter's life, numerous injuries occurring after resuscitation might be foreseeable, but would not be caused by the defibrillation.").
89. Id. at 229 (citing Lacey v. Laird, 139 N.E.2d 25 (Ohio 1956)). The court reasoned that Mr. Winter did not suffer a battery because any nonconsensual medical treatment the nurse performed was physically harmless, i.e., the defibrillation did not cause any tissue burns or broken bones. Id. The courts definition of harm results from its failure to find any harm from continued living.
90. Id.
91. Id.
92. Id. at 229. Chief Justice Moyer apparently ignored the fact that under the Anderson holding, the court had failed to provide any remedy.
93. Id. at 230 (Pfeifer, J., dissenting).
94. Id. (noting that Mr. Winter's experts should not have been given an opportunity to testify about causation because a factual dispute existed about what had caused his stroke).
likelihood that Mr. Winter would suffer a stroke. The dissent believed that Mr. Winter's estate had sufficient evidence to present the case to the jury. The plaintiff had offered an expert witness to testify that a stroke was immediately foreseeable if resuscitation occurred, and that but for the nurse's actions, the stroke would not have occurred because the patient would have died a natural death. Therefore, the dissent asserted that the majority incorrectly granted summary judgment in favor of the defendant hospital.

The court never explicitly questioned Mr. Winter's right to make the DNR decision or his competency to do so, and never examined the appropriateness of the hospital authorities' determinations. Rather, the court focused on the difficulty of determining a proper dollar amount for this type of harm. Because they viewed life as always preferable to death, they determined that placing a dollar value of Mr. Winter's harm was impossible, and thus denied Mr. Winter's fundamental right to refuse treatment.

Mr. Winter's case reveals the breadth of the failure of the right to refuse treatment. On one level, it illustrates the problems inherent in permitting no remedy for the right to refuse medical treatment. If physicians are given the power to administer lifesaving or life sustaining medical care despite a patient's express refusal of that treatment within an advance directive, then the physician could subject the individual to any number of various medical treatments without consent.

95. See id.
96. Id.
97. Id. (commenting that medical experts were prepared to testify on behalf of Mr. Winter's estate that "it was medically foreseeable that [Mr. Winter] would suffer a stroke during the days immediately following defibrillation").
98. Id.
99. Id. at 226. Indeed, the appellate court after remand had specifically found a violation of Mr. Winter's right and believed that the only issue left to determine was whether the resuscitation caused his harm. Anderson, 1995 WL 109128 at * 5 (stating "To be more precise, Edward Winter gave express directives for his medical care which were ignored, either negligently or intentionally. His right to refuse treatment was expressly violated"). The Ohio Supreme Court never disputed this finding. Rather, they reversed the appellate court based on their bizarre application of the causation rules to Mr. Winter's case resulting in Mr. Winter's failure to show any connection between the defibrillation and Winter's subsequent stroke. Anderson, 671 N.E.2d at 228.
100. Id.
101. Id. at 228-29.
102. Taking this argument to its logical end, an individual would have no right of action even if the medical provider maliciously refused to withdrawal treatment. Why should the law allow for such an abuse of medical authority on the grounds of the sanctity of human life, particularly when the rest of society must account for similar conduct in other contexts, and may even be called on to support the individual's existence. The
At another level of analysis, the decision reveals just how deferential to medical authorities courts have become. Hospitals may willfully ignore a patient's determination about what medical care they wish to receive even when the patient is competent to make that determination. Anderson and other cases like it indicate that hospitals and doctors are under no obligation to consider patient input in appropriate treatment if that determination diverges from the medical professional's opinion.

The court's deference results from its failure to acknowledge fully the scope and importance of the individual autonomy interest involved. Individuals make the decision to refuse or accept life sustaining medical treatment for many reasons. Some people want to die before the last throes of their illnesses; others want to press on despite the pain. Others reject continued life because of the conditions on which it is offered; either in chronic and uncontrolled pain, or in helpless dependence on other people, or in ways they consider degrading. Of course, people often have reasons other than self-interest for not wanting to live as long as possible through the miracles of modern medicine. They might think the final stage of their life would prove an unnecessary burden on their friends or for those who must care for them. Perhaps leaving a larger estate holds more appeal than undergoing uncomfortable medical procedures and amassing large hospital bills. Also present is some notion of dignity or self-

consequences of this argument are unreasonable.

103. See Anderson, 671 N.E.2d at 229. See also Rhoden, supra note 18 at 430 (arguing that the judiciary's unresponsiveness to wrongful living suits reflects the legal system's uncritical endorsement of the medical profession and its reluctance to sanction the medical procession's interventionist instincts).


105. Some of these fears, as noted above, are well justified. Physicians do ignore the documented wishes of patients and all-too-often allow patients to live with uncontrolled pain. See A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), 274 JAMA 1591, 1591-92 (Nov. 22, 1995). Studies of cancer patients have shown that over fifty percent suffer form unrelieved pain. See New York Task Force, When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context, x-xi, 43-47 ("Despite dramatic advances in pain management, the delivery of pain relief is grossly inadequate in clinical practice. . . . Studies have shown that only two to sixty percent of cancer pain is treated adequately."). See also Ezekiel J. Emanuel et al., Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists and the Public, 347 LANCET 1805 (1996).

106. See Gasner, supra note 17, at 504 (noting that "[p]ermitting payment for unwanted treatment provides a serious disincentive to honor patient choice," and further that, "If the provider is allowed to treat now, and decide later whether it was appropri-
respect. "None of us," as Ronald Dworkin says, "wants to end our lives out of character."

Part of the court's deference also appears to stem from a misunderstanding of the strong incentives already in place within the medical profession that support continued treatment of the patient, as well as the court's own discomfort with punishing a physician for saving a patient's life. However, by focusing only on the rights of the medical profession, the courts can do great harm, not just to the patient's autonomy interests, but also to her or her family's emotional and financial well-being. Because health care for end-of-life treatment is expensive, individuals have attempted to recover costs from nursing homes and hospitals when health care providers have ignored their right to refuse treatment and they have subsequently accrued large medical bills. As with Mr. Winter's estate,

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107. Professor Meisel makes the point that the proclivity of the courts in treatment refusal cases to assert the state interest in an adversarial fashion against the liberty interest of the individual "erroneously" suggests that the state has no concern for the autonomy, self-determination, privacy and bodily integrity of its citizens. Meisel, supra note 32 at 96-97. Personal dignity is a part of one's right of privacy. Such a right of bodily privacy led the United States Supreme Court to hold that it shocked the conscience to learn that a state, even temporarily, had put a tube into the stomach of a criminal defendant to recover swallowed narcotics. See Rochin v. California, 342 U.S. 165 (1952).

108. Ronald Dworkin, LIFE'S DOMINION 213. Dworkin observes:

Decisions about life and death are the most important, the most crucial for forming and expressing personality, that anyone makes; we think it crucial to get these decisions right, but also crucial to make them in character, and for ourselves. Even people who want to impose their convictions on everyone else through the criminal law, when they and like-minded colleagues are politically powerful, would be horrified, perhaps to the point of revolution, if their political fortunes were reversed and they faced losing the freedom they are now ready to deny others. Id. at 239.


110. See Anderson, 671 N.E.2d at 229 (Douglas, J., concurring) (stating that "[s]hort of ignoring a living will or a durable power of attorney for health care, medical professionals should not be subjected to liability for carrying out the very mission for which they have been trained and for which they have taken an oath").

111. See Katharine R. Lent et al., National Health Expenditures 1993, HEALTH CARE FIN. REV., Fall 1994, at 247 (providing list of expenditures for medical care and noting the high cost of end-of-life care in particular).

112. See Grace Plaza of Great Neck, Inc. v. Elbaum, 588 N.Y.S.2d 853, 853 (App. Div. 1992), aff'd, 623 N.E.2d 513 (N.Y. 1993). In that case, Grace Plaza, a long-term care facility, admitted Jean Elbaum on September 19, 1986 following hospital treatment for a stroke. Id. at 855. Approximately one year later, Mr. Elbaum informed Grace Plaza that his wife did not want to live in her present state and he asked that her feeding tube be withdrawn. Id. When Grace Plaza refused Mr. Elbaum's request, he stopped paying and Grace Plaza sued to recover payment for services it had rendered to Mrs. Elbaum.
these claims have not been successful. Monetary considerations and current statutory and case law do not encourage hospitals and doctors to provide appropriate care to the patient who chooses to refuse medical treatment. As one judge described it, such rulings "allow a nursing home to profit financially, while ignoring a patient's wishes, as it imposes its own ethical standards upon her."

To be sure, some judges have indicated dissatisfaction with the lack of protection accorded the right to refuse treatment. In cases squarely

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Id. Mr. Elbaum then sued Grace Plaza to remove Mrs. Elbaum's feeding tube. Id. In holding that Mr. Elbaum could not recover, the court acknowledged that, "in light of our decision today, all health care providers in charge of competent patients will have an additional financial incentive to prolong the lives of such patients over the objections of the patients' families." Id. at 860. The court stated:

This may be true, and the potential evil which we see is that some beleaguered families may, regrettably, be forced to litigation. . . . What is not noted is that, if Mr. Elbaum's conduct in this case were condoned, health care providers would have an additional financial incentive to obey, without question, the orders of those conservators who might prematurely despair of their conservatees' recovery, or the orders of those conservators whose judgment might be tainted by motives less altruistic than Mr. Elbaum's. The potential evil we see resulting from this, i.e., the possible death of one patient whose life might have been saved, is infinitely greater, in our view.

Id. 113. See, e.g., Wolf, supra note 109, at 455 (discussing how many commentators have remarked on the potential problems caused by the current system, which favors treatment over nontreatment). See also Don Colburn, The Grace of a "Good Death" Escapes Many; Despite Living Wills and Other Innovations, Doctors Often Ignore or Don't Know Patients' Wishes, WASH. POST, Dec. 5, 1995, at Z7 (noting that one of the problems with the current system is that "it does not hold itself accountable for badly handled deaths. 'If I, as a doctor, do it badly, nothing comes down on me.... I get paid well. The family is left behind in grief and goes away. The patient's suffering counts for nothing.""); Susan Gilbert, Study Finds Doctors Refuse Patients' Requests on Death, N.Y. TIMES, Nov. 22, 1995, at A11 (quoting Dr. Bernard Lo, Director of the Program of Medical Ethics at the University of California at San Francisco, as saying that "doctors have[ve] strong financial incentives to put patients in intensive care rather than to sit down and talk with them about alternatives, like dying with pain relief at home. . . . Invasive procedures are reimbursed at a higher rate than sitting down and talking to patients.").

114. One other appellate courts have also allowed nursing homes to recover for unwanted treatment, at least during the time it takes to obtain judicial permission to terminate life-sustaining treatment. See First Healthcare Corp. v. Rettinger, 467 S.E.2d 243, 244 (N.C. 1996) (per curiam), rev'd, 456 S.E.2d 347 (N.C. App. 1995) (holding that plaintiff must pay for the entire amount of medical care provided even when that care was provided over her objection).


116. Id. at 868 (Rosenblatt, J., dissenting) (remarking that "The advancement of professional ethics to support the preservation of life has epitomized the medical profession,
raising the issue of a competent individual making a decision to end his or her life, courts have indicated that liability should attach and have refused to apply deferential standards to the mistakes made by health care professionals.

These courts and judges are, however, in the minority. In most post-\textit{Cruzan} decisions, courts, by denying a remedy, effectively have expanded the discretion of hospital authorities to ignore the right to refuse medical treatment. At least arguably, these decisions have relegated the right to refuse treatment to a mere catch-phrase.

\section*{III. CONCLUSION}

Advances in medical technology have drastically changed the way physicians treat patients and how, where, and when Americans die. Today, many people have their lives prolonged for years, dependent upon life-sustaining treatment unheard even fifty years ago. In response, courts and legislatures have articulated the \textquoteleft right to die,
\textquoteright stating that patients have a constitutional or common law interest in being able to refuse unwanted medical treatment.

Despite the attempts by Congress and state legislatures, and to secure an individual's right to refuse medical treatment, the medical community is still a long way from truly honoring advance directives. This reluctance to acknowledge advance directives may be in part attributed to the fact that physicians and other health care providers are often not sanctioned for failing to abide by a patient's advance directive.

The fundamental obstacle to enforcing the right to forgo medical treatment is not the law recognizing the right and its interpretation, but the failure of courts to recognize a \textit{remedy} for a violation of the right. This need not be. State and federal law have expressly recognized the right to refuse medical treatment. Physicians should not be able to make a legislatively and judicially conferred right meaningless. If the right to refuse lifesaving treatment or life sustaining treatment is to have meaning, the law must provide a remedy for intentional or negligent violations of this right.

An understandable reluctance exists on the part of the courts to assess civil liability against health care providers when they are seen as having to the public benefit. However powerful those interest may be, they should not serve as a platform to afford compensation for unwanted services, rendered adversely to the patient's declared right to autonomy) \textit{aff'd}, 623 N.E.2d 513 (N.Y. 1993); \textit{Anderson v. St. Francis St. George Hosp.}, 671 N.E.2d 223 at 230 (Pfeifer, J., dissenting) (noting that Mr. Winter should have been allowed to show that the hospital failed to follow his instructions with regard to his medical care).
acted in good faith to preserve life. The courts themselves have not come to grip with the fundamental interests involved and have been careless in analyzing important constitutional issues. If they continue this practice, they will continue to infringe on individual autonomy and thus, make void an individual’s right to refuse treatment.

To properly accommodate these interests, the court’s inquiry must shift from philosophical discussion about the value of life to an evaluation of the practical impact of keeping alive those who have exercised their right to refuse treatment. Shifting the inquiry in this manner leads to three preliminary conclusions about the current legal regime. First, courts generally should not view the patient’s decision to forego life-sustaining treatment as one that is second-guessed, there are real familial and societal consequences for failing to uphold this right. Second, the state’s interest in encouraging doctors responsibility will often outweigh the doctor’s autonomy to practice in a manner that she sees fit and the common law rationales for failing to provide a remedy in this situation.

At some point, courts will be forced to give broader recognition to the right to refuse medical treatment damages. If health care providers are not held liable when they violate the patient’s right to refuse treatment, there will never be an incentive for them to acknowledge the legitimacy of that right.

Under such circumstances, health care providers are encouraged to act in their own best interests and not that of their patients. While the courts are understandably reluctant to interfere with the details of the doctor-patient relationship when basic bio-ethical principles are at stake, the fundamental rights of patients must be recognized. Legislative action in such an area is, of course, necessary if courts will not act appropriately.
MEDICAL MALPRACTICE:
UNDERSTANDING THE EVOLUTION –
REBUKING THE REVOLUTION

By Roger N. Braden and Jennifer L. Lawrence

I. INTRODUCTION

During the past decade, hospitals, physicians, Health Maintenance Organizations ("HMOs") and insurance companies have expended much effort to improve, revise, rewrite and even destroy the laws that have governed the rules surrounding medical malpractice and the medical-legal system that have worked for hundreds of years. Such attacks have focused on attorney fees, limiting an injured person's access to the courts, alternative dispute resolution and placing monetary caps on what an innocent patient can recover from a negligent party. These are just a few of the approaches taken in the ongoing quest to revolutionize the medical-legal system. The result has been an overall decrease in responsibility for hospitals, doctors and HMOs, accompanied by a corresponding increase in related corporate profits.

The purposes of this article are essentially three-fold: first, to serve as a basis in explaining the evolution of our medical-legal system; second, to discuss many of the suggested changes to revolutionize the medical-legal system; third, to explore the logic and reasoning behind each of the above.

A. General Perception vs. Reality

The common belief among the American public is that the United States provides the best medical care in the world. Although there are medical areas in which the United States excels, there are many others in which the nation is, at best, average. Negligence and malpractice are

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common in the United States medical care system.  

In 1990, Harvard Medical School in conjunction with medical record administrators, as well as board certified physicians and nurses, conducted The Harvard Medical Practice Study in New York.  The purpose of the study was to investigate the incident of injuries resulting from "medical interventions" and examine the incidence of injuries resulting from medical interventions or "adverse events." The study involved a sample of more than 31,000 New York hospital records drawn from the year 1984. The study utilized medical record administrators and nurses in the screening phase, and board certified physicians for the physician-review phase.  

The Harvard Medical Practice Study analyzed 30,121 (96%) of the 31,429 records selected for the study sample. After preliminary screening, physicians reviewed 7,743 records, from which a total of 1,133 adverse events were identified that had occurred as a result of medical management within the hospital or required hospitalization for treatment. Of this group, 280 were judged to have resulted from negligent care. Weighing those figures in accordance with the sample plan, they concluded that the incidence of adverse events for hospitalizations in New York in 1984 to be 3.7%, or a total of 98,609 cases. Of these, they concluded that 27.6%, or 27,179 (or 1% of all hospital discharges), were due to negligence.  

The study revealed that the risk of sustaining an adverse event resulting from malpractice increased with age. Persons over sixty-five years of age had twice the chance of sustaining an adverse event than those in the sixteen to forty-four age range. African Americans had a higher incident rate of adverse events and a greater number of adverse events that

3. See id.
4. Id.
5. Id.
6. Id.
7. Id.
8. Id.
9. Id.
10. Id.
11. Id.
12. Id.
13. Id.
occurred from negligence. 14 Furthermore, the study demonstrated that negligent acts occur more frequently within hospitals that served a higher proportion of minority patients. 15

"From a legal standpoint the study concluded that the incidence of malpractice claims filed by patients for the study year was between 2,967 and 3,888. 16 Using these figures, together with the projected statewide number of injuries from medical negligence during the same period, the study estimated that in the State of New York, eight times as many patients suffered from an injury as a result of negligence than the number of malpractice claims actually filed. 17 The study further concluded that, overall, the number of patients that sustained injuries as a result of medical negligence was approximately twice that of the patients who received compensation from the current tort liability system. 18

An examination of the study, which was conducted by unbiased medical personnel, leads one to several logical conclusions. First, there is a higher rate of incidence of medical malpractice claims than those that are actually filed in which compensatory damages are sought and received. Second, an intellectual understanding as to how the current medical-legal system evolved is necessary before a determination can be made as to whether that system should be revolutionized.

II. THE EVOLUTION BEGINS: CHARITABLE IMMUNITY

The modern hospital with its operating theaters, stainless steel equipment, and its large staffs of nurses, doctors, and support personnel has come to symbolize the delivery of medical care. It was not always so. 19

For centuries, in Europe and the United States, hospitals treated the sick and the insane but made no attempt to cure or prevent disease. 20 Hospitals were charitable institutions supported in part by the philanthropy of the wealthy and in part by religious organizations. 21 By the late 1800's, only a small minority of physicians practiced in hospitals and devoted an even smaller portion of their practice to hospital work. 22 Generally, a person

14. Id.
15. Id.
16. Id.
17. Id.
18. Id.
19. Furrow, supra note 2, at 237.
20. Id.
21. Id.
22. Id.
seeking medical treatment before 1900 did not consider hospitalization an option, because physicians routinely made house calls and would perform operations, if necessary, inside patients' homes.  

Technological developments around the turn of the century brought about an abrupt change in the medical care delivery system, moving the hospital to the forefront of patient care, and establishing it as a primary participant in the health care system. Widespread acceptance of new antiseptic and aseptic techniques in the medical field reduced the substantial risk of infection within hospitals that had initially driven physicians into relying primarily on house calls and away from treating patients at the hospital. Gradually, the hospital became a more acceptable place to perform operations and provide patient care. As therapeutic and diagnostic improvements became more readily available, wealthy patients who had previously demanded treatment in the privacy of their own homes began to appreciate the centralization that hospitals could provide as a place where the majority of medical care was now being rendered.

Until recently, hospitals were considered to be charitable institutions and, as such, were exempt from the general rule that a corporation is responsible for the negligent acts of its servants, agents and/or employees. The doctrine declaring charitable institutions immune from liability was established in 1876. The doctrine of charitable immunity protected hospitals from any form of liability through the 1940's. Essentially, hospitals as charitable institutions had absolute immunity from any and all negligent acts of its physicians, nurses, and hospital personnel.

Hospitals that were not protected through the charitable immunity doctrine were those considered to be government-owned hospitals, which were granted and protected by governmental immunity. These doctrines discouraged litigation, thus making it impossible for an innocent patient-victim who had received a devastating injury as a result of the hospital staff's negligence to receive any compensation.

Protected as a matter of public policy, hospitals had little incentive to improve medical care, establish standards for their employees and

23. Id.
24. Id.
25. Id.
26. Id.
27. Id.
28. Id. at 238.
30. FURROW, supra note 2, at 238.
independent contractors and, therefore, became increasingly more focused on their bottom line of profit. As more and more hospitals grew into medical centers they disinherited their backgrounds as charitable organizations and began to concentrate on becoming corporate giants and financial empires. Thus, the charitable immunity doctrine began to erode and hospitals gradually became accountable for the negligence of their employees.

A. Erosions of Charitable Immunity

Injustice ruled against the innocent patient-victim by denying his or her right to be compensated for injuries sustained as a result of negligent hospital employees. This injustice was further perpetuated by the adoption of legal theories which imposed liability upon physicians for the acts or omissions made by hospital employees. The erosion and eventual demise of charitable immunity, coupled with the onset of physician liability, led to stressed relationships between hospitals and physicians.

As control over the hospital began to shift from trustees of religious organizations to the physicians and board of directors, attempts were made to strengthen the relationship between the physician and the hospital. The charitable immunity doctrine, while under attack in the 1940’s and 1950’s, still existed throughout the country. During this time the physician was considered to be an independent contractor of the hospital rather than an employee thereof. Physicians were frequently named individually in lawsuits for the negligence of hospital staff employees since the hospitals remained protected from liability based upon the charitable and/or sovereign immunity doctrines.

While hospitals continued to maintain immunity, legal fictions were created placing responsibility on physicians as hospitals remained protected. The borrowed servant doctrine was one such legal fiction. It provided that a surgeon borrows the hospital’s support staff and nurses during surgery and is responsible for the negligence of the hospital's staff that occurs during surgery or during the events involving the surgery. The ultimate result was to make the surgeon liable for the negligence of the hospital employee, thereby relieving the hospital of accountability and culpability for the negligence of its own employees. The hospital would not be held liable since the nurses and other employees were considered to have been borrowed

31. Id.
32. Id.
34. Id. at 1376-77.
by the physician during surgery. During the time period that the hospital employee was borrowed, the hospital would not be vicariously liable for its own employee's negligence.

Another legal fiction which developed during this era was the "captain of the ship doctrine." This doctrine is an extension of the borrowed servant doctrine and operates on the theory that the surgeon is in complete control of the operating room. It is a strict liability theory, often predicated on the surgeon's right to control the employees of the hospital, rather than the surgeon having actual control over the employees. These fictions arose to ensure a remedy to innocent individuals injured by a hospital employee negligence during a time that hospitals were afforded immunity.

As the courts continued to provide hospitals with at least some degree of protection and insulation from liability for the injuries created by the negligence of their own employees, more relative tests were utilized to determine whether the physician in question was actually an employee of the hospital. Gradually, courts began to impose liability upon the hospital for the negligence of the physicians employed by the hospital. Courts developed judicial tests which lessened the hospital's insulation from liability.

Under the "control test", a number of criteria were used by courts to determine whether the doctor was actually an employee of the hospital. If the contract between the hospital and doctor gave the hospital substantial control over the doctor's choice of patients, or if the hospital furnished the necessary equipment, an employer-employee relationship could be found.

Another approach developed during the devolution of charitable immunity was the "inherent function" test. The "inherent function" test allowed the courts to go even further into their inquiry, examining the functions of the hospital which are essential to its operation. The Washington Court of Appeals in Adamski v. Tacoma General Hospital, held that emergency departments and radiology labs are two such functions and, therefore, the hospital could be held liable for the negligence of the doctors filling those two functions.

The charitable immunity doctrine eventually eroded and hospitals

35. Id.
36. Id.
37. Furrow, supra note 2, at 240.
38. Id.
42. Id.
43. Id at 976-77.
became responsible for the negligence of their own employees. However, until recently hospitals have enjoyed continued protection from litigation for the negligence of physicians under the independent contractor theory.

III. HOSPITAL LIABILITY

As hospitals evolved from charitable institutions into "for profit" corporations the original theory behind affording hospitals immunity dissipated. Hospitals became business entities whose ultimate goal was to increase their profit margins. During this period of hospital evolution major technological developments occurred which changed not only the level of medical care available, but also the standards of care required of providers.

One such example is that of a carbon dioxide monitor, also known as a pulse oximeter. The pulse oximeter was developed to measure an individual's oxygen saturation in the blood. In 1984, no hospital had this device, but by 1990, practically all hospitals used pulse oximeters in their operating rooms. These devices improved medical care to the point that medical malpractice insurers have lowered malpractice premiums for anesthesiologists. In fact, the Joint Commission on Accreditation of Health Care Organization, now requires that all hospitals develop protocols and procedures for anesthetic care which mandate pulse oximeter equipment for measuring oxygen saturation.

Courts have imposed liability on health care institutions for their negligent failure to maintain facilities, provide and maintain medical equipment; negligent failure to hire, supervise and retain nurses and other staff employees; and for their negligent failure to have in place procedures and protocols which protect patients. Basic negligence principles govern hospital liability for injuries caused by sources other than the medical negligence of the hospital's employees.

The primary professional duty of a hospital is to provide a safe environment in which treatment, and recovery can be carried out. If an unsafe condition on the hospital's premises exists due to the hospital's negligence, and that condition causes injury to a patient, the hospital has breached its duty to the patient and can be liable for that breach.

45. Id.
46. 16 JOINT COMMISSION PERSPECTIVES 7, Jan./Feb., 1996.
48. See FURROW, supra note 2, at 252-70.
A hospital has a duty, not only to assure that its staff is properly trained, but also to assure that there are an adequate number of staff members present to perform the task at hand. In today's medical environment, this is an area ripe for attack. Nursing and staff layoffs are commonplace, and often staffing shortages can result in the administration of substandard medical care to the patient. Liability may also be imposed premised upon the theory that understaffing, in and of itself, may constitute negligence. Even when existing hospital staff are reassigned in order to provide for a difficult patient, no defense is created to the liability that may arise therefrom.

Negligence also exists if a hospital fails to provide equipment adequate for the services it offers. The standard of care for hospitals does not require them to maintain state of the art facilities, however, their equipment must be adequate for the services offered by the hospital. This appears to create a dilemma for smaller hospitals that may not be able to afford expensive medical equipment such as CT Scans, MRI and other equipment that may cost in the millions of dollars. Although the smaller community hospital could argue that it should be held only to the same standard as other smaller community hospitals, a new duty has been created. If a smaller hospital cannot afford to buy, and therefore lacks, lifesaving medical equipment, and a patient comes into that hospital with a condition that requires such equipment, then the smaller hospital has a duty to transfer the patient to a facility which may provide the patient with the necessary medical care. Thus, courts generally have determined that hospitals, as health care institutions, owe a duty of care to the patients to whom they provide medical care. The evolution of imposing liability on hospitals for the negligence of hospital employees, gradually extended to physicians, individually, for their own negligent acts, whether employees of the hospital or independent contractors.

IV. PHYSICIAN LIABILITY

Physician culpability for negligent acts has long been a fact of life in our system. When a physician undertakes to treat a patient, the physician takes on an obligation, enforceable by law, to use minimally sound medical judgment and render minimally competent care in the course of the services.

51. Id.
54. See generally, Maxwell Mehlmen, Rationing Expensive Lifesaving Medical Treatments, 1985 Wis. L. Rev. 239 (1985).
the physician provides. 55

Years ago the standard of care was governed by what is commonly referred to as the "locality rule," defining the standard of care according to that which was common to a particular locality or community. 56 Most courts today have moved away from the locality rule, adopting some form of a national standard. 57 This was due, at least in part, to concerns regarding a "conspiracy of silence" that unfairly limits the pool of available experts. 58 Simply stated, doctors do not like to testify against one another. 59 Although the majority of courts have adopted a national standard test, many courts still permit evidence describing the practice limitations under which the physician practices. 60

In the majority of medical malpractice cases, expert medical testimony is required to establish the standard of care in the particular physician's area of expertise. 61 In any jurisdiction, the plaintiff, in order to withstand a motion for a directed verdict, must (1) qualify their medical witnesses as experts; (2) satisfy the court that the expert's testimony will assist the trier of fact; and (3) have the witnesses testify based upon facts that support their expert opinions. 62

There are some instances in which medical expert testimony is not required in the plaintiff's presentation of a medical malpractice case. These represent the exception to the general rule. Expert testimony is not required in a medical malpractice case where the allegations of negligence asserted against a defendant-physician are within the "common knowledge" of laypersons. 63 However, the general rule is that expert testimony is necessary to establish both the standard of care and the breach of that standard by the physician. 64 In certain situations, when a defendant-physician's decision violates a clearly articulated practice within that particular medical specialty, courts have been willing to make a finding of per se negligence. 65

One common difficulty encountered by courts deciding medical-legal

55. Hall v. Hilbun, 466 So.2d 856, 866 (Miss. 1985).
58. Id.
60. Hall, 466 So.2d at 871; Blair v. Eblen, 461 S.W.2d 370, 373 (Ky. Ct. App. 1970).
62. FURROW, supra note 2, at 156.
63. See e.g., Stokes v. Haynes, 428 S.W.2d 227, 228 (Ky. Ct. App. 1986).
64. Bayliss, 805 S.W.2d at 124; Jarboe, 397 S.W.2d at 778.
65. See Deutsch v. Shein, 597 S.W.2d 141, 146 (Ky. 1980).
issues is the lack of an actual national standard of practice for many medical procedures. In areas where the medical community has established clinical guidelines or practice parameters, legal questions arise as to what effect the guidelines have in regard to standard of care issues. While defendant-physicians have used compliance with the established clinical guidelines as a defense, plaintiffs have also used non-compliance as evidence of negligence and have not hesitated to use non-compliance with the guidelines in proving their case in chief. Clearly, the evolution and clarification of what role clinical guidelines will play in exonerating defendant-physicians or incriminating defendant-physicians in medical malpractice cases is yet to be determined.

Hospital liability for negligence evolved from no liability, to limited liability for the negligence of the physicians and nurses employed by the hospital. Courts continued to impose liability on hospitals as the apparent agency or ostensible agency theory emerged.

V. OSTENSIBLE LIABILITY

"An apparent or ostensible agent is an individual whom the principal (the hospital) either intentionally or unintentionally, induces to be its agent, although the principal has not, either expressly or by implication conferred authority upon the agent." The doctrine of ostensible agency imposes liability upon the hospital for the negligent acts of independent contractors working within the hospital. Typically, individuals such as pathologists, radiologists, anesthesiologists and emergency room physicians have contracts as independent contractors with the hospital to provide medical care. The ostensible agency doctrine imposes liability because the actions and conduct of the hospital have led the public into believing that a relationship existed between the hospital and the independent contractor for whom the hospital is not otherwise liable.

The doctrine of ostensible agency in the Commonwealth of Kentucky is essentially set forth in two cases. The Court of Appeals first held the doctrine of ostensible agency to be applicable in the hospital setting in Williams v. St. Claire Medical Center. The seminal case in the Commonwealth of

66. FURROW, supra note 2, at 160.
69. Id.
70. Id.
Kentucky, however, is *Paintsville Hospital Co. v. Rose.* In *Paintsville,* the Kentucky Supreme Court held that the hospital was liable for the negligence of emergency room physicians who were independent contractors via the doctrine of ostensible agency. In discussing the doctrine, the Court stated:

Since then [1955] few courts have failed to recognize the soundness of this application, and the concept has been generally applied not only to anesthesiologists, but to pathologists, radiologists, and emergency room physicians, all of whom who share the common characteristic of being supplied by the hospital rather than selected by the patient.

Although there may be important factual variations from case to case, a patient's non-selection of his physician is often the rule, rather than the exception in the case of anesthesiologists, pathologists, radiologists, and emergency room doctors.

The changing role of hospitals in contemporary society creates a greater likelihood that patients will seek medical care from institutions rather than individual care providers. Other courts agree that the role of hospitals has changed. "No longer are hospitals merely physical facilities where physicians practice their profession. Hospitals hold themselves out to the public as offering and rendering quality health care services." Hospitals are engaged in the business of providing medical treatment and an individual enters the hospital for no other reason than to seek treatment. Contrary to the perception that hospitals merely oversee the actions of doctors and nurses, today hospitals are responsible for the treatment provided by doctors and nurses whom it employs.

With the onset of Health Maintenance Organizations (HMOs) has come new and alternative theories of liability changing the present status of medical malpractice litigation. Medical malpractice continues to evolve through, among other things, theories of HMO liability.

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73. *Paintsville,* 683 S.W.2d at 255.
74. *Id.*
75. *Id.* at 256-57.
78. *Hardy,* 471 So.2d at 371.
VI. HEALTH MAINTAINENCE ORGANIZATIONS: 
THE EVOLUTION OF HMO LIABILITY

By 1997, 77 million Americans were enrolled in a health maintenance organization (HMO). The HMO system of delivering medical benefits has changed not only the way physicians provide care and patients receive it but also the way health care law is practiced. Attorneys well versed in general medical negligence litigation often find themselves ill equipped to handle a case involving an HMO defendant.  

It is essential that every medical malpractice lawyer understand the interworkings of Health Maintenance Organizations because HMOs and managed care organizations are now an integral part of our society. For example, in 1983, approximately 24% of physicians in the United States were associated with, or employed by, HMOs. By 1993, the number of physicians participating in or affiliated with HMOs had increased to 75%. 

In order to understand HMO liability one must first grasp the concept of an HMO, and how it actually works. Generally speaking, an HMO is, "an organized system of health care which provides or arranges for a comprehensive array of basic and supplemental health care services." The health care services are provided on a prepaid basis to members who voluntarily enroll in the plan as provided for by the HMO. In turn, the HMO takes responsibility for providing enrolled members with medical care coverage.

The evolution of HMO liability has, to a certain extent, paralleled that of hospital liability. Much like hospitals, HMOs were traditionally immune from liability. Unlike hospitals, however, HMOs are subject to federal law provisions, most notably the Employee Retirement Income Security Act of 1974 ("ERISA").

Today attitudes toward HMOs have also begun to change. Over time, hospitals and HMOs have been held liable for their own negligent acts. Much of the shift in sentiment regarding hospitals and HMOs is directly

81. ATLA PROF. NEG. L. RPTR.
83. Id.
85. Id.
86. Id.
correlated to their development into conglomerate institutions. Willingness to insulate such entities from liability is presently on the decline. In recent times, public opinion regarding HMOs has changed. The shift in attitude is evident in nearly every medium, from newspaper print to the movie screen. Public attitudes have shifted from the belief that a patient's own physician is primarily responsible for making medical decisions on the patient's behalf to the belief that managed care organizations are the final arbitrators on making important medical decisions. With this change in public attitude towards HMOs, courts are becoming ever more willing to impose liability on these managed care institutions.

A. Limiting HMO Liability: ERISA

Initially, courts held that sections of ERISA governed HMOs and preempted all state law claims for damages under tort theories. In determining whether ERISA preemptions apply, courts have analyzed the nature of the relationship between the parties, as well as the administrative nature of the decision being challenged. Generally, courts have concluded that ERISA preempts state causes of action against HMOs, based upon the premise that such claims arise out of an employee benefit plan as defined by ERISA. It is that plan which is the "source" of the relationship between the plaintiff-patient and the defendant-HMO.

In Lancaster v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc., a federal district court held that ERISA preempted the plaintiff's state medical malpractice and fraud claims. The plaintiff alleged that the HMO had a financial incentive program that discouraged primary care physicians from ordering necessary tests and from referring patients to physicians within other specialties. The court held that plaintiff's cause of action fell within the ERISA preemption. The Lancaster Court further held that the decision on the part of an HMO to implement a financial incentive program was an administrative decision not related to the patient's medical treatment.

88. Medical Malpractice to Managed Care Liability, Insurance Study conducted by Conning & Co. of Hartford, Connecticut.
92. Id.
94. Id.
95. Id. at 1146.
96. Id. at 1150.
97. Id.
ERISA has also been held to preempt personal injury and wrongful death suits arising from claims in which the HMO concealed financial incentive programs which discouraged referrals to other physicians and additional medical testing. However, it is important to note that other courts have held that claims against HMOs based upon financial incentive programs are not preempted by ERISA. As the structure of HMOs have evolved, so has the willingness of courts to impose liability upon HMOs. Similar to the evolution of hospital liability, courts initially did not impose liability upon HMOs, but rather sought to impose liability individually upon the physicians employed by the HMOs.

B. HMO Physician Liability

Courts traditionally discern between “benefits due” under an employee benefit plan governed by ERISA, and the “quality of the medical care” rendered to the plan’s recipient or the patient. When a claim alleges that a physician employed by the HMO was negligent and the HMO physician’s negligence concerns the “quality of the medical care” or the “quality of the benefit” provided by the HMO plan, then courts have been more willing to impose liability upon the HMO outside of ERISA preemption.

With the focus now on the quality of care rendered, physicians employed by HMOs are being subjected to the same standards of care and to the same tort theories of liability as traditional physicians. Medical malpractice claims against HMO physicians do not fall within the realm of ERISA because the allegations concern the deviation of the standard of care regarding inadequate medical care.

Physicians are subject to more detailed disclosure of their relationship with HMOs. Some courts have held that physicians may be liable for a breach of fiduciary duty when they fail to fully disclose their relationship with HMOs. In cases alleging lack of informed consent, courts have also ruled that the physician must disclose any interests, including the relationship with HMOs, which may adversely effect the physician's objective

103. See Moore v. Regents of the Univ. of Cal., 793 P.2d 479 (Cal. 1990).
C. HMO Vicarious Liability

As more physicians and private practice groups become associated with HMOs, there will be a shift in the types of lawsuits filed to include HMOs and other institutions of managed care. The status of HMO immunity is being challenged with the same theories of liability that were imposed upon hospitals. Lawyers have utilized tort theories of liability in an effort to hold HMOs accountable for their negligent acts without being preempted by the provisions of ERISA. Until recently, courts have held that HMOs could not be vicariously liable for a physician's decision not to refer the patient to another physician or order additional tests based upon the notion that the services provided by the physician were derivative from and arose out of the employee benefit plan.

Conversely, other courts have held that claims of vicarious liability against HMOs for their physicians' negligent acts are valid claims, not preempted by ERISA. In one such case, a child who was "enrolled in an HMO as a benefit of her father's employment", received medical treatment over a five year period for debilitating headaches and nausea. The child received medical treatment from primary care physicians employed by the HMO at facilities operated by the HMO. The physicians never referred the child to a physician who would have specialized knowledge regarding headaches, such as a neurologist, and never ordered any diagnostic tests to determine the cause of the child's pain. The child was subsequently diagnosed with having a brain tumor which had increased in size and covered forty percent of the brain. The child-plaintiff brought suit in state court against the HMO and the physicians individually. Although the plaintiff did not prevail on all claims brought against the HMO due to ERISA preemption, the Court in Lancaster held that ERISA did not preempt the plaintiff's claim that the HMO was vicariously liable for the allegations of

104. Id. at 129.
109. Id.
110. Id.
111. Id. at 1140.
112. Id. at 1139.
medical malpractice of the individual physicians.113

Courts have extended the bases for which HMOs can be vicariously liable for the negligent acts of physicians which they employ. In Hoyt v. Edge,114 a U.S. District Court held that plaintiff had a cause of action against the HMO for referring the plaintiff-patient to physicians who rendered a negligent second opinion.115

D. HMO Negligence

Throughout the United States, courts and legislatures are redefining the role of HMO liability. It is essential to first understand the HMO structure and environment before discussing the evolution of HMO liability.

Lawsuits have been filed around the United States alleging that HMO's administer financial incentive programs to HMO-employed physicians for not providing physician referrals and not ordering medical tests. Originally, HMO's denied particular medical testing by claiming that such tests were "investigative" or "experimental" in nature. When that strategy failed, HMOs started utilizing the phrase, "not medically necessary" as a basis for denying medical treatment. The latest strategy employed by HMOs in their effort to deny coverage for medical treatment, is based upon the review of medical articles relating to the particular treatment sought. Yet, the material is often outdated and usually reviewed by an in-house physician. HMOs are intrinsically involved structures which are organized in a complex manner that is confusing to lawyers and patients alike. As a result, the courts and legislatures have combined to establish and implement a duty of care which is now owed by HMOs.

Courts have imposed the same standards upon HMOs that have been imposed upon hospitals. For example, courts have held that HMOs can be liable for negligent credentialing.116 An HMO owes a duty of care to its patients and will be liable for its negligence in selecting, retaining, monitoring and evaluating its physicians and personnel.117 HMOs will also be liable for negligence in the selection and retention of health care facilities.118

Alternative theories of HMO liability have developed from lawyers focusing on the relationship between the patient and the physician. Plaintiff-

113. Id. at 1146.
115. Id. at *3.
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patients have alleged intentional interference by the HMO with the patient-physician relationship.119

In DeMeurers v. Health Net, California, the plaintiff sued her HMO and alleged interference with the patient-physician relationship when the HMO called the supervisors of the plaintiff’s physician and recommended that the physician change an order.120 The physician’s original order stated that the plaintiff required chemotherapy as a result of developing breast cancer.121 However, after receiving calls from the HMO, the physician changed the order to state that plaintiff did not need chemotherapy treatment.122 An arbitration panel, awarded the plaintiff an excess of one million dollars based upon the HMO’s intentional interference with the patient-physician relationship.123

Although courts have imposed similar standards, HMOs differ in many ways from hospitals and, as a result, courts have struggled to define the realm of HMO liability. Courts have been forced to analyze the relationship between HMOs, physicians, physicians’ groups and hospitals in defining HMO liability.

One court has held that HMOs can be liable for the negligence of hospitals with which it has a contractual relationship. In Ouellette v. The Christ Hospital,124 as benefit of her employment, plaintiff received her health care through ChoiceCare, which utilized a process known as “utilization management” to determine if medical treatment was necessary.125 If ChoiceCare decided that the treatment was necessary and the medical treatment required hospitalization, ChoiceCare adhered to a policy which limited the hospitalization according to a predetermined number of days.126 After approval by ChoiceCare, plaintiff went into The Christ Hospital to have her ovaries removed and was permitted by ChoiceCare to stay two days in the hospital.127 Plaintiff developed bleeding and other problems subsequent to the removal of her ovaries but was forced out of the hospital by hospital employees because ChoiceCare would no longer pay for the hospitalization.128 Plaintiff sued both The Christ Hospital and ChoiceCare

120. Id.
121. Id.
122. Id.
123. Id.
125. Id.
126. Id. at 1162.
127. Id.
128. Id.
alleging medical malpractice against both entities. In Ouellette, the Plaintiff alleged that The Christ Hospital and its employees were negligent, while also alleging that the relationship between ChoiceCare and The Christ Hospital caused the hospital to be negligent.

The court held that Plaintiffs' claims against The Christ Hospital and ChoiceCare did not challenge the benefits provided under the plan, but rather challenged the quality of the medical services actually received. As a result, the court concluded, "we find that a claim that the hospital acted negligently due to its relationship with an HMO is not a suit to 'enforce rights under the terms of the plan.'"

With the change in public opinion and attitudes towards HMOs, courts have imposed legal liability upon HMOs and legislatures are now enacting legislation to impose further restraints and standards upon HMOs. Currently, two states, Texas and Missouri, have enacted legislation governing HMO standards for denying medical treatment.

In Texas, an alliance between physicians and lawyers was formed to persuade the Texas legislature to change the current state law and impose liability upon HMOs operating within the State of Texas. The end result is a law which provides that patients may sue their HMOs directly if the HMO fails to use "ordinary care" when deciding whether or not it should pay for a medical procedure. The Texas legislature combined tort and administrative law principles in imposing liability upon HMOs. The new legislation contains a pronged test before an individual may sue an HMO in state court. The negligence on the part of an HMO in refusing to pay for a medically necessary treatment is the first step. The law provides that an individual may appeal the HMO's decision within the HMO itself. If the individual loses his appeal, the next step is to file an appeal with an Independent Review Organization ("IRO"). An IRO is a private company

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129. Id.
130. Id.
131. Id. at 1165.
132. Id.
134. Id.
135. Id.
136. Id.
137. Id.
138. Id.
139. Id.
designated and chosen by the state Department of Insurance. If the IRO determines that the treatment is indeed medically necessary, then the HMO must pay. If, on the other hand, the individual loses the appeal, the individual has the option to file suit against the HMO in state court. The individual is required by law to prove that the HMO, in failing to approve the medical treatment, failed to use "ordinary care" when making that decision. In addition, the law provides for both compensatory and punitive damages. Other states, such as Missouri, have enacted similar legislation and the trend is likely to continue. Pursuant to legislation, such as that enacted in Texas and Missouri, HMOs are treated under negligence principles as being subject to the same standards of care as that of individual physicians.

VI. TORT REFORM: WHO CARES ABOUT THE PATIENT-VICTIM ANYWAY?

Litigation over a patient injury caused by health care professionals can be found in early American law. The earliest recorded American case is Cross v. Guthery. In Cross, the court allowed a husband to sue a surgeon for negligence during an operation that subsequently resulted in his wife's death. Malpractice cases are reported in the early 1800's, increasing in number by the mid-century. As the medical profession increasingly became convoluted with modern medical technologies, litigation increased as well. After World War II, as medical malpractice insurance coverage became expensive, the frequency of claims against physicians and hospitals was viewed as a source of medical-cost inflation.

In the first detailed look by the federal government at medical malpractice litigation, the commission on medical malpractice in 1973 speculated as to the causes of the increase in medical malpractice litigation. The commission found that the increase was due in part to the simple fact that many more people were able to afford and receive medical care,

140. Id.
141. Id.
142. Id.
143. Id.
144. Id.
145. Brienza, supra note 104, at 84.
147. 2 Root 90, 1 Am.Dec. 61 (Conn. 1794).
148. Id.
149. See generally, KENNETH A. DEVILLE, MEDICAL MALPRACTICE IN NINETEENTH-CENTURY AMERICA (1990); WHITE, G., TORT LAW IN AMERICA: AN INTELLECTUAL HISTORY (1980).
automatically increasing the exposure to incidents that could lead to lawsuits. The commission further reasoned, that during this same period, innovations in medical science increased the complexities of the health care system and concluded that some of the new diagnostic and therapeutic procedures brought with them new risks of injury. While few would challenge the value of these modern technological advances, the advances did tend to produce a concomitant number of adverse results, sometimes resulting in severe disability or death.

Increases in medical technologies did not lower the percentage of negligence on the part of physicians. Medical malpractice rates among physicians still remain at an all time high and the error rate in the medical field is higher than the error rate in many other professions. In fact, the Harvard Medical Practice Study projected that up to four percent of all patients hospitalized are the victims of medical malpractice which leads to some type of disability or death.

Instead of focusing on the quality of medical care, the insurance industry and health care providers have attempted to divert the attention away from the medical care quality and toward the innocent patient-victim. During the past twenty years, the insurance industry and health care providers have spent millions of dollars imposing a marketing strategy upon society that attempts to make a medical care provider or the insurance industry the victim, rather than the innocent patient. The unspoken and highly guarded truth is that medical malpractice insurance costs are not a major cost for the health care profession. Medical malpractice premiums constitute approximately one-half of one percent of the total American health care bill that goes to pay for medical malpractice insurance. Essentially, the notion that the insurance industry and/or medical care providers are victims of malpractice cases is an unfounded myth.

Another line of attack on the innocent patient-victim has been tort reform measures throughout the United States, based upon the insurance industry-victim and medical provider-victim myth. During recent years, with these

150. Id.
151. Id.
154. Id.
myths whirling through the air, the majority of states have adopted some form of tort reform\textsuperscript{156} without seemingly ever asking should we even care about the innocent patient-victim.

Common tort reform measures can be divided into four categories: reducing the filing of claims, limiting the amount of the plaintiff's recovery, altering the plaintiff's burden of proof, and changing the role of the judiciary. The purpose behind each is to save money and reduce the amount of claims paid out by insurance companies.

Many states have attempted to limit the number of medical malpractice claims filed by shortening their respective statutes of limitation, limiting attorney fees, or requiring that an individual who is found to have filed a frivolous medical malpractice suit, pay for that frivolous claim.

The State of Ohio enacted tort reform legislation, otherwise known as House Bill 350, which became effective on January 27, 1997.\textsuperscript{157} The Ohio legislature expressly provided that one purpose behind the tort reform legislation was to reduce medical care and insurance-related costs.\textsuperscript{158} The legislation contains many of the common tort reform measures as seen in other states' tort reform legislation. The Ohio legislature expressly overruled the Ohio Supreme Court with many of its reforms.\textsuperscript{159}

Tort reform principles were not enacted for the benefit of the innocent patient-victim. The rationale and basis for enacting such legislation was to lower the insurance costs associated with medical care. The negative impact that tort reform principles would have on innocent patients-victims was never anticipated. Tort reform principles do not decrease the rate of medical malpractice, nor does it reduce medical malpractice insurance premiums. Instead, tort reform insulates physicians, hospitals, and HMO's from liability for their negligent acts, all in the name of saving money. The reality is that tort reform equates to cost-savings for neither the medical profession, nor the general public.

Tort reform measures contradict the findings of the Harvard Medical Practice Study, which determined that the health care profession has a higher rate of error than that of other professions.\textsuperscript{160} Tort reform measures do


\textsuperscript{157} OHIO REV. CODE ANN. § 2305.11 (Banks-Baldwin 1997).

\textsuperscript{158} Id.

\textsuperscript{159} See id.

\textsuperscript{160} See FURROW, supra note 2, at 32 (citing Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York, The Report of the Harvard Medical Practice Study to the State of New York (1990)).
nothing to ensure that medical care will be within the appropriate standard of care. Nor do they protect the patient's health, safety, or well-being. There is a strong argument, tort reform creates an inherent unfairness in our legal system by violating the Equal Protection\(^\text{161}\) and Due Process\(^\text{162}\) Clauses of the United States Constitution.\(^\text{163}\) Tort reform does not account for the seriousness of the injuries sustained by patients.

Instead, it lumps every patient who has been the victim of medical malpractice into one category: cost-saving. With or without tort reform, there is no way to prevent medical malpractice, except by providing patients with medical treatment that is within the applicable standards of care.

**VII. SOLUTIONS OTHER THAN REVOLUTIONIZING OR JEOPARDIZING THE SYSTEM**

The medical and the legal professions have long been honored professions in our culture, cumulating in historic achievements ranging from heart transplants to drafting the United States Constitution. Expectations within both professions should be greater than just meeting a minimum standard. In resolving concerns regarding health care and the legal system, strategies should be developed to provide solutions.

One such strategy is to consider revamping the socialization of physicians beginning in medical school and residency programs. At that level, physicians are taught to strive for error-free practice. While that is admirable, there is a powerful emphasis on perfection both in diagnosis and treatment. Physicians are expected to function without error and that expectation is translated by physicians into the need to be infallible.\(^\text{164}\) The end result of such a system is that physicians come to view error as a failure of character. It has been suggested that this need to be infallible creates a strong pressure for the physician to be intellectually dishonest and to cover up mistakes rather than to admit to the mistakes.\(^\text{165}\) A solution to this problem is to adopt a different approach for the physician beginning at the medical school level.

The legal profession is certainly not immune from criticism. Medical malpractice is serious business and considerations should be given to assuring the qualification of the lawyer handling a medical malpractice case.

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161. See U.S. CONST. amend. V
162. See U.S. CONST. amend. XIV.
164. Lucian L. Leap, Error in Medicine, 272 JAMA 1851 (1994).
165. Id.
State, or perhaps national certification, in the realm of medical malpractice, should be investigated as a requirement before the lawyer can be involved in handling medical malpractice areas. Unless the lawyer has several years' experience, the lawyer should not be able to handle a medical malpractice unless under supervision of an experienced, competent medical malpractice attorney. This suggestion is in accordance with ethical considerations which provide that an attorney should not handle matters in which the attorney is not competent to handle.\footnote{166}{MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.1 (1983); MODEL CODE OF PROFESSIONAL RESPONSIBILITY Disciplinary Rule 6-101 (1980).}

Another solution is to extend the statute of limitations. Currently, the statute of limitations in Ohio and Kentucky is one year from the time the patient discovers or should have discovered that the negligence occurred in which the patient has to file suit.\footnote{167}{KY. REV. STAT. ANN. § 411.140 (Banks-Baldwin 1997); Hart v. Hackworth, 474 S.W.2d 377 (Ky. Ct. App. 1971); OHIO REV. CODE ANN. § 2305.11 (Banks-Baldwin 1997).} A short statute of limitations creates a multitude of problems for both the plaintiff-patient and the defendant-physician. The one year statute of limitations forces the plaintiff-patient to pursue litigation without taking into consideration alternative methods of resolution, particularly when a several month period has elapsed before the injured party contacts an attorney. When the plaintiff-patient is injured individually, or brings a wrongful death action on behalf of the estate, there is a period of recovery, or in the case of death, a period of grief for the loss of a loved one. As a result, many times plaintiffs do not seek legal counsel for months after the medical malpractice event occurred. The short statute of limitations presents plaintiffs limited time to complete investigations into medical malpractice claims and effectively forces many plaintiffs to file suit without having the opportunity to resolve the matter by settlement or some other means.

The short statute of limitations also creates a disadvantage for defendant-physicians, in that a lawsuit which is filed against the physician, may have been done so without the plaintiff-patient having more than adequate time to investigate the claims and explore settlement possibilities. The solution to this problem would be for the legislatures across the country to enact legislation which extends the statute of limitation through the utilization of "180-day letters." The purpose of "180 day letters" is to put any and all potential defendant-physicians on notice that a medical claim is being considered and it also provides the plaintiff-patient with further time to investigate the claim.\footnote{168}{See OHIO REV. CODE ANN. § 2305.11 (Banks-Baldwin 1997).} There are various solutions which could be
VIII. CONCLUSION

The current status of liability for medical care providers in the United States is the result of an evolutionary process that continues today. The types of tort reform being adopted throughout our country and provoked by opponents of the current system in other states fail to address the real problem inherent in the health care industry. The real problem, as indicated in the *Harvard Practice Study* and as outlined in the *Journal of American Medical Association*, is the lack of quality medical care in many areas of our medical care delivery system. Education and changes, as recommended herein, will not eliminate the problem, but will certainly lessen the problem which exists. That is not to say that the legal system is without fault. There is always room for improvement, including the need to have educated and experienced attorneys handling medical malpractice cases and the necessity for lengthening the statute of limitations in medical malpractice actions.

What should be avoided under all circumstances is limiting an innocent victim's right to be totally and completely compensated for injuries caused by negligent medical care providers.
I. INTRODUCTION

This article examines the Supreme Court’s 1990 decision of Zinermon v. Burch, and its implications for voluntary admissions to public mental health hospitals. Its purpose is essentially two-fold. First, the article observes the inconsistency of Zinermon with the Court’s general philosophy favoring limited court involvement in mental health treatment decisions and supporting the primacy of professional decision-making.

Furthermore, this article proposes some common sense changes that can be made to the way in which state legislatures approach mental health issues. These changes would enhance the likelihood that a positive therapeutic alliance could be constructed while maintaining appropriate respect for the patient and his liberty interests, all the while minimizing the involvement of courts and other non-professionals in the process.

II. ZINERMON V. BURCH

A. Facts of the Case

In December, 1981, Darrell Burch was taken to the Apalachee Community Mental Health Services, a facility which had been designated a screening facility by the State of Florida. Bruised and bloodied, hallucinating, psychotic, and believing he was in heaven, Burch was nonetheless allowed to sign documents giving his consent to admission and treatment. Burch remained at the private facility for three days, after which time the staff decided to transfer him to Florida State Hospital (“FSH”), a public mental health facility operated by the State of Florida, for additional treatment. Burch signed papers authorizing the transfer and requesting treatment at FSH, al-

2. Id. One of the results of the deinstitutionalization movement was the creation of screening agencies, one purpose of which was to keep people out of those public hospitals.
3. Id. at 118-19.
4. Id.
though his condition had not measurably improved.5

When Burch arrived at FSH, he again signed papers given to him requesting admission to FSH as a voluntary patient.6 Clinical observations by Dr. Marlus Zinernermon, among others, that Burch was disoriented, semi-mute, confused, and bizarre in thought and appearance at the time of admission showed clearly that Burch lacked the capacity to make an informed consent decision to seek voluntary admission to FSH.7 Burch was released from the hospital five months after his initial admission.8 At that time, he filed a complaint with the Florida Human Rights Advocacy Committee claiming that he did not sign in as a voluntary patient and that his admission was inappropriate.9 After an investigation, the Committee determined that the hospital was probably violating Florida law by asking patients to make admission decisions requiring informed consent at a time when the patients were not competent to do so.10

Subsequently, Burch filed a lawsuit in federal court pursuant to 42 U.S.C. section 1983,11 claiming that the fact that he was permitted to sign an

5. Id.
6. Id. at 119.
7. Id. at 119-20.
8. Id. at 120.
9. Id.
10. Id. The statute provides in relevant part: "A mental health professional, a law enforcement officer, or a judge may effect an emergency admission. After 48 hours, the patient is to be released unless he 'voluntarily gives express and informed consent to evaluation or treatment,' or a proceeding for court-ordered evaluation or involuntary placement is initiated." FlA. STAT. § 394.463(1)(d) (West 1997). Florida law requires "express and informed consent" for voluntary admission. FlA. STAT. ANN. § 394.463(1)(d) (West 1997). The term "competent" is used here synonymously with the phrase "capacity to make an informed consent decision." Actually, there seems to be no uniform definition for the word "competent" as it may mean different things in different situations, all of which may vary from state-to-state. Since "competency" can play a role in the validity of a will, contract, deed, guardianship, evidence, and so on, I suggest that the phrase "capacity to make an informed consent decision" has but one legal usage and, therefore, should be the term of choice. As a matter of shorthand, "capacity" should be sufficiently clear to allow such usage.
11. 42 U.S.C. section 1983 reads:
Every person who, under color of any statute, ordinance, regulation, custom, or usage of any State . . . subjects, or causes to be subjected, any citizen of the United States . . . to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law . . .
The use of 42 U.S.C. section 1983 in this type of situation is primarily for the advantage of the attorney for the Plaintiff. A successful claim under section 1983 brings with it the probability of an award of attorneys' fees, unlike a state tort claim, under 42 U.S.C. section 1988. But see, Farrar v. Hobby, 506 U.S. 103 (1992) (while an award of attorneys' fees may be appropriate, the amount awarded may be as little as zero, where the successful plaintiff proves no actual damages and is awarded only nominal damages). Further,
application for voluntary admission and treatment constituted a violation of his statutory right to the protection of Florida's involuntary commitment law. Furthermore, he claimed that this violated his right, under the Fourteenth Amendment, not to be deprived of liberty under the color of state law without due process.

Two prior United States Supreme Court decisions, *Parratt v. Taylor* and *Hudson v. Palmer*, seemed to dictate that Burch's lawsuit should be dismissed. They essentially stated that where a Fourteenth Amendment right may have been violated, no claim under section 1983 would exist if: 1) the action of a state employee was random and unauthorized, i.e., not an action taken pursuant to any established state procedure, 2) a pre-deprivation hearing was not practical, and 3) the state provided a post-deprivation remedy. In applying this rule to the facts before it, the District Court dismissed the lawsuit, finding that the tort committed by the state hospital employees was random and unauthorized and that the state provided adequate post-deprivation remedies.

On appeal, a three judge panel of the Eleventh Circuit Court of Appeals affirmed the trial court's dismissal; however, the entire court, *sua sponte*, ordered a rehearing *en banc*. As a result of the rehearing, a divided court reversed the District Court's dismissal and remanded the case for further proceedings. The plurality opinion held that the state could have provided pre-deprivation due process and thus a claim under 42 U.S.C. section 1983 was not barred by *Parratt* or *Hudson*.

B. The Supreme Court's Decision

The Supreme Court accepted review of the case under the name *Zinermon v. Burch* in order to resolve the conflicting interpretations of *Parratt* and *Hudson* among the Circuit Courts of Appeals as amply illustrated by the con-
Conflict among the judges of the Eleventh Circuit, itself. Justice Blackmun, writing for the majority, noted:

Because this case concerns the propriety of a Rule 12(b)(6) dismissal, the question before us is a narrow one. We decide only whether the Parratt rule necessarily means that Burch’s complaint fails to allege any deprivation of due process, because he was constitutionally entitled to nothing more than he received — an opportunity to sue petitioners in tort for his allegedly unlawful confinement.

In this 5-4 decision, the United States Supreme Court held that Burch could pursue his claim under 42 U.S.C. §1983.

The Court began its analysis by examining the Florida civil commitment statute and then briefly identifying three types of Due Process claims: (1) a violation of the Bill of Rights; (2) substantive due process; and (3) procedural due process. Burch's claim was a procedural due process claim, as he neither challenged the constitutionality of the Florida statute nor did he claim a violation of the Bill of Rights or substantive due process. A procedural due process claim lies irrespective of whether the deprivation of a constitutionally protected interest was justified. It focuses solely upon whether the procedures used by the state to deprive an individual of this right were fair. The Court noted that "[i]n procedural due process claims, the deprivation by state action of a constitutionally protected interest in 'life, liberty, or property' is not itself unconstitutional; what is unconstitutional is the deprivation of such an interest without due process of law." Earlier Supreme Court cases established that some type of hearing was required before the state could deprive an individual of a protected interest.

22. See Zinerman, 494 U.S. at 116. This Court granted certiorari to resolve the conflict -- so evident in the divided views of the judges of the Eleventh Circuit [a plurality opinion, three concurring opinions with different rationales, and a dissenting opinion signed by five of the thirteen judges] -- that has arisen in the Courts of Appeals over the proper scope of the Parratt rule.

23. Id. at 117.

24. Id. at 139. The majority consisted of Justices Blackmun, Brennan, White, Marshall, and Stevens. Id.

25. Id. at 122-39.

26. Id. at 126-27.

27. Id. at 125. (quoting Parratt v. Taylor, 451 U.S. 527, 537 (1981); Carey v. Piphus, 435 U.S. 247, 259 (1978)). (In Carey v. Piphus, the Supreme Court held that a plaintiff was entitled to at least nominal damages for a violation of the due process clause; more if he could prove actual injury.)

However, under certain circumstances, where a pre-deprivation hearing is not possible, due process may be satisfied through the provision of an adequate post-deprivation remedy. Because Florida provided a post-deprivation tort claim, the Court focused upon the question of whether the pre-deprivation actions of petitioners were random, unauthorized, or could have included provisions for a pre-deprivation hearing.

In distinguishing *Parratt* and *Hudson*, the Court provided three reasons why Burch could proceed under 42 U.S.C. section 1983. First, the Court found that the deprivation was not unpredictable: "[i]t is hardly unforeseeable that a person requesting treatment for mental illness might be incapable of informed consent, and that state officials with the power to admit patients might take their apparent willingness to be admitted at face value and not initiate involuntary placement procedures." Second, the Court was not convinced that a pre-deprivation process was impossible. "Here, in contrast [to *Parratt* and *Hudson*], there is nothing absurd in suggesting that, had the State limited and guided [the] power to admit patients [voluntarily], the deprivation might have been averted." Finally, the action taken by the state officials was pursuant to the power and authority given them by the state to determine whether the person could lawfully sign a voluntary admission request or "initiate the procedural safeguards set up by state law to guard against unlawful confinement."

Thus, the Court concluded that Burch could proceed with his civil rights claim pursuant to 42 U.S.C. section 1983, because he alleged that he "was deprived of a substantial liberty interest without either his valid consent or an involuntary placement hearing, by the very state officials charged with the power to deprive mental patients of their liberty and the duty to implement procedural safeguards."

**C. Analysis of the Decision**

While the constitutional rule of law in *Zinermon* is quite straightforward,

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30. *Id.* at 135.
31. *Id.* at 136.
32. *Id.*
33. *Id.* at 138. Florida's statute requires that a person make application to be a voluntary patient "by express and informed consent." FLA. STAT. § 394.463(1)(d) (West 1997). The definition of "express and informed consent" is: "[C]onsent voluntarily given in writing after sufficient explanation and disclosure . . . to enable the person . . . to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion." FLA. STAT. § 394.455(22) (West 1997).
34. *Zinermon*, 494 U.S. at 138. This conclusion is based upon the rights granted to its citizens by the state of Florida through its legislative scheme regarding involuntary commitment.
it is the apparent “hidden agenda” of the majority (at least Justice Blackmun) which causes the problem in this situation. How much of a problem is determined by whether you see the penumbras of the decision while looking down at it at twelve noon or just before sundown.

*Zinermon* stands for little more than the proposition that state actors who violate state laws, resulting in injury to one’s Fourteenth Amendment life, liberty, or property interests, are subject to suit under 42 U.S.C. section 1983, unless the injured party was provided a pre-deprivation hearing. It is the irresistible temptation of Justices to hint at answers which they say are not being addressed, or to intentionally utilize imprecise language to leave gaps for future interpretations ad which allow lower courts to pursue their own agendas.

There are no decisions which rely upon *Zinermon* to decide a mental health case. Nonetheless, the reading of *Zinermon* as requiring informed consent before a state hospital can accept a request for voluntary admission is certainly on the minds of those involved in this process.

The Supreme Court has decided enough mental health/civil commitment cases to suggest certain clear parameters relating to the liberty interest involved in the involuntary commitment process. *O'Connor v. Donaldson* specifies that an individual may not be involuntarily committed where he is not “dangerous” to himself or others and he can survive “safely in freedom by himself or with the help of willing and responsible family members or friends.”

In *Addington v. Texas*, the Court held that the standard of proof required by the constitution to take away someone’s liberty, due to mental illness and dangerousness, is that of clear and convincing evidence. In *Par-

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35. One would have no trouble finding myriad citations to *Zinermon* at all levels of the federal courts addressing the *Parratt/Hudson* part of that case. *See generally*, *Gilbert v. Homar*, 117 S.Ct. 1807 (1997) (suspension of a tenured public employee without notice and hearing not unconstitutional where employee had previously been indicted); *Powell v. Georgia Department of Human Resources*, 114 F.3d 1074 (11th Cir. 1997) (case-worker’s decision to return child to abusive parent who subsequently killed the child did not require a pre-deprivation hearing); *Harris v. City of Akron*, 20 F.3d 1396 (6th Cir. 1994) (emergency demolition of structure based upon the judgment of the building inspector that an emergency existed in accordance with city law not a violation of due process); *Pruett v. Dumas*, 914 F. Supp.133, (M.D. Miss. 1997) (non-renewal of employment contract consistent with state law does not implicate either property or liberty interests guaranteed by the Fourteenth Amendment.).


37. *Id.* at 576.


39. *Id.* at 424.
ham v. J.R.,\textsuperscript{40} the Court held that the parents of a minor could not sign their child into a state hospital as a "voluntary" placement without the placement being reviewed by a neutral fact finder to ensure the minor meets the admission criteria, presumably of O'Connor v. Donaldson.\textsuperscript{41}

The Supreme Court discussed other elements bearing on the constitutionality of involuntary civil commitment in other contexts.\textsuperscript{42} The seminal case setting out the standards for determining procedural due process is Matthews v. Eldridge.\textsuperscript{43} In this case, the Court defined the elements needed to conduct the balancing needed to determine if state action complies with procedural due process. The Court decided that the following three issues need to be balanced to determine the constitutionality of state action:

First, the private interest that will be affected by the official action [must be identified]; second, the risk of an erroneous deprivation of such interest through procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.\textsuperscript{44}

The first factor which must be examined pursuant to Matthews is whether the action affects the liberty of the individual.\textsuperscript{45} There is no question that involuntary commitment constitutes a major deprivation of liberty of the person committed.\textsuperscript{46} The second factor, the risk of erroneous deprivation of such interest through the proposed process, will be addressed below.

The third and final factor to be addressed, according to the Court in Matthews, is the Government's interest, including fiscal ad administrative burdens which would be imposed by a different procedure.\textsuperscript{47} As noted by the American Civil Liberties Union, the state "has a legitimate and compelling

\textsuperscript{40} 442 U.S. 584 (1979).
\textsuperscript{41} Id. at 606.
\textsuperscript{42} Id. at 606-07.
\textsuperscript{43} That inquiry must carefully probe the child's background using all available sources, including, but not limited to, parents, schools, and other social agencies. Of course, the review must also include an interview with the child. It is necessary that the decisionmaker have the authority to refuse to admit any child who does not satisfy medical standards for admission. Finally, it is necessary that the child's continuing need for commitment be reviewed periodically by a similarly independent procedure.

\textsuperscript{44} Zinerman, 494 U.S. 127 (1990) (quoting Matthews v. Eldridge, 424 U.S. 319, 335 (1976)).
\textsuperscript{45} Matthews, 424 U.S. at 335.
\textsuperscript{47} Matthews, supra note 45.
interest under its *parens patriae* powers in providing care and treatment to its citizens who are unable to care for themselves." The Supreme Court has also squarely and cogently addressed this question in *Parham v. J.R.*

The State obviously has a significant interest in confining the use of its costly mental health facilities to cases of genuine need. The State also has a genuine interest in allocating priority to diagnosis and treatment of patients as soon as they are admitted to a hospital, rather than to time-consuming procedural minuets before admission. One factor that must be considered is the utilization of the time of psychiatrists, psychologists, and other behavioral specialists in preparing for and participating in hearings rather than performing the task for which their special training has fitted them. *Behavioral experts in courtrooms and hearings are of little help to patients.*

The Court, in *Parham*, also addressed the question of the need for judicial involvement in decisions involving liberty interests:

Due process has never been thought to require that the neutral and detached trier of fact be law trained or a judicial or administrative officer. Surely, this is the case as to medical decisions, for "neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments."

The Supreme Court further noted that it was only necessary that the neutral fact finder be one with the power to refuse admission if commitment standards are not met.

In another context, but still involving mental health law and the Fourteenth Amendment's liberty interest, the Supreme Court decided the case of

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49. 42 U.S. 584 (1979).

50. *Id.* at 604-05 (emphasis added). The Court's decision included the following footnote (n.14) at this point in its decision:

It should be realized that procedural requirements entail the expenditure of limited resources, that at some point the benefit to individuals from an additional safeguard is substantially outweighed by the cost of providing such protection, and that the expense of protecting those likely to be found undeserving will probably come out of the pockets of the deserving.


52. *Id.* at 607 (citing *In re Rogers S.*, 569 P.2d 1286, 1299 (1977) (Clark, J., dissenting).

53. *Id.*
Washington v. Harper.\textsuperscript{54} Harper, a prisoner in the Washington state prison system, was suffering from a mental illness.\textsuperscript{55} From time-to-time, Harper would accept medication for his illness, but, at one point, he continually refused to accept his medication.\textsuperscript{56} The state of Washington had an administrative process to determine if prisoners should be medicated against their will, even though the prisoner may have had the capacity to make informed consent decisions.\textsuperscript{57} Harper challenged the decision to administer medication to him against his wishes in state court.\textsuperscript{58}

The Supreme Court of Washington decided that the Fourteenth Amendment Due Process Clause required that the determination of involuntarily medicating someone required a judicial decision, not just an administrative determination.\textsuperscript{59} The State of Washington sought review in the United States Supreme Court.

The United States Supreme Court reversed the State Supreme Court and held that the administrative scheme met Due Process standards:

[Harper] contends that the State, under the mandate of the Due Process Clause, may not override his choice to refuse antipsychotic drugs unless he has been found to be incompetent, and then only if the fact finder makes a substituted judgment that he, if competent, would consent to drug treatment. We disagree. The extent of a prisoner's right under the Clause to avoid the unwanted administration of antipsychotic drugs must be defined in the context of the inmate's confinement. The Policy under review requires the State to establish, by a medical finding, that a mental disorder exists which is likely to cause harm if not treated. Moreover, the fact that the medication must first be prescribed by a psychiatrist, and then approved by a reviewing psychiatrist, ensures that the treatment in question will be ordered only if it is in the prisoner's medical interests, given the legitimate needs of his institutional confinement. These standards, which recognize both the prisoner's medical interests and the State's interests, meet the demands of the Due Process Clause.\textsuperscript{60}

\textsuperscript{54} 494 U.S. 210 (1990). Both Zunerman and Harper were decided on the same day, but from a mental health law point of view, the two cases are diametrically opposed to each other. See Robert D. Miller, The Supreme Court Looks at Voluntariness and Consent, 17 INT'L J.L. & PSYCHIATRY 239 (1994).
\textsuperscript{55} Harper, 494 U.S. at 213-14.
\textsuperscript{56} Id. at 214.
\textsuperscript{57} Id. at 214-15.
\textsuperscript{58} Id. at 217.
One wonders how the Supreme Court came to the conclusion it did in Zinermon in light of the Harper decision issued on the same day.

Applying the Matthews v. Eldridge balancing test Zinermon requires balancing the risk of an erroneous deprivation of liberty against, inter alia; 1) the pre-screening process; 2) the clinical evaluation of the hospital personnel; 3) the compelling interest to provide care and treatment for the citizens of it's state; 4) budgetary concerns; 5) keeping behavioral experts out of court and in the hospitals; 6) the judicial availability of habeas corpus; and 7) advocacy organizations like the Florida Human Rights Advisory Committee. The result is a clear demonstration that the risk of erroneous deprivation of liberty in the future is infinitesimal, while the costs and competing state interests are tremendous. One would be hard-pressed to visualize this situation other than the scale being as high as possible on one side and as low as possible on the other.

Perhaps the biggest irony of the Zinermon and Harper decisions is the time element. The seemingly anti-psychiatrist Zinermon decision would have been more understandable had it been decided prior to 1979. The essentially hands-off position of the Parham and Harper decisions go hand-in-hand. From a mental health point of view (as opposed to the due process basis for the decision), Zinermon was almost an anachronism, especially given the societal changes in place by 1990. Legislatures had revised their civil commitment statutes to adopt deinstitutionalization models. Psychiatric medications and treatments had significantly improved; advocacy groups sprung fore; and investigative journalists were competing with each other to expose governmental failings. Against this background, a system supporting voluntary hospitalization more consistent with a treatment model and a parens patriae philosophy of government should pass constitutional challenge.

III. PROPOSAL FOR CHANGE

In the Editor’s Notes to his volume on Mandatory Treatment, Mark

61. There was no challenge to the legality of involuntarily detaining Burch in the hospital awaiting the due process hearing the Supreme Court required. Thus, the issue is not whether Burch would initially have had his liberty curtailed but the period subsequent to the required hearing were the court to discharge Burch at that initial hearing.

62. The Supreme Court recognized that parens patriae was a fundamental power enjoyed by the states and “is often necessary to be exercised in the interests of humanity.” Mormon Church v. United States, 136 U.S. 1, 57 (1890), cited in Paul F. Stavis, Civil Commitment: Past, Present, and Future, an Address to the National Conference of the National Alliance for the Mentally Ill (July 21, 1995), <http://www.cqc.state.ny.us/cc64.html>, at n.14.

Munetz wrote:

Nothing is more highly valued in America than individual freedom. It has always been clear, however, that freedom is not absolute and with freedom comes responsibility. The challenge for society has been to determine the best balance between the individual’s right to autonomy and the government’s responsibility to restrict that right to protect the individual, others, or society as a whole.64

There are several fundamental principles or constructs which form the basis of the proposal which follows. One is that, except in a situation where an individual with capacity to make an informed consent decision and his psychiatrist agree to the contrary, an individual who does not meet involuntary commitment criteria should not be held involuntarily in a public mental health hospital. A second basic principle is that psychiatrists try to live up to the ethics of their profession and place the best interests of their patients first. Another basic principle is that voluntary cooperation between the patient and psychiatrist results in the best outcomes. A fourth basic principle is that most people in the acute stages of serious mental illnesses are in some type of psychological pain, which frequently can be ameliorated by medication. Fifth, the sooner medication gets started the sooner the patient is likely to be able to leave the hospital. Finally, the best legal approach is to try to strike a fair balance between individual rights and duties and societal rights and duties.

A. A Person is Better Off Out of the Hospital

While this is quintessentially a value judgment, it is the very basis upon which Americans function. “Life, liberty and the pursuit of happiness" were declared by the Declaration of Independence to be inalienable rights.65 The United States Constitution declared, inter alia, that it was being established to “secure the Blessings of Liberty.”66 In 1791, the Bill of Rights declared that the government could not deprive one of “life, liberty, or property, without due process of law.”67 Thus, the deinstitutionalization movement is firmly grounded in American history and philosophy and is based upon American values supporting individual liberty.

B. Psychiatrists Place the Best Interests of Their Patients First

From the Hippocratic Oath to Maimonides’ Prayer for the Physician to

64. Id.
65. THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776).
67. U.S. CONST. amend. V.
the current Principles of Medical Ethics of the American Medical Association, World Medical Association, and the American Psychiatric Association, the ethical obligations subscribed to by all physicians, including psychiatrists, is to strive to provide the best medical care possible for one’s patient. It was the violation of this standard in days past which lead to certain reform measures in the mental health field. The standard, however, remains viable, and there is a rather large difference between society holding its psychiatrists to this standard, and presuming that psychiatrists routinely violate this principle and need to have their treatment decisions reviewed by non-physicians.

Relevant parts of the Hippocratic Oath read “I will keep [my patients] from harm and injustice. . . . [W]hatever houses I may visit, I will come for the benefit of the sick, remaining free from all intentional injustice. . . .” 

Maimonides, a twelfth century physician and a recognized authority on Jewish Law, created a Prayer for the Physician. This Prayer takes the form of a request for the strength to respect everyone, doing a proper job for rich and poor, the wicked and the good, friend and foe, alike, for to do otherwise could bring harm to the Creator’s creatures. The late clinical ethicist, Dr. Benjamin Freedman, wrote a book on the World Wide Web about Jewish bioethics from ancient times to the present. In this book, Dr. Freedman notes the following about the ethical obligations of a physician to his patient and the patient to himself:

Throughout [Jewish Law and practice], medical care is treated as one among the other contingencies of life, and duties associated with medical care are continuous with other duties of concern for self and for others, i.e., the physician is obligated to care for his patient just as well as he would care for himself, no better and no worse, and the patient is obligated to accept appropriate medical care.

Two of the statements of the Principles of Medical Ethics of the American Medical Association and the American Psychiatric Association read: 1) a physician shall be dedicated to providing competent medical service with compassion and respect for human dignity; and 2) a physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

68. Appendix: Codes of Ethics, PSYCHIATRIC ETHICS, 519 (Sidney Bloch and Paul Chodoff eds., 2d ed. 1991).
70. Id. Section 2: “Consent: The Reasonable Caretaker’ and the Obligation to Consent.”
71. PSYCHIATRIC ETHICS, supra note 68, at 519, 526-28.
Finally, The Declaration of Helsinki, revised by the World Medical Association at Tokyo in 1975, reaffirmed the Declaration of Geneva, last amended in 1968, which "binds the doctor with the words 'The health of my patient shall be my first consideration. . . ." 72

In a report on psychiatric conditions in Japan, Timothy Harding, a psychiatrist in Geneva, Switzerland, commented on psychiatric ethics in general: Ethical issues are particularly acute in the practice of psychiatry, as compared to medicine as a whole, because of the acceptance of involuntary forms of treatment as necessary and legitimate. This creates a potential for abuse which, in turn, calls for a high degree of vigilance and sensitivity to ethical and human-rights issues among psychiatric personnel. 73

C. Voluntary Treatment is Preferable to Court Ordered Treatment

Bruce J. Winick, Professor of Law at the University of Miami, has written extensively about therapeutic jurisprudence and the effects of mandatory treatment of inpatients. In one particular article, Professor Winick suggests that "Treating patients as incompetent to make hospitalization or treatment decisions for themselves . . . may . . . actually promote psychological dysfunction." 74 It cannot be gainsaid that involuntary hospitalization ordered by a court is among the strongest statements a state could make that the person is incapable of making these decisions for himself.

D. Most People in Acute Stages of Serious Mental Illnesses are Experiencing Psychological Pain Which can be Ameliorated by Medication

One needs only to observe patients in an acute care mental health facility or talk to a psychiatrist who works in such a facility to know the veracity of this construct. While President Bill Clinton may be mocked for "feeling [other people's] pain," observing one in the acute stages of schizophrenia, mania, or depression can be a truly gut-wrenching experience. At the same time, once a medication is found to work and is started, the improvement is quite palpable.

72. Id. at 520.
73. Id. at 489.
E. The Sooner One is Medicated, the Sooner One may be Able to Leave the Hospital

The Pauline Warfield Lewis Center, a state mental health hospital located in Cincinnati, Ohio, conducted a year-long study evaluating various aspects of involuntary medication. The most startling result of this study was that a fifty-one day average reduction in getting authorization for involuntary medication treatment yielded an average reduced hospitalization of 181 days. The authors attributed at least some of the reduction in days spent in the hospital to the fact that becoming medication started sooner prevented the illness from getting more entrenched, thereby speeding the healing process and restoring the person to a functional level at which he could safely leave the hospital.

Whether these results can be duplicated is essentially of little importance. The facts indicate that starting medication for persons involuntarily hospitalized results in a dramatic reduction in bed-days and is positive for the patient as well as the public in so far as the allocation of scarce governmental resources. This supports Mr. Munetz’s comments regarding the importance of individual freedom: the sooner one leaves the hospital the more freedom that person is able to exercise.

F. The Best Legal Approach is to Attempt to Strike a Fair Balance Between Individual Rights and Duties and Societal Rights and Duties

As the Supreme Court has said, “the deprivation of life, liberty, or property is not itself unconstitutional.” Society has a right to make decisions regarding the allocation of its scarce resources, as long as those decisions are consistent with human dignity and the Constitution. In the context of the Zinermon situation, some of those scarce resources are hospital beds, time available for psychiatrists and psychologists to spend with patients, and

75. See Munetz, supra note 63, at 73.
76. Id. at 78.
77. See Munetz, supra note 63, at 73.
79. See Stavis, supra note 62, at 8. Paul Stavis has observed:

[The tendency of today’s law, although meaning to protect the patient’s rights, has rather ironically required that to treat the patient, he or she must also be sued and stigmatized a dangerous person in some increasingly vague sense of the word. This is undesirable and has been compelling consideration of new laws resurrecting the parens patriae power.]

75-79
money spent for medications. Creating a legislative scheme which encour-
gages voluntary admissions while maintaining appropriate oversight is the best
way to accomplish this complicated goal.80

Therefore, I would propose the following as one way to accomplish these
objectives:81

1. States should adopt a clear policy statement that they are exer-
cising their parenspatriae powers and not their police powers in the men-
tal health field.

2. Individuals who need the services of public mental health fa-
cilities should be assumed to be voluntary patients, even if they lack the
capacity to make an informed consent decision at the time of their admis-
sion, unless they indicate otherwise after some short period of stabilization
of not more than two or three days.

3. Neutral individuals, subject to court supervision, should be hired
by the state to review admissions to determine whether admission criteria are
met by persons who lack capacity.

4. Psychiatrists should be allowed to do their job with the presump-
tion that they are competent, caring individuals who truly subscribe to the
ethics of their profession.

5. In states which do not provide substitute decision-makers guided
by the standard of the best interests of the patient, involuntary medication
decisions should be able to be pursued either administratively or in the courts,
irrespective of the voluntary/involuntary status of the patient.

6. Independent patient rights organizations, as well as the neutral
individuals suggested in number 3, should be created with the power to bring
problematic cases to the attention of the appropriate state court.

7. The concept of “competency” or “capacity” should be addressed
in some fashion to make it clear that, while a substitute decision-maker,
whether an individual, a court, or through an administrative process, may be
appropriate for a short period of time, the general presumption of legal com-
petency and the guarantee of constitutional rights are otherwise left undis-
turbed.

IV. CONCLUSION

The battle between individual rights and treatment obligations, often

80. Sarah C. Kellogg, The Due Process Right to a Safe and Humane Environment for
Patients in State Custody: The Voluntary/Involuntary Distinction, 23 AM. J. L. & MED.

81. The fact that something is listed here is not to be taken as a statement that it
may not already exist in some or all states.
pitting lawyers against mental health professionals, is unnecessary and counter-productive. No responsible mental health professional would systematically seek to “lock-up” individuals who fail to meet constitutionally-based treatment criteria. The above proposal should provide all persons who object to their current hospitalization for treatment of a mental illness, more than adequate protection from an “erroneous deprivation of liberty.”

The government has a duty, “in the [interest] of humanity,” 82 to take care of those who cannot take care of themselves. This proposal does not suggest an abdication of society’s responsibilities to provide appropriate oversight, as may have been the situation a few decades ago. It does, however, suggest a common sense balance between individual liberty and the needs and duties of society in a manner which meets constitutional imperatives.

82. See Stavis, supra note 62.
IS THE WHISTLE CLEAN?
AN EXAMINATION OF THE ETHICAL DUTIES OF
ATTORNEYS IN INVESTIGATING AND PURSUING FALSE
CLAIMS ACT LAWSUITS

By Anthony L. Dewitt

I. INTRODUCTION

This article will endeavor to illuminate some of the obstacles and ethical obligations commonly associated with False Claims Act lawsuits, also referred to as *qui tam* actions. Furthermore, the article will suggest methods by which attorneys can avoid potentially difficult ethical situations and personal liability for costs under the False Claims Act or sanctions under Federal Rule of Civil Procedure 11 [hereinafter Rule 11].

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2. The phrase "*qui tam*" is from the Latin "*qui tam pro dominrege quam pro se ipso in hac parte sequitur*," meaning "who brings the action for the king as well as for himself." See Stinson v. Prudential Life and Accident Ins. Co., 944 F.2d 1149, 1153 (3rd. Cir. 1991).


(b) Representations to Court. By presenting to the court (whether by signing, filing, submitting, or later advocating) a pleading, written motion, or other paper, an attorney or unrepresented party is certifying that to the best of the person's knowledge, information, and belief, formed after an inquiry reasonable under the circumstances,--

(1) it is not being presented for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation;

(2) the claims, defenses, and other legal contentions therein are warranted by existing law or by a nonfrivolous argument for the extension, modification, or reversal of existing law or the establishment of new law;

(3) the allegations and other factual contentions have evidentiary support or, if specifically so identified, are likely to have evidentiary support after a reasonable opportunity for further investigation or discovery; and

(4) the denials of factual contentions are warranted on the evidence or, if specifically so identified, are reasonably based on a lack of information or belief.

(c) Sanctions. If, after notice and a reasonable opportunity to respond, the court determines that subdivision (b) has been violated, the court may, subject to the conditions stated below, impose an appropriate sanction upon the attorneys, law
There are several ethical dilemmas that often present themselves in False Claims Act cases. The first deals with the manner in which an attorney may conduct an investigation into the propriety of charges against an individual or company when the False Claims Act materially limits the type of investigation that can be done. This ethical dilemma presents problems under the Model Rules of Professional Conduct, the False Claims Act, and firms, or parties that have violated subdivision (b) or are responsible for the violation.

(1) How Initiated.

(A) By Motion. A motion for sanctions under this rule shall be made separately from other motions or requests and shall describe the specific conduct alleged to violate subdivision (b). It shall be served as provided in Rule 5, but shall not be filed with or presented to the court unless, within 21 days after service of the motion (or such other period as the court may prescribe), the challenged paper, claim, defense, contention, allegation, or denial is not withdrawn or appropriately corrected. If warranted, the court may award to the party prevailing on the motion the reasonable expenses and attorney's fees incurred in presenting or opposing the motion. Absent exceptional circumstances, a law firm shall be held jointly responsible for violations committed by its partners, associates, and employees.

(B) On Court's Initiative. On its own initiative, the court may enter an order describing the specific conduct that appears to violate subdivision (b) and directing an attorney, law firm, or party to show cause why it has not violated subdivision (b) with respect thereto.

(2) Nature of Sanction; Limitations. A sanction imposed for violation of this rule shall be limited to what is sufficient to deter repetition of such conduct or comparable conduct by others similarly situated. Subject to the limitations in subparagraphs (A) and (B), the sanction may consist of, or include, directives of a nonmonetary nature, an order to pay a penalty into court, or, if imposed on motion and warranted for effective deterrence, an order directing payment to the movant of some or all of the reasonable attorneys' fees and other expenses incurred as a direct result of the violation.

(A) Monetary sanctions may not be awarded against a represented party for a violation of subdivision (b)(2).

(B) Monetary sanctions may not be awarded on the court's initiative unless the court issues its order to show cause before a voluntary dismissal or settlement of the claims made by or against the party which is, or whose attorneys are, to be sanctioned.

(3) Order. When imposing sanctions, the court shall describe the conduct determined to constitute a violation of this rule and explain the basis for the sanction imposed.

5. The statute reads in relevant part:

Whether or not the Government proceeds with the action, upon a showing by the Government that certain actions of discovery by the person initiating the action would interfere with the Government's investigation or prosecution of a criminal or civil matter arising out of the same facts, the court may stay such discovery for a period of not more than 60 days. Such a showing will be conducted in camera. The court may extend the 60-day period upon a further showing in camera that the Government has pursued the criminal or civil investigation or proceedings with reasonable diligence and any proposed discovery in the civil action will interfere with the ongoing criminal or civil investigation or proceedings.


under Rule 11.  

The second ethical dilemma is presented by the unique nature in which a False Claims Act suit must be handled, and by the lawyer’s desire to see the federal government handle the bulk of the work. The limitations on withdrawal of counsel, particularly when combined with the limitations on investigation, create something of a Hobson's Choice for attorneys representing “relators.”

The third dilemma arises in determining how to handle the spoils of a successful qui tam action. The statute makes provisions for attorneys fees, however many of these actions are handled on contingency fee bases.

II. ETHICAL DUTIES IMPOSED BY THE MODEL RULES OF PROFESSIONAL CONDUCT AND HOW THOSE RULES IMPACT FALSE CLAIMS ACT CASES

A. Structure of the False Claims Act

The False Claims Act is a century-old law that was revitalized in 1986 to allow the government to proceed against contractors and suppliers who were costing the government millions in inflated false claims. Though primarily aimed at defense contractors, the law has recently found a great deal of favor with United States Attorneys in the area of health care fraud. The author filed four False Claims Act cases in 1997, all of which involved health care...
fraud and remain under seal.\textsuperscript{13}

The False Claims Act makes a person with knowledge of fraud, the relator, a "bounty hunter" of sorts.\textsuperscript{14} If a relator of such information can describe the fraud with sufficient particularity, the United States Attorney and Department of Justice will intervene in the case and, as a result, a settlement almost always follows.\textsuperscript{15} A successful relator may expect between 15\% and 30\% of the amount obtained by the government depending upon whether or not the government chooses to intervene in the case.\textsuperscript{16} As such, there is a tremendous incentive for the relator to find a false claims case.

Frequently, there are also concerns about the legitimacy of False Claims Act cases. For example, during 1997 the author interviewed, among others, a convicted racketeer who claimed to have information about a scam engineered by an insurance company during the savings and loan crisis. After preliminary investigation, however, the allegations seemed not only improbable and unfounded, but downright false. However, given the process by which False Claims Act cases are handled, it is often difficult for an attorney to determine the merits of a false claims case in situations where the False Claims Act procedures are strictly followed.

Under the False Claims Act,\textsuperscript{17} a relator is required to do two things to perfect a claim against a firm or an individual engaged in fraud against the

\begin{itemize}
  \item \textsuperscript{13}Due to the nature of the allegations, the requirement that these cases be kept under seal, and the pending investigation of authorities, the actual case citations will be supplied only if the cases are unsealed before publication of this article.
  \item \textsuperscript{14}This designation is used because the relator stands to gain somewhere between 15\% and 30\% of the funds recovered by the government, in addition to the attorneys fees and costs. See 31 U.S.C. § 3730 (1994). This is thought by many to color a relator's testimony in favor of the government. In fact, these cases are often characterized by defense attorneys and commentators as "Bounty Hunter" lawsuits. See, e.g., Robert Vogel, Invasion of the Bounty Hunters, LEGAL TIMES, Nov. 16, 1992, at 13; Bruce Fein, Bounty Hunters Unleashed, WASH. TIMES, Aug. 22, 1989, at F1. In the author's experience, none of the relators took the filing of the lawsuit as the first action, but rather, complained vocally and at great length inside their respective companies. The absence of a formal compliance program inside most health care companies is the single largest reason why False Claims Act cases are filed.
  \item \textsuperscript{15}Privately, United States Department of Justice officials tell the author that about 95\% of cases where the United States Department of Justice intervenes to handle the lawsuit settle prior to trial.
  \item \textsuperscript{16}See 31 U.S.C. § 3730 (1994). Under the statutory rubric of the act, if the United States Department of Justice intervenes and prosecutes the case, the relator may obtain a share of the proceeds between 15\% and 25\% of the amount recovered, with the award based on the degree of assistance provided by the relator. If the relator's counsel proceeds with the action without the assistance of the Department of Justice, the relator gets a minimum of 20\% of the proceeds and a maximum of 30\%, depending, again, on the degree to which the relator contributed to the recovery. \textit{Id.}
  \item \textsuperscript{17}31 U.S.C. § 3729 (1994) (False Claims).}
\end{itemize}
government. The relator must file a federal lawsuit under the Act, and it must serve this complaint, under seal, on the United States Attorney and the United States Department of Justice. At the same time the complaint is served, or shortly thereafter (no actual timeframe is specified in the statute), the relator must disclose "substantially all the evidence in their possession" to the United States through a document called the "evidentiary disclosure". This disclosure is significant because the statute provides for a sixty day time period in which the United States Department of Justice must begin investigating the complaint, and this time does not begin to run until the disclosure is actually served on the government. Unlike the complaint, which must be filed under seal with the District Court, there is no such requirement for filing the disclosure statement, and most relators' counsel merely file a notice with the District Court that the disclosure statement has been filed. Once the complaint is filed and placed under seal, most courts interpret the law as requiring the relator to maintain silence as to the allegations in order to permit the government sufficient time to investigate the claim. Disclosure of the contents of the lawsuit has resulted in the imposition of draconian-like measures against the relator, including dismissal of his claim.

The question is, however, to what extent does the structure of the False Claims Act, including its requirement to file under seal, place a de-facto restriction on the investigation of an attorney who is retained specifically to file such a whistleblower case?

B. Rules Regarding Case Initiation

Rule 3.1 of the Model Rules of Professional Conduct states:

A lawyer shall not bring or defend a proceeding or assert or controvert an issue therein, unless there is a basis for doing so that is

18. Id. § 3731 (1994).
19. Id.
20. Id.
21. At least one book on the False Claims Act, JOHN T. BOESE, CIVIL FALSE CLAIMS AND QUI TAM ACTIONS (1993), states that the evidentiary disclosure must be filed with the district court. The United States Department of Justice does not want the evidentiary disclosure filed. Telephone Conversation with Laurie Oberembt, Civil Division, United States Department of Justice (July, 1996).
23. See, e.g., United States ex rel. Lujan v. Hughes Aircraft Co., 67 F.3d 242 (9th Cir. 1995) (reversing and remanding a False Claims Act case that had been dismissed by the District Court for violation of the seal provisions). The Ninth Circuit reversed because the record indicated that the judge had not considered less severe penalties, but left open the possibility that an outright dismissal on this basis might be upheld in circumstances where it was the most fitting penalty. See id.
not frivolous, which includes a good faith argument for the extension, modification, or reversal of existing law. A lawyer for the defendant in a criminal proceeding, or the respondent in a proceeding that could result in incarceration, may nevertheless so defend the proceeding as to require that every element of the case be established. 24

The comments to the rule 25 note:
The filing of an action or defense or similar action taken for a client is not frivolous merely because the facts have not first been fully substantiated or because the lawyer expects to develop vital evidence only by discovery. Such action is not frivolous even though the lawyer believes that the client's position ultimately will not prevail. The action is frivolous, however, if the client desires to have the action taken primarily for the purpose of harassing or maliciously injuring a person or if the lawyer is unable either to make a good faith argument on the merits of the action taken or to support the action taken by a good faith argument for an extension, modification or reversal of existing law. 26

Thus, from a strictly ethical point of view, an attorney may take on a case and prosecute it so long as he has a good faith belief that the evidence will develop as the client asserts, and where he has no reason to believe that the client is undertaking the matter strictly for the purpose of harassing, injuring, or oppressing another party. This is sometimes a problem, however, when viewed in the context of a False Claims Act case.

C. Elements of the False Claims Act Case

There are four commonly-pleaded violations of the False Claims Act. They are (1) submission of a false claim; (2) creation of a false record in support of a false claim; (3) conspiracy to submit false claims; and (4) reverse false claims (where an individual retains a benefit they are not owed). 27 For example, to prevail on a false claim theory, the elements might include:

A showing that an invoice or payment sought from the government was caused or induced by the false representation in an invoice or grant application; A showing that the defendant knew the representation was false or proceeded with reckless disregard of the truth or falsity of the representation; and damage to the gov-

26. Id.
27. DeWitt, supra note 11, at 33 - 37.
To prevail in a false records case, the above elements must be proven along with the showing that the defendant created a false record. In a conspiracy claim, the above elements must be shown in addition to the standard showing of conspiracy. The rules vary somewhat on a reverse false claim, but generally include a showing that the defendant knowingly retained a benefit it was not owed. Although a whistleblower can take on the obligation of proving fraud by pleading this cause of action, the False Claims Act does not require proof of intent to defraud, as in a traditional fraud claim, but merely proof of knowledge.

Clearly the toughest elements to obtain direct proof on in a False Claims Act case are those of knowledge of the false claim, and falsity of the claim itself, as the fraud may involve annotations in the medical record or invoices submitted directly to a fiscal intermediary. This applies particularly to health care false claims. An attorney might be able to gather credible evidence in the form of testimony from the relator, as well as any others that the relator may list as friendly witnesses, but contacting anyone other than the relator risks violating the seal if the defendant finds out about the pending action. The normal methods of gathering evidence prior to trial, including the taking of pre-filing depositions and the gathering of medical records through providing releases, are simply not available. In short, absent smoking gun documents from the relator, the case hinges in large measure on the credibility of the relator and his knowledge of incriminating documents that the United States Attorney might be able to obtain by subpoena.

In some instances, where a relator is still employed by a defendant, the relator may be able to obtain documents that support his claim, but this too poses an ethical dilemma for the attorney representing the relator. The attorney cannot do through an agent what he could not do himself, and if the attorney counsels a relator to take documents and sensitive material, he may be crossing this line.

28. For a thorough analysis of all the claims that are normally brought in a False Claims Act case, as well as all the elements of the action, see DeWitt, supra, note 11 at 34, 37.
29. See DeWitt, supra, note 11 at 34, 37.
30. See id.
31. See id.
33. See MODEL RULES OF PROFESSIONAL CONDUCT Rule 4.4 (1983). Rule 4 states in relevant part: In representing a client, a lawyer shall not . . . use methods of obtaining evidence that violate the legal rights of such a person. Id.
D. Examining the Relator's Motivations

Normally the whistleblower will not seek out the attorney until he has exhausted all efforts to handle the matter inside his employer, using his employer's procedures. Therefore, when the potential client comes in, he may have a series of grievances against the company, their supervisors, or other individuals in the chain of command. It is not uncommon for these individuals to believe, quite emphatically, that everyone in their chain of command is guilty of some type of fraud. Often, careful interviewing will determine whether or not these suspicions have clear evidentiary support.

Employees often look for a way to get even with employers over a discharge that they feel was unwarranted or improper. Rather than resolving the merits of their claims by other means, many disgruntled employees seek to achieve justice by initiating a False Claims Act lawsuit against their employers. Thus, whenever a relator has been fired, suspended, or disciplined, or where he has a somewhat checkered employment history, a more careful and searching inquiry is required. It is wise to determine from the outset whether the individual has a real or imagined grievance, as often the alleged fraud is merely a cover for an exercise in retaliation, forcing the company to defend itself. For this reason, when an employee has been disciplined or terminated, it is important to carefully evaluate their employment history and emotional state of mind in order to determine if the individual can be impeached regarding the "real reasons" for filing a False Claims Act lawsuit.

III. OTHER LIMITATIONS ON CASE INITIATION IN FALSE CLAIMS ACT LAWSUITS

A. Federal Rule of Civil Procedure 11

Federal Rule of Civil Procedure 11 places a slightly different obstruction in the way of filing a false claims act lawsuit, and states in applicable part:

Rule 11. Signing of Pleadings, Motions, and Other Papers; Representations to Court; Sanctions

(b) Representations to Court.

By presenting to the court (whether by signing, filing, submitting, or later advocating) a pleading, written motion, or other paper, an attorney or unrepresented party is certifying that to the best of the person's knowledge, information, and belief, formed after an inquiry reasonable under the
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(c) Sanctions.

If, after notice and a reasonable opportunity to respond, the court determines that subdivision (b) has been violated, the court may, subject to the conditions stated below, impose an appropriate sanction upon the attorneys, law firms, or parties that have violated subdivision (b) or are responsible for the violation. 34

It puts teeth into the Model Rules of Professional Conduct requirements that the action be brought for a proper purpose, and that the facts pleaded either have evidentiary support, or, where so indicated, are believed to be supportable in discovery. 35 A careful search of federal cases has revealed no instances where Rule 11 has been applied in a False Claims Act context. However, Rule 11, when coupled with the False Claims Act, serves as a check against the filing of frivolous False Claims Act cases.

B. The False Claims Act's Penalty for Vexatious Filing

If Rule 11 and Model Rule of Professional Conduct 3.1 are insufficient impetus for an attorney to thoroughly and effectively evaluate a potential

34. FED. R. CIV. P. 11.
35. See, e.g., MODEL RULES OF PROFESSIONAL CONDUCT Rule 3.1 (1983); see also discussion supra Part II.B.
False Claims Act case for filing, the False Claims Act itself should be sufficient to so motivate. Section Four of the Act provides:

If the Government does not proceed with the action and the person bringing the action conducts the action, the court may award to the defendant its reasonable attorneys' fees and expenses if the defendant prevails in the action and the court finds that the claim of the person bringing the action was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.\(^6\)

This section seems to require a finding of clear and convincing evidence that the relator brought the action for an improper purpose before it will impose liability, but it still places a burden on counsel for the relator to evaluate effectively the case.\(^7\) The attorney must do so with the understanding that the relator may ultimately be responsible for thousands of dollars in attorneys fees and costs should the case turn out to be frivolous. The problem is, however, that determining the merit of the allegations, particularly in the context of health care claims, may be nearly impossible for the relator's counsel.

**IV. PRACTICAL APPLICATIONS OF ETHICAL RULES TO FALSE CLAIMS ACT CASES**

**A. Hypothetical Example of Ethical Concerns in a Medicare Fraud Case**

Consider a hypothetical where R, the relator, knows that C, the company he works for, is billing the government for one and one-half hours of time for a medical procedure that R knows takes no more than fifteen minutes to perform. The direction to code and log the medical procedure is always verbal, there being no written policy on how these times are to be recorded. R is required to fill out a form that accounts for his hours and his medical care by indicating per patient how many 'units' of therapy he completed. He is told to write six for a specific type of therapy irrespective of how long it actually took to do it. R knows that one is the correct amount to bill, and addresses this with a representative of C who assures him that these sheets are not sent to Medicare, and that it is therefore not Medicare Fraud to record six units of time instead of one. C, however, bills the government for six units in each instance. R makes copies of the actual time sheets he signs, but he cannot gain access to the actual bills submitted to Medicare because those bills are submitted initially to a nursing home, and secondarily to a fiscal intermediary for Medicare, using the patient's demographic data. Absent a


\(^{37}\) See id.
release from the patient, R has no way to be sure that what he suspects is being done, namely the false billing to Medicare, is actually being done. R approaches someone higher up in C to advise them of his concerns, and the next day he is fired. R then contacts an attorney to represent him in a False Claims Act case against C. The only evidence he has is the time logs.

Assuming the relator wants to bring a false billing case, the first element he must prove is that a claim was submitted to the federal government for payment.\textsuperscript{38} The relator in this hypothetical situation lacks any such evidence. He may have a reasonable belief that bills are submitted based on his knowledge of how the defendant operates, yet the fact remains that the relator is clearly without direct proof.

One method of circumventing this is for the relator’s counsel to make a request through the Freedom of Information Act\textsuperscript{39} to the Health Care Financing Administration\textsuperscript{40} for the number and amount of Medicare claims filed by the defendant during the past fiscal year. Though not dispositive on the issue of falsity, it helps the relator's counsel establish definitively that the defendant is doing business with the federal government.\textsuperscript{41}

The relator must also prove that the claims, when submitted, were false. The above hypothetical certainly contains some evidence of false billing. The time sheets, from which the bills are believed to be prepared, have been falsified. These, however, are not submitted to Medicare. Thus, there is no direct evidence of false billing in the relator’s possession.

Because the bills themselves are not available to R’s counsel, the only evidence that the attorney possesses are the time sheets and the client’s

\textsuperscript{38} According to the Act, a claim “[i]ncludes any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.” 31 U.S.C. §3729 (C) (1994).


\textsuperscript{41} The Freedom of Information Act, 5 U.S.C. § 552 (1994), while useful, may not be fast enough to meet the needs of counsel if there is any likelihood that other relators may try to file a False Claims Act claim also. It may take as long as six months to get information back from HCFA. In addition, counsel will be required to pay photocopying charges. There is also a danger that the request might set into motion review of the defendant by the Health and Human Services Inspector General. For these reasons, direct contact with the fiscal intermediary may be an option.
testimony as to what occurred. Is this enough to avoid sanctions under Rule 11? Does the attorney have an ethical duty to look further? In other contexts, particularly in personal injury matters, the above would not likely meet the threshold tests of Rule 11 or the Model Rules of Professional Conduct. However, given the statutory scheme of the False Claims Act, which charges the United States Attorney with doing the bulk of the investigation, there are reasons to permit a lower standard. For one, False Claims Act cases frequently lead to criminal prosecution. If the attorney were to pursue the claim and inadvertently alert the defendant to a pending federal probe, the opportunity to prosecute corporate wrongs and wrongdoers could be lost. Therefore, this author believes that the False Claims Act implicitly lowers the standards of proof and evidentiary support necessary to file a False Claims Act lawsuit to a level slightly below the guidelines set forth in Rule 11. Specifically, where there is reason to believe that the allegations are well founded, and that evidentiary support can be obtained through the use of the subpoena power of the federal government, the False Claims Act procedure almost mandates filing on the basis of something less than a full investigation.

The Act requires that the action be filed under seal. It specifically provides that the United States Department of Justice or United States Attorney can dismiss the lawsuit where the action is determined to have no merit. These safeguards protect the reputation of the innocent defendant by preventing the tarnishing of its name in the local media. Similarly, they provide an advantage in investigation of the culpable defendant by preventing otherwise public disclosure of the basis of the lawsuit. However, no court has ever addressed these issues and it seems prudent for litigators filing False Claims Act cases to document their attempts to comply with both the letter and the spirit of Rule 11.

In an ordinary medical malpractice case, for example, an attorney would

42. *See supra* Parts II.A., III.A.
44. Indeed, the False Claims Act provides for criminal as well as civil penalties, 31 U.S.C. §§ 3729(a), 3730(c)(5), and new health care legislation, S. 1028, 104th Cong. 1996, increased the number and type of criminal penalties available in this area. Therefore, particularly where the United States Attorney has an interest in conducting a secret or undercover investigation into criminal matters, the need to maintain the seal and cloak the government's investigation probably trumps the strict ethical duties of the attorney in this context, though the matter has never been litigated or decided.
46. *See, e.g., Id. § 3730 (O)(2)(A) (1994) (outlining rights of the parties to qui tam actions).*
simply launch an investigation. As long as no ethical rules are violated, employees, former employees, patients, and others may be interviewed, and documents may be gathered to obtain more evidence. Indeed, most states have means to preserve testimony prior to the actual filing of a case.\footnote{See, e.g., Mo. R. Civ. P. 57.02 (1996).}

However, in a False Claims Act case there are two significant dangers associated with in-depth investigation by the relator's counsel. Primarily, there is the risk that the company could learn about the investigation, shred all data, impose a gag order on all employees, and effectively destroy any possibility of proving the claim. It is for this very reason that the False Claims Act case is originally filed under seal.\footnote{Worse, from the plaintiff's view, the company could recognize that it was under investigation, make a disclosure to the federal government, pay smaller fines and penalties, and effectively cut the relator out of any share of the proceeds. See, 31 U.S.C. § 3729 (1994).}

Second, the complaint, when filed, may be attacked by the United States Attorney by claiming that the seal has been violated and the element of surprise has been lost. The United States may then move to dismiss the relator. Note that there is a certain interest in False Claims cases in cutting the relator out any share in the proceeds. Even if the relator is dismissed from the case, the United States Department of Justice may still pursue it.\footnote{See, e.g., United States ex rel. Neher v. N.E.C. Corp., 11 F.3d 136 (11th Cir. 1994) (illustrating how the Department of Justice went to extreme measures to cut the relator, a man dying from cancer, out of his share of a qui tam award).}

The defendant may also attack the claim based on the pre-filing disclosures of the petition, and be able to successfully get the relator dismissed for failure to follow correct False Claims Act procedure.\footnote{See United States ex rel. Lujan v. Hughes Aircraft Co., 67 F.3d 242 (9th Cir. 1995).} In either event, if the relator remained in the case, the percentage of the award would doubtless be very small. This then raises the issue of how to best go about investigating a False Claims Act case. The answer may well depend as much on the functional nature of how these cases are handled as it does on anything else.

\textit{B. Relator's Goal: Intervention}

The goal of the relator in a False Claims Act case is to get the case into the hands of the United States Attorney, and to convince the United States Attorney that the case has merit and should be prosecuted.\footnote{See DeWitt, supra note 11, at 34, 37.} If this is done, the attorney representing the relator can turn over the day-to-day evidence gathering duties to the United States Attorney, and can offer such help as is
required during the pendency of the case. The expenses of the litigation in terms of depositions, travel, and similar out-of-pocket costs, are assumed by the United States Government, and the relator does not have to advance these costs. This can be significant when the target of the probe, a huge healthcare conglomerate or defense contractor, has an unlimited budget to defeat the action. For this reason the goal of the relator's counsel in investigating a case must necessarily be limited to packaging the case for the United States Attorney, and delivering to the government all of the elements necessary for a successful prosecution. This is often more difficult than it first appears.

The testimony of the relator alone will rarely be enough to get the government interested, and for this reason, relators are asked to produce documentary evidence of fraud, false billings, or policies which support their contentions that false claims have occurred. However, as hospitals and defense contractors have become more aware of their potential liabilities under the False Claims Act, these documents are frequently difficult, if not impossible, to produce.

Recently the author learned that counsel representing relators in a Medicare case were contacted by counsel for the defendant. Counsel was served by certified mail with a demand for all documents in his possession that were authored by anyone in the company. The company claimed that it had copyrighted all of the documents, that the documents represented trade secrets, and that secondary disclosure would result in civil liability for both the author's clients as well as personally for the attorney. The letter then closed with a demand to send any documents to the counsel for the defendant.

The defendant did not know that a case had been filed. Nevertheless, this kind of heavy-handed scare tactic is frequently employed against current or former employees to induce them to divest themselves of any "smoking gun" documents they may have kept. In addition, termination agreements are now requiring, as a condition of any severance payment, that all documents in the possession of the employee be turned over prior to any negotiation of the severance check. Although there are public policy issues involved, no court has yet decided whether an employee who cooperates with the government in a probe of government fraud could have such an agreement enforced against

52. Merely finding a competent relator is not enough. Counsel should obtain as much evidence as possible within the bounds of the law; provide the names, addresses and phone numbers of potential witnesses; provide the names of expert witnesses where applicable; and offer to participate in any way reasonable.


54. The case remains under seal and counsel has asked not to be identified.
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[149x653]them." These kinds of tactics are designed to help the defendant hide its paper trail and thereby avoid liability.

C. Creating A Blueprint for the False Claims Act Case

There are three fundamental steps in filing a False Claims Act case. The first step is to exhaustively interview the relator and review the documentary evidence he provides.\(^{56}\) The second step is to draft the complaint in separate counts for each False Claims Act violation.\(^{57}\) The third step is to draft the evidentiary disclosure, indexing it directly to each count of the False Claims Act lawsuit.\(^{58}\)

The initial interview should be relatively brief (one to two hours) and should focus generally on the kinds of fraud that occurred. Ideally the information gleaned from this interview should allow the attorney to determine how many counts of false claims will be filed, and what general facts support those claims. Have the relator bring along any documentation he may have in his possession which supports the allegation of False Claims Act violations. The interview should help identify documents that might be important, and any documents the relator may have in his possession should be examined, if only briefly. Any "smoking gun" documents should be brought to the top of the pile for more thorough review. The first interview should focus on what the relator knows and to that which he can testify from personal knowledge, and additionally, what other evidence the relator knows or suspects to exist that supports his claims. After this initial interview, the next step is to work with the documents and flesh out the complaint.

Should the relator produce relevant documentation of False Claims Act violations, the first thing that the attorney should do following the interview is index and catalog the documents, prioritizing each with regard to the claims the relator wishes to advance. Each document should be indexed to the specific claim it supports, and a database should be established which further describes the meaning of each document and its relationship to the claim. A copy of this database should subsequently be provided to the government along with the disclosure statement.

Once all the documents have been cataloged and indexed, the relator should be called back for a second interview. At that point every document


\(^{57}\) See id.

\(^{58}\) See id.
should be reviewed with the relator, no matter how insignificant it may seem to counsel. The interview should be as long as is necessary to substantiate each element of every claim. Counsel should start with the first claim advanced in the petition, and should have the relator orally state what he knows. The documents should then be reviewed with an eye toward which of them will support the claim. If the documents have been appropriately indexed, this process will not take particularly long. Information obtained in this manner becomes part of the evidentiary disclosure.

As a final step, the relator's credibility should be established. This may be accomplished by allowing the relator to give a sworn statement of such information, recorded by a trusted court reporter. However, since this process involves a third party, and effectively creates another person with knowledge of the facts, it is not recommended, except in the most complex of cases, or where otherwise necessary. A better way is to prepare an affidavit to be filed with the evidentiary disclosure that states that all the information supplied is true, that the relator will testify truthfully to the facts contained therein, and that the relator knows that false testimony can submit him to prosecution.

Once this process is completed, the relator's counsel, having nearly all the evidence, will be capable of estimating if additional evidence is necessary to prosecute the claim. This will also afford counsel for the relator the ability to accurately judge whether the standards of Rule 11 and Model Rule of Professional Conduct 3.1 have been satisfied.

D. Ethical Implications of Withdrawal

At this point, counsel must make a determination as to whether or not a case exists. It is worth noting that the structure of the False Claims Act permits the relator to carry the case forward without the government.\textsuperscript{59} That the statute envisions such a result makes the evidentiary disclosure all the more important. Once the case is filed, relator's counsel cannot simply walk away should the United States Department of Justice decide not to intervene. Counsel's responsibilities under Model Rule of Professional Conduct 1.16\textsuperscript{60} may limit his ability to withdraw as counsel if the government declines to proceed with the case.\textsuperscript{61} Under Model Rule of Professional Conduct 1.16, the client is permitted to request that a judge force counsel to continue

\textsuperscript{60} MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.16 (1983).
\textsuperscript{61} MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.16(b) (1983). The rule states, in applicable part that, "[c]ounsel may withdraw from a case where . . . (5) the representation will result in an unreasonable financial burden on the lawyer or has been rendered unreasonably difficult by the client, or (6) for other good cause shown." Id.
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Counsel would then be forced to demonstrate the applicability of any of the exceptions to Model Rule of Professional Conduct 1.16.63

In such a situation, particularly where the defendant has unlimited resources, the attorney who has failed in his obligations to evaluate the case carefully may have undertaken a case that will ultimately result in financial ruin. It is specifically for this reason that counsel representing relators in *qui tam* actions should establish contracts which permit the right to re-evaluate cases in the event the United States Department of Justice, for any reason, declines intervention.

**E. Contractual and Fee-Splitting Issues**

Several safeguards are available for attorneys who wish to handle False Claims Act cases. The first safeguard is the attorney-client contract. The contract should specify that the attorney has limited rights to investigate the claim under the statute, that the federal government may have superior rights to the litigant under the statute, and that the course and scope of the case may be changed by the government without a great deal of input from relator's counsel. By establishing early on that relator's counsel is working off less than the full record, the likelihood that a successful withdrawal can be negotiated later improves.

Fee issues are also a concern. The contract should specify a fee agreement that is fair and reasonable under the circumstances, and one which establishes an hourly fee for work done on the case. While most attorneys handle these matters based on a contingency fee, an hourly billing

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62. **MODEL RULES OF PROFESSIONAL CONDUCT** Rule 1.16(c) (1983) ("When ordered to do so by a tribunal, a lawyer shall continue representation notwithstanding good cause for terminating the representation").

63. **MODEL RULES OF PROFESSIONAL CONDUCT** Rule 1.16(b) (1983). The rule states, in part:

(b) except as stated in paragraph (c), a lawyer may withdraw from representing a client if withdrawal can be accomplished without material adverse effect on the interests of the client, or if:

1. the client persists in a course of action involving the lawyer's services that the lawyer reasonably believes is criminal or fraudulent;
2. the client has used the lawyer's services to perpetrate a crime or fraud;
3. a client insists upon pursuing an objective that the lawyer considers repugnant or imprudent;
4. the client fails substantially to fulfill an obligation to the lawyer regarding the lawyer's services and has been given reasonable warning that the lawyer will withdraw unless the obligation is fulfilled;
5. the representation will result in an unreasonable financial burden on the lawyer or has been rendered unreasonably difficult by the client; or
6. other good cause for withdrawal exists.

Id.
arrangement permits more orderly remuneration when a successful case results in an award of attorneys fees. Thus the contract should specify a contingency fee with the understanding that the defendant will be billed additionally for time and expenses in the event the claim is successful.

Some firms use a standard thirty percent or forty percent contingency fee contract in *qui tam* actions, with the understanding that any attorneys fees paid to the client are to be considered a part of the total award. Under this thinking, a relator's share could be $300,000, and the attorneys could receive an additional $200,000 in hourly billing. The two amounts are aggregated to $500,000 with the firm receiving thirty percent of the total award ($150,000). However, such an arrangement probably runs afoul of Rule 5.4 of the Model Rules of Professional Conduct which prohibit the sharing of legal fees with non-lawyers. Thus a better approach would be to utilize a flat contingency fee of twenty-five percent of the relator's share where the defendant is ordered to pay legal expenses (in which case the lawyer can bill the hourly time charged to the case to the defendant) or a fee of forty percent where settlement does not require the defendant to pay the attorney separately.

A further safeguard, which may be included in the employment contract, is the right of the attorney to conduct a background check of the relator, including the use of a private investigator, or the obtaining of a consumer credit report. Since the relator's testimony will be challenged for bias, it is of vital importance to have a relator that is credible. Thus, a relator who has filed for bankruptcy, has any misdemeanor convictions, or who is otherwise untrustworthy, should be rejected, because the government normally does not intervene in cases that lack a credible relator.

V. CONCLUSION

The ethical issues facing lawyers handling *qui tam* actions are not easy ones. The best approach is to attempt provide for all foreseeable difficulties beforehand. This is best accomplished by mapping out a strategy for dealing with the government, the relator, and the defendant at the earliest possible stage of the proceedings.

The penalties for failure to secure good evidence regarding the claim are significant. A claim that is poorly documented will not be well received by the United States Attorney or the Department of Justice. The claim that relies solely on the relator's credibility opens the relator up to impeachment and attack on numerous collateral issues. In addition, there is always the possibility that the relator will be liable for expenses and costs, and the

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64. MODEL RULES OF PROFESSIONAL CONDUCT Rule 5.4 (1983).
attorney liable for sanctions, should insufficient steps be taken to secure as much evidence as possible within the boundaries of the False Claims Act. However, where the case is properly prepared, the relator credible, and the evidence of fraud strong, a *qui tam* action under the False Claims Act represents one of the truly wonderful opportunities in our American justice system to do well while doing good.