The Law of Healthcare Administration

Fifth Edition

J. Stuart Showalter

THE LAW OF HEALTHCARE ADMINISTRATION

FIFTH EDITION

THE LAW OF HEALTHCARE ADMINISTRATION

FIFTH EDITION

J. Stuart Showalter

Your board, staff, or clients may also benefit from this book's insight. For more information on quantity discounts, contact the Health Administration Press Marketing Manager at (312) 424–9470.

13 12 11 10 09 5 4 3 2 1

Library of Congress Cataloging-in-Publication Data

Showalter, J. Stuart.
The law of healthcare administration / J. Stuart Showalter. —5th ed.
p. cm.
Includes index.
ISBN 978-1-56793-957-6 (alk. paper)
1. Medical care—Law and legislation—United States. 2. Hospitals—Law and legislation—United States. 3. Medical laws and legislation—United States. I. Title.
KF3825.S65 2007
344.7303'21—dc22

2007015059

The paper used in this publication meets the minimum requirements of American National Standard for Information Sciences—Permanence of Paper for Printed Library Materials, ANSI Z39.48-1984. ♾™

Acquisitions editor: Janet Davis; Project manager: Jane Calayag;
Cover designer and layout editor: Chris Underdown

Health Administration Press
A division of the Foundation
of the American College of
Healthcare Executives
One North Franklin Street
Suite 1700
Chicago, IL 60606
(312) 424–2800

BRIEF CONTENTS

DETAILED CONTENTS

PREFACE

The Law of Healthcare Administration is intended to give readers some appreciation of the role law plays in the everyday operation of our healthcare system. The book was first published in 1988, when the late Arthur F. Southwick was a guiding light in our field. It was the first to capture the essence of health law from management's perspective. I have been privileged to carry Professor Southwick's legacy through the third and fourth editions, and now it is time for the fifth.

My publisher has told me—probably in an effort to inflate my ego and keep me writing (it worked on both counts!)—that this is one of the best-selling books ever published by Health Administration Press. Its continued popularity in a rapidly changing field is a powerful reminder that "law is the warp and woof of healthcare," to paraphrase one of my former bosses.

The goal for this edition was to retain the book's basic format but to make the following important changes:

- New developments in several areas are discussed. Although the law changes at a glacial pace, small avalanches do happen from time to time. I point these changes out, including those in the areas of HIPAA, abortion, and withholding life-sustaining treatment.
- Plain language is used as much as possible. Legalese can induce not only confusion but also somnolence; both should be avoided.
- Chapters have been reordered for a different and better flow to the material.
- The chapter formerly entitled "Corporate Compliance Programs in Healthcare" has been reworked to give greater emphasis to healthcare fraud and abuse issues. It is now called "Fraud, Abuse, and Corporate Compliance Programs."
- Chapter Objectives now introduce each chapter, giving the reader a quick preview of the lessons in each chapter.
- Legal Briefs, Legal DecisionPoints, and The Law in Action are sprinkled throughout the chapters. *Legal Briefs* offer extra information,

not always about legal matters, that adds interest to the learning of concepts. *Legal DecisionPoints* include legal scenarios for further thought. *The Law in Action* boxes lay out actual cases and outcomes and are akin to the "war stories" that I often tell in class and that seem to stimulate good discussion. Questions and scenarios raised in these three extra elements will spur critical thinking and hopefully add to students' understanding of the concepts in the chapter.

- Chapter Summaries and Chapter Discussion Questions follow each chapter.
- The appendix in the fourth edition has been abandoned in favor of some excerpts of judicial decisions in the pertinent chapter.
- Now located at the end of each chapter is *The Court Decides* section. Most cases in this section are accompanied by discussion questions. The cases in this section are compiled from the opinions of various federal and state courts. They are presented to illustrate the legal principles discussed in the chapter. Deletions I made from the original texts of the opinions are generally indicated by ellipses; in some instances, however, I summarized lengthy omissions and placed them in brackets and they are italicized. Asterisks (***) sometimes indicate omissions in the original texts of opinions because this tends to be the judiciary's style. Except where pedagogic purposes require their retention, all notes and in-text case citations have been omitted from the opinions without notation.
- A Glossary of important definitions is now available.
- Suggested Readings have been added for the inquisitive mind, whether the instructor's or the student's.
- The List of Cases in the fourth edition has been renamed Case Index, to reflect its format at the end of the book.

For professors who assign this textbook in their courses, PowerPoint presentations with accompanying notes are available. Additionally, there is an Instructor's Manual with suggested talking points for the Legal DecisionPoints, Chapter Discussion Questions, and The Court Decides discussion questions as well as chapter overviews and main topics, with additional material provided as pertinent. To gain access to the instructor's resources, e-mail hap1@ache.org.

I hope this book fills a need for a pragmatic health law text for students and faculty of healthcare administration, nursing, and public health programs and related disciplines. It may also be useful to health administration executives.

Thanks go to numerous persons who submitted suggestions and keen insights based on their experiences with the earlier editions and/or their review of the manuscript of this edition. Among these people are David V. Kraus at the University of California San Diego Medical Center;

Clifford Mills of Seattle, Washington; Jeffrey Poster of Arlington, Texas; and Tadd Pullin of Houston, Texas.

I also want to thank the staff of Health Administration Press for their patience and professional support during the long process of bringing this fifth edition to press.

J. Stuart Showalter, JD, MFS
Orlando, Florida

CHAPTER

1

THE ANGLO-AMERICAN LEGAL SYSTEM

After reading this chapter, you will

- understand that law comes from four basic sources: constitutions, statutes, administrative regulations, and judicial decisions.
- know that in the U.S. legal system, no one branch of government is meant to be more powerful than the others.
- be able to find judicial opinions in the "reporter" publications.
- understand the importance of stare decisis.
- have a basic familiarity with certain procedural concepts in legal procedure (e.g., complaint, answer, discovery).

In Charles Dickens's *Oliver Twist*, Mr. Bumble says, "The law is an ass—an idiot" while trying to talk his way out of a predicament. In the novel, it has just been shown that he is an accessory to his wife's attempt to deprive poor Oliver of his rightful inheritance. Mr. Bumble's argument does not work. He and his wife lose their jobs and become inmates of the very workhouse where Oliver's mother died while giving birth to him. The law is not so asinine after all.

The law has fascinated authors and scholars at least since biblical times. The U.S. legal system has done the same for more than two-and-a-quarter centuries. One can study law simply by reading statutes and judicial decisions, but for a full understanding, and to appreciate the context of law at any point in time, one must also read history, sociology, public policy, politics, economics, literature, ethics, religion, and other relevant fields. The choice of analytical method is only the first challenge for the student, because the roots of our legal tradition can be traced as far back as the Norman conquest of England in 1066. It is little wonder, then, that some (like myself) view the richness of the U.S. legal tradition with respect that approaches reverence.

Stated in the most basic and arguably most important way, the purpose of the Anglo-American legal system is to provide an alternative to

personal revenge as a method to resolve disputes among individuals, organizations, and governments. Considering the size and complexity of our nation, the litigious temperament of our people, and the wide range of possible disputes, our legal system is remarkably successful in achieving its purpose. It has its shortcomings, to be sure, but at least it stands as a bulwark against self-help and blood feuds. For these reasons, it is essential that the student of healthcare administration gain a level of familiarity with law and the legal system. Virtually every decision made and every action taken by healthcare administrators have legal implications, and all such decisions and actions are explicitly or implicitly based on some legal principle.

Just as law infused many of Dickens's novels, Shakespeare's plays, and other works of literature, so too does it permeate today's healthcare industry. The U.S. medical system is perhaps the most heavily regulated enterprise in the world. Not only is it subject to the principles that affect all businesses (everything from antitrust to zoning), but it must also deal with myriad regulations that are peculiar to patient care. This is why the law of healthcare administration is so important—we must understand basic legal principles well enough to recognize when professional legal advice is needed. That is the most important purpose of this book: to help keep you and your organization out of trouble.

In this chapter we encounter some general concepts essential to any study of law and give special emphasis to three areas:

1. the sources of law,
2. the workings of the court system, and
3. the basic legal procedure.

In its simplest and broadest sense, law is a system of principles and rules devised by organized society (or groups within society) to set norms for human conduct. Societies and groups within it must have standards of behavior, and the means to enforce those standards, lest we devolve toward vigilantism. The purpose of law, therefore, is to avoid conflict among individuals and between government and its subjects. Inevitably conflicts do occur, however, and then legal institutions and doctrines supply the means of resolving the disputes.

Because law is concerned with human behavior, it falls short of being an exact science. Indeed, in my years of teaching this subject at three universities the most frequent answer to students' questions has been "it depends." This response is frustrating for both the students and the instructor, but it is honest. The law usually provides only general guidance, rather than an exact blueprint for living.

But, in one sense, uncertainty about the law is a virtue and is its greatest strength. The opposite—legal rigidity—would produce decay by inhibiting initiative and the growth of social institutions. Viewed in the proper light, the law is a beautiful and constantly changing tapestry. Although it usually

evolves at the deliberate speed of a glacier, it eventually responds to economic and social developments to reflect the beliefs of society at any given location or point in time.

Sources of Law

Among other ways, law can be classified as either public law or private law, depending on its subject matter. Public law concerns the government and its relations with individuals and businesses. Private law refers to the rules and principles that define and regulate rights and duties among persons. These categories overlap, but they are useful in understanding Anglo-American legal doctrine.

Private law comprises the law of contracts, property, and tort, all of which usually concern relationships between private parties. It also includes, for example, such social contracts as canon law in the Catholic Church and the regulations of a homeowners' association. Public law, on the other hand, regulates and enforces rights where government is a party to the subject matter (e.g., labor relations, taxation, antitrust, environmental regulation, and criminal prosecution). The principal sources of public law are as follows:

- written constitutions (both state and federal),
- statutory enactments by a legislative body (federal, state, or local),
- administrative rules and regulations, and
- judicial decisions.

Constitutions

The U.S. Constitution is aptly called the "supreme law of the land" because it sets standards against which all other laws are judged. The other sources of law must be consistent with the Constitution.

The Constitution is a grant of power from the states to the federal government (see Legal Brief). All powers not granted to the federal government in the Constitution are reserved by the individual states. This grant of power to the federal government is both express and implied. For example, the Constitution expressly authorizes the U.S. Congress to levy and collect taxes, borrow and coin money, declare war, raise and support

Legal Brief

The United States is not technically a union; it is a federation (from the Latin word "foedus"—covenant), a combination of 50 self-governing states that have ceded some of their sovereignty to the central (federal) government to promote the welfare of all.

armies, and regulate interstate commerce. Congress may also enact laws that are "necessary and proper" for exercising these express powers. For example, the power to coin money includes the implied power to design U.S. currency, and the power to regulate interstate commerce embraces the power to pass antidiscrimination legislation, such as the Civil Rights Act of 1964.

The main body of the Constitution establishes, defines, and limits the power of the three branches of the federal government:

1. the legislature (Congress) has the power to enact statutes,
2. the executive branch has the power to enforce the laws, and
3. the judiciary has the power to interpret the laws.

Each branch of government has a different role to play, and none is intended to take priority over the others. The president can nominate federal judges, but the Senate must confirm those nominations; Congress can remove high-ranking federal personnel (including judges and the president) through the impeachment-and-trial process; and the judiciary can declare laws unconstitutional. A congressional bill can be vetoed by the president, but Congress can override a veto by a two-thirds vote of each chamber. Figure 1.1 illustrates this system of "checks and balances" in the federal government.

Twenty-seven amendments follow the main body of the Constitution. The first ten, ratified in 1791, are known as the Bill of Rights, which includes the well-known rights to

- exercise freedom of speech,
- practice religion,
- be secure from unreasonable searches and seizures,
- bear arms in an organized militia,
- demand a jury trial,
- be protected against self-incrimination, and
- be accorded substantive and procedural due process of law.

Of the remaining amendments, two cancelled each other (the 18th, which established prohibition, and the 21st, which repealed the 18th). Thus, as of this writing, only 15 substantive changes have been made to the basic structure of our government in more than 215 years.

The first ten amendments apply only to the federal government. However, the Fourteenth Amendment (ratified in 1870) provides "nor shall any State deprive any person of life, liberty, or property, without due process of law." The U.S. Supreme Court has held that most of the rights set forth in the Bill of Rights apply to the states because of the Fourteenth Amendment's due process clause. (An example of a due process case is shown

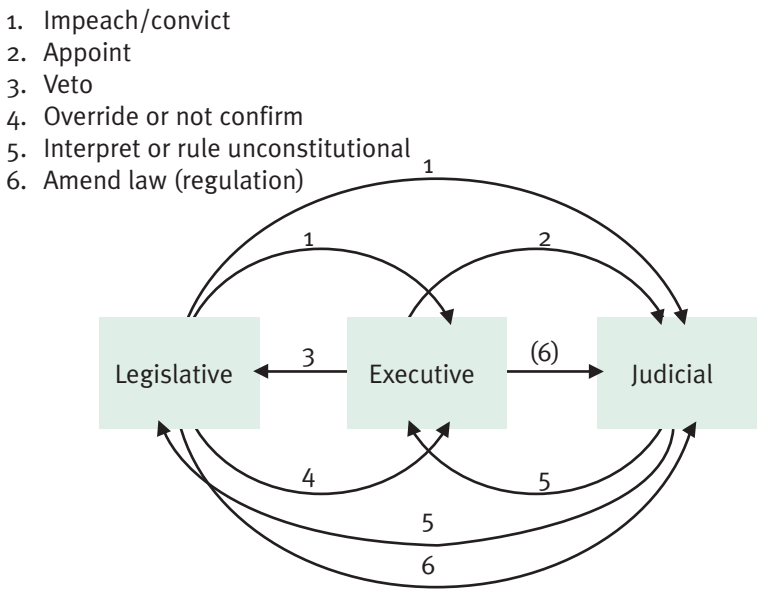


FIGURE 1.1
Checks and Balances

in The Court Decides: *Jackson v. Metropolitan Edison Co.* at the end of this chapter.) Consequently neither the states nor the federal government may infringe on the rights mentioned before.

In addition to the U.S. Constitution, each state has its own constitution, which is the supreme law of that state but is subordinate to the federal constitution. The state and federal constitutions are often similar, although state constitutions are more detailed and cover such matters as the financing of public works and the organization of local governments.

Statutes

Statutes are laws enacted by a legislative body such as Congress, a state legislature, or a unit of local government (a county or city council, for example). Statutes enacted by any of these bodies may apply to healthcare organizations. In regard to discrimination in admitting patients, for example, hospitals must comply with federal statutes such as the Civil Rights Act of 1964 and the Hill-Burton Act. Most states and a number of large cities have also enacted antidiscrimination statutes.

Judges face the task of interpreting statutes; this is especially difficult if the wording is ambiguous, as it usually is. In interpreting statutes the courts have developed several "rules of construction," and in some states these rules are themselves the subject of a separate statute. Whatever the source of the rules, it is generally agreed that the rules are designed to help one ascertain the intent of the legislature. For example, common rules of construction include the following:

1. to interpret a statute's meaning consistent with the intent of the legislature;
2. to interpret it to give effect to all of its provisions; and
3. if it is unclear, to consider its purpose, the result to be attained, the legislative history, and the consequences of one interpretation over another.

Whether of constitutions or statutes, judicial interpretation is the pulse of the law. A prominent example appears a few pages later in *Erie R. R. Co. v. Tompkins*, where the meaning of a venerable federal statute was at issue. In Chapter 10, the section on taxation of real estate discusses numerous cases involving what it means for a piece of property to be "used exclusively" for charitable purposes. These are just two of the many examples that permeate this text. The student should be alert for others and should try to discern the different philosophies of judicial interpretation that the cases' outcomes represent.

Administrative Law

Administrative law is the division of public law relating to the administration of government. According to one scholar, "Administrative law…determines the organization, powers and duties of administrative authorities."[1] Administrative law has greater scope and significance than is sometimes realized. In fact, administrative law is the source of much of the substantive law that directly affects the rights and duties of individuals and businesses and their relation to governmental authority. (See, for example, the discussion of federal healthcare privacy regulations in Chapter 14.)

The executive branch of government carries out (administers) the law as enacted by the legislature and as interpreted by the courts. However, the executive branch also makes law (through administrative regulations) and exercises a considerable amount of quasi-judicial (court-like) power. The phrase "administrative government" should be understood as encompassing all departments of the executive branch and all governmental agencies created by legislation for specific public purposes.

Administrative agencies exist at all levels of government: local, state, and federal. Well-known federal agencies affecting healthcare are the National Labor Relations Board, Federal Trade Commission, Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration), and Food and Drug Administration. At the state level there are boards of professional licensure, Medicaid agencies, worker's compensation commissions, zoning boards, and numerous other agencies whose rules affect healthcare organizations.

Legislative bodies delegate lawmaking and judicial powers to administrative government as necessary to implement statutory requirements; the resulting rules and regulations have the force of law, subject of course to the provisions of the Constitution and statutes. The U.S. Food and Drug Administration,

for example, has the power to set forth rules controlling the manufacturing, marketing, and advertising of foods, drugs, cosmetics, and medical devices.

The amount of delegated legislation increased tremendously during the twentieth century, especially after World War II. The reasons are clear: economic and social conditions inevitably change as societies become more complicated, and legislatures cannot directly provide the detailed rules necessary to govern every particular subject. Delegation of rule-making authority makes it possible to put this responsibility in the hands of experts, but the enabling legislation will stipulate the standards to be followed by an administrative agency when promulgating regulations. Such rules must be consistent with their underlying legislation and the Constitution.

Judicial Decisions

The last major source of law is the judicial decision. All legislation, whether federal or state, must be consistent with the U.S. Constitution. The power to legislate is, therefore, limited by constitutional doctrines, and the federal courts have the power to declare that an act of Congress or a state legislature is unconstitutional.[2] Judicial decisions are subordinate of course to the Constitution and to statutes, so long as the statute is constitutional. Despite this subordinate role, however, judicial decisions are the primary source of private law. Private law, especially the law of contracts and torts, has traditionally had the most influence on healthcare and thus is of particular interest here.

Legal Brief

William the Conqueror is generally considered to be the first king of all England. But do you know what or whom he conquered?

Ironically, he conquered England. He was a Norman. Before the Norman Conquest (the Battle of Hastings) in 1066, English residents (like those in many other societies of Europe) were governed by unwritten local customs that varied from place to place and were enforced inconsistently. After assuming the throne, William began a process that led to a system of courts and laws that were "common" to the entire country. This ended local control and peculiarities, and it is why the law we inherited from England is still known as the "common law." The name "King's Bench" or "Queen's Bench" (depending on the gender of the monarch) is another vestige of the Norman Conquest. It is used even today to describe the courts that William and his successors established as the national judicial system of England.

The common law—judicial decisions that were based on tradition, custom, and precedent—was developed after the Norman Conquest in 1066 (see Legal Brief) and produced at least two important concepts that persist today: the writ and stare decisis. A writ is an order issued by a court directing the recipient to appear before the court or to perform or cease performing a certain act.

The doctrine of stare decisis (literally, "to abide by decided cases") requires that courts look to past disputes involving similar facts and principles and to determine the outcome of the current case on the basis of the earlier

decisions. The use of earlier cases as precedent (see Legal Brief) leads to general stability in the Anglo-American legal system because persons embarking on a new enterprise can surmise the legal consequences of the endeavor from judicial decisions already rendered in similar circumstances. Consider the opening sentence of the 1992 abortion decision, *Planned Parenthood of S.E. Pennsylvania v. Casey* (see The Court Decides at the end of this chapter) in which Justice O'Connor wrote, "Liberty finds no refuge in a jurisprudence of doubt." In upholding *Roe v. Wade*, the landmark abortion decision of 1973, the opinion gives considerable insight into the concept of stare decisis.

Legal Brief

Use of precedent to determine the substance of law distinguishes the common law from a code-based civil law system, which traditionally relies on a comprehensive collection of rules. The civil law system is the basis for the law in Europe, Central and South America, Japan, Quebec, and (because of its French heritage) the state of Louisiana.

Stare decisis—the concept of precedent—applies downward, but not horizontally. An Ohio trial court, for example, is bound by the decisions of Ohio's Supreme Court and the U.S. Supreme Court but not by the decisions of other Ohio trial courts or by the decisions of out-of-state courts. Courts in one state may, but are not required to, examine judicial decisions of other states for guidance, especially if the issue is new to the state. Similarly, a federal trial court is bound by the decisions of the Supreme Court and the appellate court of its own circuit but not by the decisions of other appellate courts or by the decisions of other district courts. The doctrine of stare decisis should not be confused with res judicata. Res judicata literally means "a thing (res) or issue settled by judgment." In practical terms this means that once a legal dispute has been resolved in court and all appeals have been exhausted, the same parties may not later bring suit regarding the same matters.

The Court System

In a perfect world, we would not need courts and lawyers. This may have been the point of Shakespeare's famous line in *Henry VI*, "The first thing we do, we kill all the lawyers." At the time—sixteenth century—resentment against lawyers ran high in England, and the Bard was perhaps making the most famous lawyer joke of all. But because we do not live in utopia, we still need courts and lawyers, and we probably always will.

The court system is the primary venue for resolving legal disputes in the United States, where there are more than 50 different court systems, because in addition to the federal courts, the District of Columbia, the Virgin Islands, Guam, Northern Marianas, and Puerto Rico have their own systems. The large number of court systems makes study of the law in the

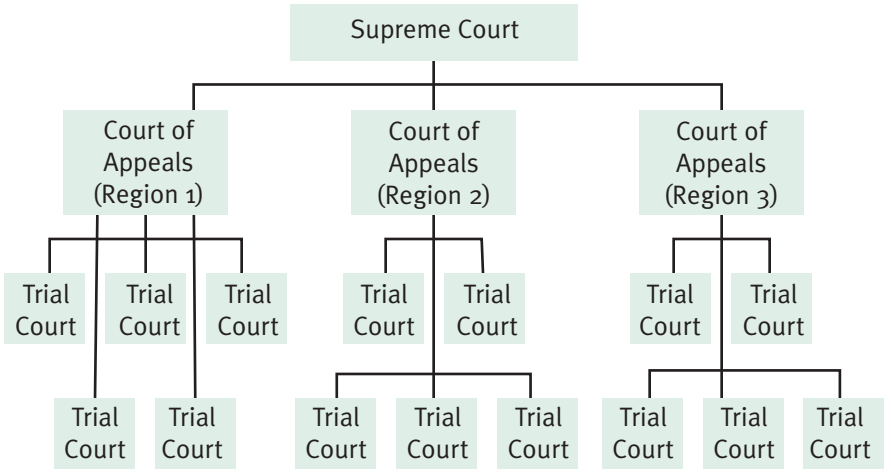


FIGURE 1.2 Model of a Typical Three-Tier Court Structure

United States complex, but the complexity adds strength and vitality; various resolutions to a particular problem can be tested in individual states before a consensus is reached regarding the most desirable solution.

State Courts

The federal court system and the court systems of most states use a three-tier structure comprising the trial courts, the intermediate courts of appeal, and a supreme court (see Figure 1.2). In a state court system, the lowest tier—the trial courts—is often divided into courts of limited jurisdiction and courts of general jurisdiction. Typically the courts of limited jurisdiction hear criminal trials involving lesser crimes (e.g., misdemeanors and traffic violations) and civil cases involving disputes of a certain, small amount. The courts of limited jurisdiction often include a small-claims court, where lawyers are not allowed to practice and complex legal procedures are relaxed.

The state courts of general jurisdiction hear the more serious criminal cases involving felonies and civil cases involving larger monetary amounts. Because of the large number of cases, the courts of general jurisdiction are often divided into special courts; a family or domestic relations court, a juvenile court, and a probate court are some examples. (The probate court is often given jurisdiction to hear cases involving such matters as surgery for an incompetent person or the involuntary commitment of a mentally ill person.)

The next tier in most states is the intermediate appellate courts. They hear appeals from the trial courts. In exercising their jurisdiction, appellate courts are usually limited to the evidence from the trial court and to questions of law, not of fact.

The highest tier in the state court system is the state supreme court. This court hears appeals from the intermediate appellate courts (or from trial

courts if the state does not have intermediate courts) and possesses limited jurisdiction to hear certain cases as if it were a trial court. A state supreme court is also often charged with administrative duties such as adopting rules of procedure and disciplining attorneys.

The states are not uniform in naming the various courts. Trial courts of general jurisdiction, for example, may be named circuit, superior, common pleas, or county court. New York is unique in that its trial court is known as the "supreme court." In most states the highest court is named the supreme court, but in Massachusetts the high court is called the "Supreme Judicial Court," and in New York, Maryland, and the District of Columbia the highest court is called the "Court of Appeals." The intermediate appellate court in New York is called the "Supreme Court Appellate Division."

Federal Courts

The federal court system is similar. At its bottom tier, the federal district court hears criminal cases involving both felonies and misdemeanors that arise under federal statutes and hears civil cases involving actions between parties of different states and those arising under federal statutes or the U.S. Constitution. (Claims involving federal statutes and the U.S. Constitution can also be heard in state court, depending on the situation.) Ninety-one U.S. district courts are established geographically in the 50 states. In addition, the District of Columbia, the Virgin Islands, Guam, Northern Marianas, and Puerto Rico each has its own federal trial court, as mentioned earlier. The district court may hear suits in which a citizen of one state sues a citizen of another state (that is, involving "diversity of citizenship") if the amount in dispute is more than $10,000.

Such was the situation in *Erie R. R. Co. v. Tompkins*,[3] in which the plaintiff, a citizen of Pennsylvania, was injured by a passing train while walking along the Erie Railroad's right of way in that state. He sued the railroad for negligence in a New York federal court asserting diversity jurisdiction. The railroad was a New York corporation, but the accident occurred in Pennsylvania. The railroad pointed out that under Pennsylvania's court decisions persons who were trespassers could not recover for their injuries. Mr. Tompkins, of course, disagreed and contended that because there was no state statute on the subject—only judicial decisions—the railroad could be held liable in federal court as a matter of "general law."

At issue here was the interpretation of a section of the Federal Judiciary Act, which states:

> The laws of the several States, except where the Constitution, treaties, or statutes of the United States otherwise require or provide, shall be regarded as rules of decision in trials at common law, in the courts of the United States, in cases where they apply.[4]

An 1842 case—*Swift v. Tyson*[5]—concluded that this language only applied to the statutes of a state. Because there was no Pennsylvania statute on the subject of liability to trespassers, Mr. Tompkins argued that the railroad's duty and liability should be determined in federal court as a matter of general common law. Based on *Swift*, the lower courts held for Mr. Tompkins. The Supreme Court disagreed, however, citing various plaintiffs' use of diversity jurisdiction and the *Swift* doctrine to circumvent an unfavorable state law. Thus, the court reversed the judgment in favor of Mr. Tompkins. It stated that in previous years,

> Experience in applying the doctrine of *Swift v. Tyson*, had revealed its defects, political and social; and the benefits expected to flow from the rule did not accrue. Persistence of state courts in their own opinions on questions of common law prevented uniformity; and the impossibility of discovering a satisfactory line of demarcation between the province of general law and that of local law developed a new well of uncertainties.
>
> . . . [T]he mischievous results of the doctrine had become apparent. Diversity of citizenship jurisdiction was conferred [by the Constitution] in order to prevent apprehended discrimination in state courts against those not citizens of the state. *Swift v. Tyson* introduced grave discrimination by noncitizens against citizens. It made rights enjoyed under the unwritten "general law" vary according to whether enforcement was sought in the state or in the federal court; and the privilege of selecting the court in which the right should be determined was conferred upon the noncitizen. Thus the doctrine rendered impossible equal protection of the law. In attempting to promote uniformity of law throughout the United States, the doctrine had prevented uniformity in the administration of the law of the state.

And finally, the Court concluded:

> Except in matters governed by the Federal Constitution or by acts of Congress, the law to be applied in any case is the law of the state. And whether the law of the state shall be declared by its Legislature in a statute or by its highest court in a decision is not a matter of federal concern. There is no federal general common law. Congress has no power to declare substantive rules of common law applicable in a state whether they be local in their nature or "general," be they commercial law or a part of the law of torts. And no clause in the Constitution purports to confer such a power upon the federal courts.

Federal and state courts have concurrent jurisdiction in cases arising under the U.S. Constitution or any of the federal statutes that do not confer exclusive jurisdiction on the federal court system. In contrast, the federal

courts have exclusive jurisdiction with respect to certain cases such as the following:

- alleged violations of federal antitrust or securities laws,
- admiralty,
- issues related to the Employee Retirement Income Security Act, and
- bankruptcy cases (which are heard by U.S. Bankruptcy Courts located in each federal judicial district).

Appeals from the federal district courts go to the U.S. courts of appeals. The United States, along with its territories (the Virgin Islands, Guam, Northern Marianas, and Puerto Rico), has 11 multistate circuits plus a separate circuit for the District of Columbia, each of which has a court that functions in the same manner as the state intermediate appellate courts (see Figure 1.3). In addition, there is a 13th Court of Appeals for the Federal Circuit that hears cases involving certain matters that are exclusively the province of federal law.

At the highest rung in the federal court system is the U.S. Supreme Court. The Supreme Court hears appeals from the U.S. courts of appeals and from the highest state courts in cases involving federal statutes, treaties, or the U.S. Constitution. Generally a party has no absolute right to have her case heard by the Supreme Court. Instead, in most cases the Court's decision whether to hear a case is entirely discretionary. (One exception is a case in which lower courts have declared a federal statute to be unconstitutional.) Parties must petition the Court for a writ of certiorari—an order to the lower court requiring that the case be sent up for the high court's review—and persuade at least four of the nine justices that the issue merits their attention. The Supreme Court normally decides only a very small percentage of the thousands of cases it is asked to consider each year. Because the Supreme Court exercises considerable discretion in controlling its docket, lower courts in effect decide many important legal issues. Typically the Court grants certiorari only in those cases that present current questions of extraordinary legal or social significance or when the federal courts of appeals have differed in deciding cases involving the same legal issue.

Aside from the Supreme Court, which is created by Article III of the U.S. Constitution, the establishment and organization of the federal court system is the responsibility of Congress. Accordingly, Congress can create additional courts from time to time and define the jurisdiction of new and existing tribunals. Complementing the district courts and the courts of appeals are several federal courts with specialized functions. Congress has created, for example, the U.S. Federal Claims Court (which hears certain contract claims brought against the government), the U.S. Court of International Trade, the U.S. Tax Court, and the U.S. Court of Appeals for the Armed Forces.

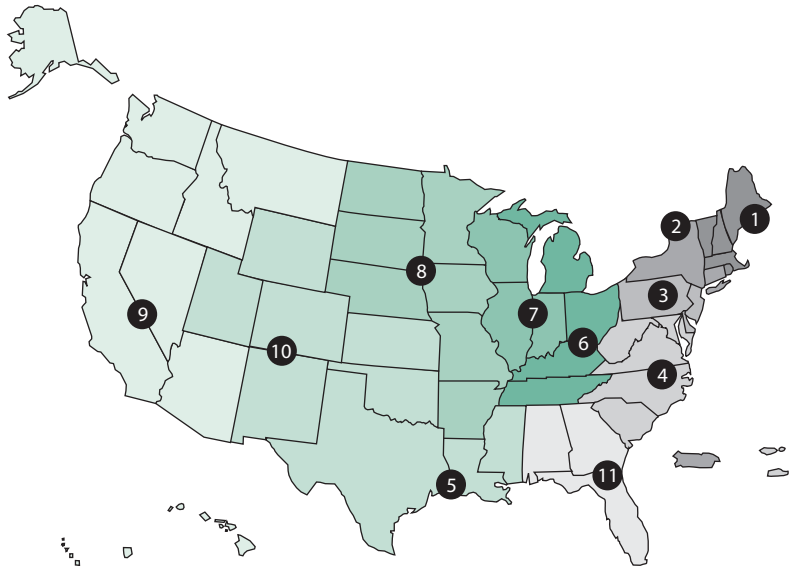


FIGURE 1.3
Map of U.S. Courts of Appeals

Circuit 1: ME, NH, MA, RI, Puerto Rico
Circuit 2: VT, NY, CT
Circuit 3: PA, DE, NJ, Virgin Islands
Circuit 4: WV, VA, NC, SC
Circuit 5: TX, LA, MS
Circuit 6: MI, OH, KY, TN
Circuit 7: WI, IL, IN
Circuit 8: ND, SD, NE, MN, IA, MO, AR
Circuit 9: WA, OR, ID, MT, CA, NV, AZ, AK, HI, Guam, Northern Mariana Islands
Circuit 10: WY, UT, CO, NM, KS, OK
Circuit 11: AL, GA, FL

Alternative Methods of Resolving Disputes

In addition to the court system, two alternative methods of resolving disputes are popular in the United States. The first is by an administrative agency or tribunal. Undoubtedly administrative bodies settle far more disputes today than do the judicial courts. (Workers' compensation cases are a familiar example.) Moreover, an administrative agency often has the statutory responsibility and power to initiate enforcement of statutory pronouncements. It frequently happens that the same agency that wrote the regulations brings the initial proceeding, hears the case, and decides the dispute. The Federal Trade Commission, for example, is empowered to compel an alleged offender to cease and desist from practicing unfair methods of competition under the Commission's regulations. Statutes, of course, prescribe the powers of administrative bodies. The role of ordinary courts will generally be limited to preventing administrative authorities from exceeding their powers and to granting remedies to individuals who have been injured by wrongful administrative action. Sometimes the statutes will grant the right of appeal to a judicial court from an adverse administrative decision.

Another alternative method for resolving disputes is arbitration, a method that is often faster, less complicated, more confidential, and less costly than commencing a lawsuit. Arbitration is the submission of a dispute for decision by a third person or a panel of experts outside the judicial process. When the parties to a dispute voluntarily agree to have their differences resolved by an arbitrator or by a panel and that the settlement will be binding, arbitration becomes a viable alternative to the court system. Statutory law in most states favors voluntary, binding arbitration and frequently provides that an agreement to arbitrate is enforceable by the courts.[6] Arbitration is distinguished from mediation, in which a third party—the mediator—simply attempts to persuade adverse parties to agree to settle their differences. The mediator has no power to require a settlement.

Legal Procedure

Substantive law is the type of law that creates and defines rights and duties. Most of this book is devoted to the substantive law as it relates to healthcare providers. Procedural law, as the name implies, provides the specific processes for enforcing and protecting rights granted by the substantive law. The branch of procedural law discussed in this section is the law relating to trial of a case.

Commencement of Legal Action: The Complaint

When claims go to court, the first stage involves filing a legal action. A claimant who begins a lawsuit (an "action") becomes the plaintiff, and the other party is the defendant. The plaintiff starts the case by filing a "complaint" that states the nature of the claim and the amount of damages or other remedy sought. (The complaint and other papers subsequently filed in court are the "pleadings.") A copy of the complaint, along with a summons, is then served on the defendant. The summons advises the defendant that the complaint must be answered or other action must be taken within a limited time (for example, 30 days) and that if the defendant fails to act the plaintiff will be granted judgment by default.

The Defendant's Response: The Answer

In the second stage of the process, the defendant files an "answer" to the complaint admitting, denying, or pleading ignorance to each allegation. The defendant may also file a complaint against the plaintiff (a "countersuit" or "counterclaim") or against a third-party defendant whom the original defendant believes is wholly or partially responsible for the plaintiff's alleged injuries.

At this stage in the proceeding the defendant may ask the court to dismiss the plaintiff's complaint because the court lacks jurisdiction, there was a prior judgment on the same matter, or the plaintiff's complaint failed to state a legal claim. Although the terminology differs from state to state, the motion to

dismiss is usually called either a motion for "summary judgment" or a "demurrer." If the court grants the motion to dismiss, the judgment is final and the plaintiff can appeal the decision immediately.

Discovery

In rare cases there is little delay between the initial two stages and the decision by the court (see The Law in Action).

Most frequently, however, especially in urban areas, there is a delay of several months or years between commencement of the action and trial. During this time, each party engages in the third stage of the litigation process—discovery, an attempt to determine the facts and the strength of the other party's case. Discovery is a valuable device that can be used, for example, to identify prospective defendants or witnesses or to uncover other important evidence. For example, in one hospital case a patient had fallen on the way to the washroom and fractured a hip.[8] During discovery the hospital was required to disclose the identity of the nurse who had directed the patient to the washroom instead of giving bedside attention.

The Law in Action

In one instance of procedural law, a wife and mother of young children had lost two-thirds of her blood supply because of a ruptured ulcer, but her husband refused to approve blood transfusions because they were Jehovah's Witnesses. The hospital petitioned the district court for permission to administer blood; the district court denied permission, and the case was taken to a court of appeals where an order was signed allowing the transfusion, all within a matter of hours.[7]

During the discovery phase, parties may use any or all of five methods to discover the strength of the other party's case. All are generally limited to relevant facts and matters that are not privileged or confidential. These methods are as follows:

1. depositions,
2. interrogatories,
3. demands to inspect and copy documents,
4. demands for a physical or mental examination of a party, and
5. requests for admission of facts.

Depositions

The most common and effective discovery device is the deposition, whereby a party subpoenas a witness to testify under oath before a court reporter, who transcribes the testimony. The opposing attorney will also be present during the deposition to make appropriate objections and, if appropriate, to cross-examine the witness. The transcript of the deposition may be read into evidence at the trial itself if the witness is unable to testify in person and can be used to impeach the witness's testimony if his "story" has changed.

Interrogatories

A second method of discovery, written interrogatories, is similar to the taking of depositions except that the questions are written. The procedure for using written interrogatories sometimes varies, depending on whether they are directed toward an adverse party or other witnesses. Interrogatories are somewhat less effective than oral depositions because there is little opportunity to ask follow-up questions.

Discovery of Documents

A party using the third method of discovery (a method especially relevant to healthcare cases) may request to inspect and copy documents, inspect tangible items in the possession of the opposing party, enter and inspect land under the control of the other party, and inspect and copy items produced by a witness served with a subpoena duces tecum (a subpoena requiring the witness to produce certain books and documents such as medical records). There are special rules governing subpoenas to produce hospital records because of their sensitivity.

Physical or Mental Examination

A physical or mental examination, the fourth discovery device, may be used when the physical or mental condition of a party to the lawsuit is in dispute and good cause is shown for the examination.

Request for Admission

The final discovery method is to request the opposing party to admit certain facts. By using these requests for admission, the parties may save the time and expense involved in unnecessary proof and may substantially limit the factual issues to be decided by the court.

The Trial

A trial begins with the selection of a jury if either party has requested a jury trial. After jury selection, each attorney makes an opening statement in which an explanation is given of matters to be proven during the trial. The plaintiff then calls witnesses and presents other evidence, and the defense attorney is given the opportunity to cross-examine each of the witnesses. After the plaintiff has rested the case, the defendant's attorney frequently asks the court to direct a verdict for the defense. Courts will grant the directed verdict if the jury, viewing the facts most favorably to the plaintiff, could not reasonably return a verdict in the claimant's favor that would be in accord with the law. If the motion is denied, the defendant proceeds with evidence and witnesses in support of her case, subject to cross-examination by the plaintiff.

When all the evidence has been presented, either party may move for a directed verdict. If the judge denies the motion, "instructions" will be given to the jury regarding relevant law, and the jury will deliberate until reaching a verdict. Many times, after the jury has reached its decision, the losing party asks the court for a "judgment notwithstanding the verdict" aka "judgment N.O.V."—an abbreviation for the Latin term "non obstante

veredicto"—and a new trial. The motion will be granted if the judge decides that the verdict is against the weight of the evidence.

The judge and the jury, of course, play key roles in the trial. The judge has the dominant role, deciding whether evidence is admissible and instructing the jury on the law before deliberation begins. As noted earlier, the judge also has the power to take the case away from the jury by means of a directed verdict or a judgment notwithstanding the verdict. The role of the jury is thus limited to deciding the facts and determining whether the plaintiff has proved the allegations by a preponderance of the evidence. Because the jury's role is to decide the facts, it is of utmost importance that the members of the jury be impartial. If there is evidence that a jury member might have been biased, many courts will overturn the verdict. In cases tried without a jury, the judge assumes the jury's fact-finding role. (This function, because it can be performed by judge or jury, is often referred to as that of the "trier of fact.")

Concluding Stages: Appeal and Collection

The next stage in litigation is often an appeal. For various reasons (e.g., satisfaction with the verdict or a party's unwillingness to incur additional expenses), not all cases go to an appellate court. In those that do, however, the party who appeals the case (the losing party in the trial court) will usually be referred to as the "appellant" and the other party will be the "appellee." In reading appellate court decisions one must not assume that the first name in the case heading is the plaintiff's because many appellate courts reverse the order of the names when the case is appealed (see Figure 1.4). The appellate court limits itself to a review of the law applied in the case; it will accept the facts as determined by the trier of fact. In its review, the appellate court may affirm the trial court decision, modify or reverse the decision, or reverse it and remand the case for a new trial.

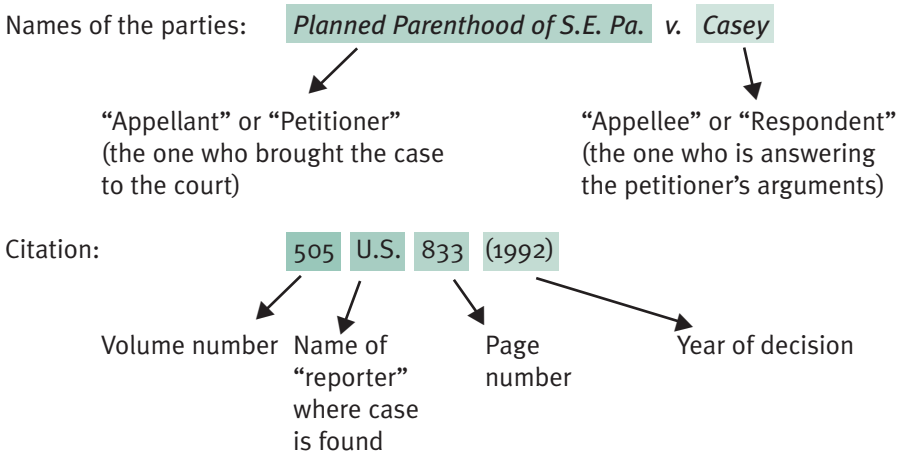
The final stage of the litigation process is collecting the judgment. The most common methods of collection are execution and garnishment. A writ of execution entitles the plaintiff to have a local official seize the defendant's property and to have that property sold to satisfy the judgment. A garnishment is an order to a third person who is indebted to the defendant to pay the debt directly to the plaintiff to satisfy the judgment. Often the third party is the defendant's employer who, depending on local laws, may be ordered to pay a certain percentage of the defendant's wages directly to the plaintiff.

Chapter Summary

This chapter discusses the sources of law, the relationships among the three branches of government, the basic structure of the federal and state court systems, and some basics of legal procedure in civil cases. (The procedures used in criminal cases are somewhat different and are beyond the scope of this text.)

FIGURE 1.4
Citation Method of the Legal System

The legal system has a unique citation method. The *Planned Parenthood* case is an example. Its heading conveys a sizable amount of information in a short space, as follows:



Following the volume number is the name of the publication where the decision can be found. Supreme Court decisions are published in the *U.S. Reports*, as above. Published federal district court decisions are found in the *Federal Supplement*. Federal appellate decisions are published in the *Federal Reporter*.

State court decisions can be found in publications of the West Publishing Company. These are grouped regionally with decisions of the courts of nearby states. Common examples are as follows:

Northeast Reporter (N.E., N.E. 2d)
Southeast Reporter (S.E., S.E. 2d)
Southern Reporter (So., So. 2d)
Pacific Reporter (P., P. 2d)

A designation of "2d" (or even "3d" in some cases) indicates that a publisher began a new numbering system at a certain point, beginning with volume 1 of the "second series," for example.

Chapter Discussion Questions

1. What are the four sources of law in the United States?
2. Describe the three branches of government and the role of each, including the system of checks and balances.
3. What is the hierarchy among the sources of law in the federal government?
4. What is the system for citing judicial opinions?
5. What is stare decisis, and why is it important?
6. Describe the structure of the federal judicial system.
7. If *Jackson v. Metropolitan Edison Co.* had been a healthcare case, what would have been the implications for healthcare organizations had the decision been different (i.e., if the regulatory scheme had implicated "state action")?

Notes

1. Jennings, W. 1959. *The Law and the Constitution.*
2. Marbury v. Madison, 5 U.S. (1 Cranch) 137 (1803)—established the court's power to declare federal legislation unconstitutional.
3. 304 U.S. 64 (1938).
4. 28 U.S.C. § 725.
5. 15 Pet. 1 (1842). Before the current system took hold, early Supreme Court reports were published by the clerk, and the name of the "reporter" was an abbreviation of the name of that official.
6. For example, Ohio Rev. Code Ann. § 2711.03 (Baldwin 1986).
7. Application of President and Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Dir. 1964), cert. denied, 377 U.S. 398 (1964).
8. Cidilko v. Palestine, 24 Misc. 2d 19, 207 N.Y.S.2d 727 (1961).

THE COURT DECIDES

Jackson v. Metropolitan Edison Co.
419 U.S. 345 (1974)

Rehnquist, J.

Respondent Metropolitan Edison Co. is a privately owned and operated Pennsylvania corporation which holds a certificate of public convenience issued by the Pennsylvania Public Utility Commission empowering it to deliver electricity to a service area which includes the city of York, PA. As a condition of holding its certificate, it is subject to extensive regulation by the Commission. Under a provision of its general tariff filed with the Commission, it has the right to discontinue service to any customer on reasonable notice of nonpayment of bills.

Petitioner Catherine Jackson is a resident of York, who has received electricity in the past from respondent. Until September 1970, petitioner received electric service to her home in York under an account with respondent in her own name. When her account was terminated because of asserted delinquency in payments due for service, a new account with respondent was opened in the name of one James Dodson, another occupant of the residence, and service to the residence was resumed....In August 1971, Dodson left the residence. Service continued thereafter but concededly no payments were made. Petitioner states that no bills were received during this period.

On October 7, 1971, employees of Metropolitan came to the residence and inquired as to Dodson's present address. Petitioner stated that it was unknown to her. On the following day, another employee visited the residence and informed petitioner that the meter had been tampered with so as not to register amounts used. She disclaimed knowledge of this and requested that the service account for her home be shifted from Dodson's name to that one of Robert Jackson, later identified as her 12-year-old son. Four days later on October 11, 1971, without further notice to petitioner, Metropolitan employees disconnected her service.

Petitioner then filed suit against Metropolitan in the United States District Court for the Middle District of Pennsylvania under the Civil Rights Act of 1871, 42 U.S.C. § 1983, seeking damages for the termination and an injunction requiring Metropolitan to continue providing power to her residence until she had been afforded notice, a hearing, and an opportunity to pay any amounts found due. She urged that...Metropolitan's termination of her service for alleged nonpayment...constituted "state action" depriving her of property in violation of the Fourteenth Amendment's guarantee of due process of law.

The District Court granted Metropolitan's motion to dismiss petitioner's complaint on the ground that the termination did not constitute state action and hence was not subject to judicial scrutiny under the Fourteenth Amendment. On appeal, the United States Court of Appeals for the Third Circuit affirmed, also finding an absence of state action. We granted certiorari to review this judgment.

The Due Process Clause of the Fourteenth Amendment provides: "[N]or shall any State deprive any person of life, liberty, or property, without due process of law." In 1883, this Court in the Civil Rights Cases affirmed the essential dichotomy set forth in that Amendment between deprivation by the State, subject to scrutiny under its provisions, and private conduct, "however discriminatory or wrongful," against which the Fourteenth Amendment offers no shield.

We have reiterated that distinction on more than one occasion since then. While the principle that private action is immune from the restrictions of the Fourteenth Amendment is well established and easily stated, the question whether particular conduct is "private," on the one hand, or "state action," on

the other, frequently admits of no easy answer.

Here the action complained of was taken by a utility company which is privately owned and operated, but which in many particulars of its business is subject to extensive state regulation. The mere fact that a business is subject to state regulation does not by itself convert its action into that of the State for purposes of the Fourteenth Amendment. Nor does the fact that the regulation is extensive and detailed, as in the case of most public utilities, do so.... [T]he inquiry must be whether there is a sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself. The true nature of the State's involvement may not be immediately obvious, and detailed inquiry may be required in order to determine whether the test is met.

Petitioner advances a series of contentions which, in her view, lead to the conclusion that this case should fall on the [state action] side of the line...rather than on the [private action] side of that line. We find none of them persuasive.

[The Court here embarks on a lengthy discussion of each of the petitioner's arguments. First, she argued that there was state action because Metropolitan was a state-recognized monopoly. The Court doubted that Metropolitan had been granted a monopoly, but even if it had, the Court found this fact did not make Metropolitan's actions state action because the actions complained of had no relationship to whether it was or was not a monopoly. Next, she argued that Metropolitan supplied an "essential public service" that state law required it to provide and that it was therefore performing a public function that amounted to state action. The Court dismissed this argument, saying that there is a difference between providing a utility service and performing a function traditionally exercised only by government (such as eminent domain). The Court continued:]

Perhaps in recognition of the fact that the supplying of utility service is not traditionally the exclusive prerogative of the State, petitioner invites the expansion of the doctrine of this limited line of cases [on state action] into a broad principle that all businesses "affected with the public interest" are state actors in all their actions.

We decline the invitation for [these] reasons...:

It is clear that there is no closed class or category of businesses affected with a public interest * * *. The phrase 'affected with a public interest' can, in the nature of things, mean no more than that an industry, for adequate reason, is subject to control for the public good....

Doctors, optometrists, lawyers, Metropolitan, and [a] grocery selling a quart of milk are all in regulated businesses, providing arguably essential goods and services, "affected with a public interest." We do not believe that such a status converts their every action, absent more, into that of the State.

We also find absent in the instant case the symbiotic relationship presented in Burton v. Wilmington Parking Authority. There where a private lessee, who practiced racial discrimination, leased space for a restaurant from a state parking authority in a publicly owned building, the Court held that the State had so far insinuated itself into a position of interdependence with the restaurant that it was a joint participant in the enterprise. We cautioned, however, that while a "multitude of relationships might appear to some to fall within the Amendment's embrace," differences in circumstances beget differences in law, limiting the actual holding to lessees of public property.

...We therefore have no occasion to decide whether petitioner's claim to continued service was "property" for purposes of that Amendment, or whether "due process of law" would require a State [that took] similar action to accord petitioner the procedural rights for which she contends. The judgment of the Court of Appeals for the Third Circuit is therefore Affirmed.

THE COURT DECIDES

Planned Parenthood of S.E. Pennsylvania v. Casey
505 U.S. 833 (1992)

...[T]he Court's legitimacy depends on making legally principled decisions under circumstances in which their principled character is sufficiently plausible to be accepted by the Nation.

...The Court is not asked to [overrule prior decisions] very often....But when the Court does [so], its decision requires an equally rare precedential force to counter the inevitable efforts to overturn it and to thwart its implementation. Some of those efforts may be mere unprincipled emotional reactions; others may proceed from principles worthy of profound respect. But whatever the premises of opposition may be, only the most convincing justification under accepted standards of precedent could suffice to demonstrate that a later decision overruling the first was anything but a surrender to political pressure, and an unjustified repudiation of the principle on which the Court staked its authority in the first instance. So to overrule under fire in the absence of the most compelling reason to reexamine a watershed decision would subvert the Court's legitimacy beyond any serious question....

...The promise of constancy, once given, binds its maker for as long as the power to stand by the decision survives and the understanding of the issue has not changed so fundamentally as to render the commitment obsolete. From the obligation of this promise this Court cannot and should not assume any exemption when duty requires it to decide a case in conformance with the Constitution. A willing breach of it would be nothing less than a breach of faith, and no Court that broke its faith with the people could sensibly expect credit for principle in the decision by which it did that.

....

The Court's duty in the present case is clear. In 1973, it confronted the already divisive issue of governmental power to limit personal choice to undergo abortion, for which it provided a new resolution based on the due process guaranteed by the Fourteenth Amendment. Whether or not a new social consensus is developing on that issue, its divisiveness is no less today than in 1973, and pressure to overrule the decision, like pressure to retain it, has grown only more intense. A decision to overrule *Roe*'s essential holding under the existing circumstances would address error, if error there was, at the cost of both profound and unnecessary damage to the Court's legitimacy, and to the Nation's commitment to the rule of law. It is therefore imperative to adhere to the essence of *Roe*'s original decision, and we do so today.

CHAPTER

2

CONTRACTS AND INTENTIONAL TORTS

After reading this chapter, you will

- know the essential elements of a valid and enforceable contract.
- understand why contract law is important to physician–patient and hospital–patient relationships.
- appreciate how the contract principle of breach of warranty can apply to the healthcare setting.
- grasp the basics of intentional torts and how they can affect healthcare professionals.

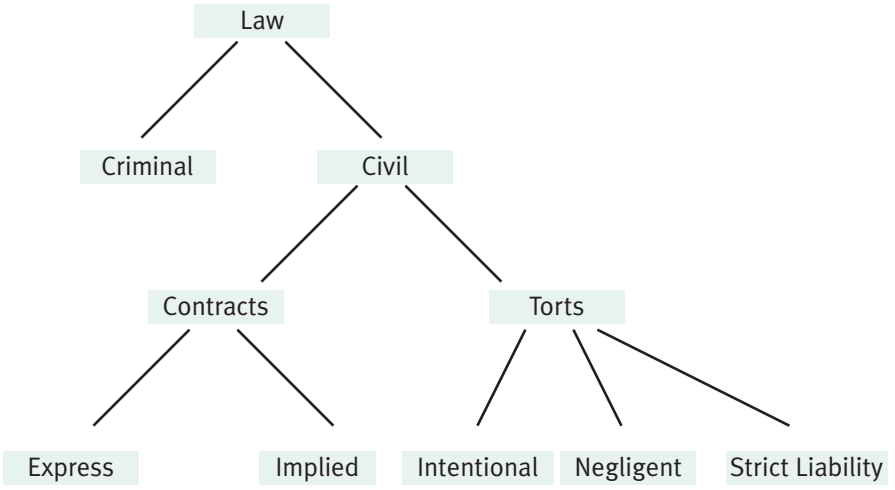
In the previous chapter, law was described as being either public or private. But law can be categorized in other ways as well, one of the most common being the distinction between criminal law and civil law; civil law also has subdivisions. Figure 2.1 shows these classifications.

When people think of professional liability in healthcare, they usually think of medical malpractice, a form of negligence. Negligence is, to be sure, the most common type of malpractice, but medical malpractice can also be based on intentional torts and breaches of contract. In fact, many malpractice suits allege more than one cause of action, the reasons for which are discussed later in the chapter.[1]

The existence of a legal duty is essential to any professional liability case, and the concept of duty tends to change as our society and values change. The legal duty may be imposed by constitution, legislation, common law, or even contract. In healthcare, special legal duties arise from the contractual aspects of the physician–patient relationship.[2]

This chapter does not address the law of contracts as it relates to operational issues such as employment, materials management, facilities maintenance, and procurement. Although many of the basic principles discussed here apply in those areas too, the full topic of contracts is beyond the scope of this text. After all, in law schools contracts is a full credit course of its own.

FIGURE 2.1
A Taxonomy of Law



Elements of a Contract

In simple terms, for a contract to be valid, four elements must exist:

1. *Both parties must be "legally competent" to enter into the contract.* Contracts entered into by mentally incompetent persons are not valid; neither are most contracts entered into by minors.
2. *There must be a "meeting of the minds."* One party must make an offer—to buy or sell, for example—and the other party must accept that offer. The terms of the offer and acceptance must be identical.
3. *"Consideration" must be given.* Consideration is basically the price paid for the contract, but it need not be in the form of money. It may also be a promise (a) to do something you otherwise would not be required to do or (b) to refrain from doing something you otherwise would be able to do.
4. *The purpose of the contract must be legal.* A contract with a hit man to "off" another person is void because its purpose is illegal. Likewise, many exculpatory contracts—those in which a party excuses the other from liability in advance—are invalid because they are against public policy.

Contracts may be express (written or spoken) or implied. Many of our day-to-day human interchanges are implied contracts. For example, consider a patron ordering lunch in a restaurant. Implicit in the situation

is this message (the offer): "If you serve me what I order, I will pay the bill." By taking the order and serving the food, the restaurant accepts the patron's offer and a contract exists. The offer and acceptance are rarely expressed in words, but the contract is still valid. Similarly, the doctor–patient relationship includes an offer ("If you treat me, my insurance or I will pay") and an acceptance ("We've scheduled your appointment for next Tuesday").

The Physician–Patient Relationship

The physician–patient relationship is founded on a contract in which the physician agrees to provide treatment in return for payment. Professional liability can arise if this contract is breached. In the absence of a contract between physician and patient, the law usually imposes no duty on the physician to treat the patient, although it may impose other duties on the physician. For example, like other passersby, physicians have no legal obligation to help accident victims. The law in most states will not require them to be "Good Samaritans."[3] (See Legal DecisionPoint.)

This principle was illustrated in *Childs v. Weis*.[4] A Dallas woman who was seven months pregnant was visiting another town when she began to suffer labor pains and bleeding. At a local hospital's emergency department a nurse examined her, called the defendant physician, and told the woman to go to her doctor in Dallas. The woman left the hospital and, about an hour later, gave birth to her baby in a car. Twelve hours later the infant died. The court held that the physician had no duty to the woman because no physician–patient relationship had been established. (There was a dispute about what the doctor actually told the nurse. The physician said that he had instructed the nurse to have the woman call her own doctor and see what he wanted her to do.) The hospital's and nurse's duties are a different matter, of course. And as noted in Chapter 8, "Emergency Care," federal law now requires emergency department personnel to stabilize emergency conditions irrespective of whether a provider–patient relationship exists.)

Legal DecisionPoint

You are at the beach having a picnic with your significant other. You notice a man struggling in the surf. You put down your wine and run to his rescue. A couple of minutes into the rescue you notice that your companion is about to finish the last of the wine, so you leave the sputtering victim to return to your picnic before the wine is gone.

What were your legal and moral responsibilities before you began to assist the victim? Were they the same after you began to give aid? Do the answers change depending on whether you were trained in CPR? What if you were an off-duty EMT? What other hypothetical facts might affect your analysis?

Creation of the Relationship

A contract is a prerequisite to a physician–patient relationship. As noted earlier, the contract can be express or implied. Sometimes the patient is unconscious or otherwise unable to express consent for treatment, so the law will treat the rendering of services to an unconscious person as an implied contract. This prevents "unjust enrichment" by requiring the patient to pay for the services she never really agreed to (but presumably would have). It also imposes the same duties on the physician that would arise under an express or implied contract.

Although clear enough in the abstract, these principles of contract law are sometimes difficult to apply in the widely varying circumstances that arise in medical practice. For example, physicians commonly consult one another regarding their patients' diagnosis and treatment. This often happens informally (the proverbial "hallway consult"), and the consulted physician may not see the patient or know his name. Do these informal consultations create a physician–patient relationship? Generally the answer is "no." For example, in *Oliver v. Brock*[5] a physician phoned a colleague, Dr. Brock, to discuss the former's treatment of the patient, Anita Oliver. As summarized in the treating physician's affidavit (see Legal DecisionPoint) to the court,

> [I] had the occasion to and did call Dr. Ernest C. Brock, a practicing physician in Tuscaloosa, Alabama, with reference to Dr. Brock's recommendations concerning the care and treatment of another patient [and] during the course of such conversation [I] did describe generally the injuries of plaintiff and the type of treatment [I] was then giving plaintiff, and Dr. Brock did indicate to [me] that under the circumstances described he thought the treatment to be correct; [I] did not disclose to Dr. Brock the name of the patient; [my] discussion with Dr. Brock was gratuitous on his part and for [my] guidance in connection with the treatment of plaintiff; [I] did not employ Dr. Brock to care for or treat plaintiff and Dr. Brock did not care for or treat plaintiff to [my] knowledge. In the discharge summary...[I] did make note of the telephone conversation with Dr. Brock and of the suggestions made to [me] by Dr. Brock but did not suggest...that Dr. Brock was in any way employed...in the care and treatment of plaintiff....

The court decided that there was no doctor–patient relationship between Dr. Brock and Anita Oliver. This view is supported by this general rule:

> A physician is under no obligation to engage in practice or to accept professional employment.... The relation is a consensual one wherein the patient knowingly seeks the assistance of a physician and the physician knowingly accepts him as a patient. The relationship between a physician and patient may result from an express or implied contract...and the rights and liabilities of the

> parties thereto are governed by the general law of contract.... [T]he voluntary acceptance of the physician–patient relationship by the affected parties creates a prima facie presumption of a contractual relationship between them. A physician may accept a patient and thereby incur the consequent duties although his services are performed gratuitously or at the solicitation and on the guaranty of a third person.[6]

On the other hand, a physician need not come into direct contact with a patient for a doctor–patient relationship to exist. A pathologist, for example, has a relationship with the patient even though the pathologist probably never sees the person whose specimen comes to the lab and the patient does not know the pathologist exists.[7]

Another important issue involves the duty of a physician providing services to someone who is not the other party to the contract. This happens when, for example, a physician conducts a preemployment examination, examines an applicant for life-insurance purposes, or examines a plaintiff for a personal injuries case. The general rule is that in these situations a physician–patient relationship is not established between the physician and the person being examined and, therefore, that the physician owes no duty to the individual being examined, only to the party who contracted for the examination.

Some courts, however, have found at least a limited duty toward the plaintiff even in the absence of a contractual relationship. In *James v. United States* the plaintiff applied for a position at a shipyard and, as a condition of employment, was required to take a physical examination. A chest x-ray revealed an abnormality, but through a clerical error the physician never saw the x-ray or the radiologist's report. Almost two years later the plaintiff was diagnosed with an inoperable cancer. The defense argued that the absence of a physician–patient relationship precluded any duty of care. But the court awarded damages anyway because

Legal DecisionPoint

An affidavit is a written document in which the "affiant" (the one who signs the document) swears under penalty of perjury that the facts asserted in the statement are true. Affidavits generally cannot substitute for in-court testimony because they are not subject to cross-examination. But affidavits are sometimes used to support arguments on collateral matters, especially if the opposing attorney does not object. In this case, the affidavit (page 26) was used to support Dr. Brock's position that he did not have a doctor–patient relationship with Mrs. Oliver.

Who do you suppose wrote this affidavit? Are any of its assertions not, strictly speaking, facts? If you were opposing counsel, would you object to the use of such an affidavit? If you were the judge, what weight would you give it? If you could cross-examine the affiant (the treating physician who consulted with Dr. Brock), what kinds of questions would you like to ask him about his assertions?

> [h]aving made a chest X-ray an essential part of the preemployment examination to determine an applicant's physical fitness, however, defendant failed to use due care when...the report on the X-ray was not brought to the attention of the examining physician.[8]

Employees' Remedies and Workers' Compensation Laws

When an employee suffers an injury or illness arising out of her employment, the workers' compensation system is usually the exclusive remedy for the employee. This means that workers are precluded from recovering from their employer or co-employees for negligence or other claims, apart from the workers' compensation claim. If an employee is injured on the job and the company physician provides negligent treatment, can the employee recover from either the employer or the physician?

Again, the general rule is, workers' compensation is the employee's exclusive remedy.[9] However, some courts have found that when an employer operates in two capacities—as both an employer and a hospital, for example—the second capacity imposes obligations unrelated to and independent of the hospital's obligations as an employer. This is known as the "dual capacity doctrine." In *Guy v. Arthur H. Thomas Co.*, the plaintiff worked as a laboratory technician at the defendant hospital and in the performance of her duties operated a magnetic blood gas apparatus that used mercury.[10] In her complaint against the hospital the plaintiff alleged that she contracted mercury poisoning from the apparatus, that the hospital's employees negligently failed to diagnose her condition as mercury poisoning, and that her injuries were aggravated as a result.

The court held that as an employer the hospital was liable for workers' compensation benefits and that as a hospital it was liable in tort:

> Appellant's need for protection from malpractice was neither more nor less than that of another's employee. The…hospital, with respect to its treatment of the appellant, did so as a hospital, not as an employer, and its relationship with the appellant was that of hospital–patient with all the concomitant traditional obligations.

In addition to the issue of exclusive remedy, another issue is whether workers' compensation laws protect a company physician from liability for negligent treatment of fellow employees. These laws generally provide immunity from suits by co-employees, and some courts have dismissed suits against company physicians on this basis.[11]

Scope of the Duty Arising from the Relationship

In the typical physician–patient relationship, the physician has agreed to diagnose and treat the patient in accordance with the standards of acceptable

medical practice and to continue to do so until the natural termination of the relationship. (The standards of practice and termination of the relationship are discussed later in this chapter.) The patient has agreed to pay the physician for the services rendered. (The patient has not agreed to follow the doctor's orders; failure to do so, however, may excuse the physician from liability for untoward results.) Ordinarily the physician does not promise to cure the patient. In some cases, however, such a warranty or guarantee may be found from express promises made by the physician, and if no cure results he will be liable for breach of warranty. This subject is discussed further later in this chapter.

The physician may limit the scope of the contract to a designated geographic area or medical specialty. In *McNamara v. Emmons* a woman sustained a bad cut, which was treated by an associate of the defendant physician.[12] The next morning the patient left for a vacation in a town 20 miles away. While there, she felt she needed further treatment and asked the defendant physician to come to the town. He refused but gave her instructions and named a local physician whom she might call. The court held that in these circumstances the physician was justified in limiting his practice to his own town. In other cases the courts have decided that, at least when no emergency exists, the physician has no obligation to make house calls but instead may require the patient to come to the office for treatment.

Duties to the Person Other than the Patient

In many states the contractual relationship between the patient and the physician not only allows the physician to warn certain persons when a patient has an infectious disease but also obliges the physician to do so. For example, state law may require the healthcare provider to notify the sexual partners of persons diagnosed with HIV or AIDS.

Similarly, a physician might be subject to liability when a patient injures a third party. In *Freese v. Lemmon* a pedestrian was injured by an automobile when its driver suffered a seizure.[13] Both the driver and his physician were sued by the injured person—the physician on the theory that he was negligent in diagnosing an earlier seizure and in advising the driver that he could operate an automobile. The Supreme Court of Iowa reversed the trial court's dismissal of the case against the physician on the theory that a physician is subject to liability to third persons for negligently treating or giving false information to a patient when an unreasonable risk of harm to a third party or class of persons was foreseeable.

In the well-publicized case *Tarasoff v. Regents of the University of California* the California Supreme Court ruled that despite a confidential relationship with patients, a doctor has a duty to use reasonable care to warn persons threatened by a patient's condition.[14] The patient in *Tarasoff* had told his psychotherapist that he intended to kill a certain person and later carried out his threat. On these facts the court determined that the

victim's parents had a valid cause of action against the psychotherapist for failure to warn.

An important consideration in such cases is whether the injury to the third parties was foreseeable. In *Brady v. Hopper*, a suit by persons injured in the assassination attempt on President Reagan in 1981, the court held that John Hinckley, Jr.'s psychiatrist owed no duty to the plaintiffs because there was no evidence that Mr. Hinckley had made specific threats against the plaintiffs that would make his act foreseeable.[15]

Termination of the Relationship

Like all contracts, the one between the physician and the patient is terminated at certain points:

- when the patient is cured or dies,
- when the physician and the patient mutually consent to termination,
- when the patient dismisses the physician, or
- when the physician withdraws from the contract.

Withdrawal by a physician before the patient is cured often results in a claim of abandonment by the patient. Whether abandonment is a breach of contract, an intentional tort, or negligence has been a matter of considerable confusion. There might be valid claims for all three, especially when the physician thought the patient had been cured and prematurely discharged her from the hospital.[16] The confusion has been compounded by the absence of a clear line between abandonment and lack of diligence in treating the patient.

Abandonment may be either express or implied. Express abandonment occurs if a physician notifies a patient that he is withdrawing from the case but fails to give the patient enough time to locate another physician. In *Norton v. Hamilton* the plaintiff reported being in labor several weeks before her baby was due.[17] According to the plaintiff's allegations, the physician examined her and concluded that she was not in labor. When the pains continued, the plaintiff's husband called the physician twice to say that his wife was still in pain. At that point the physician said he was withdrawing from the case. While the husband was looking for a substitute physician, the plaintiff delivered her child alone and suffered unnecessary pain and distress. The court held that the physician's acts would be abandonment, if proven.

Implied abandonment occurs when the physician's conduct makes abandonment of the patient obvious. In *Johnson v. Vaughn*[18] Dr. Vaughn admitted the patient to the hospital, treated him, and then went home leaving word that he was to be called if the patient's condition grew worse. Because at the time the patient seemed dangerously ill, the patient's son called a Dr. Kissinger who "gave such attention as appeared to be most

urgent" but felt that he could not proceed further without a release from Dr. Vaughn. He called Dr. Vaughn and told him that the patient was dying and needed immediate attention. At this, Dr. Vaughn apparently became abusive, called Dr. Kissinger a louse for trying to steal his patient, and hung up. A call from the patient's son produced more abuse. Finally Dr. Vaughn said he would release the patient if he was paid $50 by nine o'clock the next morning. Meanwhile 30 or 40 minutes had passed before Dr. Kissinger could operate, and the patient later died. The court held that these facts were sufficient to state a claim of abandonment against Dr. Vaughn.

Physicians can raise various defenses to claims of abandonment. If the physician gives notice of withdrawal early enough for the patient to find another physician of equal ability, the claim will fail. And physicians have the right to limit their practice to a certain specialty or geographic area. A physician who is too ill to treat a patient or to find a substitute also has a valid defense to an abandonment claim. If a physician obtains a substitute physician, she has a valid defense so long as the substitute is qualified and the patient has enough time to find another if the substitute is unacceptable.

A physician may not abandon a patient simply because he thinks another physician is handling the case; *Maltempo v. Cuthbert* is an example.[19] The plaintiff's diabetic son was in a county jail awaiting transportation to a state prison to serve a sentence for a drug violation. In jail the son's health deteriorated, and his mother called her family physician for assistance but could only reach the defendant physician, who was taking the family physician's calls. This physician told the mother that he would investigate and call back if there were any problems. He then called the jail, learned that the son was being treated by the jail physician, and did nothing further. The young man died while being transported to the state prison. The appellate court affirmed a jury verdict in favor of the plaintiff. Even if it were unethical for the defendant physician to treat the young man without the jail physician's consent (a questionable proposition, at best), the jury could find negligence in the doctor's failure to ask the other doctor about the man's condition or at least to inform the parents that he was proceeding no further. The physician's actions "lulled the [plaintiffs] into believing that their son was being cared for, and effectively prevented them from seeking other emergency help."

Two California cases raised questions about the freedom of a healthcare provider to refuse initial or continued treatment of a patient whom the provider does not wish to treat. In *Payton v. Weaver* a physician informed his patient—a 35-year-old indigent woman with end-stage renal disease and a history of drug and alcohol abuse—that he would no longer continue as her physician because of her intensely uncooperative behavior, antisocial conduct, and refusal to follow instructions.[20] The patient tried without success to find alternative treatment and petitioned the court to compel the physician to continue treating her. The

parties then agreed that the physician would continue to treat her if she met reasonable conditions of cooperation. When she did not keep her part of the bargain, the doctor again notified her that he was withdrawing, and she again sought a court order. This time the trial court found that she had violated the previous conditions and in the process adversely affected other dialysis patients. The court also found that there was no emergency requiring treatment under a California statute,[21] that the physician's notice was sufficient to end the relationship, and that the doctor was not responsible for the fact that no other dialysis unit would accept the patient (see Legal DecisionPoint). The appellate court sustained the trial court decision. (It is not known what happened to poor Ms. Payton.)

Legal DecisionPoint

End-stage renal disease (ESRD) is chronic kidney failure that has progressed to the point of requiring kidney dialysis or transplant. An ESRD patient needs to undergo dialysis every three or four days but lives a somewhat normal existence between treatments (subject to contributing conditions such as high blood pressure and diabetes).

The court stated that "there was no emergency" in Ms. Payton's case. Do you agree? Was she a patient with a chronic disease, or was she a patient who was bound to have serial emergencies? Instead of seeing Dr. Weaver as scheduled (which of course she did not), what if she had been taken to the emergency department every few days in extremis and in need of dialysis? If you were a hospital administrator, how would you advise the emergency department to deal with Ms. Payton?

A different situation resulted in the decision that a medical group and hospital could not refuse nonemergency care to a husband and wife. In *Leach v. Drummond Medical Group, Inc.*, the plaintiffs, who were patients of the medical group, had written to a state agency commenting adversely on the performance of the group's physicians.[22] The group then told the couple that because they complained to the medical board, "a proper physician–patient relationship" could not be maintained and they would receive only 30 days of care, and then only if there was an emergency. The couple sued to compel continued treatment of their many health problems. The trial court denied relief, but the appellate court reversed the decision and allowed the suit to continue. The court decided that although one physician may not be required to treat a patient that she does not like, the whole group can be ordered to.[23] Because the patients had not publicly criticized the doctor but only discreetly contacted the appropriate state agency, the court held that denying services to them was not justified. (It is significant to note that the defendants were the only medical group available within 100 miles.)

Duties Following Termination of the Relationship

Some cases have extended the physician's duty to the patient even after the doctor–patient relationship has ended. In *Tresemer v. Barke* the plaintiff's physician had implanted an intrauterine device (IUD) in 1972.[24] The physician had seen the patient only on that one occasion. The plaintiff later suffered injury from the device (a Dalkon shield) and filed suit against the

physician. She alleged that he learned about the risks of the IUD but failed to warn her. The court held that the defendant had a duty to warn the plaintiff, noting that a physician is in the best position to alert a patient and that death or great bodily harm might be avoided without much inconvenience.[25]

Liability for Breach of Contract

In the typical physician–patient contract, the physician agrees (or implies agreement) to perform a service. Failure to perform the service with reasonable skill and care may give the patient a claim not only for negligence but also for breach of contract. We have already seen breach-of-contract cases based on abandonment in connection with ending the physician's contractual duty; *Alexandridis v. Jewett* offers one example.[26]

In *Alexandridis* two obstetricians implied that they would be available when the patient went into labor. On learning that the woman was in labor, one of the obstetricians notified his partner, who was on call. The partner did not arrive in time, however, and an episiotomy (a small incision that eases childbirth) had to be performed by a first-year resident and caused injury to the patient. In the suit that followed, the appellate court found enough evidence to send the case to a jury and that the partners would be liable for breach of contract if their superior skill would have protected the patient from injury. In a similar case the court noted that a valid claim could be stated for breach of contract against a urologist because he allegedly agreed to perform an operation on the plaintiff but was not present during the surgery. Two colleagues from his medical group performed the operation instead.[27]

A physician who uses a different procedure from the one that was promised will also be liable for breach of contract. In *Stewart v. Rudner* the physician promised to arrange for an obstetrician to deliver a child by cesarean section.[28] The patient was a 37-year-old woman who had had two previous stillbirths and was extremely eager to have a "sound, healthy baby." While the patient was in labor the physician told another obstetrician to "take care of this case" but did not tell him about the promise to perform a cesarean section. At the end of a lengthy labor the baby was stillborn. The appellate court upheld a jury verdict for the patient on the ground that the physician breached his promise that a cesarean operation would be used to deliver the baby.

Liability for Breach of Warranty

Physicians are especially susceptible to liability not only if they promise to perform a certain service but also if they promise a specified result. A physician who

guarantees a result gives the patient a contract basis for a lawsuit if the treatment is not successful. In *Sullivan v. O'Conner* a professional entertainer thought her nose was too long.[29] She contracted with a physician to have cosmetic surgery. The physician promised that the surgery would "enhance her beauty and improve her appearance." In fact, the surgery was unsuccessful, and after two more operations the nose looked worse than before. Physicians do not guarantee results simply by agreeing to perform an operation, and it is often hard to draw the line between an opinion and a guarantee. But the jury decided in this case that there was a guarantee, and the appellate court affirmed the jury's verdict for the plaintiff (see Legal Brief).

Legal Brief

Sullivan v. O'Conner is a good example of the roles juries and appellate courts play in our legal system. The jury decides what the facts are, and the appellate court must accept those facts as true unless they are indisputably wrong.

In some respects the function of these roles is like the instant replay rule in the NFL: Unless there is clear evidence to the contrary, the "call on the field" stands.

Guilmet v. Campbell is a well-known case in medical–legal circles. The plaintiff had a bleeding ulcer and talked with a surgeon about a possible operation. He testified that the surgeon told him this:

> Once you have an operation it takes care of all your troubles. You can eat as you want to, you can drink as you want to, you can go as you please. Dr. Arena and I are specialists; there is nothing to it at all—it's a very simple operation. You'll be out of work three to four weeks at the most. There is no danger at all in this operation. After the operation you can throw away your pill box. In twenty years if you figure out what you spent for Maalox pills and doctor calls, you could buy an awful lot. Weigh [that cost] against an operation.[30]

With this alleged assurance, the plaintiff underwent the operation. Postoperative evaluation showed that the plaintiff had a ruptured esophagus. His weight dropped from 170 to 88 pounds, and he developed hepatitis. He then sued the physician on both a negligence theory and a warranty (guarantee) theory. The jury decided that the physicians were not negligent but had breached their promise to cure. The state's supreme court affirmed the decision. In response to *Guilmet*, and presumably after some heavy lobbying by the medical profession, the Michigan legislature passed a statute requiring that any alleged promise or guarantee of a cure will be void unless it is in writing and signed by the physician alleged to have made it.[31]

Liability for Intentional Tort

Another basis for professional liability is intentional tort. A tort is a civil wrong not based on contract that results in injury to another person or another person's property or reputation. Torts are usually divided into three categories, each of which involves a different type of proof (see Figure 2.1). An intentional tort, as the name implies, results when a person intends to do the wrongful act. Negligence occurs when a person intends no harm but fails to do what a reasonably careful person would do under the circumstances. Strict liability results when an act is wrongful, not because the actor intended the wrong or was negligent but because the act involved a high risk of harm to others. As noted earlier, most malpractice cases are based on negligence. (Strict liability is uncommon in healthcare administration, but it surfaces in relation to defective drugs and medical devices.)

Lawsuits based on intentional tort are less common in healthcare than negligence cases, but they are important because they give plaintiffs some flexibility they would not have otherwise. There may also be multiple consequences for the healthcare provider who commits an intentional tort. Because intent is usually an essential element in proving both the intentional tort and a crime, many intentional torts, such as assault and battery, entail both criminal and civil liability. The commission of a criminal act could lead to a third consequence: revocation of the license to practice.

Assault and Battery

Assault and battery is actually a combination of two intentional torts. An assault is conduct that places a person in fear of being touched in a way that is insulting, provoking, or physically harmful. Battery is the actual touching (see Legal Brief). Both assault and battery are acts done without legal authority or permission. A move to kiss someone without consent is an assault, and the act of kissing is assault and battery. If the person were asleep when kissed there would be no assault (because the person was not apprehensive), but there would be a battery. (Obviously, kissing someone with permission is neither an assault nor a battery, but rather fun for both parties.)

Legal Brief

We accept the incidental touching that accompanies everyday life, but there are certain boundaries. This is why being jostled on an elevator is not battery; being groped is. Battery is summarized by the aphorism, "Your right to swing your arm ends where my nose begins."

The question of consent to medical or surgical treatment is complex; we discuss it completely in Chapter 9. For present purposes, assault and battery

cases can be grouped into three categories. First are the intentional acts committed by the healthcare provider with no consent from the patient whatsoever. In *Burton v. Lefwich*, for example, a physician who was having trouble removing sutures from the toe of a four-year-old child (whose parents were apparently not much help) hit the tot's thigh several times with his open hand, leaving bruises that were visible for three weeks.[32] An appellate court upheld a jury verdict that the physician had committed battery.

Compare that case with *Mattocks v. Bell*, where a 23-month-old girl—whom a medical student was treating for a lacerated tongue—clamped her teeth on the student's finger and would not let go.[33] After trying to free his finger by forcing a tongue depressor into the child's mouth, the student slapped her on the cheek. The parents' battery suit failed. The force used was proper under the circumstances.

In these kinds of cases a physician's liability for striking someone is no different from the liability of any other person; this is true as well when a physician performs an operation without consent. In the oft-cited *Schloendorff v. Society of New York Hospital* (which is discussed in more detail in Chapter 9), a doctor was liable for battery after he operated on a patient who had consented only to an examination under anesthesia but not to an operation.[34] In another case a patient signed a consent form naming a specific urologist to remove his kidney stones. After surgery, the patient discovered that the operation had been performed not by the urologist but by two other members of the urologist's medical group. He then sued all three physicians for malpractice and failure to obtain informed consent. After the jury found in favor of the defendants, the Supreme Court of New Jersey reversed the decision. It found that the plaintiff had claims for battery and malpractice and that even if no physical injury occurred, the defendants could be liable for mental anguish and perhaps even punitive damages.[35] The court stated:

> Even more private than the decision who may touch one's body is the decision who may cut it open and invade it with hands and instruments. Absent an emergency, patients have the right to determine not only whether surgery is to be performed on them, but who shall perform it.[36]

A second category of assault and battery includes situations where the duty to obtain permission has been met but the physician goes beyond the scope of the consent (more on this later). In a third category the physician acts within the scope of the consent but does not adequately advise the patient of the risks of the treatment. In that situation, the patient's consent is not well informed and the permission is invalid. As discussed in Chapter 3, a suit can be brought in both the second or third categories on a theory of either negligence or assault and battery. Negligence is the most common allegation, but liability on assault and battery is also possible.[37] *Mohr v. Williams*

illustrates the last two kinds of cases.[38] In *Mohr* the plaintiff consented to an operation on her right ear. After she was anesthetized, the surgeon discovered that her left ear needed surgery more than the right ear and operated on the left one instead. On the ground, among others, that the surgeon's conduct amounted to a technical assault and battery, the appellate court upheld a trial court's decision to let the case proceed.

Although the surgeon in *Mohr* should have consulted the patient before operating on the other ear, a surgeon will sometimes be justified in operating beyond the scope of the consent—for instance, when an emergency makes obtaining the patient's consent impossible or dangerous. In *Barnett v. Bachrach* a surgeon operating on a patient with an ectopic pregnancy (a pregnancy outside the uterus) discovered that the pregnancy was normal but that the patient had acute appendicitis.[39] He removed the appendix and later sued the patient for not paying the operating fee. The patient defended the suit by alleging that the appendix was removed without her consent. In holding for the surgeon the court noted that if he had not taken out the appendix, the patient and child might have been endangered.

Defamation

Defamation is wrongful injury to another person's reputation. Written defamation is libel, and oral defamation is slander. To be actionable, the defamatory statement must be "published"—that is, the defendant must have made the statement to a third party, not just to the plaintiff. This was the point of *Shoemaker v. Friedberg*.[40] In this case, a physician wrote a letter to a patient stating that she had a venereal disease. The patient showed the letter to two or three other women and later, in the presence of a friend, discussed the diagnosis with the physician. In suing him she alleged a breach of confidentiality, but the court held that no recovery should be allowed because the patient had "published" the diagnosis herself. (This could be thought of as the "it's your own dumb fault" rule.)

Physicians have several defenses available to them in defamation suits:

- *The truth of a statement is an absolute defense, if the defendant can prove that the statement was true.*[41] Even a true statement, however, can lead to liability for an invasion of privacy or breach of confidentiality.
- *Some statements, such as those made during a judicial proceeding or by one physician to another in discussing a patient's treatment, are privileged and provide a defense.* In *Thornburg v. Long*, for example, a specialist incorrectly reported to a family physician that a patient had syphilis.[42] When the patient sued the specialist for libel, the court held that the statement was privileged because the specialist had a duty to communicate the information to the family physician.

- *Statements made in good faith to protect a private interest of the physician, the patient, or a third party are entitled to a qualified privilege*. An example is a false but good-faith report of a sexually transmitted disease diagnosis to a state health department, as required by law.

False Imprisonment

False imprisonment arises from unlawful restriction of a person's freedom. Many false imprisonment cases involve patients who have been involuntarily committed to a mental hospital. In *Stowers v. Wolodzko* a psychiatrist was held liable for his treatment of a patient who had been committed against her will.[43] Although this type of commitment was allowed under state law, the psychiatrist kept the woman from calling an attorney or a relative. His actions amounted to false imprisonment because her freedom was unlawfully restrained. (The unusual facts of this case are laid out in The Court Decides: *Stowers v. Wolodzko* at the end of this chapter.)

Invasion of Privacy and Breach of Confidentiality

Truth is a defense in defamation cases, but there are two other bases for possible liability even when a physician's statement about the plaintiff is true: (1) invasion of privacy and (2) wrongful disclosure of confidential information. Invasion of privacy occurs when a patient is subjected to unwanted publicity. For example, in *Vassiliades v. Garfinckel's*, *Brooks Bros.*, the defendants (a physician and the famous department store) used "before" and "after" photographs of the plaintiff's cosmetic surgery without her permission. This was sufficient to support a verdict for invasion of privacy and breach of fiduciary duty.[44] Similarly, a Michigan physician was held liable for invasion of privacy when he allowed a lay friend to observe the delivery of a baby in the patient's home. Clearly, a patient's expectation of privacy should be respected.

A suit for wrongful disclosure of confidential information was brought on behalf of a man who had been a patient at the Holyoke Geriatric and Convalescent Center.[45] His family had sought the court's permission to remove him from the kidney dialysis treatments that were sustaining his life. The court granted the petition, but several nurses and aides from the center, with the approval of the center's administrator, wrote a letter to a local newspaper protesting the decision. The letter appeared on the front page of the paper. A jury awarded the plaintiff's widow and estate $1 million for violation of a statute that prohibits release of personal information. The case clearly shows the danger of disclosing confidential patient information without proper authority.

Frequently, state or federal law requires disclosure of confidential information. For example, confidential information from a patient's medical record may be disclosed for the purpose of quality assurance and peer-review

activities and to state authorities in cases of suspected child abuse. Other reporting requirements include those relating to communicable disease, abortion, birth defect, injury or death resulting from use of a medical device, environmental illness and injury, injuries (such as knife or gunshot wounds) resulting from suspected criminal activities, and conditions (such as epilepsy) affecting one's ability to drive safely or operate heavy machinery.

Obviously, disclosures made in conformity with law are not "wrongful," and no liability will attach. Similarly, there is no liability for disclosing patient information when the patient (or the patient's guardian) has given permission or when a search warrant or other legal procedure requires it. Healthcare facilities must be aware of the federal and state requirements regarding confidentiality of medical records and must have policies and procedures in place to protect the information contained in them. (All of these requirements are discussed in more detail in Chapter 14.)

Misrepresentation

This is another tort for which physicians have been held liable. Misrepresentation can be either intentional (fraudulent or deceitful) or negligent. Either way, it must be shown that a fact was falsely represented and that the person claiming injury relied on the misrepresentation. Misrepresentation cases involving physicians are of two types: (1) representations to persuade a patient to submit to treatment and (2) representations about a prior treatment or its results.

Physicians who misrepresent the nature or results of treatment they have given are liable for fraud even if the treatment was done carefully. In *Johnson v. McMurray*[46] Dr. McMurray had performed an earlier surgery on Mr. Johnson and had left a surgical sponge in his body. Mr. Johnson specifically asked that Dr. McMurray not participate in the follow-up surgery that was needed to remove the sponge, and he sought out a Dr. Griffith to operate. Unknown to Mr. Johnson, Dr. Griffith intended to have Dr. McMurray assist in the surgery anyway, which he did. More complications arose, and the patient eventually lost his leg. The court decided that the two doctors had fraudulently concealed a significant fact and a jury could award damages.

Misrepresentation sometimes allows a patient to bring suit after the statute of limitations expires. In *Hundley v. Martinez* a physician repeatedly assured his patient—an attorney—that his eye would be all right after a cataract operation.[47] Over the years, the attorney became virtually blind in that eye. In this case, although the statute of limitations had run, the court held that the limitation period was suspended if the jury found that the physician had obstructed the plaintiff's case by fraud or in other indirect ways.

Outrage

The intentional tort of outrage—sometimes called "intentional infliction of emotional distress"—arises from extreme and offensive conduct by the

defendant; *Rockhill v. Pollard*[48] provides a graphic example. The plaintiff, her mother-in-law, and her ten-month-old daughter were injured in an automobile accident on a wintry evening in Oregon shortly before Christmas; the accident knocked the baby unconscious. A passing motorist picked them up and arranged for a physician to meet them at his office. Here is a portion of the court's opinion describing the encounter with the defendant, Dr. Pollard:

> Both plaintiff and [her mother-in-law] Christine Rockhill testified that defendant was rude to them from the moment they met him. Plaintiff testified:
>
> "And the first thing, he looked at us, and he had a real mean look on his face, and this is what he said. He said, 'My God, women, what are you doing out on a night like this?'…and my mother-in-law tried to explain to him why we were on the road, and her and I both pleaded to him."
>
> Without making any examination, defendant told them there was nothing wrong with any of them. [The baby] was still unconscious at this time. According to plaintiff:
>
> "She was very lifeless. I was saying her name, and she wouldn't respond at all. Her eyelids were a light blue. She was clammy, very cold.
>
> "In fact, I thought she was dead at the time."

After repeated requests to do so, the doctor finally gave the child a cursory examination and said there was nothing wrong with her. The baby had vomited, and both the adults had blood and vomit on them. The opinion states that the doctor told the mother-in-law, "Get in there and clean yourself up. You are a mess." The opinion continues:

> "The doctor was out of the room, and I told her [Christine Rockhill, her mother in law], I says, 'We have got to get help for this baby,' and she said, 'Well, what are we going to do?'
>
> "And the doctor came back in the room, and she asked the doctor, she says, 'What are we going to do?' And he just shrugged his shoulders and said he didn't know."
>
> When Christine Rockhill suggested that her brother would pick them up at defendant's office, defendant said, "My God, woman, I can't stay here until somebody comes and gets you." Although the temperature was below freezing and [the baby's] clothing and blanket were wet with vomit, he told them to wait outside by a nearby street light while someone came…to get them.

After a 20-minute wait in the cold, the group was taken to a hospital, where the baby arrived only semiconscious and apparently suffering from shock. The women were given emergency treatment and released. The child had surgery to repair a depressed skull fracture and was released after a week in the hospital.

The trial court had dismissed the lawsuit thinking that the plaintiff had not presented a prima facie case—that is, enough evidence to win unless the defendant presents contradictory evidence. The Supreme Court of Oregon disagreed, stating, "We think the issue should have been submitted to the jury."

It is not hard to see why a jury could find that the defendant's conduct was outrageous, is it?

Violation of Civil Rights

For at least 40 years courts have recognized causes of action for violations of patients' civil rights. Discrimination on the basis of race, religion, ethnicity, and other protected categories is an obvious example.[49] *Eidgeion v. Eastern Shore Hospital Center* is an example of less apparent discrimination. The plaintiff was involuntarily committed to a Maryland hospital after an ex parte hearing (one in which only one party is present) in which the plaintiff's wife testified that he had exhibited abnormal and violent behavior. Two physicians examined the plaintiff on his arrival at the hospital, and although he showed no outward signs of mental illness the doctors ordered that he be held at the hospital. The plaintiff maintained that his wife lied about his behavior because she wanted to be free to join her male friend in Florida. In fact, as soon as she met up with her "friend," the hospital released the plaintiff. He promptly sued his wife, the physicians, and the hospital for violation of federal and state civil rights statutes, negligence, false imprisonment, false arrest, defamation, intentional infliction of emotional distress, and conspiracy to commit these wrongs. The court held that the complaint stated a valid cause of action.[50]

Chapter Summary

This chapter addresses the essential elements of a valid contract (competent parties, a "meeting of the minds," consideration, and legality of purpose) and the importance of contract law in the relationship between patients and their physicians and between patients and hospitals. The chapter also briefly discusses issues relating to workers' compensation and intentional tort, pointing out that both can affect doctor–patient and hospital–patient relationships.

Chapter Discussion Questions

1. Referring to *Oliver v. Brock*, what factors did the court use in determining whether Dr. Brock had a contractual relationship with Mrs. Oliver? What differences in the facts might have changed the outcome of the case?
2. Why are workers' compensation benefits the sole remedies for workplace injuries of employees as they were in *Guy v. Arthur H. Thomas Co.*?
3. Explain why a case of a pursuit of a breach of contract, such as *Guilmet v. Campbell*, would be easier than a standard case alleging negligence.
4. In what ways can intentional torts arise in the healthcare field?

Notes

1. Some physicians and hospitals believe they have complete professional liability coverage under their malpractice insurance policies, but in fact they are covered only for negligent acts. For example, in Security Ins. Group v. Wilkinson, 297 So. 2d 113 (Fla. App. 1974), the court held that a hospital's professional liability policy did not cover a breach of contract to treat the plaintiff's wife.
2. Note that courts can and do apply legal principles to find legal duties where none existed previously. In Tarasoff v. Regents of the Univ. of Cal., 118 Ca. Rptr. 129, 529 P.2d 553 (1974), aff'd, 131 Cal. Rptr. 14, 551 P.2d 334 (1976), the court found that a psychiatrist had a duty to warn the person whom the patient had threatened to kill, even though there was no relationship between the doctor and the threatened person and in spite of the fact that doctor–patient communications are normally confidential. This case is discussed in detail in Chapter 14, "Health Information Management."
3. For example, in Hurley v. Eddingfield, 156 Ind. 416, 59 N.E. 1058 (1901), the only physician available to aid a critically ill person refused, for no reason, to assist. The court stated that unless some special contract or other commitment exists physicians have no legal responsibility to treat people. Vermont and Minnesota have statutes that require a bystander to render aid in an emergency—Vt. Stat. Ann. Tit. 12, § 519 (1973); Minn. Stat. Ann. § 604.05 (Supp. 1985).
4. 440 S. W.2d 104 (Tex. Civ. App. 1969). This case is discussed in greater detail in Chapter 8.
5. 342 So. 2d 1 (Ala. 1976).
6. *Am. Jr.* 2nd, "Physicians, Surgeons and Other Healers," § 96.
7. Holder, A. 1978. *Medical Malpractice Law*, 2nd ed., 6.
8. 483 F. Supp. 581 (1980).
9. See, for example, Young v. St. Elizabeth Hosp., 131 Ill. App. 3d 193, 475 N.E.2d 603 (1985)—the plaintiff alleged negligent treatment of injuries sustained on the job; suit dismissed; McAlister v. Methodist Hosp. of Memphis, 550 S.W.2d 240 (Tenn. Sup. Ct. 1977)—a hospital employee alleged negligent treatment of work-related back injury.
10. 55 Ohio S. 2d 183, 378 N.E.2d 488 (1978).
11. See, for example, Garcia v. Iserson, 42 A.D.2d 776, 346 N.Y.S.2d 572 (1973), aff'd, 33 N.Y.2d 421, 353 N.Y.S.2d 955, 309 N.E.2d 420 (1974). Others have found that a company physician is an independent contractor for purposes of the workers' compensation exclusion and have permitted suits against physician-employees. See, for example, Stevens v. Kimmel, 182 Ind. App. 187, 394 N.E.2d 232 (1979); Ross v. Schubert, 180 Ind. App. 402, 388 N.E.2d 623 (1979). The dual capacity doctrine has also been invoked to find physicians liable for negligent treatment of workers. See, for example, Hoffman v. Rogers, 22 Cal. App. 3d 655, 99 Cal. Rptr. 455 (1972); Duprey v. Shane, 39 Cal. 2d 781, 249 P2d 8 (1952).
12. 36 Cal. App. 2d 199, 97 P.2d 503 (1939).
13. 210 N.W.2d 576 (Iowa 1973). See also Kaiser v. Suburban Transp. Sys., 65 Wash. 2d 461, 398 P.2d 14 (1965), amended by 65 Wash. 2d 461, 401 P.2d 350 (1965)—passengers on a patient's bus

were allowed to recover damages from the defendant physician; Duvall v. Goldin, 139 Mich. App. 342, 362 N.W.2d 275 (1984)—physician owed a duty to third persons injured in auto accident after the physician failed to warn his patient not to operate a motor vehicle.

14. 118 Cal. Rptr. 129, 529 P.2d 553 (1974) aff'd, 131 Cal. Rptr. 14, 551 P.2d 334 (1976). See also Davis v. Lhim, 124 Mich. App. 291, 335 N.W.2d 481 (1983)—a psychiatrist was held liable for discharging a patient who subsequently killed his mother and for failing to warn the patient's mother. But see Soto v. Frankford Hosp., 478 F. Supp. 1134 (E.D. Pa. 1979).
15. 751 F.2d 329 (10th Cir. 1984).
16. Louisell, D., and H. Williams. 1973. *Medical Malpractice* § 8.08, at 219.
17. 92 Ga. App. 727, 89 S.E.2d 809 (1955).
18. 370 S.W.2d 591 (Ky. 1963).
19. 504 F.2d 325 (5th Cir. 1974).
20. 131 Cal. App. 3d 38, 182 Cal Rptr. 225 (1982).
21. Cal. Health & Safety Code § 1317 (West 1979).
22. 144 Cal. App. 3d 362, 192 Cal. Rptr. 650 (1983).
23. Cal. Civ. Code § 51.
24. 86 Cal. App. 3d 656, 150 Cal. Rptr. 384 (1978).
25. Id. at 672, 150 Cal. Rptr. at 394. See also Tuchman v. Cutter Laboratories (no. 976,275, Cuyahoga Cty., Ohio, Ct. of Common Pleas; unpublished)—failure to warn the patient of allegedly defective prosthetic heart valve.
26. 388 F.2d 829 (1st Cir. 1968).
27. Perna v. Pirozzi, 92 N.J. 446, 457 A.2d 431 (1983). This case is discussed in more detail in relation to assault and battery.
28. 349 Mich. 459, 84 N.W.2d 816 (1957).
29. 363 Mass. 579, 296 N.E.2d 183 (1973).
30. 385 Mich. 57, 68, 188 N.W.2d 601, 606 (1971).
31. Mich. Comp. Laws Ann. § 566.132 (Supp. 1985), amending, Mich. Comp. Laws Ann. § 566.132 (1967).
32. 123 So. 2d 766 (La. Ct. App. 1960).
33. 194 A.2d 307 (D.C. Ct. App. 1963).
34. 211 N.Y. 125, 105 N.E. 92 (1914).
35. Perna v. Pirozzi, 92 N.J. 446, 438, 457, A.2d 431, 461 (1983)—against the urologist, plaintiff had a cause of action for breach of contract, breach of fiduciary duty, and malpractice.
36. Id. at 461, 457 A.2d at 439.
37. Prosser, W. 1984. *Law of Torts,* 5th ed., 189.
38. 95 Minn. 261, 104 N.W. 12 (1905).
39. 34 A.2d 626 (D.C. Mun. Ct. App. 1943).
40. 80 Cal. App. 2d 911, 916, 183 P.2d 318, 322 (1947).
41. Even a true disclosure, however, may give rise to liability for invasion of privacy or wrongful disclosure of confidential information. See also the discussion on confidentiality of medical records in Chapter 14, "Health Information Management."
42. 178 N.C. 589, 101 S.E. 99 (1919).
43. 386 Mich. 119, 191 N.W.2d 355 (1971)—the court also held the psychiatrist liable for assault and battery for giving the patient involuntary medication beyond what was permitted by the statute.
44. 492 A.2d 580 (D.C. App. 1985)—the department store was not liable because it had obtained assurances from the physician that the plaintiff had given her consent.
45. Spring v. Geriatric Authority of Holyoke, 394 Mass. 274, 475 N.E.2d 727 (1985).
46. 461 So. 2d 775 (Ala. 1984).
47. 151 W. Va. 977, 158 S.E.2d 159 (1967).
48. 259 Or. 54, 485 P.2d 28 (1971).
49. See, for example, Washington v. Blampin, 226 Cal. App. 2d 604, 38 Cal. Rptr. 235 (1964).
50. 479 A.2d 921 (Md. 1984). See also Johnson v. Silvers, 742 F.2d 823 (4th Cir. 1984)—the plaintiff's complaint, which stated that while voluntarily committed he had been forced to take antipsychotic medication against his will, alleged a deprivation of liberty within the contemplation of 42 U.S.C. § 1983.

THE COURT DECIDES

Stowers v. Wolodzko
386 Mich. 119, 191 N.W.2d 355 (1971)

Swainson, J.

This case presents complicated issues concerning the liability of a doctor for actions taken subsequent to a person's confinement in a private mental hospital pursuant to a valid court order....

Plaintiff, a housewife, resided in Livonia, Michigan, with her husband and children. She and her husband had been experiencing a great deal of marital difficulties and she testified that she had informed her husband...that she intended to file for a divorce.

On December 6, 1963, defendant appeared at plaintiff's home and introduced himself as "Dr. Wolodzko." Dr. Wolodzko had never met either plaintiff or her husband before he came to the house. He stated that he had been called by the husband, who had asked him to examine plaintiff. Plaintiff testified that defendant told her that he was there to ask about her husband's back. She testified that she told him to ask her husband, and that she had no further conversation with him or her husband. She testified that he never told her that he was a psychiatrist.

Dr. Wolodzko stated in his deposition...that he told plaintiff he was there to examine her. However, upon being questioned upon this point, he stated that he could "not specifically" recollect having told plaintiff that he was there to examine her. He stated in his deposition that he was sure that the fact he was a psychiatrist would have come out, but that he couldn't remember if he had told plaintiff that he was a psychiatrist.

Plaintiff subsequently spoke to Dr. Wolodzko at the suggestion of a Livonia policewoman, following a domestic quarrel with her husband. He did inform her at that time that he was a psychiatrist.

On December 30, 1963, defendant Wolodzko and Dr. Anthony Smyk, apparently at the request of plaintiff's husband and without the authorization, knowledge, or consent of plaintiff, signed a sworn statement certifying that they had examined plaintiff and found her to be mentally ill. Such certificate was filed with the Wayne County Probate Court on January 3, 1964, and on the same date an order was entered by the probate court for the temporary hospitalization of plaintiff until a sanity hearing could be held. The Judge ordered plaintiff committed to Ardmore Acres, a privately operated institution, pursuant to the provisions of [Michigan law].

Plaintiff was transported to Ardmore Acres on January 4, 1964....

....

The parties are in substantial agreement as to what occurred at Ardmore Acres. Defendant requested permission to treat the plaintiff on several different occasions, and she refused. For six days, she was placed in the "security room," which was a bare room except for the bed. The windows of the room were covered with wire mesh. During five of the six days, plaintiff refused to eat, and at all times refused medication. Defendant telephoned orders to the hospital and prescribed certain medication. He visited her often during her stay.

When plaintiff arrived at the hospital she was refused permission to receive or place telephone calls, or to receive or write letters. Dr. Wolodzko conceded at the trial that plaintiff wished to contact her brother in Texas by telephone and that he forbade her to do so. After nine days, she was allowed to call her family, but no one else. Plaintiff testified on direct examination that once during her hospitalization she asked one of her children to call her relatives in Texas and that defendant took her to her room and told her, "Mrs. Stowers, don't try that again. If you do, you will never see your children again." It is undisputed that plaintiff repeatedly requested permission to call an

attorney and that Dr. Wolodzko refused such permission.

At one point when plaintiff refused medication, on the written orders of defendant, she was held by three nurses and an attendant and was forcibly injected with the medication. Hospital personnel testified at the trial that the orders concerning medication and deprivation of communication were pursuant to defendant's instructions.

Plaintiff, by chance, found an unlocked telephone near the end of her hospitalization and made a call to her relatives in Texas. She was released by court order on January 27, 1964.

Plaintiff filed suit alleging false imprisonment, assault and battery, and malpractice, against defendant Wolodzko, Anthony Smyk and Ardmore Acres. Defendants Ardmore Acres and Smyk were dismissed prior to trial. At the close of plaintiff's proofs, defendant moved for a directed verdict. The court granted the motion as to the count of malpractice only, but allowed the counts of assault and battery and false imprisonment to go to the jury. At the Conclusion of the trial, the jury returned a verdict for plaintiff in the sum of $40,000....

Defendant has raised five issues on appeal....

....

The second issue involves whether or not there was evidence from which a jury could find false imprisonment.

"False imprisonment is the unlawful restraint of an individual's personal liberty or freedom of locomotion." [Citation omitted.] It is clear that plaintiff was restrained against her will. Defendant, however, contends that because the detention was pursuant to court order (and hence not unlawful), there can be no liability for false imprisonment. However, defendant was not found liable for admitting or keeping plaintiff in Ardmore Acres. His liability stems from the fact that after plaintiff was taken to Ardmore Acres, defendant held her incommunicado and prevented her from attempting to obtain her release, pursuant to law. Holding a person incommunicado is clearly a restraint of one's freedom, sufficient to allow a jury to find false imprisonment.

Defendant contends that it was proper for him to restrict plaintiff's communication with the outside world. Defendant's witness, Dr. Sidney Bolter, testified that orders restricting communications and visitors are customary in cases of this type. Hence, defendant contends these orders were lawful and could not constitute the basis for an action of false imprisonment. However, the testimony of Dr. Bolter is not conclusive on this point.

....Psychiatrists have a great deal of power over their patients. In the case of a person confined to an institution, this power is virtually unlimited. All professions (including the legal profession) contain unscrupulous individuals who use their position to injure others. The law must provide protection against the torts committed by these individuals. In the case of mental patients, in order to have this protection, they must be able to communicate with the outside world. In our country, even a person who has committed the most abominable crime has the right to consult with an attorney.

Our Court and the courts of our sister States have recognized that interference with attempts of persons incarcerated to obtain their freedom may constitute false imprisonment. Further, we have jealously protected the individual's rights by providing that a circuit Judge "who willfully or corruptly refuses or neglects to consider an application, action, or motion for, habeas corpus is guilty of malfeasance in office." [Citation omitted.]

...[P]laintiff was...attempting to communicate with a lawyer or relative in order to obtain her release. Defendant prevented her from doing so. We...hold that the actions on the part of defendant constitute false imprisonment....

A person temporarily committed to an institution pursuant to statute certainly must have the right to make telephone calls to an attorney or relatives. We realize that it may be necessary to restrict visits to a patient confined to a mental institution. However, the same does not

apply to the right of a patient to call an attorney or relative for aid in obtaining his release. This does not mean that an individual has an unlimited right to make numerous telephone calls, once he is confined pursuant to statute. Rather, it does mean that such an individual does have a right to communicate with an attorney and/or a relative in attempt to obtain his release.

Dr. Bolter was unable to give any valid reason why a person should not be allowed to consult with an attorney. We do not believe there is such a reason. While problems may be caused in a few cases because of this requirement, the facts in the instant case provide cogent reasons as to why such a rule is necessary. Mrs. Stowers was able to obtain her release after she made the telephone call to her relatives they, in turn, obtained an attorney for her. Prior to this, because of the order of no communications, she was virtually held a prisoner with no chance of redress. We, therefore, agree with the Court of Appeals that there was sufficient evidence from which a jury could find that Dr. Wolodzko had committed false imprisonment.

The Court of Appeals is affirmed.

Stowers v. Wolodzko Discussion Questions

1. What other information would you like to have to fully consider this case?
2. According to the opinion, Mrs. Stowers was committed on the strength of the statement of two physicians that she was "mentally ill." Would that evidence be sufficient today to have someone committed involuntarily? If not, what would the evidence have to prove? Why?
3. How should these kinds of cases be handled today?

CHAPTER

3

NEGLIGENCE

"Even a dog distinguishes between being stumbled over and being kicked."

—O. W. Holmes, "Trespass and Negligence," 14 American Law Review 1, 15 (1880)

After reading this chapter, you will

- know that four essential elements must be proven for a plaintiff to prevail in a negligence case.
- realize that the standard of care (the duty) can be proven by expert testimony, published principles, or the jury's common experience of what is reasonable.
- understand that the plaintiff's injuries must be caused by the defendant's breach of the duty.
- be aware that under the concept of "vicarious liability," one can be liable for the actions of someone else.

This chapter is one of the longest in the book because negligence is the most common type of liability case that healthcare organizations face. It occurs when the wrongdoer (the tort-feasor) fails to live up to accepted standards of behavior—that is, fails to use "due care." Four elements are essential to prove negligence: (1) a duty of care, (2) breach of that duty, (3) injury, and (4) causation. We will review each of these elements in turn.

Standard of Care

The duty of due care requires all persons to conduct themselves as a reasonably prudent person would do in similar circumstances. One who fails to meet this standard has committed a breach of duty, and the tort-feasor will be liable if the

breach causes injury to property or another person. The most common negligent tort is a motor vehicle accident. The standard of care in these cases is relatively easy to prove by relying on measures such as the following:

- traffic laws (e.g., speeding, licensure),
- the driver's physical or mental condition (e.g., intoxication or physical impairment), and/or
- analysis of what would constitute due care under the circumstances (i.e., what an average, reasonable driver would do if faced with the same situation).

However, criteria like these—readily understandable to the average juror—are often unavailable in professional liability cases. Most jurors can rely on their own experience and common sense to determine whether a driver acted negligently, but they usually do not have the knowledge or experience to judge whether a healthcare provider has acted reasonably in a medical malpractice case. As a result, courts have adopted a special standard in such cases: Physicians are measured against other physicians, not against the average person.

One case stated the rule as follows: "A physician is bound to bestow such reasonable and ordinary care, skill, and diligence as physicians and surgeons in good standing in the same neighborhood, in the same general line of practice, ordinarily have and exercise in like cases."[1] Courts generally agree with this concept, but like most legal standards it is subject to various interpretations. The differences have to do with three aspects of the definition:

1. Who is a "reasonable physician"?
2. What level of skill is to be applied?
3. What school of medicine do other physicians follow?

The Reasonable Physician

The first standard requires only "reasonable and ordinary" treatment. Physicians are not measured against their most knowledgeable and highly skilled colleagues but against the knowledge and skill of average physicians in the same line of practice.[2]

If a physician chooses among alternative methods of treatment or uses experimental techniques, he will not be guilty of malpractice if the selection is one that in the physician's opinion best meets the patient's needs. Thus, it is sometimes stated that there will be no liability if the treatment would be recognized by a "respectable minority" of the medical profession, even though most physicians would have adopted another treatment plan.[3] In one case a physician performing a thyroidectomy severed the patient's laryngeal

nerves.[4] The patient did not claim that the physician was not careful. Rather, he claimed that two types of treatment were recognized and that the surgeon should have chosen the other one. The court rejected this argument because both methods were acceptable.

A more difficult problem arises when the physician treats the patient by a method that even a respectable minority would deem unacceptable because it verges on experimentation. But physicians are clearly right to use innovative techniques when standard methods have failed and the condition is serious. In one case a surgeon performed an unorthodox operation on an ankle after trying standard techniques and when other physicians had advised amputation.[5] The court held that the operation was justified as a last resort. But a doctor who follows an experimental procedure before attempting standard methods is likely to be considered negligent. In one instance a physician treating an infant for a curvature of the spine used a surgical procedure he had developed but no one else had used. The child died after suffering a severe hemorrhage. In the lawsuit that followed, the court found both the doctor and the hospital liable for not disclosing to the child's parents that the procedure was unorthodox.[6]

Local, State, or National Standard

The second aspect of the standard of care compares the treatment in question to that used by physicians and surgeons "in the same neighborhood." Originally the neighborhood was considered the community in which the physician practices or similar areas elsewhere in the state or the nation. This has been called the "locality rule" because it measures the standard of care in a given instance solely by the practices of other physicians in the same or a similar locality.[7]

This rule was based on the theory that doctors in remote areas should not be held to the same standards of medical expertise as doctors in urban areas because of difficulties of communication and travel and because they have limited opportunities to keep abreast of medical advances. It also relied on the fact that in such areas physicians were often forced to practice in inadequate hospital facilities.[8] However, the traditional locality rule has given way in most states to a broader standard because the original reasons for the rule have all but disappeared.[9] As one court stated:

> Locality rules have always had the practical difficulties of: (1) a scarcity of professional people…qualified [or willing] to testify; and (2) treating as acceptable a negligent standard of care created by a small and closed community of physicians in a narrow geographical region. Distinctions in the degree of care and skill to be exercised by physicians in the treatment of patients based upon geography can no longer be justified in light of the presently existing state of transportation, communications, and medical education and training which results in a

> standardization of care within the medical profession. There is no tenable policy reason why a physician should not be required to keep abreast of the advancements in his profession.[10]

For these reasons, the court held that the "language 'same neighborhood'...refer[s] to the national medical neighborhood or national medical community, of reasonably competent physicians acting in the same or similar circumstances."[11] Thus, a "national standard" has been created.[12] (This newer standard is all the more reasonable given recent advances in communications technology, including the Internet.)

For physicians practicing under less-than-ideal conditions, the burden of meeting a national standard has been lightened by permitting "justifiable circumstances" as a defense.[13] For example, a physician would not be responsible for providing certain care if the necessary facilities or resources were not available. The test is what is reasonable under the circumstances. All surrounding circumstances are to be considered in determining whether there was a breach of the standard of care.[14]

The "School Rule"

The third consideration in determining the standard of care is whether the care is comparable to that of physicians and surgeons "in the same general line of practice." This principle, sometimes called the "school rule," is a throwback to the days when there were distinctly different schools of treatment. For example, the allopathic school (whence MDs come) treated diseases by using agents (such as antibiotics) whose effects differ from the agent causing the disease. Another was the homeopathic school, which posits that to cure a person's symptoms, the doctor should give medicine that will cause in healthy people the same set of symptoms from which the patient suffers. There are also practitioners of osteopathic medicine and chiropractic medicine (i.e., DOs and DCs), which (at least in their "pure" form) emphasize manipulative techniques to correct bodily anomalies thought to cause disease and inhibit recovery.

Although still recognized, the distinctions between these schools have blurred in recent decades, leaving what is sometimes called the "regular practice of medicine." For example, for years osteopathy was not considered "regular medicine" in some states and osteopaths were not allowed to prescribe drugs or perform surgery; they were judged only by the standards prevailing in their own school of medicine.[15] Today, most states allow osteopaths to perform surgery and prescribe drugs, and they are held to the standard of care of the so-called regular practice of medicine. The school rule remains important, however, because a few branches of medicine remain and the trend in medicine is toward specialization. The standard for judging practitioners in specialties or schools is usually established by the practices of others in the same school or specialty.

For example, alternative remedies like acupuncture, herbal medicine, faith healing, naturopathy, massage, and music and aroma therapies claim numerous adherents. These practitioners (who usually do not have medical degrees) apply their crafts (which are recognized to improve psychological and physical well-being) without promising or implying that they are treating a medical condition. They are not judged by the standards of medical practice, but if they stray from their areas of expertise they will be judged against the standards taught in traditional medical schools.

In Hawaii an MD who practiced alternative medicine was deemed unqualified to testify as an expert witness on the cause of his patient's symptoms following breast-implant surgery. The court noted,

> Dr. Arrington does not possess any education, training, or experience with silicone. He is a general practitioner with an orientation toward holistic medicine and alternative therapies, such as nutritional, vitamin, and herbal remedies. He is not a pathologist, general surgeon, plastic surgeon, or an immunologist. Prior to moving to Hawaii, Dr. Arrington practiced with chiropractic, naturopathic, and holistic medicine specialists. Nothing in Dr. Arrington's background or experience suggested that he would be competent to testify regarding the effects of silicone on the human body.[16]

In applying the school rule, courts must decide whether the "school" is legitimate. Legitimacy generally depends on whether rules and principles of practice have been set up to guide the members in treating patients. When standard of care is in question, the existence of licensing requirements will usually suffice as a recognition of a separate school.[17] In an early case the court did not recognize a spiritualist's practice as following a school of treatment because the practitioner's only principle was to diagnose and treat the disease by means of a trance. Because there was no legitimate school, the practitioner was held to the standards of medical practice.[18] In the case of a Christian Science practitioner, however, the court held the defendant to the standard of care, skill, and knowledge of ordinary Christian Science healers because he belonged to a recognized school.[19]

Within these school-rule standards, nonphysician practitioners are held responsible for knowing which diagnoses are within their area of practice and which cases should be referred to a licensed physician for standard treatment. For example, in *Mostrom v. Pettibon* a chiropractor was held liable for not identifying medical problems for which chiropractic treatment was not appropriate.[20]

Even MD-physicians can be held responsible for failing to refer a case to a specialist if the problem is beyond their training and experience. For example, a general practitioner was held liable for negligence when a patient died of a hemorrhage after coughing up blood for two days. The court found

that the physician should have grasped the seriousness of the patient's condition and called in a thoracic surgeon who might have saved the patient's life.[21] On the other hand, a court found that a laminectomy and spinal fusion (procedures used on a slipped disk in the back) were within the scope of general surgeons and that the defendant was not negligent in failing to call in an orthopedist or neurosurgeon.[22] (This decision might be questioned in today's era of greater specialization.)

Assuming that a general practitioner remains within her area of expertise and does not fail to refer a patient to a specialist when required, most courts hold the physician to the standards of other general practitioners and not to the standards of specialists.[23] Physicians who present themselves as specialists, however, are held to a higher standard of care than that for general practitioners.[24]

Practitioners who are licensed, trained, or credentialed only in certain fields of medicine are held to higher standards of care if they go beyond their ken. This situation has arisen not only with licensed practitioners such as chiropractors and podiatrists but also with nurses, medical students, and other clinical personnel. In *Thompson v. Brent* a medical assistant working in an orthopedist's office was held to the standard of care required of physicians in using a Stryker saw to remove a cast.[25]

Reasonable Prudence: The Helling Standard

The common practices of the profession itself traditionally set the standard of care in any given case. That is, physicians are usually judged by what other physicians would do under the circumstances. However, courts sometimes find the profession's standard inadequate and permit juries to decide for themselves—without expert witnesses—whether a physician was negligent. In so doing they have found negligence "as a matter of law" from the facts of the case.

In *Favolora v. Aetna Casualty and Surety Company*, a 71-year-old patient fell while being x-rayed. She suffered numerous injuries, including a fractured femur.[26] The subsequent prolonged hospitalization brought on a pulmonary embolism and a kidney infection. In bringing suit the patient claimed that the fall would not have occurred if her radiologist had examined her medical records, which cited her history of sudden fainting spells. At the time, it was not the practice of radiologists to take the patient's medical history into account; the radiologist was just taking and interpreting pictures, after all. After the judge explained the law to the jury in this way, they returned a verdict for the defendant. The appellate court reversed the decision, however, on the belief that the accepted practices of the radiology profession were inadequate. In reaching this decision the court looked to the custom of teaching hospitals, which did require radiologists to examine patients' histories.

The *Favolora* case got little "ink" (as they say in the newspaper business) perhaps because it was decided in Louisiana, which is not often considered a bellwether of jurisprudence. But 12 years later, in 1974, a landmark case from the state of Washington made headlines in medicolegal circles. Barbara Helling, the plaintiff, had been treated by two ophthalmologists from 1959 until 1968 while experiencing difficulty with her contact lenses. After being diagnosed with glaucoma in 1968, she sued her (by now former) ophthalmologists because she had permanent damage to her vision. This injury, she alleged, was caused by the defendants' negligence in not conducting some simple tests nine years earlier. Both the trial and appellate court decisions were for the ophthalmologists because, according to expert witnesses, the standard of practice at the time did not require routine testing for glaucoma in patients under the age of 40. The Supreme Court of Washington disagreed and sent shock waves through the physician community (see The Court Decides: *Helling v. Carey* at the end of this chapter).

Following the *Helling* decision, and at the behest of the medical profession, the Washington legislature passed a statute that purported to overturn the *Helling* rule:

> In any civil action for damages based on professional negligence against a hospital...or against a member of the healing arts...the plaintiff in order to prevail shall be required to prove by a preponderance of the evidence that the defendant or defendants failed to exercise that degree of skill, care, and learning possessed at that time by other persons in the same profession, and that as a proximate result of such failure the plaintiff suffered damages, but in no event shall the provisions of this section apply to an action based on the failure to obtain the informed consent of a patient.[27]

Despite the statute, a later case, *Gates v. Jensen*, held that *Helling's* rule—that "reasonable prudence may require a standard of care higher than that exercised by the relevant professional group"—was still in effect.[28] The court noted that the original bill had used the word "practiced" rather than "possessed" (as it appears in the enacted version quoted above). According to the *Gates* court the change in the bill showed that the standard was not limited to what members of the profession actually did but could be extended to what they ought to do. (See Legal Brief on page 54.)

Proving the Standard of Care and Breach of the Standard

To succeed in a professional liability suit a plaintiff must first prove the standard of care and then show that the defendant breached that standard. This usually requires expert testimony, which normally comes from the defendant's fellow practitioners because they know the standards of practice best. Unlike

Legal Brief

Many in the medical community assailed *Helling* as judicial impertinence toward the medical profession. However, the outcome of the case might have been different had a more critical analysis been presented. Tonometry (a test to measure intraocular pressure) is inexact and produces a high rate of false positives. To illustrate, if the incidence of disease is 1 in 25,000, there will be 250 actual cases in a population of that size. If the diagnostic test is 95 percent accurate, it will accurately diagnose about 237 of those cases (95 percent x 250), but it will falsely diagnose as positive 1,238 others (5 percent x the remaining 24,750), whom we postulate do not have the disease. Thus, there will be a total of 1,475 positive test results, and each one is a true positive only about 16 percent of the time (237 ÷ 1,475). Each positive test result will require further diagnostic procedures, which undoubtedly contribute to a higher cost and a heightened level of patient anxiety. Negative test results are similarly unrealistic and may lead to a false sense of security in the 13 persons who have the disease but tested negative.

Given the inaccuracy of the tests, the relatively low incidence of the disease in younger persons, and some disagreement about the effectiveness of existing treatment options, there is an issue as to whether universal glaucoma screening makes good public policy, irrespective of *Helling*'s outcome.

lay witnesses, an expert witness is not limited to testifying about facts; he may express opinions about the nature and cause of a patient's illness or injury.

Because of the need for expert testimony, proving malpractice can be difficult even if a valid case exists because the plaintiff cannot always find a qualified expert witness. Some believe that a "conspiracy of silence" among physicians makes them reluctant to testify against other members of the profession,[29] and if a physician is not a party to the lawsuit, she cannot be forced to testify.[30] Evidence other than expert opinion is admissible in some instances to prove negligence, however, and occasionally even the defendant physician may provide the needed expert testimony. The various methods of proof are discussed in the following sections.

Expert Testimony

As mentioned before, the normal method of proving professional negligence is to establish by expert testimony the appropriate standard of care and to show that that standard was breached. The expert witness must have certain qualifications:

1. *The witness must be familiar with the jurisdiction's standard-of-care requirements.* If the court follows the locality rule, the witness must practice in the same locality as the defendant physician (or at least be familiar with the local practice, if practicing elsewhere).[31] If a national standard applies, any otherwise qualified expert in the country is acceptable. A national standard of care, therefore, eases the burden of proof for the plaintiff because the search for a willing expert need not be limited to a particular locality. (This is another reason the "locality rule" has been relaxed: Finding physicians in a particular town to testify against their colleagues and friends was often a daunting task.)

2. *The expert witness must be professionally qualified.* The basic requirement is knowledge of the standard of practice involved in the patient's care. The witness need not practice the same specialty or even follow the same school of medicine, but he must be familiar with the type of care involved in the lawsuit. For example, a specialist may testify about the standards for general practitioners if she is knowledgeable about them.[32] Similarly, if the issue concerns the standards for doctors of osteopathy,[33] doctors of medicine can testify, although the school rule generally prohibits the imposition of their standards on the practice of others.[34] Unless special qualifications can be established, a member of one specialty would not be allowed to testify about the standards of practice in another specialty. The plaintiff must lay a foundation for expert testimony by persuading the judge that the witness has the appropriate training and experience to qualify as an expert. If the judge decides that the witness meets the qualifications, the testimony is allowed and the jury decides what weight to give it. Otherwise the witness is not permitted to testify. Qualification is a matter within the judge's discretion.

For example, in *Gilmore v. O'Sullivan* (decided in 1981), an obstetrician–gynecologist's negligence was alleged in the prenatal care and delivery of the plaintiffs' son. The court refused to permit the plaintiffs' expert to testify because (a) he was not board certified in obstetrics and gynecology, (b) there was no evidence of the number or types of maternity cases he had handled, (c) he had not delivered a baby since 1959 or performed surgery since 1967, and (d) he had pursued no research in or study of obstetrics and gynecology in recent years.[35]

Sometimes even the defendant will be called as an expert witness. Unlike criminal defendants, who can invoke the constitutional privilege against self-incrimination, defendants in a civil case must testify to facts within their knowledge. Most courts have thought it unfair to require the physician not only to testify regarding such facts but also to provide the expert testimony needed to establish the standard of care. The New York decision in *McDermott v. Manhattan Eye, Ear and Throat Hospital*[36] illustrates a contrasting view. The defendants, one of whom was one of the world's leading ophthalmologists, advised the plaintiff to undergo a series of operations to correct a condition of the cornea in her left eye. The operations resulted in blindness, and the plaintiff claimed that the surgery was not approved by accepted medical practice for the original diagnosis. At the trial the plaintiff presented no expert witness of her own but called on the defendant to testify to the standard of care required and the deviation from that standard. The appellate court stated that the plaintiff had the right to require the defendant to testify both to his actual knowledge of the case and as an expert to establish the generally accepted medical practice.

Even though statements made out of court are hearsay and are normally excluded from evidence, in some circumstances a physician's out-of-court statements may be used as evidence of breach of the standard of care.[37] Courts face a difficult task in determining whether a given statement was really an admission of negligence or merely an expression of sympathy (see Legal Brief). After the death of one patient, for instance, the physician said, "I don't know; it never happened to me before. I must have gone too deep or severed a vein." The court said this was too vague to be an admission of negligence.[38]

Legal Brief

An admission (a statement that a party to the suit makes against his own interest) is an exception to the hearsay rule because it is inherently reliable. This is true even if the statement is made during negotiations for settlement and would not normally be allowed into evidence.[39]

On the other hand, in another case a physician doing a sigmoidoscopy (a visual examination of the colon in search of polyps) tore the patient's large intestine.[40] On the way from the operating room the patient's husband heard him say to another physician, "Boy, I sure made a mess of things," and to the husband himself he said, "In inserting the sigmoidoscope into the rectum, I busted the intestine." The court held that this admission could take the place of expert testimony because a jury could infer that the physician had not exercised the requisite degree of care.

Other Evidence of the Standard

In some instances a plaintiff is permitted to introduce medical treatises into evidence to prove the standard of care. Because medical publications are hearsay (out-of-court statements offered to prove the truth of the matter asserted), most states limit their use to attacking the credibility of an expert witness[41] or reinforcing the opinion given in evidence by an expert.[42] A few states, however, permit medical treatises to be used as direct evidence to prove the standard of care. In a Wisconsin case the court took "judicial notice" of the standard of care set forth in a loose-leaf reference service, *Lewis' Practice of Surgery*, to determine whether an orthopedic surgeon was negligent in performing surgery for a ruptured disk.[43] In states using the Wisconsin approach, the author must be proved to be a recognized expert or the publication to be a reliable authority.

Written rules or procedures of the hospital, regulations of governmental agencies, standards of private accrediting agencies, and similar published material may be admissible to show the requisite standard of care. The landmark decision of *Darling v. Charleston Community Memorial Hospital* held, among other things, that the standards promulgated by the Joint Commission on Accreditation of Hospitals (now the Joint Commission),

standards of a governmental licensing authority, and provisions of the hospital's medical staff bylaws were admissible as evidence of negligence.[44]

Negligence Per Se

In some cases a statute or other law may be used to establish the standard of care.[45] Negligence that is established by showing a violation of law is called negligence per se or statutory liability. This doctrine requires that several elements be proven, including:

1. violation of the statute occurred and an injury resulted from the violation,
2. the injured person was one whom the statute was meant to protect, and
3. the harm was the type that the statute was enacted to prevent.[46]

In *Landeros v. Flood* the defendant physician examined an 11-month-old child. She was suffering from a fracture of the right tibia and fibula, an injury that appeared to have been caused by a twisting force. Her mother gave no explanation for the injury, but in fact the child had been beaten repeatedly by both her mother and her mother's common-law husband. The physician failed to diagnose battered-child syndrome, and he did not take x-rays that would have revealed a skull fracture and other injuries. The child returned home where she was again severely injured. Because the doctor did not report the matter to the authorities, as required by law, a civil damage action was allowed on the theory that the physician breached his duty to report child abuse.[47] Similar laws require reporting abuse of other vulnerable persons.

Common-Knowledge Doctrine

Occasionally no expert testimony is required to establish professional negligence, such as when the negligence is so obvious that it is within common knowledge.[48] One clear example is amputation of the wrong limb. In *Hammer v. Rosen* three witnesses, not experts, testified that the defendant had beaten an incompetent psychiatric patient.[49] Although the defendant physician claimed that without expert testimony it could not be shown that the beatings deviated from standard treatments, the court held otherwise because "the very nature of the acts complained of bespeaks improper treatment and malpractice." (Why expert testimony was not presented is not made clear in the opinion, but it might be that the plaintiff's attorneys never thought it would be necessary. As it turns out, they were right.)

Res Ipsa Loquitur

Perhaps the most complex exception to the expert-testimony rule is the doctrine of res ipsa loquitur ("the thing speaks for itself"). The doctrine goes back to an English case decided in 1863, *Byrne v. Boadle*.[50] Plaintiff Byrne

was walking down the street and was hit on the head by a barrel of flour that had rolled out of an upper level of a warehouse owned by Boadle. Although the precise negligent act or omission could not be proven, the court found that Boadle was negligent because it is obvious that barrels of flour do not fall out of buildings unless someone has been negligent.

Three conditions are essential for the use of res ipsa loquitur:

1. the accident must be of a type that normally would not occur without someone's negligence,
2. the defendant must have had sole control of the apparent cause of the accident, and
3. the plaintiff could not have contributed to the accident.

Whether the doctrine should be applied in a particular case is determined by the judge. Once a judge decides that res ipsa applies, an inference of negligence has been created. This means that the case must go to the jury, who can then decide for plaintiff or defendant.[51] In medical malpractice cases it is sometimes impossible for patients to know the cause of the injury, particularly if they were anesthetized during the treatment. If a plaintiff is permitted to invoke the doctrine of res ipsa loquitur, she can prevail even without proving any specific negligent acts of the defendant. (Plaintiffs' attorneys would prefer, however, to point to specific negligent acts in making their case rather than rely on res ipsa. Doing so has a more dramatic effect on the jury.)

Requirement 1

The primary difficulty for malpractice plaintiffs in res ipsa cases has been the first requirement: the injury ordinarily would not occur in the absence of negligence. The general test is whether in light of ordinary experience—as a matter of common knowledge—one could infer that the defendant was negligent.[52] In one example a patient underwent surgery for removal of part of his colon.[53] The incision was closed with sutures, but eight days later it opened and a second operation was required to close it. The court held that res ipsa loquitur did not apply because a layperson would not know whether the incision failed to close because of the physician's negligence or for some other reason. Thus, the doctrine cannot be based simply on bad treatment results.

In contrast, leaving foreign objects in a patient after surgery is negligence within the common knowledge of laypeople, and in such cases res ipsa loquitur is frequently used. In *Jefferson v. United States* the plaintiff was a soldier who had undergone a gallbladder operation.[54] Eight months later, after he had been suffering spells of nausea and vomiting, another operation disclosed that a towel had eroded into his small intestine. It was 30 inches long and 18 inches wide and was marked "Medical Department U.S. Army."

These facts, the court held, clearly showed negligence on the part of the defendants. (The "thing" clearly "spoke" for itself!)

Some courts permit common knowledge among physicians to satisfy the threshold test; that is, expert testimony—not just common knowledge of laypersons—is permitted to establish that the injury would ordinarily not occur without negligence. In *Hale v. Venuto* the plaintiff suffered from palsy of her left foot following surgery to correct a dislocation of her kneecap.[55] A neurologist and an orthopedic surgeon testified on her behalf that the injury was more likely than not a result of negligence. The appellate court ruled this sufficient to permit use of res ipsa loquitur, adding that California courts have relied on both common knowledge and expert testimony in determining probable negligence.

Requirement 2

In addition to showing that the accident or injury would not normally occur without someone's negligence, the plaintiff must show that the defendant had exclusive control of its apparent cause. This can be a problem for malpractice plaintiffs. Traditionally the doctrine cannot be applied in an action against several defendants, any one of whom could have caused the plaintiff's injury[56]; this is very often the case for patients who have undergone surgery.

A major departure from the rule, however, was the California case of *Ybarra v. Spangard*.[57] After an appendectomy, the plaintiff felt sharp pains in his right shoulder and later suffered paralysis and atrophy of the shoulder muscles. The subsequent suit went to a California appellate court, which allowed the use of res ipsa loquitur against all of the defendants who had any control over the patient while he was anesthetized. These included the surgeon, the consulting physician, the anesthesiologist, the owner of the hospital, and several hospital employees. The court held that the test had become one of "right of control rather than actual control."[58] The rationale for imposing on the defendants the burden of explaining the cause of the injury was that a special trust and responsibility arises from the physician–patient relationship.

Requirement 3

The third requirement for use of res ipsa loquitur is showing that the plaintiff could not have contributed to the injury. In many cases this is not difficult to prove. For instance, if the plaintiff was under anesthesia, it is clear that he had no responsibility. If it is possible, however, that the accident was caused by the plaintiff's negligence, res ipsa loquitur will not apply. In *Rice v. California Lutheran Hospital* a hospital employee left a cup, saucer, tea bag, and hot water on a table beside a patient who was recovering from surgery and was under the influence of painkilling drugs.[59] Scalding water spilled on the patient, who claimed that res ipsa loquitur should apply because the injury occurred while she was under sedation and did not understand what was going on. The court held that the doctrine did not apply in this case because witnesses testified that the plaintiff confessed to spilling the

water on herself and that she was awake and alert at the time. As this case shows, the third requirement for res ipsa then is based on the facts of each case.

Strict Liability

By definition, strict liability does not fall into a discussion of negligence because strict liability imposes liability without fault—that is, without any showing of negligence. A brief discussion is nevertheless relevant here because the concept is closely tied to the doctrine of res ipsa loquitur and the standard of reasonable prudence discussed earlier.

A showing of fault was not required to impose liability until the mid-nineteenth century, but then society decided that some wrongdoing must be shown before holding persons responsible for injuries that their actions caused. Thus, negligence is required in most tort cases. "Strict liability" has been imposed, however, on those whose activities—such as using dynamite or keeping dangerous animals—entail a high degree of risk to others. The rationale behind strict liability is to place the burden of inevitable losses on those best able to bear them, even if they were as careful as possible in dealing with the danger.[60]

Developments in product-liability law have imposed strict liability on the manufacturers and vendors of various dangerous products. The doctrine imposes liability on those responsible for defective goods that pose an unreasonable risk of injury and do in fact result in injury, regardless of how much care was taken to prevent the dangerous defect.[61] (Accidents caused by defective tires or automobile parts are good examples.) The doctrine does not apply to services, only to products. For example, courts have generally held that in giving blood hospitals are providing a service, not a product, and therefore strict liability does not apply.[62]

Injury and Causation

It is not enough to prove that a physician failed to meet the standard of care and that the patient was injured. A plaintiff must show that the injury was the "proximate cause" of the negligence. The law considers an injury to be the proximate result of a negligent act if

- the injury would not have occurred but for the defendant's act, or
- it was a foreseeable result of the negligent conduct.

The purpose of a malpractice trial is not to convict the defendant but to decide whether the plaintiff's loss is more likely than not the result of the defendant's substandard conduct. Therefore, the plaintiff's burden of proof

is lower than the government's in a criminal prosecution. The plaintiff need only prove that there is a strong likelihood (a "preponderance of the evidence") that negligence caused the result, and the negligence need not be the sole cause of but only a significant factor in the injury.

If a physician has failed to meet the standard of care, the injuries resulting from that lapse, if any, may be difficult to determine. This is especially true in healthcare because the patient presumably already had some illness or injury resulting from other causes. A number of physicians have been completely absolved from liability, despite their negligence, because of inadequate proof of causation. For example, in *Henderson v. Mason*, the defendant physician failed to discover a piece of steel embedded in the patient's eye. The steel was eventually discovered and removed by another physician.[63] The court denied recovery because testimony showed that the patient would have suffered infection and loss of vision even if the defendant's diagnosis had been correct.

A court may determine that only some of a patient's injuries resulted from negligence. In one case a woman and her obstetrician lived near each other. In the sixth month of pregnancy she experienced labor pains, and her husband summoned the doctor. The doctor did not arrive for several hours, however, and the patient miscarried. In the suit charging him with negligence in failing to treat her, the court decided that the obstetrician's negligence did not cause the miscarriage because his presence in the house would not have prevented it. He was nevertheless held liable for the patient's pain and suffering, which he might have eased or prevented had he arrived sooner.[64]

"Loss of a Chance"

Sometimes the nature of a disease means that a patient has virtually no chance of long-term survival, but an early diagnosis may prolong the patient's life or permit a slim chance of survival. Should a practitioner who negligently fails to make that early diagnosis be liable even though the chances are that she could not ultimately prevent the patient's death? The courts have been divided on this question. Some jurisdictions have held that the defendant should not be liable if it was more likely than not that the patient would have died anyway.[65] Other courts have concluded that if the defendant increased the risk of death by lessening the chance of survival, such conduct was enough to permit the jury to decide the proximate-cause issue, at least where the chance of survival was significant.[66] "The underlying reason is that it is not for the wrongdoer, who put the possibility of recovery beyond realization, to say afterward that the result was inevitable."[67]

In a Washington case the defendant allegedly failed to make an early diagnosis of the patient's lung cancer, and the patient eventually died.[68] The

defendants offered evidence that, given that type of lung cancer, death within several years was virtually certain, regardless of how early the diagnosis was made. The defendants moved for summary judgment. Because the plaintiff could not produce expert testimony that the delay in diagnosis "more likely than not" caused her husband's death, the trial court dismissed the suit. For purposes of appeal, both parties stipulated that if the cancer had been diagnosed when the patient first saw the defendants, his chances of surviving five years would have been 39 percent, and that at the time the cancer was actually diagnosed his chances were 25 percent. Thus, the delay in diagnosis may have reduced the chance of a five-year survival by 14 percent. The appellate court held that the reduction was sufficient evidence of causation to allow the issue to go to the jury, who would then decide whether the negligence was a substantial factor in producing the injury. "To decide otherwise would be a blanket release from liability for doctors and hospitals any time there was less than a 50 percent chance of survival, regardless of how flagrant the negligence."[69] The court also noted, however, that if the jury found the defendants liable they would not necessarily be liable for all damages caused by the patient's death but only for those resulting from the early death.

The question of damages is closely related to the element of causation. In addition to proving that the injury was caused by negligence, the plaintiff must prove which injuries resulted from the negligent conduct and what those injuries are worth. The most common damages are called actual or compensatory damages. These compensate the plaintiff for out-of-pocket loss, such as the cost of medical and rehabilitation treatments and lost earnings, and for noneconomic loss, such as pain and suffering.[70] (While economic losses can be fairly accurately demonstrated, it can be difficult to attach dollar values to pain and suffering. Nevertheless, juries do assign dollar amounts to these noneconomic injuries, sometimes in very large amounts. For this reason some of those who argue for reform in the tort system suggest limitations on recovery for pain and suffering, and in fact several states have enacted statutes limiting these damages. One such statute was recently upheld as constitutional.) Punitive damages are seldom awarded in negligence cases.

Defenses

Malpractice defendants may have legal defenses that can avoid or reduce liability even if a plaintiff can prove all the elements of the case. A statute of limitations can prevent a case from going to trial. Other defenses, such as comparative negligence, require a decision by the trier of fact (the jury or the judge in nonjury trials). Defenses especially relevant in malpractice actions are discussed in the following sections. Other legal defenses, such as res judicata

(discussed in Chapter 1), are of course available but have no unique significance in malpractice cases.

Assumption of Risk

A defendant in a tort action can occasionally raise assumption of risk as a defense. In many jurisdictions, people who perceive a risk and still voluntarily expose themselves to risk will be precluded from recovering damages if injury results. In medical malpractice cases the risk often involves a new method of treatment, and an important issue is whether the possible effects of such treatment were made known to the patient. This issue is closely related to informed consent (see Chapter 9) because a physician who informs the patient of the risk will not be liable because the patient knowingly assumed the risk. In *Karp v. Cooley*, for example, the surgeon was not held liable for the patient's death after a heart transplant because he had fully informed the patient of the risks and had obtained consent to perform the operation.[71]

Assumption of risk does not usually include a physician's negligence. In the *Karp* case if death had been caused by an error unrelated to the novelty of the surgery (such as a mishap in administering anesthesia), the defendants could have been held liable.

Contributory and Comparative Negligence

Even if a physician has been negligent, contributory negligence is a complete defense in many states. Under this theory, if the patient failed to act as a reasonably prudent person would have done, and if the patient's negligence contributed in any way to the injury, he cannot recover damages for the physician's negligence. In one case a physician who was grossly intoxicated treated a patient negligently.[72] The court refused to hold the doctor liable on the ground that the patient was negligent in accepting treatment from a physician who was obviously drunk.

There are cases, however, in which the patient's contributory negligence merely aggravated an injury caused by the physician's negligence. If the injury would have occurred despite due care by the patient, the patient will be allowed at least a partial recovery. In a Wisconsin case, *Schultz v. Tasche*, an 18-year-old woman was treated negligently for a fracture of the femur (thigh bone).[73] As a result her right leg was one and one-half inches shorter than the left and was "deformed and painful." The appellate court decided that the patient could recover for the doctor's negligence despite her own negligence in leaving the hospital early, driving 15 miles to her home, and failing to return for additional treatment. The plaintiff's negligence, the court decided, merely aggravated the existing injury, and its only relevance was to reduce the damage award.

Although nominally a contributory negligence case, *Schultz* illustrates the comparative-negligence approach adopted by many states because of the

harsh "all or nothing" requirement of traditional contributory negligence. Different theories of comparative negligence exist, but all attempt to compensate the injured party in some way despite the injured's own negligence. A later Wisconsin case illustrates one variation.[74] A hospital patient slipped while taking a shower and was injured. The jury decided that the hospital was 20 percent negligent, possibly for failing to install safety devices in the shower, but the patient was found 80 percent negligent and was awarded only $4,500.

The Law in Action

The disputed section of the *Tunkle* contract read: "In consideration of the… services to be rendered and the rates charged [for them], the patient or his legal representative agrees to and hereby releases…the hospital from any and all liability for the negligent or wrongful acts or omission of its employees, if the hospital has used due care in selecting its employees."

The contract was not part of a fair bargain. It pretty much said: If you wanted to get treated, you had to sign on the dotted line.

Exculpatory Contracts

Historically defendant physicians could raise as a defense a contract clause, signed prior to treatment, in which the patient agreed to forfeit the right to sue. Exculpatory contracts are invalid in most contexts, and the same applies in healthcare. In *Tunkle v. Regents of the University of California* the court held that a contract between a hospital and a patient that attempted to release the hospital from liability was against public policy (see The Law in Action).[75]

Release

In contrast to an exculpatory contract, a release executed by a patient following treatment may operate as a defense. If a physician and patient reach a settlement on a malpractice claim, a release given by the patient will bar a later suit for injuries arising from the same negligent act. A more complicated situation results when one person wrongfully injures a patient and a physician aggravates the injury by negligence. If the patient settles with the original tort-feasor and gives that person a release, does the release also cover the physician? It depends.

In *Whitt v. Hutchison* the plaintiff, who was injured at a ski resort, claimed that his injuries were aggravated by the negligence of the physicians treating him. Three-and-a-half years after the original injury, the plaintiff settled with the ski resort for $6,000 and signed a form releasing

> the resort from any and all liability…and any and all other loss and damages of every kind and nature sustained by or hereafter resulting to the undersigned… from an accident which occurred on or about the first day of March, 1969, at Clear Fork Ski Resort, Butler, Richland County, Ohio, and of and from all liability, claims, demands, controversies, damages, actions, and causes of action whatsoever, either in law or equity, which the undersigned, individually or in any

> other capacity, their heirs, executors, administrators, successors and assigns, can, shall or may have by reason of or in any wise incident [to] or resulting from the accident hereinbefore mentioned.[76]

The court held that this release was broad enough to include malpractice claims and upheld a dismissal of the suit against the defendant physicians and hospital. The reasoning was that aggravation of the injury because of malpractice is considered a "proximate result of the negligence of the original tort-feasor." In some cases courts have held the release effective for all tort-feasors, even when there was an express provision to the contrary.[77] In most instances, however, a release will not be effective for those explicitly excluded. In *Whitt* the physicians and hospital were not excluded from the release, and hence the release was considered unconditional. "Such a release is presumed in law to be a release for the benefit of all the wrongdoers who might also be liable, and to be a satisfaction of the injury."[78]

Good Samaritan Statutes

Good Samaritan statutes, discussed more completely in Chapter 8, offer a defense if the physician has rendered aid at the scene of an accident. These statutes, which most states have in some form, commonly provide that a physician rendering emergency care will not be held liable for negligence unless she is grossly negligent or acts in a reckless manner.[79] Most of these statutes do not require doctors to assist in emergencies but protect those who volunteer their aid. Some states, however, have gone further and created a duty to assist along with immunity from civil suit for persons complying with the law.[80] References to a Good Samaritan statute may thus indicate either immunity or a duty to assist, or both.[81]

Workers' Compensation Laws

Workers' compensation statutes may provide a defense to physicians who are employed by companies and are sued by employees whom they treat in the course of their employment. In many states, workers' compensation laws are the exclusive remedy for such a patient, and a malpractice suit against the physician will not be permitted. Some courts, however, have allowed such suits.[82]

Governmental Immunity

Statutes grant immunity to many physicians employed by governmental agencies. This immunity is based on the historical concept of "sovereign immunity," a principle that derives from early English law. Generally speaking it is the doctrine that the sovereign (in the United States, the government) cannot commit a legal wrong and is immune from suit or prosecution. In many cases, the government has waived this immunity to allow suits for

discretionary acts of government agents (but not for "ministerial" acts—those performed without exercise of judgment).

Governmental immunity normally applies, if at all, only to negligent acts and not to intentional or grossly negligent conduct.[83] A governmental physician will also not be immune from suit under civil rights acts for deprivation of medical treatment if the alleged acts or omissions are "sufficiently harmful to evidence deliberate indifference to serious medical needs."[84] As discussed earlier, a physician may also be sued under these kinds of statutes for violation of other civil rights.[85]

Statutes of Limitations

Statutes of limitations specify a period during which lawsuits must be filed. The time allowed for malpractice actions (often two years) is generally shorter than for other actions, although the statutory provisions vary greatly from state to state.[86] California's statute of limitations for medical malpractice applies to "any action for damages arising out of the professional negligence" of a physician.[87] This leaves in doubt whether the statute applies only to suits that specifically plead negligence or to other causes of action—such as breach of contract or intentional tort—resulting from a negligent act. Florida's statute, on the other hand, seems clearly intended to apply to any cause of action commonly referred to as malpractice, not only those based on a theory of negligence:

> An "action for medical malpractice" is defined as a claim in tort or in contract for damages because of the death, injury, or monetary loss to any person arising out of any medical, dental, or surgical diagnosis, treatment, or care by any provider of health care.[88]

Statutes of limitation generally specify that the period begins when the cause of action "accrues." A cause of action in an assault-and-battery case, for example, accrues the moment the defendant threatens or touches the plaintiff. In malpractice cases, however, it is often difficult to determine when the statutory period begins, particularly if the adverse result appears much later. There are three specific times when the statute might begin, depending on the state's law and the particular circumstances:

1. when the alleged negligent treatment is rendered,[89]
2. when the patient discovers or should have discovered the alleged malpractice (the "discovery rule"),[90] and
3. when the treatment ends or, in a few states, when the physician–patient relationship ends.[91]

Particular circumstances create other possibilities. For example, if a physician fraudulently conceals malpractice, the statutory period will begin

only with actual discovery of the negligence.[92] Likewise, the beginning of the limitations period is often delayed for minor patients. In *Chaffin v. Nicosia*, for example, a physician's negligent use of forceps during a birth caused an almost complete loss of sight in the child's right eye.[93] Suit was allowed 22 years later because it was brought within two years after the injured person reached the age of majority. Moreover, some courts have decided, despite the discovery rule, that an action for wrongful death accrues at the date of the death.[94]

Liability for Acts of Others: Vicarious Liability

A healthcare provider can be held liable for the negligence of others, even though he has not been personally negligent. This is called vicarious liability, and it is based on the principle of respondeat superior—let the superior respond for the negligence of agents or employees. Thus, physicians and other providers are responsible for the negligent acts of their nurses, paramedics, x-ray technicians, and other persons in their employ.[95] (The liability of hospital employees is discussed in Chapter 5.)

Liability under the theory of respondeat superior does not depend on the negligent person being employed by the superior (although this is a consideration) but on whether the person was under the direction and control of the superior. In *Baird v. Sickler* a surgeon was held liable for the acts of a nurse-anesthetist employed by the hospital. The court judged that the close relationship between the surgeon and the anesthetist resembled that of an employer and employee in that the former had the right of control over the latter. A significant factor in this case was that the surgeon had instructed the anesthetist in some of the procedures and participated in positioning the patient and administering the anesthetic. This created the appearance of a "master–servant" (employer–employee) relationship, and the physician "had to answer for the servant's failures." By contrast, when a nurse had negligently administered an injection ordered by a physician, the physician was found not vicariously liable for the negligent act because he did not control the administering of the medicine.[96]

In addition to being liable for the acts of employees, physicians who refer cases to physicians not in their employ may also be held liable. In general, physicians are not liable when a substitute physician or a specialist takes over a case, but if they are careless in selecting the substitute or the specialist, they will be liable for their own negligence. One who continues to participate in the treatment of the patient is involved in a joint venture with, and will be liable for the negligence of, the other.[97]

A physician in a legal partnership with other physicians is liable for the torts of the partners (as long as they acted within the scope of the partnership)

because every partner is legally an agent of the other partners (see the discussion in Chapter 4). If judgment is rendered against a partnership that has insufficient assets, the physician's personal assets may be used to satisfy the judgment. In one extreme case a man sued a medical partnership for alienation of affections, claiming that his wife had an affair with one of the partners.[98] Normally there is no vicarious liability for intentional torts; however, in this case the court decided that the partnership was liable if the other partners did not use reasonable means to prevent their associate from wrongfully injuring the plaintiff's family relations. (Liability of this type could be limited by incorporating the partnership. The corporation would then have to respond in damages, although physicians who personally committed such torts would of course still be individually liable for their own wrongful acts.)

Legal DecisionPoint

Suppose that your hospital has a laboratory that provides services to physician practices. You have drivers who travel a route, picking up specimens for lab work. One day a driver deviates from his assigned route for a two-hour lunch with his girlfriend. Afterward, he is on his way to the next assigned pickup point when he has an accident. Is the hospital liable?

What other facts, if any, do you need to know to answer that question? What, if anything, should be done about the driver?

Determining whether the supposed "servant" was acting within the scope of the "master's" business can be tricky. Years ago, there was a case in which a sailor received orders to report to a new duty station across the country by a date 30 days in the future. The sailor was on leave in the interim. He was not told by what means to travel or what route to take, just to be at the Navy base by a certain time. He drove his own car and took a detour to visit friends and family for a few days. While in his hometown he was involved in a motor vehicle accident. The occupants of the other car sued the U.S. government claiming that the sailor was the government's agent carrying out the government's orders and that, therefore, the government should be liable on the theory of respondeat superior. How should this case be decided? Develop the arguments for each side of the case. (For a similar situation in healthcare, see Legal DecisionPoint.)

Distinctions Among Causes of Action

Of course a single set of facts may support more than one cause of action. There will likely be tactical and legal advantages and disadvantages to each. These depend on the time the action commenced, the legal defenses available, the need for expert witnesses, the existence of insurance coverage, and the type of damages recoverable.

Statutes of limitation, discussed ealier, vary according to the type of cause of action. For example, in Ohio the distinctions are as follows[99]:

Causes of Action	Limitation Period
Malpractice, defamation, assault/ battery, false imprisonment	1 year
Other personal injury	2 years
Wrongful death	2 years from date of death
Actions on oral contract	6 years
Actions on written contract	15 years

Thus, if a patient in Ohio visited an attorney one year and a day after malpractice occurred, it would be too late to sue on that theory (unless the discovery rule is in effect). But if the malpractice resulted in the patient's demise and the heirs approached the attorney one year and a day after the death, it would still be timely to sue for wrongful death. Either a patient or a family could sue for intentional tort within two years or for breach of contract within six or 15 years. Thus, one set of facts can support numerous causes of action and numerous limitations periods.

Other defenses, also discussed earlier, are not available in every type of action. Assumption of risk, contributory and comparative negligence, Good Samaritan statutes, workers' compensation law, and governmental immunity usually apply only to suits for negligence, and intentional torts are almost always excluded from such legal protection. Governmental immunity will sometimes protect a person from liability for gross negligence, but it generally will not be a defense to actions for intentional torts or violation of civil rights. A release executed by a plaintiff after the incident, usually pursuant to a settlement, may apply to actions based on breach of contract, negligence, or intentional tort.

A third distinction among causes of action rests on the need for expert testimony. Most negligence cases and many contract cases require expert testimony that the defendant did not exercise the requisite care and skill. This type of evidence is usually not necessary, however, to prove an intentional tort or violation of a contract.[100]

Another fact to consider in choosing a cause of action is that medical malpractice insurance does not cover all types of professional liability. A professional liability policy, for example, usually does not cover intentional torts. For this reason, a plaintiff's attorney might choose a negligence or breach-of-contract theory so that damages will be collectible from the malpractice insurer. The Minnesota Supreme Court held that a physician's "professional liability and personal catastrophe" policy did not cover sexual assaults on several young patients. The court found that the physician's sexual conduct involved neither the providing nor the withholding of professional services, and therefore the insurer's policy did not cover the plaintiffs' damages.[101] By contrast, the Wisconsin Court of Appeals held that a defendant psychiatrist's

malpractice insurance covered a claim for damages resulting from the defendant's sexual acts with the plaintiff during the course of treatment. The court held that such conduct can constitute a failure to give proper treatment.[102]

Obviously, the availability of damages is important in the choice of possible causes of action. Damages are often classified as actual, nominal, or punitive. Actual damages—sometimes called compensatory damages—are the damages awarded to a plaintiff to compensate for past and future medical costs, past and future loss of income, physical pain, and mental anguish. Nominal damages are awarded to a plaintiff who proves the elements of a case but cannot prove actual damages. Punitive damages—also called exemplary damages—are designed to punish a defendant for conduct that the court considers willful or malicious. A plaintiff's right to recover any of the three types of damages will depend on the nature of the action. Table 3.1 shows the general rule regarding the types of damages that are recoverable in the various kinds of actions.

Actual damages fall into two major categories: economic and noneconomic. Economic damages include expenses for medical care, rehabilitation, nursing care, child care, and lost earnings. Such damages are relatively easy to prove and are available in every kind of action. Noneconomic damages are for injuries that are real but cannot easily be assigned a dollar value—pain and suffering and emotional distress, for example. Pain and suffering, which covers some of the intangible damages accompanying physical injury, is allowed as an item of damages in all but contract actions, but some states have enacted laws that place a dollar limit on such damages.

Courts vary on whether to allow damages for emotional distress, and this question is somewhat unsettled. As a general rule, recovery for emotional distress is allowed if the defendant has acted willfully or maliciously. Damages for mental distress are therefore usually allowed in suits for intentional tort and in negligence actions if the emotional distress results from physical contact that inflicts bodily injury. Courts are extremely reluctant, however, to allow damages for mental distress in a negligence action unless physical injury to the plaintiff

TABLE 3.1 Possible Types of Damage Recovery*

Type of Action	Actual Damages	Nominal Damages	Punitive Damages
Intentional tort	Yes	Yes	Yes
Breach of contract	Yes	Yes	Rare
Negligence	Yes	No	Rare

*These generalizations are ordinarily true, but some exceptions occur. In an assault-and-battery case, nominal and punitive damages can be recovered even if no actual damages were incurred.

occurred. Courts usually allow such damages only when there was reckless disregard for the well-being of the plaintiff and the emotional distress was so great that it injured the plaintiff physically. Most medical malpractice cases do not show the willful malice or gross negligence needed to sustain a claim for damages for emotional distress in the absence of physical injury.

In some malpractice cases, however, the defendant's negligence is deemed so gross, willful, wanton, or malicious as to suggest reckless indifference or actual intent to harm. These are the cases in which courts may award damages for emotional harm, or even punitive damages, even in the absence of physical injury.[103] For example, in *Grimsby v. Samson* a husband brought suit against a hospital and a physician because they allegedly failed to provide treatment for his dying wife. He claimed damages for the extreme mental distress he suffered as he watched his wife die. The Washington Supreme Court denied recovery for negligent infliction of emotional distress, but it held that the plaintiff had stated a cause of action for the intentional tort of "outrage" and could recover under that theory.[104] Outrage, it should be noted, is an intentional tort and an action under which punitive damages are available.

Examples of cases in which punitive damages were allowed in malpractice actions where the defendant's conduct was judged extreme include the following:

- injecting silicone into the plaintiff's breasts knowing that the silicone was labeled "not for human use"[105];
- leaving the operating room without obtaining a qualified replacement[106];
- removing a patient's uterus without authorization[107]; and
- opening the patient's abdomen inexpertly to drain accumulated pus, making no attempt to remove a bowel obstruction, suturing the wound, and sending the patient home in a hearse after telling her that she was going to die.[108]

On the other hand, a claim for punitive damages was denied when a physician unknowingly operated on the wrong patient[109] and when a resident circumcised a baby against the wishes of the parents. In these cases the evidence established only negligence, not the "aggravated disregard of defendants' [professional] duties which has heretofore been considered by this court as a prerequisite in malpractice cases to the allowance of punitive damages for deterrent purposes."[110]

Countersuits by Physicians

For physicians, being the defendant in a lawsuit is usually an expensive proposition. Even if insurance covers attorneys' fees and other expenses, patients and

work time are lost, anxiety increases, reputation suffers, and malpractice insurance premiums may rise. When, after a number of years, the defendant finally prevails in the suit she, in high dudgeon, often asks, "Can I now sue the plaintiff or the plaintiff's lawyer to get back at them for this outrage?" In most cases the answer is, "Yes, you can, but you will lose." And even if the original suit was completely frivolous, it is difficult to recover damages in most states. Besides, getting involved in yet another lawsuit seldom seems worth the time, money, and angst that would be involved (see Legal Brief).

Legal Brief

"The revenge-seeking defendant would be well advised to hear Judge Learned Hand's remark: 'After some dozen years of experience I must say that as a litigant I should dread a lawsuit beyond almost anything else short of sickness and death'."

—Quoted in R. Posner, *Law and Literature* (1998)

The legal theories on which physicians have based countersuits in malpractice cases include defamation, negligence, abuse of process, and malicious prosecution.

Defamation has rarely been successful because statements made in the course of legal proceedings are privileged.[111] Furthermore, courts have held that an attorney does not owe a duty to the adverse party to determine the basis for the plaintiff's claim before filing suit. Attorneys are liable only to their clients for professional malpractice.[112] Abuse of process is difficult to prove because filing suit in itself does not sustain the cause of action.

Physicians have, however, sometimes successfully sued on the theory of malicious prosecution. This generally requires that the following be shown:

- the malpractice suit was decided in favor of the physician,
- there was no probable cause to believe that the physician was liable, and
- the plaintiff or attorney acted maliciously in bringing the suit.

Ill will or the lack of any reasonable possibility of success may support an allegation of malice. Most states also require a showing of actual damages. In some states special damages must be proved—for example, damages that arise from an arrest of the person or seizure of property.[113] Damages common to anyone involved in litigation—such as attorneys' fees, injury to reputation, and mental distress—are not sufficient.

Reforming the Tort System

Periodically the healthcare system encounters a "malpractice crisis" during which the cost of professional-liability insurance rises steeply. There are multiple

causes of these crises, including sharp drops in the stock market (when insurance companies lose investment income) and an increase in jury verdict awards. These crises are usually accompanied by calls for reform of the tort system, and legislatures respond in various ways. Following are some reform measures:

- shortening the statute of limitations;
- limiting awards for "pain and suffering";
- eliminating "joint and several" liability so that any one of multiple defendants is only liable for his percentage fault;
- requiring pretrial screening, arbitration, or mediation;
- limiting attorneys' contingency fees;
- allowing the defendant to deduct from jury award payments made to the plaintiff by other sources (such as health insurance);
- creating joint underwriting associations to spread malpractice risks among various insurance carriers;
- establishing "secondary" insurance plans to cover judgments beyond the limit of the primary insurance; and
- allowing insurers to pay out the award over time rather than in a lump sum (so-called "structured settlements"—see page 76).

Other reforms have involved protecting the public from incompetent physicians through heightened licensing standards, mandatory continuing education, reporting of disciplinary actions, periodic recredentialing, and similar means. The federal government, for example, maintains the National Practitioner Data Bank (NPDB), a resource that is intended to contain all disciplinary actions, license suspensions, malpractice settlements and judgments, and similar information for all physicians. A hospital's failure to query the NPDB during the medical staff privileging and credentialing process (see Chapter 7), for example, could be construed as corporate liability for the organization; thus, providers are more closely monitoring the quality of care of the physicians on their medical staffs.

The various types of tort reforms have had mixed success, and it is clear that the system for adjudicating malpractice claims remains imperfect. For this reason, people have begun to look at alternatives to the traditional litigation process.

Alternatives to the Tort System

Arbitration has been proposed not only for pretrial screening of claims but also as a system for resolving disputes. Other proposed alternatives to the tort system include no-fault compensation and problem solving by private contract rather than by litigation.

Arbitration

Arbitration is a method of resolving disputes at a hearing before an impartial referee without involving the court system. Among the advantages cited for arbitration are as follows:

- arbitration is speedier than the court system;
- once the dispute is aired, arbitration saves the time of all parties;
- matters under arbitration may be decided by an expert in the field;
- in arbitration, the formalities and complex rules of court proceedings are relaxed;[114]
- arbitration costs much less than a jury trial; and
- arbitration proceedings allow greater privacy than court proceedings.[115]

Two major types of arbitration are relevant to malpractice disputes. The first type is mandatory arbitration, which may be imposed on the parties by statute or court rule. The second type of arbitration is voluntary, agreed to by the parties either when they initially enter into a contractual relationship or after the dispute arises. Voluntary arbitration is not a recent development, having been introduced in some California health plans as early as the 1960s.

One of the major legal problems with arbitration provisions is that a court might consider them to be "contracts of adhesion" and therefore unenforceable. A contract of adhesion is one entered into by a person whose bargaining position is weak because she cannot do without the other party's services. An obvious example would be an arbitration clause forced on a patient who urgently needs emergency care.

Despite the possibility of adhesion problems, the California Supreme Court upheld an arbitration clause in the leading case of *Doyle v. Guiliucci*, which contested the arbitrator's decision in favor of the health plan and against the three-year-old patient. The court decided that "the arbitration provision in such contracts is a reasonable restriction, for it does no more than specify a forum for the settlement of disputes."[116]

Patients attempting to avoid arbitration have usually failed in their attempts if the agreement was entered into fairly. In *Burton v. Mt. Helix General Hospital* the court considered and rejected several contentions of a patient who had signed an arbitration agreement. First, the court decided that the patient's failure to read or understand the agreement did not make the agreement invalid because a person who signs a contract he is capable of understanding is bound by its terms, and the terms of the agreement were "clear and unmistakable." Second, the court found no evidence that the hospital defrauded the patient or exercised undue influence. Third, the court noted that arbitration is beneficial because it provides an alternative to litigation and saves time and expense. Finally, the court decided that the arbitration agreement in question was not a contract of adhesion. (The court distinguished it from an earlier California case in which an agreement

that relieved the hospital of all liability was offered as a condition of being admitted to the hospital. That agreement was invalidated because it violated public policy.[117])

The California experience with arbitration has proven attractive to state legislators. A Michigan statute, for instance, provides that a hospital and members of its medical staff must offer arbitration to patients at the hospital. (Physicians treating patients in their offices, however, are not required to offer arbitration.) The arbitration agreement may not be offered as a prerequisite to treatment, and patients may revoke the agreement within 60 days after execution (or, if it was signed on admittance to a hospital, within 60 days after discharge). Arbitration hearings in many states are conducted by an attorney, a physician, and a layperson, although a hospital administrator may be substituted for the physician if the claim is solely against a hospital.[118] The Michigan Supreme Court has held that this arbitration scheme does not deprive the patient of due process.[119]

The No-Fault Concept

No-fault systems, another proposed alternative to the traditional tort system, have existed in the United States for many years in other contexts. One form of no-fault—workers' compensation—was first established in the early 1900s. More recently many states have adopted no-fault to supplement the tort system in automobile accident cases. In its simplest terms, when an automobile owner purchases no-fault coverage and a person riding in the automobile is injured, the owner's insurance pays for the loss, no matter who caused the accident.

No-fault concepts are fairly adaptable to automobile accidents because it is usually clear when injury resulted from the accident. The concepts are more difficult to apply to medical injuries because the patients are to some degree ill or injured before receiving treatment. Thus, in medical injuries a major problem with a true no-fault system is proving that the physician caused the harm.

A medical-injury compensation system that is not fault-oriented presumably would authorize compensation for a "medical accident," an "untoward result," "a therapeutic misadventure," or some similar concept. All these phrases in substance describe an unanticipated event or result, and although they may be intelligible in the abstract, one must still discover the causes of the compensable event.[120]

Some legal observers suggest that healthcare providers could avoid malpractice suits by offering to compensate patients for economic losses from adverse medical occurrences.[121] Others suggest developing a list of "designated compensable events" that would be covered by insurance much as in the case of workers' compensation.[122] Injury caused by such an event would be covered by the insurer, and the patient would be precluded from suing in tort. The insurance would be purchased by the healthcare provider, who would pass the costs on to patients. Some compensation for pain and suffering could be made,

but there would be ceilings on such amounts.[123] Despite the various proposals, a workable no-fault plan for medical injuries has not yet been discovered.

Risk Management

Risk management is not really an alternative to the tort system but an organized effort to avoid the tort system entirely. In healthcare, the purpose of risk management is to identify and reduce risks to healthcare consumers. The fundamental basis for the malpractice system is the fact that adverse medical outcomes do occur; thus, risk management is essentially preventive medicine.

Avoiding risk requires identifying problems and forestalling incidents that lead to claims. It also includes dealing in a timely, reasonable manner with incidents that do occur. Healthcare providers should exercise appropriate skill in treating patients and maintain thorough, accurate medical records. Perhaps most importantly, providers should take a personal interest in each patient. Despite the impersonality often prevalent in our society, patients still have high expectations for sympathetic treatment when they visit their physicians. If they are disappointed,

> there is a strong get-even, or revenge factor. I have heard plaintiffs' attorneys say that their clients did not really want to sue for money. What they really wanted was a chance to be alone in the room with the defendant doctor for about fifteen minutes. When a physician has maltreated you in a psychological sense, the revenge motive arises. If we ever had a tort in this country known as psychological malpractice we would not have enough courthouses to take care of all the cases.[124]

Structured Settlements

This, too, is not really an alternative to the tort system, but it is a related concept. If a defendant (or insurance company) wants to resolve a case without trial, there are numerous ways to design a settlement agreement. Structured settlements are financial arrangements that compensate the plaintiff through periodic payments rather than in a lump sum, as was traditional. A structured settlement incorporated into a trial judgment by agreement of the parties and with the approval of the court is called a "periodic payment judgment." Structured settlements have the benefit of compensating the plaintiff for her damages without creating the possibility of a windfall. One example of a kind of structured settlement is shown in The Court Decides: *Perin v. Hayne* at the end of this chapter.

Another example of a structured settlement involved negligence at a U.S. Navy hospital in the 1970s. Lack of oxygen during delivery resulted in severe brain damage to the baby, but with proper care she was expected to have a normal life expectancy. The parents and the government settled the case by creating a "reversionary trust" to care for the child as long as she lived. Calculations showed that a principal amount of $1 million, plus reinvested earnings, would cover the expected cost of custodial care for 72 years, the life expectancy of a

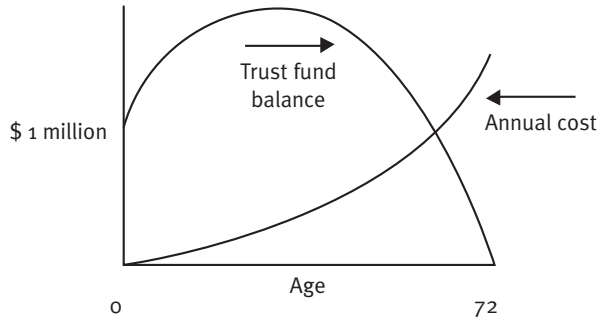


FIGURE 3.1
Example of a Structured Settlememt

newborn at the time. To prevent the parents from receiving a windfall, the reversionary trust language provided that the trust funds would be returned to the government if the child died before the age of 72. (See Figure 3.1 for a graph depicting this example of a structured settlement.)

Chapter Summary

This chapter outlines four basic elements of proof in a tort case—duty, breach, injury, and causation. The duty (the standard of care) can be proven in various ways, and the plaintiff's injuries must have been caused by a breach of that duty by the defendant or the defendant's agent. In the case of an agency relationship, the concept of respondeat superior (vicarious liability) applies. In the case of a physician's negligence (medical malpractice), the standards of different "schools" of practice (traditional medicine versus osteopathy, for example) might determine the standard of care to be applied. When proof of specific negligence is difficult to demonstrate, res ipsa loquitur might be applied. Also explored in this chapter are a number of defenses to malpractice suits and reform of and alternatives to the tort system.

Chapter Discussion Questions

1. What are the four elements of proof necessary for a plaintiff to prove a negligence case?
2. What is the significance of *Helling v. Carey* in relation to the standard of care in medical malpractice cases?
3. How can the standard of care be proven?

4. What is an exculpatory contract, and when is one held to be enforceable?
5. What is the principle of "vicarious liability" (respondeat superior)?
6. What are some examples of "tort reform," and how successful have they been?

Notes

1. 61 *Am. Jur.* "Physicians and Surgeons," § 205 (1981). See also Roady, T., and W. Andersen. 1960. *Professional Negligence*, 70.
2. For a comparison of the standards imposed on general practitioners and specialists, see the section on the school rule, infra.
3. Baldo v. Rogers, 81 So. 2d 658 (Fla. 1955), reh'g denied, 81 So. 2d 661 (Fla. 1955); Holder, A. 1978. *Medical Malpractice Law,* 2nd ed., 47.
4. DeFillipo v. Preston, 53 Del. 539, 173 A.2d 333 (1961).
5. Miller v. Toles, 183 Mich. 252, 150 N.W. 118 (1914).
6. Fiorentino v. Wenger, 272 N.Y.S.2d 557, 26 A.D.2d 693 (1966), rev'd on other grounds, 19 N.Y.2d 407, 227 N.E.2d 296 (1967). Decision against the hospital was reversed, however; the court of appeals decided that the hospital had no obligation to disclose or to make certain that disclosures were made unless it knew or should have known that informed consent was lacking and that the operation was not permissible under existing standards. Informed consent, which is often treated as a cause of action separate from negligence, is discussed in Chapter 11, "Antitrust Law."
7. Locality can, of course, mean the same community or a wider area that is still in the general vicinity where the physician practices. The term is generally used in contrast to a national standard, which is discussed in this chapter.
8. Faulkner v. Pezeshki, 44 Ohio App. 2d 186, 189, 337 N.E.2d 158, 162 (1975).
9. Small v. Howard, 128 Mass. 131, 35 Am. R. 363 (1880) was overruled in 1968 by Brune v. Belinkoff, 235 N.E.2d 793 (Mass. 1968).
10. Zills v. Brown, 382 So. 2d 528, 532 (Ala. 1980).
11. Id. at 532.
12. At least 18 states have adopted a national standard. See, for example, Sullivan v. Henry, 160 Ga. App. 791, 287 S.E.2d 652, 659 (1982); Drs. Lane, Bryand, Eubanks & Dulaney v. Otts, 412 So. 2d 254 (Ala. 1982); Hall v. Hilburn, 466 So. 2d 856 (Miss. 1985).
13. Drs. Lane, Bryand, Eubanks & Dulaney v. Otts, 412 So. 2d 254 (Ala. 1982).
14. A Texas court noted that "[t]he circumstances to be considered include the state of medical knowledge at the time the complained of treatment was performed. " Guidry v. Phillips, 580 S.W.2d 883, 887/88 (Tex. Civ. App. 1979, writ ref'd n.r.e.).
15. Waltz, J., and F. Inbau. 1971. *Medical Jurisprudence*, 54.
16. Craft v. Peebles, 893 P.2d 138 (Haw. 1995).
17. See, for example, Dolan v. Galluzzo, 77 Ill. 2d 279, 396 N.E.2d 13 (1979)—a podiatrist was held to standards of podiatrists; MD testimony excluded.
18. Nelson v. Harrington, 72 Wis. 591, 40 N.W. 228 (1888). See also Hansen v. Pock, 57 Mont. 51, 187 P. 282 (1920)—a herbologist was held to standards of surgical and medical practice in the absence of a school of practice.
19. Spead v. Tomlinson, 73 N.H. 46, 59 A. 376 (1904).
20. 25 Wash. App. 158, 607 P.2d 864 (1980). See also Kelly v. Carroll, 36 Wash. 2d 498, 219 P.2d 79 (1950), cert. denied, 340 U.S. 892 (1950)—a naturopath was liable for a patient's death from appendicitis; the naturopath must know when treatment is ineffective and when medical care is needed.
21. Pittman v. Gilmore, 556 F.2d 1259 (5th Cir. 1977). See also Lewis v. Soriano, 374 So. 2d 829 (Miss. 1979)—a general practitioner had a duty to refer a complicated fracture to an orthopedic specialist.

22. Mata v. Albert, 548 S.W.2d 496 (Tex. Civ. App. 1977, writ ref'd n.r.e.).
23. See, for example, Sinz v. Owens, 33 Cal. 2d 749, 705 P.2d 3 (1949)—a physician who did not use skeletal traction in treating a double comminuted fracture of a patient's leg would be held to the skill of a specialist only if he should have known that greater skill than a general practitioner's was necessary; Reeg v. Shaughnessy, 570 F.2d 309 (10th Cir. 1978)—physicians held to that degree of care commensurate with their training and experience.
24. See, for example, Lewis v. Soriano, 374 So. 2d 829 (Miss. 1979).
25. 245 So. 2d 751 (La. App. 1971).
26. 144 So. 2d 544 (La. App. 1962).
27. Wash. Rev. Code § 4.24.290 (1975, as amended 1983).
28. 92 Wash. 2d 246, 595 P.2d 919 (1979).
29. In Faulkner v. Pezeshki, 44 Ohio App. 2d 186, 193, 337 N.E.2d 158, 164 (1975), the court noted: "Locating an expert to testify for the plaintiff in a malpractice action is known to be a very difficult task, mainly because in most cases one doctor is reluctant and unwilling to testify against another doctor. Although doctors may complain privately to each other about the incompetence of other doctors, they are extremely reluctant to air the matter publicly."
30. For this reason, attorneys have on occasion named a physician as a defendant in a suit solely for the purpose of obtaining testimony. In one such instance the physician so named successfully sued the attorney for malicious prosecution. See Carlova. 1981. "'Shotgun' Malpractice Suits Suffer a Costly Setback." *Medical Economics* 58: 29. Physicians' countersuits are discussed in this chapter.
31. See, for example, Callahan v. William Beaumont Hosp., 400 Mich. 177, 254 N.W.2d 31 (1977).
32. See, for example, Siirila v. Barrios, 398 Mich. 576, 248 N.W.2d 171 (1976).
33. See, for example, Ferguson v. Gonyaw, 64 Mich. App. 685, 236 N.W.2d 543 (1976).
34. Id. In this case, the DO and his instructor were the only practicing osteopathic neurosurgeons in all of Michigan. The court rejected the plaintiff's argument that they should not be permitted to set their own standards. A growing number of states have overturned the school rule when standards of different schools are similar.
35. 106 Mich. App. 35, 307 N.W.2d 695 (1981).
36. 15 N.Y.2d 20, 203 N.E.2d 469 (1964), aff'd, 278 N.Y.S.2d 209, 224 N.E.2d 717 (1966). See Waltz, J., and F. Inbau. 1971. *Medical Jurisprudence*, supra note 15, at 82.
37. Hearsay is an out-of-court statement offered into evidence to prove the truth of the matter asserted in the statement. Hearsay, as defined, is not admissible, but there are some notable exceptions, such as the business record exception, which makes medical records admissible under some circumstances. Out-of-court statements are admissible if offered for purposes other than to prove the truth of the statement—for example, to impeach the credibility of the witness.
38. Scacchi v. Montgomery, 365 Pa. 377, 380, 75 A.2d 535, 536 (1950).
39. The law tries to encourage settlements and will not allow into evidence an offer of settlement if the case goes to court. If the offer of settlement includes an admission of negligence, however, the admission itself can be used as evidence.
40. Wickoff v. James, 159 Cal. App. 2d 664, 324 P.2d 661 (1958). Both of these cases are discussed in Long. 1968. *The Physician and the Law*, 28–30.
41. Discrediting the testimony of a witness is called impeachment.
42. Bergen. 1971. "Medical Books as Evidence." *JAMA* 217: 527.
43. Burnside v. Evangelical Deaconess Hosp., 46 Wis. 2d 519, 175 N.W.2d 230 (1970).
44. 33 Ill. 2d 326, 211 N.E.2d 253, 14 A.L.R.3d 860 (1965), cert. denied, 383 U.S. 946 (1966).
45. Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965).
46. See, for example, Cal. Evid. Code § 669 (1985 Supp.)—it raises a presumption of negligence under these circumstances but permits the defendant to rebut the presumption by showing that he did what a "person of ordinary prudence," who desired to comply with the law, might do under similar circumstances.
47. 17 Cal. 3d 399, 131 Cal. Rptr. 69, 551 P.2d 389 (1976)—the cause of action for negligence in failing to diagnose the syndrome was also stated by the complaint.
48. See, for example, Sinz v. Owens, 33 Cal. 2d 749, 205 P.2d 3, 8 A.L.R.2d 757 (1949).

49. 7 N.Y.2d 376, 380, 165 N.E.2d 756, 757 (1960). See Long. 1968. *The Physician and the Law,* supra note 40, at 74–75.
50. 2 H. and C. 722, 159 Eng. Rep. 299 (1863).
51. This is a simplified description of the operation of the doctrine. Actual application varies from state to state. In some states the doctrine raises only a permissible inference of negligence; in some it creates a presumption of negligence to shift the burden of rebutting the presumption over to the defendant; in still others the defendant has the burden of persuasion. See Prosser, W. 1984. *Handbook of the Law or Torts,* 5th ed., 244, 258–59. For a more thorough discussion, see Podell. 1977. "Application of Res Ipsa Loquitur in Medical Malpractice Litigation." *Ins. Counsel* J, 44: 634.
52. Prosser, W. 1984. *Handbook of the Law or Torts,* 5th ed., § 39, at 244.
53. Jamison v. Debenham, 203 Cal. App. 2d 744, 21 Cal. Rptr. 848 (1962).
54. 77 F. Supp. 706 (Md. 1948), aff'd, 178 F.2d 518 (4th Cir. 1949), aff'd, 340 U.S. 135 (1950).
55. 137 Cal. App. 3d 910, 187 Cal. Rptr. 357 (1982).
56. Waltz, J., and F. Inbau. 1971. *Medical Jurisprudence*, supra note 15, at 100.
57. 25 Cal. 2d 486, 154 P.2d 687 (1944).
58. Id. at 493, 154 P.2d at 691. Ybarra v. Spangard has been followed in California; see, for example, Hale v. Venuto, 137 Cal. App. 3d 910, 187 Cal. Rptr. 357 (1982)—it has also been cited with approval in various jurisdictions; see Louisell, D., and H. Williams. 1984. *Medical Malpractice* § 14.02, at 14–18.
59. 158 P.2d 579 (Cal. App. 1945), rev'd on other grounds, 27 Cal. 296, 163 P.2d 860 (1945).
60. Alternatives to allocating loss on the basis of fault are discussed at the end of this chapter under "Alternatives to the Tort System."
61. See Restatement (Second) of Torts § 402A.
62. See, for example, Perlmutter v. Beth David Hosp., 308 N.Y. 100, 123 N.E.2d 792 (1954). Many states have dealt with this issue by legislation; see, for example, Wis. Stat. § 146.31(2) (West Supp. 1986)—this precludes application of warranty or strict tort liability in cases involving contaminated blood.
63. 386 S.W.2d 879 (Tex. Civ. App. 1964).
64. Mehigan v. Sheehan, 94 N.H. 274, 51 A.2d 632 (1947).
65. See, for example, Cornfeldt v. Tongen, 295 N.W.2d 638 (Minn. 1980); Hanselmann v. McCardle, 275 S.C. 46, 267 S.E.2d 531 (1980); Hiser v. Randolph, 126 Ariz. 608, 617 P.2d 774 (Ct. App. 1980); Cooper, 272 N.E.2d 97.
66. See, for example, Hamil v. Bashline, 481 Pa. 256, 392 A.2d 1280 (1978); McBride v. United States, 462 F.2d 72 (9th Cir. 1972).
67. Herskovits v. Group Health Cooperative of Puget Sound, 99 Wash. 2d 609, 614, 664 P.2d 474, 476 (1983).
68. Herskovits, 664 P.2d 474. See also Glicklich v. Spievack, 16 Mass. App. 488, 452 N.E.2d 287 (1983), appeal denied, 454 N.E.2d 1276 (1983)—diagnosis of breast cancer delayed for nine months; jury verdict for plaintiff upheld.
69. Herskovits, 99 Wash. 2d at 614, 664 P.2d at 477.
70. Mansur v. Carpenter, 273 Ind. 374, 404 N.E.2d 585 (1980).
71. 349 F. Supp. 827 (S.D. Tex. 1972), aff'd, 493 F.2d 408, cert. denied, 419 U.S. 845. This case is discussed in greater detail in Chapter 11, "Antitrust Law." See also Holder, A. 1978. *Medical Malpractice Law*, 2nd ed., supra note 3, at 306–9.
72. Champs v. Stone, 74 Ohio App. 344, 58 N.E.2d 803 (1944).
73. 166 Wis. 561, 165 N.W. 292 (1918). See also Heller v. Medine, 377 N.Y.S.2d 100, 102, 50 A.D.2d 831, 832 (1976)—"A patient's failure to follow instructions does not defeat an action for malpractice where the alleged improper professional treatment occurred prior to the patient's own negligence. Under such circumstances, damages are reduced to the degree that the plaintiff's negligence increased the extent of the injury."
74. Schuster v. St. Vincent Hosp., 45 Wis. 2d 135, 172 N.W.2d 421 (1969).
75. 60 Cal. 2d 92, 32 Cal. Rptr. 33, 383 P.2d 441 (1963). See 61 *Am. Jur*, 2. "Physicians and Surgeons," § 164 (1981).
76. 43 Ohio St. 2d 53, 54, 330 N.E.2d 678, 679–80 (1975).

77. See, for example, Ellis v. Bitzer, 2 Ohio 89 (1925).
78. Whitt v. Hutchison, 43 Ohio St. at 61, 330 N.E.2d at 684 (1975). See also Berger v. Fireman's Fund Ins. Co., 305 So. 2d 724 (La. Ct. App. 1974)—a child was injured in a schoolyard by a piece of wire thrown by a lawn mower. The surgeons either punctured her kidney or failed to discover a wound already there, and the child died the next day. The parents settled with the school board and executed a release, then brought a wrongful death action against the hospital and physicians. An appellate court ruled improper a summary judgment in favor of the defendants, because neither the release nor any testimony established negligence by the school board. Thus, a factual issue remained: whether the school board and physicians were joint tort-feasors who could be released by a single release.
79. See, for example, Vt. Stat. Ann. tit. 12, § 519(b) (1973).
80. Vt. Stat. Ann. tit. 12, § 519 (1973); Minn. Stat. Ann. § 604.05 (as amended 1984) (West Supp. 1985).
81. Some have questioned the need for Good Samaritan statutes. Given that negligence is judged according to a standard of care under the circumstances, it is hard to see how anything but gross negligence could lead to liability for rendering care in an emergency situation. Indeed, research fails to reveal any cases in which Good Samaritan statutes have been applied to traditional emergency situations, such as when a physician happens upon the scene of an automobile accident.
82. See the discussion on workers' compensation in Chapter 2.
83. See, for example, Pangburn v. Saad, 326 S.E.2d 365 (N.C. Ct. App. 1985)—immunity for state hospital personnel was qualified and did not extend to gross negligence and intentional torts; thus, the rule may not apply in a case in which the plaintiff's brother was released by the defendant after an involuntary psychiatric commitment and less than a day later attacked and stabbed the plaintiff. According to the court, the plaintiff could maintain an action for negligent release, distinct from a "classic medical malpractice" action; negligent release would be based on a general duty to the public not to create an unreasonable risk of harm at the hands of a psychiatric patient, such duty being independent of the physician–patient relationship.
84. Id., citing Estelle v. Gamble, 429 U.S. 97, 106 (1976), reh'g denied, 492 U.S. 1066.
85. See the discussion on violation of civil rights in Chapter 2.
86. A summary of statutes of limitations may be found in Moritz, A., and R. Morris. 1970. *Handbook of Legal Medicine*, 212–14.
87. Or certain other specified, licensed healthcare providers. Cal. Civ. Proc. Code § 411.30 (as amended 1984) (West Supp. 1985).
88. Fla. Stat. Ann. § 95.11(4) (b) (West 1982).
89. Moritz, A., and R. Morris. 1970. *Handbook of Legal Medicine*, supra note 86, at 211; Hill v. Hays, 193 Kan. 453, 395 P.2d 298 (1964).
90. See, for example, Cates v. Baol, 54 Mich. App 717, 221 N.W.2d 474 (1974).
91. 1970 Wis. L. Rev. 915, 918; 6 Akron L. Rev. 265, 267–68 (1973).
92. Barrier v. Bowen, 63 N.J. Super. 225, 164 A.2d 357 (1960).
93. 261 Ind. 698, 310 N.E.2d 867 (1974).
94. Hubbard v. Libi, 229 N.W.2d 82 (N.D. 1975).
95. See, for example, Thompson v. Brent, 245 So. 2d 751 (La. App. 1971)—the physician was liable because a medical assistant in his employ was negligent in removing a cast with a Stryker saw.
96. Honeywell v. Rogers, 251 F. Supp. 841 (W.D. Pa. 1966). Vicarious liability is discussed in greater detail under the captain-of-the-ship and borrowed-servant doctrines in Chapter 5.
97. Morrill v. Komasinski, 256 Wis. 417, 41 N.W. 2d 620 (1950). See Waltz, J., and F. Inbau. 1971. *Medical Jurisprudence*, supra note 15, at 119–21.
98. Kelsey-Seybold Clinic v. Maclay, 456 S.W.2d 229, aff'd, 466 S.W.2d 716 (Tex. 1971).
99. Ohio Rev. Code Ann. §§ 2305.06-2305.11.
100. Holder, A. 1973. "Abandonment: Part I." *JAMA* 225: 1157.
101. Smith v. St. Paul Fire and Marine Ins. Co., 353 N.W.2d 130 (Minn. 1984).
102. L.L. v. Medical Protective Co., 122 Wis. 2d 455, 362 N.W.2d 174 (1984).
103. A case permitted damages for a mother's emotional distress when a prescription for her infant daughter was improperly filled; the pharmacist's act was labeled "willful and wanton misconduct." Lou v. Smith, 285 Ark. 249, 685 S.W.2d 809 (1985).

104. 85 Wash. 2d 52, 530 P.2d 291 (1975)—court adopted the requirements for outrage as defined in Restatement (Second) of Torts § 46, including the necessity for the plaintiff to be an immediate relative of the victim and present at the event.
105. Short v. Downs, 36 Colo. App. 109, 537 P.2d 754 (1975).
106. Medveca v. Choi, 569 F.2d 1221 (3d Cir. 1977) (applying Pennsylvania law).
107. Pratt v. Davis, 118 Ill. App. 161, aff'd, 224 Ill. 300, 79 N.E. 562 (1905).
108. Morrell v. Lalonde, 45 R.I. 112, 120 A. 435 (1923), appeal dismissed, 264 U.S. 572 (1924).
109. Ebaugh v. Rabkin, 22 Cal. App. 3d 891, 99 Cal. Rptr. 706 (1972).
110. Noe v. Kaiser Found. Hosps., 248 Or. 420, 435 P.2d 306 (1967).
111. Huene v. Carnes, 121 Cal. App. 3d 432, 175 Cal. Rptr. 374 (1981).
112. See, for example, Friedman v. Dozorc, 412 Mich. 1, 312 N.W.2d 585 (1981); Hill v. Willmott, 561 S.W.2d 331 (Ky. App. 1978).
113. Ohio is one of the states requiring special damages. See Dakters v. Shane, 64 Ohio App. 2d 196, 412 N.E.2d 399 (1978); New York is another—see Berlin v. Nathan, 64 Ill. App. 3d 940, 381 N.E.2d 1367 (1978), cert. denied, 444 U.S. 828, reh'g denied, 444 U.S. 974 (1979). The American Medical Association has recommended that the special injury requirement be eliminated in physician countersuits for malicious prosecution and that the physician be permitted to recover costs in a frivolous suit (Professional Liability in the '80s, American Medical Association Special Task Force on Professional Liability and Insurance, Report 3, p. 14. March 1985.)
114. U.S. Department of Health, Education, and Welfare. 1973. *Report of the Secretary's Commission on Medical Malpractice*, App. at 215. Washington, DC: U.S. Government Printing Office.
115. Bergen. 1970. "Arbitration of Medical Liability." *JAMA* 211: 176.
116. Doyle v. Guiliucci, 62 Cal. 2d 606, 610, 43 Cal. Rptr. 697, 699, 401 P.2d 1,3 (1965).
117. Cal. Ct. App. 4th Dist., Div. 1 (Feb. 24, 1976). This case, originally certified for publication, was later decertified and thus does not stand as precedent. Burton and related cases are discussed in greater detail in Chapter 9, "Consent for Treatment and Withholding Consent."
118. Mich. Comp. Laws Ann. §§ 500.3053–3061 (West 1983) and §§ 600.5041–5044 (West Supp. 1985).
119. Morris v. Metriyakool, 418 Mich. 423, 344 N.W.2d 736 (1984).
120. U.S. Department of Health, Education, and Welfare, supra note 114, at 101.
121. See Moore and O'Connell. 1984. "Foreclosing Medical Malpractice Claims by Prompt Tender of Economic Loss." *La. L. Rev.* 44: 1267. For other no-fault proposals see Havighurst and Tancredi. 1974. "Medical Adversity Insurance: A No-Fault Approach to Medical Malpractice and Quality Assurance." *Ins. L. J.* 69; Carlson. 1973. "Conceptualization of a No-Fault Compensation System for Medical Injuries." *Law & Society Review* 7: 329; Switzer and Reynolds. "Medical Malpractice Compensation: A Proposal." *Am. Bus. L. J.* 13: 65.
122. The American Bar Association Commission on Medical Professional Liability studied the feasibility of developing a list of compensable events and concluded that it was possible. Boyden and Tancredi. 1979. "Part III: Identification of Designated Compensable Events (DCEs)." In *Commission on Medical Professional Liability, Designated Compensable Event System: A Feasibility Study.*
123. Havighurst and Tancredi. 1974. "Medical Adversity Insurance: No-Fault Approach to Medical Malpractice and Quality Assurance." *Ins. L. J.* 69.
124. McDonald, D. 1971. *Medical Malpractice*, 4.

THE COURT DECIDES

Helling v. Carey
83, Wash. 2d 514, 519 P.2d 981 (1974)

Hunter, J.

We find this to be a unique case. The testimony of the medical experts is undisputed concerning the standards of the profession for the specialty of ophthalmology.... The issue is whether the defendants' compliance with the standard of the profession of ophthalmology, which does not require the giving of a routine pressure test to persons under 40 years of age, should insulate them from liability under the facts of this case....

[The court points to evidence that the incidence of glaucoma in persons under the age of 40 was about 1 in 25,000.] However, that one person, the plaintiff in this instance, is entitled to the same protection, as afforded persons over 40, essential for timely detection of the evidence of glaucoma where it can be arrested to avoid the grave and devastating result of this disease. The test is a simple pressure test, relatively inexpensive. There is no judgment factor involved, and there is no doubt that by giving the test the evidence of glaucoma can be detected....

Justice Holmes stated in *Texas & Pac. Ry. v. Behymer:*

What usually is done may be evidence of what ought to be done, but what ought to be done is fixed by a standard of reasonable prudence, whether it usually is complied with or not.

In [another case,] Justice [Learned] Hand stated:

[I]n most cases reasonable prudence is in fact common prudence; but strictly it is never its measure; a whole calling may have unduly lagged in the adoption of new and available devices. It never may set its own tests, however persuasive be its usages. Courts must in the end say which is required; there are precautions so imperative that even their universal disregard will not excuse their omission.

Under the facts of this case reasonable prudence required the timely giving of the pressure test to this plaintiff. The precaution of giving this test to detect the incidence of glaucoma to patients under 40 years of age is so imperative that irrespective of its disregard by the standards of the ophthalmology profession, it is the duty of the courts to say what is required to protect patients under 40 from the damaging results of glaucoma.

We therefore hold, as a matter of law, that the reasonable standard that should have been followed under the undisputed facts of this case was the timely giving of this simple, harmless pressure test to this plaintiff and that, in failing to do so, the defendants were negligent, which proximately resulted in the blindness sustained by the plaintiff for which the defendants are liable.

....

The judgment of the trial court and the decision of the Court of Appeals [are] reversed....

Helling v. Carey Discussion Questions

1. The Supreme Court of Washington is often viewed as nontraditional—liberal, activist, or bellwether, depending on one's point of view. Do you agree with the court's decision in this case to abandon a traditional, physician-determined standard of care? Why or why not?
2. Is this "judge-made law"? If so, is it to be admired or disliked? Fashion an argument supporting each point of view.
3. The legislation that attempted to overturn the healing precedent has been on the books for three decades but has had little effect. Why do you suppose this is so, and why has the legislature not seen fit to reinforce it?
4. Consider the Legal Brief on page 54 relating to whether *Helling* is good public policy. Do you understand how it can be that a test that is 95 percent accurate can result in positive test results that are truly positive only 16 percent of the time?

THE COURT DECIDES

Perin v. Hayne
210 N.W.2d 609 (Ia. 1973)

McCormick, J.

This is an appeal from a directed verdict for a doctor in a malpractice action. We affirm.

The claim arose from an anterior approach cervical fusion performed on plaintiff Ilene Perin by defendant Robert A. Hayne.... The fusion was successful in eliminating pain, weakness and numbness in plaintiff's back, neck, right arm and hand caused by two protruded cervical discs, but plaintiff alleged she suffered paralysis of a vocal chord [sic] because of injury to the right recurrent laryngeal nerve during surgery.... The injury reduced her voice to a hoarse whisper.

She sought damages on four theories: specific negligence, res ipsa loquitur, breach of express warranty and battery or trespass. After both parties had rested, the trial court sustained defendant's motion for directed verdict, holding the evidence insufficient to support jury consideration of the case on any of the pleaded theories. Plaintiff assigns this ruling as error. We must review each of the pleaded bases for recovery in the light of applicable law and the evidence.

I. Specific negligence. Plaintiff alleges there was sufficient evidence to support jury submission of her charge [that] defendant negligently cut or injured the recurrent laryngeal nerve. Plaintiff had protruded discs at the level of the fifth and sixth cervical interspaces. The purpose of surgery was to remove the protruded discs and fuse the vertebrae with bone dowels from her hip. Removal of a disc ends the pinching of the nerve in the spinal column

which causes the patient's pain. The bone supplants the disc.

The procedure involves an incision in the front of the neck at one side of the midline at a level slightly below the "adam's apple." Four columns run through the neck. The vertebrae and spinal chord are in the axial or bone column at the rear. In order to get to the axial column the surgeon must retract the visceral column which lies in front of it. The visceral column, like the vascular columns on each side of it, is covered with a protective fibrous sheath, called fascia. It contains the esophagus and trachea. The recurrent laryngeal nerve, which supplies sensitivity to the muscles that move the vocal chord [sic], is located between the esophagus and trachea.

The surgeon does not enter the visceral column during the cervical fusion procedure. The same pliancy which enables the neck to be turned enables the visceral column to be retracted to one side to permit access to the axial column. The retraction is accomplished by using a gauze-padded retractor specifically designed for retraction of the visceral column during this surgery.

The record shows the defendant used this procedure in the present case. Plaintiff was under general anesthetic. The anesthesia record is normal, and there is no evidence of any unusual occurrence during surgery. Defendant denied any possibility the laryngeal nerve was severed. He said it could not be severed unless the visceral fascia was entered, and it was not. He also believed it would be impossible to sever the nerve during such surgery without also severing the esophagus or trachea or both.

[An expert witness for the plaintiff testified that it would be unusual to specifically encounter the laryngeal nerve during this surgery but that "the injury could occur despite the exercise of all proper skill and care."]

Defendant testified he did not know the cause of the injury but presumed it resulted from contusion of the nerve incident to retraction of the visceral column. He thought plaintiff's laryngeal nerve may have been peculiarly susceptible to such injury. He insisted the surgery was done just as it always was and if he were doing it again he would do it the same way. He said one study has shown the surgery will result in paralysis of a vocal chord [sic] in two or three-tenths of one percent of cases in which it is used. He also said there is no way to predict or prevent such instances.

....

In considering the propriety of the verdict directed for defendant we give the evidence supporting plaintiff's claim the most favorable construction it will reasonably bear.

We recognize three possible means to establish specific negligence of a physician. One is through expert testimony, the second through evidence showing [that] the physician's lack of care is so obvious as to be within comprehension of the layman, and the third (actually an extension of the second) evidence that the physician injured a part of the body not involved in the treatment. The first means is the rule and the others are exceptions to it.

In this case plaintiff asserts [that] a jury question was generated by the first and third means. We do not agree.

Plaintiff alleges the laryngeal nerve was negligently cut or injured. The record is devoid of any evidence the nerve was severed during surgery....

The doctors agree the technique employed by defendant was proper. The sole basis for suggesting the expert testimony would support a finding of specific negligence is that the nerve was injured during retraction. Where an injury may occur despite due care, a finding of negligence cannot be predicated solely on the fact it did occur.

....

Plaintiff also maintains there is evidence of negligence from the fact this is a case of injury to a part of the body not involved in the treatment. However, that is not so. The surgical procedure did include retraction of the visceral column. It was very much in the surgical field.

....

Trial court did not err in directing a verdict for defendant on the issue of specific negligence.

II. Res ipsa loquitur. Plaintiff also alleges the applicability of the doctrine of res ipsa loquitur. Our most recent statement of the doctrine appears in [a 1973 case]:

Under the doctrine of res ipsa loquitur, where (1) injury or damage is caused by an instrumentality under the exclusive control of defendant and (2) the occurrence is such as in the ordinary course of things would not happen if reasonable care had been used, the happening of the injury permits, but does not compel, an inference defendant was negligent.

The contest in this case concerns presence of the second foundation fact [from the quoted paragraph].

....

Defendant argues the second foundation fact for res ipsa loquitur is absent because it does not lie in the common knowledge of laymen to say injury to the laryngeal nerve does not occur if due care is exercised in anterior approach cervical fusion surgery.

We must initially decide what has previously been an open question in this jurisdiction: may the common experience to establish the second foundation fact for res ipsa loquitur be shown by expert testimony?

[The court proceeds to review cases from Wisconsin, California, Oregon, and Washington, plus three legal treatises on the subject. It quotes with favor the following:]

In the usual case the basis of past experience from which this conclusion may be drawn is common to the community, and is a matter of general knowledge, which the court recognizes on much the same basis as when it takes judicial notice of facts which everyone knows. It may, however, be supplied by the evidence of the parties; and expert testimony that such an event usually does not occur without negligence may afford a sufficient basis for the inference.

Thus we disagree with defendant's contention [that] the second foundation fact must be based exclusively on the common knowledge of laymen.

In this case, however, even considering the expert testimony, the record at best only supports an inference [that] plaintiff suffered an extremely rare injury in anterior approach cervical fusion surgery which may occur even when due care is exercised. Rarity of the occurrence is not a sufficient predicate for application of res ipsa loquitur.... There is no basis in the present case, in expert testimony or otherwise, for saying plaintiff's injury is more likely the result of negligence than some cause for which the defendant is not responsible.

....

We do not believe there was any basis in this case for submission of res ipsa loquitur. Trial court did not err in refusing to submit it.

III. Express warranty. [The court dismisses this count, saying that the evidence supporting her argument that the physician guaranteed a good result was equivocal in nature: "There comes a point when a question of fact may be generated as to whether the doctor has warranted a cure or a specific result. However, in the

present case the evidence does not rise to that level."]

IV. Battery or trespass. Plaintiff contends there was also sufficient evidence to submit the case to the jury on the theory of battery or trespass. In effect, she alleges she consented to fusion of two vertebrae (removal of only one protruded disc) thinking there would be a separate operation if additional vertebrae had to be fused. She asserts the fact four vertebrae were fused combined with defendant's assurances and failure to warn her of specific hazards vitiated her consent and makes the paralyzed vocal chord [sic] the result of battery or trespass for which defendant is liable even without negligence. There was no evidence or contention by her in the trial court nor is there any assertion here that she would not have consented to the surgery had she known those things she says were withheld from her prior to surgery.

Defendant testified plaintiff was fully advised as to the nature of her problem and the scope of corrective surgery. He acknowledges he did not advise her of the hazard of vocal chord [sic] paralysis. He believed the possibility of such occurrence was negligible and outweighed by the danger of undue apprehension if warning of the risk was given.

[The court next begins a discussion of the distinction between consent and informed consent, quoting with approval from its own landmark case of Cobbs v. Grant:*]*

Where a doctor obtains consent of the patient to perform one type of treatment and subsequently performs a substantially different treatment for which consent was not obtained, there is a clear case of battery. However, when an undisclosed potential complication results, the occurrence of which was not an integral part of the treatment procedure but merely a known risk, the courts are divided on the issue of whether this should be deemed to be a battery or negligence.

....

We agree with the majority trend. The battery theory should be reserved for those circumstances when a doctor performs an operation to which the patient has not consented. When the patient gives permission to perform one type of treatment and the doctor performs another, the requisite element of deliberate intent to deviate from the consent given is present. However, when the patient consents to certain treatment and the doctor performs that treatment but an undisclosed inherent complication with a low probability occurs, no intentional deviation from the consent given appears; rather, the doctor in obtaining consent may have failed to meet his due care duty to disclose pertinent information. In that situation the action should be pleaded in negligence.

From our approval of this analysis it should be clear we believe the battery or trespass theory pleaded by plaintiff in this case is limited in its applicability to surgery to which the patient has not consented. There must be a substantial difference between the surgery consented to and the surgery which is done. Plaintiff asserts she consented to only one fusion rather than two. Assuming this is true, the most that could be argued is [that] the second fusion was a battery or trespass. But she does not claim damages for a second fusion. She asks damages because of injury to the laryngeal nerve during surgery. The evidence is undisputed that whether one or two fusions were to be done the path to the axial column had to be cleared by retraction of

the visceral column. Hence, any injury caused by such retraction occurred during a procedure to which consent had been given. Retraction of the visceral column during the surgery was not a battery or trespass.

We have no occasion to reach the question whether failure to advise plaintiff of the risk of laryngeal nerve injury would in the circumstances of this case have generated a jury issue on negligence, but we do point out that recovery on such basis is precluded unless a plaintiff also establishes he would not have submitted to the procedure if he had been advised of the risk.... There is no evidence plaintiff would have withheld her consent in this case.

....

Affirmed.

Perin v. Hayne Discussion Questions

1. Has due care been shown? Does it need to be?
2. What is the "second foundation fact," and how does "common experience" matter in relation to it?
3. The opinion states, "There must be a substantial difference between the surgery consented to and the surgery which is done [for a battery case to be made]." What would amount to a "substantial difference" in your mind? What if throat cancer had been discovered and cleanly removed with no aftereffects? Would that be a substantial difference justifying damages for battery even though no other injury (and, in fact, a benefit) had resulted?
4. Why did the court "have no occasion" to decide whether failure to advise the plaintiff of the risk of nerve injury raised a negligence issue?

CHAPTER

4

THE ORGANIZATION AND MANAGEMENT OF A CORPORATE HEALTHCARE INSTITUTION

After reading this chapter, you will

- understand that a corporation is a "person" for many legal purposes, but it is not an "individual" or a "citizen" in the view of the law. Laws that apply to persons also apply to corporations; laws that specify individuals or citizens do not.
- recognize that incorporation has many advantages, the most significant of which is limiting the liability of the individuals who own the corporation.
- realize that the powers of a corporation are limited and must be specified in state law and/or the corporate charter.
- understand that the governing board must be actively involved in overseeing the affairs of the company without meddling in management's control of day-to-day operations.
- know the ways to avoid "piercing the corporate veil."

Most institutional providers of healthcare are corporations, and this chapter will focus on the fundamental nature of the corporate form of organization. However, healthcare can also be provided by sole proprietorships and partnerships. In a sole proprietorship, an individual (such as a family physician in solo practice) assumes all possible organizational roles: employer, employee, and owner. The proprietor usually retains any profits, or suffers any losses, and bears the full risks of the enterprise.

A partnership exists if the proprietor is joined by someone who will share in the rewards and risks. Partnerships are governed by state law and by an agreement between the parties,[1] and the parties have great latitude to develop an agreement that will suit their needs.

The simplest kind of partnership is a general partnership. Although this can be changed by agreement, general partners usually receive equal shares of profits or losses, are entitled to equal voting rights, and are personally liable for the debts of the venture.[2] On the death or departure of a partner, the partnership is automatically dissolved, but the business operation does not necessarily end.[3] All owners of a general partnership ordinarily control the business by consensus; however, as the volume of business and the number of partners increase, owners often change the business into a limited partnership or a corporation.

A limited partnership is an organization that provides limited liability to some persons who invest in the organization.[4] It has some of the characteristics of both a general partnership and a corporation with respect to formation, operation, and liabilities.[5] (The characteristics of corporations are discussed later in this chapter.) It requires one or more general partners who have the managerial powers and unlimited liability that "partner" normally implies. Limited partners, on the other hand, have no right to participate in the day-to-day management or control of the business; in return, they are not liable to third-party creditors for the partnership's debts. To create a limited partnership, one files with a designated public official—typically the county recorder or the secretary of state—a certificate containing essential information about the partnership. Typically the certificate must contain:

- the partnership's name,
- the partnership's street and mailing address, and
- the names and business addresses of the general partners.

A joint venture is a special form of partnership created by contract to accomplish an identified, specific purpose—for example, operation of a free health-screening service for the poor. A joint venture will usually exist for a limited period. Each participant will ordinarily share in management; profits and losses will be shared in accordance with the agreement; and liability is unlimited. Two or more corporations may create a joint venture.[6] Joint ventures have become popular in the healthcare industry. The rest of this chapter will focus on corporations, the predominant form of healthcare organization.

Formation and Nature of a Corporation

A corporation is "an artificial being, invisible, intangible, and existing only in contemplation of law. Being the mere creature of the law, it possesses only those properties which the charter confers upon it, either expressly or as incidental to its very existence."[7] (See The Law in Action.)

Accordingly, a corporation is purely a creation of the legislature and can exist only by virtue of a statute providing for its formation and the grant of a franchise ("charter"). In both England and the United States the early corporations were ecclesiastical, educational, charitable, or even governmental in purpose and were usually created by special act of the legislature. (The American Red Cross, for example, is a corporation chartered by the U.S. Congress.)

The modern corporation came into prominence in the latter part of the nineteenth century with passage of state statutes for incorporating businesses. In effect these laws allowed any group of persons (or even a single individual in some states) to incorporate an enterprise for any lawful purpose, as long as statutory requirements are met. These corporation laws eliminated the need for special legislative action each time a corporation was created.

Legislation characterized as "general business corporation acts" provides for the formation and operation of business corporations organized for profit and embracing a wide range of enterprises such as manufacturing, wholesaling, and retailing. Some states have no separate corporate statute for not-for-profit organizations, but most have a not-for-profit corporation statute. Many states also have separate corporation laws governing the creation and operation of particular types of business such as banking; public utilities; and the practice of law, medicine, dentistry, accountancy, and similar professions.

It is important for the executives of a corporation to know the relevant statute under which it is incorporated, because this statute will limit the conduct of the corporation's affairs. The organization has only the powers granted to it by its charter and as specified or implied in the relevant statute. (See the section "Powers of a Corporation" later in the chapter.)

Implicit also in the definition of a corporation is the fact that it is an artificial person or legal entity distinct from the individuals who created, own, or manage it. Accordingly, corporations are usually included in the definition of "person" under constitutions and statutes. For example, the Fifth and Fourteenth Amendments to the U.S. Constitution provide that no "person" shall be deprived of "life, liberty, or property without the due process of law," and the Fourteenth Amendment provides that no state "shall deny to any person...

The Law in Action

A nine-decade-old case from the House of Lords (England's equivalent of the U.S. Supreme Court) alludes to the artificial "personhood" of a corporation:

"A corporation is an abstraction. It has no mind of its own any more than it has a body of its own; its active and directing mind must consequently be sought in the person of somebody who for some purposes may be called an agent, but who is really the directing mind and will of the corporation, the very ego and center of the personality of the corporation."

Thus, the Lords found that the corporation itself was liable for the negligence of its director (see *Lennard's Carrying Co., Ltd., v. Asiatic Petroleum Co., Ltd., 1915* A.C. 705).

the equal protection of the laws." It has long been held that corporations as well as individuals are protected by these fundamental doctrines.

On the other hand, a corporation is not a "person" under state licensure statutes governing the practice of the professions. A corporation, as an artificial person, cannot obtain a license to practice a profession because it cannot possess the educational requirements or meet the standards of personal character required for professional licensure. (This prohibition on corporate licensure must, of course, be distinguished from those statutes that permit licensed individuals to incorporate their practice.) Similarly, a corporation is not a person within the meaning of the Fifth Amendment's protection against self-incrimination because the purpose and intent of the provision applies only to people.

Although a corporation is generally a "person," it is not a "citizen" and thus cannot vote in an election. Thus, a corporation is not protected by the Fourteenth Amendment's provision that "no state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States." Hence, a particular state can require that a corporation incorporated elsewhere pay special taxes, franchise fees, or other fees in return for the privilege of doing business within the state's borders. In other words, a natural person who is a citizen has freedom of mobility from state to state without special restrictions, whereas a corporation does not.

A corporation is a legal entity distinct from those who created it, own it, or are employed by it. Hence, the corporation can acquire, own, and dispose of property (including stock in other corporations) in its own name, and it can sue and be sued. In short, a corporation is an independent entity with rights and responsibilities of its own.

A corporation is formed by filing articles of incorporation with the secretary of state or other designated official of the state in which incorporation is sought. As soon as these are approved by the authorized official, the corporate charter is said to have been issued. Although requirements regarding the proper form of the articles differ somewhat from state to state, the principal information in the articles includes the following items:

- the name of the corporation,
- the address of the corporation's office,
- the name of the registered agent authorized to receive service of process,
- the names and addresses of the incorporators,
- the duration of corporate existence (on which there is usually no limit),
- the purposes of the corporation,
- the names of the initial members of the board of directors, and
- the number and classification of shares of stock (in a profit-making corporation) or the designation of "members" if any (in a not-for-profit organization).

The incorporators are those who prepare, sign, and file the articles of incorporation. Some states require a minimum number of incorporators, but many others permit a single individual to act as the incorporator.[8]

Advantages of the Corporate Form of Organization

There are five principal advantages to incorporation—limited liability, perpetual existence, free transfer of ownership interests, taxation separate from individual income taxes, and the ability to raise capital. Each is discussed below.

1. The primary advantage of incorporation is limited liability. Normally the owners of a corporation are not personally liable for the corporation's contracts or torts. A shareholder of a profit-making corporation is not personally liable, with some few exceptions, for corporate debts beyond the extent of the investment in its stock. The magnitude of this advantage is easily appreciated if one considers how a catastrophic loss can affect a sole proprietor or partner. Limited liability also encourages socially desirable ventures that may otherwise entail an unacceptable risk. Employees are also favored because agents of a corporation are not personally liable for corporate obligations, so long as they act within the scope of delegated authority.
2. The second advantage is perpetual existence. Unlike in a sole proprietorship or partnership, a corporation's continued legal existence and operational capabilities in most instances are not affected by the death or disability of an owner.
3. The third benefit of incorporation is free transfer of ownership interests, (at least if the corporation is organized as a for-profit). Shareholders in the organization can sell their interests to fellow shareholders or the general public (unless special provisions are made and noted on the stock certificates). Free transferability is an important attribute because it increases the liquidity and value of corporate investments. In the case of a not-for-profit corporation, however, state statutes usually provide that membership interests may not be transferred unless the bylaws specifically provide for transferability.[9]
4. The fourth benefit is that a corporation's taxation is separate from individual income taxes. That is, if the corporation has taxable income, the tax liability belongs to the corporation rather than to the individuals. The corporate tax rate is generally lower than the personal income tax, and the persons who own the corporation are taxed only on the distributions of income (dividends) they receive, not on their proportionate shares of the entire corporate profit.
5. The final advantage is that the corporate form has the ability to raise outside capital easier, because third-party investors enjoy limited risks

and an opportunity for reward. In a competitive market, access to equity capital, as distinct from borrowing and creating debt, is a major consideration when undertaking new or expanded ventures.

Powers of a Corporation

A corporation may act only within its corporate authority—that is, it has only those powers that are consistent with the statute under which it is formed and its state-approved charter. The language of the purpose clause in the articles of incorporation is, therefore, extremely important in determining the limits of corporate power.

There are two kinds of powers: express and implied. Express powers are those specifically designated by charter or statute. The relevant statute under which the corporation is formed will enumerate various express powers such as the power to buy, lease, or otherwise acquire and hold property and the power to make contracts to effectuate corporate purposes. Implied powers flow directly from express powers and are the powers to enter into transactions that are reasonably necessary to carry out the express powers. The existence of implied power is generally determined by whether a transaction tends to directly further or accomplish the corporation's purposes and objectives.

Charlotte Hungerford Hospital v. Attorney General, although not involving a typical "corporate charter," illustrates the importance of knowing the limits of corporate power. To read this case, see The Court Decides at the end of this chapter.

Any departure from express or implied corporate power is said to be ultra vires ("beyond the power" of the corporation). Therefore, in planning for the future and in making commitments, the governing body of the corporation must keep a close eye on the corporation's legal authority, and legal advice regarding this issue is of utmost importance. For example, if a not-for-profit corporation makes a donation or transfers assets to another institution for a purpose not included in its own charter, the transfer would be ultra vires.

An ultra vires contract is usually void and can be challenged in a suit for an injunction. In an extreme situation the state could revoke the corporate charter; however, given the ease of amending the articles of incorporation and bylaws, ultra vires problems are relatively rare today.[10] One should note, however, that members of the governing body and corporate officers can be held personally liable for losses suffered by the corporation as a result of an ultra vires transaction in which they acted knowingly or in bad faith. No personal liability will accrue, however, as long as they acted honestly and were simply mistaken in their judgment of the matter.

Transactions that raise the issue of corporate power in healthcare include the following:

- lending credit or guaranteeing the debts of another corporation, because such a transaction would be outside the purpose of a hospital;
- making loans to its corporate trustees, officers, or members;
- forming a partnership with another corporation or an individual; and
- consolidating or merging with another corporation.[11]

These transactions are not necessarily ultra vires, but the corporate authority to enter into them must be verified with legal counsel. (Corporate consolidations and mergers are discussed later in the chapter.)

The doctrine of ultra vires applies to governmental institutions as well as private corporations. For example, the attorney general of Florida ruled that in the absence of an express statutory provision, a county hospital lacked the authority to lease the hospital's facilities to a private corporation.[12] Similarly, a taxpayer in Georgia successfully challenged a public hospital's purchase and operation of a retail store that leased and sold medical equipment to the general public. When affirming the trial court's decision to enjoin the transaction, the Georgia Supreme Court observed that a public hospital may not engage in independent private business enterprises without statutory authority.[13]

Not-for-Profit Corporations

A not-for-profit (aka "nonprofit")[14] corporation is one in which no part of the income or profit of the organization can be distributed for private gain to shareholders, members, directors, trustees, officers of the corporation, or other private individuals.[15] A profit-making corporation is owned by shareholders, who are entitled and expect to receive dividends from the earnings of the corporation and to share in assets should the corporation be dissolved. Not-for-profit corporations, on the other hand, are almost always prohibited by statute from issuing shares of stock. A not-for-profit corporation can, of course, earn income and actually make a profit without sacrificing its not-for-profit status, so long as it uses that profit for institutional purposes. Moreover it can, without question, pay a salary or wage to corporate members, trustees, or other individuals who are actually employees or professional persons rendering actual service. As long as the compensation paid is reasonable, it is not "private gain" that would jeopardize the corporation's not-for-profit status.[16]

In sum, motive is important in determining not-for-profit status. In a not-for-profit institution, motives of ethical, moral, or social purposes predominate and profit is not fundamental to the purpose of the endeavor. But a mere declaration of not-for-profit purpose in a corporate charter is never conclusive if in fact the entity is being used as an alter ego for private gain.[17] For this reason the purpose clause in the articles of incorporation of a not-for-profit corporation is usually quite restrictive. Although a not-for-profit

corporation can be organized for many lawful purposes, the incorporators normally state a specific purpose such as establishing a hospital, a symphony orchestra, or a museum of fine arts.

Not-for-profit status is a necessary first requirement for tax exemption, not only under the federal income tax statutes and regulations[18] but also under the various state statutes providing for taxes on income, real or personal property, and sales.[19] Aside from taxes, many state laws make significant distinctions between regulations governing not-for-profit and business organizations.

A not-for-profit corporation must be distinguished from a charitable corporation. Although charitable status demands not-for-profit status, a not-for-profit corporation need not have a charitable purpose. Many social clubs and similar organizations that provide services exclusively to members are organized and operated as legitimate not-for-profit corporations without being formed for charitable or benevolent purposes. Such corporations, therefore, will not qualify for the tax-exempt status that charitable corporations enjoy.[20]

In addition to the fact that a private business corporation has shareholders entitled to dividends and a not-for-profit corporation does not, there are other significant differences. Not-for-profit corporations may or may not have "members," depending on the provisions of the law under which they are incorporated. Members of a not-for-profit corporation are roughly equivalent to a business corporation's shareholders, but they are not entitled to receive dividends. Like shareholders, however, they hold certain "reserved powers" such as the authority to do the following:

- elect members of the governing body;
- approve merger or dissolution of the corporation;
- amend the articles of incorporation and bylaws, including changing the corporate purpose;
- set the corporate philosophy and mission; and
- adopt annual budgets, unless the board of directors is given this power.[21]

In most states, members must meet at least annually to conduct business. In a corporation without members the board of directors is the sole governing authority, and it has the statutory power to exercise the reserved powers.[22]

Upon the dissolution or merger of a not-for-profit corporation, the assets of the corporation must be distributed in accordance with state law and the provisions of the articles of incorporation. Generally, the assets must be distributed to another corporation with a similar purpose. According to some cases, however, when dissolution occurs, assets acquired by gift are to be

returned to the donor; in others, all assets are held to revert to the state; and in still others, it has been ruled that members of a membership corporation are entitled to the assets in certain circumstances.[23]

Internal Management of a Corporation

Corporate bylaws contain rules for the internal management and governance of the corporation. Unless statutes or the articles of incorporation provide otherwise, the power to adopt and amend bylaws of the corporation lies with the membership or shareholders. In short, the governing body (board of directors or trustees) cannot adopt or amend corporate bylaws unless it has been specifically granted this power in the statute or charter. The bylaws define the rights and duties of the corporate members or shareholders, the powers and responsibilities of the governing body, and the rights and duties of the major corporate officers. Corporate bylaws are an internal document; hence, they need not be filed in any public office or otherwise made available for public inspection (unless state law so requires).

As noted before, certain extraordinary matters normally require the vote of members or shareholders. As noted below, other major powers reside with the governing board. Otherwise, the day-to-day management of the corporation is the responsibility of its chief executive officer and other management staff.

The Governing Board of a Healthcare Institution

The governing body of a healthcare institution has four major functions:

1. Develop policy and strategic plans.
2. Appoint senior administration and medical staff members.
3. Delineate clinical privileges.
4. Oversee the professional performance of both lay administrators and the medical staff.

Committee Structure and Execution of Policy

To fulfill these functions properly, the board must ensure the proper organization of its own committee structure, management committees, and medical staff. For example, the board must be sure that its executive committee is functioning and operating properly in executing board policy between board meetings. This committee must not assume the power to make decisions that are legally reserved to the board as a whole or to the members. Moreover, the executive committee is not permitted to delegate its responsibilities to any individual member of the committee.

In addition to the executive committee, other standing committees typically include the following:

- Finance. The finance committee is given authority for managing and investing hospital funds and for the overall supervision of fiscal policies.
- Buildings and grounds. The buildings and grounds committee generally oversees the physical plant.
- Personnel. This committee develops policies regarding salaries, wages, and fringe benefits for employees.
- Public relations. The public relations (or corporate communications) committee oversees the message being distributed to stakeholders and the general public.
- Education. The education committee recommends training programs for personnel.
- Corporate compliance. This compliance committee ensures that measures are in place to enable compliance with legal standards.
- Medical staff relations. The medical staff relations committee promotes mutual understanding between the lay board and the professional staff.

Each committee's role is to offer recommendations and advice to the governing body, because the ultimate responsibility for all decisions usually remains with the board.[24]

Having set policy for the institution, the board must ensure that committees and management carry it out effectively. The board should not become involved in the details of day-to-day management and operations—these are delegated to the hospital administration and to the medical staff—but it must have mechanisms in place to review performance and hold the corporation's agents accountable. It is basic law that when authority for implementing policy is delegated, the authority can be revoked if performance is unsatisfactory. The board must not abdicate its responsibilities by delegating responsibilities and not monitoring their execution. Accordingly, all corporate officers and the medical staff are in fact subordinate to the board.

As previously noted, the corporate bylaws govern the board's structure and the administration of the hospital, control internal operations, and provide for management of corporate property. The bylaws define the powers, duties, and limitations of the board's responsibilities, always of course in accord with state incorporation statutes. In addition to corporate bylaws, the board is empowered to adopt bylaws for its own government. Special bylaws, rules, and regulations govern and control the organization of the hospital's professional staff, its officers and committee structure, and its functions. These medical staff bylaws and subsequent amendments to them must be approved by the board of trustees and are incorporated by reference as part of the corporate bylaws.

Composition and Meetings of the Board

The board's size is determined by the articles of incorporation or bylaws. Some states require a minimum number of board members, usually three, while others allow as few as one board member.[25] In a membership type of not-for-profit corporation, the members of the corporation ordinarily elect the members of the governing body. Most statutes permit a nonmember of the corporation to be elected to the board. In a not-for-profit corporation without members, the board itself may select new members. This is called a "self-perpetuating" board. In some situations, such as in a state or county hospital, a public official or body may appoint board members. Terms of office and qualifications of the members of the board will be determined by charter or bylaw provisions drafted in accordance with statutory requirements. For example, local statutes may require that trustees be of majority age and that a certain number of trustees be residents of the state of incorporation.[26] (See The Law in Action.)

The Law in Action

A West Virginia licensing statute requires that at least 40 percent of the members of governing boards of both local governmental and not-for-profit hospitals be composed of "consumer representatives." These are individuals in small businesses, members of labor organizations, elderly persons, and low-income persons. Each of these groups is entitled to equal representation on each board. Women, members of racial minorities, and the handicapped are to be given special consideration when appointments or nominations are made for board membership. The statute may be enforced by an action for a court injunction initiated by any citizen or the state department of health.[27]

The West Virginia statute was enacted primarily to help control healthcare costs. There has been no subsequent evidence, however, that the presence of consumer representatives on healthcare organizations' boards has had an effect on reducing healthcare expenditures.

A special election may be called to fill sudden vacancies on the governing board, and directors can be removed from their posts for legal cause or justification. Generally this must be done by those possessing the power of election. To put the matter another way, the governing board of a not-for-profit membership corporation may not usually vote to remove a member of the board unless the statutes, charter, or bylaws provide for such action.[28] Depending on the circumstances and local statute, the removal of a board member sometimes requires court action or action of the state's attorney general. Regardless of who has the power of removal, the individual who is subject to the proceeding has a right to due process of law—a statement of the reasons of removal and an opportunity to hear and challenge evidence and cross-examine witnesses. One who has been the subject of an improper removal may bring an action in court for reinstatement.[29]

Members of the governing board usually cannot be paid or compensated for their services on that body unless local statutory law permits the corporate charter or bylaws to provide for compensation. The rule is particularly relevant

to not-for-profit corporations because of the fundamental doctrine that members and trustees of such an institution must not derive any personal financial gain from the corporation. Hence, salaries to board members or special financial benefits, such as a discount for hospital services rendered to board members and their families, are usually improper even if local corporate law would otherwise authorize such payments. This prohibition, of course, excludes salary paid to a corporate officer who is also a voting member of the board. For example, most healthcare organizations place the chief executive officer on the board; this individual could be paid a reasonable salary for her executive services, although she may not participate in the board action that establishes the salary. Similarly, a hospital attorney who sits on the board may be paid reasonable fees.[30]

In managing the affairs of the corporation the board must act in a properly constituted, formal meeting. Independent action by one or even a majority of board members does not bind the corporation. Except for regular meetings provided for in the articles of incorporation or corporate bylaws, proper notice of a meeting must be given to each board member, usually in writing. Unless such notice is given, the meeting is invalid, except that if all members have actually attended the meeting, it can be said that they have waived the notice requirement. Even so, decisions made at a casual, unannounced gathering of the board may be ineffective. If the statutes permit, meetings can be held by teleconference; otherwise, members must attend in person.[31]

A written record (minutes) should be made of the action taken at each meeting of the board. Members who object to any proposed action should make certain that their dissents are noted in the record. The frequency of meetings depends on provisions in the charter or bylaws and on particular circumstances. Unless the local statutes, charter, or bylaws provide otherwise, the choice of the place of the board meeting may be at the discretion of the board. Meetings may even occur outside the state of incorporation, as long as the place selected is reasonably convenient.

The charter or bylaws will fix the number of board members necessary for a quorum. In the absence of a provision, the rule is that a quorum is a simple majority of the board and that a majority vote of those voting on an issue is sufficient to bind the corporation. Members of the board may not vote by proxy in the absence of a specific statutory or bylaw provision because each member has a fiduciary duty to attend meetings personally and to exercise independent judgment.[32]

Note that the foregoing general principles of corporate law are reflected in the Hospital Accreditation Standards published by the Joint Commission.

Duties of the Governing Board

As previously pointed out, directors or trustees of a corporate entity are not agents or employees of the corporation. They are not personally liable for

corporate debts and contracts, and they are not personally liable for the torts committed by corporate employees.[33] In these matters, the corporation itself is the responsible party. (But if employees commit a tort within the scope of their employment, both the corporation as the employer and the person who committed the tort are liable to the injured third party.)

Notwithstanding these general principles of corporate law, members of the governing board can sometimes be personally liable for failure to carry out their fiduciary duties properly (see Legal Brief). The term "fiduciary" means simply that one is in a position of great trust and confidence and has rights and powers to be exercised solely for the benefit of others. The members of the governing board of a profit-making enterprise owe their fiduciary duties to the corporation and the stockholders. In a not-for-profit corporation the duties are owed to the corporation and its members, if any, and in some cases to the community at large.

Legal Brief

Members of the governing board of charitable corporations are frequently called "trustees." Strictly speaking, however, they are not trustees because a trustee is vested with the title to property that is held and managed for the benefit of others. In a corporation the title to property is vested in the corporation itself. Under trust law the duty of a trustee is generally higher than the duty of a member of the governing body of a corporation. For example, the trustee of a trust may be liable for poor business judgments in the management of the property held for the beneficiaries' benefit. A governing board member, however, will generally be held liable only for actual negligence, willful disregard of duty, or wrongful acts.

Hospital board members' duties can be listed a number of ways. For teaching purposes, I usually list eight:

1. Act with loyalty and due care.
2. Protect hospital property.
3. Avoid self-dealing and conflicts of interest.
4. Establish and oversee hospital strategic goals.
5. Select the chief executive officer.
6. Select a qualified medical staff.
7. Supervise the quality of medical care.
8. Establish operating budgets.

These specific duties can probably be boiled down to two: loyalty and responsibility.

Duty of Loyalty

The duty of loyalty means that the individuals must put the interests of the corporation above all self-interest (a principle based on the idea that "no one can serve two masters"). Specifically, no trustee is permitted to gain

any secret profits personally, to accept bribes, or to compete with the corporation.[34]

The duty of loyalty also raises the question of whether a director can personally contract with the corporation. Can directors, for instance, sell supplies or services to the hospital? The answer is "yes," if certain high standards are met. A director or trustee may usually contract with the corporation if the contract is fair, if full disclosure of all personal interest is made, and if utmost good faith is exercised.[35] The director should never vote on or participate in the discussion of the transaction, either directly or through an agent. Competitive bidding should be used to establish the fairness of the contract. The burden of proving the fairness of a contract and disclosing self-interest is always on the individual director, and the court will closely scrutinize the transaction if the matter is challenged. It is, therefore, riskier for a director to buy from a hospital and then resell at a personal profit than to sell personal property or services to the institution at fair market value.[36] A contract with a governing board member that does not meet the aforementioned standards is not void, but it is voidable. [37]

There may be specific state statutes pertaining to board members' contracts with the corporation they serve.[38] In a governmental hospital, state law may prohibit all transactions between a board member and the corporation, even if full disclosure is made and the contract is fair. Whenever members of a governing board wish to contract with the corporation they serve, it follows that they must seek careful legal advice based on local law.

In addition to making certain that the letter of the law is followed, every hospital should have and should follow conflict-of-interest policies. Each board member must be required to file a written declaration of possible conflicts of interest and disclose gifts, gratuities, and lavish entertainment offered by companies doing business with the hospital.

Duty of Responsibility

The fiduciary duty of responsibility means that members of the hospital governing board must act with due care in every activity of the board. Good faith and honesty are the major tests in determining whether due care has been exercised. This is the same standard of care imposed on the director of a business corporation.[39]

The first word in "act with due care" is act. The directors of a hospital corporation must actually direct the company. It is not enough that they merely preserve corporate property as caretakers; they must use corporate property to achieve corporate objectives. Directors must, therefore, attend meetings of the board and actively participate in decisions.

Included in the duty of responsibility is the idea that directors and trustees must exercise reasonable care in selecting and appointing the chief

executive officer and other corporate agents, such as outside legal counsel.[40] They must also use reasonable care in supervising the agents whom they appoint and in holding them accountable, and they have a duty to remove a chief executive officer or other agent whom they know (or should know) is incompetent.

There is also a duty to use reasonable care in appointing individuals to the medical staff. Case law now makes it clear that a corporate duty exists to restrict clinical privileges or to terminate an appointment when the board knows or should know of incompetence on the part of a medical staff member.[41] That is, there is corporate liability when the board knew of professional malpractice or when it should have known this from the management and medical staff departments charged with reviewing each staff physician's clinical performance.

Board members may rely on written, documented reports and recommendations from responsible professional sources such as medical staff committees, hospital accountants, and legal counsel. They need not personally verify all items in these reports if nothing arouses suspicion or question,[42] but there is a liability risk if they fail to obtain professional advice when there is an apparent problem—for example, if they fail to obtain competent legal counsel when the hospital has a recognizable legal issue.

In general, board members are not personally liable for honest errors in business judgment. This is consistent with the standard applicable to the directors of for-profit corporations and means simply that board members must exercise the judgment that reasonably prudent directors or trustees would be expected to exercise under similar circumstances. (An example of the lack of honest business judgment that could render a member of a governing board personally liable is permitting institutional funds to remain in a bank that the member knew or ought to have known was in financial straits.[43])

Stern illuminates the kinds of responsibilities board members carry and the difficulties that can arise when they are not adhered to. (See The Court Decides: *Stern v. Lucy Webb Hayes National Training School for Deaconesses and Missionaries* at the end of this chapter for an example of these responsibilities not being met.) As you read this case, remember that the facts occurred nearly 50 years ago. For this reason, the sanctions the court meted out are mild compared to what would be ordered if a board today abdicated its responsibilities in the way the Sibley Memorial Hospital's board did many years ago.

Protection Against Liability

In general, personal liability of hospital directors is not a serious financial risk so long as they regularly attend board meetings, vote personally, avoid conflicts of interest, and exercise utmost good faith and honesty in conducting the corporation's affairs. The best means of establishing good faith and honesty is a written record of all the board's deliberations, including the

votes of individual trustees on individual transactions. Any member who dissents from majority action of the board should, therefore, make sure that the dissent is part of the written record.[44]

Individual trustees and corporate officers have two means of protecting themselves: (1) purchasing liability insurance and (2) making sure that the corporation has appropriate indemnification provisions to protect board members if they suffer any personal loss because of exercising their (good faith) board responsibilities.

Because insurance may be expensive and not sufficiently comprehensive, many not-for-profit corporations favor indemnification plans or a combination of insurance and indemnity. Insurance for directors and officers may, for example, exclude coverage for gross negligence, for intentional acts, and for criminal activity. Indemnification means that if a trustee faces a civil suit alleging violation of fiduciary responsibilities or is prosecuted in a criminal action, the individual may be repaid by the corporation for personal expenses, including attorney's fees and perhaps even amounts paid as a result of the action. The hospital may in turn purchase insurance covering the costs of indemnification.

Most state laws authorize a corporation to provide for indemnification.[45] Many such statutes apply to directors and officers of the corporation, and frequently they apply to both civil and criminal actions. Thus, depending on local and state law, the trustees and officers have the right to indemnification under certain circumstances. On this matter, careful legal advice is necessary to ensure that the governing body understands the circumstances under which indemnification can and cannot be provided. It is also imperative that the corporate charter or bylaw provisions covering this matter be drafted with the utmost care.

Some statutes—those in New York, for example—are exclusive; that is, a corporation can have an indemnification agreement with its governing board and officers only to the extent precisely authorized by statute.[46] Most statutes, however, are permissive so that corporations may indemnify to a greater extent than the statutes provide. Delaware's is a prototype of this model.[47] In general, the statutes authorize indemnification plans for legal actions brought against trustees and officers by stockholders or by members on behalf of the corporation as well as for actions by third parties.

Responsibilities of Management

In one sense this entire book involves the responsibilities of management. A group of people known as "management" runs the day-to-day operations of the corporation (under the overall guidance of the governing board, of course.) All the topics covered in this text are important for managers to keep in mind as they discharge their duties.

Management comes from the Latin "manu agere"—to lead by the hand. The literal translation may strike a discordant note to twenty-first century ears. We prefer to think of ourselves as "leaders" who set goals and empower others to reach them, not people driving a team of oxen. But the fact remains that the job of management (or leadership, if you prefer) is to get things done through people.

Management is an art. Like art, it is hard to define. From Adam Smith and John Stuart Mill in the nineteenth century through Frederick Winslow Taylor, Henri Fayol, and Peter Drucker in the twentieth century, many have tried to define management in scientific terms. All have failed to some degree. But no matter how one describes management, clearly it is that function of an organization concerned with setting a goal (strategy), creating an action plan (tactics) to achieve those goals, measuring outcomes, and reassessing the strategy and tactics based on the outcomes.

In a healthcare organization, management functions begin with the senior administration (from the Latin "administratio," a compound of ad [to] and ministratio [serve]; the word is also the source of "minister"). Senior administrative positions include, by whatever title, the chief executive officer, vice presidents, and department directors. Their responsibilities include the following duties:

1. Support the governing board in its strategic planning and policymaking activities.
2. Carry out (implement, administer, execute) the board's policies and strategic goals.
3. Communicate board policies and the strategic plan to employees and the medical staff.
4. Oversee day-to-day hospital operations.
5. Measure the quality of patient care.
6. Manage operating funds.
7. Select qualified junior executives.
8. Conduct necessary business transactions.

Management must report regularly to the governing board on the status of all these activities.

The Independent Hospital and Reasons for Change

For many years the corporate model of a hospital was that of a single legal entity—one corporation with a governing board—providing acute care for medical and surgical patients. All activities permitted by the corporate charter, including those not directly related to the care of patients, were conducted by the single entity, more often than not a tax-exempt, not-for-profit corporation.

We now see that there are disadvantages to remaining a stand-alone hospital corporation. For example, if the hospital corporation governs all activities of whatever kind, all those activities are subject to the laws that affect hospitals. Among these are tax laws and, where they still exist, laws requiring certificates of need for capital improvements and major changes in services.[48] Stand-alone hospital corporations are also limited in their ability to diversify and change their service lines. (Hospital charters may limit the corporate purpose to inpatient care and directly related activities.)

For a quarter century (or more) hospitals have asked themselves, "What business are we in?" Historically the answer was essentially, "We are in the business of providing doctors with a building, equipment, and supplies for them to treat people who have acute illnesses." Over time, however, the answer has become,

> We are a team of people who work together to improve the health and quality of life of the individuals and communities we serve.

This is obviously a far different vision, and it requires not only different leadership skills but a different corporate structure as well. The new vision—a focus on promoting health rather than simply treating illness—involves activities that are alien to a traditional hospital corporation. Therefore, the single corporate hospital entity is less and less common, and the landscape is now populated with reorganized corporations that are better suited to the new image of what healthcare is all about. As noted in the next section, corporate reorganization (restructuring) takes several forms, with the particular form determined by the needs of each situation.

It cannot now be disputed that healthcare in the United States has been transformed from a professional service to a giant industry. Beginning in the 1980s these factors led to a huge number of corporate reorganizations (and re-reorganizations) to enable corporations to do the following:

- add new service lines,
- maximize revenues,
- reduce costs,
- grow market share,
- partner with physicians or other organizations, and
- obtain freedom from governmental regulation (to the extent possible).

A multiorganizational system can diversify the system's operations and can engage in a wide range of activities that a single institution cannot undertake, because subsidiary entities can provide special services or perform functions not related to healthcare without being hampered by certificate-of-need regulations, restrictive corporate law, and third-party reimbursement regulations.

Multi-institutional Systems and Corporate Reorganization

"Multi-institutional system" and "corporate reorganization" are generic terms, and no single definition, model, or form exists that describes either concept. The term "system" has been applied to agreements to affiliate or to share services, consortiums of healthcare institutions, leases, contract-management arrangements, and chains of institutions formed via consolidations, mergers, or acquisition of assets. Each of these relationships has quite different legal implications. Thus, the term "system" can apply to a mere contractual agreement at one extreme and to integrated corporate ownership and managerial control at the other. In any event, formation of a system is a linking together of existing or new legal entities and services.

The American Hospital Association once defined a system as two or more acute care hospitals that are owned, leased, or contract-managed by a corporate office. This definition is outdated. Many systems now include skilled nursing facilities, extended care facilities, ambulatory care centers, outpatient surgical centers, owned physician practices, home health agencies, managed care plans, and other health-related organizations. (See Figure 4.1 for a view of a possible multi-institutional healthcare system.)

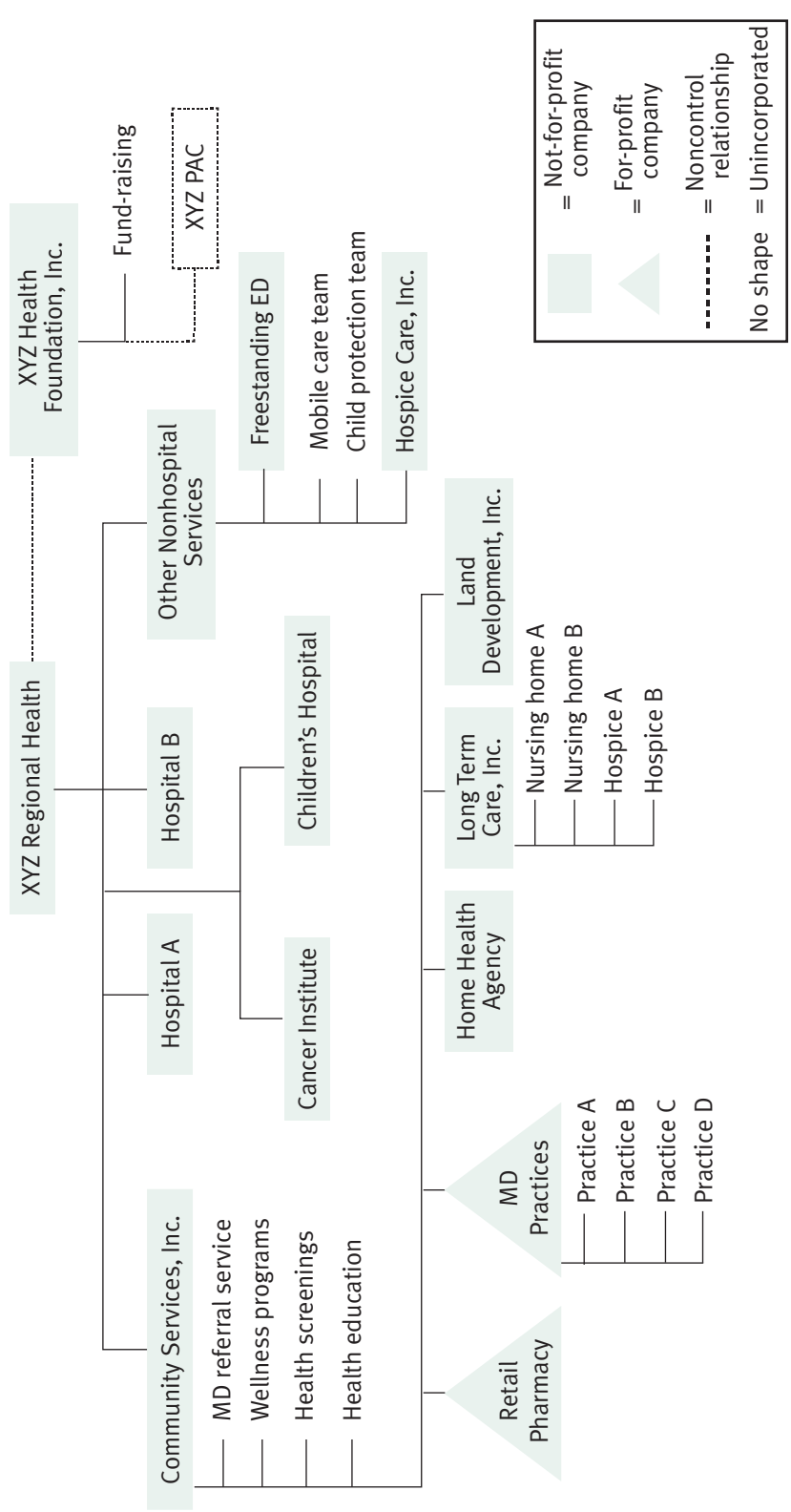
Systems may be not-for-profit, proprietary (for-profit), or a combination of both types. For example, a not-for-profit system corporation may own both not-for-profit and for-profit subsidiary corporations. A system may also be owned and managed by state or local government.

Whether composed of multiple corporate entities or a single corporation with multiple divisions, all multi-institutional systems have a corporate office responsible for those activities that are best performed in a centralized manner, thus providing efficiency and economies of scale. Some of the kinds of functions that are commonly performed at the "corporate" level include the following:

- finance,
- billing,
- legal,
- compliance,
- human resources and recruiting,
- protective services (security),
- health information management,
- strategic planning,
- education
- risk management,
- quality assurance,
- engineering,
- housekeeping, and
- food service.

Some healthcare observers once suggested that multi-institutional systems use resources less efficiently than independent hospitals do, earn lower rates of return on investment, and sometimes charge inpatients higher room rates.[49] If not run wisely, the cost of supporting a corporate office may be a burden on an organization's resources, and the allegiance of individual hospitals may shift from the local community to the system at large in such a way that

FIGURE 4.1
XYZ Regional Health System Organization Chart



unneeded services are offered or local services are inadequate. Independent hospitals should engage in a careful study of all relevant factors and probable outcomes before they make a commitment to form or join a multi-institutional system.

Nevertheless, the multi-institutional system is now well entrenched in the healthcare environment, and a quarter century of experience shows that they are likely to remain on the landscape for many decades to come.

Piercing the Corporate Veil

As we now know, a corporation is a legal entity that has its own rights and responsibilities separate and distinct from its owners. It is a convenient legal fiction, and because it can limit legal and financial liability it has been an invaluable vehicle for encouraging investment in both for-profit and not-for-profit activities. On the other hand, if a corporation is used to "defeat public convenience, justify wrong, protect fraud, or defend crime," the law will disregard the corporate fiction and place liability on the owners of the corporation.[50] This is known as "piercing the corporate veil." Most of the litigated cases in which the corporate veil has been pierced have concerned closely held corporations or corporate parent–subsidiary relationships.

For a court to pierce the corporate veil, three elements must normally be proved by the party challenging corporate existence:

1. There was complete domination of the corporation by its owner(s).
2. Control of the corporation was used by the owner(s) to commit fraud or perpetrate a wrong, violate a statutory or other duty, or commit a dishonest or unjust act.
3. Corporate control was the proximate cause of the injury that is the subject of the suit.[51]

The burden of proving all three elements is on the party that is challenging corporate existence. Although as early as 1910 the U.S. Supreme Court noted a growing tendency to look beyond corporate form, courts remain reluctant to do so.[52] Accordingly, as a general rule all three elements must be proved to the satisfaction of the trier of fact (the judge or the jury, as appropriate).[53]

Complete domination of the corporation means domination of finances, business practices, and corporate policies to such an extent that the entity has no mind or will of its own.[54] Mere directorship of the corporation by a sole shareholder entitled to corporate profits is not enough to justify piercing the veil. Courts look, on a case-by-case basis, for unity of interest and ownership sufficient to destroy the separate identities of the owner or owners and the corporation. Evidence of this unity is found in such facts as:

- mingling of corporate assets with the owner's personal funds;
- neglect of business formalities such as filing separate tax returns, holding regular meetings of the board of directors, and keeping adequate corporate minutes;
- having a mere "paper" corporation with nonfunctioning officers and directors listed in the articles of incorporation; and
- insufficient capitalization of the corporation.[55]

The decision whether to disregard the corporate fiction, however, will not rest on a single factor. Courts will most often look for several factors suggesting that the corporation and owner should be treated as one and the same.[56] *United States v. Healthwin-Midtown Convalescent Hospital*[57] is a good example. Defendant Zide owned half of the stock of Healthwin, a convalescent center that provided skilled nursing care in return for payments from Medicare. Mr. Zide also had a 50 percent interest in a partnership that held title to both the real estate occupied by Healthwin and the furnishings of the nursing home. Concluding that the nursing home had been overpaid, the government brought suit against Healthwin and against Mr. Zide himself for the amount of the alleged overpayment. Mr. Zide defended the claim against him on the basis that the debt was solely the corporation's and that he was entitled to limited liability.

In rejecting his defense the court noted these factors:

- Mr. Zide alone controlled the corporation's affairs.
- He was a member of the board, the president of the corporation, and the administrator of the nursing facility.
- He alone signed corporate checks without concurrence of another corporate officer.
- The board of directors did not meet regularly.
- Mr. Zide failed to maintain an arm's-length relationship with the corporation by permitting Healthwin's funds to be "inextricably intertwined" with his personal accounts and other business transactions.
- The corporation was seriously undercapitalized, having liabilities consistently in excess of $150,000 with an initial capitalization of only $10,000.
- Mr. Zide diverted corporate funds to the detriment of creditors.[58]

In the court's opinion, these facts made it clear that Mr. Zide used the corporation to accommodate his personal business dealings. The court held that to allow him to escape liability in these circumstances would be unfair to his creditors (including Medicare). Accordingly, Mr. Zide was found personally liable for the amount due the federal government because the corporation was a mere alter ego of its principal shareholder.[59]

In addition to the various factors showing a unity of interest and ownership strong enough to outweigh the separate identity of the corporation, for the corporate veil to be pierced limited liability must result in an inequity. An inequitable result is often found when a statutory duty has been violated or fraud or other wrongful action has been perpetrated. (See The Court Decides: *Woodyard, Insurance Commissioner v. Arkansas Diversified Insurance Co.* at the end of this chapter for another case that illustrates judicial application of the doctrine.[60])

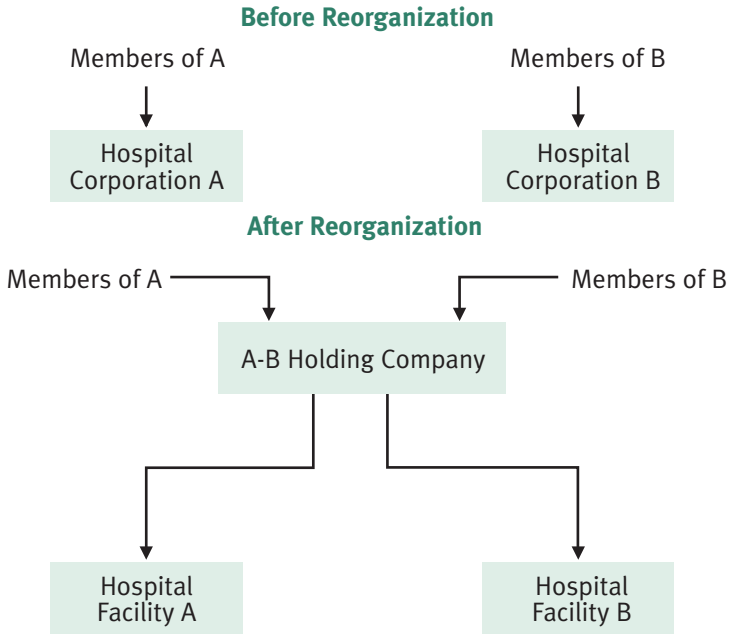
Alternative Strategies: Sale, Consolidation, and Merger

To effect cost savings, some institutions find it advantageous to sell assets or stock to another corporation or to consolidate or merge with other entities. The sale of a corporation's assets is a relatively straightforward transaction, except that local law must be followed carefully when the seller is a charitable corporation. Normally the governing boards of both the buyer and the seller must approve the terms of the sale. The stockholders or members of the selling corporation must also approve the sale, because selling all or a substantial portion of assets constitutes an extraordinary transaction beyond the authority of the board acting alone.[61] After the sale is completed, the selling corporation may dissolve and cease doing business or may continue to operate on a more restricted scale. If the seller is a charitable corporation, many local laws require that a designated state officer approve the final arrangement, because the state has the ultimate responsibility of enforcing terms of the charitable trust.

In a merger, one corporation is absorbed by the other and ceases to exist. A consolidation (see Figure 4.2), in contrast, is a transaction that creates a new corporation comprising two or more existing companies, both of which then dissolve.[62]

Before engaging in a merger or a consolidation, each party must carefully scrutinize state corporation law; certificate-of-need legislation; if applicable, the state and federal statutes relevant to charitable organizations; and perhaps other regulatory requirements. Normally the governing boards of the corporations involved and the shareholders or any members or shareholders with voting rights must approve the plan. If an acquired corporation has issued tax-exempt bonds, the terms of the bond documents may require approval of the bondholders. The plan to merge or consolidate will, of course, contain a comprehensive explanation of the terms and conditions of the proposal. When the interested parties approve the plan, articles of merger or consolidation are prepared and filed with the appropriate state officer responsible for enforcing the relevant corporate law, who then issues a certificate authorizing the transaction. Once this is issued, the new corporation owns all the property of those entities that no longer exist, has all their rights and privileges, and is also liable for all their debts.[63]

FIGURE 4.2
Corporate Consolidation



Consolidations and mergers of existing institutions frequently benefit the community at large and the institutions involved. Such arrangements not only improve the ability of a previously independent unit to diversify but also enable the surviving corporation to provide a wider range of services, improve quality assurance and risk management, and have greater economies of scale to reduce healthcare costs. On the other hand, if market power is significantly increased, the merger or consolidation may invite charges that it violates antitrust laws. The antitrust aspects of asset acquisitions, consolidations, and mergers are thoroughly discussed in Chapter 11.

Joint Ventures with Physicians

In today's competitive, cost-conscious environment healthcare institutions and physicians' organizations often wish to develop contractual or business arrangements with each other to share risk and reap economic rewards. Cooperative arrangements between healthcare institutions and physician organizations usually take the form of joint ventures, although they are sometimes incorporated. A joint venture is a mutual endeavor by two or more legal entities for a specific, single purpose and for a limited duration. A joint venture is thus one way of integrating two or more business organizations. In a true joint venture most of the rules of a general partnership normally apply:

- The parties have created more than a contractual relationship and owe fiduciary duties to each other.
- Each party has a right to participate in management.
- Property is owned jointly.
- Profits and losses are shared according to an agreement.
- Each participant has unlimited liability to third parties.

A joint venture differs from a general partnership, however, in that its participants are not agents of each other.[64]

In healthcare the term "joint venture" has been used more broadly to refer to a variety of legal relationships between institutional providers of care and physicians who have in many cases formed a corporation or a group practice. For example, the term may simply denote a contractual agreement between two legal entities, or a stock corporation created by physicians and others, or a limited partnership distinct from a general partnership. The participants may enter a contract with another or create a partnership or a corporation for a number of reasons:

- to diversify their activities,
- to provide new or additional services to the community,
- to seek capital from interested investors,
- to maximize their reimbursement from Medicare and other governmental healthcare programs, and
- to gain tax benefits.

Joint ventures are usually formed for one purpose only. For example, a hospital and a physician organization may establish a joint venture to

- provide ambulatory, surgical, or emergency care to outpatients;
- create a health maintenance organization;
- own and manage a nursing home, medical office building, clinical laboratory, laundry service, or home health service; or
- conduct utilization reviews.

In joint ventures the hospital and the physicians share the rewards and the risks while contractually agreeing on matters of ownership, control, and management. This preference for risk sharing has been stimulated by a number of factors, primarily changes in Medicare reimbursement rules. Although physicians decide treatments and the patients' length of stay, hospitals receive a fixed, predetermined amount based on diagnosis. There are, therefore, good reasons for the hospital to share its financial risks with physicians. The latter also find merit in a joint venture because the growth of health maintenance organizations, preferred provider organizations, and group medical

practices, coupled with the excess number of physicians in some parts of the country, have substantially reduced the attractiveness of solo practice. In short, the theory is that physicians can gain competitive advantages by joining together with healthcare institutions.

For what purpose and in what context (e.g., antitrust or tax laws) must legal advice be sought? Physicians, healthcare executives, and their respective counsel need to analyze carefully both the business arguments and the legal reasons for undertaking a particular venture before embarking on it. A complete legal analysis of each form of venture is beyond the scope of this text, but some of the tax implications of a joint venture are mentioned in Chapter 10, and the antitrust aspects of various forms of joint action are analyzed in Chapter 11. Of unique importance is the possible effect of federal statutes (the "antikickback laws") that prohibit certain agreements concerning remuneration for medical services or the use of facilities.

As noted in Chapter 12, federal law makes bribes, kickbacks, and rebates illegal whenever medical services or goods are to be paid for by a federal health program.[65] Joint ventures must, therefore, be closely scrutinized to make certain that a provider's economic benefits are related to substantive financial risks and not simply a payment intended to induce referrals of business. Clearly, the substance rather than the form of an agreement will determine the outcome of a given case. Designating a payment, for example, as a "consulting fee" when in reality it is a payment for referral of patients will not save the transaction from being considered illegal.

Another consideration is the prohibition of physician referrals to healthcare organizations in which the physician holds a "financial interest."[66] Known as the Stark self-referral law (named after its sponsor, Rep. Fortney "Pete" Stark of California), this statute is intended to remove the incentive to overuse healthcare services and thus drive up the cost of federal healthcare programs. It provides for fines and exclusion from Medicare and Medicaid participation if physicians violate its complicated provisions. A joint venture between a healthcare organization and a physician or physician group may create a financial relationship that will trigger the self-referral statute.

In summary, joint ventures must be carefully designed and implemented. The participants in a venture must be certain that they have legitimate business reasons for adopting their agreement, that the terms comply with commonly accepted business practices, and that the venture does not increase the cost of federal or state healthcare programs.

Chapter Summary

This chapter reviews the basic concepts of corporation law, including a corporation's "personhood," its ability to shield owners from personal liability,

the foundations of corporate power, and the duties of a corporation's governing board. The concept of "piercing the corporate veil" and the various reasons for and methods of restructuring a healthcare corporation are also explored in the chapter. The powers of a corporation are limited by state corporation law and the company's organizing documents (the "corporate charter"). Healthcare executives must be aware of those powers and must assist the governing board to accomplish corporate objectives within their limits.

Chapter Discussion Questions

1. Why is a corporation considered an "artificial person" under the law? What are the consequences of this concept?
2. Describe the advantages of incorporation, as opposed to being organized as a partnership.
3. Where does one look to find the powers of a corporation?
4. What are the functions and responsibilities of the governing board of a healthcare corporation?
5. Why is the concept of "piercing the corporate veil" important to any corporation and its subsidiaries?

Notes

1. Forty-nine states and the District of Columbia have adopted the Uniform Partnership Act (U.P.A.). Louisiana is the only state that has not adopted the U.P.A. 6 U.L.A. 1 (Supp. 1986) (table of jurisdictions).
2. See, generally, Bromberg, A. R. 1968. *Crane and Bromberg on Partnership* (1968) [hereinafter cited as Crane and Bromberg]. Personal liability of the owners is one of the most significant differences between partnerships and corporations.
3. Unif. Partnership Act § 31 (4), 6 U.L.A. 394 (1969). See Crane and Bromberg, supra note 2, at 432–34; Reuschlein, H. G., and W. A. Gregory. 1979. *Handbook on the Law of Agency and Partnership,* 368–70 [hereinafter cited as Reuschlein and Gregory].
4. Nineteen states and the District of Columbia have adopted the Uniform Limited Partnership Act of 1916, and 30 states have adopted the Revised Uniform Limited Partnership Act of 1976. Louisiana is the only state that has not adopted either act. 6 U.L.A. 151, 201 (Supp. 1986) (These are tables of jurisdictions that have adopted the 1916 and 1976 acts).
5. See, generally, Crane and Bromberg, supra note 2, at 143–51; Reuschlein and Gregory, supra note 3, at 433–38.
6. See, generally, Crane and Bromberg, supra note 2, at 189–95; Reuschlein and Gregory, supra note 3, at 441–46.
7. Trustees of Dartmouth College v. Woodward, 17 U.S. (4 Wheat) 518, 636 (1819).
8. See, generally, Henn, H. G., and J. R. Alexander. 1983. *Laws of Corporations and Other Business Enterprises* [hereinafter cited as Henn and Alexander].
9. Id. at 130–32.
10. An ultra vires transaction should be distinguished from an illegal act. The latter is an absolutely void transaction; an example would be employment by the hospital of an unlicensed professional person. Tovar v. Paxton Memorial Hosp., 29 Ill. App. 3d 218, 330 N.E.2d 247 (1975)—a

physician licensed in Kansas but not licensed in Illinois could not maintain an action for an alleged breach of an employment contract with an Illinois hospital.

11. See, generally, Oleksy v. Sisters of Mercy, 92 Mich. App. 770, 285 N.W.2d 455 (1979)—a private charitable hospital has statutory authority to convey its assets to another not-for-profit private hospital; the transaction is not ultra vires.
12. 82 Op. Fla. Att'y Gen. 44 (1982).
13. Tift County Hosp. Auth. v. MRS of Tifton, Ga., Inc., 255 Ga. 164, 165, 335 S.E.2d 546, 547 (1985) (quoting Keen v. Mayor of Waycross, 101 Ga. 588, 29 S.E. 42 (1897).
14. The terms "not-for-profit" and "nonprofit" are synonymous. I prefer the former, however, because it emphasizes the essential point that the purpose of such a corporation is not to make a profit even though it may, and usually does, do so.
15. See, generally, Oleck, H. L. 1980. *Non-Profit Corporations, Organizations and Associations,* 4th ed., § 3 [hereinafter cited as *Non-Profit Corporations*].
16. For example, the Michigan statute specifically states that a not-for-profit corporation "may pay compensation in a reasonable amount to shareholders, members, directors, or officers for services rendered to the corporation." Mich. Comp. Laws. Ann. § 450.2301(3)(a).
17. See *Non-Profit Corporations*, supra note 15, at 4. The author states: "Motive is the acid test of the right to nonprofit status, in most cases. When altruistic, ethical, moral, or social motives are the clearly dominant ones in an enterprise, that enterprise is nonprofit. Obviously, it is difficult to test for human motives in an enterprise. Abuse of nonprofit status, however, often is best tested by testing the motives of the organizers or officers of nonprofit organizations." Id. at 22.
18. See I.R.C. § 501 (1985); see also *Non-Profit Corporations*, supra note 15, at § 281. (This contains general discussion of applicable federal tax code provisions.)
19. See Jordan. 1977. "Trends in Tax Exemption," ABA-ALI *Trends in Nonprofit Organization Law* § 11.
20. Charitable status is reviewed and explained in Chapter 10.
21. Typically members vote on such decisions as those to merge or dissolve the corporation; amend articles and bylaws; appoint the chief executive officer; adopt budgets; and establish corporate philosophy, mission, and values.
22. The reserved powers will be set forth in the not-for-profit corporation law and the articles of incorporation.
23. See, generally, *Non-Profit Corporations*, supra note 15, at 383–84. Generally, distribution problems arise in charitable organizations. Not-for-profit organizations that are not charitable generally distribute their free assets to members or, in some cases, transfer those assets to another organization depending on distribution procedures set up in their articles or bylaws.
24. There may be some exceptions to this general rule. For example, regarding the actual investment of financial resources, some states' incorporation statutes may authorize the corporate charter or bylaws to provide that investment of funds may be delegated by the board exclusively to the finance committee, thereby removing possible liability from other board members for improper investment. Investment of funds, however, must be distinguished from application of funds for hospital purposes. The board must always carry the responsibility for the latter on its own shoulders.
25. See, for example, Ohio Rev. Code Ann. § 1702.27 (A)(1) (page 1985). The Ohio Non-Profit Corporation Statute states: "The number of trustees as fixed by the articles or the regulations shall not be less than three or, if not so fixed, the number shall be three." See, for example, Mich. Comp. Laws Ann. § 450.2505 (1) (West Supp. 1986). The statute states: "The Board shall consist of 1 or more directors. The number of directors shall be fixed by or in the manner provided by the bylaws, unless the articles of incorporation fix the number."
26. For example, a California statute prohibits anyone who owns stock or has any property interest in a private hospital or is a director or officer of a private hospital from serving as a director or officer of a public hospital servicing the same area. Cal. Health & Safety Code § 32110 (West 1973 and Supp. 1986). Accordingly, in Franzblau v. Monardo, 108 Cal. App. 3d 522, 166 Cal. Rptr. 610 (1980), the president of a not-for-profit private hospital was prohibited from serving as a director of the public hospital district.

27. W. Va. Code § 16-5B-6a (1985).
28. For example, the Ohio law permits a trustee of a not-for-profit corporation to be removed from office by any procedure that is provided for in the articles of incorporation or the bylaws. The remaining trustees may then fill any vacancy on the board by majority vote for the unexpired term, unless the articles or bylaws provide otherwise.
29. State ex rel. Welch v. Passaic Hosp. Ass'n, 59 N.J.L. 142, 36 A. 702 (1897)—the director cannot be removed from office without fair notice and the opportunity to be heard.
30. See, generally, Henn and Alexander, supra note 8, at §§ 243–45. In a very few states, however, the statutes for not-for-profit corporations are so worded that they seemingly prohibit members of the governing body from receiving any compensation, making no distinction between ordinary and extraordinary services. In such jurisdictions salaried officers may not be able to sit as voting members of the governing board.
31. See, for example, Mich. Comp. Laws Ann. § 450.2521(3) (West Supp. 1986).
32. See, generally, Henn and Alexander, supra note 8, at § 209.
33. Hunt v. Rabon, 275 S.C. 475, 272 S.E.2d 643 (1980)—trustees of the hospital were not personally liable when a patient died as result of crossed oxygen and nitrous acid gas lines; see, generally, Henn and Alexander, supra note 8, at § 234.
34. With respect to the duty of loyalty, see Patient Care Services, S.C. v. Segal, 32 Ill. App. 3d 1021, 337 N.E.2d 471 (1975)—a corporate officer and director who actively engaged in a rival and competing business to the detriment of a corporation must answer to the corporation for injury sustained. The defendant physician was an officer and director of the professional service corporation bringing the charge. He had established another professional service corporation to perform identical medical planning services for a hospital client, thereby attempting to seize an opportunity due the plaintiff corporation.
35. 18B *Am. Jur.* 2D, "Corporations," § 1736 (1985).
36. See Henn and Alexander, supra note 8, at § 238.
37. In Gilbert v. McLeod Infirmary, the sale of hospital property to a corporation controlled by Mr. Aiken, a hospital trustee, was voided even though there was no actual fraud and in spite of the fact that Aiken had refrained from discussing the matter and had not voted on the transaction. However, the attorney for Aiken, who was also a member of the board, had favorably discussed the sale and voted in favor of the proposal. Moreover, Aiken had failed to carry his burden of proof to show fair and adequate consideration for the sale of the property. 219 S.C. 174, 64 S.E.2d 524 (1951).
38. See, for example, Wyo. Stat. Ann. § 17-6-104 (1977) and Md. Health-General Code Ann. § 19-220 (1982).
39. The Michigan Corporation and Non-Profit Corporation Acts provide, for example, that a director shall discharge the duty of responsibility "in good faith and with that degree of diligence, care, and skill which an ordinarily prudent person would exercise under similar circumstances in a like position." Mich. Comp. Laws Ann. §§ 450.1541 (1), 450.2541 (1) (West 1973 and Supp. 1986); see also Cal Corp. Code §§ 309(a), 5231(a), 7231(a), 9241(a), 12371(a) (West 1977 and Supp. 1986); Conn. Gen. Stat. Ann. § 33–447 (d) (West Supp. 1986).
40. See Reserve Life Ins. Co. v. Salter, 152 F. Supp. 868 (S.D. Miss. 1957).
41. See text and cases discussed in chapters 5 and 7.
42. State statutes generally specify what items a trustee may rely on in discharging duties. See, for example, Mich. Comp. Laws Ann. § 450.2541 (1) (West Supp. 1986)—a director may rely on "opinion of counsel for the corporation, upon the report of an independent appraiser selected with reasonable care by the board, or upon the financial statements of the corporation represented to the director or officer to be correct...."
43. See Epworth Orphanage v. Long, 207 S.C 384, 36 S.E.2d 37 (1945); see also Queen of Angels Hosp. v. Younger, 66 Cal. App. 3d 359, 136 Cal. Rptr. 36 (1977)—there was an improper exercise of sound business judgment or breach of fiduciary duties when the board of a not-for-profit charitable corporation compromised a $16 million claim by a religious order for past services rendered to the hospital by members of the order. The settlement agreement provided that the hospital should pay the motherhouse $200 per month for each

Sister in the Order older than 70 years of age, whether or not the particular sister had performed services at the hospital, plus $200 per month "for each lay employee who had worked for the congregation for over 20 years, not to exceed ten lay employees at any one time." Although the claim was made in good faith and was not dishonest, the agreement was invalid and constituted a diversion of corporate assets, because there was no lawful obligation on the part of the hospital to pay for past services.

44. For example, a Michigan statute provides that board members are presumed to have concurred in a board action unless their dissent is entered in the minutes. Further, directors who are absent from meetings are presumed to have concurred with any board action unless they file a dissent with the secretary. Mich. Comp. Laws Ann. § 450.2553 (West Supp. 1986).
45. See, for example, Id. at §§ 450.2561, .2562, .2563.
46. N.Y. Not-for-Profit Corp. Law § 721 (McKinney 1970); N.Y. Bus. Corp. Law § 721 (McKinney 1986). The statute provides that no provision to indemnify directors or court-awarded indemnification "shall be valid unless consistent with this article." See also N.Y. Not-for-Profit Corp. Law §§ 722–26 (McKinney 1970 and Supp. 1986) and N.Y. Bus. Corp. Law §§ 722–26 (McKinney 1986)—permissible indemnification provisions.
47. Del. Code Ann. tit. 8, § 145(f) (1983). The statute provides: "The indemnification provided by this statute shall not be deemed exclusive of any other rights to which those seeking indemnification may be entitled under any bylaw, agreement, vote of stockholders...."
48. The certificate-of-need (CON) program was established by the National Health Planning and Resource Development Act of 1974. CON required approval for acquisition of major medical equipment and expansion of clinical health services. See U.S.C. § 300m-6 (1982). States were compelled to administer this program via State Health Planning and Development Agencies or face loss of federal health allocation funds. Persons were compelled to comply with this law on penalty of fine, loss of license, or enjoinment from further activity. See 42 C.F.R. § 123.408 (1985). The federal health planning program was terminated in 1986, although a significant number of states continue to have CON programs. CON approvals are usually costly, time consuming, and, to some extent, political, which works to the detriment of small, independent hospitals. See, generally, Hamilton. 1985. "Barriers to Hospital Diversification: The Regulatory Environment," 24 *Duq. L. Rev.* 425, 428–32 (Symposium: Current Developments in Health Law).
49. Zuckerman. 1979. "Multi-Institutional Systems: Promise and Performance." *Inquiry* 16: 291.
50. Fletcher, W. 1983. *Cyclopedia of the Law of Private Corporations*, § 41 [hereinafter cited as Fletcher].
51. Id. at § 43.10; see also Lowendahl v. Baltimore & Ohio R.R., 247 A.D. 144, 287 N.Y.S. 62, aff'd, 272 N.Y. 360, 6 N.E.2d 56 (1936).
52. J.J. McCaskill Co. v. United States, 216 U.S. 504, 515 (1910).
53. But see Church of Scientology v. Blackman, 446 So. 2d 190 (Fla. App.), reh'g denied, 456 So. 2d 1181 (1984); Dania Jai–Alai Palace, Inc. v. Sykes, 425 So. 2d 594 (Fla. App. 1983), aff'd in part, rev'd in part, 450 So. 2d 1114 (1984). In a succession of Florida appellate cases, the courts had held that total domination, by itself, justified piercing the corporate veil. However, on appeal of Dania Jai–Alai Palace, the Florida Supreme Court held that the corporate veil could "not be pierced absent showing of improper conduct." 450 So. 2d 1114, 1121 (Fla. 1984). Thus, the almost universal rule that all three factors must be present to pierce the corporate veil.
54. See Fletcher, supra note 50, § 43.10.
55. "In a sense, faithfulness to these [corporate] formalities is the price paid for the corporate fiction, a relatively small price to pay for limited liability." Labadie Coal Co. v. Black, 672 F.2d 92, 97 (D.C. Cir. 1982).
56. See Jabczenski v. Southern Pac. Memorial Hosp., 119 Ariz. 15, 579 P.2d 53 (1978)—mere existence of interlocking directorates between a not-for-profit and a for-profit corporation was insufficient to justify disregarding the corporate identities.

57. 511 F. Supp. 416 (1981), aff'd, 685 F.2d 448 (1982).
58. Id. at 419.
59. Id. at 420.
60. 268 Ark. 94, 594 S.W.2d 13 (1980).
61. See Henn and Alexander, supra note 8, at § 341; see, for example, Mich. Comp. Laws Ann. §§ 450.1753, 450.2753 (West 1973 & Supp. 1986).
62. See, generally, Henn and Alexander, supra note 8, at § 346.
63. See, for example, Mich. Comp. Laws Ann. §§ 450.1701-.1722, 450.2703–.2722 (West 1973 and Supp. 1986); see, generally, Henn and Alexander, supra note 8, at § 346.
64. See, generally, Henn and Alexander, supra note 8, at § 49.
65. 42 U.S.C. § 1395nn(b) (Medicare), § 1396n(b) (Medicaid) (1982).
66. Similarly, in Komanetsky v. Missouri State Medical Ass'n, 516 S.W.2d 545 (Mo. Ct. App. 1975) the Missouri State Medical Association was held to have implied power to join with the Missouri Association of Osteopathic Physicians and Surgeons to form an independent corporation for the purpose of conducting reviews of quality assurance and cost reviews of services rendered by physicians. Compare Queen of Angels Hosp. v. Younger, 66 Cal. App. 3d 359, 136 Cal. Rptr. 36 (1977)—in which a charitable corporation formed to maintain and operate a hospital could not lease its premises, abandon hospital operations, and devote proceeds of the lease to operate medical clinics in low-income areas, regardless of the worthy purpose of the clinics, because this would constitute a violation of the hospital's articles of incorporation.

THE COURT DECIDES

Charlotte Hungerford Hospital v. Attorney General
26 Conn. Supp. 394, 225 A.2d 495 (1966)

MacDonald, J.

The plaintiff in this action for a declaratory judgment is a nonstock corporation which for many years has owned and operated a voluntary general hospital in a complex of buildings located on a 120-acre tract of wooded land about one mile from the center of the city of Torrington. The land was acquired under a deed of trust providing that the premises thus conveyed "are to be held and used by said grantee for the purpose of maintaining and carrying on a general hospital and, if a majority of corporators so elect, a training school for nurses in connection therewith may be established, and for no other purpose whatsoever." The deed of trust in question, executed in 1917, specifically provided that "if the land herein granted shall cease to be used for the [stated] purposes, title...shall thereupon pass to and vest in said town of Torrington...to be used forever as a public park." *[A state statute later chartered the hospital subject to the "terms, conditions, restrictions and provisions" of the deed of trust.]*

Plaintiff [now wants to erect] a medical office building on the hospital grounds [because it] would be of great convenience and advantage both to the individual doctors and to the hospital....

.... [However,] various questions have arisen with respect to the right, power and authority of plaintiff, under the terms of said deed of trust and special act, to proceed with such a project.... The specific questions which the court is requested to answer...are (a) whether plaintiff is authorized...to construct and operate, as an integral part of its general hospital complex, a medical office building for members of its medical staff; (b) whether such a medical office building may, under the terms of the aforesaid deed of trust, be located on a portion of the land held by plaintiff thereunder; (c) whether...the plaintiff is authorized and empowered to lease...a portion of the land included in the aforesaid deed of trust [to a subsidiary corporation that will operate the medical office building]; [and] (d) whether, in addition to offices and office suites for members of plaintiff's medical staff, said building may contain facilities related to or supporting such offices and suites, such as medical laboratories, pharmacies and dispensaries.

The court, after hearing the evidence and the arguments of counsel with full participation by counsel representing the only interested parties, namely, the attorney general of the state of Connecticut, as representative of the public interest in the protection of trusts for charitable uses...has no hesitation in answering all four of the questions posed in the affirmative. It is clear...that the proposed project would materially aid the plaintiff in more efficiently carrying out the stated purposes of the trust deed under which it was founded.... It is equally clear from the extremely impressive testimony of [the president of the American Hospital Association and another witness] that the modern trend is almost universally toward the practice of having nonprofit hospitals provide physicians' private offices for rental to staff members, either in the hospital buildings themselves or on the hospital grounds....

The language of the deed of trust is to be construed in light of the settlor's purpose.

And reasonable deviations and expanded interpretations must be made from time to time in order to keep pace with changes in recognized concepts of the proper sphere of general hospital operations.... Such deviations are recognized by our Connecticut courts even though the elements for applying cy pres principles are not present.

A decree may enter advising plaintiff of its rights, powers and authority herein by answering the four questions propounded in the affirmative.

Charlotte Hungerford Hospital v. Attorney General Discussion Questions

1. Why is the state attorney general the defendant?
2. What is a "settlor"?
3. What are "cy pres" principles?
4. How does this case enhance your understanding of the limits of corporate power?

THE COURT DECIDES

Stern v. Lucy Webb Hayes National Training School for Deaconesses and Missionaries
381 F. Supp. 1003 (D. D.C. 1974)

[This is a class action in which patients of Sibley Memorial Hospital, known officially by the name shown, challenged various aspects of the hospital's management and governance. The defendants were certain members of the hospital's board of trustees and the hospital itself. For a summary of the differences between trustees of a trust and directors of a corporation, see the discussion in this chapter.]

Gesell, J.

The two principal contentions in the complaint are that the defendant trustees conspired to enrich themselves and certain financial institutions with which they were affiliated by favoring those institutions in financial dealings with the Hospital, and that they breached their fiduciary duties of care and loyalty in the management of Sibley's funds....

[The court explains that the hospital was begun by the Methodist Church–related Lucy Webb Hayes School in 1895 and eventually became the school's main activity.]

In 1960...the Sibley Board of Trustees revised the corporate by-laws.... Under the new by-laws, the Board was to consist of from 25 to 35 trustees, who were to meet at least twice each year. Between such meetings, an Executive Committee was to

represent the Board [and in effect had full power to run the hospital]....

In fact, management of the Hospital from the early 1950's until 1968 was handled almost exclusively by two trustee officers: Dr. Orem, the Hospital Administrator, and Mr. Ernst, the Treasurer. Unlike most of their fellow trustees, to whom membership on the Sibley Board was a charitable service incidental to their principal vocations, Orem and Ernst were continuously involved on almost a daily basis in the affairs of Sibley. They dominated the Board and its Executive Committee, which routinely accepted their recommendations and ratified their actions. Even more significantly, neither the Finance Committee nor the Investment Committee ever met or conducted business from the date of their creation until 1971, three years after the death of Dr. Orem. As a result, budgetary and investment decisions during this period, like most other management decisions affecting the Hospital's finances, were handled by Orem and Ernst, receiving only cursory supervision from the Executive Committee and the full Board.

[It was only after the deaths of Dr. Orem and Mr. Ernst (in 1968 and 1972, respectively) that other trustees began to assert themselves and exercise supervision over the financial affairs of the hospital. At that point, it became known that over the years "unnecessarily large amounts of [Sibley's] money" had been deposited in accounts bearing little or no interest at banks in which trustees had a financial interest. At the same time, the hospital bought certificates of deposit that paid lower-than-market rates and took out loans with interest rates higher than the interest rates being paid on funds deposited.

Because there was no evidence that the trustees, other than Orem and Ernst, had ever actually agreed to engage in or profit from these activities, the court found insufficient evidence to prove a conspiracy among them. The court then proceeds to discuss the allegations of breach of fiduciary duty.]

III. Breach of Duty.

Plaintiffs' second contention is that, even if the facts do not establish a conspiracy, they do reveal serious breaches of duty on the part of the defendant trustees and the knowing acceptance of benefits from those breaches by the defendant banks and savings and loan associations.

A. The Trustees.

Basically, the trustees are charged with mismanagement, nonmanagement and self-dealing. The applicable law is unsettled.... [H]owever, the modern trend is to apply corporate rather than trust principles in determining the liability of the directors of charitable corporations, because their functions are virtually indistinguishable from those of their "pure" corporate counterparts.

1. Mismanagement.

.... Since the board members of most large charitable corporations fall within the corporate rather than the trust model, being charged with the operation of ongoing businesses, it has been said that they should only be held to the less stringent corporate standard of care. More specifically, directors of charitable corporations are required to exercise ordinary and reasonable care in the performance of their duties, exhibiting honesty and good faith.

2. Nonmanagement.

.... A corporate director...may delegate his [sic] investment responsibility to fellow directors, corporate officers, or even outsiders, but he must continue to exercise general supervision over the activities of his delegates. Once again, the rule for charitable corporations is...the traditional corporate rule: directors should at least be permitted to delegate investment decisions to a committee of board members, so long

as all directors assume the responsibility for supervising such committees by periodically scrutinizing their work.

Total abdication of the supervisory role, however, is improper even under traditional corporate principles. A director who fails to acquire the information necessary to supervise investment policy or consistently fails even to attend the meetings at which such policies are considered has violated his fiduciary duty to the corporation. While a director is, of course, permitted to rely upon the expertise of those to whom he has delegated investment responsibility, such reliance is a tool for interpreting the delegate's reports, not an excuse for dispensing with or ignoring such reports....

3. Self-dealing.

Under District of Columbia Law, neither trustees nor corporate directors are absolutely barred from placing funds under their control into a bank having an interlocking directorship with their own institution. In both cases, however, such transactions will be subjected to the closest scrutiny to determine whether or not the duty of loyalty has been violated.

....

.... Trustees may be found guilty of a breach of trust even for mere negligence in the maintenance of accounts in banks with which they are associated while corporate directors are generally only required to show "entire fairness" to the corporation and "full disclosure" of the potential conflict of interest to the Board.

Most courts apply the less stringent corporate rule to charitable corporations in this area as well. It is, however, occasionally added that a director should not only disclose his interlocking responsibilities but also refrain from voting on or otherwise influencing a corporate decision to transact business with a company in which he has a significant interest or control.

[The court goes on to point out that the hospital board had recently adopted the American Hospital Association's policy guidelines that essentially imposed the standards described above: (1) a duality or conflict of interest should be disclosed to other members of the board, (2) board members should not vote on such matters, and (3) the disclosure and abstention from voting should be recorded in the minutes.]

...[T]he Court holds that a director...of a charitable hospital...is in default of his fiduciary duty to manage the fiscal and investment affairs of the hospital if it has been shown by a preponderance of the evidence that

(1)...he has failed to use due diligence in supervising the actions of those officers, employees or outside experts to whom the responsibility for making day-to-day financial or investment decisions has been delegated; or

(2) he knowingly permitted the hospital to enter into a business transaction with himself or with any [business entity] in which he then had a substantial interest or held a position as trustee, director, general manager or principal officer [without disclosing that fact]; or

(3) except [with disclosure], he actively participated in or voted in favor of a decision...to transact business with himself or with any [business entity] in which he then had a substantial interest or held a position as trustee, director, general manager or principal officer; or

(4) he otherwise failed to perform his duties honestly, in good faith, and with a reasonable amount of diligence and care.

Applying these standards to the facts in the record, the Court finds that each of the defendant trustees has breached his fiduciary duty to supervise the management of Sibley's investments....

[In conclusion, the court noted that the plaintiffs pushed for strict sanctions against the various defendants: the removal of certain board members, the cessation of all business transactions with their related firms, an accounting of all hospital funds, and awards of money damages against the individual defendants. But the court declined to adopt these rather severe measures.

The court points out the factors that it considered significant: (1) the defendant trustees are a small minority of the board, whereas all board members were in some way guilty of nonmanagement; (2) the defective practices have been corrected, and those who were most responsible for them have either died or been dismissed; (3) the defendants did not profit personally from the transactions; (4) the defendants will soon leave the board because of age, illness, or the completion of a normal term; and (5) this is essentially the first case in the District of Columbia to discuss these issues comprehensively, and thus no clear legal standards previously existed.

For these reasons, the court declines to remove the defendants from the board, to assess money damages, or to take other more severe actions. Instead, it requires new policies and procedures to make certain that all present and future trustees are aware of the requirements of the law and that they fully disclose all hospital transactions with any financial institutions in which they have an interest or position.]

Stern v. Lucy Webb Hayes National Training School for Deaconesses and Missionaries Discussion Questions

1. If this case were decided today—more than three decades later—would the outcome have been the same? If so, how?
2. As the chief executive officer or board member of a not-for-profit hospital corporation, what measures would you put in place to prevent a repeat of the activities that led to the lawsuit involved here?
3. How would you summarize the duties of board members based on the holding in this case?

THE COURT DECIDES

Woodyard, Insurance Commissioner v. Arkansas Diversified Insurance Co.
268 Ark. 94, 594 S.W.2d 13 (1980)

Hickman, J.

The appellant is Arkansas Insurance Commissioner W. H. L. Woodyard, III. The appellee is Arkansas Diversified Insurance Company (ADIC).

ADIC sought a certificate of authority from Woodyard to sell group life insurance to Blue Cross and Blue Shield...subscriber groups. Woodyard denied the application. On appeal, his decision was reversed by the Pulaski County Circuit Court as being arbitrary and not supported by substantial evidence. We find on appeal [that] the circuit court was wrong and [we] reverse the judgment. We affirm the commissioner.

The only evidence before the commissioner was presented by ADIC. The appellee candidly admitted it was a wholly owned subsidiary of a corporation named Arkansas Diversified Services, Inc. (ADS) which is a wholly owned subsidiary of Blue Cross and Blue Shield, Inc.

....

ADIC candidly admitted it was created solely to serve Blue Cross customers. It would provide services that could not otherwise be provided by law....ADS wanted its own life [insurance] company to better compete in the market place.

Blue Cross owns all the stock of ADS, which in turn owns all the stock of ADIC. The president of Blue Cross is the president of both ADS and ADIC. Other Blue Cross officials hold positions in ADS and ADIC. The companies use the same location and similar stationery. ADIC will use Blue Cross employees to sell insurance. Underwriting for ADIC will be done by a division of ADS.

There was no real controversy over the commissioner's findings of fact. He concluded that:

(2) That [Arkansas law] would apparently authorize a hospital and medical service corporation [of which Blue Cross is one] to invest in a wholly owned subsidiary insurance corporation with the Commissioner's consent.

(3) That Blue Cross is limited by [law] to transact business as a non-profit hospital and medical service corporation.

(4) That ADIC is not a separate corporate entity from Blue Cross since Blue Cross through ADS owns all the capital stock of ADIC. ADIC has common Officers and Directors with Blue Cross, Blue Cross pays the salary for the Officers and employees of ADIC, ADIC will sell its products only to Blue Cross subscriber groups and the record indicates that ADIC is to be treated as a division of Blue Cross. The evidence indicates that ADIC's management will not act independently but will conduct the affairs of ADIC in a manner calculated primarily to further the interest of Blue Cross.

....

The commissioner found that since Blue Cross could not sell life insurance itself, it should not be able to do so through corporate subsidiaries. We find that decision neither arbitrary nor unsupported by substantial evidence.

....

We agree with the commissioner's finding that [Arkansas law] limits the power of medical corporations to providing medical service. If it did not, they could not only sell life insurance, but automobiles or anything else. Clearly, an insurance company organized under a charter or statute

empowering it to sell one kind of insurance lacks authority to sell another.

The appellees argue that even if the commissioner was right in ruling Blue Cross could not market its own life insurance policies, Blue Cross could...invest in a wholly owned subsidiary which would [have that power]. The statutes, however, provide that such an investment can be made only with the commissioner's consent....

Blue Cross is a tax exempt, non-profit corporation enjoying a financial advantage over conventional insurers. Allowing it to sell, through subsidiaries, its own life insurance policies, could be unfair to competitors. While the commissioner did allow Blue Cross to invest in ADS, we can see why he disapproved of ADIC. ADS unlike ADIC, could sell only policies written by insurance companies which lacked the competitive advantages of Blue Cross.

The appellee argues the commissioner arbitrarily pierced the corporate veil of these subsidiaries.... [C]ourts will ignore the corporate form of a subsidiary where fairness demands it. Usually, this will be where it is necessary to prevent wrongdoing and where the subsidiary is a mere tool of the parent. We believe both criteria were met here....

Blue Cross, through its president and other officials, candidly admitted why they wanted ADIC to sell insurance. Blue Cross can, through its total control of both subsidiaries by stock, officers and directors, direct all efforts and endeavors of ADIC, and collect all profits.

We cannot say the commissioner was wrong in piercing the corporate veil or in denying the application. The facts are clearly there to support his findings. This order is not contrary to law.

Reversed.

Woodyard, Insurance Commissioner v. Arkansas Diversified Insurance Co. Discussion Questions

1. How does a Blue Cross health plan fall under the definition of a "hospital and medical service corporation"?
2. What is the function of that type of corporation in the healthcare system? (Note: other states assign different names to them.)
3. What differences in this factual situation might have led to a different outcome in the case?

CHAPTER 5

LIABILITY OF THE HEALTHCARE INSTITUTION

After reading this chapter, you will

- know that most healthcare institutions began as religious works of mercy and that, as such, they were usually immune from liability for any negligence they might commit.
- understand that the concept of "independent contractor" is nearly irrelevant today in the world of healthcare malpractice.
- realize that under "respondeat superior" the corporation is responsible through the acts of an agent, whereas under "corporate liability" it owes a duty directly to the plaintiff.
- learn that managed care organizations are under financial pressure to minimize the amount of acute care service their enrollees receive.

Although most basic tort principles still apply, the liability of healthcare institutions differs from that of the individual clinician. This is so because, obviously, institutions are not human beings; they are organizations created by law and/or society to achieve stated goals through collective human effort.

The history of healthcare institutions begins with the almshouses of the Middle Ages—pits of misery and horror for the poor and the insane. Before the nineteenth century, almshouses had little to do with medical care and more to do with housing unfortunates and keeping them away from "respectable" society. They were religious—mainly Christian—charities and (as their name implies) were supported by donated money and services. The fact that church groups (Catholic religious orders, notably) sponsor so many of today's hospitals is a vestige of this history.

Given their charitable character, hospitals—and other organizations, the purpose of which was to relieve poverty, advance education and religion, and serve similar community needs—were held to be immune from tort liability lest their good deeds be diminished by jury awards. Some courts

adopted this position because they considered the assets of a charitable corporation to be held in trust for its beneficiaries and feared that the trust would be violated by payment of money damages. Others held that the beneficiaries of a charity (including the general public) impliedly waived their rights to sue when accepting the benefits of charitable services. Still others based the rule simply on concepts of public policy, specifying that tort liability should apply only to a profit-making enterprise.[1]

Whatever the rationale supporting immunity for charitable hospitals, the reasons for the demise of the doctrine grew out of the transformation of healthcare that began after the U.S. Civil War, and it had virtually disappeared by the 1960s. The public's perception of hospitals as charitable organizations gradually changed.[2] Health plans and governmental programs (rather than alms) paid for operational expenses; liability insurance was available to cover defense costs and jury awards; and healthcare more readily adopted the traits of market-driven industries. The understanding grew that these "not-for-profit" enterprises should be treated in the same manner as other companies so far as third-party liability claims were concerned. Thus, charitable immunity was overturned in a series of state-by-state judicial decisions once the justification for immunity dissolved. (It should be noted, however, that even today governmental hospitals still enjoy immunity or partial immunity in some jurisdictions. This is the result of "sovereign immunity," rather than charitable immunity as discussed in Chapter 3.)

After the decline of charitable immunity, healthcare became one of the most dramatically changing areas of personal injury law. This chapter reviews important legal theories that have affected traditional hospital-liability principles in the last few decades, including:

- the erosion of independent contractor status,
- the concepts of apparent agency and agency by estoppel,
- the decline of the captain-of-the-ship and borrowed-servant doctrines, and
- the doctrine of corporate liability.

We begin with a refresher course in the traditional rules of respondeat superior, proceed to address the factors mentioned, and end with a section on the liability of a relatively new form of healthcare institution—the managed care organization.

Respondeat Superior Versus Independent Contractor Status

The duty of a healthcare institution (here referred to as a hospital from now on) is to have its employees use the same reasonable level of care as that practiced in

similar hospitals in similar communities.[3] Patients are entitled to the care that their conditions require.[4] To prove a breach of this duty the plaintiff must usually produce expert testimony about how similar clinicians and hospitals treat this kind of case.[5] Miraculously the plaintiff's experts will testify that other hospitals or other doctors would treat the condition differently. The defense will call witnesses who will say, "Oh, no! What the [doctor/nurse/hospital] did was perfectly reasonable." The battle of the experts is on, and the jury will be asked whom to believe.

Sometimes expert testimony is not required. It is not necessary when the situation involves routine or nonprofessional care, such as helping a patient to the bathroom or out of a wheelchair.[6] This applies also when a physician's order is violated[7] or when common sense makes the breach of duty apparent.[8] In those kinds of cases, expert testimony is not required and laypersons are capable of determining that reasonable care was not exercised. (See The Court Decides: *Norton v. Argonaut Insurance Co.*, at the end of this chapter. In this case all parties—hospital, physician, and nurse—were held liable for a fatal medication error that common sense indicates was avoidable.)

When liability is asserted on the basis of respondeat superior, essentially three questions are asked:

1. Was a tort committed?
2. Was the person who committed the tort an agent or an employee of the defendant?
3. Was the tort committed within the scope of the agent's or employee's duties?

As noted in Chapter 3, respondeat superior—also known as vicarious liability—means that an employer is liable for a tort that an employee commits within the scope of employment. It is based on the principle, "qui facit per alium, facit per se"—that is, the one who acts through another, acts in his own interests. Thus, the employer answers vicariously for the employee's negligence (even though the employer is not directly at fault) because the employer controls the means and methods of the employee's work and benefits from her actions. (Presumably the imposition of liability encourages the employer to apply sound procedures for controlling employees' job performance.)

Holding the employer vicariously liable is based on public policy considerations. The employer usually has insurance coverage or superior financial means to compensate for the damage caused by the employee's tort. Besides, a corporation can act only through agents and employees. Not holding the organization liable for its employees' actions would mean that the company would not be responsible for decisions taken and acts committed in furtherance of institutional aims. Of course, the employee who committed the tort can also be held liable for the wrongful act or omission; therefore, the

employer and the employee are often sued together. (The employer is usually the main target because of its "deep pockets.")

Because respondeat superior is based on the employer's right to control the means and methods of the employee's work, it follows that the employer is not vicariously liable for the negligence of an independent contractor. By definition an independent contractor is one who has sole control over the means and methods of the work to be accomplished, although the person who employs, hires, or appoints a contractor retains the general power of approval over the final result of the work. For example, if a person hires an independent contractor to build a house, the homeowner provides the plans and retains the power to approve the final result but does not control the day-to-day activities of the builders—that is the responsibility of the contractor. In effect, the owner says, "Here's what I want built. Go do it, and tell me when you're done."

In the field of hospital liability, a physician in private practice who is a member of the medical staff has traditionally been considered an independent contractor. Accordingly, the hospital has not been liable to the patient for the malpractice or negligence of the physician. There are numerous cases to this effect.[9] For example, in a Michigan case, *Heins v. Synkonis*, the hospital was not held liable when a private physician saw the patient in the hospital facility, and the hospital merely provided facilities for the doctor's outpatient clinic.[10] The absence of either an actual or apparent employment relationship led to the conclusion that the hospital was not liable for the alleged negligence of the independent contractor doctor.

Erosion of Independent Contractor Status

Heins was decided more than 30 years ago. In recent years courts have eroded independent contractor status as a defense. They have expanded the doctrine of respondeat superior and have found an employment (or employment-like) relationship in situations where none would have been found previously. This phenomenon is the result of such factors as the following:

- An increasing number of patients no longer select their own physicians; rather, the hospital, an employer, or some other third party designates the doctor or a panel of doctors.
- Patients use hospitals' emergency services more frequently. It is common for a private physician to tell the patient to go to the emergency department outside normal office hours. "Meet me at the ER" has morphed into "The ER docs will take care of you."
- Healthcare institutions have increased the number of employed physicians on their staffs and in their clinics.

- Medical practice has become increasingly institutionalized and specialized.
- The number of contracts with hospital-based specialists has increased dramatically.

As these developments occur, respondeat superior expands. As respondeat superior expands, the independent contractor defense shrinks.

Employment of Physicians

Payment of a salary or wage to an employed physician clearly justifies the application of vicarious liability principles. Even a physician on a part-time salary is considered an employee of the institution. In *Niles v. City of San Rafael*, a part-time salaried director of a hospital pediatrics department was negligent in making only a cursory examination of a head injury and in sending the patient home with incomplete instructions for continued observation.[11] The doctor's negligence resulted in delayed diagnosis of intracranial bleeding and permanent brain damage. The hospital was held liable even though the physician, before being called to examine the patient, was in the hospital emergency department seeing a private patient and thus was not serving as an employee at the time.

The hospital will also be liable for the negligence of interns, residents, and nurses performing their customary functions on behalf of the institution. As long ago as 1957 the New York Court of Appeals, in the landmark case of *Bing v. Thunig*, eliminated the distinction between administrative and medical acts and settled the issue of whether the professional status of an employee prevented the imposition of vicarious liability.[12] An oft-quoted passage from *Bing* reads:

> The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility no longer reflects the fact. Present day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and interns, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of "hospital facilities" expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.[13]

Both the administrative and medical personnel of teaching hospitals must be particularly alert to the duties owed to patients with respect to the role of resident physicians and interns. Clearly these persons are employees, and the hospital is liable for negligent acts committed within the scope of their employment.[14]

Doctrine of Apparent Agency

Even though they are not technically hospital employees, many physicians—such as anesthesiologists; radiologists; pathologists; and specialists in emergency medicine, nuclear medicine, and other clinical fields—have contracts with hospitals to provide specific services to hospital patients. Although to the average person they seem like employees, their contracts frequently state that the physicians hold independent contractor status. Thus, hospitals have frequently asserted the defense of "independent contractor" in cases of alleged liability arising from the professional practice of the specialists.

Legal Brief

If the principal's conduct would lead a reasonable person to believe that the agent was authorized to act on behalf of the employer, the person is entitled to rely on this apparent (or ostensible) agency relationship. If a principal creates the impression (implies) that an agent is authorized when in truth he is not, the third parties are protected so long as they have acted reasonably. This latter situation is sometimes termed "agency by estoppel," and the principal will be estopped (barred) from denying the grant of authority if the third parties have relied on the representations made. The two concepts—apparent agency and agency by estoppel—are so close in meaning that they are virtually indistinguishable for practical purposes.

This defense has not been too successful. The doctrine of apparent agency (which is sometimes termed "ostensible agency" and is similar to "agency by estoppel") has often been used to defeat the independent contractor defense (see Legal Brief).

In the healthcare setting, the essential elements of an apparent agency or an agency by estoppel are as follows:

- Patients have been invited by the hospital to use the services of medical specialists; indeed, many times the patient has no choice but to use the specialists furnished by the hospital.
- A full-service hospital holds itself out as providing the complete range of medical care, including all of the generally recognized specialties.
- Patients rely on these representations.
- This reliance justifiably permits them to consider the specialists as employees or as an integral part of the hospital.

Whether an allegedly negligent specialist was an independent contractor is a question for the jury; that is, the jury must decide on whether the patient was justified in "looking to" the hospital to provide treatment.

Two Delaware cases illustrate these principles. In *Vanaman v. Milford Memorial Hospital*, a private physician was on call to provide emergency services.[15] The court held that it was for the jury to decide whether

the allegedly negligent doctor treated the patient in a private capacity or while fulfilling the hospital function of providing emergency care. The court said that the hospital could be liable for the doctor's negligence if it represented the physician as its employee and the patient justifiably relied on that representation. To the same effect is *Schagrin v. Wilmington Medical Center*, where it was held proper to deny a hospital's motion for summary judgment.[16] The court found that a medical partnership staffing an emergency department may be an agent of the hospital and not an independent contractor depending on the degree of hospital control, the methods of paying the doctors, and the degree of patients' reliance on the hospital compared with their reliance on the physicians.[17]

Similarly, in *Hannola v. City of Lakewood* an Ohio appellate court provided two reasons for finding agency by estoppel in holding that, regardless of contractual provisions, the hospital could be liable for the malpractice of a physician member of an independent foundation operating its emergency department if (1) the hospital held itself out to the public as providing emergency care, and (2) the hospital governing body had control over staff appointments of physicians employed by the foundation.[18] In addition, the hospital monitored the quality of care and had the power to revoke the privileges of individual emergency department doctors for justifiable cause.[19]

Thus, a hospital cannot contractually insulate itself from liability. In fact, with increasing frequency the courts are inclined to find the hospital liable under principles of vicarious liability, irrespective of a purported independent contractor status.

The doctrines of apparent agency and agency by estoppel may be applied even if the allegedly negligent physician is not a medical specialist with an exclusive contract to perform a designated hospital service. In *Grewe v. Mt. Clemens General Hospital*, the plaintiff was taken to the hospital after suffering a severe electrical shock and shoulder trauma.[20] He was first seen by an internist, who consulted with Dr. Fagen, an orthopedic surgeon. Dr. Fagen diagnosed a dislocated right shoulder and in turn designated an orthopedic resident to reduce the dislocation (restore the shoulder to its normal condition), but the reduction was unsuccessful. A specialist in internal medicine, Dr. Katzowitz, was summoned to assist. (The choice of an internist is curious.) According to his own testimony, Dr. Katzowitz did not view the patient's x-rays before attempting to reduce the dislocated shoulder "by placing his foot on the plaintiff's chest and pulling his arm." The plaintiff suffered an injury to a network of nerves in his shoulder (the brachial plexus) and a bone fracture. Additional surgery was necessary to remove bone fragments and to make other repairs.

The Supreme Court of Michigan held that agency by estoppel is established if the "patient looked to the hospital to provide him with treatment," and it affirmed the jury's verdict against the hospital. The jury had found that

the plaintiff had no previous physician–patient relationship with Dr. Katzowitz or the other physicians outside the hospital setting; there was nothing to put the patient on notice that Dr. Katzowitz was an independent contractor; the plaintiff had gone to the hospital expecting to be treated there; and all the physicians were thus ostensible agents of the hospital. Because the patient had not personally selected the physicians, he relied on the institution to provide care. Under the factual circumstances the hospital was estopped to deny the absence of an employment relationship with the physicians.[21]

We thus see how the doctrines of apparent agency and agency by estoppel have contributed substantially to the demise of the hospital's independent contractor defense. In *Grewe, Capan*, and similar cases the doctor was neither an employee of the hospital nor the plaintiff's personal physician. The patients were entitled to jury trials on the issues of whether they had relied on the hospital (rather than on self-selected physicians) to furnish care and whether the hospital had held out the doctors as ostensible employees of the hospital when furnishing emergency services.[22]

The Law in Action

Physicians and hospitals often used the captain-of-the-ship and borrowed-servant rules to try to escape liability. Physicians asserted that operating room nurses were hospital employees and as a matter of law could not visit liability on a surgeon. The captain-of-the-ship doctrine considers this an issue for the jury to decide. The jury will be instructed substantially as follows: "Regardless of who employs or pays the nurse who assists with surgery, if the nurse is under the direction of the surgeon in charge so as to be the surgeon's temporary servant or agent, any negligence on the part of the nurse is the negligence of the surgeon as well." Hospitals try to assert this rule to escape their own liability for nurses' actions.

The criteria for determining whether the nurse is a "temporary servant or agent" (borrowed servant) are (1) whether an express or implied agreement exists between the nurse and the surgeon that the former will assist the latter, (2) whether the work being done at the time of the alleged negligence was essentially that of the surgeon, and (3) whether the power to control the details of the work being done resided with the surgeon.

Erosion of Captain-of-the-Ship and Borrowed-Servant Doctrines

For many years, two other doctrines helped hospitals escape liability for physicians' acts—the "captain of the ship" and the "borrowed servant" concepts. The former doctrine presumed that a surgeon was the "captain of the ship" during surgery and, like the captain of a real ship, was responsible for what occurred under his command. Thus, the hospital's argument was that the surgeon, not the hospital, was liable for negligence during surgery. This argument was bolstered by the borrowed-servant doctrine—that is, one who is normally an employee of one person or entity may be borrowed by another, thereby becoming a servant of the latter and rendering the latter vicariously liable for the negligence of the former. (See The Law in Action.)

In any vicarious liability case, the basis for liability is one's right of control over the negligent activities of another. As the number of persons on surgical teams has grown in size, and as anesthesiologists, nurses, surgical assistants, and others have been increasingly recognized as performing independent functions pursuant to hospital policies and their own professions' standards of care, the courts have realized that it is not sound legal doctrine to impose liability on the chief surgeon alone for the negligent acts of all surgical team members.

Numerous cases involving the miscount of surgical sponges or instruments illustrate this trend (see The Law in Action). In *Tonsic v. Wagner* the trial court applied the captain-of-the-ship doctrine to hold the surgeon liable when neither the scrub nurse, a circulating nurse, nor an intern counted the surgical instruments at the conclusion of a colectomy.[23] As a result, a clamp was not removed from the patient. The trial court felt bound by the captain-of-the-ship doctrine and refused to permit the jury to consider the vicarious liability of the hospital. The Pennsylvania Supreme Court reversed the decision, noting that under the law of agency a negligent party may be the employee of two masters simultaneously, even though the masters are not joint employers. In such situations both masters may be liable.[24] Accordingly the plaintiff was entitled to a new trial in her suit against the hospital. It is a question for the jury whether the surgeon or the hospital was the sole controlling master, or whether there was joint control justifying joint liability.

The Law in Action

I once represented a hospital in a case involving a retained sponge. During a deposition, an exchange between the chief operating room nurse and the plaintiff's lawyer went as follows:

Attorney: When the operation was over and the surgeon had sewn up the wound, did you or anyone else count the sponges that had been used?

Nurse: No, sir.

Attorney: Why not?

Nurse: Well, we didn't count them before the surgery, so it wouldn't have done any good to count them afterward, would it?

We settled the case before trial.

Similar facts were involved in *Sprager v. Worley Hospital*, where there was a failure to remove a surgical sponge from the patient.[25] In a suit against both the surgeon and the hospital the jury found that the surgeon was not personally negligent, and it refused to hold the surgeon liable for the nurses' negligence. A verdict was rendered against the hospital alone. On appeal to the intermediate appellate court, the judgment was reversed and a judgment was entered against the surgeon on the basis of the captain-of-the-ship doctrine. On further appeal, the Texas Supreme Court specifically disapproved the captain-of-the-ship doctrine and held that the determining factor was how much control the doctor actually had over the nurses' activities. The

court pointed out that the nurses had been hired by the hospital, were assigned to surgery by the hospital, and were therefore the general agents of the hospital. At a new hearing the original jury decision (against the hospital and not the surgeon) was reinstated.[26]

The trend toward imposing vicarious liability on the hospital for acts of physicians—whether they are employees or independent contractors—has been observable for decades.[27] When medical care is provided by highly specialized, sophisticated teams of professionals working within an institutional setting, it is frequently difficult to determine who is exercising what control over whom at any given time. When this happens, many consider it logical that the corporate institution share the liability.

Doctrine of Corporate Liability

Under the doctrine of corporate liability it is the hospital itself that is negligent. This liability is not vicarious, as it is under the doctrine of respondeat superior. Rather, it attaches independently to the corporation. In other words, the hospital owes a legal duty directly to the patient, and this duty is not delegable to the medical staff or other personnel. A Connecticut court once defined corporate liability in these words: "Corporate negligence is the failure of those entrusted with the task of providing accommodations and facilities necessary to carry out the charitable purpose of the corporation to follow…the established standard of conduct to which the corporation should conform."[28]

What direct duties does the healthcare organization owe the patient or another person? Isn't patient care the responsibility of physicians and other clinical personnel, not the impersonal corporation? To answer, one must consider the corporate purposes of a community hospital or health system. Is its role simply to furnish physical facilities and accommodations wherein private physicians care for and treat their patients? Or is its role broader?

If a hospital is considered to be nothing more than bricks and mortar—a doctor's workshop, so to speak—then its duties to the patient are quite limited. On the other hand, organizations with broader purposes and functions can be expected to have broader legal duties. As previously discussed, hospitals and health systems do more than provide physical facilities and accommodations for the practice of medicine. They are the focus for arranging, furnishing, and providing the community with an entire range of health-related services—preventive, curative, and palliative; outpatient and inpatient; acute and long term. As their vision has expanded, their duties have expanded in like measure.

Before the mid-1960s, courts generally limited hospitals' corporate duties to such issues as selection and retention of employees and maintenance of hospital equipment, buildings, and grounds. Negligence regarding equipment is seen when there are unrepaired defects, when equipment

is misused,[29] or when it is used for an unintended purpose.[30] The duty of reasonable care regarding the use of equipment and its selection for an intended purpose also includes a duty to inspect the equipment systematically and regularly before use.[31] Rules and regulations of licensing authorities, accreditation standards, and instructional manuals supplied by manufacturers to maintain equipment can be admitted at trial as evidence of expected standards of care. Failure on the part of hospital and medical personnel to comply with such standards would constitute evidence of breach of duty for the jury to consider.

Under negligence theories, physicians and institutional providers have a duty to warn a patient of known risks when the patient is furnished with a medical device. Moreover, courts are now extending the duty to include informing patients of risks that become known after the device is furnished. Thus, if a heart pacemaker is implanted and the particular device is later recalled because of a defect, the hospital and the physician have a duty to notify the patient if the physician knew or should have known of the recall.

With regard to the availability of equipment and services, the rule is that there is no duty to possess the newest and most modern equipment available on the market, but there is a duty to have available the usual and customary equipment and staff for any service that the hospital undertakes to render. (The same applies to physicians' offices, nursing homes, and other facilities.) Accordingly, use of unsterilized hypodermic needles has been found to form the basis of liability.[32] In *Garcia v. Memorial Hospital* a hospital did not have a pediatric endotracheal tube in the emergency department that might have saved a child's life.[33] The hospital operated an emergency department and held itself out as providing a full range of emergency services. It was held to be usual and customary to have a pediatric endotracheal tube available. Another example is provided by a Pennsylvania hospital that was found liable when its emergency department EKG machine broke down and no backup instrument was available.[34] An emergency patient then had to be taken to another location for the test, but he died there.

Healthcare organizations also have a corporate responsibility to exercise reasonable care in selecting and retaining employees. In the Texas case of *Wilson N. Jones Memorial Hospital v. Davis*,[35] the hospital's failure to investigate the background and references of an applicant for the position of orderly resulted in an award of both compensatory and punitive damages. The hospital's normal procedure in hiring employees was to obtain four employment references and three personal references. Established policy was to verify at least one of the employment references and one of the personal references before hiring the applicant. In this case, a hospital executive employed the applicant as an orderly without checking *any* of the references. (The reason given later was that the hospital had a critical need for orderlies.)

After the individual began work, an inquiry was sent to one of the references, who verified that the orderly had worked for them for approximately four months but did not answer any of the other questions asked on the reference form. The hospital failed to follow up. The applicant had represented that he had received his training as an orderly while in the U.S. Navy. The hospital said it did not inquire of the Navy because it had had unsatisfactory cooperation with the armed services in the past. However, the plaintiff requested information from the Navy and promptly learned that the orderly had been expelled from the Navy Medical Corps School after a single month's training, that he had been diagnosed as having a serious drug problem, and that he had a criminal record. At the time he applied for the position of orderly, the applicant also listed three personal references, all of whom were shown to have had local telephone numbers and two of whom were residents in the same city as the hospital. The hospital made only one attempt to reach one of these references, and this was unsuccessful.

Soon after employment the orderly attempted to remove a Foley catheter from a patient's bladder without first deflating the bulb. This attempt resulted in serious injuries to the patient. The hospital was held liable for both compensatory and punitive damages. The hospital's critical need for orderlies at the time did not justify the failure to exercise reasonable care in the employee selection process. Moreover, the punitive damages awarded in the case were a result of "an entire want of care" and "conscious indifference to the rights, welfare, and safety of the patients in the hospital."

Violation of Rules and Failure to Adopt Rules as Corporate Negligence

Hospital bylaws, rules and regulations, and the accreditation standards of the Joint Commission are admissible in evidence at trial.[36] If violation of a hospital rule is the proximate cause of a plaintiff's injury, liability can be premised on the fact that the rule is the expected standard of care. Violation of a rule or written standard does not automatically amount to negligence, but it is certainly strong evidence. For example, in *Pederson v. Dumouchel* a hospital was liable as a matter of law when it permitted nonemergency dental surgery to be performed under a general anesthetic without the supervision of a medical doctor in violation of hospital policy.[37]

Typically, the existence of a rule and evidence of its breach will be submitted to the jury as a question of fact. As would be expected, evidence that a rule has been violated is often persuasive to jurors. For example, a jury verdict for the plaintiff was affirmed in *Burks v. Christ Hospital*, citing a hospital policy that bedside rails be raised if the patient was restless, obese, or under sedation unless the attending physician had issued an order to the contrary.[38] The plaintiff sustained injuries when he fell from the bed, and the jury was entitled to consider the violation of this written standard as evidence of negligence. A

Michigan case noted that an administrative regulation requiring hospitals to have written policies regarding medical consultations and consultations to be recorded was intended to protect hospitalized patients.[39] Accordingly, the plaintiff was entitled to have the jury instructed on the purpose of this rule.

In addition to failing to follow published standards, the failure even to have appropriate rules necessary for patients' safety may constitute corporate negligence. There was liability in *Habuda v. Trustees of Rex Hospital* where the hospital had inadequate rules relating to the handling, storage, and administration of medications.[40]

Another variation of corporate liability is a hospital's failure to have and to implement adequate rules for communicating vital information on patient care to others who are or will be responsible for treating the patient. For example, in *Keene v. Methodist Hospital* an injured patient was seen by a physician on duty in a hospital emergency department on Christmas Eve and sent home after x-rays were taken.[41] Early Christmas morning the radiologist detected a possible skull fracture and suggested further x-ray studies. The physician dictated a tentative diagnosis and recommendations into a dictating machine without further communication to the attending physician, the patient, or hospital administrators. Apparently as a result of the Christmas holiday the dictation was not transcribed for two days. During this period the patient lost consciousness, was returned to the hospital for emergency surgery, and died as a result of a fractured skull and hemorrhage. The hospital, not just the physicians, was held liable for its failure to transmit the radiologist's report promptly to the treating physician or, in his absence, to hospital administrators. This factual situation is characterized as corporate negligence because it is the duty of the hospital to have a system for prompt transcription of dictated communications as a component of its responsibility to maintain and transmit the patient's medical record.

Thus, we see that the failure to have and to follow proper rules, regulations, or systems in place when indicated by recognized professional standards can result in liability whether it is called corporate negligence or vicarious liability.[42] It is becoming increasingly difficult to determine in any given case whether the applicable legal theory is one of corporate negligence or respondeat superior. It probably does not matter much. Just as in *Bing v. Thunig*[43]—which in 1957 eliminated any distinction between the administrative and professional acts of nurses for the purposes of respondeat superior—the distinction between hospitals' vicarious liability (respondeat superior) and direct liability (corporate negligence) has nearly disappeared for all practical purposes. In any event, hospital rules, standards of accreditation, and licensure regulations must be realistic, known to all affected persons, capable of implementation, and consistently enforced. Further, the rules must be regularly and systematically reviewed; if they are not realistic and workable, then they should be eliminated.

Negligence in Selection and Retention of Medical Staff

The law in every state now recognizes that a corporate healthcare institution owes a duty directly to its patients to exercise reasonable care in the selection and retention of medical staff. The corporation may be liable if it knows or should have known that an individual physician was not competent to perform the permitted clinical procedures. This doctrine began to emerge as the result of the 1965 landmark case of *Darling v. Charleston Community Memorial Hospital*.[44] In that litigation the Illinois Supreme Court held that a hospital could be liable either (a) under respondeat superior, if nurse employees failed to notify medical and hospital administrators when they knew that a patient was receiving inadequate medical care, or (b) under corporate liability, if the hospital failed to review and monitor the quality of care generally rendered to patients by the private physician.

The private physician was a general practitioner who had been permitted by the hospital to practice orthopedic medicine and whose clinical competence had not been reviewed during more than three decades of practice.

Significantly, *Darling* also established that standards set forth in medical staff bylaws, as well as those promulgated by the Joint Commission and state licensing authorities, might be considered by the jury to prove the standard of care. Moreover, the case abolished the "locality rule" in Illinois. In short, the hospital could no longer fully defend itself by asserting that other hospitals in the area also did not enforce their medical staff bylaws or review the performance of members of the medical staff.

The Illinois court rejected the view that a hospital undertakes simply to procure nurses and doctors to act on their own responsibility. Such a role no longer reflects current hospital management. In fact, a hospital undertakes to treat the patient and to act through its nurses and doctors, even if the latter are not employees.[45] Following the *Darling* decision, one commentator wrote:

> Even in the absence of an employer–employee...relationship...there now appears to be some chance...to impose liability on the hospital on the theory of independent negligence in failing to review, supervise, or consult about, the treatment given by the physician directly in charge, if the situation indicates that the hospital had the opportunity for such review but failed to exercise it, or that its servants (usually nurses or residents) were negligent in failing to call the attention of the proper hospital authorities to the impropriety or inadequacy of the treatment being given.[46]

Case law has now firmly established that hospital administration and medical staff have a joint role with respect to the clinical performance of

individual practitioners. The governing body of the hospital has the responsibility to adopt corporate and medical staff bylaws providing for an organized medical staff accountable to the board for quality of care. The governing board grants medical staff appointments and delineates privileges on an individual basis, and reappointments are made by the governing body on the recommendations of medical staff committees. In ruling on these recommendations, the board must be satisfied that the peer review process is in fact working and must avoid simply rubber-stamping recommendations that are submitted by medical staff. The responsibility of the governing body is nondelegable; the board does, however, delegate to medical staff the authority to implement the credentialing process and to prepare recommendations for appointments and reappointments (more on this in Chapter 7).

Other leading cases have recognized the corporate duty of a hospital to exercise reasonable care in the selection and retention of medical staff. A 1971 Georgia case, *Joiner v. Mitchell County Hospital Authority*, held that members of the medical staff who make recommendations to the governing body of the hospital for appointment of physicians were agents of the hospital.[47] In considering these recommendations the governing body must act in good faith and with reasonable care.[48] A similar institutional duty was recognized by Nevada's Supreme Court in a medical staff privileges case entitled *Moore v. Board of Trustees of Carson–Tahoe Hospital*.[49] There the court stated:

> The purpose of the community hospital is to provide patient care of the highest possible quality. To implement this duty of providing competent medical care to the patients, it is the responsibility of the institution to create a workable system whereby the medical staff of the hospital continually reviews and evaluates the quality of care being rendered within the institution. The staff must be organized with the proper structure to carry out the role delegated to it by the governing body. All powers of the medical staff flow from the board of trustees, and the staff must be held accountable for its control of quality.... The role of the hospital vis-à-vis the community is changing rapidly. The hospital's role is no longer limited to the furnishing of physical facilities and equipment where a physician treats his private patients and practices his profession in his own individualized manner.
>
> Licensing [of physicians], per se, furnishes no continuing control with respect to a physician's professional competence and therefore does not assure the public of quality patient care. The protection of the public must come from some other authority, and that in this case is the Hospital Board of Trustees. The Board, of course, may not act arbitrarily or unreasonably in such cases. The Board's actions must be predicated upon a reasonable standard.[50]

In *Gonzales v. Nork* the defendant performed an unsuccessful and allegedly unnecessary laminectomy and spinal fusion procedure on a 27-year-old man who had been injured in an automobile accident.[51] Various complications developed that substantially reduced the patient's life expectancy. Evidence was presented showing that the surgeon had performed more than three dozen similar operations that were either negligently done or unnecessary. The trial court issued a lengthy opinion recognizing that the hospital owed a duty of care to the patient with respect to the delineation of surgical privileges extended to private surgeons. The court stated forcefully that this duty included the obligation to protect the patient from acts of malpractice by an independently retained doctor if the hospital knew or should have known that such acts were likely to occur. Even though the hospital had no actual knowledge of Dr. Nork's propensity to commit malpractice, its demonstrated lack of a workable system for acquiring such knowledge justified a finding of negligence.

A landmark Wisconsin case took a particularly enlightened view of the role of a hospital in its relations with the medical staff. In *Johnson v. Misericordia Community Hospital* (see The Court Decides at the end of this chapter) the plaintiff alleged that the hospital was negligent in granting orthopedic surgical privileges to a particular physician.[52] The Wisconsin Supreme Court affirmed a jury verdict for the plaintiff on the following basis:

1. that the hospital had failed to inquire into the physician's professional background and qualifications prior to granting a staff appointment,
2. that it failed to adhere to its own bylaw provisions and to Wisconsin statutes pertaining to medical credentialing,
3. that the exercise of ordinary care would have disclosed the physician's lack of qualifications,
4. that had it done due diligence it would not have appointed him to the medical staff, and
5. that not doing so exposed patients to a "foreseeable risk of unreasonable harm."

This case stands for the now well-recognized proposition that "a hospital has a duty to exercise due care in the selection of its medical staff."[53]

None of the case decisions since *Darling* has implied a supervisory role for lay hospital administrators or trustees over physicians' clinical activities. Only physicians can practice medicine and exercise clinical judgment for proper care and treatment of patients. But it is the responsibility of the governing board and administration to be certain that the organized medical staff is periodically reviewing the clinical behavior of staff physicians. Rather than second-guessing medical care, the governing board merely delegates the review and evaluation functions to the medical staff, which in turn is

accountable to the board for its recommendations in a process known as "credentialing"; see a complete discussion in Chapter 7.

It is the medical staff's job to develop reasonable criteria and fundamentally fair procedures for evaluation, appointment, and delineation of privileges. Information and data must be gathered and forwarded to the governing body in support of recommendations. The board, in turn, approves both the criteria and procedures for appointment, the delineation of privileges, and the renewal of appointments. It then acts on the medical staff's recommendations after making certain that all supporting information is complete.

Consistent with these responsibilities, hospitals must develop a credentialing process for other professionals working within the institution. Physician's assistants, nurse practitioners, podiatrists, technicians, pharmacists, and other clinicians provide services in the hospital setting. It is clear that the hospital must evaluate the competencies of these individuals just as it does those of the medical staff. Moreover, procedures must be developed to review periodically the performance of each of these persons. The scope of their clinical activities is a matter for the medical and nursing staff to develop according to local licensure laws and professional custom and usage.

The cases in this chapter illustrate significant changes in the theories of hospital liability. The law of agency and respondeat superior no longer explain liability based on a violation of a corporate duty. It should be evident that in the hospital setting the rules of respondeat superior and corporate or independent negligence have essentially become one.

Liability of Managed Care Organizations

The emphasis on efficiency and cost savings that characterized the 1980s and 1990s led many to question whether the healthcare system was neglecting the quality of the care being provided in deference to economic considerations. Issues arise when managed care organizations (MCOs)—health maintenance organizations and similar health plans—make payment decisions that adversely affect the medical outcome.

Some argue that irrespective of whether the MCO concurs and assumes financial responsibility, the decision to admit patients or extend their stay is a medical one that only a physician can make. Indeed this was the key point in *Wickline v. California*,[54] one of the first cases to attempt to assert liability against an MCO (in this case, the state's Medi-Cal program) when a utilization review (UR) decision forced a patient's early discharge. The court wrote, "Third party payers of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms...." It also held that the physician had the final responsibility to make the medical decision whether to discharge. Because the physician in question had not appealed the UR decision and should have done so, the physician and not the MCO was held liable.

A later California case found otherwise, however. In *Wilson v. Blue Cross of Southern California*, a physician requested a 30-day admission for a depressed psychiatric patient. The request was denied by UR, and the patient later committed suicide.[55] The court found that Blue Cross's refusal to pay for the admission was a "substantial factor" in the patient's death and that the MCO was liable, stating, "The language in *Wickline* which suggests that civil liability for a discharge decision rests solely within the responsibility of a treating physician in all contexts is dicta." Thus, the MCO was held liable. ("Dicta" are comments in a decision that are not required to reach the decision but may state a related legal principle as the judge understands it. Although they may be cited in legal argument, they do not have the full force of a precedent.)

There are substantial challenges for plaintiffs who wish to hold MCOs responsible for decisions that adversely affect patient care. The most imposing hurdle is ERISA, the Employee Retirement Income Security Act of 1974,[56] which preempts "any and all State laws insofar as they...relate to any employee benefit plan." Numerous cases have held that medical malpractice claims against MCOs are barred by the ERISA preemption provisions.[57] To date there has been no congressional action to amend ERISA and explicitly provide for MCO liability for UR decisions, but some related action has been taken at the state level.

Texas, for example, allows an individual to sue an MCO for injuries caused by adverse UR decisions. The act provides, in relevant part, as follows:

> (a) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.
> (b) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan is also liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by its:
> (1) employees;
> (2) agents;
> (3) ostensible agents; or
> (4) representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control which result in the failure to exercise ordinary care.[58]

This statute was upheld in *Corporate Health Insurance, Inc. v. Texas Department of Insurance*,[59] in which the court wrote, "Claims [such as malpractice claims] challenging the quality of a benefit...are not preempted by ERISA.... Claims based upon a failure to treat where the failure was the result of a determination that the requested treatment wasn't covered by the plan,

however, are preempted by ERISA." The court held that the Texas statute addresses the quality of benefits actually provided and that its effect on ERISA plans was too tenuous to constitute an improper imposition of state law liability on them.

Notwithstanding the Texas case, until Congress or the Supreme Court speaks definitively, the question of whether ERISA provides immunity to MCOs for their financially motivated treatment decisions will continue to be the subject of much litigation.

Chapter Summary

The law of hospital liability has come a long way in the past 70 years or so. In the 1930s and 1940s most charitable hospitals were immune from tort liability. After charitable immunity was abolished, courts began to apply the doctrine of respondeat superior to the hospital setting—timidly, at first. A distinction was clearly drawn between an employee and an independent contractor. Then emerged the concepts of apparent agency and agency by estoppel, together with the decline of the captain-of-the-ship and borrowed-servant doctrines. The notion of apparent agency has now expanded to the point that the independent contractor defense is no longer viable or desirable as a matter of substantive tort law in the field of hospital liability.

More significant, the expanded doctrine of corporate negligence—the nondelegable responsibility of reviewing and evaluating clinical practices—has essentially obliterated the distinction between vicarious liability and direct liability, as illustrated in the cases discussed here.

Finally, the rise of managed care in the 1980s and 1990s has led to questions about whether efforts to control costs compromise the quality of care. This facet of liability promises to be the subject of legal scrutiny into the foreseeable future.

Chapter Discussion Questions

1. Why is the history of healthcare institutions important to an understanding of their legal liability today?
2. Why has the defense of "independent contractor" status declined in importance in recent years?
3. How is "corporate liability" different from liability under respondeat superior?
4. What is the liability of a managed care organization (e.g., health maintenance organization, preferred provider organization) when it makes decisions about insurance coverage for hospital stays?

Notes

1. The origin of immunity in the United States is generally attributed to the often-cited McDonald v. Massachusetts Gen. Hosp., 120 Mass. 432, 21 A.529 (1876). For a general discussion of the social forces behind the doctrine, see Starr, P. 1982. *The Social Transformation of American Medicine.*
2. For a landmark case abolishing charitable immunity, see President & Directors of Georgetown College v. Hughes, 130 F.2d 810 (D.C. Cir. 1942).
3. Foley v. Bishop Clarkson Memorial Hosp., 185 Neb. 89, 173 N.W.2d 881 (1970); Kastler v. Iowa Methodist Hosp., 193 N.W.2d 98 (Iowa 1917); McGillivray v. Rapides Iberia Management Enterprises, 493 So. 2d 819 (La. Ct. App. 1986). Additionally, Lamont v. Brookwood Health Services, Inc., 446 So. 2d 1018 (Ala. 1983) held that the standard of care for hospitals was determined by the national hospital community.
4. Foley v. Bishop Clarkson Memorial Hosp., 185 Neb. at 95, 173 N.W.2d at 885.
5. For example, Reifschneider v. Nebraska Methodist Hosp., 222 Neb. 782, 387 N.W.2d 486 (1986)—when a semiconscious patient was placed on a cart in the hospital emergency department without use of restraints, expert testimony was required to establish expected standard of care; Rosemont, Inc. v. Marshall, 481 So. 2d 1126 (Ala. 1985)—standard of care with respect to observation and supervision of patient's ambulatory status requires expert testimony.
6. For example, Keeton v. Maury County Hosp., 713 S.W.2d 314 (Tenn. App. 1986)—where the hospital staff knew or could foresee that the patient would be in danger if moving about unassisted, expert testimony was not necessary to establish breach of duty.
7. Reifschneider v. Nebraska Methodist Hosp., 387 N.W.2d at 489—violation of a physician's order that patient be attended at all times presented a prima facie case of negligence.
8. Hastings v. Baton Rouge Gen. Hosp., 498 So. 2d 713 (La. 1986)—violation of hospital bylaws constitutes breach of duty and eliminates the need for expert testimony; Therrel v. Fonde, 495 So. 2d 1046 (Ala. 1986)—where facts establish a significant delay in treatment, expert testimony is not necessary to support a jury verdict that the defendant failed to provide adequate security.
9. For example, Mayers v. Litow & Midway Hosp., 154 Cal. App. 2d 413, 316 P.2d 351 (1957); Zelver v. Sequoia Hosp. Dist., 7 Cal. App. 3d 934, 87 Cal. Rptr. 79 (1970); Dickinson v. Mailliard, 175 N.W.2d 588 (Iowa 1970).
10. 58 Mich. App. 119, 227 N.W.2d 247 (1975).
11. 42 Cal. App. 3d 260, 116 Cal. Rptr. 801 (1974).
12. 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).
13. Id., 2 N.Y.2d at 666.
14. With respect to hospital liability for negligence of residents and interns, see Waynick v. Reardon, 236 N.C. 116, 72 S.E. 2d 4 (1952); City of Miami v. Oates, 152 Fla. 21, 10 So. 2d 721 (1942); Klema v. St. Elizabeth's Hosp., 170 Ohio St. 519, 166 N.E.2d 765 (1960); Wright v. United States, 507 F. Supp. 147 (E.D. La. 1980)—the resident staffing an emergency department was held to standards of physicians specializing in emergency medicine; Scott v. Brookdale Hosp. Center, 60 A.D.2d 647, 400 N.Y.S.2d 552 (1977).
15. 272 A.2d 718 (Del. 1970).
16. 304 A.2d 61 (Del. Super. Ct. 1973).
17. See also Mduba v. Benedictine Hosp., 52 A.D.2d 450, 384 N.Y.S.2d 527 (1976); Mehlman v. Powell, 281 Md. 269, 378 A.2d 1121 (1977); Rucker v. High Point Memorial Hosp., 20 N.C. App. 650, 202 S.E.2d 610 (1974); Paintsville Hosp. Co. v. Rose, 683 S.W.2d 255 (Ky. 1985).
18. 68 Ohio App. 2d 61, 426 N.E.2d 1187 (1980).
19. Other leading cases illustrating application of the doctrines of apparent agency or agency by estoppel are Seneris v. Haas, 45 Cal.2d 811, 291 P.2d 915 (1955) (anesthesiologist); Lundberg v. Bay View Hosp., 175 Ohio St. 133, 191 N.E.2d 821 (1963) (pathologist); Kober v. Stewart, 148 Mont. 117, 417 P.2d 476 (1966) (radiologist). See also Griffin v. Matthews, No. CA 86-09-127, unreported, Butler County, Ohio Ct. App. (May 11, 1987)—representations by a full-service hospital establish an agency by estoppel even in absence of reliance by

plaintiff; Smith v. Baptist Memorial Hosp. Sys., 720 S.W.2d 618 (Tex. Ct. App. 1986)—factual issues determine application of ostensible agency doctrine, and a hospital may not contractually disclaim liability for negligence of physicians employed by a professional association; Sztorc v. Northwest Hosp., 146 Ill. App. 3d 275, 496 N.E.2d 1200 (1986), reh'g denied, Sept. 8, 1986—the hospital's radiation therapy department staffed by a group of private physicians represented as an integral part of the hospital precludes summary judgment for the defendant hospital. Cf. Greene v. Rogers, 147 Ill. App. 3d 1009, 498 N.E.2d 867 (1986)—in the absence of representations by hospital and reliance by patient, a summary judgment for the hospital is proper.

20. 404 Mich. 240, 273 N.W.2d 429 (1979).
21. See also Restatement (Second) of Torts § 429 (1965). One who employs an independent contractor to perform services for another that are accepted in the reasonable belief they are being rendered by the employer is liable for physical harm caused by negligence of the contractor.
22. A physician who is on call for emergencies within the hospital may be personally liable as the result of a failure to respond—Hiser v. Randolph, 126 Ariz. 608, 617 P.2d 774 (1980). The hospital may also be liable.
23. 458 Pa. 246, 329 A.2d 497 (1974).
24. See Restatement (Second) of Agency § 226 (1958).
25. 547 S.W 2d 582 (Tex. 1977).
26. 552 S.W.2d 534 (Tex. 1977). Accord Truhitte v. French Hosp., 128 Cal. App. 3d 332 (1982); City of Somerset v. Hart, 549 S.W.2d 814 (Ky. 1977); Grant v. Touro Infirmary, 254 La. 204, 223 So. 2d 148 (1969); Buzan v. Mercy Hosp., 203 So. 2d 11 (Fla. App. 1967); Miller v. Tongen, 281 Minn. 427, 161 N.W.2d 686 (1968); Contra Swindell v. St. Joseph's Hosp., Inc., 161 Ga. App. 290 (1982)—hospital employees' negligent act during performance of a myelogram was imputed to the physician.
27. This trend was anticipated and forecast by Professor Southwick as early as 1960 when he wrote: "The third trend in the law of hospital liability is the most significant. It is the increasing tendency...to impose vicarious liability on facts where none would have been imposed heretofore. By some leading decisions it no longer follows that a professional person using his own skill, judgment and discretion in regard to the means and methods of his work is an independent contractor.... Gradually, the test of hospital liability for another's act is becoming simply a question of whether or not the actor causing injury was a part of the medical care organization." Southwick, A. *Vicarious Liability of Hospitals*, 44 Marq. L. Rev. 151, 182 (1960).
28. Bader v. United Orthodox Synagogue, 148 Conn. 449, 453, 172 A.2d 192, 194 (1961).
29. Shepherd v. McGinnis, 257 Iowa 35, 131 N.W.2d 475 (1964); Ardoin v. Hartford Accident & Indem. Co., 350 So. 2d 205 (La. App. 1977).
30. Phillips v. Powell, 210 Cal. 39, 290 P.2d 441 (1930); Milner v. Huntsville Memorial Hosp., 398 S.W.2d 647 (Tex. App. 1966).
31. South Highlands Infirmary v. Camp, 279 Ala. 1, 180 So. 2d 904 (1965); Nelson v. Swedish Hosp., 241 Minn. 551, 64 N.W.2d 38 (1954).
32. Peck v. Charles B. Towns. Hosp., 275 A.D. 302, 89 N.Y.S.2d 190 (1949).
33. 557 S.W.2d 859 (Tex. 1977).
34. Hamil v. Bashline, 224 Pa. Super. 407, 307 A.2d 57 (1973).
35. 553 S.W.2d 180 (Tex. App. 1977). See also Hipp v. Hospital Auth., 104 Ga. App. 174, 121 S.E.2d 273 (1961); Garlington v. Kingsley, 277 So. 2d 183 (La. App. 173), rev'd on other grounds, 289 So. 2d 88 (La. 1974).
36. Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253, cert. denied, 383 U.S. 946 (1966). There are many other cases in accord, some of which are cited infra.
37. 70 Wash. 2d 73, 431 P.2d 973 (1967).
38. 19 Ohio St. 2d 128, 249 N.E.2d 829 (1969).
39. Kakligian v. Henry Ford Hosp., 48 Mich. App. 325, 210 N.W.2d 463 (1973).
40. 3 N.C. App. 11, S.E.2d 17 (1968).

41. 324 F. Supp. 233 (N.D. Ind. 1971).
42. Hospitals owe a duty to exercise such reasonable care as the patient's known condition requires and to guard against conditions that should have been discovered by the exercise of reasonable care. Foley v. Bishop Clarkson Memorial Hosp., 185 Neb. 89, 173 N.W.2d 881 (1970). Moreover, hospitals are held to standards and practices prevailing generally, not only in the local community but also in similar or like communities in similar circumstances—Dickinson v. Mailliard, 175 N.W.2d 588 (Iowa 1970).
43. 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).
44. 33 Ill. 2d 326, 211 N.E.2d 253, cert. denied, 383 U.S. 946 (1966).
45. In support of its position, the court cited Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).
46. 14 A.L.R.3d 873, 879 (1967).
47. 125 Ga. App. 1, 186 S.E.2d 307, aff'd, 229 Ga. 140, 189 S.E.2d 412 (1972).
48. The New York courts have also recognized that the hospital has a duty to the patient to select and retain staff physicians with care. See Fiorentino v. Wagner, 19 N.Y.2d 407, 227 N.E.2d 296, 299, 280 N.Y.S.2d 373, 378 (1967), where the court stated: "More particularly, in the context of the present case, a hospital will not be liable for an act of malpractice performed by an independently retained healer, unless it has reason to know that the act of malpractice would take place."
49. 88 Nev. 207, 495 P.2d 605, cert. denied, 409 U.S. 879 (1972).
50. Id., 495 P.2d at 608. Readers will recognize that this language of the Nevada court is a paraphrased summation of Arthur Southwick's "Hospital Medical Staff Privileges," 18 *DePaul L. Rev.* 655 (1969). See also Pedroza v. Bryant, 101 Wash. 2d 226, 677 P.2d 166 (1984)—hospitals owe independent duty to patients to use reasonable care in selection and retention of medical staff; duty does not extend to the patient of a physician who allegedly committed malpractice in private office practice.
51. No. 228566 (Super. Ct. Cal., Sacramento County, 1973), rev'd on other grounds, 60 Cal. App. 3d 728 (1976).
52. 99 Wis. 2d 708, 301 N.W.2d 156 (1981). The opinion of the intermediate court of appeals is reported at 97 Wis. 2d 521, 294 N.W.2d 501 (1980).
53. 99 Wis. 2d at 723.
54. 239 Cal. Rptr. 810 (Ct. App. 1986).
55. 271 Cal. Rptr. 876 (Ct. App. 1989).
56. 29 U.S.C. § 1001 et seq.
57. See, for example, Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992) and Rodriguez v. Pacificare of Tex., Inc., 980 F.2d 1014 (5th Cir. 1993). But see Dukes v. U.S. Healthcare, 57 F.3d 350 (3rd Cir. 1995) and Pacificare of Oklahoma, Inc. v. Burrage, 59 F.3d 151 (10th Cir. 1995).
58. Tex. Civ. Prac. & Rem. Code Ann. § 88.002.
59. Civ. No. H-97-2702 (U.S.D.C., S.D. Tex., Sept. 18, 1998).

THE COURT DECIDES

Norton v. Argonaut Insurance Co.
144 So. 2d 249 (La. Ct. App. 1962)

[The plaintiffs are the parents of an infant who died after a medication error in a hospital. She was given an injection of a heart drug that should have been administered orally. The trial court found in the plaintiffs' favor, and the defendants appealed.

Shortly after her birth, the Norton baby was diagnosed as having congenital heart disease and was placed on Lanoxin (a form of digitalis) to strengthen her heart and reduce her pulse rate. She was discharged from the hospital at two and one-half months of age, and her mother administered the medication at home by using a medicine dropper. The child was readmitted about two weeks later, on December 29, 1959, by her pediatrician, Dr. Bombet.]

Landry, J.

On this occasion [Dr. Bombet] issued admission orders on the infant to be placed in the child's hospital chart or record. Included in his admission orders were instructions regarding medication, diet, etc., and the notation that special medication was being administered by the mother. In this connection it appears that Mrs. Norton preferred to continue administration of the daily maintenance dose of the Lanoxin herself since she had been performing this function since the child's initial admission to the hospital on December 15th. Dr. Bombet noted in the hospital admission orders of December 29, 1959, that special medication was being given by the mother to thusly advise the hospital staff and employees that some medication was being administered the child other than that which he placed on the order sheet and would, therefore, be administered by the hospital nursing staff.

On January 2, 1960 (Saturday) Dr. Stotler examined the Norton baby at approximately noon while in the course of making his rounds in the hospital. As a result of this examination he concluded that the child needed an increase in the daily maintenance dose of Lanoxin and instructed Mrs. Norton, who was present in the room, to increase the daily dose of the Lanoxin for that day only to 3 c.cs. instead of the usual 2.5 c.cs. Following this instruction to Mrs. Norton, Dr. Stotler went to the nurse's station in the hospital pediatric unit floor to check the hospital chart or record on the Norton infant and noted on the Doctor's Order Sheet contained therein certain instructions among which only the following is pertinent to the issues involved herein: "Give 3.0 cc Lanoxin today for 1 dose only".

Dr. Stotler's entry of the foregoing order for medication constitutes the basis of plaintiff's claim against Aetna as the professional liability insurer of Dr. Stotler. It is frankly conceded by Aetna that unless Dr. Stotler indicated on the order sheet that he had instructed the patient's mother to increase the daily maintenance dose of Lanoxin to 3.0 c.cs. and administer the medication, his entry of the aforesaid prescription on the order sheet would indicate that the nursing staff of the hospital was to give the medication prescribed. It is further conceded that under such circumstances the child was subjected to the possibility of being administered a second dose of Lanoxin. The possibility thus presented is exactly what occurred in the instant case. A member of the nursing

staff noting Dr. Stotler's orders, administered 3 c.cs. of Lanoxin in its injectible form instead of the elixir form which Dr. Stotler intended.... It is readily conceded by all concerned that the 3 c.cs. of Lanoxin administered the baby by hypodermic was a lethal overdose and was in fact the cause of the infant's demise.

....

[The day in question was a Saturday, and the regular staff was not on duty. Mrs. Florence Evans, an R.N. whose regular duties were administrative in nature, was assisting in the pediatric unit that day. She had not engaged in the actual clinical practice of nursing for some time, and she did not know that Lanoxin was available in oral form; the last she knew, Lanoxin was given only by injection. Noting the doctor's orders for "3 cc of Lanoxin," and seeing no indication that it had been given, she decided to inject the medication herself, even though she sensed that this "appeared to be a rather large dose," according to the court.]

.... She discussed the matter very briefly with the student nurse, Miss Meadows, and inquired of the Registered Nurse, Miss Sipes, whether or not the child had previously received Lanoxin. Mrs. Evans then examined the patient's hospital chart and found nothing [to indicate that] the child had been receiving Lanoxin while in the hospital.... Considering administration of the drug only by hypodermic needle, Mrs. Evans, accompanied by the Student Nurse, Miss Meadows, went to the medicine room of the pediatric unit and obtained two ampules of Lanoxin each containing 2 c.cs. of the drug in its injectible form. While pondering the advisability of...administering what she considered to be a large dose, Mrs. Evans noted that Dr. Beskin, one of the consultants on the child's case, had entered the pediatric ward so Mrs. Evans consulted him about the matter and was advised that if Dr. Stotler prescribed 3 c.cs. he meant 3 c.cs. Still not certain about the matter Mrs. Evans also discussed the subject with Dr. Ruiz and was informed by him in effect that although the dose was the maximum dose that if the doctor had prescribed that amount she could give it. *[Despite her misgivings, she did give the injection. The baby went into distress, and despite emergency efforts, she died a little more than an hour later.]*

....The rule applicable in the instant case is well stated in the following language [of an earlier Louisiana case]:

(1) A physician, surgeon or dentist, according to the jurisprudence of this court and of the Louisiana Courts of Appeal, is not required to exercise the highest degree of skill and care possible. As a general rule it is his duty to exercise the degree of skill ordinarily employed, under similar circumstances, by the members of his profession in good standing in the same community or locality, and to use reasonable care and diligence, alone with his best judgment, in the application of his skill to the case.

[I]t is manifest that Dr. Stotler was negligent in failing to denote the intended route of administration and failing to indicate that the medication prescribed had already been given or was to be given by the patient's mother. It is conceded by counsel for Dr. Stotler that the doctor's oversight in this regard exposed the child to the distinct possibility of being given a double oral dose of the medicine. Although it is by no means certain from the evidence that a second dose of oral Lanoxin would have proven fatal, Dr. Stotler's own testimony dose [sic] make it clear that in all probability it would have produced nausea. In this regard his testimony is to the effect that even if the strength of two oral doses were sufficient to produce death in all probability death

would not result for the reason that nausea produced by overdosing would have most probably induced the child to vomit the second dose thereby saving her life.

The contention that Dr. Stotler followed the practice and custom usually engaged in by similar practitioners in the community is clearly refuted and contradicted by the evidence of record herein. Of the four medical experts who testified herein only Dr. Stotler testified in effect that it was the customary and usual practice to write a prescription in the manner shown. The testimony of Drs. Beskin, Bombet and Ruiz falls far short of corroborating Dr. Stotler in this important aspect. The testimony of Dr. Stotler's colleagues was clearly to the effect that the better practice is to specify the route of administration intended.... In view of the foregoing, we hold that the act acknowledged by Dr. Stotler does not relieve him from liability to plaintiffs herein on the ground that it accorded with that degree of skill and care employed, under similar circumstances, by other members of his profession in good standing in the community. We find and hold that the record before us fails to establish that physicians in good standing in the community follow the procedure adopted by defendant herein but rather the contrary is shown.

Pretermitting the issue of charitable immunity (with which we are not herein concerned in view of the fact that the suit is against the insurer of the hospital in the instant case) it is the settled jurisprudence of this state that a hospital is responsible for the negligence of its employees including, inter alia, nurses and attendants under the doctrine of respondeat superior.

[I]t is not disputed that Mrs. Evans was not only an employee of the hospital but that on the day in question she was in charge of the entire institution as the senior employee on duty at the time.

Although there have been instances in our jurisprudence wherein the alleged negligence of nurses has been made the basis of an action for damages for personal injuries..., we are not aware of any prior decision which fixes the responsibility or duty of care owed by nurses to patients under their care or treatment. The general rule, however, seems to be to extend to nurses the same rules which govern the duty and liability of physicians in the performance of professional services. Thus...we find the rule stated as follows:

* * * The same rules that govern the duty and liability of physicians and surgeons in the performance of professional services are applicable to practitioners of the kindred branches of the healing profession, such as dentists, and, likewise, are applicable to practitioners such as drugless healers, oculists, and manipulators of X-ray machines and other machines or devices.

The foregoing rule appears to be well-founded and we see no valid reason why it should not be adopted as the law of this state. Tested in the light of [this rule] the negligence of Mrs. Evans is patent upon the face of the record. We readily agree with the statement of Dr. Ruiz that a nurse who is unfamiliar with the fact that the drug in question is prepared in oral form for administration to infants by mouth is not properly and adequately trained for duty in a pediatric ward. As laudable as her intentions are conceded to have been on the occasion in question, her unfamiliarity with the drug was a contributing factor in the child's death. In this regard we are of the opinion that she was negligent in attempting to administer a drug with which she was not familiar. While we concede that a nurse does not have the same degree of knowledge regarding drugs as is possessed by members of the medical profession, nevertheless, common sense

dictates that no nurse should attempt to administer a drug under the circumstances shown in [this] case. Not only was Mrs. Evans unfamiliar with the medicine in question but she also violated what has been shown to be the rule generally practiced by the members of the nursing profession in the community and which rule, we might add, strikes us as being most reasonable and prudent, namely, the practice of calling the prescribing physician when in doubt about an order for medication.... For obvious reasons we believe it the duty of a nurse when in doubt about an order for medication to make absolutely certain what the doctor intended both as to dosage and route....

....

The evidence...leaves not the slightest doubt that when Dr. Stotler entered the order for the medication on the chart, it was the duty of the hospital nursing staff to administer it. Dr. Stotler frankly concedes this important fact and for that reason acknowledged that he should have indicated on the chart that the medication had been given or was to be given by the mother, otherwise some nurse on the pediatric unit would give it as was required of the hospital staff. Not only was there a duty on the part of Dr. Stotler to make this clear so as to prevent duplication of the medication but also he was under the obligation of specifying or in some manner indicating the route considering the drug is prepared in two forms in which dosage is measured in cubic centimeters. In dealing with modern drugs, especially of the type with which we are herein concerned, it is the duty of the prescribing physician who knows that the prescribed medication will be administered by a nurse or third party, to make certain as to the lines of communication between himself and the party whom he knows will ultimately execute his orders. Any failure in such communication which may prove fatal or injurious to the patient must be charged to the prescribing physician who has full knowledge of the drug and its effects upon the human system. The duty of communication between physician and nurse is more important when we consider that the nurse who administers the medication is not held to the same degree of knowledge with respect thereto as the prescribing physician. It, therefore, becomes the duty of the physician to make his intentions clear and unmistakable. If, as the record shows, Dr. Stotler had ordered elixir Lanoxin, or specified the route to be oral, it would have clearly informed all nurses of his intention to administer the medication by mouth. Instead, however, he wrote his order in an uncertain, confusing manner considering that the drug in question comes in oral and injectible form and that in both forms dosage is prescribed in terms of cubic centimeters.

It is settled jurisprudence of this state that where the negligence of two persons combines to produce injury to a third, the parties at fault are [jointly] liable to the injured plaintiff.

[Thus, in unfortunately awkward language, the court affirms the jury's verdict and hold everybody liable.]

Norton v. Argonaut Insurance Co. Discussion Questions

1. How many mistakes can you count in this set of facts? At how many points could the chain of errors have been interrupted?
2. If you were the hospital administrator, the chief of the medical staff, or the chief of nursing, what action would you take to prevent recurrence of this tragedy?
3. It is nearly 50 years after this child's death, yet a 2007 report by the Institute of Medicine ("Preventing Medication Errors") states that at least 1.5 million people are injured each year because of medication errors. According to the report, on average there is at least one medication error per hospital per patient per day. What safeguards are in place in hospitals today to avoid these kinds of mistakes?
4. What does "pretermitting" mean?

THE COURT DECIDES

Johnson v. Misericordia Community Hospital
99 Wis. 2d 708, 301 N.W.2d 156 (1981)

[This case involves negligent surgery performed on Mr. Johnson by a Dr. Salinsky at Misericordia hospital in July 1975. Because of undisputed negligence by the doctor, the patient (plaintiff) has "a permanent paralytic condition of his right thigh muscles with resultant atrophy and weakness and loss of function." The doctor settled before trial, but the hospital disputed allegations that it was negligent. A verdict in favor of the plaintiff was affirmed by the court of appeals.

The Misericordia Community Hospital had previously been a religiously affiliated hospital but was sold to a private group of physicians who first operated it as a nursing home but subsequently reinstituted acute care services there. At the time of the incidents complained of, it had never been accredited by the Joint Commission.]

Coffey, J.

On March 5, 1973, ...Dr. Salinsky applied for orthopedic privileges on the medical staff. In his application, Salinsky stated that he was on the active medical staff of [other hospitals and that] his privileges at other hospitals had never "been suspended, diminished, revoked, or not renewed." In another part of the application form, he failed to answer any of the questions pertaining to his malpractice insurance, i.e., carrier, policy number, amount of coverage, expiration date, [and] agent, and represented that he had requested privileges only for those surgical procedures in which he was qualified by certification.

In addition to requiring the above information, the application provided

that significant misstatements or omissions would be a cause for denial of appointment. Also, in the application, Salinsky authorized Misericordia to contact his malpractice carriers, past and present, and all the hospitals that he had previously been associated with, for the purpose of obtaining any information bearing on his professional competence, as well as his moral and ethical qualifications for staff membership. *[The application also contained language releasing the hospital for any liability as a result of doing a background check on the applicant.]*

Mrs. Jane Bekos, Misericordia's medical staff coordinator (appointed April of 1973) testifying from the hospital records, noted that Salinsky's appointment to the medical staff was recommended by the then hospital administrator, David A. Scott, Sr., on June 22, 1973. Salinsky's appointment and requested orthopedic privileges, according to the hospital records, were not marked approved until August 8, 1973. This approval of his appointment was endorsed by Salinsky himself. Such approval would, according to accepted medical administrative procedure, not be signed by the applicant but by the chief of the respective medical section. Additionally, the record establishes that Salinsky was elevated to the position of Chief of Staff shortly after he joined the medical staff. However, the court record and the hospital records are devoid of any information concerning the procedure utilized by the Misericordia authorities in approving either Salinsky's appointment to the staff with orthopedic privileges or his elevation to the position of Chief of Staff.

Mrs. Bekos testified that although her hospital administrative duties entailed obtaining all the information available regarding an applicant from the hospitals and doctors referred to in the application for medical staff privileges, she failed to contact any of the references in Salinsky's case. In her testimony she attempted to justify her failure to investigate Salinsky's application because she believed he had been a member of the medical staff prior to her employment in April of 1973, even though his application was not marked approved until some four months later on August 8, 1973. Further, Mrs. Bekos stated that an examination of the Misericordia records reflected that at no time was an investigation made by anyone of any of the statements recited in his application.

....

At trial, the representatives of two Milwaukee hospitals...gave testimony concerning the accepted procedure for evaluating applicants for medical staff privileges. Briefly, they stated that the hospital's governing body, i.e., the board of directors or board of trustees, has the ultimate responsibility in granting or denying staff privileges. However, the governing board delegates the responsibility of evaluating the professional qualifications of an applicant for clinical privileges to the medical staff. The credentials committee (or committee of the whole) conducts an investigation of the applying physician's or surgeon's education, training, health, ethics and experience through contacts with his peers in the specialty in which he is seeking privileges, as well as the references listed in his application to determine the veracity of his statements and to solicit comments dealing with the applicant's credentials. Once [this has been done, a recommendation is relayed] to the governing body, which...has the final appointing authority.

The record demonstrates that had [such an investigation been conducted, Misericordia] would have found, contrary to [Dr. Salinsky's] representations, that

he had in fact experienced denial and restriction of his privileges, as well as never having been granted privileges at the very same hospitals he listed in his application. This information was readily available to Misericordia, and a review of Salinsky's associations with various Milwaukee orthopedic surgeons and hospital personnel would have revealed that they considered Salinsky's competence as an orthopedic surgeon suspect, and viewed it with a great deal of concern.

[The court summarizes some of Dr. Salinsky's professional history. At one hospital his request for expanded orthopedic privileges was denied after being on the staff for a year and a half. At another, his privileges were temporarily suspended and subsequently limited after a report of "continued flagrant bad practices." At a third, his initial application for privileges was flatly denied. The court adds, "The testimony at trial established many other discrepancies in Salinsky's Misericordia application," and it points out that experts in the field testified that, in their opinion, a prudent hospital would not have granted Salinsky's application under these circumstances.]

The jury found that the hospital was negligent in granting orthopedic surgical privileges to Dr. Salinsky and thus apportioned eighty percent of the causal negligence to Misericordia. Damages were awarded in the sum of $315,000 for past and future personal injuries and $90,000 for past and future impairment of earning capacity....

Issues

1. Does a hospital owe a duty to its patients to use due care in the selection of its medical staff and the granting of specialized surgical (orthopedic) privileges?

2. What is the standard of care that a hospital must exercise in the discharge of this duty to its patients[,] and did Misericordia fail to exercise that standard of care in this case?

At the outset, it must be noted that Dr. Salinsky was an independent contractor, not an employee of Misericordia, and that the plaintiff is not claiming that Misericordia is vicariously liable for the negligence of Dr. Salinsky under the theory of respondeat superior. Rather, Johnson's claim is premised on the alleged duty of care owed by the hospital directly to its patients.

.... "The concept of duty in Wisconsin, as it relates to negligence cases, is irrevocably interwoven with foreseeability. Foreseeability is a fundamental element of negligence." In [a prior case,] this court set the standard for determining when a duty arises:

A defendant's duty is established when it can be said that it was foreseeable that his act or omission to act may cause harm to someone. A party is negligent when he commits an act when some harm to someone is foreseeable. Once negligence is established, the defendant is liable for unforeseeable consequences as well as foreseeable ones. In addition, he is liable to unforeseeable plaintiffs.

Further, we defined the term "duty" as it relates to the law of negligence:

The duty of any person is the obligation of due care to refrain from any act which will cause foreseeable harm to others even though the nature of that harm and the identity of the harmed person or harmed interest is unknown at the time of the act.

....

Thus, the issue of whether Misericordia should be held to a duty of due care in the granting of medical staff privileges depends upon whether it is foreseeable that a hospital's failure to properly

investigate and verify the accuracy of an applicant's statements dealing with his training, experience and qualifications as well as to weigh and pass judgment on the applicant would present an unreasonable risk of harm to its patients. The failure of a hospital to scrutinize the credentials of its medical staff applicants could foreseeably result in the appointment of unqualified physicians and surgeons to its staff. Thus, the granting of staff privileges to these doctors would undoubtedly create an unreasonable risk of harm or injury to their patients. Therefore, the failure to investigate a medical staff applicant's qualifications for the privileges requested gives rise to a foreseeable risk of unreasonable harm and we hold that a hospital has a duty to exercise due care in the selection of its medical staff.

Our holding herein is in accord with the public's perception of the modern day medical scientific research center with its computed axial tomography (CATscan), radio nucleide imaging thermography, microsurgery, etc., formerly known as a general hospital. The public is indeed entitled to expect quality care and treatment while a patient in our highly technical and medically computed hospital complexes. The concept that a hospital does not undertake to treat patients, does not undertake to act through its doctors and nurses, but only procures them to act solely upon their own responsibility, no longer reflects the fact.... [T]he person who avails himself of our modern "hospital facilities"...expects that the hospital staff will do all it reasonably can to cure him and does not anticipate that its nurses, doctors and other employees will be acting solely on their own responsibility.

Further, our holding is supported by the decisions of a number of courts from other jurisdictions. These cases hold that a hospital has a direct and independent responsibility to its patients, over and above that of the physicians and surgeons practicing therein, to take reasonable steps to (1) insure that its medical staff is qualified for the privileges granted and/or (2) to evaluate the care provided.

[The court here embarks on a lengthy discussion of similar cases from various other states. It particularly points out the leading case of Darling v. Charleston Community Memorial Hosp. in which the Supreme Court of Illinois found a direct duty flowing from hospital to patient regarding the qualifications of members of the medical staff. The Johnson court favorably quotes from the Darling opinion, including the following passage: "The Standards for Hospital Accreditation, the state licensing regulations and the defendant's bylaws demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient."]

There was credible evidence to the effect that a hospital, exercising ordinary care, [would have known of the deficiencies in Dr. Salinsky's qualifications and] would not have appointed Salinsky to its medical staff....

This court has held "* * * a jury's finding of negligence * * * will not be set aside when there is any credible evidence that under any reasonable view supports the verdict. * * *" Thus, the jury's finding of negligence on the part of Misericordia must be upheld [because] the testimony of [the expert witnesses] constituted credible evidence which reasonably supports this finding.

In summary, we hold that a hospital owes a duty to its patients to exercise reasonable care in the selection of its medical staff and in granting specialized privileges. The final appointing authority resides in

the hospital's governing body, although it must rely on the medical staff and in particular the credentials committee (or committee of the whole) to investigate and evaluate an applicant's qualifications for the requested privileges. However, this delegation of the responsibility to investigate and evaluate the professional competence of applicants for clinical privileges does not relieve the governing body of its duty to appoint only qualified physicians and surgeons to its medical staff and periodically monitor and review their competency. The credentials committee (or committee of the whole) must investigate the qualifications of applicants. [Paragraph break added.]

The facts of this case demonstrate that a hospital should, at a minimum, require completion of the application and verify the accuracy of the applicant's statements, especially in regard to his medical education, training and experience. Additionally, it should: (1) solicit information from the applicant's peers, including those not referenced in his application, who are knowledgeable about his education, training, experience, health, competence and ethical character; (2) determine if the applicant is currently licensed to practice in this state and if his licensure or registration has been or is currently being challenged; and (3) inquire whether the applicant has been involved in any adverse malpractice action and whether he has experienced a loss of medical organization membership or medical privileges or membership at any other hospital. The investigating committee must also evaluate the information gained through its inquiries and make a reasonable judgment as to the approval or denial of each application for staff privileges. The hospital will be charged with gaining and evaluating the knowledge that would have been acquired had it exercised ordinary care in investigating its medical staff applicants and the hospital's failure to exercise that degree of care, skill and judgment that is exercised by the average hospital in approving an applicant's request for privileges is negligence. This is not to say that hospitals are insurers of the competence of their medical staff, for a hospital will not be negligent if it exercises the noted standard of care in selecting its staff.

The decision of the Court of Appeals is affirmed.

Johnson v. Misericordia Community Hospital Discussion Questions

1. In 1881 Oliver Wendell Holmes, Jr., wrote this in his classic treatise *The Common Law*: "The life of the law has not been logic; it has been experience. The felt necessities of the time, the prevalent moral and political theories, institutions of public policy, avowed or unconscious, even the prejudices which judges share with their fellow men, have had a good deal more to do than the syllogism in determining the rules by which men should be governed." How is this case an example of the truth of this passage?

2. Do you agree with the court's rationale? What would have been the implications of the opposite result?
3. Do you agree with the court's statement of how the public perceives a modern hospital today? What evidence is there to support this statement?
4. Does this decision mean that a hospital will be liable for every incident of malpractice committed by its nonemployee members of the medical staff? Why or why not?

CHAPTER

6

ADMISSION AND DISCHARGE

After reading this chapter, you will

- know the law regarding the hospital's duty to admit and care for patients under routine and emergency circumstances.
- recognize that not-for-profit hospitals have certain obligations to provide benefits to the community because of their not-for-profit, tax-exempt status.
- understand the kinds of issues that arise upon the admission and discharge of psychiatric patients.
- have new knowledge about issues in managed care.

As the title suggests, this chapter addresses legal issues relating to hospital admission and discharge. The chapter covers the following:

- access to healthcare and voluntary admission (including the right to care, the admissions process, the right to equal protection, and hospitals' obligations under the Hill-Burton Act and similar laws);
- admission and treatment of mentally ill patients (including involuntary commitment and the standard of care for administering medications);
- discharge from the hospital; and
- utilization review, peer review, and managed care issues.

Access to Healthcare and Voluntary Admission

The General Right to Care

It is important to emphasize at the beginning that hospitals do not admit patients; physicians do. Nevertheless, hospitals must have admission and discharge policies because, among other reasons, hospital policies often

dictate the legal issues involved in any given case. For example, the types of services the hospital offers determine who can be admitted, and information gathered during the admission process determines whether vital medical and business records will be accurate.

Various factors affect a patient's right to be admitted to a healthcare facility. The first consideration is whether the patient's condition is an emergency and whether the hospital has the facilities and staff to treat that emergency. (Care of emergency patients is discussed in more detail in Chapter 8.) A second factor may be whether the patient has been treated at the hospital before. A third relates to the hospital's ownership; a governmental hospital is often subject to different standards of care than those imposed on private hospitals. A fourth point is whether the facility has received federal funding under the Hill-Burton Act; if so, there may be a duty to provide service for an indigent person.

It is "black-letter law" (a general rule) that a nonemergency patient has no legal right to be admitted to any voluntary or proprietary hospital or to most governmental hospitals.[1] (See The Court Decides: *Hill v. Ohio County* at the end of this chapter.) Thus, most institutions can generally accept or refuse nonemergency cases with impunity as long as admission policies are not illegally discriminatory and the relevant Hill-Burton Act regulations are followed. Refusal to admit, therefore, does not ordinarily give the patient grounds to challenge hospital admission policies. However, contractual arrangements could create an exception to this general rule. A hospital that enters into a contract with a particular group of patients or with another party (such as an employer or a managed care plan) has a duty to admit group members whenever the need arises and the hospital is capable of providing needed services. Breach of this contractual obligation gives the other party or the beneficiary a right to sue for damages.[2]

In addition, individuals' rights under the U.S. Constitution and various civil rights statutes must be respected. Healthcare is not considered a fundamental right—such as voting,[3] freedom of speech, and the right to counsel in a criminal trial[4]—but hospitals may not discriminate on the basis of race, color, creed, national origin, or similar suspect classifications. The reasons are sometimes based on constitutional principles (for example, when "state action" is involved), but more often they depend on federal and state civil rights laws (the details of which are beyond the scope of this text).

In short, although there is usually no constitutional basis for claiming that an individual has a right to healthcare or payment for it from public funds,[5] both access and payment are affected by various statutes.[6] These laws differ from jurisdiction to jurisdiction and in accordance with political and economic developments. For example, it remains to be seen

how public policy will ultimately deal with the social issue of the many millions of U.S. residents who do not have health insurance coverage.

Right to Admission and Services

Despite most hospitals' relative freedom to refuse care for nonemergency patients, legal risks arise when a hospital asserts this right too vigorously (these risks are explored more fully in Chapter 8). Admission policies based on discriminatory criteria, such as race or inability to pay, raise serious legal issues and generate lawsuits. Even refusing treatment of difficult, disruptive persons whose presence may seriously interfere with the care of other patients is a matter of concern.

Rather than focusing on whether a patient has a right to be admitted, the hospital should be attentive to its purpose and role in the community. Having defined its purpose and role—its mission—the hospital must work to provide adequate facilities, equipment, and staff to fulfill that mission. If such policies are adhered to, the narrow legal question of the patient's right to admission does not generally appear.

Governmental Hospitals and the Duty to Provide Services

Governmental hospitals are creatures of statute and are established for specific purposes. Many such statutes sort the hospital's intended beneficiaries according to their particular disease, financial status, or place of residence. Under these statutes, a patient who falls within the intended class of beneficiaries usually has a right to be treated. However, even if such a legal right exists, it is not absolute. For example, a right to treatment will be subject to the hospital's actual ability (e.g., staffing levels, available space and equipment) to provide the care needed. The right to treatment will also depend on the rules and regulations of the governing board. For example, the board might properly require proof of inability to pay when the hospital's statutory purpose is to serve the indigent. (Note that even if the hospital's statutory mandate is to care for those unable to pay, the law does not prevent the hospital from admitting patients who are able to pay if facilities are available.)

Like a private hospital, a governmental hospital may usually exclude persons suffering from a condition that the facility is not equipped to treat. For example, a general hospital may ordinarily deny admission to a mental health patient or to one afflicted with a contagious disease when facilities and staff are not available to care for these people properly. The patients would have no cause of action for being refused admission, particularly if their admission would endanger other patients.

Governmental hospitals owe the same duty of care to emergency patients as do other hospitals: to stabilize the patient's condition. Even if an individual is not within the group of persons the facility was set up to serve, refusing to give emergency care is not justified just because that

individual is outside the class of persons the governmental hospital is set up to serve (see discussion and case citations on this in Chapter 8).

Local Government's Duty to Reimburse for Care

Most states have statutes providing for payment from public funds for certain medical services furnished to indigent persons. Legislation differs significantly from state to state on the services covered, the patients entitled to care, the process for payment, and the facilities that can render services. Typically the statutes require municipal or county governments to pay for emergency medical care given to indigent persons wherever the care is rendered. These laws have withstood constitutional challenges.[7] Healthcare administrators must be aware of local statutes and judicial decisions that determine an institution's right to reimbursement.

In many states, counties are required to reimburse for emergency medical care given to indigent residents. In Arizona, for example, if an indigent patient who needed emergency care were admitted to a private hospital, the county's obligation to pay for the services would continue throughout the period of hospitalization, even after the emergency ended. In *St. Joseph's Hospital and Medical Center v. Maricopa County* an indigent patient was admitted to a private hospital for emergency treatment. Later the agency responsible for paying the medical expenses could have ended its obligation to reimburse the private hospital by arranging the patient's transfer to a county-owned facility. It did not do so, and the government had to pay for the entire hospitalization.[8] Similarly, in Nevada a county has a duty to pay for emergency care whether rendered at a county hospital or elsewhere, and prior governmental consent is not required if the patient's condition threatens his life or causes permanent impairment.[9]

The duty to pay for the care of indigents is, obviously, becoming a major policy issue given the sharp increase in the number of illegal immigrants and other uninsured persons in many states.

Also of concern is reimbursement for healthcare furnished to persons who (a) have been found guilty of a crime, (b) are in custody or under arrest awaiting trial, and (c) have been injured during apprehension. The duty to pay may differ depending on the status of the patient. One must also distinguish between the duty to provide or summon care and the government's duty to pay for that care. Failure to obtain medical assistance for a prisoner or person in custody can lead to liability for negligence. For example, an Indiana municipality was liable for the wrongful death of a person arrested for being drunk and disorderly on the ground that the police knew or ought to have known that the person needed medical treatment.[10]

The Bill of Rights prohibits "cruel and unusual" punishment, and this has been interpreted to require governments to provide convicted prisoners with adequate medical treatment.[11] The due process clauses of the Fifth and Fourteenth Amendments require that persons who have not been convicted

but who have been detained or are under arrest be given essential food, shelter, clothing, and medical care.[12] On the other hand, a person not dependent on the government has no constitutional right to medical care,[13] and the right to receive care is not necessarily accompanied by a right to have that care paid for by the government.

Some laws clearly say that the government must pay for care given to prisoners[14] or persons in police custody (see The Law in Action).[15] (The duty to pay might be limited to cases in which the government's institutional facilities are inadequate[16] or where the prisoner, or the family, is unable to pay.[17]) Most states' legislation, however, simply upholds a prisoner's right to receive medical care and is silent on the question of the government's duty to pay a nongovernment provider for that care.[18] The statutes might not apply to persons injured by the police at the scene of an alleged crime or while being apprehended, because such a person is not under arrest or in custody. Although the police probably have a duty in such circumstances to seek medical care for the injured person, the government is not obligated by either common or constitutional law to pay the care provider; that obligation arises, if at all, only through legislation.

The Law in Action

In my experience, the government's obligation to pay for care is the reason some police forces will not officially arrest an injured suspect until after emergency treatment has been completed.

For example, in *City of Revere v. Massachusetts General Hospital*, Patrick Kivlin attempted to flee from the scene of a crime and was shot by a police officer.[19] The police summoned an ambulance, which took Mr. Kivlin to Massachusetts General Hospital, where he remained for nine days. Although he was in police custody and a warrant had been issued, he was not officially arrested until the date of his discharge from the hospital. A month later he was again hospitalized, but the city of Revere refused to pay for either hospitalization.

The Supreme Judicial Court held that Massachusetts contract law provided no basis for ordering the city to pay, but it found that the Eighth Amendment's prohibition against cruel and unusual punishment did require it to do so.[20] After granting certiorari, the U.S. Supreme Court overruled the Supreme Judicial Court's finding on the Eighth Amendment issue: "Because there had been no formal adjudication of guilt against Kivlin at the time he required medical care, the Eighth Amendment has no application." Although the Supreme Court noted that due process requires persons in Mr. Kivlin's situation be given care, local government had no duty to pay for that care in the absence of state legislation. Thus, just as the state may deny payment for an elective abortion[21] and the federal government may restrict Medicaid payments for abortions,[22] the city of Revere was not required to pay Massachusetts General Hospital.[23]

The Law in Action

Remember, the Supreme Court's role is not necessarily to do justice in every case but to decide fundamental issues. In *Revere* the issue was an interpretation of the Eighth Amendment. Because the source of payment is not a constitutional issue (under the Eighth Amendment or otherwise), that issue was left to the wisdom of the legislature of the Commonwealth of Massachusetts.

Not exactly an equitable result, but so sayeth the Supreme Court of the United States (see The Law in Action).

Reasonable Care Requirements and Admission Forms

Once patients are admitted to a hospital there is, of course, a duty to exercise reasonable care for their treatment. Moreover, a kind of virtual admission can occur and the duty to exercise reasonable care can arise even without formal admission procedures. Consider *LeJeune Road Hospital, Inc. v. Watson*.[24] In this case the hospital refused a bed to a minor suffering from appendicitis because his mother had not paid the required advance deposit. Staff members had already put a hospital gown on the boy and examined him, but surgery was delayed until his parents could find an institution that would care for him. In defending against the parents' lawsuit the hospital contended that formal admission had not occurred and that no duty to exercise reasonable care had been created. This argument was flatly rejected. The court held that even though the hospital had no positive duty to admit, as a practical matter admission had occurred.

Certain practices must be followed once a decision is made to admit a patient. Although the specifics may vary from hospital to hospital, in general the admission process ("registration") must include collection of the following types of information:

- demographics, such as patient name, address, telephone number, marital status (or personal representative if other than a spouse), gender, race, and social security number;
- religious affiliation (if the patient cares to disclose that information);
- emergency contacts;
- identity of and demographics on the financially responsible party (e.g., patient, parent, guardian);
- insurance coverage(s);
- name of the admitting physician;
- patient's language preferences and English proficiency;
- special needs (e.g., sign-language interpretation); and
- special requests regarding release of patient information.

Also at the time of registration the patient and family must be given a wide range of information, both out of general courtesy and because of legal requirements. This information includes the following:

- general hospital information (e.g., maps; telephone numbers; parking restrictions; visiting, cafeteria, and gift-shop hours);
- where to store personal belongings, and what to do with valuables;
- smoking regulations;
- generalized consent for routine care and diagnostic procedures (which must be signed and placed in the medical record and which does not substitute for a detailed informed consent for significant medical procedures);
- the hospital's "Notice of Privacy Practices"; and
- other relevant hospital information.

The preceding lists are not all inclusive and are provided here for the reader's information only. Legal counsel can discuss the full range of issues to be addressed at registration.

Hill-Burton Act and Mandated Free Care

The purpose of the Hospital Survey and Construction Act, enacted in 1946 and commonly known as the Hill-Burton Act, was to provide federal financing for the construction and modernization of publicly owned and not-for-profit hospital facilities.[25] For political reasons, and despite President Truman's attempts to create a national health service, the legislation did not contain any provisions for the government to pay for services rendered in Hill-Burton facilities. Two decades passed before Congress enacted Medicare.

To accommodate President Truman, Hill-Burton required recipients of financial assistance to furnish a "reasonable volume" of services for persons unable to pay, unless the providers were financially unable to do so.[26] This provision became known as the hospital's uncompensated care obligation. The statute also required that hospital facilities financed with federal funds be made available to all persons in the community, a duty commonly referred to as the community service obligation.[27]

For political reasons the Hill-Burton program was implemented through the states. The states were given responsibility for determining the need for facilities, establishing a statewide plan, and obtaining assurances from grant applicants that they would comply with the uncompensated care and community service obligations.[28] Thus, the Hill-Burton Act potentially represented a means of providing healthcare to the poor. For many years, however, the requirements were not implemented effectively. The initial administrative regulations did not actually require the states to ensure that financially assisted institutions were furnishing free care. They also failed to define a "reasonable volume" of services or to specify patient eligibility criteria. Because of these enforcement lapses, several Hill-Burton class-action lawsuits contended that some institutions were violating the law because (a) they required cash deposits or evidence of adequate insurance

before admitting patients or (b) they automatically billed patients without regard to their ability to pay. The first case of this kind—in a federal district court in Louisiana—held that the Secretary of the Department of Health, Education, and Welfare (HEW; this is now the Department of Health and Human Services) had violated his statutory obligations to enforce the Hill-Burton assurances.[29] The court ordered the hospitals to develop rules for implementing their obligations and to submit these for court review.[30]

Following this and other decisions, HEW set forth new regulations holding that an institution that received Hill-Burton financing could presume to meet its uncompensated care obligation by budgeting a certain minimum amount for free care or by simply certifying that it did not refuse admission solely because of inability to pay. (The latter option for compliance was sometimes referred to as the "open-door policy."[31])

The community-service obligation was interpreted as requiring all Hill-Burton hospitals to serve Medicaid patients[32] and to extend emergency care to any person residing or employed in the hospital's service area regardless of ability to pay.[33] All services had to be nondiscriminatory with regard to race, color, creed, or national origin. A patient denied charity care was entitled to procedural due process: adequate notice of eligibility criteria, written reasons for denial, and an opportunity to appeal an adverse decision to an impartial administrator.[34] When a hospital could not demonstrate compliance for particular years it could be required to remedy the deficits.[35]

The regulations held that the uncompensated care obligation lasted for 20 years after construction of the facility (in the case of a loan, for the length of the loan). They also delegated to state Hill-Burton agencies the task of identifying persons eligible for uncompensated care according to certain specified criteria and made states responsible for monitoring hospital compliance, applying sanctions in cases of noncompliance, and posting notices to patients that uncompensated care was available.[36] The 1973 rules, however, permitted hospitals to treat bad debts as "free care" by allowing the determination of eligibility to be made after rendering the services and billing the patient (see Legal Brief). Factors used to determine uncompensated care included insurance coverage, family income, family size, state standards for Aid to Families with Dependent Children, and federal poverty guidelines. The state agency also established for each healthcare institution the reasonable level of uncompensated services after considering the institution's budget and annual statement, the nature and volume of services, the need within the service area, and the ability of other nearby healthcare organizations to provide charity care.

Several lawsuits were filed to challenge these regulations. The uncompensated care guidelines were consistently upheld,[37] and the 20-year limitation on

the obligation was said to be consistent with congressional intent.[38] On the other hand, the regulations permitting routine billing of patients and postponing the determination of eligibility for free care until services were rendered were held to be invalid.[39] Subject to certain exceptions—including a medical emergency, for example—the amended rules required a written determination of a patient's eligibility before services were provided.

Legal Brief

Equating "bad debts" with "free care" meant that whether a patient could not pay or simply would not pay, the hospital could still count the amount of the unpaid bill toward its Hill-Burton obligation. This was seen as contrary to the spirit of the law, which was to provide care to those unable to pay.

The National Health Planning and Resource Development Act of 1974 (Public Law 93-641) essentially terminated the original Hill-Burton program and substituted a somewhat more restrictive scheme of providing federal funds to modernize healthcare institutions.[40] This legislation not only recognized the continuing obligation of hospitals to provide uncompensated care and community service, but it also mandated new regulations. Congress now acknowledged that Hill-Burton had never been effectively implemented, and thus the new law placed greater responsibility on HEW to enforce the provisions for care of the indigent. The statute also provided that funding of projects under the new law would obligate the recipients to furnish uncompensated care and community service for an indefinite period. Because the new law was not retroactive, however, institutions that received funds before 1975 could still claim the 20-year limit on their obligation.[41]

Over the years, restraints on the federal budget have restricted appropriations of new funds for hospital construction, and the 20-year uncompensated care obligations have expired. Healthcare administrators must, therefore, review their institutions' history of federal funding to determine their obligations under either the Hill-Burton law or the regulations that implemented the health planning law. Because of the passage of time, these two measures are less significant now than they once were. They may have some lingering viability for some institutions, however.

Admission and Treatment of Mentally Ill Patients

The legal rights of a mentally ill and incompetent patient are determined by both constitutional law and state statutes. Because both of these sources of law are continually evolving, hospital management needs competent, current advice concerning emergency treatment, temporary detention, and formal admission of these persons.

As explained in Chapter 8, a general hospital's refusal to extend emergency care to an incompetent or mentally ill patient could lead to tort liability. On the other hand, a refusal to admit such a person will not usually lead to liability if the hospital is not staffed or equipped for psychiatric patients. Nevertheless, at the request of relatives, social welfare agencies, or the police an acute care hospital may decide to admit temporarily an unwilling, incompetent patient for the patient's own safety or for the protection of others. Unless admission procedures follow local statutory procedures carefully, the hospital risks liability to the unwilling patient for the intentional torts of false imprisonment and/or assault and battery.

The hospital should make certain that only reasonable force is used to restrain a patient, that detention continues only for a reasonable time within statutory limits, and that restraint or detention have the legitimate purpose of protecting the patient or third parties. Medical and administrative personnel must be certain that they are following statutory requirements regarding involuntary admission.[42] Unwilling, incompetent patients should be admitted or detained only on the order of a licensed physician exercising professional judgment in good faith. When professional persons are acting in good faith and according to constitutional and statutory requirements, the risks of liability are small.[43]

Involuntary Commitment

Because institutionalization represents a significant deprivation of personal liberty, state statutes governing the civil commitment of mentally ill persons must ensure that the patient is granted both substantive and procedural due process of law.[44] A person may not be committed involuntarily unless mental illness presents a danger to the patient or to third parties.[45] Danger to self can be found if patients cannot provide the basic necessities of life or if there are indications that they may harm themselves. Unless persons are adjudged dangerous to themselves or others, indefinite confinement in a state mental hospital without treatment violates their right to due process, and the officials responsible for such confinement can be personally liable under civil rights laws.[46]

When mentally ill patients present a danger to themselves, a state has a legitimate interest—under its parens patriae powers—to provide needed care.[47] If mentally ill patients present a danger to the community or to third parties, civil commitment is justified by the state's police power to regulate matters of health, safety, and welfare.[48] Many states require evidence of a timely overt act or threat of violence to show that the patient represents a danger. To meet such a standard, however, requires psychiatrists and other professionals to predict a patient's behavior, a task that may be scientifically or medically impossible (see Legal Brief).

Balancing the legitimate rights of patients with the recognized interests of society involves difficult questions of social policy and medico-legal

judgments. The attempt to achieve such a balance creates a twofold risk: (1) some patients who are not dangerous might be released when in fact they need further care for other reasons, and (2) patients who are thought to pose no risk might be released and then proceed to harm others.[49] (Misdiagnosis standing alone does not constitute negligence or malpractice. When a patient or third party alleges that a physician's negligent diagnosis was the proximate cause of damage, the plaintiff must carry the burden of proof and show by expert witness testimony that the defendant departed from generally recognized standards of practice.) The possibility of error is increased by the fact that the concept of "dangerousness" is ill defined in both medicine and law, and in many commitment hearings the matter is left for the jury to decide on the basis of testimony from expert witnesses.

Legal Brief

"The American Psychiatric Association (APA)... informs us that '[the] unreliability of psychiatric predictions of long-term future dangerousness is by now an established fact within the profession. The APA's best estimate is that two out of three [such] predictions are wrong. The Court does not dispute this proposition, and indeed it could not do so; the evidence is overwhelming."

—*Barefoot v. Estelle,* 463 U.S. 800 (1983)

Local statutes typically allow involuntary detention in emergencies for a limited period ranging from 48 hours to several days, depending on the jurisdiction. Because patients suffering acute psychotic episodes may seek help from the emergency staff of a community hospital, the personnel must be especially aware of relevant provisions authorizing short-term detention of such persons. In essence, the statutes require that the patient be either discharged from the hospital following the emergency or granted a timely hearing as specified by the statute.

In a civil commitment the patient must receive a notice of the contemplated proceedings and a statement of the reasons for commitment. Such patients have the right to be present and to be represented by counsel at the hearing, the right to examine and cross-examine witnesses, the right to a jury trial, and the right of appeal.[50]

Due process does not require that civil commitment proceedings use the "beyond a reasonable doubt" standard of proof that is required in criminal proceedings.[51] On the other hand, the "preponderance of evidence" standard—which is applicable to most civil litigation—is not strong enough; after all, involuntary hospitalization deprives the patient of liberty, and the risks of an erroneous decision are grave.[52] An intermediate standard of proof is more likely to balance the rights of the mentally ill with the legitimate concerns of society. This modified standard, endorsed by the Supreme Court, is often expressed as "clear, convincing, and unequivocal" evidence of danger to self

or others.[53] (Due process, however, does not require the states to use the same uniform standard of proof in civil commitment proceedings. Some states have, in fact, adopted the criminal-law standard by statute or judicial decision. It is permissible to use a standard higher than constitutionally required.)

Courts distinguish between civil commitment of a mentally ill person not charged with a crime and commitment of one who has been charged. In *Jones v. United States* the defendant was acquitted in a criminal trial by reason of insanity and then placed in an institution for the mentally ill. An insanity finding was based on a "preponderance of evidence" rather than "clear and convincing" proof. The majority ruling held that the less demanding standard was consistent with due process even if the period of hospital confinement would exceed the prison term for the criminal charge.[54]

Standard of Care and Administration of Medication

Once committed, a patient retains substantive constitutional rights not only to adequate food, shelter, clothing, and medical care[55] but also to safe physical conditions, reasonable freedom from physical restraints, and rehabilitation or training appropriate to the individual's diagnosis.[56] Officials of hospitals that fail to implement these duties can be held personally liable.[57]

Minimally adequate medical care and treatment for mentally ill persons was defined by one federal court as follows:

> In order to render effective care and treatment, a hospital for the mentally ill must not only hire qualified individuals, but must ensure the continuation of their training and education during their employment.... [T]he court finds there are four standards generally advanced by mental health professionals as essential for minimally adequate treatment: a humane and therapeutic environment; qualified staff in sufficient numbers; an individualized treatment plan for each patient; and planned therapeutic programs and activities. It is against these standards that the conditions at a psychiatric facility must be measured in order to determine whether those operating the facility have failed to provide treatment for those mentally ill individuals involuntarily confined for such purpose in violation of the Fourteenth Amendment of the United States Constitution.[58]

With respect to conditions of confinement and the patient's right to rehabilitation and training, the Supreme Court has held that the Constitution

> only requires that the courts make certain that professional judgment in fact was exercised[:] the appropriate standard [is] whether the defendants' conduct

> [is]...such a substantial departure from accepted professional judgment, practice, or standards in the care and treatment of this plaintiff, as to demonstrate that the defendants did not base their conduct on a professional judgment.[59]

In the Supreme Court's view, this standard "affords the necessary guidance and reflects the proper balance between the legitimate interests of the State and the rights of the involuntarily committed to reasonable conditions of safety and freedom from unreasonable restraints."

In several contexts, courts have developed the principle that mentally ill persons should not be presumed incompetent to make treatment decisions. The decision to commit someone involuntarily is not the same as a finding of incompetence. Thus, a competent patient has the right to consent (or refuse to consent) to her own care unless her or others' safety requires it. For example, competent psychiatric patients who are not a danger to themselves or others may not be given antipsychotic medications (which may have serious side effects) against their will and may not be forced to become subjects of medical research. The foundation for this rule has been described as part of a "right of privacy" or, more simply, as a principle of common law.[60]

The right to give informed consent (see Chapter 9) can be overcome, and medications, restraints, and other measures can be forcibly administered, only when there are compelling reasons for doing so. In all jurisdictions, unless an immediate danger or threat of harm exists, the patient is entitled to (1) professional determination that medication or restraint is necessary, (2) evaluation of alternatives, and (3) regular review of the recommended course of treatment.[61] A formal hearing is not required, but a judicial determination of incompetence and the appointment of a guardian might be required.

Discharge from the Hospital

In most cases, discharge from the hospital presents no significant legal issues. Most discharged patients (psychiatric or other) are of sound mind and do not present a health risk to themselves or others. As soon as they are able, most wish to be at home or at another institution that better suits their needs. (In the emergency department, discharges and transfers of psychiatric patients entail particular legal hazards—see Chapter 8).

It is elementary that patients should not be discharged without a written order from a licensed physician and that a hospital or a physician can be held liable for abandonment when discharging a patient who needs further care. The test is whether the healthcare provider acted reasonably under the circumstances[62] and whether the patient's condition was likely to be aggravated by the discharge.[63] If an unreasonable risk was taken, it does not matter why the hospital discharged the patient. (The patient's

failure or inability to pay the bill is certainly no justification for discharge.) When contemplating a patient's transfer to a less costly institution (for example, when required by a managed care plan), attending physicians must be certain that the receiving institution is adequately equipped and staffed to care for the patient's condition properly. Most states have statutes that contain standards for proper patient transfers, and federal standards apply in the emergency setting.

Several cases illustrate the prospect of this kind of liability. For example, in *Meiselman v. Crown Heights Hospital* the defendant was liable for discharging a minor while his legs were in casts and open wounds were draining.[64] Further professional care at home was necessary, and this was to be arranged and supervised by the chief of the hospital's surgical staff. The home care proved to be inadequate, however, and the patient had to be sent to another hospital. Because the need for further care was foreseeable and there was evidence that the motive for discharging the patient was financial, the discharge was considered unreasonable.

Patients can be discharged or given temporary leaves of absence only on the written order of a physician, but the decision is not solely a medical matter. In fact the hospital itself owes the patient a duty to have proper discharge policies. In one case a physician mistakenly diagnosed a diabetic patient who was near death; he thought the patient was suffering from delirium tremens and called for the sheriff to remove him from the facility. When the patient's estate claimed that premature release was the proximate cause of death the court held that the plaintiff was entitled to a trial on questions relating to the hospital's possible negligence.[65] "We cannot agree that the hospital operates as a slavish handmaiden to the physicians on its staff.... Under Alabama law a hospital [has] a duty of care to its patients."[66] (See Chapter 7 for a discussion of staff physician as an independent contractor.) Had there been hospital policies requiring trained staff to be involved in discharge planning, the problem might have been avoided.

If a patient represents a known threat to third persons, the hospital and attending physician can be liable to persons injured by the patient after discharge. In *Semler v. Psychiatric Institute of Washington, D.C.*, a man who pleaded guilty to abducting a young girl received a suspended prison sentence contingent on continued inpatient treatment at a psychiatric institution.[67] On later recommendations of his physician and probation officer, the court approved his transfer to day care, permitting him to live at home and commute daily to the hospital with his parents. Soon, however, he began living alone and working as a bricklayer's helper, all with the knowledge of his attending physician and the court probation officer but without court approval. He then murdered a girl. The psychiatric facility, the physician, and the probation officer were all held liable for allowing the patient full

outpatient status without obtaining the court's approval. Because the court had not given the probation officer authority to approve the transfer, that approval did not shield the institution from liability and the officer's unauthorized act made him personally liable.

There can also be liability when a readily identifiable potential victim suffers foreseeable harm and was not warned of the danger. Depending on the circumstances, some courts have drawn a distinction between breach of duty to the community at large (negligent discharge) and breach of duty to warn a third party who is at particular risk (see The Law in Action).[68]

The Law in Action

The famous *Tarasoff* case in California is perhaps the most notorious and tragic of cases involving a duty to warn third parties of a patient's dangerous propensities. It is discussed in Chapter 14 under the heading "Release of Information Without the Patient's Consent."

Programs for home care—for any patient, not just psychiatric patients—require careful planning and monitoring to meet the individual's needs. Discharge of a patient to home care requires attending physicians and hospital personnel to be careful in instructing the patient and family and to relay medical information to professional persons responsible for the home health program.[69] Failure to do so would constitute a breach of the hospital's duty. The hospital would also remain vicariously liable for the negligence of those responsible for continuing care of the patient if they are hospital employees or apparent employees. If the patient's care and treatment are rendered under the jurisdiction of the court, the orders of the court must be strictly followed.

Leaving Against Medical Advice

A problem arises when patients—even those of sound mind—insist on leaving the hospital though they are still in need of care. They cannot be held in the hospital against their will because that would constitute false imprisonment,[70] but if at all possible they should not be allowed to just walk away. Attending physicians should advise these patients on why remaining is recommended and what the consequences are of leaving early. If the patients insist, however, they must usually be allowed to go. The hospital must have a detailed policy to cover these situations. It should include documentation of the advice given and the patient's signature on a form releasing the hospital from liability. This form should state that the patient was fully aware of the medical reasons for remaining and had been advised not to leave the hospital, that the discharge was solely on the patient's own initiative, and that the refusal to stay was a matter of the patient's free will and volition. Some patients who insist on leaving "AMA" (against medical advice) refuse to sign the release. If so, they cannot be forced to sign, but the hospital policy should require that the substance

of the form be explained and that the patient's refusal to sign be documented.

Restraining patients of unsound mind from leaving the hospital is permissible if their departure would endanger their health or life[71] or the lives or property of others.[72] On the same grounds, patients of sound mind who are suffering from a contagious disease may be detained to protect themselves and others. (In fact the hospital may have an affirmative duty to the community to refuse to discharge such patients.) Restraint in preventing them from leaving the hospital must be reasonable according to the circumstances of each case. It is essential to provide competent medical evidence of the contagious disease or the mental instability of patients detained on either of these grounds, and all relevant facts must be documented in the medical record. Hospital policies should address this possibility.

A patient should never be held in the hospital for failure to pay a bill or until arrangements for settlement are complete. This amounts to false imprisonment, especially if force is used or threats are made.[73] Of course, proper policies should ensure that the payment question is addressed at the time of admission, not discharge.

Nonemancipated minors below the age of discretion should be discharged only to their parents or to persons who are legally entitled to custody. If the whereabouts of the parents are unknown and there is no court-appointed guardian, steps should be taken to have a guardian appointed. Social welfare agencies should help the hospital in these situations. If the parents can be located but for some reason cannot come to the hospital, the patient should be discharged only to someone who has written permission from a parent.

Emancipated minors—those who are old enough to consent for themselves under state law—can be discharged from the hospital in the same manner as adults. Emancipation is usually a matter of agreement between the parent and child; it is a question of fact in each case and does not depend on whether the youth is or is not living at home. In some states emancipation results when a minor marries. It can also be decreed by a court in some cases.

Generally it is legally sound to discharge the infant child of a minor mother to the custody of the mother. The hospital cannot prevent the mother from claiming her child, especially when she intends to retain custody and responsibility for raising the infant. Even if she intends to place the child for private adoption, most states recognize her legal right to do so in accordance with local limitations and restrictions. If the mother does not claim the child herself but requests discharge to a third party, the child should not be discharged except on the recommendation of an approved social service agency that handles adoptions. Legal counsel should be consulted for advice consistent with law.

Most states now have safe haven (or "Baby Moses") laws that allow mothers to leave unwanted children in the hands of care providers anonymously and with no questions asked. These laws were adopted to prevent infanticides and baby abandonment. They were not passed with in-hospital births in mind, but their premise is consistent with the idea that at the time of the mother's discharge from the hospital the question of the baby's discharge depends on the mother's wishes (see Legal DecisionPoint).

Legal DecisionPoint

A new mother is about to be discharged but does not want custody of the baby. She has not made any arrangement for private adoption, does not want to take the baby home with her, and has not named another person to take custody. If she were to leave the hospital with the baby, she could walk across the street to a fire or police station and abandon the child anonymously. She could also return to leave the baby outside the hospital emergency department, also anonymously. But if she simply leaves the baby behind when she is discharged, the abandonment is not anonymous: hospital personnel have a record of the baby's birth, the mother's name, and other information.

How should the hospital deal with the privacy issues that can arise? What if the supposed father, learning of the situation, arrives to claim the child? What if he or someone else alerts the media or state child protection agencies? Can hospital authorities confirm anything about the case? Why or why not? What can be said to whom, and (especially) what can be said in public?

Utilization Review, Peer-Review Organizations, and Managed Care

Utilization Review and Case Management

Hospital policy includes a utilization review and case management (UR/CM) process that makes recommendations on the appropriateness of continued hospitalization and that arranges for any needed postdischarge care (such as skilled nursing services or home health care). This process serves an advisory purpose and does not have the authority to order a patient's discharge or transfer—that is the prerogative of the attending physician.

Normally UR/CM recommendations are based on sound professional judgment related to the patient's medical needs. Unfortunately, however, sometimes there is financial pressure from a managed care plan that wants to keep its costs (its "medical loss ratio") as low as possible (see Legal Brief on page 176). Under the terms of the managed care contract, the plan can tell the hospital and the physician that the patient's insurance will only pay for a certain number of days in the hospital. Obviously, when this happens there is an incentive to discharge the patient "sicker and quicker."

A physician who believes the patient is not ready for discharge should carefully document the reasons for not signing a discharge order and should use her professional judgment in deciding whether to do so.

If the physician bows to pressure and orders a discharge that is contrary to professional standards and her better judgment, there may be significant liability consequences. A California court summarized the rule as follows:

> [T]he physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid…ultimate responsibility for [the] patient's care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour.[74]

Legal Brief

In the vocabulary of insurance, the "loss ratio" is a formula that compares claims payments to income:

$$LR = \frac{\text{losses + loss-related expenses}}{\text{earned premiums}}$$

In the health insurance business, "losses" means claims paid for healthcare services. Fewer claims paid means a lower loss ratio, which in turn means higher retained earnings. The loss ratio is much higher in government programs than in private insurance plans because government programs are not motivated to earn a profit.

Tensions Between Insurance Coverage and the Need for Care

Both government payers and private health insurance plans require UR to manage its costs. The focus of the process is primarily financial (within the bounds of good patient care, of course). When a patient's medical condition no longer warrants continued hospitalization, the insurer will frequently deny coverage. This type of review is a result of the ever-increasing ("skyrocketing") cost of healthcare. Because financial considerations and medical needs sometimes conflict, the persons charged with UR/CM should consult with the patient's attending physician before a decision about discharge is made. There are usually processes for the physician to appeal the decision on insurance coverage, but if the physician continues to believe treatment is necessary, he must ensure that the treatment is provided, at whatever expense.

When review committees find no need for continued hospitalization and recommend discharge or transfer to a less expensive location, patients must bear the costs if they stay in the hospital. Attending physicians and case management staff must carefully explain all this to patients and their family members, and together they must decide on the future course and site of care. As long as a UR committee functions within its defined role and exercises good faith consistent with recognized standards for UR programs, individual members of the review committee run no significant risk of legal liability.[75] Statutes in many states give immunity to members of a UR panel who act in good faith while carrying out the review function.

Patients whose medical condition justifies discharge or transfer have no common law or constitutional right to remain. A patient who does so is a trespasser, and a court may be asked to issue an injunction to remove the person

from the premises.[76] The courts have reasoned that general hospitals have a duty to reserve their beds and facilities for patients who genuinely need them and should not permit a patient to remain when adequate care could be provided elsewhere. On the other hand, the hospital and physician may not abandon or discharge a patient in need of further care without making appropriate arrangements for that care. Thus, someone who needs continuing care—in a nursing home, for example—presents a dilemma for all the parties involved if no appropriate facility is available, especially if the patient is unable to pay the ongoing hospital charges.

Monmouth Medical Center v. State[77] illustrates the conflict between economic and human values in these circumstances. At issue were New Jersey's administrative regulations prohibiting reimbursement from the Medicaid program for indigent patients no longer in need of acute hospital care and awaiting transfer to a nursing home. Because there was a shortage of nursing home beds, the state regulations required the hospital to absorb the cost of continuing care. The hospital was unwilling to "eat" this cost, and it filed suit.

The purpose of federal Medicaid legislation is to provide financial assistance for "medically necessary" services, and federal regulations require states to furnish services "sufficient in amount, duration, and scope to reasonably achieve [their purpose]."[78] The New Jersey Supreme Court held that the state regulations conflicted with the federal rules. So long as the hospital exercised good faith and reasonable diligence in attempting to place patients in nursing homes, it was legally entitled to reimbursement from Medicaid. In essence the court said that fairness required society to absorb the costs of continuing care even if the patient no longer needed the services of a general hospital.

To put the issue in sharper focus, a later case—*Monmouth Medical Center v. Harris*—upheld the government's right to deny Medicare reimbursement to a hospital for a patient who no longer required either hospital or skilled nursing care.[79] Beds in a nursing home that provided custodial care were not available, but this was essentially irrelevant because Medicare does not reimburse providers for custodial care anyway.

Federally Mandated Peer-Review Organizations

Federal law requires organizations under contract with Medicare to conduct utilization and quality control review to evaluate services being provided to Medicare beneficiaries.[80] Through retrospective reviews of data, the responsibility of these peer-review organizations (PROs)—also known as quality improvement organizations (QIOs)—is to determine whether

- hospital services are reasonable and medically necessary,
- the quality of those services meets professional standards, and
- the services could be provided more economically elsewhere.

Each PRO/QIO is expected to conduct reviews of admission patterns and identify groups of patients whose diagnoses or contemplated treatments indicate that they could be safely cared for elsewhere than in an acute care hospital. Each PRO/QIO is empowered to set objectives for reducing inappropriate admissions in its geographic region and to identify unacceptable admission patterns in use by particular institutions and medical practitioners.

To measure the quality of care furnished to Medicare patients the review organization has the following specific responsibilities:

- ensure that patients with certain diagnoses receive adequate medical services, especially where appropriate facilities are available but are underused;
- review hospital readmissions caused by previous substandard care;
- identify instances of unnecessary surgery; and
- reduce the number of avoidable deaths.

To achieve these objectives, PROs/QIOs develop treatment protocols for particular diagnoses and set specific statistical goals. In addition to performing these functions on behalf of the federal government, PROs/QIOs have the power to deny reimbursement to a Medicare provider for unnecessary or inappropriate care.[81] In certain circumstances the review organization may also recommend penalties to providers, ranging from monetary fines to exclusion from the Medicare program.

Managed Care Plans

Cost control through reduction of hospital utilization was the main impetus for the development of managed care plans in the mid-1980s and their increasing use (albeit with mixed results) in the years since. The plans use primary care physicians as "gatekeepers" to determine the appropriate point of service for the patient's particular condition. Preauthorization from the managed care plan (an HMO, for example) is generally required before a patient can be admitted to a hospital. If admission is approved, the patient cannot remain hospitalized longer than a predetermined period set by the plan unless additional approval is obtained.

In addition, some managed care plans pay physicians by means of a "capitated" rate—a set amount per enrolled individual per month. The physicians are then obligated to treat all enrolled persons who present for treatment, regardless of the cost that is incurred. Physicians in a capitated plan assume the risk that the costs of treatment may exceed the sum of their capitated payment. In theory, such a system encourages wellness and prevention activities and treatment of illnesses in the most inexpensive manner possible (for example, as outpatients or by use of physician assistants and nurse practitioners). The tension between financial incentives and physicians' ethical obligations should be obvious.

Managed care plans create significant legal issues when a patient is refused admission to a hospital or is discharged prematurely and sustains injury as a result. As has already been discussed, it is ultimately the physician's responsibility to decide what is in the patient's best interest, and a number of cases have held the physician liable for admission or discharge decisions that were motivated by a managed care plan's cost-control policies.[82] On the other hand, some courts have taken the view that if the managed care plan is in effect dictating whether and for how long a patient can be hospitalized, it must assume liability for decisions that have adverse effects on patient care.[83]

In addition, state legislatures have begun to consider bills that will hold managed care organizations liable for coverage denials and UR decisions that adversely affect patient care (see Legal Brief). Texas, for example, passed a law in 1997 that allows beneficiaries of health plans to bring suit against plans that do not exercise "ordinary prudence" under the circumstances.[84] The law was immediately challenged, and although parts of it were held to conflict with the federal Employee Retirement and Income Security Act, the portions relating to beneficiaries' lawsuits were upheld.[85]

As with the decisions of managed care plans, all UR activities significantly affect the common law of malpractice liability for both healthcare institutions and physicians. Medicare's system of payment—by means of fixed amounts for each diagnosis—may encourage the premature discharge of an inpatient. Denying prior authorization for admission may increase the risks to the patient and, accordingly, the risk of claims for damages.

The courts will give weight to professional protocols for specific medical conditions. Proof of deviation from those standards will be considered evidence of negligence. Adherence to them will usually be considered evidence of due care.

It follows that careful documentation of adherence to the specified criteria should be in each patient's medical record. For the same reasons any

Legal Brief

Managed care plans argue, of course, that they do not make treatment decisions and that all they do is tell the provider whether admission or continued treatment will be covered under the particular insurance contract.

It is important for the hospital and the physician to serve as the patient's advocate if insurance coverage is threatened. The Joint Commission speaks to this dilemma in *Comprehensive Accreditation Manual for Hospitals* (2007, RI-9):

> When an individual requests or presents for care, treatment, and services, the hospital is professionally and ethically responsible for providing care...within its capability, mission, and applicable law and regulation. At times, indications for such care...can contradict the recommendations of an external entity performing a utilization review (for example, insurance companies, managed care reviewers, and federal or state payers). If such a conflict arises, ...decisions are made based on the patient's identified needs, regardless of the recommendations of the external agency.

apparent deviation from the criteria should be documented and justified. Internal reviews should then help to identify cases of unnecessary or inappropriate surgery and avoidable medical and surgical complications. Reducing the number of such cases by means of review can help reduce the number of malpractice claims.

Finally, managed care plans, UR organizations, and others working toward reducing utilization should encourage hospitals to improve their risk management and quality assurance programs. Effective programs of this nature can have a beneficial effect on malpractice exposure.

Chapter Summary

This chapter reviews the "black letter" rule that there is no common-law right to be admitted to a hospital, and then it considers a number of exceptions to that principle. In its discussion of the law relating to emergency services, the chapter foreshadows a more thorough treatment of the topic in Chapter 8. In addition, the chapter presents special circumstances that attend the admission and discharge of psychiatric patients and the "uncompensated care" and "community service" obligations of many not-for-profit organizations. Finally, the chapter discusses the fact that there can be tensions between managed care organizations' desire to limit healthcare expenditures and providers' moral and legal duties to provide quality patient care.

Chapter Discussion Questions

1. Who has the authority to admit patients to hospitals, and why do patients not usually have a right to be admitted?
2. What is a hospital's responsibility to provide care to the indigent, and how does it differ depending on the type of care (emergency versus nonemergency) and the type of hospital (public, private, for-profit, not-for-profit, tax-exempt)?
3. What are the Hill-Burton "uncompensated care" and "community service" obligations?
4. What are the standards and processes for involuntary admission of persons who are mentally ill?
5. What kinds of issues can be confronted when discharging a patient from the hospital?
6. What are the tensions between managed care's objectives and medical judgment?

Notes

1. Hill v. Ohio County, 468 S.W.2d 306 (Ky. 1971), cert. denied, 404 U.S. 1041 (1972)—a pregnant patient had no right to be admitted to a hospital when no emergency was apparent; Fabian v. Matzko, 236 Pa. Super. 267, 344 A.2d 569 (1975); cf. Federal legislation prohibits denial of services to persons needing emergency care and to those in active labor. 42 U.S.C. § 1395dd.
2. Norwood Hosp. v. Howton, 32 Ala. App. 375, 26 So. 2d 427 (1946).
3. Harper v. Virginia Bd. of Elections, 383 U.S. 663 (1966).
4. Douglas v. California, 372 U.S. 353 (1963).
5. See also Brooks v. Walker County Hosp. Dist., 688 F.2d 334 (1982), cert. denied, 462 U.S. 1105 (1983)—it is proper to dismiss federal court suit by indigents contending that they were entitled to free healthcare services under Texas constitution pending clarification of state legal issues.
6. Spivey v. Barry, Mayor, District of Columbia, 665 F.2d 1222 (1981)—closing a medical clinic serving indigents did not violate either statutory or constitutional rights.
7. Idaho Falls Consol. Hosps., Inc. v. Bingham County Bd. of County Comm'rs, 102 Idaho 838, 642 P.2d 553 (1982).
8. St. Joseph's Hosp. and Medical Center v. Maricopa County, 142 Ariz. 94, 688 P.2d 986 (1984). The county's indigent care requirement is found in Ariz. Stat. § 11-292.
9. Washoe County, Nev. v. Wittenberg & St. Mary's Hosp., 676 P.2d 808 (1984).
10. Brinkman v. City of Indianapolis, 141 Ind. App. 662, 231 N.E.2d 169 (1967). See also Hart v. County of Orange, 254 Cal. App. 2d 302 (1967); Porter v. County of Cook, 42 Ill. App. 3d 287, 355 N.E.2d 561 (1976).
11. Estelle v. Gamble, 429 U.S. 97, reh'g denied, 429 U.S. 1066 (1977)—Eighth Amendment is violated by "deliberate indifference to serious medical needs." See also Bivens v. Six Unknown Federal Narcotics Agents, 403 U.S. 388 (1971)—persons subjected to constitutional violations by federal officials have a right to recover damages against the official.
12. Youngberg v. Romero, 457 U.S. 307 (1982)—an involuntarily committed mental patient was entitled to medical care.
13. Maher v. Roe, 432 U.S. 464 (1977); Harris v. McRae, 448 U.S. 297 (1980).
14. For example, Conn. Gen. Stat. § 18-7 (Supp. 1985); see also Hillcrest Medical Center v. State of Okla., ex rel. Dep't of Corrections, 675 P.2d 432 (Okla. 1983)—the county was liable for medical expenses of a convicted murderer injured in automobile accident while in the county's custody.
15. Idaho Code § 20-209 (1979); but see Sisters of Third Order of St. Francis v. County of Tazewell, 122 Ill. App. 3d 605, 461 N.E.2d 1064 (1984)—the county was not liable for care furnished an arrestee in the custody of municipal police.
16. Alaska Stat. § 33.30.050 (1982).
17. Md. Ann. Code art. 27, § 698 (Supp. 1985). See also Fla. Stat. § 901.35, which establishes a hierarchy of responsibility for medical expenses provided to "any person ill, wounded, or otherwise injured during or at the time of arrest...." The first tier of responsibility includes (1) insurance, (2) the patient, and (3) a financial settlement relating to the cause of the injury or illness; only if those sources are not available may the provider seek reimbursement from governmental authority. Based on the "during or at the time of arrest" language, some law enforcement officials attempt to avoid governmental responsibility by not formally arresting the suspect until after treatment is rendered.
18. See "Comment, City of Revere v. Massachusetts General Hospital: Government Responsibility for an Arrestee's Medical Care," 9 *Am. J.L. & Med.*, 361, 369–70 (1983–84).
19. 463 U.S. 239 (1983).
20. Massachusetts Gen. Hosp. v. City of Revere, 385 Mass. 772, 484 N.E.2d 185 (1982). Rev'd. on other grounds, Revere v. Massachusetts Gen. Hosp., 463 U.S. 239 (1983).
21. Maher, supra note 13.
22. Harris, supra note 13.
23. City of Revere v. Massachusetts Gen. Hosp., 463 U.S. 239 (1983).
24. 171 So. 2d 202 (Fla. Dist. Ct. App. 1965).

25. Pub. L. No. 79-725; codified as amended 42 U.S.C. § 291-(o)-1 (1982).
26. 42 U.S.C. § 291c (e) (1982).
27. Id.
28. 42 U.S.C. §§ 291c (a), (e) (1982).
29. Cook v. Ochsner Found. Hosp., 61 F.R.D. 354 (E.D. La. 1972).
30. Id.
31. 42 C.F.R. § 53.111(d)(2) (1984).
32. Cook v. Ochsner Found. Hosps., 61 F.R.D. 354 (E.D. La. 1972).
33. 42 C.F.R. § 124.603(b) (1) (1984).
34. Newsom v. Vanderbilt Univ. Hosp., 453 F. Supp. 401 (M.D. Tenn. 1978).
35. Id.; Newsom v. Vanderbilt Univ. Hosp., No. 75-126, slip op. (M.D. Tenn. 1979), aff'd in part, rev'd in part, modified in part, 653 F.2d 1100 (6th Cir. 1981).
36. 42 C.F.R. §§ 53.111(I), (j) (1984).
37. Cook v. Ochsner Found. Hosp., 559 F.2d 968 (5th Cir. 1977); Corum v. Beth Israel Med. Center, 373 F. Supp. 550 (S.D.N.Y. 1974); Newsom v. Vanderbilt Univ. Hosp., 453 F. Supp. 401 (M.D. Tenn. 1978).
38. Cook, supra note 37; Lugo v. Simon, 426 F. Supp. 28 (N.D. Ohio 1976); Newsom, supra note 37—the 20-year limit on the uncompensated-care obligation dates, however, from final approval of federal funds rather than from completion of construction, while the community service obligation is of indefinite obligation.
39. Corum, supra note 37.
40. 42 U.S.C. §§ 300o/300t (1982).
41. Cook v. Ochsner Found. Hosp., 559 F.2d 968 (5th Cir. 1977)—the 20-year limit on uncompensated care obligations is valid on projects funded before 1975.
42. For example, Lowen v. Hilton, 142 Colo. 200, 351 P.2d 881 (1960); Maben v. Rankin, 55 Cal. 2d 139, 10 Cal. Rptr. 353, 358 P.2d 681 (1961); Geddes v. Daughters of Charity, 348 F.2d 144 (5th Cir. 1965); Jillson v. Caprio, 181 F.2d 523 (D.C. Cir. 1950).
43. See, for example, Jackson v. Indiana, 406 U.S. 715 (1972); Humphrey v. Cady, 405 U.S. 504 (1972).
44. Lewis v. Donahue, 437 F. Supp. 112 (W.D. Okla. 1977)—a patient released from state hospital and transferred to outpatient status may not be recommitted without due process protections; see also In re Anderson, 74 Cal. App. 3d 38, 140 Cal. Rptr. 546 (1977).
45. People v. Paiz, 43 Colo. App. 352, 603 P.2d 976 (1979).
46. O'Connor v. Donaldson, 422 U.S. 653 (1975); 42 U.S.C. § 1983.
47. Addington v. Texas, 441 U.S. 418 (1979).
48. Id.
49. See Tobias v. Manhattan Eye and Ear Hosp., 283 N.Y.S.2d 398, 28 A.D.2d 972 (1967), aff'd, 23 N.Y.2d 724, 296 N.Y.S.2d 368 (1968).
50. Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), vacated, 414 U.S. 473 (1974), on remand, 413 F. Supp. 1318 (1976); Doremus v. Furrell, 407 F. Supp. 509 (D.C. Neb. 1975).
51. Addington v. Texas, 441 U.S. 418.
52. Id.
53. Id.
54. 463 U.S. 354 (1983).
55. Youngberg v. Romero, 457 U.S. 307 (1982); Wyatt v. Stickney, 344 F. Supp. 387 (M.D. Ala. 1972); 344 F. Supp. 373 (M.D. Ala. 1972), aff'd in part, remanded in part, 503 F.2d 1305 (5th Cir. 1974), enforcing 325 F. Supp. 781 (M.D. Ala. 1971).
56. Youngberg v. Romero, 457 U.S. 307 (mentally retarded person).
57. Id.
58. Rome v. Fireman, 473 F. Supp. 92, 104, 119 (N.D. Ohio 1979); see also Ohlinger v. Watson, 652 F.2d 775 (9th Cir. 1980).
59. Youngberg, supra note 56 at 314, quoting and adopting the view of concurring Chief Judge Seitz, Court of Appeals, Third Circuit, 644 F.2d 147, 178 (1980).
60. Rennie v. Klein, 653 F.2d 836 (3d Cir. 1981), vacated, 458 U.S. 1119, on remand, 720 F.2d 266 (1983); Davis v. Hubbard, 506 F. Supp. 915 (N.D. Ohio 1980); Rogers v. Okin, 634

F.2d 650 (1st Cir. 1980), vacated, 457 U.S. 291; Goedecke v. State, 198 Colo. 407, 603 P.2d 123 (1979)—common law recognizes a mental patient's right to refuse medication.

61. Rennie v. Klein, 653 F.2d 836 (3d Cir. 1981).
62. Parvi v. City of Kingston, 394 N.Y.S.2d 161, 41 N.Y.2d 553, 362 N.E.2d 960 (1977)—the city was potentially liable in negligence when intoxicated persons attempting to cross New York Thruway were struck by a car after being abandoned by the police in a rural area.
63. But see Modla v. Parker, 17 Ariz. App. 54, 495 P.2d 494, cert. denied, 409 U.S. 1038 (1972)—the hospital was entitled to summary judgment in a suit alleging wrongful discharge where there was no evidence that the release retarded treatment or worsened the patient's condition.
64. 285 N.Y. 389, 34 N.E.2d 367 (1941); see also Anderson v. Moore, 202 Neb. 452, 275 N.W.2d 842 (1979).
65. Morrison v. Washington County, Ala., 700 F.2d 678 (11th Cir. 1983), cert. denied, 464 U.S. 864 (1983).
66. Id., 700 F.2d at 683.
67. 538 F.2d 121 (4th Cir. 1976), cert. denied, 429 U.S. 827 (1976).
68. Chrite v. United States, 564 F. Supp. 341 (E.D. Mich. 1983)—Veterans Administration could be liable for failure to warn a patient's mother-in-law of threats of violence. Cf. Leedy v. Hartnett & Lebanon Valley Veterans Admin. Hosp., 510 F. Supp. 1125 (1981), aff'd, 676 F.2d 686 (1982)—Veterans Administration owed no duty to warn the plaintiff's family when a discharged mental patient posed no greater danger to the plaintiff than to the community at large.
69. Kyslinger v. United States, 406 F. Supp. 800 (W.D. Pa. 1975), aff'd, 547 F.2d 1161 (3d Cir. 1977)—there was no evidence to support allegations that a patient with polycystic kidney disease and spouse were given inadequate information and training in use of home hemodialysis unit at time of discharge from hospital.
70. Cook v. Highland Hosp., 168 N.C. 250, 84 S.E. 352 (1915); see, generally, False Imprisonment in Nursing Home, 4 A.L.R.2d 449.
71. Marcus v. Liebman, 59 Ill. App. 3d 337, 375 N.E.2d 486 (1978)—a psychologically disturbed patient was entitled to a jury trial on the issue of whether her suspicion that force was threatened was "reasonable," thereby constituting tort of false imprisonment; see also Rice v. Mercy Hosp. Corp., 275 So. 2d 566 (Fla. App. 1973).
72. Paradies v. Benedictine Hosp., 431 N.Y.S.2d 175 (1980), appeal dismissed, 435 N.Y.S.2d 982 (1980)—it is proper to dismiss action against hospital and physician when the patient, voluntarily admitted to the general hospital for psychiatric evaluation, left the hospital contrary to medical advice and subsequently committed suicide; at the time of discharge there was no apparent danger to the patient or others.
73. Gadsden v. Hamilton, 212 Ala. 531, 103 So. 553 (1925); Bedard v. Notre Dame, 89 R.I. 195, 151 A.2d 690 (1959). Cf. Baile v. Miami Valley Hosp., 8 Ohio Misc. 193, 221 N.E.2d 217 (1966)—there was no false imprisonment when no threat of force against a mother of an infant patient existed and the patient was unaware of detention.
74. Wickline v. State of Cal., 183 Cal. App. 3d 1175, 228 Cal. Rptr. 661 (1986), reh'g granted, 727 P.2d 753, 231 Cal. Rptr. 560 (1986)—a patient's physician determines medically necessary course of treatment and duration of acute care hospitalization in accordance with prevailing professional standards.
75. Id., 228 Cal Rptr. at 671—third-party payers are "legally accountable when medically inappropriate decisions result from defects in design or implementation of cost containment mechanisms...."
76. Jersey City Medical Center v. Halstead, 169 N.J. Super. 22, 404 A.2d 44 (1979); Lucy Webb Hayes Nat'l School v. Geoghegan, 281 F. Supp. 116 (D.C.D.C. 1967).
77. 80 N.J. 299, 403 A.2d 487 (1979), cert. denied, 444 U.S. 942 (1979).
78. 42 C.F.R. § 440.230(b) (1984).
79. Monmouth Medical Center v. Harris, 646 F.2d 74 (3d Cir. 1981).
80. 42 U.S.C. §§ 1320c to 1320c-13 (1983 and Supp. 1987).
81. 42 U.S.C. § 1320c-3.
82. See, for example, Wickline v. State, supra 74, and Corcoran v. United Health Care, Inc., 965 F.2d 1321 (5th Cir. 1992), cert. denied 113 S.Ct. 812 (1992).

83. See, for example, Bauman v. U.S. Healthcare Inc., 1 F. Supp. 2d 420 (D.N.J. 1998) and Murphy v. Arizona Bd. of Medical Exam'rs, 190 Ariz. 441, 949 P. 2d 530 (1997). Tex. Civ. Pract. & Rem. §§ 88.001 et seq.
84. Tex. Civ. Prac. & Rem. Code § 88.002.
85. Corporate Health Ins. Inc. v. Texas Dept. of Ins., 12 F. Supp. 2d 597 (S.D. Tex. 1998).

THE COURT DECIDES

Hill v. Ohio County
468 S.W.2d 306 (Ky. 1971)

[This case is a wrongful death action against Ohio County, Kentucky, the owner of Ohio County Hospital. The trial court granted a motion for summary judgment in favor of the defendant, without giving any reasons for that action. The "uncontradicted material facts" are as follows.]

Smith, Special Commissioner

Decedent approached Nurse Hartley [who was "in charge of the floor," according to the court] at her desk in the hospital before 9 a.m. on May 12, 1967, said that her name was Juanita Monroe, her doctor was in Illinois, she had come to Ohio County to attend a funeral and she was afraid she would not be able to get back to Illinois before she had her baby. Nurse Hartley assumed she wanted to be admitted for obstetrical (herein OB) care.

There were only four doctors admitted to practice in the hospital. Nurse Hartley consulted her list and found that Dr. Beard (according to the doctors' informal agreement among themselves) was "on call" that week. He was at the time in the operating room. Upon Nurse Hartley's inquiry whether to admit decedent, Dr. Beard [replied] that he did not handle OB cases. Upon advice from the hospital administrator that another of the four doctors, Dr. Johnson, was making rounds, Nurse Hartley asked him the same question and Dr. Johnson replied that he did not handle "walk-in OBs."

Decedent did not advise that she had been delivered of a child at the Ohio County Hospital in June 1964, admitted by Dr. Charles Price of Hartford (one of the four doctors practicing in the Hospital) and had again consulted Dr. Price within the past year.

Decedent was advised that she could get OB service in Owensboro and Louisville, with doctors on call, and replied she did not want to go to Owensboro or Louisville, but would call a taxi to go home. Nurse Hartley assisted her in making the call. Being advised that decedent was still there more than an hour later, Nurse Hartley consulted with the hospital administrator and was told to call Bill Danks, ambulance driver, who promptly appeared and offered to take decedent wherever she wanted to go. She declined, and a taxi finally took her away.

Her baby was born at home (apparently unattended) during the night. Decedent called Bill Danks who came immediately, and about 6 a.m. called Dr. Johnson, who asked some questions concerning the state of mother and child and advised Danks to take them to Owensboro. Decedent was dead on arrival at the Owensboro Hospital, some 25 miles from Hartford.

Ohio County Hospital is a public hospital, constructed (at least in part) with

Hill-Burton funds which are for construction only. It is a one-floor building and the county pays the cost of operation, including an administrator (not a doctor) and at least two registered nurses. There are no salaried doctors, no residents or interns, and only four local doctors are admitted to practice. The hospital rules properly provide that no patient may be admitted without an order from a doctor to do so [and Kentucky law] provides that no one may practice medicine without being licensed to do so.

....

[The court quotes favorably from American Jurisprudence, Second Edition:]

With respect to a public hospital, it has been said that since all persons cannot participate in its benefits, no one has, individually, a right to demand admission. The trustees or governing board of a public hospital alone determine the right of admission to the benefits of the institution, and their discretion in this regard will not be reviewed by the courts at the suit of an individual applicant.

....

In the instant case, the decedent was not admitted to the hospital nor was the element of critical emergency apparent. The hospital nurse acted in accordance with valid rules for admission to the facility. The uncontradicted facts demonstrate that no breach of duty by the hospital occurred. The nurse could not force the private physicians to accept decedent as a patient. The nurse did all she could do for the decedent on the occasion in question. Therefore, the hospital and the nurse were entitled to a dismissal as a matter of law.

The judgment is affirmed.

Hill v. Ohio County Discussion Questions

1. What other facts would you like to know about this situation?
2. Would the case be decided differently today than it was in 1971? If so, why?
3. In a separate portion of the opinion the court uses the expression "plaintiff's intestate" in referring to the plaintiff, Mr. Hill. What does that expression mean? Why is Mr. Hill the plaintiff in a case involving an OB patient?
4. What is the significance, if any, of the fact that the hospital is a public hospital that received Hill-Burton funds?

CHAPTER

7

MEDICAL STAFF APPOINTMENTS AND PRIVILEGES

After reading this chapter, you will

- know that the hospital governing board is ultimately responsible for the overall quality of care being rendered in the facility.
- understand that once there were different "due process" standards for public and private hospitals, but these requirements have essentially disappeared.
- recognize that medical staff membership is not limited to those with an MD but must be open to all qualified practitioners.
- appreciate the confidentiality and liability issues involved in peer review of professional performance.
- be aware that the courts will support a hospital's decisions on medical staff privileges and discipline if the decisions are supported by a fundamentally fair process.

Hospitals depend on physicians—without them, after all, a hospital has no reason to exist—and a loyal and supportive medical staff is essential to a well-run healthcare organization. For these reasons, legal disputes with members of the organized medical staff must be avoided if at all possible; they are difficult, disruptive, expensive, and frustrating to all concerned.

This chapter concentrates on relationships between the general acute care hospital and the organized medical staff, particularly those issues that relate to how medical staff privileges are granted and maintained. With some minor variations, however, these principles may apply

to any kind of hospital and any other healthcare institution that grants licensed professionals the privilege to care for people within its walls. Therefore, readers should interpret the word "hospital" to include those other kinds of healthcare organizations.

The chapter also explores differences in the hospital–physician relationship when physicians are employees rather than independent contractors.

Duty to Use Reasonable Care in Appointment of Medical Staff

The hospital corporation has the ultimate responsibility for the quality of care rendered within the organization. Thus, the hospital governing board (board of trustees or directors) has a duty to its patients to exercise reasonable care in selecting the physicians who are given privileges to work in the facility. If the physicians are employees, liability under respondeat superior obviously applies; thus, when there is no employment relationship, there is no vicarious liability. A hospital is not liable for the negligence of a physician who is an independent contractor. Even if the physicians are independent contractors, a hospital's negligence in granting medical staff privileges can result in liability for the hospital corporation.[1] Stated another way, the hospital's duty to select medical staff physicians carefully is separate from its responsibility as an employer.

Patients who allege a breach of this duty do not need to prove that the physician's negligence was within the scope of an employment relationship.[2] All that is needed is to establish that the hospital should not have granted (or renewed) this individual's staff privileges in the first place. Liability will attach if the hospital knew or should have known that the physician was incompetent. This concept is sometimes referred to as "corporate," "institutional," or "direct" liability.

The hospital's governing board may not abdicate its legal responsibility to manage the institution, whether in business or clinical affairs. Therefore, its duty to use reasonable care in granting medical staff privileges cannot be delegated to the organized medical staff, the local medical society, or any other group or individual. Although lay members of the governing board are not qualified to judge physicians' professional competence, they are qualified to judge whether there is a reliable process in place to assess those persons' abilities. The board may authorize the medical staff to investigate physicians' backgrounds and make recommendations about staff privileges (these recommendations are generally approved), but the staff's role is advisory only; the board has the ultimate decision-making responsibility.[3] (See The Law in Action.)

Medical Staff Bylaws

An organized medical staff is an integral part of the hospital corporation. It is a miniature version of a corporation (and some actually are incorporated) with a structure of its own, complete with bylaws, rules, and regulations set up to achieve the functions delegated to it by the governing board. Under the board's supervision, the medical staff's functions include the following:

- serving as liaison between the board and the members of the medical staff as a whole,
- implementing the clinical aspects of corporate policies on patient care,
- investigating applicants for medical staff membership and making recommendations on whether to grant medical staff privileges,
- supervising the quality of medical care throughout the facility by means of a peer-review process, and
- providing continuing education.

The Law in Action

A physician friend of mine and I were talking about the issue of medical-staff decision making. He made a comment that led me to ask him, "who makes the decision on medical staff privileges?" His reply was that the decision belonged to the medical staff credentialing committee, "of course."

Not! It is true that as a practical matter whatever the credentialing committee recommends is usually adopted, but the committee only makes recommendations; the board ultimately decides.

The medical staff bylaws must define the structure of the medical staff, its areas of delegated authority, the functions of its committees, and the lines of communication between the staff and the governing board. The hospital's attorney should play a key role in making these matters clear. (Some medical staffs hire attorneys of their own. If this is the result of a perceived conflict of interest between the medical staff and the hospital, it is highly unfortunate. The two parties should have one interest only: quality patient care.)

If a multihospital system has separate medical staffs for each facility, there must be a mechanism for the corporate (overall) governing board to communicate with each facility's medical staff and for each medical staff to interact with the corporate levels in matters relating to patient care services. This can be done in various ways, and commonly today healthcare systems have an employed physician who serves as corporate director of medical affairs. This position serves as a liaison between the various medical staffs and the corporate office.

At least two salient issues emerge with respect to the hospital–physician relationship:

1. How can physicians be best integrated into the management of hospital affairs to encourage institutional responsibility and loyalty?

2. What are the rights of a licensed physician to attain and retain a hospital staff appointment?

Because the institution is responsible for selecting the medical staff, and because the governing board must oversee an effective process of peer review, it is advisable to have physician representation on the board. (In many hospitals, the chief of the medical staff is the ex officio appointee.) In the past, the business administration and clinical administration of a hospital were kept separate. It was thought that conflicts of interest would exist if members of the medical staff were also members of the board. Although it is true that conflicts between clinical and operational interests occur, the situations can usually be resolved by full disclosure of the conflict and, if necessary, by declining to participate in decisions that affect one's divided loyalties. The reasons for integrating physicians into hospital governance far outweigh those in favor of a board of trustees made up entirely of lay members.

Two competing principles are at work here: (1) hospitals must control the quality of care being rendered, and (2) many physicians need hospital admitting privileges to practice their profession. Although undeniably essential and praiseworthy, these two principles sometimes create tension. The courts traditionally approached these issues by first looking to whether the particular hospital is public or private, because that distinction determined which legal principles applied. Although the public–private dichotomy does not have the significance it once did, it is the starting point for our discussion, if for no other reason than to present the historical perspective.

Due Process and Equal Protection Requirements

As long ago as 1927 the U.S. Supreme Court held that a licensed physician does not have a constitutional right to a medical staff appointment.[4] But as later cases show, when the hospital is owned by the government—and thus is taking "state action"—it must afford the constitutional due process and equal protection required by the Fourteenth Amendment (see Legal Brief).

Legal Brief

"No state [shall] deprive any person of life, liberty, or property, without due process of law; nor deny to any person...the equal protection of the laws."

—The Fourteenth Amendment, U.S. Constitution

What is state action? Clearly a state-, county-, or city-owned hospital engages in state action. After all, it is an arm of government and acts on the government's behalf. On the other hand, most courts hold that state action is not implicated in the actions of a private hospital to deny

medical staff privileges.[5] The accepted principle is that even though the organization receives governmental funding and is highly regulated, state action exists only when

- government involvement with the private hospital is significant;
- state activity is the cause of the alleged injury; and
- the state aids, encourages, or approves the activity.

Recognizing that general propositions do not decide concrete cases, some examples are given here to help clarify how these principles are applied. Ultimately we demonstrate that because of either the constitutional state action concept or another theory, the standards are virtually the same for both public and private hospitals.

It can be said with some certainty that private hospitals, although highly regulated and funded in large part by the government, are not instrumentalities of the state for constitutional purposes. Thus, the government does not aid or approve the activity or cause the injury simply by providing funding to the hospital or by regulating it through licensure, certificate-of-need legislation, or other controls.[6] A private hospital is simply not performing a public function when it appoints physicians to its medical staff.[7] When the government owns the hospital, however, it must extend due process and equal protection to any physician who applies for a medical staff appointment and to any current staff member who is subject to disciplinary action.[8]

Referring to the Fourteenth Amendment, there are two kinds of due process: substantive and procedural. Substantive due process concerns the essence of the legal relationship between the state and the individual. Procedural due process relates to the particular methods of dealing with that relationship—that is, the way rules are made and administered. Equal protection of the laws simply means that persons must not be discriminated against on the basis of unfair categories such as race, religion, gender, national origin, and socioeconomic status. Both due process and equal protection issues can surface whenever fundamental rights are directly affected by state action, and both require the "state actor"—for our purposes, a hospital—to act reasonably, not "capriciously" or "arbitrarily."

To summarize, governmental hospitals clearly take state action, and they must grant due process and equal protection in their medical staff proceedings. Private hospitals are not directly subject to these constitutional principles, but, as discussed later in the chapter, they now provide essentially the same kind of rights when dealing with medical staff appointments. The distinction between the duties of public and private hospitals is now of little more than academic interest. (At least a quarter-century ago some commentators suggested that the public–private dichotomy is inequitable and anachronistic because both public and private hospitals serve the same community.[9])

Standards for Medical Staff Appointments

In terms of the standards for medical staff appointments, all hospitals must act reasonably when considering medical staff appointments and must use fair procedures in applying their rules and regulations. Several developments have led to this result:

- state statutes that prohibit certain forms of discriminatory or arbitrary decisions by a hospital governing board,
- state judicial decisions that require the hospital to act reasonably and with fairness as a matter of public policy,
- application of state and federal antitrust statutes prohibiting unlawful restraints of trade, and
- rules prohibiting malicious interference with a licensed physician's right to practice medicine.

Both Medicare's "Conditions of Participation" and the Joint Commission standards require the essence of due process. As with a governmental hospital, if a private hospital's medical staff bylaws arbitrarily exclude whole classes of practitioners they may be invalid either because a local state statute prohibits such discriminatory conduct or simply by virtue of common law. Statutes, for example, may prohibit a hospital from summarily dismissing an application solely because the applicant is an osteopathic physician, a podiatrist, or other type of licensed practitioner. One of the more comprehensive statutes of this type is the District of Columbia's, which grants procedural safeguards to clinical psychologists, podiatrists, nurse midwives, nurse anesthetists, and nurse practitioners.[10]

In short, applications for hospital access from these practitioners must be evaluated fairly in light of the individual's qualifications and competence and the needs of the hospital. A few statutes go further by providing that certain designated licensed practitioners must be allowed to use the hospital's facilities, but not as full members of the medical staff.[11] In any event, the medical staff bylaws should always provide for a credentialing process and for well-defined physician supervision of practitioners who are entitled to render medical services under such direction.

As a further example of legislative influence, the relevant Ohio antidiscriminatory statute reads:

> The governing body of any hospital, in considering and acting upon applications for staff membership or professional privileges within the scope of the applicants' respective licenses, shall not discriminate against a qualified

> person solely on the basis of whether such person is certified to practice medicine or osteopathic medicine, or podiatry, or dentistry.[12]

The purpose of the statute is to prevent classwide discrimination against applicants while still observing the hospital's responsibility to establish reasonable standards for its staff and to determine the qualifications for each individual. Hence, one Ohio hospital's rules were discriminatory on their face because they (a) required all podiatrists to complete two years of postgraduate training in an approved residency program in addition to board certification or eligibility, (b) prohibited podiatrists from conducting surgical procedures with anesthesia, and (c) denied podiatrists the right to vote or hold office within the staff organization.[13] The court held that such provisions were unreasonable and lacked any rational purpose because fewer than 10 percent of all podiatric graduates in the United States had completed a two-year residency, no residency programs were available in Ohio, and similar restrictions did not apply to dentists or oral surgeons.

Qualifications of Staff Physicians

On the basis of various state and federal laws, no healthcare organization that receives federal financial assistance (including Medicare payments) may discriminate in medical staff appointments on the basis of race, creed, color, sex, disability, national origin, or other prohibited category.[14] Such discrimination violates not only specific statutory prohibitions but also, in the case of governmental facilities, the equal protection clause of the Fourteenth Amendment.[15] These subjects were at issue in *Sosa v. Board of Managers of Val Verde Hospital*.[16] In that case the court upheld the hospital's decision to deny Dr. Sosa admission to the medical staff. In recommending denial of the physician's application, the medical staff credentials committee considered the applicant's character, qualifications, and standing in the community. The court deemed these factors reasonable and not arbitrary.

Significantly, the court held that not all possible standards need to be spelled out precisely in the medical staff bylaws.[17] Because the defendant was a county facility, the court discussed at length the application of the due process clause. But the court's viewpoint could be applied to a private hospital as well:

> [S]taff appointments may be…refused if the refusal is based upon any reasonable basis such as the professional and ethical qualifications of the physicians or the common good of the public and the Hospital. Admittedly, standards such as "character, qualifications, and standing" are very general, but this court recognizes that in the area of personal fitness for medical staff privileges precise standards are difficult if not impossible to articulate. The subjectives of selection simply cannot be minutely codified.

> The governing board of a hospital must therefore be given great latitude in prescribing the necessary qualifications for potential applicants. So long as the hearing process gives notice of the particular charges of incompetency and ethical fallibilities, we need not exact a precis of the standard in codified form.
>
> On the other hand, it is clear that in exercising its broad discretion the board [may] refuse staff applicants only for those matters which are reasonably related to the operation of the hospital. Arbitrariness and false standards are to be eschewed. Moreover, procedural due process must be afforded the applicant so that he may explain or show to be untrue those matters which might lead the board to reject his application.[18]

The court noted that there was considerable evidence of Dr. Sosa's lack of ethical and professional competency, and it upheld the decision to deny his application (see The Law in Action). In doing so, it pointed out that it would not substitute its own judgment for that of the board because the board, not the court, is charged with the responsibility of providing a competent medical staff.[19]

Due process essentially means fundamental fairness. It has no fixed meaning; it is a judgment call based on the time, place, and circumstances of each case. One of the basic elements of fundamental fairness is that the individual who is at risk of losing medical staff privileges or of having an application rejected is given sufficient notice of the charges to attempt to rebut them at a hearing on the matter.

The Law in Action

At the hearing for *Sosa v. Board of Managers of Val Verde Hospital*, evidence showed that the doctor

- abandoned obstetrics patients in active labor because they could not pay his bill;
- had an unstable physical demeanor and showed nervousness, both of which were likely to jeopardize surgical patients;
- failed to use basic surgical techniques;
- showed an unstable mental condition by numerous fits of anger and rage;
- had unsatisfactory references;
- pleaded guilty to two felony charges in criminal courts; and
- had his license to practice suspended in two states.

Charges of lacking surgical judgment, being without a surgical assistant, and assisting another who had no surgical privileges (all backed by supporting evidence) constituted "sufficient notice" for discipline in the case of *Woodbury v. McKinnon*.[20] The court held that to satisfy the fairness standard the hearing can be informal, the plaintiff's attorney need not be permitted to question the other doctors present (as long as the plaintiff could ask questions), and cross-examination need not be a part of every hearing. (In the proper circumstances a summary suspension of privileges will not violate due process as long as the physician is afforded an opportunity for a hearing within a reasonable time.[21]) Thus, hospitals may exercise considerable

discretion in medical staff appointments and privileges—especially when the motive is to enhance the quality of care—so long as the process is intuitively "fair."

It has been held proper for a hospital to have and enforce rules regarding the maintenance and completion of medical records.[22] Rules such as this that state well-recognized professional qualifications as prerequisites for defined privileges will be upheld as long as the rules are reasonable and capable of objective application.[23] The key to validating a particular rule is that it be related to an individual's specific qualifications rather than to class-based distinctions such as race or creed. In formulating the rules, which should be stated in the hospital or medical staff bylaws, the board may rely on professional standards recommended by the medical staff. Thus, in *Selden v. City of Sterling* the court approved a rule that stated that an associate medical staff member could not perform major surgery without having a full staff member in attendance.[24] Similarly, in the interests of patient care a hospital may have a closed staff in the radiology department as long as legitimate reasons for the decision can be adequately documented.[25]

Does a similar philosophy prevail with respect to physicians who do not hold an MD degree? With osteopathic physicians, for example, state law is the paramount consideration. If the licensing statutes make no substantive distinction between MDs and DOs (as is the case today), doctors of medicine and osteopathy must be accorded equal rights and opportunities.[26] Today, there is little real difference between the two professions, and the antitrust statutes apply to the hospital–physician relationship without distinguishing the type of physician. It is contrary to public policy for hospitals to exclude osteopathic doctors (or other non-MD physicians) as a group.

Hospital Access by Allied Healthcare Practitioners

Statutes are also crucial in determining the rights of allied health professionals to practice in healthcare institutions. For example, North Carolina and North Dakota extend chiropractors the right to practice within the scope of their licenses.[27] On the other hand, Oklahoma and Oregon distinguish between physicians and chiropractors; they permit the latter to be excluded from the staff of governmental hospitals because they are licensed by different professional boards.[28] (The decisions are rather narrowly drawn, and the issue appears not to have arisen in those states in the context of private hospitals. Neither has it shown up again in any judicial opinion in more than 25 years.)

Bylaws that allow exclusion of an entire class of licensed allied health practitioners may be rejected as unreasonable and contrary to constitutional law, state statutes, or common law.[29] When local law gives rights of limited practice to designated individuals, hospitals are required to act reasonably when granting privileges to these persons.[30] It is not, however, necessary to

grant them full clinical privileges; instead, hospitals are required to evaluate applications for privileges by allied healthcare professionals fairly and objectively and to base their decisions on reasonable criteria.[31] Such evaluation calls for an assessment of the individual's training, experience, and competence in relation to recognized standards of patient care and institutional objectives. Of course, neither an evaluation of this kind nor a due process hearing necessarily requires actually granting privileges (see Legal Brief).[32]

Legal Brief

Hospitals must have policies, based on state licensure laws, outlining the "scope of practice" for each category of allied health professional.

A North Carolina case illustrates this concept. In *Cameron v. New Hanover Memorial Hospital, Inc.*, the governing board of a governmental hospital granted limited privileges to two podiatrists but denied them the privilege to perform major surgery, which they sought.[33] The denial was based on the fact that the plaintiffs had not been declared eligible or certified by the American Board of Podiatric Surgery. Because the hospital required all persons appointed to the medical staff to meet the standards of eligibility or certification set by their specialty boards, the hospital board's decision was upheld as reasonably related to the hospital's operational needs and goals. A complete review of the podiatrists' experience and training had been conducted, and procedural due process had been followed.

The Joint Commission recognizes that the medical staff may "include other licensed individuals permitted by law and the hospital to provide patient care services independently."[34] Under the standard a given hospital is not required to accept limited practitioners unconditionally; they may be appointed to membership and granted clinical privileges consistent with their scope of practice as set forth in local licensure law and the individual's training, experience, and demonstrated competence.

Discipline of Professional Staff

A hospital may discipline, suspend, or refuse to reappoint a staff physician if there is sufficient evidence of incompetence or intolerable behavior.[35] In *Koelling v. Skiff Memorial Hospital* the Iowa Supreme Court upheld an indefinite suspension of a staff physician charged with preparing deceptive and misleading medical records; giving fabricated, inconsistent explanations for his handling of a case; and rendering seriously inadequate medical care. In such circumstances physicians are entitled to a hearing, the right to present proof, and the right to cross-examine witnesses, and the court held that these were accorded in the plaintiff's case.[36]

The 1972 case of *Moore v. Board of Trustees of Carson-Tahoe Hospital* is quite instructive with respect to the hospital's twofold duties: (1) to exercise reasonable care in selecting and retaining medical staff and (2) to extend both substantive and procedural rights of due process to the physician when disciplinary action is undertaken.[37] *Moore* involved the termination of a medical staff appointment at a Nevada public hospital. Dr. Moore had been licensed to practice in Nevada and was certified by his professional board in obstetrics and gynecology. Acting in accordance with the medical staff bylaws, the governing body terminated his appointment on the ground of "unprofessional conduct."

The specific acts that led to Dr. Moore's termination were not expressly prohibited in the medical staff bylaws or the hospital's rules and regulations. The doctor had allegedly attempted to administer a spinal anesthetic to an obstetrics patient without proper sterile technique. (He had prepared the medication, performed a minimal skin preparation, and handled the spinal needle, all without using sterile gloves.) Two days later the chief of the medical staff, with concurrence of another physician, canceled Dr. Moore's scheduled surgery for that day, considering that he was "in no condition physically or mentally to perform surgery" (see Legal DecisionPoint).

Legal DecisionPoint

Why do you suppose Dr. Moore was "in no condition" to perform the intended surgery? Should the trial record and appellate decision have been more specific in describing his condition?

Dr. Moore brought suit to regain his hospital privileges. He did not allege any violation of his rights to procedural due process. (Indeed, at the medical staff hearing he was permitted to have counsel present, to call friendly witnesses, and to cross-examine adverse witnesses.) He maintained, however, that he was denied substantive due process by reason of the uncertain meaning of "unprofessional conduct," the basis on which his privileges were revoked. (Nevada statutes authorize the board of trustees of a public hospital to adopt bylaws, rules, and regulations governing admission of physicians to the staff, and they grant the board power to organize the staff. The bylaws of the medical staff authorized alteration or revocation of privileges on recommendation of the medical staff for "unprofessional conduct."[38]) The Nevada Supreme Court disagreed with Dr. Moore's argument, citing a Florida case that said: "Detailed description of prohibited conduct is concededly impossible, perhaps even undesirable in view of rapidly shifting standards of medical excellence and the fact that a human life may be and quite often is involved in the ultimate decision of the board."[39] The *Moore* court held that the language "unprofessional conduct" was objective enough to justify the board's decision to terminate the doctor's privileges. (See The Court Decides: *Moore v. Board of Trustees Carson-Tahoe Hospital*, and The Court Decides: *Leach v. Jefferson Parish Hospital District No. 2*, both at the end of this chapter.)

In addition to holding that the board had followed sufficiently objective standards, the court held that the evidence justified the decision to terminate Dr. Moore's privileges.[40]

Moore provides an excellent illustration of how

- the medical staff properly exercises its responsibility for quality of care issues,
- a governing board should act on the medical staff's recommended corrective action before injury to a patient occurs, and
- courts will usually defer to a hospital's decisions if they are based on reasonable criteria that are related to the quality of care.

The Common Law

For years courts regarded voluntary hospitals as private institutions that could adopt and enforce whatever rules they wished to control medical staff appointments and staff discipline, so long as the action was not capricious and was without malice (see The Law in Action).[41] As a result of this judicial attitude, the hospital's discretion was virtually unlimited; courts hesitated to intrude into hospitals' internal management and did not inquire into the arbitrariness or reasonableness of rules concerning medical staff membership. Current or prospective members of the medical staff were not entitled to a hearing or other procedural safeguards unless the bylaws of the hospital or medical staff positively provided such protection.[42]

The Law in Action

Under the traditional view, neither receipt of federal or state funds nor possession of tax-exempt status changed the private nature of a voluntary hospital, and accordingly neither brings into play the rules of judicial review that would apply to a government hospital.[43] *Shulman v. Washington Hospital Center*[44] and *Foote v. Community Hospital of Beloit*[45] illustrate the traditional approach. They gave the voluntary hospital's governing board nearly absolute discretion in denying staff privileges. In *Foote* the Kansas court indicated that it was not necessary for the hospital to grant a hearing to an applicant for a staff position upon denial of his application.[46] In other words, the decision of the hospital's governing board was final and not subject to judicial review.[47]

The traditional judicial attitude—allowing the private hospital almost unfettered discretion in matters relating to medical staff appointments—began to erode with recognition that malicious interference with a physician's right to practice is a tort.[48] There is never a privilege to act with malice. Accordingly, in one case, where it was shown that certain doctors were motivated by financial interests in preventing the plaintiff from obtaining staff privileges at the only hospital in the county, the plaintiff had a legitimate cause of action against the hospital, the doctors, and the individuals on the governing board.[49]

Another chink in hospitals' armor was state antitrust law. Aggrieved physicians relied on "unlawful restraint of trade" to challenge denial of medical staff privileges.

The action can be brought against individual members of the board of trustees, the medical staff, and/or the hospital corporation, when the defendant intentionally prevents admission to hospital practice on some basis other than the plaintiff's professional qualifications or quality of patient care.[50]

Beginning in the 1980s, physicians used federal antitrust laws more often, but without much success, to challenge adverse decisions on medical staff applications. (Both the states and the federal government have antitrust statutes, but the federal statutes are more significant and are used more often.) For a variety of legal and practical reasons the plaintiff physicians have generally failed. (Application of the antitrust laws to the hospital–physician relationship is discussed more thoroughly in Chapter 11.)

More significant than the tortuous interference and antitrust arguments was the straightforward view that the private hospital should not have unlimited discretion. This was evident in the New Jersey case *Griesman v. Newcomb Hospital* (see The Law in Action). Without benefit of a constitutional or statutory foundation, and without relying on the tort and antitrust principles mentioned above, the supreme court of New Jersey simply held that a private hospital could not arbitrarily refuse to consider the application of an osteopathic physician.[51] The decision was based on a fundamental public policy: a hospital is vested with a public interest and a special responsibility (a fiduciary duty) to both patients and the medical community, especially when the hospital is the only game in town.[52]

The Law in Action

In *Griesman v. Newcomb Hospital* the plaintiff was a doctor of osteopathy (DO) who had been granted an unrestricted license to practice medicine and surgery in the state of New Jersey. He was the only osteopath in the metropolitan area of Vineland, New Jersey, which was said to have a population of about 100,000 people. Newcomb Hospital, a private not-for-profit corporation, was the only hospital in the area.

Despite being requested to do so, Newcomb Hospital refused to permit Dr. Griesman to apply for admission to its medical staff. It rested this decision on a provision in the hospital bylaws that said applicants must be graduates of an American Medical Association (AMA)–approved medical school and must be members of the county medical society. Dr. Griesman's application to the county medical society had never been acted on, and he was not a graduate of an approved school because the AMA approved no schools of osteopathy.

By the time the case came to the New Jersey Supreme Court, the American Hospital Association and the Joint Commission had changed their policies and had begun to approve of hospitals having DOs on their staffs; the AMA adopted a policy statement allowing DOs "where it was determined locally that they practice on the same scientific principles as those adhered to by the American Medical Association." The state medical society in New Jersey had also dropped its opposition.

The New Jersey court invalidated the hospitals' requirement that all staff physicians be graduates of an AMA-approved medical school and be members of the county medical society.[53] The hospital must at least consider the application of an osteopathic physician. This conclusion relied heavily on *Falcone v. Middlesex County Medical Society*, in which the defendant's denial

of medical society membership to a licensed osteopathic physician was found to violate the state's public policy.[54] Accordingly the New Jersey court was willing to look into the reasonableness of a rule pertaining to staff privileges and to strike down the rule if it was arbitrary and unrelated to standards of patient care or other legitimate hospital concerns. Following *Griesman*, another New Jersey court held that a voluntary hospital could not refuse applicants without giving them the opportunity to have a hearing and learn the reasons for the rejection.[55]

Other courts have followed suit. Whether for constitutional reasons (in the case of state actors) or because of statutory or common-law principles, it is now generally held that all applications for medical staff privileges and all disciplinary actions must be fully evaluated on their own merits and that at least a modicum of due process must be provided to the physician concerned.[56] The decision-making procedures need not amount to a trial, and a right to counsel is not mandated (although it is permitted). But however the process is structured, it must include, at a minimum, the physician's rights to

- appropriate notice,
- a timely hearing,
- an opportunity to produce evidence and witnesses,
- cross-examine the hospital's witnesses,
- a finding based on substantial and credible evidence,
- a written notice of the hearing body recommendations and the reasons for them, and
- an opportunity to appeal.

Both Medicare's "Conditions of Participation for Hospitals"[57] and Joint Commission's standards[58] reach essentially the same conclusions. The Medicare conditions require the hospital's governing body to appoint physicians and establish privileges on the basis of written, defined criteria. Criteria for selection are individual character, competence, training, experience, and judgment. All qualified candidates are to be considered by the credentials committee of the medical staff, which then makes recommendations to the governing board. Similarly, Joint Commission standards require that the appointment and reappointment of physicians as well as the delineation of an individual's clinical privileges, whether or not that person is a member of the medical staff, be based on the periodic reappraisal of each practitioner's training, experience, current competence, and health.[59]

Most hospitals have decided that it is easier to focus on the kind of due process just described than to worry about whether specific bylaws criteria are "arbitrary and capricious." Therefore, it is recommended that all hospitals have policies that provide both substantive and procedural

due process. All hospitals should be held to the same standards in appointing physicians to their medical staffs or delineating clinical privileges. The sole criterion for making medical staff appointments and defining privileges should be the practitioner's competence to provide quality professional care to further the hospital's mission. Any reasonable criteria for medical staff appointment and privileges that provide essential fairness and relate objectively to the quality of patient care, the purposes of the hospital, and the clinical and ethical behaviors of the individual physician are considered legally sufficient.

Many cases support hospitals' efforts to improve quality of care. To illustrate, a hospital may require physicians to do the following:

- sign and abide by reasonable medical staff bylaws[60];
- serve on a rotating basis in the emergency department[61];
- be responsible for timely completion of medical records[62];
- supply references with their applications[63];
- obtain consultations in surgical or medical cases, as defined by medical staff protocols[64]; and
- carry malpractice insurance coverage, because such a requirement protects the institution's fiscal integrity.[65]

In addition, surgical or specialty privileges can be restricted. For example, performance of major surgery in a given specialty may be limited to those who are board certified or board eligible or who have a minimum number of years of experience in the specialty.[66]

Hospitals are within their rights to suspend, discipline, or refuse to appoint physicians who are professionally incompetent.[67] Even when a physician is legally entitled to due process, summary suspension for clinical incompetence will be upheld as long as a hearing is granted within a reasonable time after suspension.[68]

Aside from clinical competence, questions of ethics, morals, and good character are sometimes the focus of cases involving physicians' medical staff privileges. How far a hospital may go in denying a staff appointment or disciplining a physician for behavior that is not directly related to patient care but is contrary to generally accepted social norms depends on the particular facts (see Legal DecisionPoint on page 202).

In summary, courts will give deference to hospitals' decisions if they are well documented, are thoroughly vetted by appropriate committees, have some relationship to the quality of medical care, and are the result of a fundamentally fair hearing process. As stated by the supreme court of Ohio, "It is the [governing] board, not the court, which is charged with the responsibility of providing a staff of competent physicians. The board has chosen to rely upon the advice of medical staff, and the court may not surrogate for the staff in discharging their responsibility."[69]

Legal DecisionPoint

May a hospital discipline or deny privileges to a physician who

- is convicted of conspiracy to murder his wife?[70]
- fails to provide evidence of rehabilitation from past wrongful conduct?[71]
- has falsified information on the application for privileges?[72]
- uses unacceptable language and is rude in the presence of patients and visitors?[73]
- shows an inability to work with others ?[74]

Reporting Disciplinary Actions

Many states require hospitals to file a report with a designated state agency whenever disciplinary action is taken against a physician or other licensed clinical personnel.[75] Some states require healthcare practitioners to report any impairments of or professional misconduct by fellow practitioners. These reporting requirements were developed about 30 years ago in response to a "malpractice crisis" and as part of reform legislation designed to improve the quality of patient care. Although well intentioned, a practical difficulty with this approach is that reports are sometimes not filed in a timely manner or at all. As a result, an impaired or incompetent physician, even when disciplined by a given hospital, can continue in practice by simply admitting patients to another hospital or by practicing in a different locale. The difficulty is compounded when the other hospitals do not adequately perform background checks on applicants for medical staff privileges. The reporting statutes provide for certain administrative penalties and fines for failure to report instances of professional misconduct or incompetence, but in many cases the penalties are not severe enough or are deferred in favor of rehabilitation for the physician in question. Physicians and administration should become familiar with the reporting requirements in their jurisdictions.

Exclusive Contracts with Physicians

Along with the governing board's responsibility to select a competent medical staff, the board has the authority to enter into an exclusive contract with a given physician or group of physicians for specialty services. Hospitals frequently enter into exclusive contractual arrangements for staffing the radiology, emergency, or pathology departments, for example. Such contracts have been upheld, even for a governmental hospital, as long as the reasons relate to standards of patient care and efficient hospital operation and can be satisfactorily documented.[76]

In *Adler v. Montefiore Hospital Association of Western Pennsylvania* a private hospital employed Dr. Edward Curtiss as the full-time salaried director

of the cardiology laboratory and granted him the exclusive privilege to perform cardiac catheterizations. This, of course, meant that other qualified cardiologists were not permitted to perform this specialized procedure. In the subsequent lawsuit by Dr. Adler challenging the exclusive contract, the parties stipulated that the hospital was "at least a quasi-public institution" and that the doctrine of state action would apply. Nevertheless, the exclusive arrangement was upheld as reasonably related to the hospital's purposes, especially because it was a teaching institution.[77]

Catheterization, the court held, was a laboratory procedure—more like radiology than surgery. There had been no denial of the plaintiff's right to admit his private patients to the hospital or treat them, and neither was there denial of a corresponding patient right to select a physician. The exclusive contract was considered part of the hospital's effort to ensure quality of care. The court said this was evidenced by the facts that catheterizations require teamwork, and a single physician can best train and supervise the team; physicians can best maintain their competence if they perform more than just a few catheterizations over time; equipment failure can be minimized by having only one physician responsible for its use and maintenance; scheduling problems can be minimized; a full-time physician is better able to teach students; it is in the patient's best interest that the physician performing the procedure be on the hospital premises at all times in the event of complications; and, finally, the hospital board can better monitor the quality of care when one person is in charge of the laboratory. Accordingly, there was no violation of Dr. Adler's rights to substantive due process and equal protection because he must yield to reasonable rules intended to benefit the hospital's patients, the physicians, the university's medical students, and the public.

This case is fairly old, and exclusive contracts for "cath lab" services are not especially common, but courts in other jurisdictions have also refused to intervene in decisions of hospital authorities to confer exclusive privileges on designated physician groups, especially in the areas of radiology, pathology, emergency services, and anesthesiology. This is so, even though the contracts have the effect of restricting the medical staff privileges of other qualified and competent physicians.[78]

Exclusive service contracts have been challenged as violating federal or state antitrust legislation. The underlying purpose of antitrust law is to foster competition in the marketplace, and the argument is that exclusive contracts reduce competition and amount to a "group boycott." For the most part, however, the challenges have not been successful because an exclusive contract is seen as a reasonable restraint of trade that actually promotes competition among hospitals and as being consistent with efforts to promote high-quality care.[79] The leading cases are discussed in Chapter 11.

Economic Credentialing

Ideally, decisions on medical staff privileges will be based on physicians' competence and the quality of care they deliver. But the institution's financial stability obviously depends on providing care at a cost that will be covered by reimbursement. When physicians' utilization patterns begin to affect the bottom line negatively, there is a danger that financial considerations will creep into credentialing decisions. This practice has come to be known as economic credentialing. Although there is no standard definition of that term, the AMA defines it as "the use of economic criteria unrelated to quality of care or professional competence in determining a physician's qualifications for initial or continuing hospital medical staff membership or privileges."[80] Whether economic criteria are permissible is a matter of considerable dispute.

Conceptually at least two scenarios would provide a motive for economic credentialing. The first occurs when physicians admit patients to the acute care hospital when those patients could be served more economically on an outpatient basis or in another type of inpatient facility (e.g., skilled nursing, inpatient hospice, nursing home). Judging by the dearth of reported decisions, it seems that the utilization review/case management function, rather than the credentialing process, is coping with this situation adequately. This is not surprising given the hospital's incentive to keep costs as low as possible.

The second scenario involves a kind of "loyalty oath." Physicians are asked whether they have any financial interest in a competing facility, such as another hospital, an imaging center, or an ambulatory surgery center. If they do, their medical staff privileges will be conditioned on their agreeing not to use those other facilities (or to use them only a certain percentage of the time) if the same services can be provided at the hospital. This scenario raises issues under both state law and federal law. At least one old case upheld the practice, but a recent case found that it might violate federal and state antikickback laws and the issue was returned to the trial court for further consideration.

In a 1978 case, *Cobb County-Kennestone Hospital Authority v. Prince*, a Georgia governmental hospital authority purchased a whole-body computed tomography (CT) scanner and then resolved that "if a treatment, procedure, diagnostic test or other service is ordered for a patient…and that procedure, test or service is routinely offered by the Hospital, then the [hospitalized] patient will receive that service within the confines of the Hospital complex."[81] Some staff physicians—who privately owned and operated a CT scanner outside the hospital complex—challenged this policy as arbitrary, unreasonable, and restrictive of their medical judgment. In upholding the hospital's policy as reasonable and as

"strikingly similar" to exclusive service contracts, the Supreme Court of Georgia observed:

> This appeal represents a classic confrontation between two entities who play major roles in the health and welfare of the citizens of our state. The relationship which exists between hospital and physician is delicate, each one exercising exclusive as well as concentric areas of responsibility in the treatment and diagnosis of patients. In addition to the roles played by these two entities in providing this essential health service, the state has the duty of monitoring this function in order to protect the health and welfare of its citizens....
>
> The Hospital Authority's resolution requiring use of in-house facilities and services for hospitalized patients rather than permitting them to be taken from the hospital to utilize like facilities or services elsewhere is reasonable and reflects a well-intentioned effort by the Authority to deal with the intricate and complex task of providing comprehensive medical services to the citizens of our state. The preeminent consideration in the adoption of such a resolution by the Authority was the health, welfare and safety of the patient.... The Authority's resolution is a reasonable and rational administrative decision enacted in order for the Authority to carry out the legislative mandate that it provide adequate medical care in the public interest. The resolution does not invade the physician's province. Although he is required to use the facilities and equipment provided within the hospital complex for testing rather than similar facilities and equipment outside, he is nevertheless free to interpret the results of such tests and free to diagnose and prescribe treatment for all his patients.

In contrast, in the 2006 case *Baptist Health v. Murphy*[82] the defendant was a multihospital system that adopted a loyalty-oath policy to deny staff appointments or clinical privileges "to any practitioner who, directly or indirectly, acquires or holds an ownership or investment interest in a competing hospital." The policy was apparently a revenue-enhancing measure, but it was challenged by cardiologists who had an ownership interest in another hospital and held medical staff privileges at both Baptist Hospital and the other facility. The trial court issued a preliminary injunction against enforcement of the policy, and on appeal the Supreme Court of Arkansas affirmed that decision:

> Defendant knew that the adoption of the economic credentialing policy would inevitably result in a disruption of the relationship between Plaintiffs and a significant number of their patients. The economic credentialing policy was adopted with the intention of forming a relationship with the Plaintiffs' patients, potential patients, and referring physicians who were required to use

its facilities by establishing relationships with cardiologists other than the Plaintiffs.

Defendant, by adopting the economic credentialing policy, intended to disrupt the business expectancies arising out of Plaintiffs' relationships with their patients and with referring physicians with whom they have established patterns of referral. Further, by adopting the economic credentialing policy, Defendant intended to disrupt and interfere with the doctor–patient relationship existing between Plaintiffs and their patients and Plaintiffs' ability to provide health care to their patients. Defendant's actions are an attempt to secure treatment of patients at Defendant's facilities and not Plaintiffs' facilities.

....

Defendant's economic credentialing policy creates a disincentive for Plaintiffs to refer their patients to facilities other than Baptist. Privileges to admit and treat patients at Defendant's facilities are economically advantageous to Plaintiffs. Defendant's economic credentialing policy confers the advantage only to physicians that do not have investments in facilities that Baptist deems as competitors.

Plaintiffs have a substantial likelihood of success in establishing at trial on the merits that this economic credentialing constitutes a conferral of economic benefits, a remuneration, in consideration for the referral of patients to Defendant's facilities, which practice is prohibited by the federal anti-kickback statute, 42 U.S.C. § 1320a-7b(b), and comparable Arkansas statutes.

Because the case was before the court on a procedural issue (the validity of the preliminary injunction), it will have to return to the trial court for a decision on the facts and the merits of the plaintiffs' case. Nevertheless, the decision casts economic credentialing in doubt.

In addition to the antikickback statute referred to in the *Baptist Health* opinion, these loyalty-oath policies raise possible issues under the False Claims Act, antitrust law, and some state statutes. The Office of Inspector General of the U.S. Department of Health and Human Services has solicited comments on the subject, but as this book is being written no final guidance has been issued. Hospital administration would be well advised to seek legal counsel when considering adopting a policy that sets economic criteria for medical staff appointments and privileges.

Peer Review of Professional Practice

In addition to the governing board's responsibility to monitor the professional qualifications of the medical staff, the medical staff itself should continually assess the quality of care being provided in the facility. This topic is

closely related to the utilization review/case management function discussed in Chapter 6. Peer review is a discreet retrospective evaluation of a physician's performance or undesired outcome to see if accepted standards of care were met and to suggest quality improvements if they were not. Under the Health Care Quality Improvement Act of 1986 (HCQIA),[83] there is a framework for discreetly investigating a physician's performance to ensure that she is meeting accepted standards of care. Because peer-review committee members are often competitors of the doctors being reviewed, and because in smaller institutions it may be difficult to find a physician within the same subspecialty, many hospitals turn to third parties (such as independent review organizations) to conduct peer reviews in an unbiased way.

Two major legal issues arise in the context of peer review and quality improvement: confidentiality and potential liability. The records of peer-review committees are often sought by plaintiffs' attorneys to support their case, and physicians who are disciplined often allege that the peer-review function has damaged their character or professional practice.

Confidentiality of Peer-Review Records

Obviously, to be most effective the peer-review process must involve an honest assessment of a practitioner's activities. Confidentiality of the peer-review committee's minutes and deliberations is essential to their success. As one court stated, "There is an overwhelming public interest in having [peer review] meetings held on a confidential basis so that the flow of ideas can continue unimpeded."[84] The court also stated:

> Confidentiality is essential to effective functioning of these staff meetings; and these meetings are essential to the continued improvement in the care and treatment of patients. Candid and conscientious evaluation of clinical practices is a sine qua non of adequate hospital care. To subject these discussions and deliberations to the discovery process, without a showing of exceptional necessity, would result in terminating such deliberations. Constructive professional criticism cannot occur in an atmosphere of apprehension that one doctor's suggestion will be used as a denunciation of a colleague's conduct in a malpractice suit.[85]

Following this line of reasoning, various state legislatures began to address the confidentiality issue in the early 1970s. Today all jurisdictions have some form of legislation establishing a degree of peer-review privilege. For example, a Georgia statute, upheld in *Eubanks v. Ferrier*,[86] immunized medical-review committee proceedings both from pretrial discovery and from use as evidence against a healthcare provider. It also stated that no person in attendance at a meeting of a review committee could be required to testify with respect to evidence presented during committee proceedings.

Note that, as is usually the case, the statutes vary from state to state on such matters as the type of legal proceeding to which they apply; whether the information is protected from discovery, admission into evidence, or both; the type of information and the nature of the committee whose records are confidential; and various express exceptions to the protection. The application of the privilege to particular sets of facts is, therefore, likely to vary from state to state and even from court to court. Furthermore, almost universally the privilege does not apply to records, such as medical records and routine business records, created for purposes other than peer review.

Liability of Peer-Review Participants

Members of medical staff executive, peer-review, credentials, and similar committees are often worried that their service will subject them to liability. This worry is unjustified. The major areas of potential liability involve defamation and interference with a person's professional practice or business relationships. If the committees' proceedings are conducted in good faith, neither theory will succeed.

Under the law of defamation, there is a protection (known as a "privilege") for people who carry out important duties that are in the public interest. For the privilege to be recognized, the communication in question must have been made in good faith for the purpose of upholding a moral or legal duty, limited in scope to that purpose, made in a proper manner on a proper occasion, and transmitted only to proper and interested parties. It seems clear that physicians and other members of peer-review committees will be protected by this privilege under most circumstances. Numerous cases have so held.[87] In addition, the majority of states have passed statutes that confirm and clarify the common-law privilege for medical-review activities.

With regard to the second concern, the actions of a peer-review committee may allegedly constitute an intentional tort, such as interference with one's professional or business relationships, interference with economic expectancy, wrongful suspension of staff privileges, and so on. The law in this area is similar to that concerning defamation. As noted earlier, all states have some form of protective statute for peer-review functions, and most of these contain protection from personal liability of the participants. There are few, if any, cases in which members of a peer-review committee have been held liable in the absence of malice or bad faith.

The HCQIA has similar protections. Beginning with its passage in 1986, peer-review committee members are not liable "under any law of the United States or of any State (or political subdivision thereof)" if they take action (a) in good faith, (b) after a reasonable attempt to obtain the facts, (c) after a fair hearing is afforded to the physician involved, and (d) in the reasonable belief that the action was warranted.[88] Thus, persons involved in

peer-review activities may proceed in good faith with reasonable confidence that their committee deliberations and actions will not present legal exposure.

Medical Staff Privileges of Employed Physicians

Some brief notes are warranted regarding the medical staff privileges of a physician who is employed by a hospital. An employed physician is in a different legal position than is an independent member of the medical staff. An employee, whether or not a physician, is entitled to neither substantive nor procedural due process with regard to his job, except as stated in the employment contract. Unless the contract provides otherwise, the employee can be dismissed from the job at will without a hearing, without prior notice, and without a statement of the reasons for the dismissal.[89] (Most states have this "employment at will" doctrine.)

The employed physician's medical staff privileges are a different matter, however. Unless the physician's employment contract makes employment and staff privileges conterminous, a separate action must be taken if the hospital wants to revoke the medical staff privileges of a physician who is no longer employed. If so, the normal procedures for actions on medical staff issues must be followed. Similarly, a hospital's decision not to renew an exclusive service contract—with a radiology group, for example—does not require due process but depends on the term of the contract.[90] Thus, a municipal hospital (state actor) that had an oral at-will contract with a doctor to be its director of pathology could discontinue the arrangement without following the due process contained in the hospital bylaws that applied to other medical staff members.[91] (In this case, however, the doctor's medical staff privileges remained in effect; see Legal Brief.)

Legal Brief

Members of a physician group that provides exclusive services for certain hospital departments (pathology, radiology, anesthesiology, and the like) must not be only members of the group but also members of the hospital medical staff. Contracts between the hospital and the group should provide that if the physician leaves the group, for whatever reason, his medical staff appointment also terminates and a new application must be submitted and approved by the governing board.

Judicial review of controversies concerning medical staff privileges is limited to determining whether the decision of the hospital's governing board was based on reasonable (not "arbitrary or capricious") criteria and was accompanied by essential due process. When credible evidence shows that the decision is reasonable in the circumstances, the court will not interfere to substitute its own judgment for that of the hospital's board. As stated by the U.S. Court of Appeals for the Fifth Circuit:

> No court should substitute its evaluation of such matters for that of the Hospital Board. It is the Board, not the court, which is charged with the respon-

> sibility of providing a competent staff of doctors. The Board has chosen to rely on the advice of its Medical Staff, and the court cannot surrogate for the Staff in executing this responsibility. Human lives are at stake, and the governing board must be given discretion in its selection so that it can have confidence in the competence and moral commitment of its staff. The evaluation of professional proficiency of doctors is best left to the specialized expertise of their peers, subject only to limited judicial surveillance. The court is charged with the narrow responsibility of assuring that the qualifications imposed by the Board are reasonably related to the operation of the hospital and fairly administered.

The Court of Appeals concluded with a succinct summary of the state of the law regarding medical staff appointments when it held:

> In short, so long as staff selections are administered with fairness, geared by a rationale compatible with hospital responsibility, and unencumbered with irrelevant considerations, a court should not interfere.[92]

Chapter Summary

This chapter focuses on decisions about medical staff privileges. It points out that the ultimate responsibility for appointing a competent medical staff lies with the hospital governing board, as supported by management and medical staff personnel themselves. In recent decades practitioners other than MDs have been given medical staff privileges and that entire classes of physicians may not be excluded; these include those with degrees of DO, DMD, DPM, and DC and others depending on state law. Decisions on medical staff membership must be made on the individual's qualifications rather than on a bias against a particular school of practice.

The chapter also addresses issues related to the peer-review and quality assurance functions, both of which are efforts to ensure that the care rendered within the facility meets professional standards.

Chapter Discussion Questions

1. Who has the ultimate responsibility for decisions about medical staff membership, and why? How should this responsibility be discharged?
2. What differences are there, if any, in the due process standards that apply to public hospitals and private hospitals?
3. What categories of professionals are permitted membership on the medical staff?

4. What issues of confidentiality and liability are presented by the hospital's peer-review function?

Notes

1. Joiner v. Mitchell County Hosp. Auth., 125 Ga. App. 1, 186 S.E.2d 307 (1971), aff'd, 229 Ga. 140, 189 S.E.2d 412 (1972); Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335, 341 (1972); Gonzales v. Nork, No. 228566—Sacramento County Super. Ct., Cal. 1973, rev'd on other grounds, 131 Cal. Rptr. 717, 60 Cal. App. 3d 728 (1976); Corleto v. Shore Memorial Hosp., 138 N.J. Super. 302, 350 A.2d 534 (1975); Johnson v. Misericordia Community Hosp., 99 Wis. 2d 708, 301 N.W.2d 156 (1981); Sophia Elam v. College Park Hosp., 132 Cal. App. 3d 332, 183 Cal. Rptr. 156, modified, 133 Cal. App. 3d 94 (1982); compare Schenck v. Government of Guam, 609 F.2d 387 (9th Cir. 1979)—district court did not err in declining to apply emerging theory of independent or corporate hospital liability.
2. Cooper v. Curry, 92 N.M. 417, 589 P.2d 201 (1979).
3. See Mich. Comp. Laws Ann. § 333.21513 (1980 and Supp. 1986); Mich. Stat. Ann. § 14.15(21513) (West Supp. 1986); Ind. Code Ann. § 16-10-1-6.5 (West 1984 and Supp. 1986); and Ariz. Rev. Stat. Ann. § 35-445 (1986) as examples of statutory expression of the corporate liability doctrine. See also Shields, "Guidelines for Reviewing Applications for Privileges," 9 *Hosp. Med. Staff* 11 (Sept. 1980); Leonard v. Board of Directors, Power County Hosp. Dist., 673 P.2d 1019 (Colo. App. 1983)—the governing board has the authority to reject a medical staff committee's recommendation and terminate a physician's privileges; Ad Hoc Executive Comm. of the Medical Staff of Memorial Hosp. v. Runyan, 716 P.2d 425 (Colo. 1986)—the executive committee of the medical staff has no standing to challenge the decision of the board restoring a physician's privileges.
4. Hayman v. Galveston, 273 U.S. 414, 416/17 (1927)—the exclusion of an osteopathic physician does not violate the equal protection clause of the Fourteenth Amendment.
5. Barrett v. United Hosp., 376 F. Supp. 791 (S.D.N.Y. 1974), aff'd mem., 506 F.2d 1395 (2d Cir. 1974) and Jackson v. Metropolitan Edison Co., 419 U.S. 345 (1974).
6. Barrett, supra 5, at 800–5.
7. Id. at 799; accord Lubin v. Critenden Hosp. Ass'n, 713 F.2d 414 (8th Cir. 1983), cert. denied, 465 U.S. 1025 (1984).
8. For example, Sosa v. Board of Managers of Val Verde Memorial Hosp., 437 F.2d 173 (5th Cir. 1971)—notice of charges "reasonably related to operation of hospital" is required for denial of admission to medical staff; Moore v. Board of Trustees of Carson-Tahoe Hosp., 88 Nev. 207, 495 P.2d 605 (1972), cert. denied, 409 U.S. 879 (1972).
9. See, for example, Southwick, "The Physician's Right to Due Process in Public and Private Hospitals: Is There a Difference?" 9:1 *Medicolegal News* 4 (1981). Their insights have proven true.
10. D.C. Code Ann. § 32-1307 (Supp. 1986). See also, for example, Wis. Stat. Ann. § 50.36 (3) (Supp. 1985) (osteopathic physician); N.M. Stat. Ann. § 61-10-14 (1986) (osteopathic physician); Fla. Stat. § 395.011 (1986) (osteopathic physician, dentist, podiatrist); Va. Code § 32.1-134.2 (1985) (podiatrist); Okla. Stat. tit. 63, § 1-707A (1984) (osteopaths and podiatrists).
11. For example, Cal. Health & Safety Code §§1316, 1316.5 (West 1979 and Supp. 1986)—a hospital must provide for use of facilities by podiatrists and allow them staff privileges; it may afford privileges to clinical psychologists.
12. Ohio Rev. Code Ann. § 3701.35.1(B) (Baldwin Supp. 1986).
13. Dooley v. Barberton Citizens Hosp., 11 Ohio St. 3d 216, 465 N.E.2d 58 (1984). Cf. Fort Hamilton-Hughes Memorial Hosp. Center v. Southard, 12 Ohio St. 3d 263, 466 N.E.2d 903 (1984) (Ohio Rev. Code Ann. § 3701.35.1(B)—this does not apply to chiropractors; private hospitals need not accept patients referred by a chiropractor for x-rays.
14. Civil Rights Acts of 1964, 42 U.S.C.A. § 2000 (d) (1981); 42 U.S.C.A. §§ 1395-1395zz (1983 and Supp. 1987).

15. Foster v. Mobile Hosp. Bd., 398 F.2d 227 (5th Cir. 1968); Meredith v. Allen County War Memorial Hosp., 397 F.2d 33 (6th Cir. 1968); Eaton v. Grubbs, 329 F.2d 710 (4th Cir. 1964); Simkins v. Moses H. Cone Memorial Hosp., 323 F.2d 959 (4th Cir. 1963), cert. denied, 376 U.S. 938 (1964)—a private hospital receiving governmental financial support is subject to the Fourteenth Amendment; Birnbaum v. Trussell, 371 F.2d 672 (2d Cir. 1966).
16. 437 F.2d 173 (5th Cir. 1971).
17. Id. at 176.
18. Id. at 176–77 (citations omitted).
19. Id. See also Shooler v. Navarro County Memorial Hosp., 375 F. Supp. 841 (N.D. Tex. 1973), aff'd, 515 F.2d 509 (5th Cir. 1975)—when procedural due process is followed, a hospital may deny staff appointment if there is evidence that the physician displayed an inability to work harmoniously with other doctors and hospital personnel and charged patients excessive fees.
20. 447 F.2d 839 (5th Cir. 1971).
21. Id. at 844. Citta v. Delaware Valley Hosp., 313 F.Supp. 301 (E.D. Pa. 1970)—Fourteenth Amendment applied to private hospital because it had received federal funds.
22. Board of Trustees of the Memorial Hosp. v. Pratt, 72 Wyo. 120, 262 P.2d 682 (1953); accord Peterson v. Tucson Gen. Hosp., Inc., 559 P.2d 186 (Ariz. Ct. App. 1976) (private hospital).
23. Green v. City of St. Petersburg, 154 Fla. 399, 17 So. 2d 517 (1944); Selden v. City of Sterling, 316 Ill. App. 455, 45 N.E.2d 329 (1942); Jacobs v. Martin, 20 N.J. Super. 531, 90 A.2d 151 (1952). Cf. Armstrong v. Board of Directors of Fayette County Gen. Hosp., 553 S.W.2d 77 (Tenn. 1977)—a public hospital could not require certification or eligibility for certification by the American Board of Surgery for the granting of specified surgical privileges when the physician was in fact competent.
24. 316 Ill. App. 455, 45 N.E.2d 329 (1942).
25. Rush v. City of St. Petersburg, 205 So. 2d 11 (Fla. App. 1967); Benell v. City of Virginia, 258 Minn. 559, 104 N.W.2d 633 (1960). See also Letsch v. County Hosp., 246 Cal. App. 2d 673, 55 Cal. Rptr. 118 (1966); Blank v. Palo Alto–Stanford Hosp. Center, 234 Cal. App. 2d 377, 44 Cal. Rptr. 572 (1965).
26. Stribling v. Jolley, 241 Mo. App. 1123, 253 S.W.2d 519 (Mo. 1952). A Wisconsin statute—Wis. Stat. Ann. § 50.36 (3) (Supp. 1985–86)—prohibits denial of hospital staff privileges to any licensed physician solely on the basis that he is an osteopath. The crucial importance of statutory law with respect to the rights of osteopathic physicians is also illustrated by Taylor v. Horn, 189 So. 2d 198 (Fla. App. 1966).
27. N.C. Gen. Stat. § 90–153 (1985); N.D. Rev. Code § 43-06-17 (1978). These statutes also apply to almost all private hospitals. See also Nev. Rev. Stat. §§ 633.161, 450.430 (1986)—public institutions may not discriminate against dentistry, psychology, podiatry, and Eastern medicine.
28. Boos v. Donnell, 421 P.2d 644 (Okla. 1966); Samuel v. Curry County and Curry Gen. Hosp. Bd., 55 Or. App. 653, 639 P.2d 687 (1982).
29. Shaw v. Hospital Auth. of Cobb County, 507 F.2d 625 (5th Cir. 1975)—a podiatrist is entitled to a hearing; Davidson v. Youngstown Hosp. Ass'n, 19 Ohio App. 2d 246, 250 N.E.2d 892 (1969)—a private hospital must act reasonably in passing on applications for staff membership; Touchton v. River Dist. Community Hosp., 76 Mich. App. 251, 256 N.W.2d 455 (1977)—the application of a podiatrist cannot be summarily dismissed. Cf. Limmer v. Samaritan Health Serv., 710 P.2d 1077 (Ariz. App. 1985)—a private hospital may deny privileges to an osteopath; bylaws were not unreasonable or arbitrary. Some state statutes prohibit hospitals from arbitrarily discriminating against persons practicing in certain allied health professions. For example, Cal. Health & Safety Code § 1316 (1974) and § 1316.5 (1978); Nev. Rev. Stat. §§ 450.005,.430 (1975).
30. N.Y. Pub. Health Law § 2801-b (McKinney 1976)—podiatrists and others may not be denied staff privileges without stating reasons. In this connection, see Fritz v. Huntington Hosp., 39 N.Y.2d 399, 348 N.E.2d 547 (1976); § 393 N.Y.S.2d 334, 361 N.E.2d 984 (1977).
31. See Reynolds v. St. John's Riverside Hosp., 382 N.Y.S.2d 618 (Sup. Ct. 1976)—physician's assistants must be considered for privileges by a hospital.
32. Shaw v. Hospital Auth. of Cobb County, 614 F.2d 946 (5th Cir. 1980), cert. denied, 449 U.S. 955 (1980).
33. 293 S.E.2d 901 (N.C. App. 1982), appeal dismissed, 297 S.E.2d 399 (1982).

34. Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Hospitals*, 109 (1987); this standard has been retained in subsequent editions of the manual.
35. See, for example, Mizell v. North Broward Hosp. Dist., 175 So. 2d 583 (Fla. App. 1965)—proof that a physician's mistakes in diagnosis were too frequent is an adequate basis for suspending surgical privileges.
36. 259 Iowa 1185, 146 N.W.2d 284 (1966). See also Anderson v. Caro Community Hosp., 10 Mich. App. 348, 159 N.W.2d 347 (1968)—Michigan appellate court upheld the right of a public hospital to dismiss a staff physician who was extended the right of a hearing, when documented behavior clearly violated adequately defined standards of conduct.
37. 88 Nev. 207, 495 P.2d 605 (1972), cert. denied, 409 U.S. 879 (1972).
38. Nev. Rev. Stat. §§ 450.160,.180,.440 (1986).
39. North Broward Hosp. Dist. v. Mizell, 148 So. 2d 1, 5 (Fla. 1962).
40. A dissent by two justices was based on the following arguments: "Unprofessional conduct" is a vague and an ambiguous standard, not defined, even generally, in the medical staff bylaws. Hence, there is "substantial danger or arbitrary discrimination" and a grant to the board of "almost unlimited power, susceptible of abuse." Moreover, the dissent said that Dr. Moore's use of an anesthetic without sterile gloves was no more than an isolated instance of negligence that did not result in injury or damage to the patient and thus was not a reasonable basis for revoking privileges. Because the hospital could not have been liable to the patient as a result of this occurrence, arbitrariness was indicated. 88 Nev. At 214, 495 P.2d at 610.
41. See, for example, Edson v. Griffin, 21 Conn. Supp. 55, 144 A.2d 341 (1958); West Coast Hosp. Ass'n v. Hoare, 64 So. 2d 293 (Fla. 1953); Levin v. Sinai Hosp., 186 Md. 174, 46 A.2d 298 (1946); Moore v. Andalusia Hosp., Inc., 284 Ala. 259, 244 So. 2d 617 (1969)—Moore held that the appointment of medical staff to a private hospital is solely in the discretion of the governing body, and a refusal to appoint is not subject to judicial review; Van Campen v. Olean Gen. Hosp., 210 A.D. 204, 205 N.Y.S. 554 (1924); Lakeside Community Hosp. v. Levenson, 710 P.2d 727 (Nev. 1985)—the decision refusing appointment or declining to renew was not subject to judicial review; Hoffman and Rasansky v. Garden City Hosp., 115 Mich. App. 773, 321 N.W.2d 810 (1982).
42. Joseph v. Passaic Hosp. Ass'n, 26 N.J. 557, 141 A.2d 18 (1958); Berberian v. Lancaster Osteopathic Hosp. Ass'n, 395 Pa. 257, 149 A.2d 456 (1959).
43. Shulman v. Washington Hosp. Center, 222 F. Supp. 59 (D.D.C. 1963), aff'd on rehearing, 319 F. Supp. 252 (D.D.C. 1970); West Coast Hosp. Ass'n, supra note 41; Halberstadt v. Kissane, 51 Misc. 2d 634, 273 N.Y.S.2d 601 (Sup. Ct. 1966), aff'd, 31 A.D.2d 568, 294 N.Y.S.2d 841 (1968); Bricker v. Sceva Speare Memorial Hosp., 111 N.H. 276, 281 A.2d 589 (1971), cert. denied, 404 U.S. 995 (1971).
44. Shulman, supra note 43.
45. Foote v. Community Hosp., 195 Kan. 385, 405 P.2d 423 (1965).
46. Id., Dr. Moore's troubles were not over. Kansas eventually revoked his license to practice medicine on the ground of "extreme incompetency." Kansas State Bd. of Healing Arts. v. Foote, 200 Kan. 447, 436 P.2d 828 (1968)—the Supreme Court upheld that decision.
47. See also Sams v. Ohio Valley Gen. Hosp. Ass'n, 149 W.Va. 229, 140 S.E.2d 457 (1965)—where the doctor was apparently denied staff privileges as a consequence of his participation in a closed-panel group practice, although such was never formally stated as a reason for his exclusion; this state court decision upheld the hospital's denial of privileges to Dr. Sams. See also Mauer v. Highland Park Hosp. Found., 90 Ill. App. 2d 409, 232 N.E.2d 776 (1967)—medical staff privilege decisions by private hospital are not subject to judicial review.
48. Raymond v. Cregar, 38 N.J. 472, 185 A.2d 856 (1962).
49. Cowan v. Gibson, 392 S.W.2d 307 (Mo. 1965). See also Burkhart v. Community Medical Center, 432 S.W.2d 433 (Ky. 1968); Nashville Memorial Hosp., Inc. v. Brinkley, 534 S.W.2d 318 (Tenn. 1976)—allegations of conspiracy without justification or excuse to injure another in the practice of a profession constitute a cause of action; moreover, express allegations of malice are not necessary, as malice is inferred from allegations that damage was done intentionally without legal justification. Cf. Campbell v. St. Mary's Hosp., 252 N.W.2d 581 (Minn. 1977)—unsubstantiated broad allegations of malice do not create a cause of action when staff privileges were revoked.

50. Willis v. Santa Ana Community Hosp. Ass'n, 58 Cal. App. 2d 806, 376 P.2d 568, 26 Cal. Rptr. 640 (1962).
51. 40 N.J. 389, 192 A.2d 817 (1963); contra Limmer v. Samaritan Health Serv., 710 P.2d 1077 (Ariz. App. 1985)—a private hospital may deny privileges to an osteopath; bylaws are not arbitrary and capricious.
52. 40 N.J. at 403–4, 192 A.2d at 825.
53. Id. at 394, 192 A.2d at 819.
54. 34 N.J. 582, 170 A.2d 791 (1961). See also Blende v. Maricopa County Medical Soc'y, 96 Ariz. 240, 393 P.2d 926 (1964). The court ruled that a local medical society cannot arbitrarily deny membership if there is a relation between society membership and hospital staff privileges. But later litigation established that there was no definite, formal relation between society membership and hospital staff privileges, and therefore the society could not be required to admit the doctor as a member. Maricopa County Medical Soc'y v. Blende, 5 Ariz. App. 454, 427 P.2d 946 (1967).
55. Sussman v. Overlook Hosp. Ass'n, 95 N.J. Super. 418, 231 A.2d 389 (1967).
56. See, for example, Woodard v. Porter Hosp., 125 Vt. 419, 217 A.2d 37 (1966).
57. 42 C.F.R. § 482.12.
58. See Joint Commission on Accreditation of Healthcare Organizations. 1998. *Hospital Accreditation Standards,* 231–35; see, generally, Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E. 2d 253 (196), cert. denied, 383 U.S. 946 (1966)—Joint Commission standards are admissible in court and failure to adhere to them can constitute evidence of negligence.
59. Joint Commission on Accreditation of Healthcare Organizations, supra note 58, at 231–33.
60. Yeargin v. Hamilton Memorial Hosp., 226 Ga. 661, 171 S.E.2d 136 (1969), cert. denied, 397 U.S. 963 (1970).
61. Yeargin v. Hamilton Memorial Hosp., 229 Ga. 870, 195 S.E.2d 8 (1972).
62. Board of Trustees of the Memorial Hosp. of Sheridan County v. Pratt, 72 Wyo. 120, 262 P.2d 682 (1953); Peterson v. Tucson Gen. Hosp., Inc., 559 P.2d 186 (Ariz. Ct. App. 1976).
63. Rao v. Board of County Commiss'rs, 80 Wash. 2d 695, 497 P.2d 591 (1972).
64. Fahey v. Holy Family Hosp., 32 Ill. App. 3d 537, 336 N.E.2d 309 (1975).
65. Pollock v. Methodist Hosp., 392 F. Supp. 393 (E.D. La. 1975). See also Jones v. State Bd. of Medicine, 555 P.2d 399 (Idaho 1976)—a statutory requirement that both physicians and hospitals obtain malpractice insurance as a condition of licensure is constitutional; Wilkinson v. Madera Community Hosp., 144 Cal. App. 3d 436, 192 Cal. Rptr. 593 (1983)—a hospital may deny privileges when a doctor's insurance company is not approved by California Department of Insurance; rule is reasonable; Kling v. St. Paul Fire and Marine Ins. Co., 626 F. Supp. 1285 (C.D. Ill. 1986)—an agreement between hospital and insurance company requiring staff to carry a minimum amount of malpractice insurance does not have a substantial effect on interstate commerce and thus is not subject to jurisdiction of Sherman Act.
66. Khan v. Suburban Community Hosp., 45 Ohio St. 2d 39, 340 N.E.2d 398 (1976). Cf. Armstrong v. Board of Directors of Fayette County Gen. Hosp., 553 S.W.2d 77 (Tenn. 1977)—a public hospital may not require board certification or eligibility for major surgical privileges.
67. For example, Koelling v. Skiff Memorial Hosp., 259 Iowa 1185, 146 N.W.2d 284 (1966); Mizell v. North Broward Hosp. Dist., 175 So. 2d 583 (Fla. App. 1965); Sosa, supra note 8; Moore v. Board of Trustees of Carson-Tahoe Hosp., 88 Nev. 207, 495 P.2d 605 (1972), cert. denied, 409 U.S. 879 (1972); Klinge v. Lutheran Charities Ass'n of St. Louis, 383 F. Supp. 287 (Mo. 1974), modified, 523 F.2d 56 (8th Cir. 1975); Storrs v. Lutheran Hosp. and Homes Soc'y of Am., Inc., 661 P.2d 632 (Alaska 1983).
68. Citta v. Delaware Valley Hosp., 313 F. Supp. 301 (E.D. Pa. 1970); Duby v. Baron, 369 Mass. 614, 341 N.E.2d 870 (1976)—a rule allowing for summary suspension of a physician was sustained when there was an immediate threat to patients' safety.
69. Khan v. Suburban Community Hosp., 45 Ohio St. 2d 39, 43–44, 340 N.E.2d 398, 402 (1976).
70. Miller v. National Medical Hosp. of Monterey Park, Inc., 124 Cal. App. 3d 81, 177 Cal. Rptr. 119 (1981).
71. Theissen v. Watonga Mun. Hosp. Bd., 550 P.2d 938 (Okla. 1976); Wyatt v. Tahoe Forest Hosp.

Dist., 345 P.2d 93 (Cal.App.1959). Contra Peterson v. Tucson Gen. Hosp., 114 Ariz. 66, 559 P.2d 186 (1976).

72. Lapidot v. Memorial Medical Center, 144 Ill. App. 3d 141, 494 N.E.2d 838 (1986).
73. Anderson v. Caro Community Hosp., 10 Mich. App. 348, 159 N.W.2d 347 (1968). See also Greer v. Medders, 178 Ga. App. 408, 336 S.E.2d 328 (1985)—a patient has cause of action for the tort of intentional infliction of emotional distress when a physician used threatening, profane language in the presence of the patient's wife and a nurse.
74. See, for example, Miller v. Eisenhower Medical Center, 166 Cal. Rptr. 826, 835, 614 P.2d 258, 267 (1980); see also Staube v. Emanuel Lutheran Charity Bd., 287 Or. 375, 600 P.2d 381 (1979), cert. denied, 445 U.S. 966 (1980); Robbins v. Ong, 452 F. Supp. 110 (S.D. Ga. 1978); Pick v. Santa Ana-Tustin Community Hosp., 130 Cal. App. 3d 970, 182 Cal. Rptr. 85 (1982)—abrasive personality, difficulty in working with staff, applicant's behavior, and unfavorable reference letters were sufficient to deny privileges. Cf. Newcomb v. Patton, 608 S.W.2d 145 (Mo. App. 1980)—harassment of an administrator justifies nonrenewal of a physician's privileges.
75. For example, Cal. Bus. & Prof. Code § 805 (Deering 1986); Tex. Rev. Civ. Stat. Ann. art. 4495b, § 4.14 (Vernon 1987); Mich. Comp. Laws Ann. §§ 333.16233, 333.16243, 333.21513 (Supp. 1986). Further, the federal HCQIA of 1986 (Pub. L. No. 99-660) requires hospitals to report certain disciplinary actions and malpractice claims data to a national clearinghouse.
76. Rush v. City of St. Petersburg, 205 So. 2d 11 (Fla. App. 1967); Benell v. City of Virginia, 258 Minn. 559, 104 N.W.2d 633 (1960); Blank v. Palo Alto/Stanford Hosp. Center, 234 Cal. App. 2d377, 44 Cal. Rptr. 572 (1965) (radiology).
77. Adler v. Montefiore Hosp. Ass'n of W. Pa., 453 Pa. 60, 311 A.2d 634 (1973), cert. denied, 414 U.S. 1131 (1974); see also Lewin v. St. Joseph Hosp., 82 Cal. App. 3d 368, 146 Cal. Rptr. 892 (1978) (renal hemodialysis).
78. Sokol v. University Hosp., Inc., 402 F. Supp. 1029 (Mass. 1975)—a hospital's restriction of cardiac surgery to a single surgeon did not violate either antitrust or civil rights statutes; Moles v. White, 336 So. 2d 427 (Fla. Ct. App. 1976)—an exclusive contract for open-heart surgery did not violate state antitrust statutes, constitutional principles, or common law; Dillard v. Rowland, 520 S.W.2d 81 (Mo. App. 1974)—a private hospital having an affiliation agreement with a university's medical school may restrict staff appointments to those physicians who also hold a university faculty appointment.
79. For example, Dattilo v. Tucson Gen. Hosp., 23 Ariz. App. 392, 533 P.2d 700 (1975)—an exclusive contract for nuclear medicine did not violate either state or federal antitrust laws; Harron v. United Hosp. Center, Inc., Clarksburg, W. Va., 522 F.2d 1133 (4th Cir. 1975), cert. denied, 424 U.S. 916 (1976)—an exclusive radiology contract does not violate the federal Sherman Antitrust Act or the civil rights statutes; 42 U.S.C. §§ 1981, 1983, 1985.
80. Amer. Med. Assoc. Policy Compendium 230.975 at 197 (1993).
81. Cobb County-Kennestone Hosp. Auth. V. Prince, 242 Ga. 139, 249 S.E.2d 581 (1978).
82. 2006.AR.0000254, http://www.versuslaw.com.
83. 42 U.S.C. §§ 11111 et seq.
84. Bredice v. Doctors Hospital, 50 F.R.D. 249, 251 (D.DC 1970), aff'd, 479 F.2d 920 (D.C. Cir. 1973).
85. 50 F.R.D. at 250.
86. 245 Ga. 763, 267 S.E.2d 230 (1980). See also Columbia/JFK Medical Center Limited Partnership v. Sanguonchitte, 920 So. 2d 711 (Fla. App. 2006).
87. See, for example, Spencer v. Community Hosp. of Evanston, 87 Ill. App. 3d 214, 408 N.E.2d 981 (1980) and Raymond v. Cregar, 38 N.J. 472, 185 A.2d 856 (1962).
88. 42 U.S.C. § 1111(a).
89. Burkette v. Lutheran Gen. Hosp., 595 F.2d 255 (5th Cir. 1979).
90. Kushner v. Southern Adventist Health and Hosp. Sys., 151 Ga. App. 425, 260 S.E.2d 381 (1979).
91. Engelstad v. Virginia Mun. Hosp. and Va. Hosp. Comm'n, 718 F.2d 262 (8th Cir. 1983).
92. Laje v. R.E. Thomason Gen. Hosp., 564 F.2d 1159, 1163 (5th Cir. 1977) (quoting Sosa, supra note 8).

THE COURT DECIDES

Moore v. Board of Trustees of Carson-Tahoe Hospital
88 Nev. 207, 495 P.2d 605 (1972)

Today in response to demands of the public, the hospital is becoming a community health center. The purpose of the community hospital is to provide patient care of the highest possible quality. To implement this duty of providing competent medical care to the patients, it is the responsibility of the institution to create a workable system whereby the medical staff of the hospital continually reviews and evaluates the quality of care being rendered within the institution. The staff must be organized with a proper structure to carry out the role delegated to it by the governing body. All powers of the medical staff flow from the board of trustees, and the staff must be held accountable for its control of quality. The concept of corporate responsibility for the quality of medical care was forcibly advanced in *Darling v. Charleston Community Memorial Hospital*, wherein the Illinois Supreme Court held that hospitals and their governing bodies may be held liable for injuries resulting from imprudent or careless supervision of members of their medical staffs.

The role of the hospital vis-a-vis the community is changing rapidly. The hospital's role is no longer limited to the furnishing of physical facilities and equipment where a physician treats his private patients and practices his profession in his own individualized manner.

The right to enjoy medical staff privileges in a community hospital is not an absolute right, but rather is subject to the reasonable rules and regulations of the hospital. Licensing, per se, furnishes no continuing control with respect to a physician's professional competence and therefore does not assure the public of quality patient care. The protection of the public must come from some other authority, and that in this case is the Hospital Board of Trustees. The Board, of course, may not act arbitrarily or unreasonably in such cases. The Board's actions must also be predicated upon a reasonable standard.

THE COURT DECIDES

Leach v. Jefferson Parish Hospital District No. 2
870 F.2d 300 (5th Cir. 1989)

Gee, J.

Facts

In December 1986, East Jefferson General Hospital summarily suspended the physician privileges of the appellant, Dr. Richard E. Leach. The physician's suspension was upheld after a hearing before the Executive Committee of the Medical Staff and an appeal to the hospital's Board of Directors. The trial court found these actions were taken in accordance with hospital Medical Staff Bylaws.

In March 1987, after Dr. Leach allegedly continued disruptive behavior despite his suspension, the hospital's Chief of Staff, Dr. Herbert W. Marks, asked the Louisiana State Board of Medical Examiners to invoke the Louisiana Medical Practitioner's Act to determine the appellant's fitness and ability to practice medicine.

Dr. Leach asked the Medical Executive Committee to lift his summary suspension on May 19, 1987. Dr. Marks responded that the Bylaws failed to provide for review after the suspension had been affirmed by the hospital's Board of Directors. About a week later, Dr. Leach sought an outline of the procedures for again becoming an active staff member from the defendant, Peter J. Betts, who was the President and Chief Executive Officer of the hospital. The request for information was referred to the Medical Executive Committee, which informed Dr. Leach of the hospital's long-standing policy of requiring a one-year moratorium for reapplication to staff membership.

The Medical Executive Committee considered the moratorium an appropriate length of time for a disciplined physician to resolve his problems. Although the Bylaws do not stipulate such a moratorium, the East Jefferson Medical Staff's Credentials Committee Handbook recommends reapplication only after a period of at least one year. Mr. Betts thus informed Dr. Leach that he could reapply on February 19, 1988, which was one year after the hospital Board affirmed his summary suspension.

Dr. Leach was also informed that the Medical Staff only accepts applications from physicians with licenses not encumbered by the Louisiana State Board of Medical Examiners. The State Board informed Dr. Leach in August 1987, that it would not restrict his license to practice medicine. Dr. Leach then sought reinstatement and the hospital's Medical Executive Committee decided to allow him to reapply in advance of the one-year moratorium since the Louisiana State Board indicated he was solving his problem.

Instead of reapplying, however, Dr. Leach filed this lawsuit. The only issue was whether Dr. Leach was deprived of the due process and equal protection of the laws guaranteed by the Constitution. The trial court granted the defendant's motion for summary judgment, determining that there were no genuine issues of material fact. We affirm.

Analysis

The appellant first argues that the hospital failed to follow its established rules and regulations. The trial court found, however, that the hospital reasonably followed its own rules in summarily suspending the appellant, and we agree. The hospital's Bylaws provided no guidance for reapplication after summary suspension, but the

Committee Handbook delineated the policy of recommending a one-year moratorium. The hospital clearly has a duty to protect patients and ensure their competent treatment. In addition, we note that courts are not the best [forums] for determining the competence of medical practitioners. As we have stated,

> No court should substitute its evaluation of such matters for that of the Hospital Board. It is the Board, not the court, which is charged with the responsibility of providing a competent staff of doctors. * * * The court is charged with a narrow responsibility of assuring that the qualifications imposed by the Board are reasonably related to the operation of the hospital and fairly administered.

We agree with the trial court's finding that the measures employed by the hospital were reasonable. The appellant's argument that the hospital failed to follow its own rules and regulations is not supported by the record. In the one instance in which the hospital deviated from its stated policy, namely by shortening the length of the appellant's moratorium when it received evidence he was addressing his problems, it did so for his benefit. We find the appellant's argument of a due process violation unpersuasive and affirm the trial court's summary judgment on this issue.

The appellant also argues that the hospital rules and regulations were themselves inadequate to protect his constitutional interests. The argument must be evaluated in light of the United States Supreme Court's test for determining the sufficiency of procedures in safeguarding due process rights. In [*Mathews v. Eldridge* (1976)], the Court stated that due process requires considering the following factors: First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the 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.

The first Mathews factor requires consideration of the private interest that will be affected. The private interest of Dr. Leach was his medical privilege. This was, of course, a very important interest; but Dr. Leach was at liberty to practice medicine at other hospitals. In addition, Dr. Leach was permitted to reapply after a one-year moratorium, a period of time that was later reduced by five months.

The second Mathews factor weighs the risk of wrongful deprivation from the procedures used against the probable value of other safeguards. As the trial court found, Dr. Leach was allowed to present any evidence he chose to bring forth, both at the hearing before the Executive Committee and the appeal before the hospital's Board. The record is devoid of any evidence that the appellant ever requested a delay in the proceedings. Nor is there any evidence that the Board acted unfairly to the appellant. The one-year moratorium for reapplication was in fact shortened when the State Board informed the hospital, more than two months after the moratorium was imposed, that Dr. Leach was addressing his problems. In light of these circumstances, we are unable to say that the hospital failed to provide further necessary safeguards to protect the appellant's interests.

Finally, the hospital clearly has an interest in providing quality medical care to its patients. If a physician is disruptive or has personal problems, the hospital has a duty to intervene. When the mora-

torium was imposed, both the Medical Executive Committee and the hospital Board had agreed that summary suspension was necessary. The procedural safeguards were adequate to ensure that the appellant's constitutional rights were protected.

On balance, [we are convinced] that the hospital's duty to maintain quality healthcare for its patients decisively outweighs the burden on the appellant of reapplying for staff privileges. The procedures provided a "meaningful hedge against erroneous action," and due process requirements of notice and an opportunity to be heard were met.

The appellant was not deprived of his constitutional rights to due process or equal protection when the hospital interpreted his summary suspension as permanent revocation and imposed the one-year moratorium on reapplying for staff privileges. We therefore find the trial court properly granted the appellee's motion for summary judgment and the ruling is Affirmed.

Moore and *Leach* Discussion Questions

1. In the *Moore* case, a dissenting judge wrote: "One searches…in vain for a description of 'unprofessional conduct' even in general terms. Herein lies the difficulty with the instant matter. A hospital should not be permitted to adopt standards for the exclusion of doctors which are so vague and ambiguous as to provide a substantial danger of arbitrary discrimination in their application." Do you believe the author of that opinion would dissent in the *Leach* case as well? Why or why not?
2. What do you suppose were the "disruptive behaviors" involved in the *Moore* and *Leach* cases? Why do the courts not describe them in detail?
3. Do you agree with the way the courts have viewed their role in relation to judging the hospitals' decisions? Should the courts have been more active in reexamining the merits of the earlier decisions? Why or why not?

CHAPTER

8

EMERGENCY CARE

After reading this chapter, you will

- learn that the moral duty to be a Good Samaritan is not congruent with the legal principle that, generally speaking, one has no obligation to help a person who is in distress.
- be able to explain a hospital's duty under the Emergency Medical Treatment and Labor Act to someone who comes to the emergency department and seeks treatment.
- understand the risks inherent in requiring all medical staff physicians to take emergency duty.

As noted in an earlier chapter, patients do not usually have a right to be admitted to a hospital or to be seen and treated in an outpatient clinic. Stated another way, the black-letter rule provides that a hospital has no duty to admit or serve all who present for treatment, except in a medical emergency. As with all generalizations, there are exceptions to the rule. (One might recall Mark Twain's aphorism, "All generalizations are false, including this one.")

One exception to the rule that there is no duty to treat arises in the hospital's emergency department. It is perfectly evident that the American public expects service from the nation's hospitals and their medical staffs in case of emergencies. In the late 1960s the courts began to recognize that a hospital's emergency department has a duty to evaluate all patients who come for service and to render emergency care to those who need it. Subsequently, federal law codified this duty in the Emergency Medical Treatment and Labor Act (EMTALA).[1] Accordingly, hospitals and their staffs must be organized and prepared to meet the public's expectations for emergency treatment, if they are equipped to do so. The law appears to be consistent with the philosophy that healthcare at the time of an emergency is a moral right and must be provided regardless of ability to pay.

The first question is whether a hospital must maintain a facility for emergency care. If it must, or if it voluntarily offers such services, the second issue regards the extent of the institution's duty to the patient.

Necessity for Emergency Care Facilities

Although common law does not impose a duty on a hospital to treat emergency patients, many states have statutes that require hospitals to maintain emergency care facilities or arrange for such care. These requirements may be found in some states' hospital licensure statutes. An Illinois statute, for example, applicable to all hospitals where surgery is performed, requires the hospital to offer emergency care.[2] All hospitals receiving payments from the Pennsylvania Department of Public Welfare must have at least one licensed doctor or resident intern on call at all times.[3] New York provides that operating certificates can be revoked for any general hospital refusing to provide emergency care.[4] In practical effect, such statutes, and the rules and regulations that implement them, require hospitals to maintain emergency departments. Violation is penalized according to the particular statute, perhaps by a criminal sanction, revocation of license, or both. Moreover, violation of such a statute could be the basis of a civil lawsuit for damages.

These statutes represent a trend toward requiring hospitals to establish and maintain emergency facilities. The public expects ready and convenient access to a hospital emergency department, but it does not follow that all general hospitals should be legally required to maintain relatively expensive capabilities for emergency care. (Some states have statutes or regulations recogni-zing differing levels of emergency services: comprehensive, basic, and standby, for example.)

Legal DecisionPoint

A physician declines to put a special tag on her license plate that would identify her as an MD. She fears that police would stop her at the scene of an accident and require her to render aid, thus exposing her to lawsuits.

Interesting legal and ethical questions can be asked about this scenario. What is a physician's legal and moral obligation to provide care at the scene of an accident? Does the fact that the person is a physician, as opposed to a random member of the public, change the analysis in any way, either ethically or legally? How real is the apprehension about liability under such circumstances? Perhaps most importantly, what would you do?

Duty to Treat and Aid

Under Common Law

It has been said that "no one has a duty to stop a blind man from walking off a cliff." This doctrine, even though contrary to human instinct, has been applied to physicians and hospitals as well as to laypersons. Hence, a physician has no common-law responsibility to respond to a call for help in the absence of a preexisting physician–patient relationship (see Legal DecisionPoint).

Illustrating the common-law rule is *Childs v. Weis*, decided nearly 40 years ago.[5] (This case is also mentioned in Chapter 2.) A pregnant patient presented

at the hospital emergency department at 2 a.m., apparently suffering from bleeding and believing she was in labor. The hospital did not require physicians who were on call to see and examine all emergency patients, so the nurse on duty examined the woman and telephoned the on-call physician. The doctor—a private practitioner—told the nurse to have the patient telephone her private physician for advice. The nurse apparently mistook the message and told the patient to go to her private doctor, located some miles away. The patient was en route when the baby was born, but it lived only 12 hours.

In a suit against the physician the court held that dismissal of the action was proper because a doctor's duty to exercise reasonable care depended on there being a contract with the patient; because no such contract existed, there was no duty to treat. In other words, no doctor–patient relationship had been established, and the physician was not liable. (With respect to the personal liability of the nurse for negligence, however, certain factual questions justified submitting the case to a jury.[6])

Note that the aptly named *Childs* case, like *Hill v. Ohio County* in Chapter 6, would be decided differently today for a variety of reasons. (One could even argue at length whether these cases were decided correctly at the time, but that would be a rather fruitless academic exercise.) As mentioned before, the only common-law exception to the rule that generally one has no duty to aid another in peril is when the person who fails to aid has a special responsibility to care for the person's well-being. Some cases have found liability only when negligent conduct placed the plaintiff in danger; other cases have found defendants liable for failing to aid no matter how they had endangered the plaintiff. As discussed later in the chapter, recent court cases and statutes have changed this position, at least with respect to hospitals that have emergency departments.

Judicial Decisions

In the 1960s, courts began to establish a duty to aid without benefit of statute. In *Williams v. Hospital Authority of Hall County*, for example, a Georgia appellate court held that a governmental hospital that had an emergency department must extend aid to an accident victim who had applied for treatment of a fracture.[7] The court stressed that the defendant hospital was a public, tax-supported institution, and it expressly rejected the argument that the hospital had an absolute right to refuse to provide emergency services. The judge described as "repugnant" a refusal to serve where emergency care was needed and available.

The Missouri Supreme Court extended the same philosophy to a private hospital in *Stanturf v. Sipes*.[8] A patient with frozen feet was refused treatment at a private hospital. The initial reason was the patient's inability to make a cash

deposit, but the hospital maintained its refusal even after friends offered the deposit. The hospital apparently was doubtful that further payment could be ensured. The delay necessitated the amputation of both feet. In the court's opinion it was an error for the trial court to apply the traditional rule and to grant summary judgment for the hospital. Rather, the plaintiff was entitled to a trial on the factual issues of whether an emergency existed, whether aid had been undertaken, and whether reasonable care had been exercised. (Because the case does not appear again in judicial reports, it is likely that it was settled.)

Likewise, in an Arizona case, *Guerrero v. Copper Queen Hospital*, it was ruled that a licensed private hospital with an emergency department must extend care.[9] A similar Arizona case, which relied on *Guerrero*, involved a youngster who had suffered a severe injury to his thigh (a transected femoral artery) and who, although treated in the emergency department, was transferred to a public hospital while more treatment was needed. He survived, but he had permanent impairment of his leg. The court found that the patient was transferred for financial reasons and "as a matter of law this was a breach of the hospital's duty." Because the permanent impairment to the leg might have been inevitable, the jury was left to decide whether the inappropriate transfer increased the harm to the patient.[10]

In contrast to the common-law rule, police officers, fire department personnel, and members of publicly owned paramedical rescue units have a duty to aid victims of accidents or other emergencies; after all, that is their job. Legislation normally specifies their responsibilities and the geographic boundaries of their departmental operations. Very few, if any, actions have been brought against police and fire department personnel (or physician bystanders either, for that matter) alleging negligence in administering first aid in a medical emergency. Somewhat more likely are lawsuits contending that injuries were aggravated or harm was done while transporting patients to hospitals for treatment. Depending on evolving local law, individuals who serve in a public capacity may be immune from personal liability simply on the basis that in rendering care they are performing a "discretionary act" requiring personal decision and judgment.

Statutory Requirements

As mentioned earlier, for years, statutes in some states have required certain hospitals to provide emergency care. The refusal of emergency care or hospital admission on the basis of race, color, creed, national origin, or other prohibited category violates various federal and state civil rights statutes and regulations governing Medicare and Medicaid programs.

Beginning in the early 1980s, however, the U.S. Congress became concerned about reports of alleged "patient dumping"—the practice of refusing to treat or transferring patients who were uninsured and unable to pay for medical care. In response to these concerns, Congress passed EMTALA in 1985—see The Law in Action.

In part, EMTALA provides the following:

> § 1395dd. Examination and treatment for emergency medical conditions and women in labor.
>
> (a) Medical screening requirement. In the case of a hospital that has a hospital emergency department, if any individual …comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.
>
> "Emergency medical condition" is defined to mean—
>
> (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in
>
> (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
>
> (ii) serious impairment to bodily functions, or
>
> (iii) serious dysfunction of any bodily organ or part; or
>
> (B) with respect to a pregnant woman who is having contractions—
>
> (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
>
> (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

The Law in Action

Part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, EMTALA is also known as the "anti-dumping act" or "medical COBRA." Its purpose was

> "to provide an 'adequate first response to a medical crisis' for all patients and 'send a clear signal to the hospital community…that all Americans regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress'."
>
> —*Baber v. Hospital Corp. of Am.*, 977 F.2d 872 (4th Cir. 1992) (quoting Sen. David Durenberger, 131 Cong. Rec. S. 13904 (Oct. 23, 1985)

EMTALA benefits all patients, not merely those who are uninsured and unable to pay for care,[11] and it applies to virtually all hospitals in the United States. Violations can result in civil fines and the Medicare "death penalty"—that is, exclusion from the program.

EMTALA requires that the patient be given an "appropriate" medical screening examination. Of what that examination should consist varies

from case to case. For instance, a quick history and physical may be enough for a child with a fever and a cold, but another child with a fever might require extensive diagnostic services if symptoms of meningitis are found. Thus, EMTALA does not simply require a physical examination; it requires the exercise of good clinical judgment and the use of all indicated ancillary diagnostic techniques to determine whether an emergency in fact exists.

If the screening examination reveals that an emergency does exist, the condition must be treated until it has been stabilized, unless the patient requests transfer or it is determined that the medical benefits of transfer outweigh the risk.[12] When a transfer is appropriate, the transfer must be in the patient's best interests and must meet certain standards of care, including the following:

- The hospital must provide what treatment it can to minimize the risks involved.
- A capable hospital must be located that is willing to accept the patient.
- Medical records, or copies of them, must accompany the patient to the second facility.
- Qualified staff and proper equipment must be used to effect the transfer.[13]

The Law in Action

A physician suddenly developed belly pain one evening at home. His family called 911, and the emergency medical technicians said they would take him to a small neighborhood hospital nearby. Correctly diagnosing his own condition (a leaking abdominal aortic aneurysm) and understanding the need for immediate surgery, the physician asked to be taken to a major medical center about half an hour away, where, incidentally, he was a member of the medical staff. Emergency surgery was successful, and the doctor returned to his practice immediately after a routine recovery.

Bypassing the ill-equipped hospital for the large medical center was correct, both legally and clinically.

Essentially, then, unless transfer is in the patient's best interests, EMTALA requires that all patients known to have emergency conditions be given medically proper care until their condition is stable. This care need not result in eventual admission to the hospital, and (once the condition is stable) discharge or transfer will not violate EMTALA (see The Law in Action). But the statute specifically states that stabilizing care may not be delayed for the purpose of determining the patient's "method of payment or insurance status."[14] This seems straightforward enough, but, as is usual in statutory interpretation, considerable ambiguity exists.

The first ambiguity concerns when the duty to stabilize arises. According to the statute, it arises when "the hospital determines that the individual has an emergency medical condition...."[15] If the patient is in the emergency department, the hospital must conduct an "appropriate medical screening examination" to make this determination.[16] (Regarding patients not in the emergency department, see the section "Coming to the Hospital," later in this

chapter.) But EMTALA does not define the latter expression, so the distinction between an appropriate medical screening examination and an inappropriate one has been the subject of considerable litigation and commentary.

Appropriate Medical Screening

Consider *Summers v. Baptist Medical Center Arkadelphia*,[17] which involved a man who fell from a platform in a tree while deer hunting. Complaining of popping sounds when he breathed and pains in his chest, the plaintiff was taken to the emergency department of Baptist Medical Center. There a physician examined him and ordered x-rays of his spine, which supposedly showed only an old fracture. No x-rays of the chest were taken. After receiving injections of pain medication (on the belief that he was suffering muscle spasms), Mr. Summers rode five hours home in a pickup truck. Two days later, when his pain became unbearable, he went to another hospital and was diagnosed with a broken thoracic vertebra, a broken sternum, and a broken rib. A physician classified these injuries as "life threatening," according to the trial record.

To summarize, Mr. Summers was given a medical screening examination at Baptist and the emergency department physician determined in good faith—albeit perhaps negligently—that no emergency medical condition existed. The physician, therefore, did not admit Mr. Summers to the hospital and did not stabilize his condition. Mr. Summers was also given a medical-screening examination at the second hospital. Based on that examination the emergency was perceived and he was treated for his injuries. Clearly, the examination at the second hospital was an appropriate one, and it triggered the obligation to stabilize Mr. Summers. But was the presumably negligent examination at Baptist also an "appropriate" one under EMTALA?

At first blush it seems logical to conclude that if an appropriate transfer is one that is medically proper and serves the patient's best interests, an appropriate screening would be one that meets the same standard of care. If so, the negligent examination at Baptist would not be considered appropriate and would be deemed a violation of EMTALA. (EMTALA provides for stiff civil monetary penalties against hospitals and physicians who violate its provisions, and it allows an individual who suffers personal harm to obtain damages from the hospital, but not the physicians, concerned.[18]) Indeed, some authors argue forcefully for just such an interpretation.[19] Authors of one article lament that although "appropriate transfer" is defined in terms of being medically adequate, "appropriate medical screening" has been interpreted merely to mean one that is nondiscriminatory.[20] They assert that if "appropriate" means medically adequate in one part of the statute, it means medically adequate in another. These commentators contend:

> Based on the plain language of the statute…and the legislative history, Congress intended to require hospitals with emergency rooms to establish fitting, proper and suitable procedures, within the capability of the hospital, to medically screen indigent and non-indigent patients to determine whether their present symptoms are life- or limb-threatening if not properly treated…. In applying these principles to a given factual scenario the question becomes, would a "reasonable physician" consider the hospital's established screening procedures appropriate to determine, "more likely than not," whether the presenting symptoms are life- or limb-threatening.[21]

Admitting that this is perhaps the "most natural" meaning of the term "appropriate" in the context of medical examinations,[22] the *Summers* court nevertheless rejected this meaning and held that the screening examination at Baptist was appropriate. Although negligent, it was undertaken in good faith and did not result in the physician or the hospital realizing that an emergency existed. Because the duty to stabilize does not arise until "the hospital determines that the individual has an emergency medical condition,"[23] the court in effect held that the hospital and the physician are not to be charged with constructive knowledge of a condition that they should have diagnosed but did not.

In rejecting the argument that a negligent examination is ipso facto inappropriate, the court pointed out that the purpose of the statute was to prevent patient dumping, not to create "a general federal cause of action for medical malpractice in emergency rooms."[24] Indeed, Mr. Summers's position, if adopted, would require the parties to conduct a miniature medical malpractice trial on the issue of appropriateness in every case where no diagnosis of "emergency medical condition" was made. The *Summers* court was not about to assume that by enacting EMTALA, Congress intended this result.[25]

The *Summers* decision is consistent with a growing body of jurisprudence holding that a negligent screening exam might not be an EMTALA violation. For example, in *Gatewood v. Washington Healthcare Co.*,[26] a U.S. Court of Appeals held that EMTALA "is not intended to duplicate preexisting legal protections, but rather to create a new cause of action, generally unavailable under state tort law, for what amounts to failure to treat."[27]

The article quoted earlier argued that EMTALA should be viewed as "a statute designed to protect the health of the consumers of emergency room services rather than an emergency room civil rights statute."[28] Unless this view prevails, the authors argued that "the effect will be to render EMTALA a serpent without fangs."[29] It can be argued, however, that given our federal system of government this "cobra" has venom enough for its intended prey. This was the point of the *Summers* court when it wrote this:

> Congress can of course, within constitutional limits, federalize anything it wants to. Whether it chooses to do so is a matter of policy for it to decide, not us. But in construing statutes that are less than explicit, the courts will not assume a purpose to create a vast new realm of federal law, creating a federal remedy for injuries that state tort law already addresses. If Congress wishes to take such a far-reaching step, we expect it to say so clearly.[30]

Other decisions addressing the medical screening issue seem to agree that EMTALA is essentially a civil rights statute.[31] It imposes on a hospital the duty to treat all individuals alike, to triage them consistently, and to treat those who are thought to have emergency conditions. It appears that the fact that some undiagnosed emergencies may go untreated is a matter for state medical malpractice law, not EMTALA.[32]

Coming to the Hospital

The second ambiguity relates to whether EMTALA applies only to persons in the emergency department or includes those with emergencies elsewhere on hospital property. According to the first paragraph of EMTALA, the cobra begins stalking when "any individual…comes to the emergency department and a request is made…for examination or treatment…."[33] The second paragraph, however, states, "If any individual...comes to the hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide [stabilization or appropriate transfer]."[34]

Cases have applied EMTALA to a patient with unstabilized depression who committed suicide the day after being discharged from a psychiatric unit[35] and to a patient in labor who was transferred to the defendant hospital's labor room from another hospital.[36] Both cases involved emergency conditions that were presumably known in the hospital but occurred outside the emergency department.

In contrast, *Baber v. Hospital Corporation of America*[37] involved a patient who was transferred to a psychiatric ward from another hospital and was not known to have an emergency condition. Because the patient was not in the emergency department, the court held that the medical screening obligation did not apply, and because the emergency condition was not discovered until fatal symptoms developed, no EMTALA liability was found.

The EMTALA regulations do not define "comes to the hospital," but they define "comes to the emergency department" to include anyone requesting examination or treatment on hospital property.[38] Additionally, according to the regulations, "hospital property" includes not only the building and grounds but also ambulances owned or operated by the hospital, wherever they may be located.[39] Persons in non–hospital-owned ambulances on hospital property are also considered to have come to the emergency department.[40] Finally, the regulations define "hospital with an emergency department" to

mean one that offers emergency services, irrespective of whether it has a defined emergency department as such.[41]

In short, if the standards set forth in the regulations meet judicial approval, it would appear that with the possible exception of situations like those in *Baber* (where the patient is in the hospital but not in the emergency department, is not requesting examination or treatment, and has an undiagnosed emergency condition), the full range of EMTALA's obligations will apply throughout the hospital.[42]

In at least one case the meaning of "comes to the hospital" was stretched even further. In *Arrington v. Wong*[43] a patient in severe respiratory distress was being transferred to a hospital in an ambulance not owned by the hospital. The ambulance personnel called ahead to announce their estimated time of arrival and to describe the patient's condition. After being told that the patient was an Army hospital beneficiary, the physician on call told the emergency medical technicians, "I think it would be okay" to go to the Army hospital, which was farther away. The ambulance diverted, and the patient died about 40 minutes after arriving at the military facility.

The U.S. Court of Appeals for the Ninth Circuit held that because the hospital was not on "diversionary status" (unable to accept any more patients because of heavy volume), it would frustrate the purpose of EMTALA to allow the hospital to turn away an ambulance that it knew was headed its way. Relying heavily on the government's regulations to interpret what it felt was an ambiguous provision, the court wrote:

> The "overarching purpose of [EMTALA is to ensure] that patients, particularly the indigent and underinsured, receive adequate emergency medical care." [Citation omitted.] The agency's interpretation achieves this purpose, ensuring that emergency patients may be diverted to other hospitals only when the diverting hospital has a valid, treatment-related reason for doing so. The agency's interpretation works no hardship on the hospital, as the Department's [EMTALA regulation] "only requires hospitals that offer emergency services to provide screening and stabilizing treatment within the scope of their capabilities." [Citation to the regulation omitted.] Furthermore, a failure to treat an emergency patient, by diverting him to another hospital, may have lethal consequences. Finally, when a hospital is unable to handle the case load and is in diversionary status, it may divert emergency patients even if they are in the process of being transported to that hospital because it is the closest. Because the agency's regulation is consistent with the purposes and language of the statute, we find that interpretation reasonable (and certainly not arbitrary or capricious).
>
> ....
>
> We follow the Department of Health's regulation and hold that a hospital may divert an ambulance that has contacted its emergency room and is on its way to that hospital only if the hospital is in diversionary status. [See Legal Brief on page 231.]

Motive

The final vexing question concerns motive: for there to be an EMTALA violation, should the defendant's decision have been motivated by the patient's inability to pay? Despite some early district court cases holding that such an allegation is necessary,[44] the appellate courts seem to be in agreement that no particular motive need be alleged or proven. They reason that EMTALA achieves its purpose (to discourage the practice of "dumping" indigent patients) by requiring that all patients—insured, uninsured, and self-pay alike—receive uniform treatment. If one does not receive uniform treatment, the reason for the lack of uniformity is immaterial.

The issue was raised in *Cleland v. Bronson Health Care Group, Inc.*,[45] where the Sixth Circuit wrote:

> We can think of many reasons other than indigency that might lead a hospital to give less than standard attention to a person who arrives at the emergency room. These might include: prejudice against the race, sex, or ethnic group of the patient; distaste for the patient's condition (e.g., AIDS patients); personal dislike or antagonism between the medical personnel and the patient; disapproval of the patient's occupation; or political or cultural opposition. If a hospital refused treatment to persons for any of these reasons, or gave cursory treatment, the evil inflicted would be quite akin to that discussed by Congress in the legislative history and the patient would fall squarely within the statutory language.[46]

Some have read this passage as support for the position that liability can be found only if the hospital had an improper motive in providing the disparate treatment.[47] One can argue, however, that the *Cleland* court recognizes the fact that a bad motive of some kind is inherent in all disparate treatment and therefore need not be a specific element of an EMTALA offense. (Of course, plaintiffs' lawyers would prefer to have evidence of an ulterior motive, but the lack of such evidence is not fatal to the case.)

For example, if physicians, acting in good faith, diagnose no emergency and discharge the patient, they have acted, whether negligently or not, in accordance with what they believe to be the patient's best interests. If, however,

Legal Brief

According to the *Arrington* court, a patient who is coming to the hospital has come to the hospital.

What?! The plain meaning of "when any individual...comes to the emergency department" means that he is already there, does it not?

But just a minute! In *Macbeth* one of the witches utters the famous line, "By the pricking of my thumbs, something wicked this way comes." The wicked thing is Macbeth himself, who clearly has not yet arrived on the scene but is on his way. Would some congressional bard had written, "when someone to the ED comes."

the physicians know that an emergency condition exists and discharge the patient anyway, their decision must have been motivated by something other than the patient's best interests. Congress chose to address the issue of patient dumping by creating a kind of "emergency room civil rights statute," which requires equal treatment for all. If inequality is found, a violation has occurred and it is not necessary to prove the motivation for the disparate treatment.

In its only decision on EMTALA to date, the U.S. Supreme Court has agreed that an "improper motive" is not a prerequisite for proving a violation of the statute.[48] EMTALA has been a significant issue for years, and the "cobra" has struck many hospitals and physicians. Its venom is always painful,[49] especially given ambiguities in the statute and the fact that a violation can subject the offender to a civil fine of up to $50,000 and possible exclusion from Medicare. (The fine, incidentally, would not be covered by standard insurance.)

Duty to Exercise Reasonable Care

Liability and Negligence

EMTALA considerations aside, there is a long-standing and well-accepted common-law rule that once care has begun there is a duty to exercise reasonable care under the particular facts and circumstances. The rule clearly applies to both physicians and hospitals. The slightest act of aid to the patient may trigger the application of this judicial doctrine. To illustrate, consider *Bourgeois v. Dade County*, in which the police brought an unconscious patient to the hospital.

The physician on emergency call conducted only a cursory examination without benefit of x-rays and decided that the patient was intoxicated. With the doctor's approval the patient was then removed to jail, where he died. It was later established that the patient had been suffering from broken ribs that had punctured his lung. The issue of negligence was one for the jury to decide.[50]

Many other cases have involved same principles and have resulted in findings of liability. There is no need to discuss all these decisions in detail here, but the reader should be aware of such other important cases as *Jones v. City of New York Hospital for Joint Diseases*,[51] *New Biloxi Hospital v. Frazier*,[52] and *Methodist Hospital v. Ball*.[53] In all three cases the facts were fundamentally the same: victims of violence or accident were accepted into the emergency department, and the hospital staff failed to exercise reasonable care in diagnosing and treating them.

In *Jones* an intern of a voluntary hospital did no more than clean and dress a patient's stab wounds before ordering a transfer to a city hospital.

The delay caused the patient's death. In *Frazier* and *Ball* the patients were unattended for 45 minutes and an hour, respectively; were given minimal attention and diagnosis from hospital nursing and medical staff; and then were transferred to other institutions with adverse results. These cases emphasize the legal and moral necessity of exercising reasonable care in making a diagnosis and deciding the course and place of treatment.[54] They also show that it is essential for hospital employees to determine which patients need immediate attention. Delay cannot be excused because others were being treated.[55]

A healthcare provider can be liable for reasons other than the negligence of hospital physicians. This fundamental principle is well illustrated by a South Dakota case, *Fjerstad v. Knutson*.[56] An intern (who was not a licensed physician) was on duty in the hospital's emergency department. He examined the patient, ordered a blood test and throat culture, and gave a prescription for an antibiotic. Unable to reach the on-call physician, the intern then released the patient, who died the following morning from asphyxia caused by a blocked trachea. In the case against both the intern and the hospital, the trial court instructed the jury that the hospital could not be held liable unless the intern was found negligent. The jury's verdicts were for both defendants, but the plaintiff's appeal succeeded to the extent of obtaining a new trial against the hospital.

The judge's instruction to the jury was wrong. The appellate court observed that the jury would have been justified in finding the hospital negligent, even if the intern had not been negligent, because of its failure to have a physician available for consultation with the emergency department staff. The failure was a violation of the institution's own standards, which required interns to contact the on-call physician before treating emergency patients and before prescribing drugs. Such alleged breaches were sufficient to create an issue for a jury (see The Law in Action). Further, on the question of proximate cause, the plaintiff had presented expert testimony at trial establishing that a person with the decedent's symptoms should have been hospitalized and that his life could probably have been saved.

The Law in Action

"It was the policy of the hospital not to release emergency room patients until the on-call physician or the patient's local doctor had been contacted. Interns were to initiate a course of treatment only in emergencies, and they were not to prescribe drugs without consulting a licensed physician.

…[T]he separate liability of Sioux Valley Hospital was not properly submitted to the jury.

… [T]he evidence of the hospital's breach of its own standards is sufficient to create a jury issue.

The failure to have an emergency room doctor available and failing to consult with him violated the hospital's own standard for treatment."

—*Fjerstad v. Knutson*
271 N.W.2d 8, (S.D. 1978)

Hospital Admissions and Transfers

Obviously not all emergency department patients need to be (or can be) admitted to the hospital. Transfer to another hospital is justified when the patient's condition has been stabilized or otherwise meets the standards of EMTALA. Indeed, a hospital is under a positive duty to transfer a patient to another institution if it does not have the appropriate facilities and staff to care for the patient properly.[57] The transferring institution also has a duty to forward, with the patient, the diagnosis and other appropriate medical information, and the receiving hospital has a duty to obtain this information.[58]

As these cases demonstrate, patients presenting themselves at a hospital's emergency department should never be turned away until they have been seen and examined by qualified healthcare personnel, who should determine the seriousness of the illness or injury and then order admission, a return home, or a transfer to another facility, depending on the circumstances. Undue delays should not be tolerated. These policies should be stated clearly in written rules that hospital personnel and emergency department personnel can readily carry out. Because ignoring or violating written rules can be evidence of negligence, it is extremely important that established hospital policies be followed meticulously once they are expressed in writing.

It is also important to comply fully with the standards of emergency care promulgated by public and private agencies and professional groups. Among the standards issued by public agencies are the rules and regulations of state licensing agencies. A violation of these regulations could be evidence of negligence. Standards established by private agencies such as the Joint Commission have the same legal implications (see Legal Brief). For example, the Joint Commission stresses initial and ongoing assessment of a patient's need for care. This is especially so at the patient's first point of contact, which is often the emergency department. This means that qualified practitioners must assess all aspects of the patient's condition, including her "physical, cognitive, behavioral, emotional, and psychosocial status" and must consider such additional factors as physical disabilities, language barriers, and vision or hearing impairments.[60]

Legal Brief

Governmental regulations, the standards of professional associations, and a hospital's own policies and medical staff bylaws can be evidence for a jury to consider in a lawsuit.[59]

A medical record must be maintained for every emergency patient and incorporated into the permanent hospital record. A plan for emergency care must exist, and no patient whom the hospital is capable of properly caring for should be arbitrarily transferred to some other institution. Medicare's "Conditions of Participation for Hospitals" also contain standards for emergency care similar to those promulgated by the Joint Commission.

In addition, professional standards require written medical records for all patients seen in the emergency department, including those not formally admitted to the hospital. Not only are such records mandatory in the interest of adequate medical care, but the hospital may also be called on later to document in the courtroom the standards of care rendered to a particular patient, in which event a medical chart is indispensable (see The Law in Action). Records should include the instructions for continuing care given to the patient at discharge and the information furnished to an institution or physician to whom the patient is referred.

The Law in Action

In a case I handled in the Navy, a military physician saw a patient in the emergency department and sent him home, where he died. At issue in the case was what "discharge instructions" the doctor gave the patient and family when the patient was released. (Discharge instructions include advice about what signs and symptoms to be aware of if the patient's condition does not improve.)

The physician presented the record from the emergency department files, which showed detailed directions to be alert for exactly the types of symptoms the patient showed after he returned home. Unfortunately for him, the doctor forgot that the record was written on self-duplicating ("NCR paper") forms and that the duplicate copy was filed in the patient's outpatient chart. The copy showed no discharge instructions at all.

Not only was the case lost, but the physician was disciplined severely.

Staffing the Emergency Department

All of the foregoing suggests that the legal duty of reasonable care owed to emergency patients mandates a well-organized department; staffed with qualified personnel; and equipped with the physical means of ensuring prompt diagnosis, stabilization, treatment, and referral.[61] Persons in charge of the emergency department must be an integral part of the organization and must be accountable for the quality of care. Ultimately the governing body of the hospital is responsible for the professional standards of the emergency department, just as it is responsible for other clinical standards of the institution.[62] Medical staff privileges must be delineated for each emergency department physician, as they are for those in other departments.

For hospitals of any significant size, providing coverage in the emergency department with just on-call physicians is asking for trouble. When physicians are only on call, there is too much opportunity for error in diagnosis and delay in treatment, both of which lead to unfortunate situations and increase liability problems.

It is ironic that liability is made more likely by the trend of specialization in medical practice. Emergency medicine has become a specialty of its own. Many specialists in other disciplines are not competent to deal with emergency cases and should not be on emergency department duty. Neither should interns, physicians' assistants, and others who lack training in

The Law in Action

In one hospital, all physicians took turns rotating through the emergency department. A psychiatrist was staffing the emergency department one night when an obviously intoxicated woman was brought in complaining of headaches and neck pain after a fall at home. The psychiatrist dismissed her story as the ramblings of a besotted crock and sent her home. As a result of an undiagnosed neck fracture, the patient suffered permanent paralysis. When asked why he did not order cervical x-rays, the doctor—unhappy to have been given emergency department call in the first place—replied, "I'm a psychiatrist. I don't look for anything below here," pointing to his eyebrows. The lawsuit was settled, of course.

Although psychiatrists are MDs, this anecdote from my experience is a reminder that not all MDs are qualified to serve in the emergency department.

emergency medicine. Hospitals that wish to furnish full-scale emergency services should have a department with a full-time staff of licensed and certified physicians, nurses, and other personnel trained to handle emergency cases (see The Law in Action).

Hospitals have several alternatives for staffing the emergency department. In most states, not-for-profit institutions may employ doctors directly, with the "corporate practice of medicine" rule having been abolished in most jurisdictions. (The prohibition on the corporate practice of medicine was announced many years ago as a means of discouraging commercialization and exploitation of the medical profession and to emphasize that the physician's individual loyalties belong solely to the patient. It was developed, however, in the context of the private, profit-making corporation and is believed to have little or no relevance to modern not-for-profit hospitals. In those few states that adhere to the "corporate practice of medicine" doctrine, or when an alternative to salary is desired, a fee-for-service arrangement can be used.)

More typical than direct employment of emergency department physicians is a contractual arrangement in which a physician corporation or partnership undertakes to provide full-time emergency department coverage. By entering into such an arrangement, the hospital must not abdicate its ultimate responsibility for the quality of healthcare. The contract must provide guidelines for full-time coverage, supervision of hospital nurses and house staff, maintenance of equipment and facilities, billing, and referral of patients. The document must also specify the duration of the arrangement and provisions for renewal. Above all, the medical staff of the hospital must be involved in monitoring the standards of practice in the emergency department and delineating clinical privileges, even when service is contracted to an independent group of physicians. This medical staff function must be clearly articulated in the contract, and the emergency department physicians should be required to carry adequate malpractice insurance and agree to indemnify the hospital if malpractice judgments arise from their negligence.

The financial arrangements between the hospital and the contracting group may legally allow two charges to the patient: one for hospital services

and another for the physician's service. The group may bill the patient directly or assign the account to the hospital for collection.

Good Samaritan Statutes

Most states have statutes commonly called "Good Samaritan laws." From the public policy viewpoint their purpose is to encourage physicians and other professionals to extend aid to strangers at the scene of an emergency. The essence of the legislation provides that a physician, registered nurse, or other healthcare professional—or in some statutes, "any person"—is not to be held liable for ordinary negligence or malpractice when extending aid at an emergency scene, as long as the aid is extended in "good faith" and without "gross negligence" or "willful and wanton misconduct."[63] Many statutes require that the aid be extended "gratuitously." Although the applicability of each statute to designated persons and to particular situations depends on its precise language, several general observations are useful.

First, the statutes were essentially unnecessary. Few if any Good Samaritan ("accident by the side of the road") situations have ever come to trial. The laws were passed anyway at the urging of medical lobbying groups. Second, many of them only apply to certain people. Professionals or laypersons not specifically designated in the relevant local statute are not protected by the legislation; they are held to the well-recognized common-law rule that the beginning of aid raises the duty to exercise reasonable care under all the facts and circumstances. Third, although some of the statutes grant immunity to professionals licensed to practice in other jurisdictions, others do not. Thus, they consider such individuals to be laypersons when they render aid outside the state of their licensure. Fourth, most of the original Good Samaritan laws did not apply to ambulance attendants or emergency service personnel, although many jurisdictions now have an entirely separate statute granting immunity to such persons.[64] Similar special legislation for emergency medical care was adopted in many states in response to a 1973 federal law that offered financial incentives and otherwise encouraged the development of local and regional emergency services by professional paramedics working outside a hospital or other medical care institution.[65] The federal statute has since been repealed, but the state Good Samaritan laws remain.

Fifth, as noted, very few lawsuits are on record against Good Samaritans who were allegedly negligent in aiding accident victims. Moreover, the refusal of a physician or another professional person to assist at the scene of an emergency has never posed a serious threat of legal liability as long as the person was not already under an established duty to act.[66] (The moral implications are beyond the scope of this text, obviously.) In short, the fear of lawsuits that prompted the

enactment of the Good Samaritan legislation was unfounded. Moreover, "reasonable care" in an emergency outside of a hospital would be a rather minimal requirement because the common law would not expect a physician, for instance, to possess life-saving equipment or drugs at the scene of a highway accident or when treating a victim of sudden illness. Finally, most of these statutes as enacted at present do not specify where the "emergency care" must take place to qualify for immunity from common-law liability. There has been some uncertainty in various states regarding the applicability of their statutes to emergencies that arise in hospitals. In some jurisdictions either the Good Samaritan statute or one covering emergency medical service specifically extends immunity to professional individuals who aid during an in-hospital emergency as long as the person had no preexisting duty to respond.[67] Hence, in a Michigan case a hospital staff physician not on call could invoke the statute when he was called to attend an accident victim at the hospital.[68] Similarly, courts have interpreted California's statute as granting immunity to physicians who voluntarily provide services to hospitalized patients in an emergency.[69]

When there is a preexisting duty to respond to a call for services in an emergency, the Good Samaritan legislation does not apply. In litigation involving the Michigan statute, the court held that the hospital was not granted any immunity when a code-blue team transporting an unconscious person allegedly permitted the patient's unsupported head to strike a guardrail.[70] Because there was a preexisting hospital–patient relationship, the statute did not abrogate the usual common law with respect to hospital liability. Furthermore, a leading California case, *Colby v. Schwartz*, held that two surgeons on a hospital's emergency call panel could not claim immunity under the statute because they had a duty to respond and thus were not "volunteers."[71]

Extending immunity to in-hospital "emergency" treatment was one of several approaches to address issues relating to the costs and burdens of malpractice litigation; however, many argue that this is not the proper solution from the viewpoint of public policy. Further, the limited applicability of the statutes, their wide variation from state to state, and their many ambiguities have made the legislation more counterproductive than productive. An alternative approach would be to enact legislation requiring all persons, whether professional or lay, to render aid to any stranger in peril, as has been done in some states and in foreign countries that operate under the Napoleonic Code (the system based on French law). A grant of immunity from tort liability, in the absence of gross negligence or wanton misconduct, would then be justified.

Chapter Summary

This chapter reviews the common-law rule about the duty to provide emergency care and its numerous exceptions, both judicial and statutory. It provides

considerable detail on the federal statute EMTALA, which currently sets the standard for emergency department personnel's review of patients' conditions, and it lays out various examples of liability for failure to meet those standards. The chapter concludes with a brief discussion of Good Samaritan statutes, which are probably unnecessary in the first place but have given some medical personnel a measure of emotional comfort.

Chapter Discussion Questions

1. What did the common law consider a bystander's duty to come to the aid of a person in need? How, if at all, is that duty different today? How might it differ depending on who the bystander is?
2. Describe a hospital's duty to a person who comes to the emergency department requesting treatment. Does it matter whether the person is indigent?
3. In the *Arrington* opinion regarding what it means when someone "comes to the hospital," the court of appeals wrote approvingly of the U.S. Department of Health and Human Services's (HHS) position. HHS regulation states that it would "defeat the purpose of EMTALA if we were to allow hospitals to rely on narrow, legalistic definitions of 'comes to the emergency department' or of 'emergency department' to escape their EMTALA obligations." Which is the more "legalistic" interpretation—that of the regulation and the court, or that of one who would read the plain meaning of the statute? The case is an excellent example of how seemingly simple language can create serious problems of interpretation. How might you have written the statute to avoid the kinds of ambiguities seen in these cases?
4. Is *Arrington* the work of "activist judges" who are "making law," as some who think in sound bites often claim about decisions they do not like?
5. What are the liability hazards of requiring all members of the medical staff to take emergency department duty?
6. What effects have Good Samaritan statutes had on the duty to render aid in an emergency?

Notes

1. 42 U.S.C. § 1395dd.
2. Ill. Ann. Stat. ch. 1111/2 §§ 86, 87 as amended (Smith-Hurd Supp. 1987).
3. Pa. Stat. Ann. tit. 35, § 435 (Purdon 1977).
4. N.Y. Pub. Health Law § 2806(1)(b) (McKinney 1985). Tennessee also requires all general hospitals to provide emergency service. Tenn. Code Ann. § 68-39-301 as amended (1983).
5. 440 S.W.2d 104 (Tex. Ct. Civ. App. 1969).
6. Childs v. Greenville Hosp. Auth., 479 S.W.2d 399 (Tex. Ct. Civ. App. 1972).
7. 119 Ga. App. 626, 168 S.E.2d 336 (1969).
8. 447 S.W.2d 558, 35 A.L.R.3d 834 (Mo. 1969).
9. 22 Ariz. App. 611, 529 P.2d 1205 (1974), aff'd , P.2d 1329 (1975).

10. Thompson v. Sun City Community Hosp., Inc., 141 Ariz. 597, 688 P.2d 605 (1984).
11. See, for example, Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266 (6th Cir. 1990); Gatewood v. Washington Healthcare Corp., 933 F.2d 11037 (D.C. Cir. 1991); Brooker v. Desert Hosp. Corp., 947 F.2d 412 (9th Cir. 1991); Collins v. DePaul Hosp., 963 F.2d 303 (10th Cir. 1992); Summers v. Baptist Medical Ctr. Arkadelphia, 91 F.3d 1132 (8th Cir., 1996).
12. 42 U.S.C. § 1395dd(c)(1)(A).
13. 42 U.S.C. § 1395dd(c)(2).
14. 42 U.S.C. § 1395dd(h).
15. 42 U.S.C. § 1395dd(b)(1).
16. 42 U.S.C. § 1395dd(a).
17. Supra note 11.
18. 42 U.S.C. § 1395dd(d).
19. See, for example, Bosler and Davis, "Is EMTALA a Defanged Cobra?" 51 *J. Mo. Bar.* 165 (May/June 1995).
20. Id. at 167–68.
21. Id. at 168 (footnotes omitted).
22. "One possible meaning, perhaps the most natural one, would be that medical screening examinations must be correct, properly done, [and] if not perfect, at least not negligent. It would be easy to say, for example, simply as a matter of the English language, that a negligently performed screening examination is not an appropriate one." 91 F.3d at 1138.
23. 42 U.S.C. § 1395dd(b)(1).
24. 91 F.3d at 1140.
25. 91 F.3d at 1141.
26. 933 F.2d 1037 (D.C. Cir. 1991).
27. Id. at 1041. During consideration of the EMTALA bill Senator Edward M. Kennedy commented, "Some states have laws which ensure that no emergency patient is denied emergency care because of inability to pay. But 28 states have no such law." 131 Cong. Rec. 28,569 (1985).
28. Bosler and Davis, supra note 19 at 168.
29. Id. The authors also argued that because of EMTALA hospitals should adopt "standardized treatment protocols" for use in emergency departments. They cite as support for this proposition a 1990 standard of the Joint Commission on Accreditation of Healthcare Organizations, which indeed called for written emergency procedures. The Joint Commission's *Accreditation Manual for Hospitals* (CC.6 [1996]) is revised annually, however, and the current manual does not contain the 1990 standard. Instead, the relevant standard today states, "The hospital provides for referral, transfer, or discharge of the patient to another level of care, health professional or setting based on the patient's assessed needs and the hospital's capacity to provide the care." Although written protocols are still favored and are something an accreditation team will look for, they no longer are an absolute Joint Commission requirement.
30. 91 F.3d at 1140–41.
31. See, for example, Bryant v. Redbud Community Hosp. Dist., 289 F.3d 1162 (9th Cir. 2002); Phillips v. Hillcrest Med. Ctr., 244 F.3d 770 (10th Cir. 2001); Guadalupe v. Agosta, 299 F.3d 15 (1st Cir. 2002).
32. "EMTALA is implicated only when individuals who are perceived to have the same medical condition receive disparate treatment; it is not implicated whenever individuals who turn out in fact to have had the same condition receive disparate treatment. The Act would otherwise become indistinguishable from state malpractice law." Summers v. Baptist Medical Ctr. Arkadelphia, 91 F.3d 1132, 1147 (1996).
33. 42 U.S.C. § 1395dd(a) (emphasis added).
34. 42 U.S.C. § 1395dd(b)(1) (emphasis added).
35. Helton v. Phelps County Regional Medical Ctr., 794 F. Supp. 332 (E.D. Mo. 1992)—denying a motion to dismiss for failure to state a claim.
36. Smith v. Richmond Memorial Hosp., 416 S.E.2d 689 (Va. 1992).
37. Supra note 29.
38. 42 C.F.R. § 489.24(b) (1995).
39. Id.
40. Id. In Johnson v. University of Chicago Hosps., 982 F.2d 230 (1992), an infant was being transferred to a hospital by a Chicago Fire Department ambulance. When the ambulance was only five

blocks away, the hospital advised the ambulance by radio that its emergency department was overcrowded and that it should go instead to a certain other hospital. The Seventh Circuit held that the patient had not come to the emergency department within the meaning of EMTALA.

41. 42 C.F.R. § 489.24(b).
42. Whether the law would apply to a hospital-owned clinic on a separate campus is an open question. In King v. Ahrens, 16 F.3d 265 (8th Cir. 1994), the court held that EMTALA does not apply to a private physician practicing in his privately owned clinic. Because hospitals today frequently own clinic facilities staffed with employed physicians, this issue will undoubtedly be litigated in the next few years.
43. 237 F.3d 1066 (9th Cir. 2001).
44. See, for example, Evitt v. University Heights Hosp., 727 F. Supp. 495 (S.D. Ind. 1989) and Steward v. Myrick, 731 F. Supp. 433 (D. Kan. 11990).
45. 917 F .2d 266 (6th Cir. 1990).
46. 917 F.2d at 272.
47. See, for example, Bosler and Davis, supra note 19.
48. Roberts v. Galen of Virginia, Inc., 525 U.S. 249 (1950).
49. See discussion of penalties at note 18.
50. 99 So. 2d 575, 72 A.L.R.2d 391 (Fla. 1957).
51. 134 N.Y.S.2d 779 (Sup. Ct. 1954), modified, 286 A.D. 825, 143 N.Y.S.2d 628 (1955).
52. 245 Miss. 185, 146 So. 2d 882 (1962).
53. 50 Tenn. App. 460, 362 S.W.2d 475 (1961).
54. See also Barcia v. Society of N.Y. Hosp., 39 Misc. 2d 526, 241 N.Y.S.2d 373 (Sup. Ct. 1963)—inadequate examination and a decision by a hospital intern in the emergency department to send the patient home before results of throat culture were known; Heddinger v. Ashford Memorial Community Hosp., 734 F.2d 81 (1st Cir. 1984)—had medical standards been followed, patient's finger would not have required amputation; jury verdict awarding $175,000 was justified; Tatrai v. Presbyterian Univ. Hosp., 439 A.2d 1162 (Pa. 1982)—a hospital employee being treated in employer's emergency department has cause of action in negligence; workers' compensation is not exclusive remedy.
55. To collect damages, of course, the plaintiff must prove, usually by expert testimony, that a delay in diagnosis and treatment, or a delay occasioned by transfer to another institution, was the proximate cause of death or a worsened condition. See, for example, Ruvio v. North Broward Hosp. Dist., 186 So. 2d 45 (Fla Dist. Ct. App. 1966), cert. denied, 195 So. 2d 567 (Fla. 1966); Cooper v. Sisters of Charity of Cincinnati, 27 Ohio St. 2d 242, 272 N.E.2d 97 (1971)—although a physician was negligent in not adequately examining a minor struck by a truck, no proof was shown that an appropriate examination would have saved the patient; hence, neither the physician nor the hospital was liable. Accord Rosen v. Parkway Hosp., 265 So. 2d 93 (Fla. Dist. Ct. App. 1972). Cf. Martin v. Washington Hosp. Center, 423 A.2d 913 (D.C. App. 1980)—expert testimony is not required on issue of proximate cause when jury has enough information to enable factual inferences; jury's verdict for plaintiff was justified when hospital emergency personnel released a patient suffering anxiety caused by drug abuse who died in an automobile accident 12 hours later; Valdez v. Lyman-Roberts Hosp., Inc., 638 S.W.2d 111 (Tex. Ct. App. 1982)—when evidence creates a reasonable inference that a patient's condition could have been stabilized with proper care, a jury question is presented on the issue of proximate cause.
56. 271 N.W.2d 8 (S.D. 1978).
57. Carrasco v. Bankoff, 220 Cal. App. 2d 230, 33 Cal. Rptr. 673, 97 A.L.R.2d 464 (1963).
58. Mulligan v. Wetchler, 39 A.D.2d 102, 332 N.Y.S.2d 68 (1972).
59. Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253, 14 A.L.R.3d 860 (1965).
60. See Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, at PC-12 through PC-13 (2007).
61. A survey conducted in 1983 by the Institute for Health Policy Studies at the University of California Medical School and the American Hospital Association revealed that 96.5 percent of 3,788 hospitals responding to the survey provide emergency services. The vast majority of these furnish care only within the institution, although the number of freestanding facilities operated by hospitals is increasing as a consequence of the current competitive environment. Ninety percent of the hospitals furnishing services have a formally organized emergency department. "Survey Reflects Emergency Care Changes," *Hosps.*, Oct. 1, 1984 at 65.

62. Darling, supra note 59.
63. For example, Michigan's statute protects a physician, registered nurse, or licensed practical nurse from liability, even if care is rendered nongratuitously at the scene of an emergency, if no gross negligence or willful and wanton misconduct occurred and no previous patient relationship existed. Mich. Comp. Laws Ann. §§ 691.1501–.1502 (West 1987).
64. See, for example, Mich. Comp. Laws Ann. § 333.20737 (West Supp. 1987); see also Ohio Rev. Code Ann. § 3303.21 (Baldwin 1986)—a licensed emergency medical technician or paramedic is not civilly liable for administering care, unless conduct was willful or wanton; Ill. Rev. Stat. ch. 111 1/2, § 5517 (1987)—any person, agency, or governmental body authorized by this act who provides life support services in good faith in normal course of duties or in an emergency is not liable unless conduct was willful or wanton; N.J. Stat. Ann. § 2A:53A-12 (West Supp. 1987)—no member of volunteer rescue or emergency squad, including members of National Ski Patrol, shall be liable if services rendered in good faith and conduct are not willful or wanton; immunity does not extend to operation of motor vehicle.
65. Emergency Medical Services Systems Act of 1973 (Pub. L. No. 93-145), codified as 42 U.S.C. § 300d-d-3 (repealed Oct. 1, 1981).
66. Nevertheless, Idaho considered it necessary to provide affirmatively that a physician shall not be required to furnish medical care and shall not be liable for refraining. Idaho Code § 39-1391c (1985).
67. Mich. Comp. Laws § 691.1502 (West 1987). See also Haw. Rev. Stat. § 663-1.5(c) (1985).
68. Matts v. Homsi, 106 Mich. App. 563, 308 N.W.2d 284 (1981).
69. McKenna v. Cedars of Lebanon Hosp., 93 Cal. App. 3d 282, 155 Cal. Rptr. 631 (1979)—a resident physician is not on call and not a member of hospital rescue team; Burciaga v. St. John's Hosp., 232 Cal Rptr. 75 (1986)—a staff pediatrician responded to a medical emergency by treating a newborn infant at the request of obstetrician attending the mother; see also Markman v. Kotler, 52 A.D.2d 579, 382 N.Y.S.2d 522 (1976)—Good Samaritan statute applied on facts even though a previous doctor–patient relationship existed.
70. Hamburger v. Henry Ford Hosp., 91 Mich. App. 580, 284 N.W.2d 155 (1979).
71. 78 Cal. App. 3d 885, 144 Cal. Rptr. 624 (1978); See also Gragg v. Neurological Assocs., 152 Ga. App. 586, 263 S.E.2d 496 (1979)—a surgeon who responded to an emergency in the hospital's operating room is not protected by Good Samaritan statute; Guerrero v. Copper Queen Hosp., 112 Ariz. 104, 537 P.2d 1329 (1975)—Good Samaritan law does not apply to hospital staff.

CHAPTER

9

CONSENT FOR TREATMENT AND WITHHOLDING CONSENT

After reading this chapter, you will

- understand the two basic types of consent for medical treatment and when each is used.
- recognize when the concept of "implied consent" comes into play.
- know how to judge what information must be given to a patient (or personal representative) for a purported consent to qualify as "informed."
- be able to distinguish between the physician's and the hospital's role in obtaining informed consent.
- be aware of the difficulties inherent in decisions to forgo life-sustaining treatment for minors and incompetent adults.
- have greater empathy for those involved in decisions to withdraw artificial nutrition and hydration from a person in a persistent vegetative state.
- have a greater appreciation for the importance of living wills and healthcare powers of attorney.

The United States is usually enthralled with the concept of individual rights, such as the rights to free speech, a fair trial, privacy, freedom of religion, due process, and equal protection of law. All these and many more public policy issues are commonly argued using "rights" language: "I/we have a right to (or not to) [insert your cause here]."

Rights language has a strong, popular appeal. It hearkens to our War for Independence, the days when heroes like Washington, Jefferson, and Adams founded this country on the "self-evident" truths of "certain unalienable

rights." Rights language also has a practical advantage: convince someone that what you want is a right (especially a constitutional right), and you have won the argument. Rights language is absolute; it is not concerned with such niceties as cost, practicality, the common good, or the reasonableness of others' viewpoints.

The subject of this chapter is strongly affected with rights language. The patient (or someone legally authorized to act for the patient) has a fundamental right to decide whether to permit nonemergency medical or surgical treatment, and any unauthorized intentional touching of the patient's person is battery, even if the person touched is not harmed in any way. (The law of assault and battery is discussed in more detail in Chapter 2.) The classic judicial statement of this general principle was written by Justice Cardozo in *Schloendorff v. Society of New York Hospital:*

> 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 for which he is liable in damages. This is true except in cases of emergency, where the patient is unconscious and where it is necessary to operate before consent can be obtained.[1]

Battery must be distinguished from medical malpractice (the failure to adhere to the standards of the medical profession). Essentially, malpractice is the lack of due care under the circumstances. In contrast, battery is an intentional tort that can occur even if all established professional standards have been followed. All that is required is a touching that has not been consented to. Lack of care is not relevant. Both the torts of battery and of malpractice may result, however, from a failure to obtain proper consent.

Court decisions have emphasized that in the malpractice arena, an effective consent must be an informed consent. To grant an informed consent the patient must possess reasonably complete information about the proposed treatment, its risks and benefits, the acceptable alternative methods of treatment, and the consequences of not consenting. Without this information, the consent is not "informed" and is ineffective. A physician's failure to provide this information would result in liability if an untoward result occurs.

Types of Consent and Recommended Procedures

Legally sufficient consent can be either express or implied. The difference between an express consent and an implied consent is in the method by

which the patient, or the one authorized to consent, manifests agreement. Express consent is made known by words—oral or written—while implied consent is manifested by acts that show that the patient has agreed to the treatment. To be sufficient, both types of consent require that the person be legally competent to give consent and possess knowledge and understanding about the medical or surgical treatment that is about to occur. Express consent need not be in writing: spoken consent, if proved, is adequate. Moreover, voluntary submission to routine treatment is usually adequate to protect the physician, nurse, or hospital from allegations of nonconsensual touching. To illustrate, a routine physical examination of a mentally competent adult patient in a physician's office need not be fortified by an express consent (although it usually is anyway).

When physicians or hospitals rely on an oral consent or implied consent, at least two problems of proof arise. First is the question of whether the patient, or the one authorized to consent, in fact consented to any treatment at all. Consent may be difficult to prove if reliance must be placed on an alleged oral or implied consent. Second, even if consent of some sort is established, a further question is whether the one consenting had enough information about the treatment to make a reasonable decision.

Even when a written consent is obtained, subsequent proof by the patient that he lacked a basic understanding of what in fact took place may negate the written consent. Hence, one should never use a written consent purporting in very general language to authorize the surgeon or physician to do any procedure the physician deems necessary. Such a vague, general consent form is no better protection for the physician and the hospital than simple reliance on voluntary submission.

To illustrate, in *Rogers v. Lumberman's Mutual Casualty Company*[2] the patient signed a general consent form. The defendant surgeon successfully performed a hysterectomy. Subsequently the patient showed that she thought she was consenting to an appendectomy and had not understood the true nature of the operation. There was no evidence of an emergency, so the generalized consent (although written) was worthless. That the surgery was skillfully performed and that a hysterectomy was medically advisable were immaterial, because these reasons do not justify proceeding without consent. In similar fashion, surgery by a person other than the surgeon named by the patient constitutes battery by the "ghost" surgeon, and the surgeon who failed to perform the operation could be charged with malpractice.[3]

Physicians and hospitals are advised to use two different consent forms. The first should be obtained at the time of the patient's admission to the hospital, perhaps by the person processing the admission. It should recite simply that the patient, or one authorized to act, consents to routine

hospital care and nursing services (e.g., taking of vital signs, weight, medical history). The form should name the attending physician, and the wording should recognize that others—nurses and laboratory technicians, for instance—will touch the patient during hospitalization. The form should recite that no guarantees of cure have been made to the patient and that the nature of the basic hospital care to be rendered is fully understood.

In addition to the consent form obtained at the time of admission, the hospital should obtain a separate, special consent form whenever any surgery is undertaken or special diagnostic procedures are indicated. The special consent form should be used whenever the in-hospital procedure or treatment is something more than routine hospital care. The signature on the special consent form should be obtained only after the attending physician or a resident physician associated with the case has had a clear conversation with the one giving consent, has conveyed all necessary information, and has answered all of the patient's questions. The informed-consent conversation must be held in a language the patients can understand. This means that if the patient or family has limited proficiency in English or uses sign language, an interpreter must be employed (see The Law in Action).

Nonphysicians must not conduct the informed-consent session. Because the patient must fully understand the nature and extent of the proposed procedure, only a physician can properly communicate the information and answer the patient's questions. The physician must make note of the conversation in the medical record and describe the patient's level of understanding.

Once the physician has discussed the matter, the consent form must be signed and witnessed. At a minimum the form should (1) name the physician; (2) point out that others will be involved in the

The Law in Action

An interpreter is not one who merely restates the spoken word from one language to another. She must understand and convey the full meaning of both sides of the conversation; this includes medical terminology, body language, idioms, slang, and even the culture of both parties.

In one session an obstetrician was explaining to a non–English-speaking woman how to give some medicines to her newborn after they left the hospital. The woman was from a culture that taught women always to be respectful of authority figures (in this case a male physician—in a white coat, no less). Each time the doctor asked her (through the interpreter) whether she understood, the mother nodded obligingly and said, "Yes." But it was obvious to the interpreter—who was from the same culture as the woman—that she did not.

The interpreter stopped the conversation and said, "Doctor, she's saying 'yes,' but she doesn't really have a clue about what you're saying." The interpreter recommended that they bring in the doctor's female colleague to explain the instructions to the new mother. Somewhat abashed, the doctor agreed and the colleague was able to conduct this important patient-education session successfully, thus avoiding a potential disaster for all concerned.

patient's care; (3) list in lay terms the procedure(s) to be undertaken (see The Law in Action); (4) recite that the patient understands; (5) recite consent to the administration of anesthesia, if any, under the supervision of a named physician or nurse; and (6) state that the patient has received an explanation of the contemplated procedures. In addition, the consent should explain that unforeseen conditions sometimes arise and that additional or different procedures may be necessary. It should state that the patient realizes this and consents to such additional or different procedures as may be advisable in the physician's judgment if the situation prevents the medical personnel from getting a new consent.

The Law in Action

I once reviewed a form that said the patient was consenting to a "bilateral salpingo-oophorectomy." How many laypeople know that this means the patient was going to have her ovaries and fallopian tubes removed and that this would mean she could not have children?

A consent obtained by misrepresentation is no consent at all. Moreover, signatures obtained while the patient is under the influence of drugs (for example, preoperative anesthesia) may be worthless if the patient is able to show that he was unable to understand the consequences of the purported consent.[4]

Hospitals and physician practices generally have consent forms available for their most common procedures and medical treatments. These forms should be reviewed for clinical accuracy, legal sufficiency, and reading level. They should also be translated into the most common non-English languages spoken in the service area. Experience shows that a physician's use of consent forms like these has beneficial effects on the physician–patient relationship. It improves rapport, gives the physician a sort of checklist for discussion with the patient, helps ensure that the patient understands what is being said, and gives some measure of protection from claims that the patient did not truly consent. Tactful application of any technique that makes for better communication between doctor and patient is always encouraged. Proper consent procedures are recommended primarily for that reason, not just as a matter of legal formality.

Consent in Medical Emergencies

No consent is required in a medical emergency. In the absence of a competent refusal, the law presumes that consent would be given, and the lack of consent will not justify a lawsuit based on assault and battery or negligence. This rule applies to all patients, regardless of age, and is sometimes called implied consent (although grammatically it should be "inferred" or "presumed" consent).

It is not always easy, however, to define a medical emergency. To justify medical treatment without consent, the defendant must show that the

urgency of the situation made it impossible to obtain consent in a timely manner. Because a conscious, competent adult is entitled to refuse even life-saving care, proceeding to treat without consent is permitted only when patients or those authorized to act for them are unable, because of the emergency situation, to express either approval or disapproval of the proposed treatment. Also, "emergency" means a situation in which there is an immediate danger of death or permanent impairment of health. A desire to treat quickly is not the same as an emergency. If delaying treatment while consent is obtained would not increase the hazards to the patient, the emergency is not sufficient to justify treatment without consent.[5] The Emergency Medical Treatment and Labor Act provides a now well-established minimum definition of emergency:

> A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate attention could reasonably [be] expected to result in…placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy of serious impairment to bodily functions, or serious dysfunction of any bodily organ or part....[6]

Akin to the medical emergency, where treatment can proceed without consent, is the discovery of unanticipated conditions during surgery. The legal issue is whether the surgeon is justified in extending the surgery to correct the unanticipated or undiagnosed condition. Certainly, if the patient had prohibited any extension of the procedure, then the surgeon must not perform any extension, even if life depends on it. Normally, however, there are no specific instructions from the patient prohibiting extensions of surgery. The traditional legal rule is that the surgeon must not engage in any extension of the contemplated procedure unless an unanticipated emergency condition is found.[7] Under this rule, in the absence of an intra-operative emergency, the better procedure is to complete the original surgery and correct the discovered condition at a later time.

Doing so, of course, subjects the patient to a second procedure and the risks inherent in any surgery. Therefore, a few cases have adopted a more generous legal rule: a surgeon may extend the originally contemplated surgery whenever an unanticipated condition becomes evident during surgery and makes it medically advisable to correct the condition immediately.[8] This concept is rather vague, and it should not be considered a license for the surgeon to proceed just because she feels like it. The courts will insist that the advisability of proceeding be significant (a near emergency, perhaps). Medical and surgical treatments remain essentially a matter for the patient to decide, except for exceptional circumstances.

To avoid the risk of a court later holding that extension of surgery was not justified, it is wise to include in the surgical consent form a statement that

surgeons may, in the exercise of their professional judgment, extend the originally contemplated procedure to correct or alleviate unanticipated conditions discovered during the course of the operation.[9] Such language in the consent form and the liberalized attitude of some courts are consistent with common sense and good surgical technique. Patients should realize that a precise diagnosis is often difficult to make prior to surgery, and physicians should adequately explain to the patient the frequent advisability of surgical extensions. With proper explanations of this kind before the surgery is begun, the surgeon has little need to fear that a medically justified extension will produce a claim by the patient alleging treatment without consent.

The Healthcare Institution's Role in Consent Cases

Most lawsuits alleging lack of consent are brought against the attending physician. Any clinician could be the alleged wrongdoer, however; thus, all individuals who have clinical responsibilities must be familiar with the law of informed consent.

In cases alleging battery or negligence, the hospital or other institution can be liable on either of two theories: vicarious liability (respondeat superior) or corporate negligence (both discussed in other chapters). When the patient proceeds against the hospital on the theory of respondeat superior, he must establish that the individual committing the wrong was an employee or agent of the hospital. In the hospital setting, all nonprofessionals and most nurses, x-ray technicians, physiotherapists, resident physicians, and other clinical personnel are normally employees rather than independent contractors. The hospital is usually liable for their torts.[10] Having established that the individual committing the wrong was an employee, the patient must also prove that the wrong was committed within the scope of employment. This is done simply by showing that the tort was committed while furthering the employer's business.

In contrast, medical staff physicians are generally not employees of the hospital but are independent contractors. Normally, therefore, under respondeat superior the hospital is not liable for lack of informed consent by a staff physician.[11] However, some courts have developed the theory of "ostensible" or "apparent" agency (discussed in Chapter 5) to justify holding the hospital liable for the tort of one who is in fact an independent contractor. This theory rests on the notion that the hospital has given the appearance that a certain physician is in its employ, such as when the hospital contracts with a group of emergency physicians to provide coverage for the emergency department.

We have emphasized that consent must be "informed" and that hospitals and physicians use different types of consent forms depending on the

situation. The next issue is, how far must a hospital go in making certain that its medical staff physicians are in fact obtaining informed consent from their patients? If a hospital is to protect itself from liability for treatment without consent, the hospital must, at a minimum, have policies and procedures relating to documentation of consent. Having adopted such rules, it must then have procedures to ensure their enforcement.[12] Someone on the hospital staff (an operating room supervisor, for example) should be assigned responsibility for checking the patient's identity and making certain that no procedure is performed without documentation of consent in the medical record. Hospitals need not independently confirm that the physician has explained the contemplated treatment or procedure well enough to meet the legal tests of informed consent (this is the physician's responsibility), but they need to verify that the documentation is present.[13] If it is not, the procedure should be stopped.

In conclusion, as far as the doctrine of informed consent is concerned, the hospital appears to perform its duty to the patient by making physicians aware that they must properly inform patients and by insisting that adequate written documentation of patients' consent be placed in the medical chart. The hospital, in other words, need not be an actual party to or participant in a physician's consent discussions, but if nursing or administrative staff of the hospital know that sufficient consent was not given, then the hospital has a duty to prevent the unauthorized treatment. Liability could follow from a breach of this duty. (This is why most hospitals' risk management departments prepare a consent form for most types of procedures performed in the facility. The form contains detailed explanations of the risks, alternatives, and other related matters based on the most recent medical literature.)

How "Informed" Must Informed Consent Be?

Because the patient is in control of her person, consent granted for medical care or surgery must be "informed." But how far must a physician go in the informed-consent discussion?

Misrepresentation

There are three types of cases on this question. In the first type, the issue is whether the physician has misrepresented the true nature of the treatment; this can be considered an intentional tort (assault and battery or fraud). *Rogers v. Lumberman's Mutual Casualty Company*,[14] discussed earlier in this chapter, is an example. The doctor did not explain the true nature of the proposed surgery and the reasons for it. The doctor–patient relationship certainly requires, at a minimum, full disclosure of the nature of the diagnosed condition, all significant facts concerning the proposed surgery, and an explanation of the probable risks involved.

Corn v. French illustrates a doctor's intentional misrepresentation.[15] After examining the patient, the physician recommended that she submit to a "test" for a possible malignancy. The patient then asked her doctor if he intended to remove her breast, and he apparently said no. She signed a written consent form indicating that a "mastectomy" was to be performed, but she did not know what that term meant. Clearly there was liability for an unauthorized operation, even absent proof of medical malpractice.

Lack of Information on the Consequences

The second type of case is based on the concept that the patient is entitled to know the inevitable consequences of the contemplated surgery. For example, in *Bang v. Charles T. Miller Hospital*,[16] a patient expressly consented to a transurethral resection of the prostate, but he was not told that because of the particular circumstances, including his age and the possibility of infection, this professionally acceptable surgical technique would likely render him sterile. It did, and there was liability. (This case also stands for the proposition that a patient is entitled to an explanation of the alternatives to a proposed course of treatment. In this situation the surgeon should have explained to the patient that there were other treatments that might prevent sterility but might also entail a substantial risk of infection.)

Lack of Information on the Risks

The third and perhaps most difficult type of case involves the duty to disclose the foreseeable risks of the proposed treatment. Two cases, *Natanson v. Kline*[17] and *Mitchell v. Robinson*,[18] represent what has come to be known as the reasonable doctor rule—the physician must disclose those risks that a reasonable doctor would disclose under the circumstances.

In *Natanson* the physician recommended cobalt radiation therapy following removal of the patient's cancerous breast. The therapy was skillfully performed, but the patient was not informed that the therapy involved substantial risk of tissue damage. The Kansas Supreme Court held that the patient was entitled to be told in advance of the hazards known to the doctor and that the physician was obligated to make such "reasonable disclosures" as other medical practitioners would make under the circumstances. In *Mitchell* the Missouri Supreme Court held that the plaintiff, who was given electroshock and insulin therapy, had the right to be informed that 18 to 25 percent of patients who underwent such treatment suffered convulsions as a result of the treatment. In this particular case a convulsion caused fractured vertebrae. Although there was no allegation or evidence of negligence in the diagnosis or treatment, the court held that a jury must decide whether the doctor was negligent in failing to apprise the patient of the risks. The physician's duty was to make reasonable disclosure of significant facts

and probable consequences. What amounts to "reasonable disclosure" is a question of fact for the jury to decide.

In contrast to the reasonable-doctor rule, which is highly favorable to the physicians, later cases rebuff the idea that the duty to disclose is based on what other doctors disclose. (See *Helling v. Carey* in Chapter 3. What is the parallel to this case?) This newer approach stems from the idea that the physician should fully tell the patient the facts and risks that are relevant to the patient, regardless of what other physicians usually disclose. The issue is still one for the jury to decide, but it will turn on lay testimony rather than expert evidence. The rule has been characterized as the "reasonable patient" rule or the "right to know" rule. This eliminates the necessity of expert testimony on what other physicians do.

One of the cases that rejected the reasonable-doctor rule was a Rhode Island case, *Wilkinson v. Vesey*.[19] A diagnosis of malignancy was made without benefit of a biopsy. Radiation treatments resulted in severe burns that required eight operations later, and it was finally discovered that the patient had never suffered from cancer in the first place. The Rhode Island Supreme Court ruled that the patient was entitled to know all "material" (important) information, regardless of how much other physicians usually tell their patients. In effect, the court held that what the medical profession knows about risks would require expert testimony, but what the patient needs to know to make an intelligent choice is a question for laypeople (the jury) to decide. What information is material depends on both the inherent danger of the treatment and any other matters that would be significant to a reasonable person. The statistical remoteness of a risk does not determine its materiality because even a very small chance of serious consequences can be significant to a reasonable person.

Legal Brief

The reasonable patient test: What would a prudent person in the patient's position have decided if adequately informed of all significant perils?

The "reasonable patient" concept (see Legal Brief) was perhaps best summarized in the 1972 landmark California Supreme Court case *Cobbs v. Grant*:

> A physician's duty to disclose is not governed by the standard practice in the community; rather it is a duty imposed by law. A physician violates his duty to his patient and subjects himself to liability if he withholds any facts [that] are necessary to form the basis of an intelligent consent by the patient to the proposed treatment.

See The Court Decides: *Cobbs v. Grant* at the end of this chapter for the citation to the case. Readers are encouraged to read the entire excerpt and to consider the accompanying discussion questions.

This concept has been extended beyond informed consent to informed refusal. In the now famous case of *Truman v. Thomas* a young woman refused to have a Pap test (a test for cervical cancer), apparently because she was unable to afford it, that her family doctor recommended. The defendant treated the patient over a six-year period for several routine conditions, rendered advice on family matters, and cared for her during her second pregnancy, but he did not specifically advise her of the risk involved in failing to have the Pap test performed. When a specialist eventually discovered a tumor, it was too far advanced for surgical removal, and alternative forms of treatment proved unsuccessful. The California Supreme Court held that the trial court erred by not instructing the jury that the physician had a duty to disclose all relevant and material information, including the risks of refusing recommended care.[20]

As these cases show, physicians must exercise "reasonable care under the circumstances." Unless physicians know that a patient is already aware of the risk or that a given risk would not have any apparent significance to the patient's decision, or unless they can establish that disclosure would adversely affect the rationality of a patient's decision, they must provide the patient with all significant information to allow for an informed consent. All such matters are to be submitted to the jury for decision without requiring the plaintiff to present expert testimony showing materiality of the nondisclosure, although experts must of course be used to establish medical facts such as the risks of a given procedure.

In a few other cases the courts recognized that the physician may limit or withhold information from the patient for sound therapeutic reasons.[21] For example, if full disclosure would complicate or hinder treatment because of a patient's emotional state or personal traits, the physician might in his professional judgment provide less than a full explanation of risks and hazards of a proposed treatment. The occasions when this "therapeutic privilege" can be justified are extremely rare, and if they are thought to exist the physician must document them fully in the medical record. Consultation with a colleague would be advisable, and the "privilege" will not withstand if the facts indicate that a competent and rational patient would have declined treatment had there been disclosure.

As should be evident, it is especially important to obtain an informed consent for any innovative therapy. Such consent must be evidenced by a specially drafted consent form, because the fact that the treatment has not yet been recognized as standard practice and that the potential risks and benefits are uncertain are of profound importance to the patient. In a malpractice case involving a well-known cardiologist and surgeon, Dr. Denton A. Cooley, the estate of a deceased patient alleged that Dr. Cooley and his physician team failed to obtain informed consent for ventriculoplasty surgery (a then-innovative procedure to repair a certain kind of heart defect). A carefully prepared

consent form and clear testimony at trial resulted in a directed verdict for the physicians.[22]

There is a difference between innovative therapy and clinical research. Like standard medical practice—interventions that are designed to enhance the well-being of the patient and have a reasonable expectation of success[23]—innovative therapy is intended to benefit the patient. In contrast, clinical research (sometimes called "experimentation") is a departure from standard practice that is intended to test a hypothesis or develop new knowledge.[24] Thus, research or experimentation is conducted to prove or disprove a researcher's hypothesis about a new course of treatment for the possible benefit of a large number of patients.

Because the risks and benefits of both innovative therapy and clinical research are uncertain, it is essential that the patient be fully informed and that written consent be evidenced by a specially drafted form. The duty of physicians recommending innovative therapy is determined by the general principles of tort law and malpractice liability on a state-by-state basis.[25] (Note, however, that new drugs and medical devices are regulated by the Food and Drug Administration [FDA)], and the FDA's regulations may impose certain additional standards beyond those of tort law. This topic is beyond the scope of this discussion, however.) The doctrine of informed consent is especially relevant, and the consent form should be written in a way that the patient can readily understand. This means in an appropriate language and at an appropriate reading level (tenth grade, for example).

When biomedical and behavioral research involves human subjects, both the common law and federal legislation govern the selection of subjects, the obtaining and documentation of an informed consent, and the monitoring of data to ensure the subjects' safety and privacy and to minimize the risks.[26] Each institution conducting research that is regulated must create an institutional review board consisting of at least five persons. This board approves the program and ensures ongoing compliance with the regulations and procurement of valid informed consent.[27] Specifically, the review board has the responsibility to determine that the "risks to subjects are reasonable in relation to anticipated benefits, if any, to subjects, and to the importance of the knowledge that may reasonably be expected to result."[28] Thus, the board has the responsibility of balancing the risks and benefits when approving biomedical and behavioral research projects.

Without doubt the doctrine of informed consent raises significant issues for physicians. The courts are interested in increasing communication between physicians and their patients and in emphasizing the competent individual's freedom of choice. This is a laudable aim because a fully informed patient is much less likely to be surprised, disappointed, or angry when an untoward result occurs. Increased communication and mutual understanding are excellent antidotes to litigation by the patient.

How Much to Tell a Patient?

In determining how much to tell patients, physicians should keep the patient's welfare and needs foremost in mind. The physician should review questions such as the following:

- Is the patient likely to be unaware of a known hazard or risk?
- Would a reasonably prudent patient be likely to withhold consent if aware of the risk?
- Is there any acceptable justification for failing to disclose?
- Is the risk or hazard, however remote, material to the patient's decision?

Patients do not need to be given a virtual medical school education, but they should be informed and have trust and confidence in those caring for them. There is now a clear-cut judicial attitude that physicians must practice the golden rule and inform others as they would want to be informed.

Consent of a Spouse or Relative

If the patient is competent to consent, neither the spouse nor a relative is authorized or (generally) required to render consent. Marriage or blood relationship alone does not make one the agent of the other. Because a spouse's or relative's consent is not normally necessary,[29] the only reason for discussing the patient's condition with a spouse or a relative would be to improve relations with the patient's family, not to get someone else to concur. (If, for example, it is possible to obtain the patient's consent before administration of sedatives, the spouse's consent will not protect the surgeon or the hospital from liability.[30])

In special circumstances, however, a spouse's consent may be mandatory or advisable as a legal matter, even though the patient is competent. This most often occurs when the procedure to which the patient has consented involves artificial insemination or surrogate motherhood. There are state statutory requirements pertaining to these procedures. The statutes often contain a specific requirement that both the husband and wife must consent voluntarily to artificial insemination with another man's sperm. Similarly, when a married woman is to become a surrogate mother, the consent of her husband should be obtained to overcome the usual presumption that a married man is the father of a child born to his wife.

When the patient's health and welfare are at risk, even if reproductive capacity is adversely affected, the consent of the spouse is not necessary. An Oklahoma case held that the husband, who had not consented to his wife's hysterectomy, had no cause of action for loss of consortium.[31] In short, the wife's right to health is supreme, and her decision alone, based on the professional

advice of her physician, is controlling. "Health of the patient" will be very broadly construed, and courts will be reluctant to recognize a right to have a fertile partner as justification for overriding the wife's consent. If a competent adult patient seeks and consents to such a procedure, and if the surgery is necessary to the health of the patient, or if the patient has a constitutional right to the procedure, as in the case of an abortion, then consent of the spouse is not necessary. (Even though one spouse generally has no right to prevent the surgical procedure on the other, whenever surgery affects the reproductive capacity of the patient, it is wise to obtain the spouse's concurrence, if possible, in deference to sound physician–family relations.)

If the patient is not competent to consent and has not appointed a "healthcare surrogate," state law will usually provide for a hierarchy of individuals who may make healthcare decisions for the patient. Florida law, for example, provides that these persons, in this order of priority, may consent for an incompetent patient:

1. a judicially appointed guardian;
2. the patient's spouse;
3. the adult child, or, if more than one, a majority of the adult children;
4. a parent;
5. the adult sibling, or, if more than one, a majority of the adult siblings;
6. an adult relative who has care and concern for the patient; or
7. a close friend.[32]

Special circumstances concerning withholding or discontinuing life-saving treatment are discussed later in this chapter.

Refusal of the Patient to Consent

Recall that an emergency eliminates the need to obtain consent because the law values preserving life and preventing permanent impairment to health. This rule, however, applies only when the patient is incapable of expressing consent and the person legally authorized to consent for the incompetent patient is unavailable.

The legal situation is quite different when a competent adult patient expressly refuses to consent to medical or surgical treatment, for whatever reason. The competent patient's express refusal to consent must be honored, even if death is the likely result. Accordingly, one frequently hears that there is a legally recognized "right to die" unless a compelling state interest overrides the rights of the patient. It follows that there would be civil liability for treatment that is rendered in the face of a competent patient's refusal to consent and that a court would normally not order treatment for such a patient.

The personal right of self-determination trumps the interest of society in preserving life. There are several leading cases to this effect.[33] Moreover, the common-law right to refuse medical care, expressed while competent and proven by clear and convincing evidence, must be honored if the patient later becomes incompetent. On such facts a court should not order continuation of treatment, nor will the "substituted judgment" rule (discussed later) apply.[34]

A physician will not be criminally liable for honoring a competent adult's wish to forgo treatment or withdraw from ongoing treatment, even when that decision will lead to death. The physician's duty to render care (even "ordinary" care) ends when consent is refused, thus eliminating any possible criminal liability.[35] Of course, active euthanasia (affirmative steps to end the patient's life) will be considered homicide.

The test of mental competence is whether patients understand their condition, the nature of the medical advice rendered, and the consequences of refusing to consent. Irrationality does not necessarily indicate incompetence. In one famous case, a 72-year-old man with extensive gangrene in both legs faced death within three weeks unless his legs were amputated; with surgery, his chances of recovery were good. The hospital petitioned the court for a determination of incompetence, appointment of a guardian, and authorization of amputation and other necessary treatment. The hospital argued that the man's refusal was "an aberration from normal behavior" and that the refusal amounted to suicide. But the court decided that even though the decision might seem irrational to many, the man was competent. Such an extensive surgery was unacceptable to him, and his right to privacy outweighed the state's interest in the preservation of life.[36]

Mental competence is, of course, a matter for physicians to decide in their professional judgment. If it is determined that the patient is incompetent, the matter can be referred to the appropriate court for appointment of a guardian. If there is no time for a court determination and there is no proxy to consent, it is better to render treatment in the interest of attempting to protect life. The legal exposure is greater in a malpractice suit based on inaction than in one based on lifesaving treatment contrary to wishes, assuming, of course, that the doctors have fully documented their determination of incompetence. When a competent adult refuses consent or withdraws consent, the physician or hospital, or both, should obtain written acknowledgment of the refusal from the patient and a release of liability. The form should be filed in the patient's medical record. If the patient refuses to sign such a form, then those who witnessed the patient's refusal must fully document the refusal of treatment in the medical record.

The patient's right to choose or refuse treatment is based on common law, the right of self-determination on which the doctrine of informed consent is grounded, and the right to privacy first enunciated in the abortion

decisions. In addition, some state statutes specifically give the patient the right to refuse treatment.[37] However, the right is not unlimited. The state is usually said to have four interests that may override the individual's freedom to decide:

1. the preservation of life,
2. the protection of innocent third parties,
3. the preservation of the ethical integrity of the medical profession, and
4. the prevention of suicide.

The interest most often promoted by courts ordering treatment over a patient's objections is the protection of third parties, usually minor children or the unborn fetus. For example, in *In re Application of the President and Directors of Georgetown College, Inc.*, despite a woman's refusal on religious grounds the court ordered a blood transfusion for her for the sake of her 7-month-old child.[38] The survival of dependent children, however, is not always sufficient to override the patient's right of refusal. A court did not order a transfusion to save the life of a 34-year-old Jehovah's Witness, even though he had two young children. The judge was convinced that adequate provision had been made for the children's welfare.[39]

The state has sometimes been said to have an interest in "maintaining the ethical integrity of the medical profession."[40] Thus, the argument goes, physicians should not be forced to give (or withhold) treatment against their medical judgment or to assist in suicide or expose themselves to possible manslaughter charges or malpractice suits. This supposed state interest, however, is no longer persuasive.[41] Instead, the courts and legislatures have attempted to provide legal protection for physicians who agree to their patients' wishes. For example, according to the "natural death acts" (discussed later) healthcare providers who comply with the law are not subject to criminal prosecution or civil liability. It also recognized that withholding or withdrawing life-sustaining treatment is, in some instances, consistent with medical ethics:

> [I]t is perfectly apparent…that humane decisions against resuscitative or maintenance therapy are frequently a recognized de facto response in the medical world to the irreversible, terminal, pain-ridden patient, especially with familial consent.… [P]hysicians distinguish between curing the ill and comforting and easing the dying.... [M]any of them have refused to inflict an undesired prolongation of the process of dying on a patient in irreversible condition when it is clear that such "therapy" offers neither human nor humane benefit.[42]

Many courts have held that society's interest in preserving life, in and of itself, is not sufficient to prevent a competent adult from making her own decisions about treatment, at least when no third persons might be affected.[43] The less hopeful the patient's condition, and the more intrusive the therapy, the weaker is the state's interest in preserving life. Even when the prognosis for recovery is good, the patient's right is usually upheld.[44]

Because most courts have determined that forgoing medical treatment is not the equivalent of suicide but is a decision to permit nature to take its course, the fourth interest—the prevention of suicide—is usually not relevant to decisions concerning termination of treatment. However, the line between actively taking life—suicide and euthanasia—and letting nature take its course is not always clear. Courts will not condone suicide or euthanasia, but they may differ on whether a given set of facts constitutes either.

For example, an 85-year-old resident of a nursing home was suffering from multiple ailments and deteriorating health. Although the resident, a former college president, did not have a terminal illness, he was very discouraged about his future and decided to hasten his death by fasting. A court found that the man was competent and had the right to refuse food and that the nursing home was neither obligated nor authorized to force-feed him. The man was permitted to die of starvation.[45]

By contrast, a 26-year-old woman, severely handicapped by cerebral palsy since birth, checked herself into the psychiatric unit of a hospital and demanded that she not be fed but only be given medication to relieve her pain. Her intent was to starve herself to death. She was not otherwise in need of hospitalization. When the hospital sought to force-feed her, she petitioned the court for an injunction to prevent it, asserting her constitutional right to privacy. The court refused to issue an injunction, finding that the patient was not terminally ill and that society had no duty to help her end her life. The court found that her right of self-determination was outweighed by the state's interests in preserving life, maintaining the integrity of the medical profession, and protecting third parties, because other patients might be adversely affected if they knew the hospital was helping a patient to die.[46] Three years later this woman's health had so deteriorated that she was in constant pain and was hospitalized because she was totally unable to care for herself. After her physicians determined that she was not obtaining sufficient nutrition by being spoon-fed, a nasogastric tube was inserted despite her objections. A trial court denied the patient's request to have the tube removed but was overruled by the appellate court, which held that the patient, who was still mentally competent, had a constitutional right of privacy and this included the right to refuse medical treatment. The court further ruled that the decision to refuse the tube feedings was not equivalent to suicide and the patient's motives were irrelevant.[47]

Consent for Treatment of Incompetent Adults

A patient may be unable to grant an effective consent by reason of incompetence or other disability. (Note, however, that mental illness does not equate to incompetence; a person in a mental institution may still be competent to consent to treatment.[48]) If a guardian has been appointed for an incompetent patient, the physician and the hospital must obtain the guardian's consent, unless the guardian is unavailable and a medical emergency is present. In the absence of a court-appointed guardian, state law may provide a hierarchy of persons who can consent as the patient's proxy, as noted earlier. In the absence of a statutory provision, courts have from time to time recognized the authority of a spouse or relative to grant consent for the treatment of an incompetent patient.

For example, judicial interpretation of California statutes relating to the involuntary commitment of mentally ill persons led the court in one case to conclude that the family could grant consent for treatment of a committed patient.[49] Similarly, where local law provides that named relatives have the financial responsibility for maintaining an incompetent person, the relatives may have a right to consent.[50] In still other individual cases the courts have recognized the authority of a spouse or relative to speak for an incompetent adult.[51]

Because of the uncertainty and differing opinions, in the absence of statutory authority for a proxy to consent for an incompetent patient, obtaining legal advice and a court order is the safest way to proceed unless a medical emergency exists.

Decisions to Forgo Treatment for Incompetent Adults

As discussed, competent adults have a right to decide what medical treatment they receive, and the right extends even to the decision to refuse lifesaving treatment. This is a relatively simple concept, but its application gets difficult when the patient was once competent but now is not, and it becomes dreadfully thorny when the individual has always been incompetent.[52] Decisions about treating incompetent patients involve three questions that have troubled the courts in the past 30 years or so:

1. Who should make the decision?
2. What standards should apply?
3. What procedures should be followed to make such decisions?

The first landmark case dealing with these issues was *In re Quinlan*.[53] In 1975 Karen Quinlan, a 22-year-old patient who had sustained severe brain damage, perhaps as a result of consuming alcohol or drugs,

became comatose and remained for several months in a persistent vegetative state (see top Legal Brief.) Attending physicians used a respirator to assist Karen's breathing. When the physicians and the hospital later refused to terminate this life-support system at the request of her parents, who recognized the hopelessness of the situation, her father filed suit to be appointed his daughter's guardian and have the court authorize discontinuance of the respirator. (The expression "pull the plug" hardly does justice to the legal, medical, and emotional issues attendant in such cases.) All parties stipulated that Karen was incompetent and that she was not dead by either the classical medical definition of death—cessation of circulation and respiration—or by the criteria of "brain death"—permanent cessation of all brain functions, including those of the brain stem (see bottom Legal Brief). At the time the state did not have a statutory definition of death, and there were no judicial decisions on the concept of brain death, although Karen would not have met the criteria for death, no matter how it would have been measured.

Legal Brief

Persistent vegetative state (PVS) is a condition akin to coma in which the patient is alive and appears to be awake but has no detectable awareness. It is a permanent organic brain syndrome resulting from prolonged anoxia (lack of oxygen to the brain) and characterized by the absence of higher mental functions such as thought, reason, and emotion. The PVS patient is incapable of performing voluntary acts and responds only reflexively to external stimuli. There is some controversy about whether the condition is reversible, but my research shows no known case of a PVS patient recovering.

The New Jersey trial court denied Mr. Quinlan's requests for guardianship and termination of the respirator.[54] On appeal the decision was reversed. The New Jersey Supreme Court held that Mr. Quinlan was entitled to be appointed guardian of his daughter, could select a physician of his choice to care for her, and could participate with this physician and the hospital's medical ethics committee in a decision to withdraw the respirator. The legal basis for the decision was the patient's right of privacy, which gave her (through her guardian) the right to decline treatment.

Legal Brief

There is no legal or ethical duty to treat a dead body. Although this seems obvious, it has sometimes been difficult to determine when a person is dead and life-support systems may be discontinued. The common law defined death as the "cessation of life," which is not a very helpful standard. Until the 1970s, death meant the cessation of respiration and circulation. But with the use of mechanical respirators and other devices, respiration and circulation can often be continued indefinitely. For this reason, many states have adopted "brain death"—the compete cessation of all functions of the entire brain, including the brain stem—as the legal standard for diagnosing death.

The court went on to rule that where the patient is incompetent and cannot express her wishes on her own behalf, the guardian may do so under the doctrine of "substituted judgment." This concept allows the surrogate decision maker (in this case, the guardian) to determine what the patient herself would decide under these circumstances. The guardian was not to use his own judgment in determining what was best for the patient, but only to judge what the patient's wishes would be if she were competent to decide. To guard against abuse of the substituted judgment doctrine, the court spoke approvingly of relying on the hospital's ethics committee. In fact, it required the guardian and the attending physicians to consult with such a committee, which would then review the medical evidence and render an opinion about the probability that the patient might emerge from her chronic comatose state.

In summary the court ruled that on concurrence of the guardian, the attending physician, and the ethics committee, the life-support system could be withdrawn without the fear of civil or criminal liability, which was the impetus for the physicians' initial refusal. (After Karen was removed from the respirator, she continued to receive antibiotics to ward off infections and was fed a high-calorie diet through a nasogastric tube. She continued to breathe on her own until her death in 1985.)

Many other courts have followed *Quinlan* and have adopted the substituted judgment doctrine. In *Superintendent of Belchertown State School v. Saikewicz* the doctrine was applied to the case of a 67-year-old man who had always been profoundly mentally retarded (he had an IQ of 10 and a mental age of under three) and who was suffering from an acute form of leukemia for which chemotherapy was the indicated treatment.[55] The state institution where he was a resident petitioned the court for appointment of a guardian for Mr. Saikewicz and a guardian ad litem (for the litigation) to decide what treatment he should receive. His illness was incurable, and without chemotherapy he would die a relatively painless death within weeks or months. With chemotherapy he had a 30 percent to 40 percent chance of remission (abatement of symptoms), but if remission occurred it would last for only 2 to 13 months. The chemotherapy would not cure the illness and would cause serious and painful side effects. The guardian ad litem thought that withholding treatment would be in the patient's best interests. He stated:

> If [Mr. Saikewicz] is treated with toxic drugs he will be involuntarily immersed in a state of painful suffering, the reason for which he will never understand. Patients who request treatment know the risks involved and can appreciate the painful side effects when [those side effects] arrive. They know the reason for the pain and their hope makes it tolerable.[56]

The probate judge weighed the factors for and against chemotherapy for Mr. Saikewicz and concluded that treatment should be withheld. In favor of treatment was the fact that most people elect chemotherapy and that it would offer a chance for a longer life. Weighing against it were the patient's age, the probable side effects, the slim chance of a remission against the certainty that the treatment would cause suffering, the patient's inability to cooperate with those administering the treatment, and the "quality of life possible for him even if the treatment does bring about remission."[57]

Adopting the standard of substituted judgment that was applied in *Quinlan*, the appellate court, held that

> both the guardian ad litem in his recommendation and the judge in his decision should have attempted (as they did) to ascertain the incompetent person's actual interests and preferences. In short, the decision in cases such as this should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person.[58]

The court approved of the probate judge's decision, convinced that it "was based on a regard for [Mr. Saikewicz's] actual interests and preferences"[59] and was supported by the facts. Rejecting any analysis that would equate "quality of life" with the value of a life, the appellate court interpreted the judge's reference to the quality of life "as a reference to the continuing state of pain and disorientation precipitated by the chemotherapy treatment."[60]

In cases of persons who have never been competent or who have never expressed any desire regarding termination of medical treatment, the substituted judgment doctrine is pure fiction. The decision makers cannot possibly "know" what the patient would choose. While calling it substituted judgment, they actually make a decision based on the best interests of the patient. Any such decision will be a subjective judgment based on the values, biases, and prejudices of the proxy decision maker.

These troubling legal and ethical issues were recognized by a New York court that refused to authorize discontinuation of regular blood transfusions for a 52-year-old mentally retarded man suffering from terminal cancer.[61] The treatment was in accordance with standard medical practice, and although the patient's life could not be saved, the transfusions were necessary to prolong his life. Because the patient had never been competent, the court drew an analogy with cases denying parents the right to withhold usual and customary medical care from their minor children. The court did not address the question of whether an incompetent patient has the same right to refuse medical care as a competent person.

The problem inherent in allowing surrogate decisions was brought into focus by the New Jersey Supreme Court in another landmark case, *Matter of Conroy*,[62] which involved a legally incompetent resident of a nursing home: an 84-year-old woman with serious and irreversible physical and mental impairments and a limited life expectancy. Her nephew, who was her legal guardian, sought permission to remove a feeding tube. The trial court granted his petition, but her guardian ad litem appealed.[63] The intermediate appellate court reversed, holding that the right to terminate life-sustaining treatment for incurable and terminally ill patients cannot be based on the guardian's judgment unless the patient is brain dead, irreversibly comatose, or in a persistent vegetative state.[64] The court also ruled that the feeding tube was not treatment but rather a basic necessity of life and that withdrawal of nourishment would be active euthanasia.

Although the patient in *Conroy* died pending the appeal, the New Jersey Supreme Court granted review and took the opportunity to review the issues

> to determine the circumstances under which life-sustaining treatment may be withheld or withdrawn from an elderly nursing-home resident who is suffering from serious and permanent mental and physical impairments, who will probably die within approximately one year even with the treatment, and who, though formerly competent, is now incompetent to make decisions about her life-sustaining treatment and is unlikely to regain such competence. Subsumed within this question are two corollary decisions for incompetent patients, and what procedures should be followed in making them.[65]

Although the holdings in *Conroy* were technically limited to this category of patients, the principles the court set forth could be applied more widely. The court reiterated the patient's right to privacy and self-determination as stated in *Quinlan*, and it noted that the "goal of decision-making for incompetent patients should be to determine and effectuate, insofar as possible, the decision that the patient would have made if competent."[66] Under this subjective test, life-sustaining treatment may be withheld or withdrawn when it is clear that the incompetent patient would have refused the treatment under the circumstances. But the court recognized that determining these patients' wishes is impossible and that it is "naive to pretend that the right to self-determination serves as the basis for substituted decision-making."[67] The court, therefore, concluded that the state's parens patriae power provided the authority to make the decision for incompetent patients whose actual desires could not be established. This authority, the court said, allows withholding or withdrawing treatment if it is

"manifest" that the action would be in the patient's best interests (see Legal DecisionPoint).

Legal DecisionPoint

Is making a decision about treatment for someone like Mr. Saikewicz or Ms. Conroy legally or morally different from the decision to euthanize a terminally ill pet? Why or why not?

In the years since *Quinlan* and *Conroy,* numerous courts have weighed in on the question of terminating artificial nutritional devices for incompetent, terminally ill patients. The nearly universal view now is that there is no significant difference between disconnecting a respirator (as in *Quinlan*) and discontinuing artificial nutrition and hydration (as in *Conroy*). Furthermore, the decisions have abandoned attempts to draw a distinction between what is "ordinary" and "extraordinary" medical care (as earlier cases had done); instead, today the analysis is made by weighing the benefits of the particular treatment against the burden that it places on the patient (or even, in some circumstances, the family). When the burden outweighs the benefit, the care is called "disproportionate" and hence may be terminated.

In the years immediately following *Quinlan,* many cases addressed the questions of who could make decisions for incompetent patients and whether the courts must be involved in all cases. The *Quinlan* court believed that routine involvement by the courts would be "impossibly cumbersome," and most other courts have agreed. Of course, where there is no family or guardian, or where family members disagree, the courts are proper forums for resolving the matter. The courts have also become involved when the family's and the healthcare providers' views on the matter conflict. One such case, *Cruzan v. Director, Missouri Department of Health*,[68] was the occasion for the U.S. Supreme Court's first and, to date, only decision regarding termination of medical treatment for incompetent patients. In this case, a young woman (Nancy Cruzan) lay in a persistent vegetative state as a result of injuries suffered in an automobile accident. Although she could breathe without assistance, she required artificial means for providing nutrition and hydration. After it became obvious that she would never regain her mental faculties, her parents asked officials at the state hospital where she was being treated to remove her feeding tube and allow her to die. When the hospital refused, the parents filed suit to compel termination of the treatment. At trial, evidence was presented that Nancy had "expressed thoughts at age twenty-five in somewhat serious conversations with a housemate friend that if sick or injured she would not wish to continue her life unless she could live at least 'half-way normally'." Based on this evidence, the trial court entered an order in favor of the parents and permitting the artificial feeding to be terminated.

The state appealed, and the supreme court of Missouri reversed the trial court's findings. Although it recognized a right to refuse treatment based on the common-law doctrine of informed consent, the court held that Missouri had a strong public policy favoring life over death and that evidence of an individual's wishes regarding termination of treatment must be "clear and convincing." The court found that Nancy's "somewhat serious conversation" was not sufficient to meet this standard. On certiorari to the U.S. Supreme Court, the Missouri court's decision was affirmed on narrow grounds.

Although no other supreme court had set such a high standard for these kinds of treatment decisions, and although it recognized that there is a right to refuse medical treatment, the Supreme Court held that there is nothing in the U.S. Constitution that "prohibits Missouri from choosing the rule of decision which it did." Furthermore, the Supreme Court commented:

> The choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements. It cannot be disputed that the Due Process Clause protects an interest in life as well as interest in refusing life-sustaining medical treatment. Not all incompetent patients will have loved ones available to serve as surrogate decisionmakers. And even where family members are present, "[t]here will, of course, be some unfortunate situations in which family members will not act to protect a patient." A State is entitled to guard against potential abuses in such situations. Similarly, a State is entitled to consider that a judicial proceeding to make a determination regarding an incompetent's wishes may very well not be an adversarial one, with the added guarantee of accurate fact finding that the adversary process brings with it. Finally, we think a State may properly decline to make judgments about the "quality" of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.
>
> In our view, Missouri has permissibly sought to advance these interests through the adoption of a "clear and convincing" standard of proof to govern such proceedings.

Following the U.S. Supreme Court's decision, the *Cruzan* case returned to the trial court in Missouri. After hearing additional testimony, the trial judge ruled that the evidence was clear and convincing, and he again ruled that Nancy's artificially supplied nutrition and hydration could be withdrawn. The state's attorney general declined to appeal, the treat-

ment was terminated, and Nancy died in a matter of days (see The Law in Action). No other state has set forth a "clear and convincing" standard, and thankfully most of these difficult, heartrending decisions today are made by physicians and family members and without the necessity of judicial approval.

The *Cruzan* decision was the last major judicial pronouncement on the subject of terminating treatment for incompetent patients for nearly a decade. Then came the tragic, much-publicized, and highly politicized case of Terri Schiavo.

Terri Schiavo was a 26-year-old woman in St. Petersburg, Florida, who suffered a cardiac arrest of undetermined cause on February 25, 1990. Emergency personnel took her to a local hospital where she was ventilated and given a tracheotomy but never regained consciousness. She was diagnosed as being in a persistent vegetative state and survived through a feeding tube. She lived in nursing homes with constant care, and there was no reasonable likelihood of recovery.

The Law in Action

As a resident of Missouri at the time of this case, I closely followed the case and subsequent events through the news media. Nancy Cruzan's artificial feeding was discontinued in December of 1990. Fifteen members of Operation Rescue (an anti-euthanasia group), including a nurse, appeared at the hospital to reinsert the feeding tube, but they were arrested. Cruzan died 11 days later on December 26, 1990. Sadly, depressed and apparently overwhelmed by grief, her father committed suicide in 1996.

The Missouri Attorney General was William L. Webster, who was nominated for governor in 1992. His campaign was marked by allegations of corruption, and he lost the election. The following year Webster pleaded guilty and was sentenced to two years in prison. This effectively ended his political career.

In 1998 Terri's husband and guardian, Michael, petitioned to authorize the termination of life-support procedures. Terri's parents opposed the decision. There followed years of contentious litigation, including 13 Florida appellate court decisions and five orders by the U.S. Supreme Court declining to grant certiorari. On October 15, 2003 the feeding tube was removed. Six days later the Florida legislature passed what came to be known as "Terri's Law," a single-purpose, politically motivated statute intended to permit Governor Jeb Bush to order reinsertion of the tube, which he did with considerable public interest. After continued legal maneuvering (Terri's parents opposed her husband's decisions every step of the way), the Florida Supreme Court unanimously held Terri's Law to be unconstitutional. The decision deserves to be quoted at length not only because it ended (legally at least) a family's long human misfortune but also because of its perspective on the separation of powers in the U.S. system of government. (See The Court Decides: *Bush v. Schiavo* at the end of this chapter.)

The case returned to the lower courts for more procedural squabbling, more efforts by conservative Republicans to overturn the judicial

decision, and even an attempt by the U.S. Congress to hold hearings and thus delay the outcome. In the end, the trial court's order to discontinue artificial nutrition and hydration stood, and on March 31, 2005, more than 15 years after she collapsed into unconsciousness, Terri Schiavo died. Thus concluded one of the longest, saddest, and most contentious right-to-die cases in recent years.

Natural Death and Power of Attorney Legislation

Because of the difficult issues the aforementioned cases represent, in the mid-1970s state legislatures began responding to the need for guidance. Twenty years later, most states had enacted "natural death acts" aimed at allowing terminally ill patients to "die with dignity." These laws vary from state to state, both in their approach and in the situations covered, but they do offer assistance and some measure of protection for those who face these troubling situations.

California was the first to pass such a statute, and many states have modeled their laws after California's. The California natural death act provides that competent adults may execute a directive, commonly called a "living will," instructing their physician to withhold or withdraw life-sustaining procedures in the event of a terminal illness.[69] A terminal condition is defined as an incurable state that, according to reasonable medical judgment, will cause death with or without life-sustaining procedures. Life-sustaining procedures are those that "would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician, death is imminent whether or not such procedures are utilized."[70] The California statute concludes with a strong statement that the legislature does not in any way condone or approve mercy killing or "any affirmative or deliberate act or omission to end life other than to permit the natural process of dying," as provided in this chapter.[71]

The strength of a living-will law is that it clarifies the procedure to be used to forgo life-sustaining treatment for certain patients under certain circumstances. It avoids judicial involvement and permits the substituted judgment doctrine to be carried out according to the written desires of the patient. Competent adults who feel strongly that they do not wish to be kept alive artificially when death is imminent and the treatments offer no hope of recovery can express their wishes with confidence that they will be fulfilled.

The major problem with a living-will statute, however, is that too many difficult decision-making situations are not covered: cases in which patients do not have a terminal illness but for whom life-prolonging or life-sustaining treatment is considered futile or not in the patient's best interests—*Quinlan*, *Saikewicz*, and *Schiavo* fit into this category—and those in which no directive has been executed. To remedy some of the shortcomings of the living-will laws, many states provide for a "durable power of attorney for health care."[72] Under

this type of statute, persons can designate a proxy to make healthcare decisions for them if they become incompetent. Decisions by the proxy would be as valid as the patient's if the patient were competent. On behalf of the patient a proxy could consent to or refuse most treatments. Physicians who rely in good faith on the decisions of the proxy are usually provided immunity from civil and criminal liability and professional disciplinary action.

The proxy system eliminates the need for a court to be involved either by appointing a surrogate decision maker or by making the decision itself, although judicial review is usually available.[73] The statute typically sets forth the standards to be used in proxy decisions; these are similar to those established by case law. The proxy must make decisions consistent with the patient's desires. The patient may, and probably should, express his wishes in the durable power of attorney. If the patient's desires are unclear or unknown, the proxy is to decide in the best interests of the patient.

All hospitals should have procedures to handle decisions for incompetent patients in accordance with the laws of their state. Whenever possible, physicians should discuss treatment options with the patient and family while the patient is lucid, especially when the illness is terminal. The physician can call the patient's attention to the living-will or power-of-attorney options if these are recognized in that state. Relevant discussions and decisions, advance patient directives, durable powers of attorney, or any other such document should be made part of the patient's medical record. Any revocation of such a document should also be in the chart.

If the hospital, physician, family, or anyone else involved in the decision on treatment doubts the propriety of the proposed course or the manner in which the decision is being made, a judicial determination should be sought. Some states will require a court hearing under certain circumstances. These circumstances should be enumerated in the hospital's written policies. Figures 9.1 through 9.3 present examples of a living will, a durable power of attorney, and a patient's bill of rights statement.

Consent and Refusal of Treatment for Minors

Recall that no consent is necessary when there is a medical emergency. As previously noted, an emergency involves an immediate threat to life or health where delay would cause permanent damage. The medical desirability of treatment does not constitute an emergency if a delay to obtain consent would not permanently harm the patient. Even when a minor's condition is an emergency, physicians and hospital staff should make a reasonable effort to reach the parents (or the person standing in a parental relationship) if there is opportunity to do so. The medical emergency should be documented by professional consultation.

FIGURE 9.1 Example of a Living Will

LIVING WILL

Declaration made this _____ day of _____ 20 _____

I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstance set forth below, and I do hereby declare:

If at any time I have a terminal condition and if my attending physician and another consulting physician have determined that there is no probability of my recovery from such a condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate as my surrogate to carry out the provisions of this declaration:

Name_____
Address_____City _____
State/Zip _____Phone _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

NUTRITION AND HYDRATION

❑ **I do** ❑ **I do not** desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

Additional Instructions (optional)_____
_____
_____

Signed _____

Witness Signature _____
Name_____
Address _____City _____
State/Zip _____Phone _____

Witness Signature _____
Name _____
Address _____City _____
State/Zip _____Phone _____

The case of *Luka v. Lowrie* is illustrative.[74] A 15-year-old boy was hit by a train. Five physicians determined that it was necessary to amputate his foot, and they acted without obtaining the consent of his parents. Their action was justified because in the physicians' professional judgment the patient's condition was a threat to his life or health unless immediate action was taken. The case shows the importance of consultation with other physicians before administering care.

Age of Majority

Proper consent for the treatment of minors when there is no emergency requires that physicians and hospital personnel first determine the age of majority in their particular jurisdiction. With common law, the age of majority was 21 years, but in most states it is now 18. (Majority is reached the day

DESIGNATION OF HEALTHCARE SURROGATE

Name _____
Last First MI

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for healthcare decisions:

Name _____
Address _____ City _____
State/Zip _____ Phone _____

If my surrogate is unwilling or unable to perform these duties, I wish to designate as my alternate surrogate:

Name _____
Address _____ City _____
State/Zip _____ Phone _____

I fully understand that this designation will permit my designee to make healthcare decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of healthcare; and to authorize my admission to or transfer from a healthcare facility.

NUTRITION AND HYDRATION

❑ **I do** ❑ **I do not** desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

Additional Instructions (optional)_____
_____
_____

I further affirm that this designation is not being made as a condition of treatment or admission to a healthcare facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they will know who my surrogate is:

Name_____
Name_____
Name_____

Signed _____ Date _____

Witness Signature _____
Witness Signature _____

FIGURE 9.2 Example of a Durable Healthcare Power of Attorney

before the patient's birthday.) In many jurisdictions married persons are considered adults, regardless of age, and parents who are minors may consent to the treatment of their children. The statutory and case law of each particular jurisdiction must be consulted to determine the age of majority. Hospitals should have clear policies outlining the age of majority for their state.

Consent Granted by Mature Minors

Some believe that in the absence of an emergency the consent of a minor's parent or someone standing in loco parentis is necessary before treatment can be administered. This is not always true. The clearest policy perhaps would be to insist on parental consent in all cases of medical treatment or surgery involving minors, except in medical emergencies or when a local statute specifically eliminates the need for the consent of parents. Yet such a policy is not practical. There are too many nonemergency situations in

FIGURE 9.3
Example of a Patient's Bill of Rights

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your healthcare provider or healthcare facility recognize your rights while you are receiving medical care and that you respect the healthcare providers or healthcare facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your healthcare provider or healthcare facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his individual dignity and with protection of his need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he does not speak English.

A patient has the right to know what rules and regulations apply to his conduct.

A patient has the right to be given by his healthcare providers information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.

A patient has the right to refuse treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the healthcare provider or healthcare facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his consent or refusal to participate in experimental research.

A patient has the right to express grievances regarding any violations of his rights, as stated in Florida law, through the grievance procedure of the healthcare provider or healthcare facility which served him and to the appropriate state licensing agency.

A patient is responsible for providing for his healthcare provider, to the best of his knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his health.

A patient is responsible for reporting unexpected changes in his condition to his healthcare provider.

A patient is responsible for reporting to his healthcare provider whether he comprehends a contemplated course of action and what is expected of him.

A patient is responsible for following the treatment plan recommended by his healthcare provider.

A patient is responsible for keeping appointments and, when he is unable to do so for any reason, for notifying the healthcare provider or healthcare facility.

A patient is responsible for his actions if he refuses treatment or does not follow the healthcare provider's instructions.

A patient is responsible for ensuring that the financial obligations of his healthcare are fulfilled as promptly as possible.

A patient is responsible for following healthcare facility rules and regulations affecting patient care and conduct.

which medical or surgical care for a "mature minor" is advisable but where the parent is not available. Moreover, depending on the circumstances, a mature minor may seek care and object to obtaining parental consent, especially for treatment of medical conditions relating to pregnancy or family planning, for example.

The basis for the common-law rule that a parent's consent is necessary is the belief that minors are incapable, by reason of their youth, of understanding the nature and consequences of their own acts and must therefore be protected from the folly of their own decisions. But in terms of intelligence and insight, there is nothing magical about being 18, or 21, or 57 for that matter. And research reveals no judicial decisions holding a

physician or a hospital liable for treatment of a mature minor without the parents' consent when the treatment was beneficial. An ultraconservative policy of always insisting on parental consent regardless of the minor's maturity or status in life is not justified.

Most states now allow a minor to consent to abortion or contraceptive services. Statutes in numerous states specifically provide that emancipated minors, regardless of age, may give their own consent for medical treatment. Most states have statutes providing that minors may consent to treatment of conditions relating to pregnancy, family planning, venereal disease, and addictions. Thus, public policy and common sense permit mature minors to receive some health services without having to reach the age of majority (see Legal DecisionPoint). In other words, the test of the validity of a minor's consent should depend on maturity and the condition being treated. Maturity should be measured more in terms of the ability to comprehend the nature of a decision than the patient's chronological age.

Legal DecisionPoint

If an apparently intelligent 14-year-old falls in the parking lot of a health clinic, should clinic staff clean and dress the abrasion without contacting the parents? Would it matter if the wound required sutures, or if the injury included a simple fracture? Would it matter if the patient had been treated in the clinic before with the parents' consent? What, if any, efforts should the clinic make to contact the parents in each of the scenarios described here?

Another important factor in applying the age-of-discretion doctrine is whether the minor has living parents who are readily available to grant consent. For example, in 1971 the Probate Court of the District of Columbia held that an 18-year-old girl (the age of majority then being 21) who was without parents and without a legally appointed guardian could consent to an abortion.[75] Another example is *Younts v. St. Francis Hospital*, where a Kansas court held that a 17-year-old could consent to surgery on an injured finger. The patient's mother was herself hospitalized and semiconscious, and the father was unavailable.[76]

A strong judicial tendency is thus evident to permit minors to give an effective consent whenever they are mature enough to understand the nature of the contemplated treatment and the consequences of their action whenever the treatment clearly benefits the patient, and especially when the risk is low. Even in a jurisdiction that has not yet clarified the law by judicial decision or statute, necessary medical treatment should never be withheld from a mature and knowledgeable minor solely because parental consent has not been obtained. Even though technically a battery or interference with parents' rights might be involved, withholding services will create more legal risk than would furnishing the needed services. Simply put, damages for failure to treat might be far greater than damages for treatment without consent. Accordingly, each provider of medical care

should develop guidelines for the treatment of minors based on local law, recognized standards of clinical care, and common sense.

It seems perfectly clear that married minors can give consent for the treatment of their minor children, and this has been codified by statute in some states. New York law, for example, provides: "Any person who has been married or who has borne a child may give effective consent for medical, dental, health and hospital services for his or her child."[77] Note that this wording would not seem to authorize an unmarried father to give consent for the treatment of his minor child but would allow the unmarried mother to do so. (One can smell an equal-protection case in the wind.)

Several reported cases have considered the question of whether a parent or a court may authorize surgery performed on a minor for the benefit of a person other than the minor. The typical example is organ donation. Although a few courts have permitted transplants to be performed on twins who were mature minors and who gave their own consent to the surgery, parental consent should be obtained when the surgery has as its primary purpose the benefit of a person other than the patient. The issues still remain, however, whether a parent is authorized to consent to such an operation and whether a court may grant consent, especially when patients are too young or otherwise unable to express their own wishes. The cases are split. For example, cases that have held that the parent or guardian of a minor or an incompetent may not consent to a sterilization of the patient have expressed concern that the interest of the patients must be protected until they are in a position to make an individual choice on such an important matter as reproductive capacity.[78]

When it is determined that parental consent is necessary, a common issue is whether both parents must consent. The consent of either parent is sufficient if the parents are living together, but if the parents are divorced or voluntarily separated, the consent of the parent having custody of the child should be obtained. No individual having temporary custody of a minor child, whether a relative or not, is authorized at common law to give consent for treatment of the minor. Babysitters, thus, have no authority to consent to treatment of a minor unless given specific authority by a parent. In the absence of the parents or a legally appointed guardian, the legal test of an individual's authorization to consent to treatment of a minor is whether the person having custody stands in place of the parent. This requires more than a showing of mere temporary custody. Some states have statutes addressing this situation.

Refusal of Consent for Treatment of Minors

If the parent or guardian consents to treatment but a mature minor refuses, the physician and the hospital should not proceed. If mature minors are capable of giving consent, they are capable of refusing and should be treated as if they were adults.

If the tables are turned—the mature minor consents, but the parents refuse—the minor's wishes still trump the parents'. Much effort should be expended to resolve the conflict, but all other things being equal, one should rely on the mature minor's consent and proceed with the treatment. (Disregarding the interests of one who is not a patient involves less legal risk than disregarding the patient's desires, especially if the treatment is relatively routine.)

If the parent refuses consent for treatment of a young minor who is legally incapable of expressing her own consent, the situation poses greater practical, ethical, and legal difficulties, especially when serious consequences attend the decision. If the condition of the patient does not permit delaying treatment until a court order is obtained, the physician and the hospital should proceed with treatment despite parental objections. In situations in which life or health is at stake, humanitarian action to save life is preferable to inaction that may cause death (even if technically the parents may have a viable cause of action). In most of these situations, the damages obtainable by the parents would be small. (Besides, defense attorneys would rather point to clients who tried to save a life than to ones who stood by passively and watched a child suffer and die.)

If clinical judgment indicates that treatment is indicated but the patient's condition will not be seriously harmed by a delay, and if no parental consent is forthcoming, the physician or the hospital should seek a court order. The delay may not be long; it would depend on local procedure and on the working relations that the medical personnel have developed with the court. Courts have been known to act quickly and at all hours.

Under the early common law, (strangely, perhaps) parents' refusal to consent was not considered neglect. Some, therefore, doubted a court's power to order medical care for a minor over the objections of the parents. All the states now have statutes that provide that the appropriate court has jurisdiction to protect the interests of dependent and neglected children. These protective statutes differ, but in general the state, a social agency, a hospital, a physician, and even other relatives of a neglected child may petition the court for an order removing the child from the parents' custody and placing custody in a court-appointed guardian. Most of these statutes also require that suspected child neglect or abuse be reported to the appropriate authorities. Thus, the physician and hospital have an affirmative duty toward the child who needs medical care.

These statutes are clearly a valid exercise of the state's power to protect the general health and welfare of society. Hence, they are constitutional, even when their application conflicts with or violates the parents' religious beliefs. In a leading case, *State v. Perricone*,[79] the New Jersey Supreme Court affirmed a trial court's order that a blood transfusion be administered to an

infant child of Jehovah's Witness parents. With respect to the constitutional issue of the parents' religious freedom, the court said:

> [T]he [first] amendment embraces two concepts—freedom to believe and freedom to act. The first is absolute, but, in the nature of things, the second cannot be.
>
> The right to practice religion freely does not include the liberty to expose…a child…to ill health or death. Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.

Decisions in these types of cases turn on whether parental refusal to allow medical care fits the definition of a "dependent and neglected" child. Other factors include the medical condition of the child, the probable outcome if treatment is withheld, the child's age, whether (even though a minor) his wishes have been considered, and the basis for parental refusal. Even where statutes do not explicitly consider refusal to consent as being child neglect, most courts have readily found it to be so and have upheld orders for treatment. In *Jefferson v. Griffin Spalding County Hospital Authority*[80] statutory protection was extended to the unborn when custody was transferred to the state and the mother was ordered to submit to a cesarean section to save the child's life. This was done over the religions objections of the pregnant woman.

The legal result is less predictable where no emergency exists, however needed and desirable the recommended treatment may be. These are the cases in which all of the other aforementioned factors are weighed. In *In re Hudson*,[81] the Washington Supreme Court respected the mother's refusal of consent and reversed a trial court order, holding that it would not order nonemergency treatment of an 11-year-old. Each of the following factors was of some significance: (1) the statute granting the court "custody, care, guardianship and control" of "delinquent and dependent children" did not specifically provide that denial of medical care was included; (2) the only medical treatment for the child's deformity was amputation of the arm, which entailed considerable risk; and (3) the mother's refusal to consent was apparently based on the genuine medical risk involved and on a desire to postpone surgery until her daughter was mature enough to express her own wishes. In a subsequent Washington case—in which the court refused to remove custody from a father who had failed to seek treatment for his child's speech impairment—the result was similar.[82] Similarly a New York court refused to order care for a minor needing correction of a harelip and cleft palate.[83] The father had a fear of surgery and had apparently passed that fear on to his son. The influential

factors were that the child was old enough to have opinions of his own, which should be respected, and that the surgery (although likely to be highly beneficial and free from risk) could wait.

In a number of other cases the factual situation, the particular statute involved, and the philosophy of the judges have sometimes led courts to order nonemergency medical or surgical care for minors deemed to be neglected. Illustrative is *In re Sampson*,[84] in which a New York court ordered surgery to correct a serious deformity in a 15-year-old who had not attended school for several years.

When issues of constitutional law are introduced into situations of nonemergency care, the matter becomes somewhat more complicated and emotional. In the 1972 Pennsylvania case *In re Green*,[85] the 16-year-old patient needed corrective surgery of the spine as a result of polio. The mother gave consent to the surgery but refused permission to administer blood because she was a Jehovah's Witness. The trial court—apparently seeking some way to allow the surgery—declared the minor "neglected" and appointed a guardian. The decision was reversed on the ground that the state could not interfere with a parent's religious beliefs unless the patient's life was in immediate peril. Further, said the appellate court, the lower court had not taken into account the minor's own wishes. There was a strong dissent by three judges who argued that the only concern should be the health of the minor and that parents should not be permitted to make martyrs of their children. (Recall the language of the *Perricone* case, mentioned earlier.)

Withholding Treatment from Handicapped Newborns

Infants are in the same legal position as other immature minors: the parents are authorized to consent or withhold consent to treatment as long as they are competent to do so and their actions do not constitute neglect of their child. However, modern technology is keeping alive newborn infants who just a few years ago would not have survived because of low birth weight or severe birth defects. Decisions to administer or withhold treatment for these newborns can be extremely difficult. It is not always clear whether a decision to withhold or withdraw treatment constitutes neglect or is medically, ethically, and legally sound. Furthermore, the same questions that arise for incompetent adults arise also for infants: Who should make such decisions, and what standards should prevail?

If treatment is available that would clearly benefit an ill newborn—particularly if such treatment is necessary to save the child's life or prevent serious, permanent consequences—then those providing medical care should respond to the parents' refusal in the manner suggested in the previous section. If time permits, seek a court order; if it does not, treat the child despite the parents' objections. A third alternative is to render sufficient

treatment to keep the child alive, pending judicial decisions about future treatment.

Infants with terminal illnesses or those in a persistent vegetative state have essentially the same rights as incompetent adults with similar conditions. Ordinarily, the parents or guardian may have treatment withheld or discontinued if it is clearly futile or inhumane in the light of the infant's condition. *In re L.H.R.*[86] involved a terminally ill infant who was in a persistent vegetative state, and the court found that a life support system was prolonging the dying process rather than her life.[87] The court ruled that the right of a terminally ill person to refuse treatment was not lost because of incompetence or youth. The parent or legal guardian could exercise the right on the child's behalf after the attending physician's diagnosis and prognosis were confirmed by two other physicians who had no interest in the outcome. The court did not require review by either an ethics committee or a court.

Newborns with serious birth defects or extremely low birth weight raise more difficult issues. For example, the proposed treatment may be beneficial, even lifesaving, but will leave the infant with a handicap. The handicap might be caused by the treatment itself (blindness from the administration of oxygen, for example), or it might be a result of an existing condition, such as Down syndrome or spina bifida. In other cases the proposed therapy might be neither clearly beneficial nor clearly futile: The child might survive with therapy but with only a dim chance of long life and the likelihood of suffering. In making these difficult decisions parents or other surrogates must be fully informed of the medical alternatives and the prognosis, and all means must be used to ensure that such children are protected from decisions that are clearly contrary to their best interests.

The once well-publicized case of "Baby Doe" focused national attention on the manner of deciding whether to treat seriously ill newborns.[88] In 1982, a boy was born in Indiana with Down syndrome and a surgically correctable condition that prevented him from eating normally. His parents discussed his care with attending physicians and decided not to consent to the corrective surgery. Food and water were also to be withheld. Following a petition alleging neglect, a hearing was held within days. The probate court found that the parents were not neglectful but had made a reasonable choice among acceptable medical alternatives. Before an attempted appeal could be processed, the baby died. Thereafter, the parents' decision was widely criticized as being against the best interests of the child.

Also receiving national attention was the case of "Baby Jane Doe."[89] Born in October 1983, she was found to have spina bifida and other serious disorders. Surgery is the usual corrective treatment in such

cases. However, after lengthy consultation with neurological experts, nurses, religious counselors, and a social worker, the parents chose to forgo surgery and adopt a more conservative course of treatment. When the parents' decision was challenged in court, physicians testified during the hearing that the parents' choice was "well within accepted medical standards." The trial court found that surgery was required to preserve the infant's life and ordered it to be performed, but an appellate court reversed. According to the higher court, failure to perform the surgery would not "place the infant in imminent danger of death" and could result in serious complications. The appellate court concluded that this was "not a case where an infant is being deprived of medical treatment to achieve a quick and supposedly merciful death. Rather, it is a situation where the parents have chosen one course of appropriate medical treatment over another."[90] (See Legal DecisionPoint.)

Legal DecisionPoint

The "Baby Jane Doe" case was decided in large part on the basis of medical opinion that the parents' decision to refuse treatment was medically acceptable. Are such decisions ones for medical experts to make? What other disciplines are relevant? What does "acceptable medical standards" mean, anyway?

Cases such as these have caused a great deal of discussion and legislative activity concerning medical treatment for impaired newborns. The Child Abuse and Neglect Prevention and Treatment Act[91] was amended in 1984 to provide that before a state may receive grants under the act it must establish, within its child-protection system, procedures and programs for responding to reports of medical neglect, including reports of withholding medically indicated treatment for disabled infants with life-threatening illnesses. Withholding is defined as "the failure to respond to the infant's life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication) which, in the treating physician's (or physicians') reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions." Exceptions are allowed if the infant is irreversibly comatose and if the treatment would merely delay death; would not correct all of the life-threatening conditions or would otherwise do nothing toward saving the child's life; or would be virtually futile and, under the circumstances, inhumane. The Act requires state child-protection agencies to see that individuals within healthcare facilities report suspected medical neglect to pursue appropriate legal remedies. Various states have also passed laws covering medical treatment for newborns and other children.

Decisions concerning treatment for seriously ill newborns are clearly no longer immune from public scrutiny. Hospitals, physicians, and parents have positive duties to act in a child's best interests. Where once the hospital

or physician could look the other way if a parent refused consent for necessary care, the law now imposes a duty to act. As in the case with incompetent adults, hospitals must ascertain with their attorneys the applicable state and federal laws and develop procedures for complying with those laws.

Chapter Summary

In this chapter the difference between "consent" (a concept arising out of the law of battery) and "informed consent" (which relates to the standards of medical practice) is explored. If a patient's consent to a medical procedure is not well informed, it is no consent at all. For consent to be informed, it must be accompanied by a basic understanding of the patient's diagnosis and prognosis, the nature of the proposed treatment, the inherent risks, any possible alternative treatments, and the risks of not consenting at all. The chapter also considers consent issues in emergencies and such thorny issues as the so-called "right to die" (refusal to consent to life-sustaining treatment) and consent for patients who are not competent to make choices for themselves.

Chapter Discussion Questions

1. What are the two types of consent for medical treatment? When does each apply?
2. What is the standard for consent in an emergency?
3. What is the hospital's role in obtaining informed consent?
4. What are the requirements for valid informed consent?
5. How does the principle of informed consent apply to competent patients who refuse lifesaving treatment? How does it apply to incompetent patients who have signed a living will or have designated a healthcare surrogate?
6. How does informed consent apply to an incompetent adult? To a newborn? To a "mature minor"?
7. Under what circumstances may consent be refused for the artificial administration of nutrition and hydration?

Notes

1. 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).
2. 119 So. 2d 649 (La. Ct. App. 1960); see also Pegram v. Sisco, 406 F. Supp. 776 (D. Ark. 1976)—a signed consent form in generalized language does not relieve a surgeon from

explaining the nature of diagnosis, material elements, and risks of recommended treatment using radium implants as well as alternative methods of treatment.

3. Perna v. Pirozzi, 92 N.J. 446, 457 A.2d 431 (1983).
4. An example is found in Demers v. Gerety, 85 N.M. 641, 515 P.2d 645 (Ct. App. 1973)—a consent form signed when a patient was under the influence of Nembutal was not effective; rev'd and remanded on procedural grounds, 86 N.M. 141, 520 P.2d 869 (1974).
5. An example is Zoski v. Gaines, 271 Mich. 1, 260 N.W. 99 (1935)—a surgeon was held liable for removal of a minor's tonsils without parental consent. For a contrasting situation involving an immediate threat to life or health, see Luka v. Lowrie, 171 Mich. 122, 136 N.W. 1106 (1912), discussed in this chapter under the section "Consent and Refusal of Treatment for Minors."
6. 42 U.S.C. § 1395dd(e).
7. Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905); see also Tabor v. Scobee, 254 S.W.2d 474 (Ky. Ct. App. 1951)—during surgery, a surgeon discovered infected fallopian tubes; the court ruled that he might not extend operation and remove the tubes without consent unless an immediate threat to life or health existed.
8. Bennan v. Parsonnet, 83 N.J.L. 20, 83 A. 948 (Sup. Ct. 1912).
9. Davidson v. Shirley, 616 F.2d 224 (5th Cir. 1980)—where a patient signed a consent form for a cesarean section and authorized "such additional...procedures as are considered therapeutically necessary on the basis of findings during the course of the operation," there was no liability when surgeon performed a hysterectomy because extension of operation was consistent with reasonable and prudent surgical practice.
10. For example, Inderbitzen v. Lane Hosp., 124 Cal. App. 462, 12 P.2d 744 (1932)—a hospital was liable for permitting medical students, who were under hospital control and hence employees, to examine a patient without her consent.
11. Cox v. Haworth, 283 S.E.2d 392 (N.C. App. 1981)—a hospital was not liable for a staff physician's failure to reveal risks of myelogram; Cooper v. Curry, 92 N.M. 417, 589 P.2d 201 (1979)—a hospital was not liable for alleged failure of a staff physician to obtain a patient's informed consent for cataract surgery.
12. Magana v. Elie, 108 Ill. App. 3d 1028, 439 N.E.2d 1319 (1982)—a hospital must conform to reasonable and prudent conduct in light of apparent risk even when a physician is an independent contractor; see also dissenting opinion, Cooper, 92 N.M. at 423, 589 P.2d at 207 (Sutin, J.)—a physician's duty is to obtain a patient's consent, while a hospital's duty is "to ascertain whether the doctor has obtained consent."
13. Fiorentino v. Wenger, 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967). See also Cross v. Trapp, 294 S.E.2d 446 (W. Va. 1982)—as a matter of law, a hospital is not liable for a physician's alleged inadequate explanation of risks of surgery.
14. Supra, note 2.
15. 71 Nev. 280, 289 P.2d 173 (1955).
16. 251 Minn. 427, 88 N.W.2d 186 (1958).
17. 186 Kan. 393, 350 P.2d 1093 (1960), second opinion, 187 Kan. 186, 354 P.2d 670 (1960).
18. 334 S.W.2d 11 (Mo. 1960), 79 A.L.R.2d 1017; 360 S.W.2d 673 (Mo. 1962)—retrial in this litigation resulted in a verdict for defendants as they satisfactorily proved that they had adequately informed the patient. See also Shack v. Holland, 389 N.Y.S.2d 988 (Sup. Ct. 1976)—the absence of informed consent from a mother with respect to risks, hazards, and alternative delivery procedures is malpractice and gives the child born permanently deformed a derivative cause of action; the statute of limitations begins to run when the child is 21 years old.
19. 110 R.I. 606, 295 A.2d 676 (1972).
20. Truman v. Thomas, 27 Cal. 3d 285, 295–96, 611 P.2d 902, 907–8, 165 Cal. Rptr. 308, 313–14 (1980).
21. Lester v. Aetna Casualty Co., 240 F.2d 676 (5th Cir. 1957); Roberts v. Woods, 206 F. Supp. 579 (S.D. Ala. 1962); Nishi v. Hartwell, 52 Haw. 296, 473 P.2d 116, reh'g denied, 52 Haw. 296 (1970); Harnish v. Children's Hosp. Medical Center, 387 Mass. 152, 439

N.E.2d 240 (1982); Starnes v. Taylor, 272 N.C. 386, 158 S.E.2d 339 (1968).

22. Karp v. Cooley, 349 F. Supp. 827 (S.D. Tex. 1972), aff'd , 493 F.2d 408 (5th Cir.), cert. denied, 419 U.S. 845 (1974); see also Schwartz v. Boston Hosp. for Women, 422 F. Supp. 53 (S.D.N.Y. 1976)—a hospital has a responsibility to obtain informed consent when the patient is a participant in a surgical research program.
23. National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, U.S. Dep't of Health, Educ. and Welfare, Pub. No. 0012, *The Belmont Research* 2 [hereinafter *The Belmont Report*]. "The Boundaries Between Biomedical or Behavioral Research and the Accepted and Routine Practice of Medicine," Pub. No. 0013, *The Belmont Report* 1-1-1-44 App. I (1978). See Cowan and Bertsch, "Innovative Therapy: The Responsibility of Hospitals," 5 *J. Legal Med.* 219 (June 1984).
24. *The Belmont Report*, supra note 23, at 3.
25. 21 U.S.C. § 355–60k (1982).
26. National Research Act, Pub. L. No. 93-348, 88 Stat. 342 (codified in various sections of Title 42, U.S.C.). 45 C.F.R. § 46.111.
27. 45 C.F.R. § 46.107.
28. 45 C.F.R. § 46.111(a)(2).
29. Jeffcoat v. Phillips, 417 S.W.2d 903 (Tex. Civ. App. 1967)—a husband's consent was not necessary for surgery on his wife; jury found as fact that the patient had given effective consent; Rytkonen v. Lojacona, 269 Mich. 270, 257 N.W. 703 (1934)—a wife's consent was not necessary for operation on her husband; he had consented. Janney v. Housekeeper, 70 Md. 162, 16 A. 382 (1889)—a husband's consent was not necessary for surgical procedure on his wife.
30. Gravis v. Physician's and Surgeon's Hosp. of Alice, 427 S.W.2d 310 (Tex. 1968).
31. Murray v. Vandevander, 522 P.2d 302 (Okla. Ct. App. 1974).
32. Fla. Stat. § 765.401.
33. See, for example, Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct. 1978), approved, 379 So. 2d 359 (Fla. 1980)—a 73-year-old man with Lou Gehrig's disease had a right to have mechanical respirator disconnected; In re Quackenbush, 156 N.J. Super. 282, 383 A.2d 785 (Morris County Ct. 1978), a competent patient with gangrenous condition in both legs could refuse consent to amputation even though necessary to save his life; Kirby v. Spivey, 167 Ga. App. 751, 307 S.E.2d 538 (1983)—it is not malpractice for a physician to respect the refusal of a competent patient to seek recommended treatment; Erickson v. Dilgard, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962)—the court refused to order a blood transfusion for a competent adult; Winters v. Miller, 446 F.2d 65 (2d Cir.), cert. denied, 404 U.S.985 (1971)—medication may not be administered to a mentally ill patient contrary to her wishes when she has not been declared legally incompetent; In re Estate of Brooks, 32 Ill. 2d 361, 205 N.E.2d 435 (1965)—a court may not order administration of blood contrary to a patient's wishes based on religious convictions; Palm Springs Gen. Hosp. v. Martinez, No. 71–12687 (Cir. Ct. Fla. 1971)—physicians and hospital not civilly liable for complying with a competent, terminally ill patient's wishes to withdraw treatment.
34. Eichner v. Dillon, 434 N.Y.S.2d 46, 420 N.E.2d 64 (1981).
35. See Foreman, "The Physician's Criminal Liability for the Practice of Euthanasia," 27 *Baylor L. Rev.* 54, 57 (1975).
36. In re Quackenbush, 156 N.J. Super. at 290, 383 A.2d at 789.
37. See, for example, Minn. Stat. §144.651 (12) (Supp. 1985); Mich. Comp. Laws Ann. § 333.20201 (2)(f) (West Supp. 1985).
38. 331 F.2d 1000, 118 App. D.C. 80 (1964); see also Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537, cert. denied, 337 U.S. 985 (1964)—blood transfusion was ordered to preserve life of an unborn child. Courts will also order treatment to protect the public's health. See, for example, Jacobson v. Massachusetts, 197 U.S. 11 (1905) (compulsory vaccination).
39. In re Osborne, 294 A.2d 372 (D.C. Cir. 1972).
40. Eichner, 73 A.D.2d at 456, 426 N.Y.S.2d at 537.
41. In John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, 279 A.2d 670 (1971), the

court, in ruling that the state had a compelling interest to preserve the life of a 22-year-old competent adult, ordered blood transfusions over her refusal on religious grounds, giving great weight to the interests of the hospital, nurses, and physicians in carrying out their professional duties. Heston was expressly overruled in In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

42. In re Quinlan, 70 N.J. 10, 355 A.2d 647, 667, cert. denied, 429 U.S. 922 (1976); see also Leach v. Akron Gen. Medical Center, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980).
43. Bartling v. Superior Court, 163 Cal. App. 186, 209 Cal. Rptr. 220 (1984)—a competent adult with serious illnesses that were incurable but not diagnosed as terminal had a right to have life-support equipment disconnected; Tune v. Walter Reed Army Medical Center, 602 F. Supp. 1452 (D.C.D.C. 1985)—a 71-year-old woman with terminal adenocarcinoma had a right to have the respirator that sustained her life disconnected in spite of Army policy precluding the withdrawal of life-support systems; Saltz v. Perlmustter, 379 So. 2d 359 (Fla. 1980)—a 73-year-old competent patient had a right to have a respirator removed where all affected family members consented.
44. See, for example, In re Melideo, 88 Misc. 2d 974, 390 N.Y.S.2d 523 (Sup. Ct. 1976)—a Jehovah's Witness patient was permitted to refuse blood transfusion, even though death was likely to result; Lane v. Candura, 6 Mass. App. 377, 376 N.E.2d 1232 (1978)—the court would not order amputation of the gangrenous leg of a 77-year-old competent woman over her objection.
45. In re Plaza Health & Rehabilitation Center (Sup. Ct., Onandaga County, N.Y., Feb. 4, 1984).
46. Bouvia v. Riverside County Gen. Hosp., No. 159780 (Super. Ct., Riverside City, Cal., Dec. 16, 1983).
47. Bouvia v. Superior Court (Glenchur), 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986).
48. Barclay v. Campbell, 704 S.W.2d 8 (Tex. 1986)—a mentally ill person was entitled to be informed of risks from use of neuroleptic drugs.
49. Maben v. Rankin, 55 Cal. 2d 139, 358 P.2d 681, 10 Cal. Rptr. 353 (1961).
50. Ritz v. Florida Patients' Compensation Fund, 436 So. 2d 987 (Fla. App. 1983)—a father, though not an official legal guardian, who consented to brain surgery for an adult incompetent daughter may not bring action alleging that the operation was unauthorized, review denied, 450 So. 2d 488 (Fla. 1984).
51. Lester v. Aetna Casualty Co., 240 F.2d 676—a wife authorized to consent for electroshock treatments for a husband, where reasonable under all the facts and circumstances to believe that it would harm the patient to obtain a fully informed consent from him, cert. denied, 354 U.S. 923 (1957); Farber v. Olkon, 40 Cal. 2d 503, 254 P.2d 520 (1953)—a parent that is not legally appointed guardian can consent for a mentally incompetent adult child; Smith v. Luckett, 155 Ga. App. 640, 271 S.E.2d 891 (1980)—suit by a patient who did not object during preparation for surgical procedure did not succeed when spouse had consented, as authorized by statute; Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906)—a physician was liable when surgery was performed on an incompetent wife without her husband's consent; Steele v. Woods, 327 S.W.2d 187 (Mo. 1959)—when a patient is incompetent, a physician has a duty to advise her husband or a relative who is competent to speak for the patient.
52. See, for example, In re Torres, 357 N.W.2d 332 (Minn. 1984); Severns v. Wilmington Medical Center, Inc., 421 A.2d 1334 (Del. 1980); John F. Kennedy Memorial Hosp., Inc. v. Bludworth, 452 So. 2d 921 (Fla. 1984), aff'g 432 So. 2d 611 (Fla. Dist. Ct. App. 1983); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); In re Quinlan, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976); Eichner v. Dilon, 434 N.Y.S.2d 46, 420 N.E.2d 64 (1981); In re Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, cert. denied, 454 U.S. 858 (1981); Leach v. Akron Gen. Medical Center, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980); In re Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983).
53. 70 N.J. 10, 355 A.2d 647 (1976).
54. In re Quinlan, 137 N.J. Super. 227, 348 A.2d 801 (Ch. Div. 1975), modified, 70 N.J. 10 (1976).

55. 373 Mass. 728, 370 N.E.2d 417 (1977).
56. Id. at 750, 370 N.E.2d at 430.
57. Id. at 753–54, 370 N.E.2d at 432.
58. Id. at 752–53, 370 N.E.2d at 431.
59. Id. at 754–55, 370 N.E.2d at 432.
60. Id. at 754, 370 N.E.2d at 432. Other cases applying the substituted judgment doctrine include In re Hier, 18 Mass. App. 200, 464 N.E.2d 959 (1984), and John F. Kennedy Memorial Hosp., Inc. v. Bludworth, 452 So. 2d 921 (Fla. 1984), aff'd 432 So. 2d 611 (Fla. Dist. Ct. App. 1983).
61. In re Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, cert. denied, 454 U.S. 858 (1981).
62. 98 N.J. 321, 486 A.2d 1209 (1985).
63. In re Conroy, 188 N.J. Super. 523 (N.J. Ch. Div. 1983).
64. In re Conroy, 190 N.J. Super. 453, 464 A.2d 303 (N.J. Super. A.D. 1983).
65. In re Conroy, 98 N.J. at 342–43, 486 A.2d at 1219.
66. Id. at 360, 486 A.2d at 1229.
67. Id. at 364, 486 A.2d at 1231.
68. 497 U.S. 261 (1990).
69. Cal. Health & Safety Code §§ 7185/7195 (West Supp. 1985).
70. Id. at § 7187(c).
71. Id. at § 7195.
72. See, for example, Cal. Civ. Code §§ 2430/2443 (West Supp. 1985). See also 20 Pa. Cons. Stat. Ann. §§ 5601—5606 (Purdon Supp. 1985)—durable power of attorney for medical decisions.
73. Whether the court needs to be involved in determining incompetence is not clear. "The implication is that doctors will continue to have the major role in assessing incompetence. The efficiency of the law would be severely impaired if judicial review of competence were routinely requested. When the physician has doubts about the patient's ability to give informed consent, he or she may seek consent from both the patient and the agent—an approach that does not involve legal proceedings." Steinbrook and Lo, "Decision Making for Incompetent Patients by Designated Proxy," 310 *New Eng. J. of Med.* 1598, 1599 (1984).
74. 171 Mich. 122, 136 N.W. 1106 (1912).
75. In re Barbara Doe (unreported case D.C. 1971).
76. 205 Kan. 292, 469 P.2d 330 (1970).
77. N.Y. Pub. Health L. § 2504(2).
78. See, for example, In re Estate of Kemp, 43 Cal. App. 3d 758, 118 Cal. Rptr. 64 (1974); Holmes v. Powers, 439 S.W.2d 579 (Ky. Ct. App. 1968); In re Smith, 16 Md. App. 209, 295 A.2d 238 (1972); In re M.K.R., 515 S.W.2d 467 (Mo. 1974); Frazier v. Levi, 440 S.W.2d 393 (Tex. Civ. App. 1969).
79. 37 N.J. 463, 181 A.2d 751 (1962), cert. denied, 371 U.S. 890 (1962).
80. 247 Ga. 86, 274 S.E.2d 457 (1981).
81. 13 Wash. 2d 673, 126 P.2d 765 (1942).
82. In re Frank, 41 Wash. 2d 294, 248 P.2d 553 (1952).
83. In re Seiferth, 309 N.Y. 80, 127 N.E.2d 820 (1955).
84. 29 N.Y.2d 900, 278 N.E.2d 918, 328 N.Y.S.2d 686 (1972).
85. 448 Pa. 338, 292 A.2d 387, 52 A.L.R.3d 1106 (1972).
86. 253 Ga. 439, 321 S.E.2d 716 (1984).
87. See also In re Barry, 445 So. 2d 365 (Fla. App. 2d Dist. 1984)—the court authorized parents to consent to withdrawal of life-support systems for terminally ill, comatose 10-month-old child on the basis of child's right to privacy; In re Benjamin C., (Sup. Ct. Cal., Feb. 15, 1979)—parents could rely on physician's judgment in authorizing disconnection of life-support systems for a 3-year-old auto accident victim who was comatose; this would be consistent with generally accepted medical standards; Custody of a Minor, 385 Mass. 697, 434 N.E.2d 601 (1982)—the court applied the substituted judgment doctrine and

authorized a "do not resuscitate" order for abandoned, terminally ill newborn; the medical testimony was that heroic efforts to resuscitate the infant would not be in the child's best interests and would "offend medical ethics."

88. In re Infant Doe, No. 1-782A157 (Ind. App., Apr. 14, 1982). The medical circumstances of "Baby Doe" are described in a letter from John E. Pless, M.D., to the editor of the *New England Journal of Medicine,* entitled "The Story of Baby Doe," 309 *New Eng. J. of Med.* 664 (1983).
89. Weber v. Stony Brook Hosp., 95 A.D.2d 587, aff'd, 60 N.Y.2d 208 (1983).
90. Id. at 589.
91. 42 U.S.C. §§ 5116 et seq.

THE COURT DECIDES

Cobbs v. Grant
8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972)

Mosk, J.

This medical malpractice case involves two issues: first, whether there was sufficient evidence of negligence in the performing of surgery to sustain a jury verdict for plaintiff; second, whether, under plaintiff's alternative theory, the instructions to the jury adequately set forth the nature of a medical doctor's duty to obtain the informed consent of a patient before undertaking treatment. We conclude there was insufficient evidence to support the jury's verdict under the theory that the defendant was negligent during the operation. Since there was a general verdict and we are unable to ascertain upon which of the two concepts the jury relied, we must reverse the judgment and remand for a new trial. To assist the trial court upon remand we analyze the doctor's duty to obtain the patient's informed consent and suggest principles for guidance in drafting new instructions on this question.

Plaintiff was admitted to the hospital in August 1964 for treatment of a duodenal ulcer. He was given a series of tests to ascertain the severity of his condition and, though administered medication to ease his discomfort, he continued to complain of lower abdominal pain and nausea. His family physician, Dr. Jerome Sands, concluding that surgery was indicated, discussed prospective surgery with plaintiff and advised him in general terms of the risks of undergoing a general anesthetic. Dr. Sands called in defendant, Dr. Dudley F. P. Grant, a surgeon, who after examining plaintiff, agreed with Dr. Sands that plaintiff had an intractable peptic duodenal ulcer and that surgery was indicated. Although Dr. Grant explained the nature of the operation to plaintiff, he did not discuss any of the inherent risks of the surgery.

A two-hour operation was performed the next day, in the course of which the presence of a small ulcer was confirmed. Following the surgery the ulcer disappeared. Plaintiff's recovery appeared to be uneventful, and he was permitted to go home eight days later. However, the day after he returned home, plaintiff began to experience intense pain in his abdomen. He immediately called Dr. Sands who advised him to return to the hospital. Two hours after his readmission plaintiff went into shock and emergency surgery was performed. It was discovered plaintiff was bleeding internally as a result of a severed artery at the hilum of his spleen. Because of the seriousness of the hemorrhaging and since the spleen of an adult may be removed without adverse effects, defendant decided to remove the spleen. Injuries to the spleen that compel a subsequent operation are a risk inherent in the type of surgery performed on plaintiff and occur in approximately 5 percent of such operations.

After removal of his spleen, plaintiff recuperated for two weeks in the hospital. A month after discharge he was readmitted because of sharp pains in his stomach. X-rays disclosed plaintiff was developing a gastric ulcer. The evolution of a new ulcer is another risk inherent in surgery performed to relieve a duodenal ulcer. Dr. Sands initially decided to attempt to treat this nascent gastric ulcer with antacids and a strict diet. However, some four months later plaintiff was again hospitalized when the gastric ulcer continued to deteriorate and he experienced severe

pain. When plaintiff began to vomit blood the defendant and Dr. Sands concluded that a third operation was indicated: a gastrectomy with removal of 50 percent of plaintiff's stomach to reduce its acid-producing capacity. Some time after the surgery, plaintiff was discharged, but subsequently had to be hospitalized yet again when he began to bleed internally due to the premature absorption of a suture, another inherent risk of surgery. After plaintiff was hospitalized, the bleeding began to abate and a week later he was finally discharged.

Plaintiff brought this malpractice suit against his surgeon, Dr. Grant. The action was consolidated for trial with a similar action against the hospital. The jury returned a general verdict against the hospital in the amount of $45,000. This judgment has been satisfied. The jury also returned a general verdict against defendant Grant in the amount of $23,800.

He appeals.

The jury could have found for plaintiff either by determining that defendant negligently performed the operation, or on the theory that defendant's failure to disclose the inherent risks of the initial surgery vitiated plaintiff's consent to operate. Defendant attacks both possible grounds of the verdict. He contends, first, [that] there was insufficient evidence to sustain a verdict of negligence, and, second, [that] the [trial] court committed prejudicial error in its instruction to the jury on the issue of informed consent.

[In the first section of the opinion the court agrees with the defendant's argument that the evidence did not justify a verdict of negligence. Because of the general verdict, the court could not determine on which basis the jury found for the plaintiff. Accordingly, the court reverses the judgment and orders a retrial.

In the second section, the court finds that the failure to provide information on which to make an informed consent decision—although technically a battery—is really a case of professional malpractice, i.e., negligence. The opinion then segues into a discussion of the standard of care in these kinds of cases.]

Since this is an appropriate case for the application of a negligence theory, it remains for us to determine [whether] the standard of care described in the jury instruction on this subject properly delineates defendant's duty to inform plaintiff of the inherent risks of the surgery. In pertinent part, the court gave the following instruction: "A physician's duty to disclose is not governed by the standard practice in the community; rather it is a duty imposed by law. A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment."

Defendant raises two objections to the foregoing instruction. First, he points out that the majority of the California cases have measured the duty to disclose not in terms of an absolute, but as a duty to reveal such information as would be disclosed by a doctor in good standing within the medical community.... One commentator has imperiously declared that "good medical practice is good law." Moreover, with one state and one federal exception every jurisdiction that has considered this question has adopted the community standard as the applicable test. Defendant's second contention is that this near unanimity reflects strong policy reasons for vesting in the medical community the unquestioned discretion to determine [whether] the withholding of information by a doctor from his patient is justified at the time the patient weighs the risks of the treatment against the risks of refusing treatment.

The thesis that medical doctors are invested with discretion to withhold

information from their patients has been frequently ventilated in both legal and medical literature.... Despite what defendant characterizes as the prevailing rule, it has never been unequivocally adopted by an authoritative source. Therefore we probe anew into the rationale which purportedly justifies, in accordance with medical rather than legal standards, the withholding of information from a patient.

Preliminarily we employ several postulates. The first is that patients are generally persons unlearned in the medical sciences and therefore, except in rare cases, courts may safely assume the knowledge of patient and physician are not in parity. The second is that a person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment. The third is that the patient's consent to treatment, to be effective, must be an informed consent. And the fourth is that the patient, being unlearned in medical sciences, has an abject dependence upon and trust in his physician for the information upon which he relies during the decisional process, thus raising an obligation in the physician that transcends arms-length transactions.

From the foregoing axiomatic ingredients emerges a necessity, and a resultant requirement, for divulgence by the physician to his patient of all information relevant to a meaningful decisional process. In many instances, to the physician, whose training and experience enable a self-satisfying evaluation, the particular treatment which should be undertaken may seem evident, but it is the prerogative of the patient, not the physician, to determine for himself the direction in which he believes his interests lie. To enable the patient to chart his course knowledgeably, reasonable familiarity with the therapeutic alternatives and their hazards becomes essential.

Therefore, we hold, as an integral part of the physician's overall obligation to the patient there is a duty of reasonable disclosure of the available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each.

A concomitant issue is the yardstick to be applied in determining reasonableness of disclosure. This defendant and the majority of courts have related the duty to the custom of physicians practicing in the community. The majority rule is needlessly overbroad. Even if there can be said to be a medical community standard as to the disclosure requirement for any prescribed treatment, it appears so nebulous that doctors become, in effect, vested with virtual absolute discretion. Unlimited discretion in the physician is irreconcilable with the basic right of the patient to make the ultimate informed decision regarding the course of treatment to which he knowledgeably consents to be subjected.

A medical doctor, being the expert, appreciates the risks inherent in the procedure he is prescribing, the risks of a decision not to undergo the treatment, and the probability of a successful outcome of the treatment. But once this information has been disclosed, that aspect of the doctor's expert function has been performed. The weighing of these risks against the individual subjective fears and hopes of the patient is not an expert skill. Such evaluation and decision is a nonmedical judgment reserved to the patient alone. A patient should be denied the opportunity to weigh the risks only where it is evident he cannot evaluate the data, as for example, where there is an emergency or the patient is a child or incompetent. For this reason, the law provides that in an emergency consent is implied, and if the patient is a minor or incompetent, the authority to consent is transferred to the patient's legal guardian or closest avail-

able relative. In all cases other than the foregoing, the decision whether or not to undertake treatment is vested in the party most directly affected: the patient.

The scope of the disclosure required of physicians defies simple definition. Some courts have spoken of "full disclosure" and others refer to "full and complete" disclosure, but such facile expressions obscure common practicalities. Two qualifications to a requirement of "full disclosure" need little explication. First, the patient's interest in information does not extend to a lengthy polysyllabic discourse on all possible complications. A mini-course in medical science is not required; the patient is concerned with the risk of death or bodily harm, and problems of recuperation. Second, there is no physician's duty to discuss the relatively minor risks inherent in common procedures, when it is common knowledge that such risks inherent in the procedure are of very low incidence. When there is a common procedure a doctor must, of course, make such inquiries as are required to determine if for the particular patient the treatment under consideration is contraindicated—for example, to determine if the patient has had adverse reactions to antibiotics; but no warning beyond such inquiries is required as to the remote possibility of death or serious bodily harm.

However, when there is a more complicated procedure, as the surgery in the case before us, the jury should be instructed that when a given procedure inherently involves a known risk of death or serious bodily harm, a medical doctor has a duty to disclose to his patient the potential of death or serious harm, and to explain in lay terms the complications that might possibly occur. Beyond the foregoing minimal disclosure, a doctor must also reveal to his patient such additional information as a skilled practitioner of good standing would provide under similar circumstances.

In sum, the patient's right of self-decision is the measure of the physician's duty to reveal. That right can be effectively exercised only if the patient possesses adequate information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is whatever information is material to the decision. Thus the test for determining whether a potential peril must be divulged is its materiality to the patient's decision.

We point out, for guidance on retrial, an additional problem which suggests itself. There must be a causal relationship between the physician's failure to inform and the injury to the plaintiff. Such causal connection arises only if it is established that had revelation been made consent to treatment would not have been given. Here the record discloses no testimony that had plaintiff been informed of the risks of surgery he would not have consented to the operation.

The patient-plaintiff may testify on this subject but the issue extends beyond his credibility. Since at the time of trial the uncommunicated hazard has materialized, it would be surprising if the patient-plaintiff did not claim that had he been informed of the dangers he would have declined treatment. Subjectively he may believe so, with the 20/20 vision of hindsight, but we doubt that justice will be served by placing the physician in jeopardy of the patient's bitterness and disillusionment. Thus an objective test is preferable: i.e., what would a prudent person in the patient's position have decided if adequately informed of all significant perils.

....

Whenever appropriate, the court should instruct the jury on the defenses available to a doctor who has failed to make the disclosure required by law.

Thus, a medical doctor need not make disclosure of risks when the patient requests that he not be so informed. Such a disclosure need not be made if the procedure is simple and the danger remote and commonly appreciated to be remote. A disclosure need not be made beyond that required within the medical community when a doctor can prove...[that] he relied upon facts which would demonstrate to a reasonable man the disclosure would have so seriously upset the patient that the patient would not have been able to dispassionately weigh the risks of refusing to undergo the recommended treatment. Any defense, of course, must be consistent with what has been termed the "fiducial qualities" of the physician-patient relationship.

The judgment is reversed.

Cobbs v. Grant Discussion Questions

1. What do you suppose was the reaction of the physician community to this decision, and how would you have defended it to them at the time?
2. The second section of the opinion has been omitted from this excerpt, but it concerned the issue of negligence versus intentional tort (or, as the defense termed it, a "technical battery"). Had you been Dr. Grant's attorney, why would you argue that this is an intentional tort case? How would you make that argument?
3. Is it fair for Dr. Grant to be held to a standard of care that did not exist at the time of Mr. Cobbs's treatment?
4. Can you explain why the "reasonable patient" test is called "objective" while testimony from the patient on the question of causation is unreliable?
5. The court says there was not enough evidence to support a verdict of negligence, yet the original gastrectomy led to multiple hospital stays and two follow-up surgeries. All these complications were known risks that can occur even if the surgeon performs the operation flawlessly. If you were the patient and knew about these risks, would you decide to consent to the first surgery? What factors would you consider?

THE COURT DECIDES

Bush v. Schiavo
No. SC04-925 (Fla., Sept. 23, 2004)

[The facts of the case are summarized in the text beginning at page 267. The following excerpt concerns how the Florida Supreme Court addressed the constitutionality of " Terry's Law" and, by implication, the legislature's attempt to interfere in the judicial process.]

In this case, the undisputed facts show that the guardianship court authorized Michael to proceed with the discontinuance of Theresa's life support after the issue was fully litigated in a proceeding in which the Schindlers were afforded the opportunity to present evidence on all issues. This order as well as the order denying the Schindlers' motion for relief from judgment were affirmed on direct appeal. The Schindlers sought review in this Court, which was denied. Thereafter, the tube was removed. Subsequently, pursuant to the Governor's executive order, the nutrition and hydration tube was reinserted. Thus, the Act, as applied in this case, resulted in an executive order that effectively reversed a properly rendered final judgment and thereby constituted an unconstitutional encroachment on the power that has been reserved for the independent judiciary.

....

Under procedures enacted by the Legislature, ... circuit courts are charged with adjudicating issues regarding incompetent individuals. The trial courts of this State are called upon to make many of the most difficult decisions facing society. [T]hese decisions literally affect the lives or deaths of patients. The trial courts also handle other weighty decisions affecting the welfare of children such as termination of parental rights and child custody. When the prescribed procedures are followed according to our rules of court and the governing statutes, a final judgment is issued, and all post-judgment procedures are followed, it is without question an invasion of the authority of the judicial branch for the Legislature to pass a law that allows the executive branch to interfere with the final judicial determination in a case. That is precisely what occurred here and for that reason the Act is unconstitutional as applied to Theresa Schiavo.

....

In addition to concluding that the Act is unconstitutional as applied in this case because it encroaches on the power of the judicial branch, we further conclude that the Act is unconstitutional on its face because it delegates legislative power to the Governor.

....

CONCLUSION

We recognize that the tragic circumstances underlying this case make it difficult to put emotions aside and focus solely on the legal issue presented. We are not insensitive to the struggle that all members of Theresa's family have endured since she fell unconscious in 1990. However, we are a nation of laws and we must govern our decisions by the rule of law and not by our own emotions. Our hearts can fully comprehend the grief so fully demonstrated by Theresa's family members on this record. But our hearts are not the law. What is in the Constitution always must prevail over emotion. Our oaths as judges require that this principle is our polestar, and it alone.

As the Second District noted in one of the multiple appeals in this case, we "are called upon to make a collective, objective decision concerning a question of law. Each of us, however, has our own family,

our own loved ones, our own children.... But in the end, this case is not about the aspirations that loving parents have for their children." Rather, as our decision today makes clear, this case is about maintaining the integrity of a constitutional system of government with three independent and coequal branches, none of which can either encroach upon the powers of another branch or improperly delegate its own responsibilities.

The continuing vitality of our system of separation of powers precludes the other two branches from nullifying the judicial branch's final orders. If the Legislature with the assent of the Governor can do what was attempted here, the judicial branch would be subordinated to the final directive of the other branches. Also subordinated would be the rights of individuals, including the well established privacy right to self determination. No court judgment could ever be considered truly final and no constitutional right truly secure, because the precedent of this case would hold to the contrary. Vested rights could be stripped away based on popular clamor. The essential core of what the Founding Fathers sought to change from their experience with English rule would be lost, especially their belief that our courts exist precisely to preserve the rights of individuals, even when doing so is contrary to popular will.

The trial court's decision regarding Theresa Schiavo was made in accordance with the procedures and protections set forth by the judicial branch and in accordance with the statutes passed by the Legislature in effect at that time. That decision is final and the Legislature's attempt to alter that final adjudication is unconstitutional as applied to Theresa Schiavo. Further, even if there had been no final judgment in this case, the Legislature provided the Governor constitutionally inadequate standards for the application of the legislative authority delegated in chapter 2003–418. Because chapter 2003–418 runs afoul of article II, section 3 of the Florida Constitution in both respects, we affirm the circuit court's final summary judgment.

It is so ordered.

CHAPTER

10

TAXATION OF HEALTHCARE INSTITUTIONS

After reading this chapter, you will

- know the difference between tax-exempt and not-for-profit status.
- recognize the differences in standards for exemption from federal income taxation and state ad valorem (property) taxation.
- appreciate the federal rules regarding lobbying and political campaign activity and how they apply to 501(c)(3) organizations.
- understand the issues involved when it is claimed that a property is "used for charitable purposes."

A tax-exempt corporation is one that is not-for-profit and is formed and run only for religious, scientific, educational, charitable, or similar purposes. Not-for-profit status and tax-exempt status are determined by different criteria: the former by state corporation law, and the latter by federal and/or state tax law. To determine eligibility for tax-exempt status, one must generally look not only to the declaration of purpose in the corporate charter but also to the way the company operates.

Nature of a Charitable Corporation

In a few states, a charity must be incorporated. In others, incorporation is not required and other types of business organization may be used: an unincorporated association, a trust, a "community chest," or a foundation. As a practical matter most charitable healthcare institutions are corporations.

There is no single definition of a charity. For federal income-tax purposes the Internal Revenue Code and related tax regulations set the criteria.

At the state level, the definition will be found in the state constitution and statutes. The state laws differ from each other and from the federal requirements, and the various states may disagree in their interpretations of remarkably similar tax laws. For that reason, the advice of local legal counsel is crucial in a situation involving any specific taxation issue.

The word "charity" essentially refers to benevolent service for the benefit of an indefinite number of persons. A charity exists to promote the welfare of the community as a whole. It must normally be open to the general public and not restricted to a privileged few. Accordingly, charities must be distinguished from social service and not-for-profit organizations generally. All charitable corporations are not-for-profit corporations, but not all not-for-profit organizations are charities (see Figure 10.1). Countless not-for-profit corporations—for example, social clubs, fraternal organizations, and labor unions—may provide a significant degree of social service without operating for charitable purposes as that expression is defined in tax law.

A charity's benefits can be restricted to a particular type of beneficiary. In healthcare, prominent examples are children's hospitals and women's hospitals. In other words, confining the activity to a particular purpose and restricting benefits to a particular category of people do not jeopardize charitable status (as long as the restriction does not discriminate against a "suspect class" of people), nor would restrictions required by a lack of special staff and facilities. May the benefits of a charity be restricted to the members of a particular church, lodge, labor union, or fraternal order or to the employees of a particular company? The answer depends on local law and the precise issue involved in the particular case. Especially if state law requires tax-exempt organizations to be "purely public charities," their beneficiaries usually may not be restricted to the members of a specific church denomination,

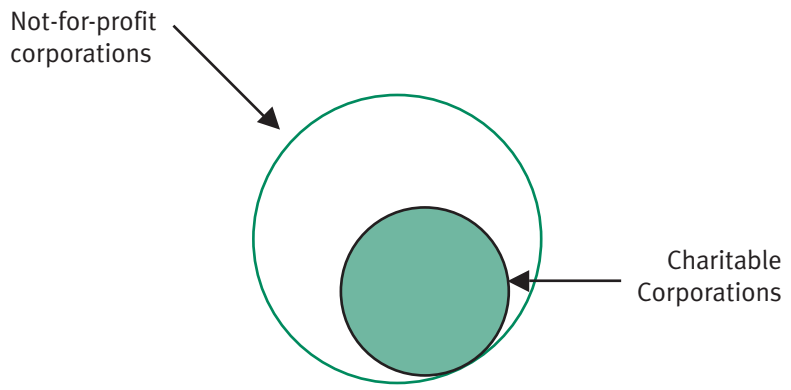


FIGURE 10.1 Charities as a Subset of Not-for-Profit Corporations

fraternal order, or similar group to qualify for exemption from certain taxes. An old but still valid case is *City of Philadelphia v. Masonic Home of Philadelphia*,[1] which denied real-estate tax exemption to a home for aged Masons because it served only Freemasons, not the general public, and therefore was not "purely public." In a later Pennsylvania case, the court relied on *Masonic Home* when it decided that a community hospital was tax exempt because it was open to all without regard to "race, color, creed, national origin, or race" and without being restricted membership in any particular social organization.[2]

Kansas does not require a charity to be "public" in the same sense that Pennsylvania does. Therefore, in Kansas a hospital may be considered tax exempt even if it serves only specific groups—for example, Masons, Methodist clergy, or members of Roman Catholic religious orders.[3] The definition of and limitations on the class of persons to be served by a "charity" thus depend on local law and are still open to question in many jurisdictions.

It is often said that a charitable healthcare organization may not restrict its services because of a patient's inability to pay. For federal income-tax exemption, and for most state real-estate exemptions, a hospital that has facilities for emergency services may not reject a patient who seeks emergency care because of indigence.[4] (This topic is discussed in more detail in Chapter 8.) The point comes into focus with respect to specialized institutions like hospitals that care only for patients with a particular disease or disability. Discrimination on the basis of indigence or other "suspect classes" is still prohibited, but charitable status is not lost by restricting benefits according to the institution's ability to serve and its purpose, facilities, and staff.

Even though a charity may not restrict its emergency care to those able to pay, the question still remains whether the organization must render some amount of free care to maintain its status. A few state courts have answered this question in the affirmative.[5] The federal government and most states, however, have not required provision of a specific amount of free care to maintain charitable status.[6] As long as there is no private gain or profit, promotion of health is usually considered a valid charitable purpose in itself. Accordingly, the institution can be self-supporting and earn a profit as long as the profits are used for institutional needs and not distributed to individuals. Profit can be invested in physical facilities or added to the organization's endowment.

Many state court decisions follow this approach, and the philosophy was well stated by a New York court in *Doctors Hospital v. Sexton*:

> Hospitals which are devoted to the care of the sick and injured, which aid in maintaining public health and which make valuable contributions to the advancement of medical science are rightly regarded as benevolent and charitable. A hospital association not conducted for profit which devotes all of its

> funds exclusively to the maintenance of the institution is a public charity and this is so irrespective of whether patients are required to pay for the services rendered.[7]

If you listen closely you can hear in this excerpt echoes of hospitals' origins in the almshouses of the Middle Ages (see the introduction in Chapter 5.)

The view that care of the indigent is not a necessary condition for charitable status is justified on the grounds that (1) both the wealthy and the poor are "needy," in one sense, when they suffer illness or injury; (2) a requirement of free care is difficult to define in terms of amount and extent; and (3) there should be governmental social-welfare programs to care for those unable to pay rather than relying on private institutions.

Finally, although promotion of health may be a valid charitable purpose for many organizations, such as research institutions and specialized hospitals, a general community hospital must actually benefit the community if it is to retain charitable status. This is the reason for the requirements that the hospital must not turn away emergency patients on the basis of indigence, must admit patients without regard to race or creed, and must welcome emergency patients if they have available facilities and staff.[8] In short, a community hospital may not turn away emergency patients on the basis of indigence.[9] Systematic refusal of admission or services to such persons may be interpreted as an unwillingness to serve the community at large. (Other aspects of "community benefit" are discussed later in this chapter.)

In the final analysis, each case will be decided on the particular facts in the context of a particular issue, and the ultimate inquiry will always be whether the hospital is serving the community as required by state law or by federal tax law.

Federal Tax Issues

Section 501(c)(3) of the Internal Revenue Code lists the following among the organizations that are exempt from federal income tax:

> Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition (but only if no part of its activities involve the provision of athletic facilities or equipment), or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise

> attempting to influence legislation (except as otherwise provided in subsection (h)), and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.[10]

As is often the case with legislation, this paragraph raises more questions than it answers. The following will explore some of the significant questions relating to exemption from federal income tax.

Requirements for Tax Exemption

Requirement: Charitable Purpose

Most tax-exempt hospitals claim their status because they are "organized and operated for…charitable…purposes." What amounts to a "charitable purpose" is not entirely clear. The statute does not define the term, and the tax regulations implementing the provision merely say:

> The term charity is used in section 501(c)(3) in its generally accepted legal sense…. Such term includes: Relief of the poor…; advancement of religion; advancement of education or science; erection or maintenance of public buildings, monuments, or works; lessening of the burdens of Government; and promotion of social welfare….[11]

Like the statute itself, this regulation raises a lot of questions. Where does healthcare fit in (see Legal DecisionPoint)? What is the "generally accepted legal sense" of the word "charity"? Does private healthcare promote "social welfare"? Does it lessen "the burdens of government"? (One can argue that the government would need to provide healthcare as a social service if community hospitals did not exist.) Does it amount to "relief of the poor"? (Perhaps it does when patients are poor, and one could argue that when we are seriously ill or injured we are all "poor" in one sense.) The regulation lists certain examples, but healthcare is not mentioned, although it is not meant to be an exhaustive list. The first question then is whether providing hospital services is charity work.

Legal DecisionPoint

What are the arguments pro and con on the issue of whether providing healthcare, in and of itself, should count as doing charity?

We know intuitively that charity involves benevolence—assisting the less fortunate, doing good works, and promoting the general welfare. But general principles do not decide concrete cases, and these kinds of instinctive responses do little to answer the legal questions. Apparently, charity—like pornography, famously—is hard to define, but you know it when you see it. One thing is certain: hospitals and other healthcare organizations are not charities per se. Providing healthcare must be accompanied by some more noble purpose.

Requirement: No Private Inurement

In addition to being organized and operated for charitable purposes (whatever that means), a tax-exempt organization's net earnings may not "inure" to the benefit of any private individual or corporation. The statute and regulations do not define "inure" for these purposes. Its usual dictionary definition—to make accustomed—is ill fitting. Nevertheless, it seems relatively clear that the intent is that a charity's net earnings must be permanently dedicated to exempt purposes and may not be distributed to private interests.

This requirement goes hand in hand with the concept of public benefit, and many questions are raised. Each case must be decided on its own merits, and no single factor or set of factors will decide whether a corporation claiming tax-exempt status is truly providing a community benefit or is merely a shield for conferring a gain on proprietary interests.

The courts will consider several factors, most of which flow from or relate directly to corporate control.[12] When control of a corporation rests exclusively with a small group of individuals, the facts require close scrutiny of the parties' motives. Private gain is indicated by such factors as (1) the division of profits among trustees, members, or officers of the corporation; (2) the private use of corporate funds or facilities; (3) exclusive privileges to admit or treat patients; and (4) failure to provide services to those unable to pay.[13] Even if tax-exempt status is granted without requiring free care, the charity record of a hospital is evidence of a willingness to serve the public. To put the matter another way, the absence or near absence of charity work is evidence of private gain and is considered along with the factors listed above.

Because of changes in healthcare financing in the last quarter of the twentieth century, hospitals developed various economic incentive plans to attract physicians to the medical staff, encourage the economical use of hospital facilities, and (hopefully) reduce overall costs. The theory is that if the physician shares in net revenues, she will have a financial incentive to be efficient and all parties will benefit. As long as the doctor's compensation is reasonable and furthers the charitable purpose of the institution, tax-exempt status is not jeopardized.[14] This means, of course, that the institution must receive value in return for the incentives granted the doctors. (Note that such arrangements may implicate state or federal "anti-kickback" and "self-referral" laws, as discussed in Chapter 12. The preceding brief discussion concerns only the effect of such arrangements on an organization's tax status, not the fraud laws, which are more likely sources of difficulties.)

Related Issues

In addition to the two fundamental requirements for federal tax exemption already mentioned (charitable purpose and no private inurement), there are at least three other factors to consider:

1. Services may not be restricted on the basis of race or creed.[15]
2. A hospital's emergency department services may not be withheld because of inability to pay.[16]
3. A hospital may not restrict the use of its facilities to a small, particular group of providers to the exclusion of other qualified persons.[17]

Regarding the last point, and as discussed more fully in Chapter 7, a hospital might not have the facilities for or the need to extend membership to all physicians who apply for medical staff privileges. If so, it may for these reasons reject an application from even a well-qualified physician without losing its tax-exempt status. However, under the law relating to medical staff privileges (see Chapter 7), the hospital must review physicians' applications fairly and carefully, provide them with an opportunity for a hearing if the application is rejected, and state the reasons for any rejection.

An organization exempt under Section 501(c)(3) is prohibited from all campaigning and electioneering on behalf of or in opposition to candidates for political office. It may, however, engage in lobbying (attempting to influence legislation) so long as lobbying does not amount to a "substantial part" of its overall activities.[18] What "substantial part" means is, obviously, a matter of dispute. To help 501(c)(3) organizations quantify this concept, the legislation permits public charities, except certain religious organizations, to file an election with the Internal Revenue Service indicating an intent to engage in lobbying. Having done so, the charity is subject to certain defined limitations on its lobbying expenditures (the details of which are not relevant here). The following costs are not considered lobbying expenses:

- publishing nonpartisan research data;
- providing testimony to a legislative body on issues that will affect the charity itself; and
- sending communications to a nonlegislative governmental official, such as an employee of an executive branch agency.

Excess Benefit Transactions

In addition to the traditional approach to private inurement and private benefit (i.e., revocation of tax exemption), the Taxpayer Bill of Rights 2 (TBOR2)[19] imposes sizable financial penalties on persons who receive "excess benefits" and on the organizational managers who approve the transactions. Suffice to say that the law makes it advisable for tax-exempt organizations to develop compensation and conflict-of-interest policies that will ensure the propriety of transactions with corporate insiders, including physicians. Failure to abide by such policies puts the insiders and corporate managers at substantial monetary risk (see The Law in Action on page 300).

The Law in Action

In the wake of several high-profile cases involving allegedly excessive executive compensation in charitable organizations, Congress created extremely stiff penalties for charities and insiders who receive or approve excessive benefits such as extremely high compensation packages. (The penalties are called "intermediate sanctions" because they are less severe than revoking the charity's tax-exempt status.) Excessive amounts must be paid back, and the Internal Revenue Service can levy fines of up to 200 percent of the amount above what would have been reasonable.

Taxability of Unrelated Business Income

Not all income of a charity is tax exempt. When a 501(c)(3) charity gets revenue from "unrelated" business activities (ones that are unrelated to a charitable purpose), they are taxable. Allowing profits from a noncharity-related line of business to remain untaxed would give charitable organizations an unfair competitive advantage; therefore, such income is taxable, just as it is for any individual or for-profit corporation. The tax-exempt status of the charity itself is not lost, however, as long as the unrelated activities do not constitute a "substantial" part of the charity's work. (The Internal Revenue Service may challenge the tax-exempt status of a charity if gross income from unrelated activities exceeds 50 percent of the charity's total revenue. It should also be noted that sales of goods or services by an exempt organization to private proprietary parties below cost may confer a private gain or inurement and may jeopardize the tax-exempt status of the seller.) The taxability of income from an unrelated trade or business is provided for by Sections 511 to 514 of the Internal Revenue Code.[20]

Investment income consisting of dividends, interest, and annuities, as well as income from research, is not taxable.[21] But income derived from the operation of hospital gift shops; restaurants, parking lots; pharmacies; physicians' offices; and residences for interns, nurses, or other staff facilities does present the question of unrelated trade or business taxation. The mere fact that income from such activities is devoted to hospital or charitable purposes does not exempt it from taxation. The reason for this general rule is that a hospital enterprise, such as a pharmacy or a parking lot, that charges its customers and is open to the general public should not be permitted an unfair competitive advantage over private businesses. The general test of a particular income-producing activity is whether it is substantially related to the charitable purpose of the tax-exempt institution.[22] In other words, does it further the purpose of the charity or simply amount to an extra line of business? To help answer that question the Internal Revenue Code provides the "convenience rule": The income is not taxable if the exempt entity can demonstrate that the activity is conducted primarily for the convenience of the institution's staff, patients, and visitors, in contrast to an enterprise selling goods and services to the general public.[23]

Even if an activity does not meet the convenience rule, the income it produces is free from tax if most of the workers producing the income are volunteers or if the profits come from merchandise donated to the tax-exempt organization.[24] This permits a hospital, for example, to engage in fund-raising supported by volunteer workers and donations, even if the efforts are carried out regularly. A "volunteer" is one who provides services without compensation. "Compensation" is the receipt of benefits that would not have otherwise been granted.[25] For example, in one case the brothers of a religious order were provided with food, clothing, shelter, and medical care—by virtue of their status as brothers—while they performed more than 90 percent of the necessary labor on a large farm the order owned. The income received from the farm's agricultural products was not taxable as unrelated income to the tax-exempt religious organization because as members of a religious order with a vow of poverty the brothers would have received the purported compensation whether they worked at the farm or not.[26]

As a general rule, income from the sale of goods and services to hospital patients and staff is not taxable. The term "hospital patients" usually includes outpatients, persons seen in the emergency department, discharged inpatients returning to the hospital pharmacy for refills of prescriptions, patients in an extended-care facility owned by the hospital, and patients enrolled in a hospital-sponsored program of home care.[27] Nevertheless, sales to persons who are not patients or to staff members are normally subject to taxation. From time to time the courts have been willing to flex the convenience rule to shield revenue from the unrelated business tax. In S*t. Luke's Hospital of Kansas City v. United States*,[28] for example, the court held that a tax-exempt teaching hospital could sell laboratory services to the community generally because such services were likely to benefit the teaching and research functions of the hospital and accordingly bore a "substantial relationship" to the hospital's charitable purpose. Such sales were also considered to be for the "convenience" of those physicians who were in fact members of the hospital's medical staff. In *Hi-Plains Hospital v. United States*[29] a federal circuit court approved sales of prescription drugs to patients of staff physicians even though some of the buyers had never been patients of the hospital. The drug sales were not advertised to the general public, and the court concluded that the sales were consistent with the convenience rule. The court noted specifically that the hospital was located in a rural community and had difficulty attracting physicians to the community.

Despite cases like these, revenue from sales to persons who have never been patients of the hospital is usually taxable income, even if prescribing physicians are members of the medical staff.[30] This follows from the fact that physicians practicing in their private capacity are not considered to be "members, officers, or employees" of the hospital.

State Taxation of Real Estate

Most real estate and personal property owned by federal or local governmental hospitals are exempt from taxation. The exemption is created by the relevant state constitution or statute. In some states, ownership and control of the property standing alone are sufficient to establish exemption. Other states add the requirement that the public property be used "exclusively for a public purpose" to justify exemption.[31]

In a Minnesota case a medical clinic owned and operated by a municipal hospital was not exempt from taxation when it was staffed by physicians practicing essentially on a fee-for-service basis. The board of the hospital and the physicians agreed annually on the fees to be charged patients. Each doctor then received 60 percent of his gross accounts receivable. Noting that the issue hinged on whether the primary use of the facility was for public purposes or for private gain, the Minnesota Supreme Court denied the exemption.[32] In the circumstances the facility was not being used exclusively for a public purpose. (Note that this arrangement would raise fraud and abuse issues today.) The real estate occupied or owned by private healthcare institutions, as well as their personal property, may or may not be tax exempt, depending on a number of factors. The first requirement of note is that the institution must qualify as a charity, a matter defined by local state law and discussed earlier. Hence, real estate owned by a proprietary hospital (one operated for profit) is fully taxable, just as is the property of any other business. When the tax is based on the value of property it is characterized as an ad valorem tax (see Legal Brief).

Legal Brief

Ad valorem tax is tax imposed in proportion to the value (in Latin, "ad valorem") of the property being assessed.

Qualifying as a Charity

In some states a mandatory constitutional provision is the source of exemption for real estate and other property owned or occupied by a public or charitable healthcare institution (see The Court Decides: *Utah County v. Intermountain Health Care, Inc.*, at the end of this chapter). The legislature of the state cannot alter such an exemption, and neither can the courts, although the courts have the power to interpret the meaning of the constitutional language. Other state constitutions contain permissive tax exemptions for charitable organizations, and a few state constitutions are entirely silent on the matter. In either of these situations, tax-exempt status depends on statute. Thus, either a permissive or nonexistent constitutional provision has the effect of granting the ultimate power of tax exemption to the legislature. The distinction between a

mandatory constitutional provision and a permissive one, or no provision at all, becomes significant when local governments search for additional revenue and when there is increasing political pressure to restrict or reduce the number of ad valorem tax exemptions.

Generally, providing free care is not necessary to qualify for state real-estate tax exemption. This is illustrated by the Nebraska case of *Evangelical Lutheran Good Samaritan Society v. County of Gage*.[33] A home for the aged was organized as a not-for-profit corporation, and it required all residents to pay if they were able. The rates were nearly the same as those charged by proprietary homes, and the home operated at a profit in some years and at a deficit in others. The court held the real estate to be exempt, ruling in effect that "charity" should be defined in broader terms than almsgiving and relief of poverty.

Likewise, in *Central Board on Care of Jewish Age, Inc. v. Henson* the court of appeals of Georgia ruled that a home for the elderly was exempt.[34] The home provided medical and nursing services to elderly persons of the Jewish faith. The residents' average age was nearly 83, and each paid a monthly charge based on financial ability—the maximum being $450. No applicant was ever refused admission because of inability to pay, and at all times a few residents were permitted to remain without paying. Deficits in annual operating expenses were covered by contributions from time to time by the Jewish Welfare Fund or by individuals. The court wrote:

> The concept of charity is not confined to the relief of the needy and destitute, for aged people require care and attention apart from financial assistance, and the supply of this care and attention is as much a charitable and benevolent purpose as the relief of their financial wants.

Subsequent cases have confirmed this broad definition of charitable for ad valorem tax purposes. For example, in 1981 the Massachusetts Supreme Judicial Court wrote:

> [W]e recognize…that major changes in the area of health care, especially in modes of operation and financing, have necessitated changes as well in definitional predicates. The term "charitable," as applied to health care facilities, has been broadened since earlier times when it was limited mainly to almshouses for the poor. As a result, the promotion of health, whether through the provision of health care or through medical education and research, is today generally seen as a charitable purpose. Such a purpose is separate and distinct from the relief of poverty and no health organization need engage in "almsgiving" in order to qualify for exemption.[35]

This is perhaps the majority rule.[36] In sharp contrast, however, is the opinion in *Utah County v. Intermountain Health Care, Inc.*[37] (see The Court Decides at the end of this chapter). In the view of the Utah court, tax exemptions are subsidies from the government, and proof of a charitable purpose requires that there has been a genuine and quantifiable quid pro quo. Accordingly, a private charity must establish that it is performing functions that the state would otherwise perform. Simply providing a benefit to the community is not enough. Although it received much attention when it was published more than 20 years ago, and although some other states have questioned hospitals' property tax exemptions, *Intermountain Health Care* remains a minority view in the lengths it requires hospitals to go in proving entitlement to an exemption.

Ownership of Exempt Property

In general, each parcel of land owned or occupied by a hospital claiming tax exemption as a charitable institution must separately qualify for such exemption. Normally, each parcel must also meet two tests: ownership by the hospital and use for a charitable purpose.

The test of ownership is not as simple as it might appear. Real-estate law recognizes various types of land ownership and leasehold interests. All states, so far as the ownership test is concerned, grant exemption to land owned by a charity when the organization holds "fee simple" (complete) legal title. Nearly all states likewise grant exemption to ownership in the form of "equitable title"—for example, purchase of land on an installment contract under which the seller retains legal title until the purchase price is paid. A few states will deny exemption to a charity holding equitable title.

Many states will deny real-estate tax exemption to the owner of land who leases it to a charitable corporation. Here, clearly, the land is not owned by the charity, which has obtained the right of possession and use through the lease but which has neither legal nor equitable title. On the other hand, some states will exempt such property from taxation because according to past experience it is sound public policy to reduce the operating costs of charitable organizations.

Use for a Charitable Purpose

Most states require that the tax-exempt property of a charity be held for the "exclusive use…for charitable purposes." Note carefully that this contemplates actual use or occupancy of the property itself. Vacant property and property owned for investment purposes would not qualify for exemption because it is not being used for charitable purposes. In other words, the use of the property determines the tax-exempt status; even the charitable use of income derived from the investment property does not qualify. Moreover, the word

"exclusive" in these provisions raises issues about property that is rented to or occupied by others, such as by medical staff members who practice as private physicians and by hospital residents and nurses. The usual analysis of these situations, which are decided case by case and state by state, is to examine how closely the use of the property relates to the primary purpose of the hospital and to analyze the relative benefits to the respective parties.

In general, property will be subject to real-estate taxation if it is rented to private physicians or others and if the rent allows the hospital a profit in excess of overhead. (See The Court Decides: *Greater Anchorage Area Borough v. Sisters of Charity* at the end of this chapter.[38]) A few states allow exemption for property rented to medical staff physicians for their private offices or to hospital personnel for their residences if the rent covers only the overhead cost or if no rent at all is charged.[39] Some courts will deny exemption to these types of facilities even if rent does not exceed the costs of maintenance and amortization of investment. They do so either (1) on the ground that the primary benefit is a private benefit, not a charitable one, and therefore the "exclusive use" test is not met or (2) on the ground that local statutes allow tax exemption only on land occupied by the hospital itself.[40]

A frequently cited New York case, *Genesee Hospital v. Wagner*, illustrates the issues of public policy that come into play with respect to the lease of hospital-owned real estate.[41] Genesee Hospital constructed an office building next to the hospital for lease to private physicians. Rent paid by the doctors was set at market prices, but at first the rents did not cover operating costs. The New York statute requires that "real property owned by a corporation or association organized or conducted exclusively for…hospital…purposes…and used exclusively for carrying out…such purposes…shall be exempt from taxation."[42] However, the statute provides that "if any portion of such real property is not so used exclusively to carry out…such purposes but is leased or otherwise used for other purposes, such portion shall be subject to taxation and the remaining portion only shall be exempt."[43] At issue, then, was whether the office building was used exclusively for hospital purposes.

The trial court held that the building was exempt from taxation. Rather than give "exclusively" its literal meaning, the court looked to whether the office building was "reasonably incident to the major purpose" of the hospital. Because the evidence clearly established that the hospital's concern was to maintain a "first-rate" medical center for both patient care and medical education rather than to benefit the private physicians personally, the trial court judge concluded in essence that the hospital, its house staff, and patients benefited relatively more from the use of the building than the private physicians did.[44] The public policy involved was made evident when the trial court concluded that the community views a modern hospital

building to be an important investment if it enables a highly trained staff of attending physicians to work together.

On appeal, the decision was reversed and the office building was held to be subject to property taxes. The appellate court recognized that a professional building was an admirable addition to the community, and without a doubt enhanced the patient care and teaching functions of the hospital, but the facility was in direct competition with privately developed professional office buildings serving an identical function of providing space for the private practice of medicine. Accordingly, the leased space did not qualify for exemption under the language of the New York statute.[45] (See also The Court Decides: *Barnes Hospital v. Collector of Revenue* at the end of this chapter.)

As in the area of unrelated business income, property tax issues are sometimes raised regarding cafeterias, gift shops, pharmacies, parking lots, and the like that a hospital owns and operates. Again, the legal issue is whether these activities are consistent with the requirement of "exclusive use for charitable purposes." If such an activity is not conducted for commercial profit, and if it takes place in an area of the hospital building or the immediate premises not open to the general public, tax-exempt status is likely to be given. If a cafeteria, gift shop, parking lot, or similar facility is not tax exempt, the hospital must then determine whether the local and state statutes permit "split-listing" of property for tax purposes, because the related activity frequently takes place in some part of an institutional building. Split-listing means essentially that the local tax authorities will list as taxable only the space that is not exempt, allowing exemption on the remainder of the hospital building. In most jurisdictions split-listing is permitted.[46] Some states do not allow it, however, and in those states it is especially important to seek competent legal advice regarding nonexempt uses of the property.

With respect to vacant or unoccupied land there is a diversity of opinion depending on the exact language of the state statute and judicial interpretation of that language. For tax exemption some states require that the land must not only be "used" for charitable purposes but must also be "occupied." Even if being occupied for a charitable purpose is not a statutory requirement, one must determine the meaning of "used." Vacant land that is held simply for possible use in the indefinite future and for which no plans for development exist would normally be taxable.[47] On the other hand, if plans for construction and development are well along, fund-raising is under way, and actual bids have been received for construction, then the land, although not yet in actual use, is exempt in some jurisdictions.[48] Other states, however, may require actual use and occupancy before granting exemption.

Finally, it should be noted that to an increasing extent healthcare institutions are choosing to lease rather than purchase equipment and other types of personal property. Just as in a number of states where the owner of land who leases it to a charity must pay real-estate taxes on the property,

leased personal property may also be subject to ad valorem taxation. In an Alaska case a hospital's lease of beds, television sets, and x-ray equipment did not entitle the property's owner (the lessor) to an exemption. The exemption provisions did not apply because the lessor was presumably earning a profit, and thus the property was not being used "exclusively for non-profit, religious, [and] charitable purposes" as required by the state constitution and the relevant statute.[49]

Chapter Summary

This chapter addresses the taxation of healthcare organizations, primarily not-for-profit corporations. All tax-exempt organizations are not-for-profit, but not all not-for-profits are tax exempt. The standards for income and property tax exemption are also discussed, as are the occasions in which some income of a tax-exempt organization may be taxable. The question of what it means to be a "charity" was raised, as well as what implications that designation may have under federal and state law.

Chapter Discussion Questions

1. How should the term "charity" be defined?
2. Compare the structure and financing of today's "medical–industrial complex" to your mental image of the nineteenth and early twentieth century hospital. Outline your arguments—both pro and con—for this debate topic: Resolved, that government shall eliminate all favorable tax treatment for not-for-profit healthcare organizations.
3. Consider the *Genesee Hospital* case. What parallels, if any, do you see between this case and the *Charlotte Hungerford Hospital* case in Chapter 4? Both cases concern the use of hospital property for a medical office building. In *Charlotte Hungerford Hospital* the arrangement was upheld; in *Genesee Hospital* it was not (in effect). What is the difference?
4. Suppose the law requires that for a property to be tax exempt it must be used for exempt purposes. Suppose also that January 1 is the assessment date, and the use of the property on that date determines its exempt status for the coming year. In July 2006 a hospital bought a parcel of land near its main campus to build a facility for housing and maintaining its fleet of ambulances. Construction began on December 1, 2006 and was completed in June 2007. The hospital started using the building as an ambulance station on June 30, 2007. Should the land be considered exempt for 2007? What if construction began on January 2, 2007?

Notes

1. City of Philadelphia v. Masonic Home of Pennsylvania, 160 Pa. 572, 28 A. 954 (1894).
2. West Allegheny Hospital v. Board of Property Apportionment, 500 Pa. 236, 455 A.2d 1170 (1982).
3. See Kansas Masonic Home v. Board of Commissioners, 81 Kan. 859, 106 P. 1082 (1910); Accord Fitterer v. Crawford, 157 Mo. 51, 57 S.W. 532 (1900)—in Crawford, a home was denied tax exemption for other reasons.
4. Of course not all tax-exempt hospitals provide emergency services. Rev. Rul. 157, 1983-42 C.B. 9–10—a tax-exempt hospital need not provide emergency services, although it will be expected to serve the community at large in other ways—for example, by serving Medicaid and Medicare patients.
5. See, for example, Cleveland Osteopathic Hosp. v. Zangerle, 153 Ohio St. 222, 91 N.E.2d 261 (1950); Vicksburg v. Vicksburg Sanitarium, 117 Miss. 709, 78 So. 702 (1918).
6. It is of historical interest that before 1969 the federal government did require a tax-exempt hospital to furnish an undefined amount of service below costs. Rev. Rul. 185, 1956-1 C.B. 202. This ruling was changed by Rev. Rul. 545, 1969-2 C.B. 117.
7. 267 A.D. 736, 48 N.Y.S.2d 201, 205 (1944), aff'd , 295 N.Y. 553, 64 N.E.2d 273 (1945). See also Bishop and Chapter of the Cathedral of St. John the Evangelist v. Treasurer of the City and County of Denver, 37 Colo. 378, 86 P. 1021 (1906)—a hospital may charge fees to all patients, and the amount received may exceed expenses.
8. Bromberg, "The Charitable Hospital," 20 *Cath. U. L. Rev.* 248–51 (1970).
9. Hart v. Taylor, 301 Ill. 344, 133 N.E. 857 (1921); Natchez v. Natchez Sanitorium Benevolent Ass'n, 191 Miss. 91, 2 So. 2d 798 (1941). Hart involved the validity of a charitable testamentary trust.
10. 26 U.S.C. § 501(c)(3).
11. 25 C.F.R. § 1.502(c)(3)-1. 82).
12. Bromberg, supra note 8.
13. See, for example, Sonora Community Hosp. v. Commissioner, 397 F.2d 814 (9th Cir., 1968).
14. Rev. Rul. 383, 1969 C.B. 113.
15. Bob Jones Univ. v. United States, 461 U.S. 574 (1983).
16. Rev. Rul. 185, 1956-1 C.B. 202.
17. Id.
18. I.R.C. § 501(h).
19. 26 U.S.C. § 4958.
20. For example, United States v. American College of Physicians, 106 S. Ct. 1591 (1986)—income received by a medical organization from commercial advertisements in professional journal is taxable as unrelated business income.
21. I.R.C. § 512(b).
22. I.R.C. § 513(a); Treas. Reg. § 1.513-1(a) (1967).
23. I.R.C. § 513(s)(2).
24. I.R.C. § 513(a)(1).
25. Id.
26. St. Joseph Farms of Ind. v. Commissioner, Tax Ct. Rep. Dec. (P-H) § 85.2 (July 1, 1985).
27. Rev. Rul. 376, 1968-2 C.B. 246.
28. 494 F. Supp. 85 (W.D. Mo. 1980).
29. 670 F.2d 528 (5th Cir. 1982)—sales to persons who were not patients of either the hospital or staff physicians would be taxable.
30. Carle Found. v. United States, 611 F.2d 1192 (7th Cir. 1979), cert. denied, 449 U.S. 824 (1980)—revenue from sales to ambulatory patients of physicians' clinic is taxable as unrelated income; I.R.C. § 513(a)(2); Rev. Rul. 85-109, 1985-30 I.R.B. 17—sale of laboratory services prescribed by private staff physicians is unrelated business when persons receiving the services have never been patients of the hospital; "Quarterly Tax Report," 8 *Health L. Vigil* (Am. Hosp. Ass'n) No. 16, at 7–8 (Aug. 9, 1985).

31. For example, Ohio Rev. Code Ann. § 5709.08 (page 1985) provides: "Real or personal property belonging to the state or United States used exclusively for a public purpose, and public property used exclusively for a public purpose, shall be exempt from taxation." See Carney v. Cleveland, 173 Ohio St. 56, 108 N.E.2d 14 (1962).
32. City of Springfield v. Commissioner of Revenue, 380 N.W.2d 802 (Minn. 1986).
33. 181 Neb. 831, 151 N.W.2d 446 (1967).
34. 120 Ga. App. 627, 629, 171 S.E.2d 747, 749 (1969).
35. Harvard Community Health Plan, Inc. v. Board of Assessors, 384 Mass. 536, 427 N.E.2d 1159 (1981).
36. See, for example, South Iowa Methodist Homes, Inc. v. Board of Review, 173 N.W.2d 526 (Iowa 1970); West Allegheny Hosp. v. Board of Property Assessments, 500 Pa. 236, 455 A.2d 1170 (1982)—patient revenues can be used to finance repairs to property and costs of acquisitions that further charitable purposes; Passavant Health Center v. Board of Assessment and Revision of Taxes of Butler County, 502 A.2d 753 (Pa. Commw. 1985)—retirement cottages located on hospital property were not exempt when residents were required to pay lump sum upon entrance and furnish evidence of ability to pay a monthly service fee and charges for future medical care.
37. 709 P.2d 265 (Utah 1985).
38. 553 P.2d 467 (Alaska 1976).
39. Aultman Hosp. Ass'n v. Evatt, 140 Ohio St. 114, 42 N.E.2d 646 (1942)—residence for nurses was exempt; Sisters of Saint Mary v. City of Madison, 89 Wis. 2d 372, 278 N.W.2d 814 (1979)—rent-free residence provided for full-time hospital chaplain was exempt; Oakwood Hosp. Corp. v. Michigan State Tax Comm'n, 374 Mich. 524, 132 N.W.2d 634 (1965)—housing for interns and residents was exempt.
40. See, for example, Milton Hosp. v. Board of Tax Assessors, 360 Mass. 63, 271 N.E.2d 745 (1971); Medical Center of Vt., Inc. v. City of Burlington, 131 Vt. 196, 303 A.2d 468 (1973)—case was remanded to determine facts of whether physician's use of offices at noncommercial rental was primarily for hospital purposes or private purposes; White Cross Hosp. Ass'n v. Warren, 6 Ohio St. 2d 29, 215 N.E.2d 374 (1966)—offices leased to physicians were not exempt; Doctors Hosp. v. Board of Tax Appeals, 173 Ohio St. 283, 181 N.E.2d 702 (1962)—housing for married staff paid a stipend by the hospital was not exempt; City of Long Branch v. Monmouth Medical Center, 138 N.J. Super. 524, 351 A.2d 756 (1976)—housing for resident interns and nurses was exempt; space rented to private physicians at less than commercial rates is taxable, aff'd, 73 N.J. 179, 373 A.2d 651 (1977).
41. Genesee Hosp. v. Wagner, 76 Misc. 2d 281, 350 N.Y.S.2d 582 (N.Y. Sup. Ct. 1973), rev'd , 47 A.D.2d 37, 364 N.Y.S.2d 934 (1975), aff'd mem., 39 N.Y.2d 863, 352 N.E.2d 133, 386 N.Y.S.2d 216 (1976).
42. N.Y. Real Property Tax Law § 420-a(1)(a) (McKinney 1984).
43. N.Y. Real Property Tax Law § 420-a(2).
44. 76 Misc. 2d at 285–89, 350 N.Y.S.2d at 586–90.
45. Genesee Hosp. v. Wagner, 47 A.D.2d 37, 364 N.Y.S.2d 934 (1975). Compare Barnes Hosp. v. Leggett, 646 S.W.2d 889 (Mo. Ct. App. 1983)—teaching hospital's lease of space to part-time medical school faculty who also practiced privately does not destroy tax exemption because faculty provided free care to indigent hospital patients.
46. Sisters of Charity v. Bernalillo County, 93 N.M. 42, 596 P.2d 255 (1979)—pro rata taxation is allowed when office building and parking structure are used for both charitable and noncharitable purposes; Barnes Hosp. v. Leggett, 646 S.W.2d 899 (Mo. Ct. App. 1983)—constitutional provisions authorize exemption for portions of property used exclusively for charitable purposes.
47. For example, Oak Ridge Hosp. v. City of Oak Ridge, 57 Tenn. Ap. 487, 420 S.W.2d 583 (1967); Cleveland Memorial Medical Found. v. Perk, 10 Ohio St. 2d 72, 225 N.E.2d 233 (1967); Hillman v. Flagstaff Community Hosp., 123 Ariz. 124, 598 P.2d 102 (Ariz. 1979).
48. For example, Good Samaritan Hosp. Ass'n v. Glander, 155 Ohio St. 507, 99 N.E.2d 473 (1951); Cleveland Memorial Medical Found. v. Perk, 10 Ohio St. 2d 72, 255 N.E.2d 233 (1967).
49. Sisters of Providence in Washington, Inc. v. Municipality of Anchorage, 672 P.2d 446 (Alaska 1983); Accord Kunnes v. Samaritan Health Serv., 121 Ariz. 413, 590 P.2d 1359 (Ariz. 1979)—to be exempt from ad valorem taxation, equipment must be owned.

THE COURT DECIDES

Utah County v. Intermountain Health Care, Inc. 709 P.2d 265 (Utah 1985)

Durham, J.

Utah County seeks review of a decision of the Utah State Tax Commission [exempting certain Intermountain Health Care (IHC) hospitals] from ad valorem property taxes. At issue is whether such a tax exemption is constitutionally permissible. We hold that, on the facts in this record, it is not, and we reverse.

[IHC is a not-for-profit hospital system that at the time of the case had 21 hospitals in the West. IHC had no stock, no dividends, and none of its revenues or assets inured to the benefit of any private individual.]

Utah County seeks the resolution of two issues: (1) whether [certain statutes] which exempt from taxation hospitals meeting certain requirements, constitute an unconstitutional expansion of the charitable exemption in...the Utah Constitution; and (2) whether [the IHC hospitals] are exempt from taxation under...the Utah Constitution.[4]

Utah County does not seriously dispute that the two hospitals in this case comply with [the statutes in question] but contends instead that these statutes unlawfully expand the charitable exemption granted by...the Utah Constitution, which provides in pertinent part:

> The property of the state, cities, counties, towns, school districts, municipal corporations and public libraries, lots with the buildings thereon used exclusively for either religious worship or charitable purposes, shall be exempt from taxation. [Ellipsis in the original opinion.]

...[*Quoting from an earlier decision the court points out that the Utah constitution*] "grants a charitable exemption and our statutes cannot expand or limit the scope of the exemption or defeat it. To the extend the statutes have that effect, they are not valid."

...These exemptions confer an indirect subsidy and are usually justified as the quid pro quo for charitable entities undertaking functions and services that the state would otherwise be required to perform. A concurrent rationale, used by some courts, is the assertion that the exemptions are granted not only because charitable entities relieve government of a burden, but also because their activities enhance beneficial community values or goals. Under this theory, the benefits received by the community are believed to offset the revenue lost by reason of the exemption.

[In considering the standards under which these rationales are to be applied,

4. One of the statutes provides that property dedicated to religious worship or charitable purposes is exempt from taxation if (1) the user is a not-for-profit organization, (2) earnings do not inure to private individuals, (3) the property is not used in a way that profits or benefits any private person, and (4) upon dissolution of the organization, the property will not be distributed to any private person. The second statute provides, "Property used exclusively for religious, hospital, educational, employee representation, or welfare purposes [and that complies with the statute summarized above] shall be deemed to be used for charitable purposes within the exemption provided for in [the Utah Constitution]."

however, the court affirms that "the clause exempting property 'used exclusively for ...charitable purposes' is to be strictly construed." Thus, it holds that an entity qualifies for the exemption only if it meets the definition of a "charity": "the contribution or dedication of something of value...to the common good."]

...[T]here are a number of factors which must be weighed in determining whether a particular institution is in fact using its property "exclusively for...charitable purposes." These factors are: (1) whether the stated purpose of the entity is to provide a significant service to others without immediate expectation of material reward; (2) whether the entity is supported...by donations and gifts; (3) whether the recipients of the "charity" are required to pay for the assistance received, in whole or in part; (4) whether the income received from all sources...produces a "profit" to the entity...; (5) whether the beneficiaries of the "charity" are restricted or unrestricted and, if restricted, whether the restriction bears a reasonable relationship to the entity's charitable objectives; and (6) whether dividends or some other form of financial benefit, or assets upon dissolution, are available to private interests.... These factors provide, we believe, useful guidelines for our analysis of whether a charitable purpose or gift exists in any particular case. We emphasize that each case must be decided on its own facts, and the foregoing factors are not all of equal significance, nor must an institution always qualify under all six before it will be eligible for an exemption.

Because the "care of the sick" has traditionally been an activity regarded as charitable in American law, and because the dissenting opinions rely upon decisions from other jurisdictions that in turn incorporate unexamined assumptions about the fundamental of hospital-based medical care, we deem it important to scrutinize the contemporary social and economic context of such care. We are convinced that the traditional assumptions bear little relationship to the economics of the medical-industrial complex of the 1980s. Nonprofit hospitals were traditionally treated as tax-exempt charitable institutions because, until late in the 19th century, they were true charities providing custodial care for those who were both sick and poor. The hospitals' income was derived largely or entirely from voluntary charitable donations, not government subsidies, taxes, or patient fees. The function and status of hospitals began to change in the late 19th century; the transformation was substantially completed by the 1920's. "From charities, dependent on voluntary gifts, [hospitals] developed into market institutions financed increasingly out of payments from patients." The transformation was multidimensional: hospitals were redefined from social welfare to medical treatment institutions; their charitable foundation was replaced by a business basis; and their orientation shifted to "professionals, and their patients," away from "patrons and the poor."

[The court next summarizes six factors from Paul Starr's The Social Transformation of American Medicine *to suggest that by about 1925 hospitals had changed significantly: (1) hospital patients began to reflect the population at large, (2) the percentage of revenue from patient fees increased dramatically, (3) doctors were allowed to charge private patients for hospital-based services, (4) virtually all doctors had hospital privileges, (5) the number of hospitals increased from 178 to more than 4,000, and (6) there was a substantial growth in for-profit hospitals. The court summarizes its argument by saying, "All of the above factors indicate a substantial change in the nature of the hospital; a part of that change was the gradual disappearance of the traditional charitable hospital for the poor."]*

...[T]he revolution in healthcare...has transformed a "healing profession" into an enormous and complex industry, employing millions of people and accounting for a substantial proportion of our gross national product. Dramatic advances in medical knowledge and technology have resulted in an equally dramatic rise in the cost of medical services. At the same time, elaborate and comprehensive organizations of third-party payers have evolved. Most recently, perhaps as a further evolutionary response to the unceasing rise in the cost of medical services, the provision of such services has become a highly competitive business....

[The court next examines the facts of the case in relation to the six factors articulated earlier for determining whether an activity is a charity. The court finds that the statement of "corporate purposes" in IHC's articles of incorporation meets the first criterion.]

The second factor we examine is whether the hospitals are supported, and to what extent, by donations and gifts.... The finding [of the Tax Commission on this point] reads: "The sources of revenue of IHC are derived primarily from patient charges, third parties (Blue Cross, Blue Shield, Medicare, Medicaid), and gifts (wills, endowments and contributions)." *[The extent of the gifts was not specified.]* The evidence was that both hospitals charge rates for their services comparable to rates being charged by other similar entities, and no showing was made that the donations identified resulted in charges to patients below prevailing market rates. Presumably such differentials, if they exist, could be quantified and introduced into evidence. The defendants have failed to provide such evidence, and it is they who bear the burden of showing their eligibility for exemption.

....

One of the most significant of the factors to be considered in review of a claimed exemption is the third we identified: whether the recipients of the services of an entity are required to pay for that assistance, in whole or in part. The Tax Commission in this case found as follows:

> The policy of [IHC's hospitals] is to collect hospital charges from patients whenever it is reasonable and possible to do so; however, no person in need of medical attention is denied care solely on the basis of a lack of funds.

...The record shows that the vast majority of the services provided by these two hospitals are [sic] paid for by government programs, private insurance companies, or the individuals receiving care.... Furthermore, the record also shows that such free service as did exist was deliberately not advertised out of fear of a "deluge of people" trying to take advantage of it. Instead, every effort was made to recover payment for services rendered....

The defendants argue that the great expense of modern hospital care and the universal availability of insurance and government healthcare subsidies make the idea of a hospital solely supported by philanthropy an anachronism. We believe this argument itself exposes the weakness in the defendants' position. It is precisely because such a vast system of third-party payers has developed to meet the expense of modern hospital care that the historical distinction between for-profit and non-profit hospitals has eroded....

The fourth question we consider is whether the income received from all sources by these IHC hospitals is in excess of their operating and maintenance expenses. Because the vast majority of their services are paid for, the nonprofit hospitals in this case accumulate capital as do their profit-seeking counterparts.... [T]here is no showing on the record that surplus funds generated by one hospital

in the system will not be utilized for the benefit of facilities in other counties, outside the state of Utah, or purely for administrative costs of the system itself.

Indeed, it is difficult to see a significant difference between the operation (as opposed to the form of corporate structure) of defendants' facilities and the operation of [a] for-profit hospital.... The significant difference between for-profit and nonprofit hospital corporations is, in effect, the method of distribution of assets upon dissolution of the corporation, which is itself a rare occurrence.

....

The final two factors we address are whether the beneficiaries of the services of the defendants are "restricted" in any way and whether private interests are benefited by the organization or operation of the defendants. Although the policy of IHC is to impose no restrictions, there were some incidents recounted in the testimony which suggested that these institutions do not see themselves as being in the business of providing hospital care "for the poor," an activity which was certainly at the heart of the original rationale for tax exemptions for charitable hospitals. Otherwise, it appears that they meet [the fifth] criterion. On the question of benefits to private interests, certainly it appears that no individuals who are employed by or administer the defendants receive any distribution of assets or income, and some, such as IHC's board of trustees members, volunteer their services. We have noted, however, that IHC owns a for-profit entity, as well as nonprofit subsidiaries, and there is in addition the consideration that numerous forms of private commercial enterprise, such as pharmacies, laboratories, and contracts for medical services, are conducted as a necessary part of the defendants' hospital operations. The burden being on the taxpayer to demonstrate eligibility for the exemption, the inadequacies in the record on these questions cannot be remedied by speculation in the defendants' favor.

In summary,...we believe that the defendants in this case confuse the element of gift to the community, which an entity must demonstrate in order to qualify as a charity under our Constitution, with the concept of community benefit, which any of countless private enterprises might provide....

....

Neither can we find on this record that the burdens of government are substantially lessened as a result of the defendants' provision of services.... In fact, government is already carrying a substantial share of the operating expenses of defendants, in the form of third-party payments pursuant to "entitlement" programs such as Medicare and Medicaid.

...A hospital, whether nonprofit or for-profit, that provides its services to paying patients relieves no public burden because, in its absence, the government would not (or would have no duty to) provide free healthcare to patients able to pay for treatment. ...[And] all hospitals use tax-supported public services, including road construction and maintenance, police protection, fire protection, water and sewer maintenance, and waste removal, to name a few. Exempt hospitals use those services at the expense of nonexempt healthcare providers and other taxpayers, commercial and individual....

We cannot find, on this record, the essential element of gift to the community, either through the nonreciprocal provision of services or through the alleviation of a government burden, and consequently we hold that the defendants have not demonstrated that their property is being used exclusively for charitable purposes under the Utah Constitution.

...Property used exclusively for hospital purposes is not automatically being used

for charitable purposes, even where the hospital is nonprofit.

We reverse the Tax Commission's grant of an ad valorem property tax exemption to defendants as being unconstitutional. We emphasize, contrary to the assertions of the dissents, that this opinion is no more than an extension of the principles of strict construction set forth in [previous cases]. This is a "record" case, and we make no judgment as to the ability of these hospitals or any others to demonstrate their eligibility for constitutionally permissible tax exemptions in the future. We note, however, that reliance on automatic exemptions granted heretofore, and on the kind of minimal efforts to show charity reflected in this record, will no longer suffice.

[The court concludes by saying that this opinion has prospective effect only and that with changes in their operations defendants might be able to qualify for the exemption in the future if they meet the criteria set forth in this decision.

Two sharp dissenting opinions were filed. One contains the following language: "The majority's suggestions that a nonprofit hospital must have a deficit in its current accounts to qualify for charitable status is both anachronistic and a prescription for lesser-quality hospital care, if not bankruptcy.... The majority's assertion that 'traditional assumptions bear little relationship to the economics of the medical–industrial complex of the 1980's is based upon the majority's refusal to acknowledge the development of case law that has occurred over at least the past 45 years."

The other dissenting justice wrote, "Courts long ago fully considered and firmly rejected the notion now advanced by the majority that the charitable character of a hospital is determined by the quantity of its almsgiving." Then, referring to the majority's favorable quotation of student law review articles, the dissenting opinion continues, "In a reckless attempt to find support for what appears to be its novel personal ideas, buttressed by references to 'literature' by writers whose credentials are not established, the majority indulges in totally irrelevant arguments." The first dissenter had described those arguments as a "flight of fantasy."]

Utah County v. Intermountain Health Care, Inc. Discussion Questions

1. Based on your definition of the term "charity," is the *Intermountain Health Care* decision correct?
2. If you were the chief executive officer of an *Intermountain Health Care* hospital, what would you do differently to try to requalify for the tax exemption?
3. Oliver Wendell Holmes, Jr., once wrote, "It is one of the misfortunes of the law that ideas become encysted in phrases and thereafter for a long time cease to provoke further analysis." [Holmes, dissenting in *Hyde v. United States*, 225 U.S. 347, 391 (1912).] How does this comment relate to the *Intermountain Health Care* decision and tax law in Utah?

THE COURT DECIDES

Greater Anchorage Area Borough v. Sisters of Charity
553 P.2d 467 (Alaska 1976)

Burke, J.

The central issue in this appeal is the tax-exempt status of a building owned by the Sisters of Charity of the House of Providence, under the provisions of Art. IX, Sec. 4, of the Constitution of Alaska and AS 29.53.020. [Footnotes omitted.]

The Sisters of Charity, a long-time healthcare provider in Alaska, erected the building in question, the Providence Professional Building, adjacent to their hospital on land deeded to them in 1959 by the United States for "hospital site, school and recreational purposes only." The construction of the Professional Building began in 1970; its first full year of operation was 1972.

The Professional Building has four floors, including a basement, and is connected by an underground tunnel to nearby Providence Hospital. Three floors are the subject of this appeal, since the parties agree that the basement and tunnel are used exclusively for hospital purposes and are, therefore, exempt from taxation.

The first, second and third floors are rented to doctors having hospital staff privileges at Providence Hospital, for use as their private office space. Approximately thirty-five doctors rent such space. These doctors, although enjoying staff privileges, are not employed by Providence Hospital, and their patients are not necessarily patients of the hospital. Thus, the actual use made of the first, second and third floors is for office space by doctors engaged in the private practice of medicine.

....

A taxpayer claiming a tax exemption has the burden of showing that the property is eligible for the exemption.... [T]herefore, the burden is on the Sisters to show that the office space is exempt. ...They must first show...that the property is "used exclusively for nonprofit...hospital...purposes." [Quoting from the Alaska statute.] ...[W]e find as a matter of law, that the office space is not used exclusively for hospital purposes.... [W]hen the property in question is used even in part by non-exempt parties for their private business purposes, there can be no exemption.

....

The record indicates that the Sisters have performed a service to doctors and patients alike in constructing the Professional Building, and that healthcare at Providence has been benefited. In order to qualify for an exemption, however, the taxpayer must show, not benefits, but exclusive use. The use of the Professional Building for nonprofit hospital purposes is not exclusive. Therefore, we reverse and remand to the superior court for the entry of an order affirming the Board of Equalization's decision denying the Sisters' appeal.

THE COURT DECIDES

Barnes Hospital v. Collector of Revenue
646 S.W.2d 889 (Mo. Ct. App. 1983)

Pudlowski, J.

This appeal by Barnes Hospital involves taxation of Queeny Tower, a 17-story building connected to, used and owned by Barnes Hospital for the tax-exempt purposes of treating patients and providing them with care and services. Washington University Medical School, whose teaching facilities are located within the Barnes Hospital complex and whose faculty members comprise the medical staff of the hospital, leases Queeny Tower from Barnes. The part-time faculty subleases offices in Queeny Tower from Washington University for use in their private practice as well as for use in their teaching, research and Barnes Hospital functions.

....

The sole question raised is whether property owned by a tax exempt hospital and leased to the medical school for use by its faculty may be taxed where its part-time faculty members, also engaged in limited private practice, maintain their offices therein.

....

The first prerequisite for exemption is that the property be "used exclusively" for charitable purposes. Nowhere in its decision did the Missouri Supreme Court define the meaning of the statutory words "used exclusively" or "purposes." Thus, the initial proviso of the qualification articulated first in Franciscan, the statutory phrase "used exclusively," must be examined. The phrase could mean "solely" or "entirely" in its narrowest sense. We do not construe it in that sense.

....

.... The statutory phrase "used exclusively" has reference to the primary and inherent use as against a mere secondary and incidental use. Our courts since Barnes have continued their reliance and acceptance of this definition.

....

The policy underlying the statute is to encourage charitable organizations. The meaning we attach to the language of the statute accords with the mandate in Barnes. Although it is the general rule that constitutional provisions exempting property are to be strictly construed, such provisions, though not subject to extension by construction or implication, are to be given a reasonable, natural and practical interpretation in light of modern conditions in order to effectuate the purpose for which the exemption is granted.

....

For the foregoing reasons, the judgment of the trial court is reversed and the cause remanded with directions that the decree of August 24, 1978, remain in full force and effect and that appellant's questioned property be removed from the tax rolls of St. Louis City and the City Collector be prohibited from levying tax or compelling payment thereon.

All concur.

Barnes Hospital v. Collector of Revenue Discussion Questions

1. How can the *Greater Anchorage* (Alaska) and *Barnes Hospital* (Missouri) courts take two nearly identical tax laws, apply them to situations with virtually identical facts, and arrive at opposite conclusions? Is this fair?
2. Which of the two interpretations do you find more persuasive?
3. Would it matter if the property in question were owned by a for-profit company but leased to Barnes Hospital for the same purposes?
4. What if a daily- or hourly-fee parking garage used by employees, patients, families, and visitors were located on a parcel of land owned by and adjacent to the hospital property? Would that be an exempt use in Alaska or Missouri? Would it matter who got the receipts from the parking garage or what fees were charged? Does your answer change if the garage could also be used by patrons of local businesses that are not related to the hospital?

CHAPTER

11

ANTITRUST LAW

After reading this chapter, you will

- have a basic understanding of the three main antitrust statutes and their exceptions.
- know why "interstate commerce" is an important constitutional concept for antitrust analysis.
- see how antitrust laws are enforced and what sanctions are possible for their violation.
- appreciate the difference between "per se" and "rule of reason" analysis.
- grasp how antitrust principles apply to healthcare organizations.
- be able to follow the possible future course of antitrust enforcement.

There are three principal federal antitrust statutes: the Sherman Act (1890), the Clayton Act (1914), and the Federal Trade Commission Act (1914). These statutes, procedures for their enforcement, and their application to healthcare organizations are described in this chapter.

The Sherman Act

Most healthcare antitrust litigation involves charges that the defendants have violated either Section 1 or Section 2 (or both) of the Sherman Act. The substantive provision of Section 1 reads as follows:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several states, or with foreign nations, is hereby declared to be illegal.[1]

Thus, in 32 simple words Congress set the stage for more than a century of litigation. It is probably not an overstatement to say that billions of

words have been written over the years to interpret this relatively simple sentence.

It is easy to grasp the idea that a "contract, combination…or conspiracy" that restrains trade should be illegal. After all, free markets are good; things that inhibit free markets are bad. (Some would contest this assumption, but we will take it as a given for now.) What is hard to grasp is how to apply that proposition to an infinite number of fact situations involving possible restraints of trade (see The Law in Action).

The Law in Action

Because the Sherman Act applies only to restraints of "trade or commerce," it was long assumed that it did not apply to the practice of a profession. However, in the landmark case, *Goldfarb v. Virginia State Bar Association*, the Supreme Court ruled that a state bar association's minimum fee schedule for attorneys amounted to an illegal price-fixing arrangement.[2] The Court rejected the defendant's position that the antitrust laws do not apply to the so-called "learned professions." Therefore, healthcare (whether provided by institutions like hospitals or by physicians and other clinicians) is as subject to antitrust laws as are automobile manufacturers, the steel industry, software companies, and other businesses.

Section 2 of the Act is similarly terse. It reads:

> Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony….[3]

Thus, both sections deal with joint action—an agreement, a conspiracy—by two or more parties that restrains trade,[4] and Section 2 adds the concept of monopolies.

Obviously, one cannot conspire with oneself, so an action by a single person does not violate Section 1 of the Sherman Act. Likewise, a corporation, being a legal "person," cannot combine or conspire with itself even though it may act through numerous employees. In 1984 the Supreme Court took this line of reasoning one step further and held that a parent corporation could not agree or conspire with a wholly owned subsidiary corporation even if the two were considered separate legal entities for many other purposes.[5] This result, of course, "leaves untouched [by Section 1] a single firm's anticompetitive conduct (short of threatened monopolization) that may be indistinguishable in economic effect from the conduct of two firms…."[6] (See The Court Decides: *Copperweld Corp. v. Independence Tube Corp.*, at the end of this chapter.)

The analysis gets more interesting when two or more competitors in a given market engage in parallel conduct but without conscious collaboration; this is especially so with respect to product pricing (see Legal Brief). The fact that the competitors charge the same price for similar products does not prove a conspiracy. It may be circumstantial evidence for the jury to consider, but

absent actual proof that the parties conspired, identical pricing by itself does not violate Section 1 of the Sherman Act.[7] On the other hand, when the evidence shows that competitors exchanged price information and caused a stabilization of prices, that is sufficient proof of a violation.[8] Whether there was illegal collusion to restrain trade is a fact question to be answered on a case-by-case basis.

Legal Brief

Antitrust law is one reason you see "manufacturer's suggested retail price" (MSRP) on some products. The retailer—who is in the same "distribution chain" as the manufacturer and the wholesaler—does not have to sell the product at that suggested price but can vary it depending on local economic conditions. This helps to avoid charges that the two entities agreed on a price, which would be a per se antitrust violation.

Of course you could wonder why there should be a "suggested" retail price at all. Why not just let the local dealer set a price based on what the market will bear?

Restraints of trade may be horizontal or vertical. Horizontal restraints occur when competitors in the same market agree on prices, divide the market, exclude others from competing, or refuse to deal with certain third parties. Vertical restraints exist when two or more entities at different levels in a distribution chain act collectively to cause changes in the competitive environment. For example, if a manufacturer and a retailer agree that the latter will sell the product at a given price, such behavior would be called "resale price maintenance" and would usually violate the Sherman Act.

In contrast to Section 1, Section 2 of the Sherman Act can apply to a single business enterprise. In addition to combinations to create a monopoly, the section prohibits actual monopolies and attempts to monopolize, even when they result from unilateral action.[9] Section 2 is violated when monopoly power—the power to control prices or exclude competition—exists as a result of "willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident."[10] In simple English, if the world beats a path to your door because you built a better mousetrap, that's okay. But if you take steps to keep other mousetrap manufacturers away from the path, you're breaking the law. As with so many other issues, making this distinction requires delicate scrutiny, and decisions will be made on a case-by-case basis.

In summary, in a case alleging violation of Section 2's monopolization provisions, a court must do the following:

1. determine the relevant market, both geographically and for the product;
2. decide whether the evidence shows actual or inferential control of prices or the exclusion of competitors; and
3. determine whether this monopoly power was acquired or maintained willfully.

The Law in Action

About 100 years ago the U.S. Supreme Court decided *Loewe v. Lawlor,* which became known as the "Danbury Hatters' Case," 208 U.S. 274 (1908). A labor union boycotted the products of a nonunion hat manufacturer in Danbury, Connecticut. The manufacturer sued, arguing that the union's activities were an illegal combination in restraint of trade. The Supreme Court agreed and let stand an injunction against the union and an award of triple the damages suffered by the manufacturer.

The Clayton Act was a direct result of the outcry among labor activists that followed in the wake of the Danbury Hatters' Case.

The Clayton Act

As noted, the language of the Sherman Act is general and broad and its application begat some unwanted consequences, as laws tend to do. For example, it was used for nearly 25 years as an antiunion tool (see The Law in Action). As a result, in 1914 Congress tried to add some clarity by passing the Clayton Act, which flatly states, "The labor of a human being is not a commodity or article of commerce"[11] and exempts union activities from the force of the antitrust laws. In addition, the Clayton Act prohibits the following:

- price discrimination,
- tying arrangements (exclusive sales contracts),
- mergers and acquisitions that lessen competition, and
- certain interlocking corporate directorates and stock holdings.

The first three are discussed in the next sections.

Price Discrimination

Part of the Clayton Act was concerned with discriminatory pricing practices, where the effect is to lessen competition or achieve monopoly power. As amended over the years it now reads, in part:

> [It is unlawful] to discriminate in price between different purchasers of commodities of like grade and quality…where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly in any line of commerce, or to injure, destroy, or prevent competition with any person who either grants or knowingly receives the benefit of such discrimination.[12]

The statute specifically allows price differentials based on "the cost of manufacture, sale, or delivery resulting from the differing methods or quantities in which such commodities are…sold or delivered." (The famous "volume discount," therefore, remains legal.)

The section applies only to sales of commodities (merchandise, wares, things), and so it does not cover intangible items like patents, stocks, bonds,

and healthcare services. It also does not apply when the things sold are different in grade and quality or when they are sold to certain not-for-profit institutions (including hospitals) "for their own use."

For example, in *Abbott Laboratories v. Portland Retail Druggists Association, Inc.*,[13] several pharmaceutical manufacturers had sold products to not-for-profit hospitals in Oregon at prices lower than those charged to commercial pharmacists for the same or similar products. The question, of course, was whether the purchases by the hospitals were "for their own use." Obviously the hospitals were not swallowing the drugs, so the issue was what kinds of uses are permissible. The Court found that the following are "[p]urchases…for their own use:"[14]

- products purchased for use in treatment of inpatients, emergency patients, and outpatients seen on the premises;
- take-home prescriptions for those three categories of patients, to the extent that the prescriptions supplemented treatment rendered at the hospital and were to be used for a limited time; and
- drugs furnished to hospital employees, students, and members of the medical staff for their dependents' personal use.[15]

Excluded from the exemption were prescription refills for a hospital's former patients and sales to walk-in buyers, except in emergencies when there was no other source of supply.[16] It was felt that permitting refills for discharged patients or sales to the general public would give a hospital-based pharmacy an unfair advantage over commercial pharmacies.

In addition to these statutory limitations on the scope of the law and the general defense based on cost justifications, Section 2(b) of the Clayton Act provides that any price is lawful if set in good faith to meet competition on a customer-to-customer or geographic basis. To assert this defense successfully, however, the seller must prove that the pricing policies in question were designed to meet competition, not drive it out. One should note that discriminatory pricing might also be an attempt to monopolize, which is a violation of Section 2 of the Sherman Act.

Tying and Exclusive Dealing Contracts

Section 3 of the Clayton Act provides:

> It shall be unlawful for any person engaged in commerce…to lease or make a sale…of goods…or other commodities…on the condition, agreement, or understanding that the lessee or purchaser thereof shall not use or deal in the goods…or other commodities of a competitor...where the effect…may be to substantially lessen competition or tend to create a monopoly in any line of commerce.[17]

More will be said later in the chapter about these prohibited restraints of trade, but suffice to say at this point that they (1) do not apply to contracts of service and (2) rarely, if ever, apply in the healthcare setting.

Mergers and Acquisitions

Corporate mergers, consolidations, and acquisitions are the subjects of Section 7 of the Clayton Act, and thus Section 7 duplicates to a certain degree the ban on monopolization and attempts to monopolize, which were already made illegal by Section 2 of the Sherman Act. This portion of the Clayton Act reads:

> No person engaged in commerce…shall acquire, directly or indirectly, the whole or any part of the stock…and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another person engaged also in commerce…where…the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.[18]

The Law in Action

Major premise: The Clayton Act vests in the following agencies the authority to enforce the Clayton Act's merger and acquisition provisions:

- the Surface Transportation Board, where applicable to common carriers;
- the Federal Communications Commission, where applicable to radio and television;
- the Secretary of Transportation, where applicable to air carriers;
- the Federal Reserve, where applicable to banks, banking associations, and trust companies; and
- the Federal Trade Commission, where applicable to all other character of commerce.

Minor premise: Not-for-profits are engaged in commerce.

Conclusion: The Clayton Act gives the Federal Trade Commission authority to enforce the Clayton Act against not-for-profits, even though it could not enforce the Federal Trade Commission Act against them.

For some time it was assumed that this provision applied only to for-profit companies because (a) they do not issue stock, and (b) the Federal Trade Commission (FTC) Act does apply to nonstock companies. However, the opinion in *United States v. Rockford Memorial Corp.*,[19] threw this assumption into a cocked hat. It said that mergers between not-for-profit enterprises are subject to FTC jurisdiction for the purpose of enforcing the Clayton Act itself. The syllogism is shown in The Law in Action.

Who cares about this? Apparently, only the academics. The standards of the Sherman and Clayton Acts do seem to be different. Section 1 of the Sherman Act prohibits contracts, combinations, and conspiracies in restraint of trade, while Section 2 prohibits monopolies or attempts to monopolize. A corporate acquisition might not violate either of those provisions, but its effect, even if unintended, might "substantially…lessen competition" or "tend

to create a monopoly," which are the Clayton Act's yardsticks. A fine distinction to be sure, yet one that is theoretically important. But the issue has seldom been addressed in other cases, and the language of *Rockford Memorial* remains dictum.[20]

In summary, whether the Clayton Act applies to not-for-profit healthcare corporations is an open question, but it does not matter much.

The Federal Trade Commission Act

In 1914, the same year that the Clayton Act was enacted, Congress passed the FTC Act. The law is enforced by the FTC, an agency with broad powers to conduct investigations, promulgate rules and regulations, and enforce statutory provisions that prohibit unfair competition and trade practices.

Section 5 of the FTC Act, as amended, states: "Unfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce, are hereby declared unlawful."[21] Under this language the agency essentially is empowered to enforce the Sherman and Clayton Acts also, at least against for-profit companies, because some unfair methods of competition will violate all three statutes. In addition to encouraging competition, Section 5 empowers the FTC to regulate trade practices that are "unfair or deceptive" to consumers. For example, the FTC has brought numerous cases charging commercial advertisers with unfair or deceptive practices, some of which could apply to healthcare:

- failing to reveal material facts about a product,
- making false claims and misrepresentations,
- offering misleading prices,
- disparaging a competitor's product by misleading or making untrue assertions,
- announcing unsupported endorsements by well-known persons,
- presenting advertising that is intended to attract a customer who will then be switched to a higher-priced product,
- conducting contests where very few prizes are actually awarded,
- sending unsolicited merchandise, and
- using overbearing methods in door-to-door sales.

Interstate Commerce

Congress normally bases its power to regulate business activity on the commerce clause of the Constitution. This clause grants Congress the power to

Legal Brief

The Constitution was written in the heydays of farmers, farriers, and similar tradesmen when much commerce was truly local. But today the "village blacksmith" can order his supplies by Internet, mail, or telephone; have them shipped from anywhere in the world by land, sea, or air; and pay for them through electronic fund transfer from a bank in London, Switzerland, or almost anyplace else. His equine "clients" may be thoroughbreds from far and wide that race on tracks across the country or around the world.

Distinguishing between interstate and intrastate commerce today is not as simple as it might have seemed 225 years ago!

"regulate Commerce with foreign nations and among the several states." Congress may, therefore, regulate *inter*state commerce. *Intra*state commerce is beyond the reach of federal regulation under the commerce clause. This begs the question, "Where is the line between the two?" (see Legal Brief). Especially in today's high-tech, highly mobile, free-trade society, virtually everything affects or is affected by interstate commerce. In essence, the Supreme Court has said that Congress may regulate even local activities so long as they have a substantial and harmful effect on interstate commerce.[22]

For many years it was widely assumed that federal antitrust statutes did not affect healthcare services because they fell into the "intra" category. A significant 1976 case, however, proved that assumption quite wrong. In *Hospital Building Co. v. Trustees of the Rex Hospital*[23] the Supreme Court held that an alleged conspiracy among a not-for-profit hospital, some hospital officials, and the head of the local health planning agency to prevent the relocation and expansion of a competing hospital did have a "substantial effect" on interstate commerce.[24] A significant portion of the hospital's medicines and supplies, some of its patients, much of its revenue, and the contemplated financing for its planned expansion came from out-of-state sources. The Court felt these factors showed enough of an effect on interstate commerce for the antitrust laws to apply.[25]

The learning from *Rex Hospital* is that most healthcare organizations today will not be able to avoid scrutiny by claiming that their conduct does not have a substantial effect on interstate commerce.

Exemptions from Antitrust Legislation

There are five possible exemptions to the federal antitrust statutes. Three of these—implied repeal, state action, and the Noerr-Pennington doctrine—were created by court decision and thus are subject to modification from time to time. The fourth exemption (established by Congress when the McCarran-Ferguson Act[26] was passed in 1924) exempts the "business of insurance" from federal antitrust law if the defendant's conduct does not amount to "boycott, coercion, or intimidation."[27] The final exemption

relates to collective bargaining agreements between a labor union and management.

Implied Repeal

Implied repeal is invoked to create an exemption from antitrust liability when the antitrust laws conflict with another federal regulatory scheme. To put the matter another way, it is felt that by regulating a specific practice Congress must have meant for the more explicit system to trump the general principles of antitrust law even if it did not clearly say so.

Cases involving implied repeal show the philosophical struggle between advocates of free-market competition and those who promote greater regulation. The tension between antitrust principles and health planning laws is a case in point. The National Health Planning and Resources Development Act of 1974 (Pub. L. No. 93-641) was meant to prevent excessive investment in and misdistribution of health facilities. Because competition alone does not appropriately determine the supply of healthcare, "93-641" (as it was often called) encouraged local and state planning agencies to allocate health facilities and services according to need. Obviously, having the government decide what facilities can and cannot be built flies in the face of the pro-competition philosophy of the antitrust laws.

National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City grew out of this health planning climate.[28] A hospital corporation built a new facility despite (a) data showing that it was not needed and (b) the planning agency's decision that it would not approve any new construction in the area. Jumping on the cost-containment bandwagon, the Blue Cross health plan announced that it would not contract with new hospitals that did not meet a "clearly evident need." After the National Gerimedical Hospital was built, it sought to participate in the Blue Cross plan, but Blue Cross said no because the hospital had not been approved by the planning agency.

The hospital filed an antitrust suit alleging a conspiracy in restraint of trade. Facing the realization that their actions did restrain trade, the defendants argued, "Implied repeal! The health planning law is more specific and so it preempts the broad principles of the antitrust laws." The district and appellate courts agreed with the defendants and dismissed the case. The Supreme Court, however, reversed the decision. It remanded the case for a new trial while making these important points:

1. The antitrust laws represent a "fundamental national economic policy."
2. Implied antitrust immunity can be justified only by a convincing showing of clear repugnancy between antitrust principles and the particular regulatory system.
3. Repeal is to be regarded as implied only if necessary to make the subsequent law work, and even then only to the minimum extent necessary.

4. Even governmental regulation does not provide evidence of congressional intent to repeal the antitrust laws.

In summary, implied repeal is disfavored. It applies in any type of case only if there is "clear repugnancy" between the two conflicting statutory provisions. Because the conduct by Blue Cross of Kansas City was "neither compelled nor approved by any governmental regulatory body," the Sherman Act prevailed. Blue Cross's refusal to contract with National Gerimedical was a voluntary decision by a private corporation in response to comments by the state planning agency acting in an advisory role. Thus, the Supreme Court forthrightly reasserted that it is not permissible for competing healthcare entities to restrain trade voluntarily even in the name of health planning.

State Action

Local and state governments regulate various private business and economic activity in the interest of promoting health, safety, and the general welfare of the public. However, sometimes state regulation restricts or restrains competition, thus generating apparent inconsistencies between state governmental regulation and antitrust legislation.

The state action doctrine, developed by the courts, grants immunity from antitrust sanctions whenever the defendants' anticompetitive conduct is the consequence of governmental regulation. The first case establishing the exemption was *Parker v. Brown*,[29] which involved California laws that restrained competition among raisin producers and increased market prices. The Supreme Court held that the state officials administering the law were exempt from antitrust claims because the program "derived its authority and efficacy from the legislative command of the state."[30] But 32 years later, in *Goldfarb v. Virginia State Bar,* the Court clarified this holding by saying that the restraint of trade must be required by the state, not merely authorized by it.[31] (See Legal Brief.)

Legal Brief

If you are a state, you can restrain trade. Otherwise, you cannot. The seeming absurdity of this statement is perhaps why "state action" has been so narrowly construed.

In summary, the state action doctrine requires that the regulation be an activity of the state itself acting in its sovereign capacity or must be conducted pursuant to a "clearly articulated and affirmatively expressed" state regulatory policy. Further, the state itself must then actively supervise the local government or private party engaged in the regulating process. Little, if any, healthcare regulation meets these criteria.

Noerr-Pennington Doctrine

The Noerr-Pennington doctrine (named after parties in two Supreme Court cases) recognizes that attempts to influence legislation or governmental regulations are exempt from antitrust restraints. The doctrine is based on the First Amendment to the Constitution, which guarantees freedom of speech and the right to petition the government. For example, in the case of *Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.*,[32] the Supreme Court held, "The Sherman Act does not prohibit two or more persons from [acting] together in an attempt to persuade the legislature or the executive to take particular action with respect to a law that would produce a restraint or a monopoly." Even though two railroads had intended to (and did) harm the trucking industry and had used unethical methods in their publicity campaign, the constitutional dimensions of the doctrine trumped the antitrust laws.

There are limitations to the doctrine, of course. An exemption will not be recognized if the conduct of the defendants otherwise violates a valid statute or if the intent is to prevent competitors' own attempts to influence the government.[33] In such circumstances, and perhaps others, the claim of exemption will be labeled a sham and denied.

Because of the Noerr-Pennington doctrine, healthcare organizations are free to collaborate in pushing for legislation or regulations that serve their own interests, even if those organizations are competitors and otherwise might violate the antitrust laws.

The Business of Insurance

Before World War II it was generally assumed that insurance companies did not do business in interstate commerce and need not concern themselves with statutes relating to restraints of trade. This changed in 1944 when the Supreme Court ruled that the sale of insurance is indeed part of interstate commerce and is therefore subject to antitrust laws.[34] But it was quickly seen that there are valid reasons for exempting some aspects of the insurance industry from antitrust principles. A completely free market characterized by open competition would cause some insurance companies to issue policies at rates that do not cover the actual risk. The consequences might well be the insurance companies' failure and inability to pay legitimate claims. Sound public policy, therefore, requires that the government be concerned for the financial integrity of insurance carriers.

Because a freely competitive environment is not appropriate for the insurance industry, it follows that certain cooperative efforts among insurance companies are legitimate and perhaps should be encouraged by regulatory authority, even if they are anticompetitive. For example, companies may benefit by sharing information on the various risks in any given book of business and by exchanging data on price and loss ratios. Cooperation in fixing

actual rates for insurance has also been thought to be consistent with desirable public policy.

Congress enacted the McCarran-Ferguson Act (MFA)[35] in 1945 as a response to these arguments and to the Supreme Court decision the year before. The MFA established in statutory form the previously assumed exemption of the insurance industry from federal antitrust laws. The MFA also provided, however, that the exemption would not apply "to any agreement to boycott, coerce, or intimidate, or [to any] act of boycott, coercion, or intimidation."[36] To this extent Congress recognized that insurance companies were capable of abusing an exemption and that engaging in a concerted refusal to do business with another or compelling a particular result by force should not be condoned.

There are three main issues in determining whether the act grants an exemption on a given set of facts:

1. Do the activities of the defendants constitute the "business of insurance"?
2. If yes, are the activities regulated by state law to a degree that justifies an exemption?
3. Even if the conduct of the defendants constitutes the business of insurance regulated by state law, do the facts indicate a boycott or business practices amounting to coercion and intimidation?

In healthcare, contractual agreements between a healthcare insurer (third-party payer) and a provider of products or services to that insurer are not considered the "business of insurance." They are merely contracts the insurer uses to reduce its costs in fulfilling its underwriting obligations (see Legal Brief). Thus, the terms of the contract, the formation of the agreement, and refusals by third-party payers to contract with particular providers are all subject to antitrust analysis on the merits of each case.

Analysis of *Group Life and Health Insurance Co. v. Royal Drug Co.*[37] will help to clarify this somewhat arcane point. In *Royal Drug* several small, independent, nonparticipating pharmacies challenged the terms of a contract for prescription drugs between Blue Shield of Texas

Legal Brief

At its core, the "business of insurance" involves the underwriting of risk in return for payment of a premium. That is, it involves the relationship between insurer and the insured. In issuing a health insurance policy, the company insures against the possibility that the insured will suffer financial loss arising from the need for healthcare products or services.

However, the business of insurance does not refer to all business aspects of an insurance company, only those that involve spreading risk, as is seen in *Royal Drug*.

(aka Group Life and Health Insurance) and the participating pharmacists. The plaintiffs alleged that the agreement amounted to price fixing. All licensed pharmacies within Blue Shield's service area were offered "participating" status and were promised direct reimbursement by Blue Shield for the cost of the prescribed drug plus a flat dispensing fee of $2 paid by the subscriber as a "copay" (note that this happened in the 1970s). If a Blue Shield subscriber obtained a prescribed drug from a nonparticipating pharmacy, she had to pay the pharmacist the actual retail price of the item and then seek reimbursement from her insurer. Blue Shield would reimburse the subscriber 75 percent of the difference between the price paid and the $2 fee—that is, the subscriber essentially had a 25 percent copay rather than a $2 copay when using a nonparticipating pharmacy.

The purpose of these arrangements was for Blue Shield to have a measure of control over its costs and to keep the subscriber's premium as low as possible. The practical effect, however, was to encourage subscribers to obtain their prescription medicines only from "participating" pharmacies. Some pharmacies, especially small independent ones, claimed that they could not operate economically for the $2 dispensing fee; hence, they alleged that the participating contract amounted to a conspiracy to fix prices in violation of the Sherman Act.

Blue Shield argued for an exemption from antitrust laws based on the MFA's "business of insurance" language. The Supreme Court disagreed. After tracing the legislative history of the MFA and noting that exemptions from antitrust legislation are to be narrowly construed, the Court wrote: "The exemption is for the 'business of insurance,' not the 'business of insurers'." That is to say, not all of the business activities of insurance companies are exempt merely because the company is in the insurance business; the business of insurance applies only to spreading and underwriting risks.[38] The agreement concerning participating pharmacies did not involve the acceptance or spreading of risks. It was not the business of insurance but simply a contract by Blue Shield to purchase goods and services on behalf of its subscribers.

Exemption for Labor-Management Activities

This topic was alluded to in the section concerning the Clayton Act. Because healthcare benefits for employees are among the mandatory subjects for collective bargaining under the provisions of the National Labor Relations Act,[39] it follows that the negotiated provisions of a contract between an employer and a labor union should be exempt from attack on antitrust grounds.

Michigan State Podiatry Association v. Blue Cross and Blue Shield of Michigan is illustrative.[40] In their 1979 labor contract the United Auto Workers and Chrysler Corporation agreed that, under the employees' health

plan, certain designated podiatric surgeries would be covered if a peer-review panel confirmed that the proposed procedure was both medically necessary and appropriate. The podiatry association challenged this preauthorization program on the ground that peer review was an unreasonable restraint of trade. The court dismissed the lawsuit, however, stating that arm's-length collective bargaining between a labor organization and management is exempt from the concepts of antitrust law.

Sanctions and Enforcement of Antitrust Statutes

The Sherman Act provides for both civil and criminal penalties[41] (see Table 11.1). Criminal prosecutions are initiated by the U.S. Department of Justice (DOJ) and filed in the district that has jurisdiction over the alleged criminal activities of the defendants.

Either the DOJ or a state attorney general may bring civil actions; those cases seek an injunction ordering the defendants to stop the illegal activity and, where an illegal monopoly is found, to break up the monopolistic position. Civil litigation may be terminated by a consent decree, an agreement among the parties in which the defendants agree to eliminate the alleged illegal behavior without admitting guilt.[42] Because it may be less costly to modify business practices than to continue defending the matter in court, consent decrees are frequently perceived as beneficial to all interested parties. (Failure to abide by a consent decree or an injunction can result in a fine of $10,000 per day.[43])

Finally, aggrieved competitors may also file civil suits under the Sherman Act and can receive triple the amount of their actual damages.[44] They may also obtain an injunction and reimbursement for their attorneys' fees and court costs. This last provision encourages settlement because attorneys' fees in a major antitrust suit can amount to several million dollars. (Needless to say, triple damages and awards of attorneys' fees are strong deterrents.)

Unlike the Sherman Act, the Clayton Act is not a criminal statute.[45] The civil remedies, however, are identical: an injunction or consent decree can be sought by the DOJ; a state attorney general may seek an injunction or damages; and private parties may sue for triple damages, or an injunction, or both.

TABLE 11.1 The Sherman Act's Criminal Penalties

Defendant	Fine per Offense	Imprisonment
Corporation	Up to $10 million	n/a
Individual	$350,000	Up to three years per offense

The FTC Act is enforced only by the FTC.[46] There is no private right of action, nor is the DOJ involved. Moreover, the Act provides only for civil remedies. The FTC has authority to enforce Sections 2, 3, 7, and 8 of the Clayton Act and does indeed do so from time to time.[47] Because several of the activities that violate Section 1 of the Sherman Act also violate sections of the Clayton Act and the FTC Act, the FTC can be said to enforce all three of the antitrust statutes.

As explained in the section concerning the Clayton Act, for many years it was assumed that the FTC had no jurisdiction over not-for-profit companies. Whether it does remains an unresolved issue, but it is probably a moot point because there is little substantive difference between the Clayton Act and the Sherman Act. The only remaining difference is which governmental agency can enforce the laws.

Rule-of-Reason Analysis and Per Se Violations

Immediately after the Sherman Act was passed in 1890, courts realized that not literally all contracts, combinations, or conspiracies in restraint of trade could be illegal (only those that are unreasonable), otherwise all contracts and joint activity between two or more persons would violate the law. (For example, any time there is a contract between a manufacturer and a supplier, the supplier's competitors have no opportunity to compete for that piece of business; thus, their ability to compete is restrained with regard to that product at that time.)

Thus, in most cases the courts apply a "rule-of-reason analysis," a time-consuming (and expensive) case-by-case consideration of a series of complex issues, including the following:

1. the geographic and product markets involved;
2. the nature of the particular industry, product, or service;
3. the motivation for the allegedly illegal activity; and
4. the condition of the industry before and after the alleged restraint of trade.

The first and last factors are the most complicated. They involve tortuous (and seemingly tortured) analyses of economic data to determine the positive and negative effects on competition.

The "rule of reason" is applied to most practices challenged under Section 1 of the Sherman Act, but some behavior is so clearly anticompetitive that a full-scale analysis of all the relevant factors and economic consequences of any restraint of trade is neither necessary nor wise. Accordingly, the courts have developed over time a per se standard of analysis best expressed in these words:

> [T]here are certain agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm they have caused or the business excuse for their use.... Among the practices which the courts have heretofore deemed to be unlawful in and of themselves are price fixing...division of markets...group boycotts...and tying arrangements.[48]

To reiterate, one must look to the competitors' behavior to see if it amounts to any of the following:

- price fixing (agreements between competitors with respect to price),
- dividing markets (either geographically or by product),
- group boycott (concerted refusals to deal), or
- tying arrangements (rarely applicable to healthcare).

If any of these circumstances is shown, there will be said to exist an automatic (per se) violation, and the rule-of-reason analysis does not need to be applied. When the per se standard of analysis is applied, the plaintiff need not prove the restraint's actual or quantitative effect on competition in a particular market. The rule of reason, by contrast, places the burden on the plaintiff to show the actual anticompetitive effects of the challenged activity.

Legal Brief

A trust was a form of business entity used in the late 1800s with intent to create a monopoly. It was often created when corporate leaders convinced or coerced the shareholders of competing companies to convey their shares to a board of trustees in exchange for dividend-paying certificates. The board would then manage all the companies in "trust" for the shareholders; in the process they would minimize competition. Eventually "trust" was used to refer to monopolies in general. Prominent trusts were Standard Oil, U.S. Steel, and Southern Pacific Railroad. "Trust busting" became a major policy and political issue in the late nineteenth and early twentieth centuries under Presidents McKinley and Roosevelt.

Applications to Healthcare

Justice Oliver Wendell Holmes once wrote, "It is one of the misfortunes of the law that ideas become encysted in phrases and thereafter for a long time cease to provoke further analysis."[49] The same may be true for the assumptions that underlie antitrust policy.

The antitrust laws date to the Industrial Revolution in the nineteenth century (see Legal Brief). It is, therefore, fair to ask whether the antediluvian principles of the Sherman Act (and other laws) are appropriate for the twenty-first century; this may be especially so in the

healthcare arena. That governmental regulators continue to try to pin the antitrust tail on today's healthcare donkey would probably cause Senator John Sherman—author of the eponymous first antitrust law—no little wonder.

Some observers assert that healthcare markets are profoundly different from other markets and that normal antitrust analyses of market power and concentration are unsuitable. As they point out, prices for hospital services are not simply a matter of supply and demand but are greatly influenced by factors totally outside hospitals' control, including the following:

- Medicare and Medicaid programs' unfettered power to set the prices they will pay,
- negotiated discounts for managed care plans,
- the aging of the patient population, and
- research and development costs for new drugs and medical technology.

Others—often governmental regulators—contend that competition is as worthy a goal in healthcare as it is in any other industry. They seek application of traditional antitrust principles to encourage competition, prevent monopolies or concentration of markets, and help control healthcare costs. This attitude prevailed throughout the 1980s and 1990s when antitrust enforcement was a rather high priority. Table 11.2 shows areas of concern for hospitals. (See Legal DecisionPoint on page 336.)

This chapter does not discuss all the concerns listed in Table 11.2, but it addresses regulators' current level of interest in reviewing hospital merger cases.

TABLE 11.2 Antitrust Concerns for Hospitals

Type of Activity	Possible Antitrust Concern
Health planning	Restraint of trade
Shared services	Possible price fixing or group boycott
Utilization review	Possible group boycott
Medical staff privileges	Possible group boycott
Third-party-payer contracts	Possible price fixing, group boycott, or monopolization
Managed care organizations	Possible price fixing, group boycott, or monopolization
Mergers and consolidations	Possible monopolization

Legal DecisionPoint

Suggested research project: Analyze how effective the activities listed in Table 11.2, and the antitrust principles applied to them, have been in reducing the skyrocketing cost of healthcare in this country. Consider the root causes of increasing costs and the available alternatives to the current way our healthcare system is financed.

In the second half of the Clinton administration, regulators became less attentive to antitrust issues in healthcare and more involved in issues such as major mergers in other industries, international restraints of trade, and the Microsoft case. By 1996 the federal government had lost a string of hospital-merger cases,[50] culminating in *Federal Trade Commission v. Butterworth Health Corporation*,[51] and the government seemed to welcome the opportunity to turn its attentions elsewhere for the nonce. (*Butterworth* is described in a later section of the chapter.)

Mergers and Consolidations

Corporations grow and diversify by (1) acquiring the stock or assets of another corporation, (2) merging with another corporation, or (3) consolidating two or more corporations into one new one (see Legal Brief). For the purpose of this discussion, the term "combination" is used to encompass all three types of transactions.

Four different antitrust provisions bear on corporate combinations. Section 7 of the Clayton Act is by far the most significant,[52] but business combinations can also be challenged under Sections 1 and 2 of the Sherman Act[53] and Section 5 of the FTC Act.[54]

Because business combinations have not been treated as per se violations, anyone who alleges that a combination restrains trade must show that the restraint results in an actual and substantial lessening of competition. The courts have recognized that some business combinations, mergers, and joint ventures may in fact increase business efficiency and favor competition. A plaintiff who must show an actual anticompetitive effect carries a heavy burden; thus, Section 1 is a less attractive legal vehicle for those challenging the decision of separate business entities to combine. Section 1 also requires that two or more persons agree to restrain trade and does not apply to unilateral action.

Legal Brief

A merger is the joining of two corporations—one transfers all of its assets to the other and the former is dissolved. (In effect, one corporation "swallows" the other.) A consolidation is a transaction in which two or more companies create a new corporation and the predecessor companies dissolve.

In contrast, Section 2 of the Sherman Act applies to unilateral action by single firms and prohibits them from engaging in monopolies, attempting to monopolize, and conspiring to monopolize.[55] Three essential elements of a Section 2 allegation require a case-by-case analysis:

1. proof of market power—the ability to exclude competitors or to fix or control prices, whether that ability is exercised or not;
2. definition of the relevant geographic and service markets; and
3. proof that the defendant has achieved or is maintaining monopoly power "willfully" or "unfairly."

Mere size and the absence of competition do not prove an illegal monopoly. Rather, what is prohibited is the intentional acquisition of monopoly power to control prices or exclude competitors. Predatory pricing policies, such as pricing below cost, or other unfair business practices may, therefore, be evidence of prohibited activities. In contrast, a dominant position in the market is not a violation in and of itself. Some firms achieve a dominant position merely by supplying a quality product or service efficiently or because the market can support only a single enterprise of its type. In a leading 1966 case the Supreme Court wrote, "growth and development as a consequence of a superior product, business acumen, or historic accident" does not violate Section 2 of the Sherman Act.[56] (Recall the mousetrap analogy earlier in this chapter.) Invention and innovation in a rapidly changing technological world actually encourage competition, and success does not by itself violate the principles of antitrust law.[57]

For a number of reasons, therefore, the provisions of the Sherman Act are difficult to enforce and are relatively ineffective in controlling monopolistic mergers and acquisitions. Although the statute remains in effect and is certainly a factor to be considered when evaluating the antitrust aspects of corporate reorganization, Section 7 of the Clayton Act is the preferred means of challenging a new or proposed business combination.[58]

As discussed earlier, Section 7 prohibits mergers and acquisitions that tend to create a monopoly. The relevant provision reads as follows:

> No person engaged in commerce…shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no corporation subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another person engaged also in commerce…where in any line of commerce…in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.[59]

Thus, the Clayton Act technically applies only to mergers or acquisitions "in commerce." This may be a more stringent standard than that of the Sherman Act, which applies to activity that "substantially affects commerce." The Clayton Act did not apply, for example, to the case of an out-of-state corporation doing business nationally that acquired two firms supplying local janitorial services in Southern California because the companies acquired were not engaged in interstate commerce.[60] As a practical matter,

the distinction between "in commerce" and "affecting commerce" is only an academic one.

Defining and Appraising Markets

Assuming there is no per se violation, a Clayton Act analysis first requires definition of the relevant product or service market and the geographic market and then appraisal of the proposed combination's effect on competition. In defining the product market, one must identify items that compete with each other as well as interchangeable substitutes. If buyers are prone to substitute a different, interchangeable product when the price of another product increases, the substitute must be included in the market. On the other hand, if the evidence shows that purchasers do not substitute a comparable item when a given product increases in price, the conclusion may well be that the targeted product stands alone as a market. (The term used in appraising this factor is "cross-elasticity of demand.")

Each case must be considered on its own facts. For example, in one case the Supreme Court held that cellophane (e.g., Saran Wrap and Cling Wrap) competes with other forms of flexible packaging materials. Because the defendant possessed only 18 percent of the market for packaging materials, an antitrust violation had not occurred, even though the defendant company had nearly 75 percent of the cellophane market.[61]

In the healthcare arena, a prime example of this concept of case-by-case market analysis can be seen in two significant hospital merger cases. In *United States v. Carilion Health System*, the DOJ brought suit to prevent the merger of two hospitals in Roanoke, Virginia.[62] The parties included (1) Carilion Health System, which owned three not-for-profit hospitals in the state—including 677-bed Roanoke Memorial Hospital—and managed six others, and (2) Community Hospital of Roanoke Valley, a 400-bed facility. Roanoke Memorial (staffed to operate 609 beds) and Community Hospital (staffed for 220 beds) wished to merge. A third hospital in the Roanoke area, which operated about 335 beds, was not involved in the merger. All three hospitals provided primary, secondary, and tertiary care, although Community Hospital provided the smallest number of tertiary services.

In considering the geographic market, the court pointed out that Roanoke Memorial drew 27 percent of its patients from three West Virginia counties and 11 Virginia counties outside the Roanoke area. It also noted that the hospital drew at least 100 patients per year from each of six other counties. Community drew about 18 percent of its patients from eight counties outside Roanoke. In this geographic area, about 20 other hospitals provided primary and, in some cases, secondary care. Based on this analysis, the court concluded that the two merging hospitals compete with the various hospitals in those surrounding counties. Furthermore, noting the increase in the number of conditions that are treated on an outpatient basis rather than in an acute

care hospital setting, the court found, "certain clinics and other providers of outpatient services compete with the defendants' hospitals to treat various medical needs" and that "the number of problems treated on an inpatient basis has declined steadily in recent years and can be expected to continue to fall."

Noting that the hospitals wanted to merge to improve their efficiency and competitive positions, the court held that the combination would not be an unreasonable restraint of trade and "would probably improve the quality of healthcare in western Virginia and reduce its cost and will strengthen competition between the two large hospitals that would remain in the Roanoke area."

In contrast, the following year a U.S. Court of Appeals decided *United States v. Rockford Memorial Corporation*.[63] This case involved the proposed merger of the two largest hospitals in Rockford, Illinois. It was estimated that the two facilities, if allowed to merge, would control between 64 percent and 72 percent of the inpatient services market and that they and the third largest hospital (which was not party to the merger talks) would control 90 percent. The court refused to include healthcare services provided in nonhospital settings in the product (service) market: "If a firm has a monopoly of product X, the fact that it produces another product, Y, for which the firm faces competition is irrelevant to its monopoly.... For many services provided by acute-care hospitals, there is no competition from other sorts of providers."[64]

Having concluded that the relevant product market was inpatient, acute care services, the court turned to the geographic market analysis. Accepting (somewhat reluctantly, it appears) the trial court's finding that the service area was a ten-county area of northern Illinois and southern Wisconsin centered on Rockford, the appellate court noted that 87 percent of the hospitals' admissions come from Rockford, the rest of the county it is located in, and "pieces of several other counties." Although the service area contained six hospitals in all, "90 percent of Rockford residents who are hospitalized are hospitalized in Rockford itself." The court concluded, "for the most part hospital services are local," and it upheld the trial court's injunction prohibiting the merger. (See The Law in Action.)

The *Rockford* court's analysis has since become the majority view: the relevant product market in most hospital merger cases is general acute care hospital services. (Of

The Law in Action

"It is always possible to take pot shots at a market definition (we have just taken one), and the defendants do so with vigor and panache. Their own proposal, however, is ridiculous—a ten-county area in which it is assumed (without any evidence and contrary to common sense) that Rockford residents, or third-party payers, will be searching out small, obscure hospitals in remote rural areas if the prices charged by the hospitals in Rockford rise above competitive levels. Forced to choose between two imperfect market definitions, the defendants' and the district judge's (the latter a considerable expansion of the government's tiny proposed market), …we choose the less imperfect, the district judge's."

—Judge Richard Posner on market definitions, *U.S. v. Rockford Memorial Corp.*, 898 F.2d 1278 (7th Cir. 1990)

course, the market is different when specialty hospitals are involved.) Nevertheless, the *Rockford* and *Roanoke* cases illustrate the difference that geography, demographics, and one's perceptions of the "product" a healthcare facility provides can make in the rule-of-reason analysis that must be undertaken. They also illustrate why the outcome of hospital antitrust cases is extremely difficult to predict: "[T]hese decisions require factual judgments regarding what the future may hold in an industry undergoing revolutionary change. Like pilots landing at night aboard an aircraft carrier, courts are aiming for a target that is small, shifting and poorly illuminated."[65]

After both the relevant product or service market and the geographic market have been determined, the competitive effect of a merger or acquisition must be predicted. The goal is to determine whether the combination, in the words of the statute, "may be substantially to lessen competition or tend to create a monopoly."[66] Among the important factors to consider in evaluating the potential competitive effect of a merger or acquisition are the following:

- whether competing firms or potential competitors have been eliminated from the market,
- whether the acquisition of a relatively small but locally dominant firm by a larger organization makes the acquired company even more dominant,
- whether the merger may lead the firms to buy each other's products and thereby harm competitors, and
- what in fact has happened to the competitive environment in situations in which mergers have already occurred.

In any event the focus is on the future and the potential adverse effects on competition. Challenges to a combination can occur long after the actual transaction because the statute of limitations does not begin to run until anticompetitive effects are felt.[67] The statute itself does not provide either a quantitative or qualitative test for changes in competition. Each combination has to be viewed functionally in the context of the particular industry.

Horizontal mergers are likely to have the most significant effects on competition. To judge this effect, the court will gather evidence of the merged firm's share of the market, the number of firms in the market, and recent merger trends in that area. To help explain this analysis, in 1982 the government published a mathematical formula—known as the Herfindahl-Hirschman Index (HHI)—for measuring market concentration. According to the formula, each firm's market share is squared and the squares are summed. Post-merger scores of less than 1,000 are considered evidence that the market is not seriously concentrated. The government is not likely to challenge these combinations. Scores of more than 1,800 represent

highly concentrated markets and may trigger an antitrust suit. Moderately concentrated markets are those that have scores between 1,000 and 1,800.[68] (Table 11.3 shows an example of the HHI at work in two hypothetical markets.) The DOJ and the courts will compare the pre- and post-merger scores to determine whether the merger results in "an undue percentage of share of the relevant market" and "a significant increase in the concentration of [firms]."[69]

Unlike a horizontal business combination, a vertical merger (acquisition) does not eliminate a competitor; it unites a customer with a supplier (at least in many industrial settings, if not so often in healthcare). It is a means of ensuring the availability of supplies, increasing retail sales of a manufacturer's product, or enabling more profitable marketing. When firms unite vertically the primary questions are as follows:

1. Has the transaction deprived a competitor of a source of supply?
2. Has it closed a competitor's or potential competitor's access to the market?[70]

TABLE 11.3 HHI Analysis of Two Hypothetical Markets

Market 1 Hospitals	Market %	%²
A	5	25
B	10	100
C	10	100
D	15	225
E	10	100
F	10	100
G	10	100
H	10	100
I	10	100
J	10	100
Sum of squares (Market 1):		1,050

Market 2 Hospitals	Market %	%²
K	30	900
L	30	900
M	30	900
N	10	100
Sum of squares (Market 2):		2,800

HHI < 1,000: light concentration; HHI 1,000 to 1,800: moderate concentration; HHI > 1,800: high concentration

Illustrating these concepts was the Ford Motor Company's acquisition of the Autolite company. Autolite manufactured spark plugs, obviously an essential component of automobiles. The acquisition violated the Clayton Act because it eliminated Ford as a potential spark plug manufacturer and removed it from the market as a significant buyer of these products.[71] On the other hand, a conglomerate—a corporation made up of numerous companies that operate in different fields—does not usually have an adverse effect on competition. By definition, firms that make up the conglomerate are not competitors, customers, or suppliers of the parent organization. But in some circumstances a conglomerate might have anticompetitive effects under the Clayton Act if it inhibits smaller firms and "substantially reduce[s] the competitive structure of the industry."[72]

Another form of business combination, quite prevalent in the healthcare arena, is the joint venture—an association of two or more firms meant to accomplish a defined economic goal. A joint venture has many of the attributes of a partnership, but a joint venture normally has a different life span; it usually ends when the economic goal is accomplished. A joint venture is subject to scrutiny under Section 7 of the Clayton Act, and the courts will evaluate all relevant factors in deciding whether a venture is likely to lessen competition.[73] A joint venture will usually be approved if the defined goal of the agreement is legitimate and if the market share after the combination is relatively small.

Summary of Enforcement Issues

In some circumstances both parties to a proposed merger or acquisition must report the pending transaction to the government.[74] The details of the requirement are not important here; suffice to say that the notice enables the government to review the implications of an agreement or an offer to merge before the transaction is completed. If the government concludes that the transaction is likely an antitrust violation, the government can seek a preliminary injunction.

Under the current approach to enforcement of the Clayton Act, Section 7, the plaintiff (whether the government or a private party) bears the burden of proving the defendant's share of the market and the market's concentration ratios. The plaintiff must also show that a merger or acquisition is likely to have an anticompetitive effect.[75] This standard of proof in turn requires a rather broad and expansive factual inquiry on a case-by-case basis beyond a mere statistical showing of market share.

The rule-of-reason analysis, then, permits the use of subjective judgment in evaluating facts presented in court and their effects. Finally, the courts are requiring that all relevant economic factors and probabilities be considered when the Clayton Act is used as the basis for challenging a merger or acquisition. Among these factors are ease of entry into a market, the economic health of the particular industry, characteristics of the products

involved, availability of substitute products, the nature of consumer demand, and characteristics of the firms in question.

Other Considerations

Defendants usually dispute the government's assertions about the relevant market and the anticompetitive effects of a proposed merger. They may also assert that (a) the company being acquired is failing financially and that the acquiring firm is the sole suitor,[76] and/or (b) that the company being acquired lacks resources to compete effectively and its acquisition does not therefore substantially lessen competition.[77] A third possible "out" is to show that the acquiring company is merely purchasing the stock of the other for investment purposes and not to lessen competition.[78] Because this is hard to prove, and because most acquisitions are not solely for investment purposes, the defense is not often asserted.

Pro-competitive Effects of Mergers

Until recently, most courts have held that administrative efficiency, economies of scale, and other allegedly beneficial effects do not alone justify a merger or acquisition. Therefore, such arguments have not been overly successful if the combination is otherwise illegal.[79] By the late 1990s, however, courts and the enforcement agencies themselves began to consider these factors in their rule-of-reason analyses.

For example, in *Federal Trade Commission v. Butterworth Health Corp.*,[80] the government sought to enjoin the merger of two of the four hospitals in Grand Rapids, Michigan. When the case began, the two facilities totaled a little more than 75 percent of the general acute care hospital beds in the region, and it was predicted that after the merger they would control about two-thirds of the total market for general inpatient services. This would make Grand Rapids a "highly concentrated" market. Despite these facts, the federal district court refused to stop the transaction. It found a number of salient points persuasive:

1. Evidence from economists showed that higher market concentration did not correlate with higher healthcare costs but in fact could result in lower prices.
2. Both organizations were community-based, not-for-profit corporations whose boards were composed of local business leaders who had an interest in providing high quality at low cost.
3. The boards of the two hospitals issued formal assurances to the community that the purpose of the merger was to reduce costs and then pass the savings along to consumers.

4. The merger would most likely temper the growing influence of managed care organizations, stabilize managed care rates, and reduce cost shifting.
5. The merger would help to avoid a "medical arms race" through significant efficiencies and avoidance of capital expenditures.

The *Butterworth* court concluded:

> Permitting defendant hospitals to achieve the efficiencies of scale that would clearly result from the proposed merger would enable the board of directors of the combined entity to continue the quest for establishment of world-class health facilities in West Michigan, a course [that] the Court finds clearly and unequivocally would ultimately be in the best interests of the consuming public as a whole.

After *Butterworth*, which was decided in 1996, hospital antitrust enforcement seemed to fall off the government's radar screen. But healthcare-related antitrust enforcement remains a distinct possibility for such targets as health insurers, pharmaceutical companies, and physician practices, and it is conceivable that the government will conduct retrospective reviews to determine the actual effects of some mergers in concentrated markets. (Note that analyses like the one in *Butterworth* are predictive only.) Other courts have given not-for-profit hospitals the benefit of the doubt in merger cases. In *Federal Trade Commission v. Freeman Hospital*,[81] both the district court and the court of appeals upheld the merger of the two smallest of three hospitals in Joplin, Missouri. (The largest hospital had 331 beds, and the other two had 158 and 96, respectively.) In denying the FTC's challenge to the combination, the trial court judge wrote:

> [A] private, nonprofit hospital that is sponsored and directed by the local community is similar to a consumer cooperative. It is highly unlikely that a cooperative will arbitrarily raise its prices merely to earn higher profits because the owners of such an organization are also its consumers.[82]

Other factors, of course, contributed to the final result, but the deference given to the hospitals' not-for-profit status is noteworthy.

The same year a district court refused to enjoin the merger of the only two hospitals in Dubuque, Iowa.[83] Although the case turned primarily on the judge's rather generous market definition, and did not accord any special significance to not-for-profit status in and of itself, the court did note that the hospitals' board members "are serious about obtaining optimum efficiencies from the merger and will do everything within their power to achieve all the potential efficiencies that may result…."[84] In addition, the court found that

the board members "have only the highest motives in proposing this merger. It is clearly their intent to provide high quality and efficient health-care to the Dubuque community."[85]

In 1996 the DOJ and the FTC issued a policy paper entitled "Statements of Antitrust Enforcement Policy in Health Care." "Statements" recognized the relevance of efficiency and economy of scale in hospital mergers and established nine "safety zones" that "describe conduct that the agencies will not challenge under the antitrust laws, absent extraordinary circumstances."[86] These safety zones are as follows:

1. mergers involving a small hospital;
2. joint ventures for expensive or high-tech equipment;
3. joint ventures to provide specialized services;
4. efforts to provide medical data;
5. arrangements to provide fee information to purchasers of health services;
6. surveys regarding prices, wages, salaries, and benefits;
7. joint purchasing arrangements;
8. exclusive and nonexclusive physician network joint ventures; and
9. multiprovider network arrangements.

Under the last category, "Statements" declares:

> In accord with general antitrust principles, multiprovider networks will be evaluated under the rule of reason, and will not be viewed as per se illegal, if the providers' integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements (or other agreements that would otherwise be per se illegal) by the network providers are reasonably necessary to realize those efficiencies.[87]

The safety zones are narrowly drawn so that they will not foreclose agency action unnecessarily. (For example, the hospital-merger safety zone only applies to mergers of two hospitals where one has fewer than 100 beds and an average census of fewer than 40 patients.) But the authors of "Statements" are careful to note, "[t]he inclusion of certain conduct within the antitrust safety zones does not imply that conduct falling outside the safety zones is likely to be challenged."[88]

Future Expectations

The trends in healthcare antitrust enforcement that began in the mid-1990s are expected to continue. Mergers, consolidations, acquisitions, divestitures, network integration, new structures for care delivery, and other activities hardly yet imagined will continue to occur in response to various social and economic pressures. As the healthcare field evolves, it will

remain under the close scrutiny of federal and state agencies charged with antitrust enforcement.

As discussed, the federal antitrust agencies recognize that healthcare is somewhat different from other industries. Nevertheless, the basic premise of the antitrust laws—that competition is to be encouraged—remains the government's mantra. Healthcare executives must be constantly aware of the possible pitfalls and must be willing to seek competent antitrust counsel as developments occur.

Indeed, in October 2005, after a retrospective review of a merger that occurred five years earlier, an administrative law judge ordered the divestiture of one of the hospitals involved in the transaction because, in his opinion, it "substantially lessened competition" and raised prices for insurers and consumers in the defined market.[89] Although the case is now on appeal, the fact that it was based on real-life experience rather than the opinions of economic oracles is significant. The victory it represents for governmental regulators could augur for more retrospective reviews of hospital mergers in the years to come.

Chapter Summary

Chapter 11 reviews the basic concepts of antitrust law, including laws against restraints of trade, monopolization, and price discrimination. It distinguishes between per se violations of the Sherman Act (division of markets, price fixing, group boycotts, and typing arrangements). It then shows how cases that do not fit one of those violation categories are decided on a rule-of-reason analysis specific to the anticompetitive effects of each set of facts. There are a few exemptions from the antitrust laws, including implied repeal, state action, the Noerr-Pennington doctrine, and one relating to the business of insurance. Also, the chapter gives some consideration to how markets are determined. The chapter concludes with a discussion of what to expect in the coming years now that the government has lost a string of recent merger cases.

Chapter Discussion Questions

1. Name and describe the per se violations of antitrust law.
2. Define "rule of reason."
3. In today's economy, give examples of intrastate commerce (business that is not in interstate commerce and does not affect it).
4. How would you define the geographic and product markets of large healthcare organizations such as the Mayo Clinic, the Cleveland Clinic, and Johns Hopkins?

Notes

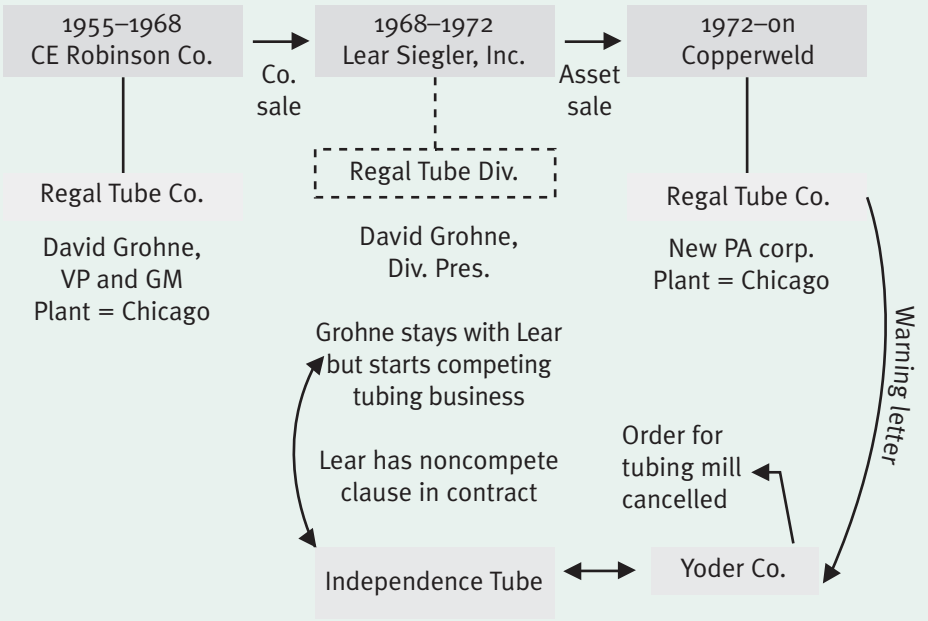
1. 15 U.S.C. § 1.
2. 421 U.S. 773 (1975). See also Boddicker v. Arizona State Dental Ass'n, 549 F.2d 626 (9th Cir. 1977), cert. denied, 434 U.S. 825 (1978); American Medical Ass'n v. Federal Trade Comm'n, 638 F.2d 443 (2d Cir. 1980).
3. 15 U.S.C. § 2.
4. United States v. Colgate & Co., 250 U.S. 300 (1919).
5. Copperweld Corp. v. Independence Tube Co., 467 U.S. 752 (1984).
6. Id. at 775.
7. Theatre Enterprises v. Paramount Film Distributing Corp., 346 U.S. 537 (1954).
8. United States v. Container Corp., 393 U.S. 333 (1969).
9. 15 U.S.C. § 2.
10. United States v. Grinnell Corp., 384 U.S. 563, 570–71 (1966).
11. 15 U.S.C. § 17.
12. 15 U.S.C. § 13(a).
13. 425 U.S. 1 (1976).
14. Id. at 14.
15. Id. at 14–17.
16. Id. at 15, 17–18.
17. 15 U.S.C. § 14.
18. 15 U.S.C. § 18.
19. 898 F.2d 1278 (1990).
20. See, for example, Federal Trade Commission v. University Health, Inc., 938 F.2d 206 (11th Cir. 1991).
21. 15 U.S.C. § 45(a)(1).
22. See, for example, Heart of Atlanta Motel, Inc. v. United States, 379 U.S. 241 (1964) in which the Court wrote: "If it is interstate commerce that feels the pinch, it does not matter how [local is] the operation which applies the squeeze." Id. at 258, quoting United States v. Women's Sportswear Mfrs. Assn., 336 U.S. 460, 464 (1949).
23. 425 U.S. 738 (1976), reversing and remanding, 511 F.2d 678 (4th Cir. 1975). As noted in the chapter, the Sherman Act prohibits "[e]very contract, combination...or conspiracy, in restraint of trade or commerce among the several States." 15 U.S.C. § 1. The act also forbids the monopolizing of "any part of the trade or commerce among the several States." 15 U.S.C. § 2.
24. 425 U.S. at 744.
25. Id. at 746–47
26. 15 U.S.C. §§ 1011–1015.
27. 15 U.S.C. § 1013(b).
28. 452 U.S. 378 (1981).
29. 317 U.S. 341 (1943).
30. Id. at 350.
31. 428 U.S. 579 (1975).
32. Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc., 365 U.S. 127 (1961). See also United Mine Workers v. Pennington, 381 U.S. 657 (1965).
33. California Motor Trans. Co. v. Trucking Unlimited, 404 U.S. 508 (1972).
34. United States v. South-Eastern Underwriters Ass'n., 322 U.S. 533 (1944).
35. 15 U.S.C. §§ 1011–1015
36. 15 U.S.C. § 1013(b).
37. 440 U.S. 205 (1979).
38. Id. at 221.
39. 29 U.S.C. §§ 151–169.
40. 1982-2 Trade Cas. (CCH) ¶ 64,801 (E.D. Mich. 1982).
41. 15 U.S.C. §§ 1–7.

42. 15 U.S.C. § 16(b).
43. 15 U.S.C. § 18a(g).
44. 15 U.S.C. § 15(a).
45. 15 U.S.C. §§ 12–27.
46. 15 U.S.C. §§ 45(1)–(m), 50.
47. 15 U.S.C. § 46.
48. Northern Pac. Ry. Co. v. United States, 56 U.S. 1, 5 (1958) (emphasis supplied, citations omitted).
49. Hyde v. United States, 225 U.S. 347 (1912).
50. See, for example, FTC v. Freeman Hospital, 911 F. Supp. 1213 (W.D. Mo.), aff'd 69 F.3d 260 (8th Cir. 1995); United States v. Mercy Health Services, 902 F. Supp. 968 (N.D. Iowa 1995); United States v. Carilion Health System, 707 F. Supp. 840 (W.D. Va. 1989), aff'd 892 F.2d 1042 (1989).
51. 946 F. Supp. 1285 (1996).
52. 15 U.S.C. § 18.
53. 15 U.S.C. § 1, 2.
54. 15 U.S.C. § 45.
55. 15 U.S.C. § 2.
56. United States v. Grinnell Corp., 384 U.S. 563, 571 (1966).
57. Berkey Photo, Inc. v. Eastman Kodak Co., 603 F.2d 263 (2d Cir. 1979)—there is no duty to disclose the introduction of new products in advance; ILC Peripherals Leasing Corp. v. International Business Mach. Corp., 458 F. Supp. 423 (N.D. Cal. 1978)—defendant's introduction of new technology at lower prices does not constitute monopolization.
58. 15 U.S.C. § 18.
59. 15 U.S.C. § 18.
60. United States v. American Bldg. Maint. Indus., 422 U.S. 271 (1975).
61. United States v. E.I. du Pont de Nemours Co., 351 U.S. 377 (1956). 122. 707 F. Supp. 840 (W.D. Va. 1989), aff'd. 892 F.2d 1041 (4th Cir. 1989). 123. 898 F.2d 1278 (7th Cir. 1990). 124.
62. 707 F. Supp. 840 (W.D. Va. 1989), aff'd 892 F.2d 1041 (4th Cir. 1989).
63. 898 F.2d 1278 (7th Cir. 1990).
64. The court used kidney transplant, mastectomy, stroke, heart attack, and gunshot wounds as examples of the point. "If you need your hip replaced, you can't decide to have chemotherapy instead because it's available on an outpatient basis at a lower price," the opinion states.
65. Greany, "Night Landings on an Aircraft Carrier: Hospital Mergers and the Antitrust Laws," 23 *Am. J. L. & Med.* 191 (1977). The author's thesis is that "courts deciding hospital merger cases are asked to make exceedingly fine-tuned appraisals of complex economic relationships." Id. at 192.
66. 15 U.S.C. § 18.
67. United States v. E.I. du Pont de Nemours Co., 353 U.S. 586 (1957)—defendant's ownership of 23 percent of stock in General Motors Corp. could be challenged 35 years after the acquisition.
68. Merger Guidelines of Department of Justice—1982, Trade Reg. Reg. (CCH) § 4500 (Aug. 9, 1982), revised and clarified in 1984 Guidelines, Trade Reg. Rep. (CCH) § 4490 (Dec. 17, 1984).
69. United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 322 (1963).
70. Fruehauf Corp. v. F.T.C., 603 F.2d 345, 352–54 (1979).
71. Ford Motor Co. v. United States, 405 U.S. 562 (1972).
72. Federal Trade Comm'n v. Procter and Gamble, Inc., 386 U.S. 568, 578 (1967). Although P&G did not manufacture household bleach, its purchase of Clorox (which already had about a 50 percent market share) gave it enough clout to have an anticompetitive effect on the market for that product. It also meant that P&G would not decide to enter the market as a new bleach manufacturer. The case probably would have produced a different result had Clorox been a relatively minor producer.
73. United States v. Penn-Olin Chem. Co., 378 U.S. 158 (1964).

74. 15 U.S.C. § 18a.
75. United States v. General Dynamics Corp., 415 U.S. 486 (1974).
76. Citizen Publishing Co. v. United States, 394 U.S. 131 (1969); International Shoe Co. v. F.T.C., 280 U.S. 291 (1930); Merger Guidelines of Department of Justice—1984, Trade Reg. Rep. (CCH) § 4490 (Dec. 17, 1984).
77. United States v. General Dynamics Corp., 415 U.S. 486.
78. 15 U.S.C. § 18 (1982).
79. F.T.C. v. Procter & Gamble Co., 386 U.S 568 (1967); United States v. Philadelphia Nat'l Bank, 374 U.S 321 (1963).
80. 946 F. Supp. 1285 (W.D. Mich. 1996).
81. 911 F. Supp. 1213 (W.D. Mo. 1995), aff'd. 69 F.3d 260 (8th Cir. 1995).
82. 911 F. Supp. at 1222.
83. U.S. v. Mercy Health Services, 902 F. Supp. 968 (N.D. Iowa 1995).
84. 902 F. Supp. at 988.
85. 902 F. Supp. at 989. The court added, however, "[T]he fact remains that for antitrust analysis, the court must assume that new and different Board members can take control of the corporation, and that if there is the potential for anticompetitive behavior, there is nothing inherent in the structure of the corporate board or the non-profit status of the hospitals which would operate to stop any anticompetitive behavior." Id. See also, U.S. v. Long Island Jewish Medical Center, 983 F. Supp. 121 (E.D.N.Y. 1997)—holding that the not-for-profit status of the merging hospitals does not provide exemption from antitrust law but can be considered as a factor if supported by other evidence.
86. Reprinted in 4 Trade Reg. Rep. (CCH) § 13,153 (Sep. 5, 1996). Documents such as these are also accessible on the Internet at www.usdoj.gov or www.ftc.gov.
87. Id.
88. Id.
89. In Re Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc., FTC Docket No. 9315.

THE COURT DECIDES

[Copperweld *involves complicated facts but a relatively simple legal conclusion: the coordinated acts of a parent company and its wholly owned subsidiary do not amount to a "combination or conspiracy" under the Sherman Act. The opinion reproduced here has been rather extensively excerpted, and my chart of the factual situation—on which facts the decision firmly rests—is given to aid your understanding. As you read the opinion, consider how* Copperweld *might apply to the corporate healthcare scene. The facts are displayed in the following graphic.]*



Copperweld Corp. v. Independence Tube Corp.
467 U.S. 752 (1984)

Burger, C. J.

We granted certiorari to determine whether a parent corporation and its wholly owned subsidiary are legally capable of conspiring with each other under § 1 of the Sherman Act.

I

A

The predecessor to petitioner Regal Tube Co. was established in Chicago in 1955 to manufacture structural steel tubing.... From 1955 to 1968 it remained a wholly owned subsidiary of C. E. Robinson Co. In 1968 Lear Siegler, Inc., purchased Regal Tube Co. and operated it as an unincorporated division. David Grohne, who had previously served as vice president and general manager of Regal, became president of the division after the acquisition.

In 1972 petitioner Copperweld Corp. purchased the Regal division from Lear

Siegler; the sale agreement bound Lear Siegler and its subsidiaries not to compete with Regal in the United States for five years. Copperweld then transferred Regal's assets to a newly formed, wholly owned Pennsylvania corporation, petitioner Regal Tube Co. The new subsidiary continued to conduct its manufacturing operations in Chicago but shared Copperweld's corporate headquarters in Pittsburgh.

Shortly before Copperweld acquired Regal, David Grohne accepted a job as a corporate officer of Lear Siegler. After the acquisition, while continuing to work for Lear Siegler, Grohne set out to establish his own steel tubing business to compete in the same market as Regal. In May 1972 he formed respondent Independence Tube Corp., which soon secured an offer from the Yoder Co. to supply a tubing mill. In December 1972 respondent gave Yoder a purchase order to have a mill ready by the end of December 1973.

When executives at Regal and Copperweld learned of Grohne's plans, they initially hoped that Lear Siegler's noncompetition agreement would thwart the new competitor. Although their lawyer advised them that Grohne was not bound by the agreement, he did suggest that petitioners might obtain an injunction against Grohne's activities if he made use of any technical information or trade secrets belonging to Regal. The legal opinion was given to Regal and Copperweld along with a letter to be sent to anyone with whom Grohne attempted to deal. The letter warned that Copperweld would be "greatly concerned if [Grohne] contemplates entering the structural tube market...in competition with Regal Tube" and promised to take "any and all steps which are necessary to protect our rights under the terms of our purchase agreement and to protect the know-how, trade secrets, etc., which we purchased from Lear Siegler."

When Yoder accepted respondent's order for a tubing mill on February 19, 1973, Copperweld sent Yoder one of these letters; two days later Yoder voided its acceptance. After respondent's efforts to resurrect the deal failed, respondent arranged to have a mill supplied by another company, which performed its agreement even though it too received a warning letter from Copperweld. Respondent began operations on September 13, 1974, nine months later than it could have if Yoder had supplied the mill when originally agreed....

B

In 1976 respondent filed this action in the District Court against petitioners and Yoder. The jury found that Copperweld and Regal had conspired to violate [the Sherman Act] but that Yoder was not part of the conspiracy. It also found that Copperweld, but not Regal, had interfered with respondent's contractual relationship with Yoder...and that Yoder had breached its contract to supply a tubing mill.

...The jury then awarded $2,499,009 against petitioners on the antitrust claim, which was trebled to $7,497,027. It awarded $15,000 against Regal alone on the contractual interference [and a slander count]. The court also awarded attorney's fees and costs after denying petitioners' motions for judgment n.o.v. and for a new trial.

C

The United States Court of Appeals for the Seventh Circuit affirmed. It noted that the exoneration of Yoder from antitrust liability left a parent corporation and its wholly owned subsidiary as the only parties to the § 1 conspiracy. The court questioned the wisdom of subjecting an "intra-enterprise" conspiracy to antitrust liability, when the same conduct by a corporation and an unincorporated division would

escape liability for lack of the requisite two legal persons. However, relying on [a previous decision], the Court of Appeals held that liability was appropriate "when there is enough separation between the two entities to make treating them as two independent actors sensible."...

We granted certiorari to reexamine the intra-enterprise conspiracy doctrine, and we reverse.

II

Review of this case calls directly into question whether the coordinated acts of a parent and its wholly owned subsidiary can, in the legal sense contemplated by § 1 of the Sherman Act, constitute a combination or conspiracy. The so-called "intra-enterprise conspiracy" doctrine provides that § 1 liability is not foreclosed merely because a parent and its subsidiary are subject to common ownership. The doctrine derives from declarations in several of this Court's opinions.

In no case has the Court considered the merits of the intra-enterprise conspiracy doctrine in depth....

The problem began with United States v. Yellow Cab Co. *[In that case, after acquiring or merging with other taxicab companies, one company controlled taxi operations in four cities. Thus, that opinion stated, the Sherman Act was violated because an unreasonable restraint "may result as readily from a conspiracy among those who are affiliated or integrated under common ownership as from a conspiracy among those who are otherwise independent.... The corporate interrelationships of the conspirators, in other words, are not determinative of the applicability of the Sherman Act." Thus, the Yellow Cab opinion continues, "the common ownership and control of the various corporate appellees are impotent to liberate the alleged combination and conspiracy from the impact of the Act."]*

It is the [above-quoted] language that later breathed life into the intra-enterprise conspiracy doctrine. The passage as a whole, however, more accurately stands for a quite different proposition. It has long been clear that a pattern of acquisitions may itself create a combination illegal under § 1, especially when an original anticompetitive purpose is evident from the affiliated corporations' subsequent conduct.... In Yellow Cab, the affiliation of the defendants was irrelevant because the original acquisitions were themselves illegal. An affiliation "flowing from an illegal conspiracy" would not avert sanctions. Common ownership and control were irrelevant because restraint of trade was "the primary object of the combination," which was created in a "deliberate, calculated" manner. Other language in the opinion is to the same effect.

....

In short, while this Court has previously seemed to acquiesce in the intra-enterprise conspiracy doctrine, it has never explored or analyzed in detail the justifications for such a rule; the doctrine has played only a relatively minor role in the Court's Sherman Act holdings.

III

...The central criticism is that the doctrine gives undue significance to the fact that a subsidiary is separately incorporated and thereby treats as the concerted activity of two entities what is really unilateral behavior flowing from decisions of a single enterprise.

We limit our inquiry to the narrow issue squarely presented: whether a parent and its wholly owned subsidiary are capable of conspiring in violation of § 1 of the Sherman Act. We do not consider under what circumstances, if any, a parent may be liable for conspiring with an affiliated corporation it does not completely own.

A

The Sherman Act contains a "basic distinction between concerted and independent action." The conduct of a single firm is governed by § 2 alone and is unlawful only when it threatens [or achieves] actual monopolization. It is not enough that a single firm appears to "restrain trade" unreasonably, for even a vigorous competitor may leave that impression. For instance, an efficient firm may capture unsatisfied customers from an inefficient rival, whose own ability to compete may suffer as a result. This is the rule of the marketplace and is precisely the sort of competition that promotes the consumer interests that the Sherman Act aims to foster.... Congress authorized Sherman Act scrutiny of single firms only when they pose a danger of monopolization....

Section 1 of the Sherman Act, in contrast, reaches unreasonable restraints of trade effected by a "contract, combination *** or conspiracy" between separate entities. It does not reach conduct that is "wholly unilateral." Concerted activity subject to § 1 is judged more sternly than unilateral activity under § 2. Certain agreements, such as horizontal price fixing and market allocation, are thought so inherently anticompetitive that each is illegal per se without inquiry into the harm [the agreement] has actually caused. Other combinations, such as mergers, joint ventures, and various vertical agreements, hold the promise of increasing a firm's efficiency and enabling it to compete more effectively. Accordingly, such combinations are judged under a rule of reason, an inquiry into market power and market structure designed to assess the combination's actual effect. Whatever form the inquiry takes, however, it is not necessary to prove that concerted activity threatens monopolization.

The reason Congress treated concerted behavior more strictly than unilateral behavior is readily appreciated. Concerted activity inherently is fraught with anticompetitive risk. It deprives the marketplace of the independent centers of decision making that competition assumes and demands. In any conspiracy, two or more entities that previously pursued their own interests separately are combining to act as one for their common benefit. This not only reduces the diverse directions in which economic power is aimed but suddenly increases the economic power moving in one particular direction. Of course, such merging of resources may well lead to efficiencies that benefit consumers, but their anticompetitive potential is sufficient to warrant scrutiny even in the absence of incipient monopoly.

B

The distinction between unilateral and concerted conduct is necessary for a proper understanding of the terms "contract, combination...or conspiracy" in § 1. Nothing in the literal meaning of those terms excludes coordinated conduct among officers or employees of the same company. But it is perfectly plain that an internal "agreement" to implement a single, unitary firm's policies does not raise the antitrust dangers that § 1 was designed to police. The officers of a single firm are not separate economic actors pursuing separate economic interests, so agreements among them do not suddenly bring together economic power that was previously pursuing divergent goals. Coordination within a firm is as likely to result from an effort to compete as from an effort to stifle competition. In the marketplace, such coordination may be necessary if a business enterprise is to compete effectively. For these reasons, officers or employees of the same firm do not provide

the plurality of actors imperative for a § 1 conspiracy.

There is also general agreement that § 1 is not violated by the internally coordinated conduct of a corporation and one of its unincorporated divisions. ...[T]here can be little doubt that the operation of a corporate enterprise organized into divisions must be judged as the conduct of a single actor....

Indeed, a rule that punished coordinated conduct simply because a corporation delegated certain responsibilities to autonomous units might well discourage corporations from creating division with their presumed benefits. This would serve no useful antitrust purpose but could well deprive consumers of the efficiencies that decentralized management may bring.

C

For similar reasons, the coordinated activity of a parent and its wholly owned subsidiary must be viewed as that of a single enterprise for purposes of § 1 of the Sherman Act. A parent and its wholly owned subsidiary have a complete unity of interest. Their objectives are common, not disparate; their general corporate actions are guided or determined not by two separate corporate consciousnesses, but one. They are not unlike a multiple team of horses drawing a vehicle under the control of a single driver....

...[A] parent and a wholly owned subsidiary always have a "unity of purpose or a common design." They share a common purpose whether or not the parent keeps a tight rein over the subsidiary; the parent may assert full control at any moment if the subsidiary fails to act in the parent's best interests.

The intra-enterprise conspiracy doctrine looks to the form of an enterprise's structure and ignores the reality. Antitrust liability should not depend on whether a corporate subunit is organized as an unincorporated division or a wholly owned subsidiary....

If antitrust liability turned on the garb in which a corporate subunit was clothed, parent corporations would be encouraged to convert subsidiaries into unincorporated divisions.... Such an incentive serves no valid antitrust goals but merely deprives consumers and producers of the benefits that the subsidiary form may yield.

The error of treating a corporate division differently from a wholly owned subsidiary is readily seen from the facts of this case. Regal was operated as an unincorporated division of Lear Siegler for four years before it became a wholly owned subsidiary of Copperweld. Nothing in this record indicates any meaningful difference between Regal's operations as a division and its later operations as a separate corporation. Certainly nothing suggests that Regal was a greater threat to competition as a subsidiary of Copperweld than as a division of Lear Siegler....

D

[The Court points out that the demise of the "intra-enterprise conspiracy doctrine" leaves a gap in the Sherman Act's treatment of restraints of trade. That is, the anticompetitive effect of the Copperweld-Regal activities is the same whether the companies are thought of as one enterprise or two, yet unreasonable restraint of trade is prohibited by the Sherman Act only if caused by a contract, combination, or conspiracy between separate entities. The Court argues that this omission was intentional for at least two reasons: (1) to continue to scrutinize individual firms' actions for reasonableness "would threaten to discourage the competitive enthusiasm that the antitrust laws seek to promote"; and (2) "whatever the wisdom of the distinction, the Act's plain language leaves no doubt that Congress

made a purposeful choice to accord different treatment to unilateral and concerted action."]

The appropriate inquiry in this case, therefore, is not whether the coordinated conduct of a parent and its wholly owned subsidiary may ever have anticompetitive effects, as the dissent suggests. Nor is it whether the term "conspiracy" will bear a literal construction that includes parent corporations and their wholly owned subsidiaries.... Rather, the appropriate inquiry requires us to explain the logic underlying Congress' decision to exempt unilateral conduct from § 1 scrutiny, and to assess whether that logic similarly excludes the conduct of a parent and its wholly owned subsidiary. Unless we second-guess the judgment of Congress to limit § 1 to concerted conduct, we can only conclude that the coordinated behavior of a parent and its wholly owned subsidiary falls outside the reach of that provision.

...A corporation's initial acquisition of control will always be subject to scrutiny under § 1 of the Sherman Act and § 7 of the Clayton Act. Thereafter, the enterprise is fully subject to § 2 of the Sherman Act and § 5 of the Federal Trade Commission Act. That these statutes are adequate to control dangerous anticompetitive conduct is suggested by the fact that not a single holding of antitrust liability by this Court would today be different in the absence of an intra-enterprise conspiracy doctrine.... Elimination of the intra-enterprise conspiracy doctrine with respect to corporations and their wholly owned subsidiaries will therefore not cripple antitrust enforcement. It will simply eliminate treble damages from private state tort suits masquerading as antitrust actions.

IV

We hold that Copperweld and its wholly owned subsidiary Regal are incapable of conspiring with each other for purposes of § 1 of the Sherman Act. To the extent that prior decisions of this Court are to the contrary, they are disapproved and overruled. Accordingly, the judgment of the Court of Appeals is reversed.

It is so ordered.

Copperweld Corp. v. Independence Tube Corp. Discussion Questions

1. If asked, could you explain the facts of this case to someone else? (Without looking at the graphic, try explaining it to someone nearby.)
2. What would you say about Copperweld Corporation's rights? After all, it won the case but still has a competitor that it thought it was shielded from by the covenant not to compete.
3. Why is the covenant itself not a violation of the antitrust laws? (Or is it?)
4. Why can Copperweld assert against Independence Tube the noncompetition agreement when the agreement was with Lear Siegler and not with Independence Tube?
5. The Court makes a strong point that "Congress made a purposeful choice to accord different treatment to unilateral and concerted conduct." Can

you think of an area of criminal law in which a similar distinction is made? Do you agree that "concerted conduct" (joint action) should be treated differently? Why or why not?

6. What are the implications of *Copperweld* for healthcare organizations today? What would the implications be had the decision been different? (Exercise: do some research on the structure of the University of California's healthcare system. What are *Copperweld's* implications for the system's joint strategic and financial planning efforts on behalf of its numerous healthcare facilities?)

CHAPTER

12

FRAUD, ABUSE, AND CORPORATE COMPLIANCE PROGRAMS

After reading this chapter, you will

- understand the basics of federal laws relating to healthcare fraud and abuse and learn that the federal False Claims Act is the major enforcement mechanism against fraud in billing healthcare payers.
- be able to identify the most significant statutes relating to fraud and abuse in federal healthcare payment programs; all three kinds of statutes are complicated and sometimes difficult to interpret.
- know the terms "kickback" and "self-referral" and how they affect hospital operations and realize that antikickback and self-referral laws are also used to punish wrongdoers.
- recognize the benefits of maintaining an active corporate compliance program; these programs can be extremely effective in preventing violations or reducing sentences if malfeasance occurs.

Healthcare organizations must be sensitive to the potential for their employees to be involved in fraud, abuse, and other illicit conduct. They must work to maintain high ethical principles, not only because an image of moral respectability is "good for business" but also because it is, simply, the right thing to do.

This chapter discusses the enforcement climate in healthcare and the various laws aimed at curbing fraud and abuse. Also explored here is the role that corporate integrity programs play in promoting legal compliance and business ethics in a well-run healthcare organization.

Legal Brief

That as much as 10 percent of the annual healthcare cost could come from fraud, waste, or abuse is a rough estimate only. I believe the amount of intentional fraud being committed is considerably less than 10 percent, and lumping "waste and abuse" into the total is deceptive. Whatever the correct figure may be, it is clear that many billions of dollars are spent unnecessarily as a result of waste or outright fraud.

Enforcement Climate

The cost of healthcare continues to rise at an alarming rate. The latest data (2004) indicate that total healthcare spending is about $2 trillion (16 percent of the gross domestic product), and a government report ten years ago estimated that as much as 10 percent of that amount could be the result of fraud (intentional deception) or waste and abuse (unsound practices that result in increased costs)[1]; see Legal Brief.

Because the government is the largest single purchaser of healthcare services, eliminating fraud and abuse was once called the U.S. Department of Justice's (DOJ) number two law-enforcement priority, second only to violent crime.[2] (It is now perhaps number three, because the war on terror has taken ascendancy.) Ever more resources have been allocated to the enforcement activities of the DOJ, the United States Attorneys, the Federal Bureau of Investigation, the Office of Inspector General, and other agencies. In addition, state attorneys general conduct their own investigations and prosecutions, often working closely with federal officials. Private citizens who have firsthand knowledge of fraud are even permitted to sue for the government and collect a percentage of the proceeds recovered, if any.

Verdicts and settlements in civil fraud cases can sometimes be for hundreds of millions of dollars (see Table 12.1), and offenders who are prosecuted for criminal offenses can receive massive fines and lengthy jail terms. One example of the severity of the penalties is *United States v. Lorenzo*,[3] in

TABLE 12.1 Examples of Successful Healthcare Qui Tam (Whistle-Blower) Lawsuits

Defendant's Name	Allegation	Settlement
TAP Pharmaceuticals	Illegal kickbacks	$875 million
HCA, Inc.	False claims	$631 million
National Health Labs.	Billing for unnecessary tests	$110 million
Lovelace Health Systems	False claims in cost reports	$24.5 million
SmithKline Beecham Labs.	Billing for unnecessary lab tests	$13 million
Beverly Enterprises	Durable med. equipment fraud	$20 million

which a dentist billed Medicare for "consultations" on nursing home residents. Although Medicare does not cover dental services or routine physicals, Dr. Lorenzo billed the government for his cancer-related examination of each patient's oral cavity, head, and neck, all of which is standard dental practice. The government proved that Dr. Lorenzo had submitted 3,683 false claims, resulting in overpayment of $130,719.20. The court assessed damages of nearly $19 million, almost 150 times the amount of the overpayment.

A second example is *United States v. Krizek*.[4] Among other things, Dr. Krizek, a psychiatrist, charged the government for a full session (45 to 50 minutes) regardless of whether he spent 20 minutes or two hours with a patient. He argued that in practice the time evened out and the government was not harmed. In one instance, however, it was shown that he submitted 23 claims for full sessions in a single day. Dr. Krizek was fined $157,000 and assessed $11,000 in court costs.[5] Other examples include criminal convictions and civil fines of more than $100 million each levied against Caremark International, Corning (Damon) Laboratories, Roche Laboratories, and National Medical Enterprises ($379 million) and a settlement in excess of $30 million with the University of Pennsylvania. In the largest settlement to-date, Columbia/HCA paid approximately $850 million.

In such a volatile climate, it is little wonder that in the late 1990s prevention of fraud and abuse became a serious topic for healthcare executives, and it will continue to be viewed seriously in the foreseeable future. A basic understanding of the major criminal and civil fraud statutes is therefore essential. Some of the most obvious types of healthcare fraud and abuse are as follows:

- filing claims for services that were not rendered or were not medically necessary;
- misrepresenting the time, location, frequency, duration, or provider of services;
- upcoding—assigning a higher payment than the procedure or diagnosis warrants;
- unbundling—the practice of billing as separate items the services that are actually performed as a battery of services, such as laboratory tests;
- violation of the "three-day rule"—the rule stating that outpatient diagnostic procedures performed on any of the three days before hospitalization are deemed to be part of the Medicare diagnosis-related group payment and are not to be billed separately;
- payment of "kickbacks" to induce referrals or the purchase of goods or services;
- billing for services said to have been "incident to" a physician's services but that in fact were not provided under the physician's direct supervision; and
- self-referral—the practice of physicians referring patients for services to entities in which they have a financial interest.

The major statutes that these kinds of activities may violate include the civil and criminal False Claims Act, the antikickback law, and the Stark self-referral laws. Depending on the facts of the case, mail- and wire-fraud statutes; the Racketeer Influenced and Corrupt Organizations Act; money-laundering statutes; and laws relating to theft, embezzlement, bribery, conspiracy, obstruction of justice, and similar matters may also be implicated. This chapter focuses on the major healthcare fraud statutes and does not address the kinds of laws noted in the previous sentence. Readers should be aware, however, that myriad legal standards (both state and federal) apply to healthcare organizations. The importance of competent legal counsel and a process to prevent criminal activity cannot be overemphasized.

False Claims Act

The major weapon in the federal government's arsenal in the "war" on fraud and abuse is the civil False Claims Act (FCA).[6] The federal statute provides that a person is liable for penalties if he

- "knowingly presents, or causes to be presented, to an officer or employee of the United States a false or fraudulent claim for payment or approval";
- "knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government";
- "conspires to defraud the Government by getting a false or fraudulent claim allowed or paid"; or
- "knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government." (This last provision was added in 1986 to deal with "reverse false claims," situations in which a person attempts to avoid paying money owed to the government.)

Most states have similar laws. Violations of the federal law result in penalties ranging from $5,000 to $10,000 per claim plus three times the amount of damages sustained by the government, if any. The costs of bringing the action are charged to the defendant. If the claim was false, penalties and costs can be assessed even if the claim was not paid and the government suffered no damages.[7]

Interestingly the FCA was enacted during the Civil War to stem the practice of certain persons to overcharge the Union Army for goods and services. Apparently what a "claim" is was better known then than it is now because the term is not defined in the statute. In healthcare, however, what

amounts to a "claim" has been a matter of some dispute. For example, each procedure code on a billing form could be considered a separate claim. Therefore, each false code could result in up to $10,000 in penalties. Twenty false CPT codes would, by this line of reasoning, allow a penalty of up to $200,000 to be assessed, plus damages and court costs. This issue was addressed in the appeal of *Krizek*, in which the U.S. Court of Appeals for the D.C. Circuit held that each billing form was one claim irrespective of the number of false codes contained on it. The court felt that the form was merely one request for payment of the sum total it represented.[8] This result seems logical, and it is consistent with other cases defining a claim as "a demand for money or for some transfer of public property."[9]

Another interesting question is, what kind of intent is required for the statute to be violated? As pointed out in the aforementioned list, the defendant's acts must have been done knowingly to constitute an offense. First-year law students are painfully aware of the kind of Socratic dialog that could attend the issue of what "knowingly" means; here is an example:

> *Professor Miller:* Mr. Showalter, what if I sign a claim form, put it in a stamped envelope, and mail it to Medicare. Have I knowingly submitted that claim?
>
> *Student Showalter:* Um…I guess so. Unless you were drunk or mentally incompetent, you knew what you were doing. You were mailing in the claim form and expecting to get paid.
>
> *Professor Miller:* How much did I expect to get paid?
>
> *Student Showalter:* Whatever amount is on the form.
>
> *Professor Miller:* What if I didn't look at the amount but just signed a bunch of forms my staff gave me at the end of the day? And what if those forms had errors on them?
>
> *Student Showalter:* Well….
>
> *Professor Miller:* Well, what? Are those false claims? The ones that have errors on them, I mean?
>
> *Student Showalter:* Uh…. Well, they're erroneous. But if you didn't know they had errors and just assumed that your staff were doing their jobs correctly….
>
> *Professor Miller:* Assumed!? Is that the kind of thing I should assume?
>
> *Student Showalter:* Uh….
>
> *Professor Miller:* Okay, let me put to you another case. Let us suppose that I know there are occasional errors on our claims—some over, some under—but I think that at the end of the year they will all balance out, sort of the "no harm, no foul" kind of approach to billing. And suppose I think that the

> False Claims Act only applies to *intentionally* overbilling the government, which I haven't done. What do you say now?
>
> *Student Showalter* [musing]: Hmm! You knew you were submitting a bill, but you didn't know that the particular bill was wrong, and you didn't know that submitting incorrect bills is illegal when you should have had a system in place to check them for errors. Good question!

And so this dialog goes for 10 or 15 uncomfortable minutes.

In legal circles this issue is known as one of scienter—knowledge by a defendant that her acts were illegal or her statements were lies. In 1986, Congress addressed this question by amending the FCA to say that "no proof of specific intent to defraud is required" and that "knowingly" with respect to a claim means either (a) actual knowledge of its falsity, (b) deliberate ignorance of its truth or falsity, or (c) reckless disregard of its truth or falsity.[10] As stated in the committee report accompanying the 1986 amendments,

> The Committee is firm in its intentions that the act not punish honest mistakes or incorrect claims submitted through mere negligence. But the Committee does believe the civil False Claims Act should recognize that those doing business with the Government have an obligation to make a limited inquiry to ensure the claims they submit are accurate.[11]

The *Krizek* case shows how this standard is used. Although Dr. Krizek was not personally involved in the billing process, the court found that he had submitted the claims "knowingly":

> These were not "mistakes" [or] merely negligent conduct. Under the statutory definition of "knowing" conduct, the court is compelled to conclude that the defendants acted with reckless disregard as to the truth or falsity of the submissions.[12]

This standard requires healthcare providers, and their top management and governing board members, to have mechanisms in place to verify the accuracy of their organization's claims. A further incentive to do so, as if one were needed, is the fact that the government may exclude from participation in the Medicare and Medicaid programs any individual (a) who has a direct or indirect ownership or control interest in a sanctioned entity and has acted in "deliberate ignorance" of the information or (b) who is an officer or managing employee of a convicted or excluded entity, irrespective of whether the individual participated in the offense.[13] Any excluded person who retains ownership or control or who continues as an officer or a managing employee may be fined $10,000 per day.[14] The threat of "exclusion"—the Medicare

and Medicaid programs' equivalent of the death penalty—and the potential for criminal convictions and massive fines have been major forces in the movement to adopt corporate compliance programs in healthcare organizations.

FCA cases are usually investigated by the Office of Inspector General and brought by a U.S. attorney or the DOJ itself. An unusual feature of the statute, however, allows private citizens to sue on their own behalf and on behalf of the government to recover damages and penalties. These qui tam (whistle-blower) lawsuits have become an important factor in FCA enforcement because, if successful, the plaintiff (a "relator" in legal parlance) can share in the amount of the award (see Table 12.1).

Any person with information about healthcare fraud can be a qui tam plaintiff, and "person" is defined to mean "any natural person, partnership, corporation, association, or other legal entity, including any State or political subdivision of a State."[15] The plaintiff must file the complaint, which is immediately sealed and thus not made public pending an investigation, and file a copy with the U.S. attorney general and the appropriate U.S. attorney. The government then has 60 days, plus extensions for good cause, in which to determine whether to pursue the case. If the government decides to take over the case, the relator will receive between 15 percent and 25 percent of the amount recovered. If the government declines to pursue the matter, the relator may still do so and, if successful, will receive up to 30 percent of the recovery.

From October 1, 1986 to September 31, 2005, the DOJ recouped more than $6.5 billion from Medicare-related qui tam cases, and whistle-blower plaintiffs received more than $1 billion of that amount (according to the organization Taxpayers Against Fraud). These figures include only those cases involving the DOJ itself; they do not include Medicare cases prosecuted by individual U.S. attorneys' offices or recoveries by the states in Medicaid claims.

The potential qui tam plaintiff must meet certain conditions to file suit. The plaintiff must be the first to file, there must not already be any governmental proceeding relating to the same facts, and the suit must not be based on matters that have been publicly disclosed (unless the relator is the "original source" of those disclosures). If these jurisdictional barriers are met and the facts of the case warrant recovery, the qui tam plaintiff can proceed to assist the government or pursue the case individually, often to significant financial advantage.

Federal law provides a remedy for whistle-blowers who are discharged, demoted, harassed, or otherwise discriminated against because of their having filed a qui tam case.[16] Given the financial incentives and the protection against employment-related retaliation, the qui tam lawsuit has become a popular and effective means of combating fraud and abuse.

Occasionally, qui tam plaintiffs have argued in healthcare-related cases that a claim involving a kickback or self-referral (described in more detail in

the following section) violates the FCA, even though the claim itself is not "false" on its face. The roots of such an argument can be traced to *United States ex rel. Marcus v. Hess*,[17] a World War II-vintage case in which a governmental contractor's claims were held to be false because the contract under which they were submitted was entered into as a result of collusion. Similarly, in *United States ex rel. Woodard v. Country View Care Center, Inc.*,[18] the defendants had submitted Medicare cost reports that included payments to "consultants" that were actually kickbacks. Not too surprisingly, because the defendant's reimbursement was based on the cost reports, the court held that the FCA applied. *United States v. Kensington Hospital*,[19] filed after the advent of the prospective payment system, brought a new twist to the argument. The defendants asserted that because their Medicaid reimbursement was a set amount, the government could not have suffered any loss, and the cost of the kickbacks did not make the claims false. Citing *Marcus* and other cases, the court disagreed, holding that the government was not required to show actual damages to prove an FCA violation.

In neither *Country View* nor *Kensington Hospital* did the plaintiffs specifically base their claim of FCA liability on the kickback or self-referral statute. Some subsequent cases, however, have done so and have survived initial scrutiny by the courts. For example, in *United States ex rel. Pogue v. American Healthcorp*,[20] a trial court refused to dismiss an FCA case based on violations of the kickback and Stark self-referral laws. The court agreed with the relator's contention that "participation in any federal program involves an implied certification that the participant will abide by and adhere to all statutes, rules, and regulations governing that program."[21] The court held in effect that Stark violations create prohibited financial relationships and that, therefore, the FCA applies.[22]

In summary, the proposition that an FCA case can be based solely on violation of the antikickback or self-referral laws seems to have gained some acceptance, but the ultimate resolution of the issue remains in doubt. Clearly, relators and the government will continue to make this argument until the point is conclusively established or rejected. In the meantime, it remains an ominous threat for healthcare organizations because the cost of litigating such cases is high and the potential exists for massive penalties. The resulting pressures to settle, rather than litigate, FCA cases may mean that the issue will remain unresolved for some time.[23]

In addition to the civil FCA, another provision of federal law makes false claims a criminal offense.[24] If convicted, an organization can be fined $500,000 or twice the amount of the false claim, whichever is greater. An individual can be fined the greater of $250,000 or twice the amount of the false claim and can be sentenced to up to five years in prison. The standards of proof are higher, of course, in criminal prosecutions than in civil cases. In a civil FCA action the standard is a "preponderance of the evidence." But in

a criminal FCA case the government must prove beyond a reasonable doubt that the defendant knew the claim was false. Therefore, and because the penalties in civil actions are already quite severe, criminal false-claims cases are brought less frequently than their civil counterparts.

Antikickback Statute

In 1972 concerned about the high cost of healthcare and the potential for overutilization of healthcare services, Congress prohibited any person to solicit, receive, offer, or pay any form of remuneration in return for or to induce referrals for healthcare goods or services for which Medicare or Medicaid would make payment.[25] Effective January 1, 1997, the statute was amended to cover payment by any federal healthcare program.[26] Violations of the antikickback law are felonies punishable by criminal fines of $25,000 per violation or imprisonment for up to five years, or both. In addition, the Office of Inspector General has the authority to exclude from Medicare and Medicaid programs those persons who have violated the act.[27] This action can be taken without criminal prosecution and using the more lenient "preponderance of the evidence" standard. Finally, a 1997 amendment provides for civil penalties of $50,000 per violation plus three times the amount of the remuneration involved, in addition to the possible criminal sanctions already noted.[28]

The statute contains numerous exceptions to the prohibition of remuneration to induce referrals.[29] The prohibition does not apply to the following:

- properly disclosed discounts that are reflected in the cost reports,
- amounts paid by an employer to an employee to provide healthcare services,
- certain amounts paid by a vendor to agents of a group purchasing entity,
- waivers of coinsurance for Public Health Service beneficiaries, and
- certain remuneration through a risk-sharing arrangement (e.g., under capitation).

In addition, a 1987 amendment required the U.S. Department of Health and Human Services to promulgate regulations "specifying those payment practices that will not be subject to criminal prosecution [or] provide a basis for exclusion…."[30] These regulations provide for certain "safe harbors"—categories of activities in which providers may engage without being subject to prosecution—but they are very technical and are interpreted quite narrowly. The safe harbors are as follows:

- fair market value leases for rental of space or equipment;
- fair market value contracts for personal services;

- purchase of physician practices;
- payments to referral services for patients, so long as the payment is not related to the number of referrals made;
- properly disclosed warranties;
- properly disclosed discounts that are contemporaneous with the original sale;
- bona fide employment relationships;
- discounts available to members of a group purchasing organization;
- waivers of coinsurance and deductibles for indigent persons;
- marketing incentives offered by health plans to enrollees; and
- price reductions offered by providers to health plans.

These regulations are quite technical, and an in-depth analysis of their provisions is beyond the scope of this chapter. Suffice to say that although the antikickback statute is one of the most important laws affecting healthcare today, it is also, unfortunately, one of the most complicated and ambiguous. Congress itself recognized this fact when it wrote in 1987: "[T]he breadth of the statutory language has created uncertainty among health care providers as to which commercial arrangements are legitimate, and which are proscribed."[31] Unfortunately, although the 1987 amendments that led to the safe harbors were intended to provide guidance and clarity, much uncertainty persists.

What Is a Referral?

The problem is illustrated by considering the meaning of the word "referral." Unfortunately, neither the statute nor its implementing regulations define the term, so we are left with considerable uncertainty regarding one of the statute's key terms. For example, is it a referral when one member of a multispecialty group practice sends a patient to another member of the same group? If the referring physician's compensation depends in part on the volume of services he orders from other group members, is he receiving referrals and is the group paying for referrals? These questions have not been answered because no enforcement action has been taken to-date regarding intragroup referrals, but a literal reading of the statute calls the practice into question. The creation of a group practice safe harbor under the Stark self-referral laws (discussed in the next section) seems to suggest that regulators believe a referral has occurred under those circumstances. After all, if it is not a referral, why have a safe harbor for it? Because intragroup referrals are not Stark violations, the government may refrain from taking enforcement action under the antikickback law for the same behavior. Whether this proves to be the case remains to be seen, of course.

A similar situation is involved when a medical group owns a hospital. Under traditional indemnity insurance plans, the physicians benefit financially if they admit patients to their own hospital, yet distribution of the hospital's prof-

its to the physician-owners would appear to violate the literal language of the statute. A proposed regulatory safe harbor for such situations was abandoned in 1993. Thus, the issue remains unresolved.

What Is Remuneration?

Hanlester Network v. Shalala illustrates what amounts to remuneration as an inducement for referrals.[32] In *Hanlester* physicians were limited partners in a network of three clinical laboratories, to which they referred their patients for laboratory work (see Figure 12.1). The laboratories contracted with Smith Kline BioScience Laboratories (SKBL) to manage the facilities for a fee of $15,000 per month or 80 percent of the laboratories' collections, whichever was greater. (As it turned out, the 80 percent figure was usually higher than the fixed monthly fee.) Because performing the tests at SKBL's own laboratories was more economical, 85 percent to 90 percent of the Hanlester labs' testing was done at SKBL. The Ninth Circuit held that even though the cash payments under the arrangement flowed from the Hanlester labs to SKBL, among other things, the arrangement was a scheme by which SKBL in effect had offered a 20 percent discount (the prohibited remuneration) for the physicians' referrals to the SKBL labs. (Note that today the arrangement would also violate self-referral laws.)

Although neither the statute nor the regulations defines remuneration, it is clear that the law reaches the provision of anything having a monetary value. The 20 percent "discount" in *Hanlester* is one example. Likewise, the provision of free goods or services has an economic value and would be prohibited.[33] Furthermore, there is no exception for remuneration of a minimal nature. In one case, a physician was excluded from the Medicare program for having received a kickback in the amount of $30.[34]

Beyond prohibiting payment of remuneration to induce referrals, the antikickback law prohibits payment of remuneration to induce or in return for

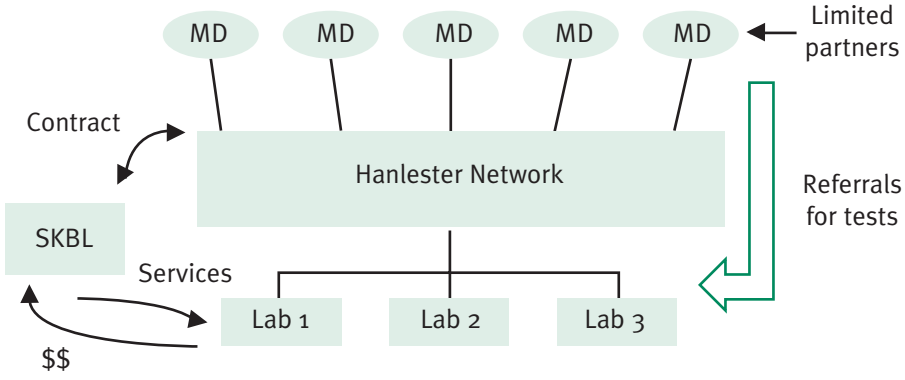


FIGURE 12.1
Hanlester Network Structure

"purchasing, leasing, or ordering of, or arranging for or recommending the purchasing, leasing, or ordering of, any good, facility, service, or item for which payment is made in whole or in part by a federal healthcare program."[35] For example, it would be illegal for a company that provides patient transportation to provide remuneration to the hospital employee who arranges for patient transportation to encourage that employee to choose that particular company. But is it illegal for a hospital or clinic to provide free transportation to patients who are otherwise unable to come to the facility? In *United States v. Recovery Management Corp. III*, a psychiatric hospital pleaded guilty to an antikickback violation after it gave patients free airfares to and from the hospital as an inducement to choose the facility.[36] This case illustrates the fact that the antikickback statute applies even where no literal "referral" per se is involved (the referral in this case being the patient's choice of the facility), and it applies to the provision of anything of value that induces patients or providers to purchase or order services.

The practice of waiving coinsurance and deductible amounts is similarly prohibited as an inducement for referrals, except in limited circumstances (such as in documented cases of financial need). The 1996 Health Insurance Portability and Accountability Act (HIPAA; the Kassebaum-Kennedy Act) added civil money penalties that can apply to any person who "offers...or transfers remuneration...that such person knows or should know is likely to influence [the recipient] to order or receive [goods or services] from a particular provider, practitioner or supplier...."[37] HIPAA defines remuneration to include

> the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term remuneration does not include—
>
> (A) the waiver of coinsurance and deductible amounts by a person if—
> (i) the waiver is not offered as part of any advertisement or solicitation;
> (ii) the person does not routinely waive coinsurance or deductible amounts; and
> (iii) the person–
> (I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need;
> (II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or
> (III) provides for any permissible waiver as specified in section 1128B(b)(3) [of the Social Security Act] or in regulations issued by the Secretary;
> (B) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers...; or

> (C) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated.[38]

Thus, the waiver of coinsurance and deductibles may be permissible in some cases that meet these criteria, but routinely waiving those amounts (especially if advertised in the hope of stimulating business) would appear to violate the antikickback statute as an inducement for referrals.

The Intent Issue

As noted earlier, Congress has provided that "no proof of specific intent to defraud is required" under the FCA. But what kind of intent is required when providing remuneration to induce referrals under the antikickback statute? Must the sole purpose of the remuneration be to induce Medicare and Medicaid referrals for it to be illegal? Or is it sufficient for the government to show that one of multiple purposes was to do so? This question was at the heart of *United States v. Greber* and *United States v. McClatchey* (see The Court Decides at the end of this chapter). In both cases, payments were made that had legitimate purposes but also could be viewed as being intended to induce referrals. In each case the court held that the statute was violated if one purpose was to induce referrals even if the remuneration was also given for other legitimate purposes.

"Stark" Self-Referral Laws

The Ethics in Patient Referrals Act (EPRA),[39] first enacted in 1989 and amended in 1993, was championed by Rep. Fortney "Pete" Stark of California. Its purpose, like that of the antikickback statute, is to discourage overuse of healthcare services and thus reduce the cost of Medicare and Medicaid programs. As stated by the Healthcare Financing Administration (HCFA, now the Centers for Medicare and Medicaid Services [CMS]):

> Congress enacted this law because it was concerned that many physicians were gaining significant financial advantages from the practice of referring their [Medicare and Medicaid] patients to providers of health care services with which they (or their immediate family members) had financial relationships. For example, if a physician owns a separate laboratory that performs laboratory tests for his or her patients and shares in the profits of that laboratory, the physician has an incentive to overuse laboratory services. Similarly, if a physician does not own any part of an entity but receives compensation from it for any reason, that compensation may be calculated in a manner that reflects the volume or value of referrals the physician makes to the entity.

> The reports of 10 studies in the professional literature, taken as a whole, demonstrate conclusively that the utilization rates of medical items and services generally increase when the ordering physician has a financial interest in the entity providing the item or service. These self-referrals generate enormous costs to the Medicare and Medicaid programs and jeopardize the health status of program beneficiaries.[40]

The provisions of the two eponymous "Stark" laws (usually referred to in the singular) are extremely complicated, and their application must be analyzed on a case-by-case basis. The law can, however, be summarized as follows.

In general, Stark prohibits a physician (a medical doctor, doctor of osteopathy, dentist, podiatrist, optometrist, or chiropractor) from referring Medicare or Medicaid patients for certain "designated health services" to entities with which the physician or an immediate family member has a financial relationship. "Financial relationship" is defined as a compensation arrangement or an ownership or investment interest, such as through equity or debt. If such a relationship exists, the physician may not, unless an exception applies, refer patients to the entity for the following kinds of services:

- clinical laboratory services;
- radiology services, including MRIs, CAT scans, and ultrasound;
- radiation therapy services and supplies;
- physical and occupational therapy services;
- durable medical equipment and supplies;
- parenteral and enteral nutrients, equipment, and supplies;
- prosthetics, orthotics, and prosthetic devices and supplies;
- outpatient prescription drugs;
- home health services;
- outpatient prescription drugs; and
- inpatient and outpatient hospital services.

Violations of the Stark law can result in various sanctions, including denial of payment for the services, an obligation to refund any payments made, civil money penalties of up to $15,000 for each illegal referral, and possible exclusion from Medicare and Medicaid programs. In addition, a physician or entity that enters into a scheme to bypass Stark can be fined up to $100,000 for each such arrangement and can be excluded from the programs. Stark also imposes an obligation on each entity that provides designated health services to report the names and identification numbers of all physicians who have a compensation arrangement or an ownership or investment interest in the entity to the Secretary of Health and Human Services. Failure to do so can result in a civil money penalty of up to $10,000 for each

day for which reporting was required. Unlike the antikickback law, which requires proof that the defendant acted "knowingly and willfully," making a prohibited referral is a per se violation of Stark and no proof of intent is required (see Legal Brief). The fact that a defendant acted in good faith or that she was unaware of the law is not a defense. The antikickback and Stark laws differ in one other respect: the former applies to anyone, whereas the latter applies only to physicians.

Legal Brief

The Stark laws apply only to physician referrals. Intent is irrelevant; thus, violations are automatic if the physician has a financial interest in the entity referred to.

The basic provisions of Stark are extremely broad and complex, as the government recognizes:

> The law is...complex because it attempts to accommodate the many complicated financial relationships that exist in the health care community. The prohibitions are based on the general principle that if a physician has a financial relationship with an entity that furnishes items or services, he or she cannot refer patients to the entity. However, the law provides numerous exceptions to this general principle, and it is the exceptions that contain the most detailed and complicated aspects of the law. The exceptions are complicated because they attempt to achieve a balance that allows physicians and providers to maintain some of their financial relationships, but within bounds that are designed to prevent the abuse of the Medicare and Medicaid programs or their patients.[41]

Statutory Exceptions

As the previous quotation shows, Congress provided for certain exceptions to the self-referral ban because without them the law's sweeping language would have made many legitimate, laudable, and even necessary arrangements illegal. For example, the law excepts referrals for services provided by other physicians in the same group practice and most in-office ancillary services furnished "personally by the referring physician, personally by a physician who is a member of the same group practice…or personally by individuals who are directly supervised by the physician or by another physician in the group practice...."[42] Such in-office ancillary services must, however, be billed by the physician or the group practice,[43] and they must be provided in the group's building or in another building used by the group for the centralized provision of such services.[44]

Likewise, because the financial incentive for self-referral does not exist with prepaid health plans (health maintenance organizations, for example), the statute does not apply when a physician refers members of such plans for designated health services.[45] It also does not apply to referrals for services

provided by a hospital in which the physician has an ownership or investment interest and at which the physician is authorized to perform services.[46] It is notable that physicians who are merely employed by a hospital rather than owners or investors cannot avail themselves of this exception; instead, a more detailed exception relating to employment relationships is provided later in the statute.[47]

In addition to the aforementioned exceptions, there are exceptions for certain kinds of financial relationships.[48] The financial relationships that will not trigger Stark can be summarized as follows:

- owning stocks or bonds in a large, publicly traded company or mutual fund;
- owning or investing in certain rural providers or hospitals in Puerto Rico;
- reasonable rent for office space or equipment;
- amounts paid under fair and bona fide employment relationships;
- reasonable payments for personal services provided to the entity or for other services unrelated to the provision of designated health services;
- compensation under a legitimate "physician incentive plan," such as by withholds, capitation, or bonuses in managed care;
- reasonable payments to induce a physician to relocate to the hospital's service area;
- isolated transactions, such as a one-time sale of property or a practice;
- an arrangement that began before December 19, 1989, in which services are provided by a physician group but are billed by the hospital; and
- reasonable payments by a physician for clinical laboratory services or for other items or services.

These exceptions to Stark are much more complicated than this simple list implies. They have been the subject of much controversy and have generated many ambiguities. For example, it is unclear whether the "isolated transactions" exception would apply to the purchase of a physician's practice where payment for the practice is made in installments rather than in a lump sum. CMS takes the position that the exception would not apply and that installment payments are prohibited, but because the question has not been litigated, it stands unresolved as an example of the law's ambiguity.

One can see another example of ambiguity in the case of plans for a patient's care by a home health agency (HHA). A physician employed by a hospital that owns an HHA would presumably want to order home health services from the hospital's own HHA. The question now is, does the physician's financial relationship with the hospital also amount to a financial relationship with the HHA? HCFA opined privately in 1996 that it does, and therefore the physician cannot refer to the HHA. This opinion had not been the basis for enforcement, but proposed regulations issued in January 1998 seem to perpetuate this view. Specifically, in addressing the physician "ownership or investment interest"

exception, the regulations indicate that the physicians may refer to hospitals in which they have an ownership or investment interest, but only for services provided by the hospital. They may not avail themselves of the "ownership or investment" exception with regard to services provided by the hospital-owned HHA. This interpretation, of course, raises a whole new set of ambiguities. What are "services provided by the hospital," for example? If the hospital uses a separate provider number to bill for some services (e.g., radiology), are those services considered to be provided by the hospital or by a separate entity?

As this example shows, each attempt at "guidance" and "clarification"—although helpful in some respects—adds new uncertainties, increases healthcare providers' unease, and makes the practice of law in this area extremely difficult (or quite profitable, depending on your point of view). Because of the ambiguities and complexities involved, the importance of expert legal counsel cannot be overemphasized.

Corporate Compliance Programs*

In any corporation, violations of law can lead to criminal convictions and financial penalties. Healthcare organizations are no exception. Punishment can be levied against both the perpetrators and the corporation itself, even if the crime occurred at the lowest levels and was contrary to express company policy. Even though they may never have authorized the act or had knowledge of it, officers and managers may be held personally accountable if they deliberately or recklessly disregarded the possibility that illegal conduct might occur. It is, therefore, clearly a mistake for executives to believe "what I don't know can't hurt me."

One of the most effective tools to minimize the exposure of an organization and its board and management is an effective corporate compliance program (CCP; see Legal Brief on page 374). An effective CCP helps healthcare organizations develop effective internal controls that promote adherence to federal and state laws and the program requirements of federal, state, and private health plans. Adoption and implementation of voluntary compliance programs significantly assist in the prevention of fraud, abuse, and waste while helping the organization achieve its mission: providing quality care to patients. Programs promoting legal compliance and corporate integrity guide the governing body, top management, other employees, and healthcare professionals in the efficient management and operation of the entity. They are especially critical as an internal control in the reimbursement and payment areas, where claims and billing operations can be the

*Portions of this section appeared in Gunn, Goldfarb, and Showalter, "Creating a Corporate Compliance Program," 79 *Health Progress* 60 (May/June 1998). Copyright 1998 by The Catholic Health Association. Reproduced from *Health Progress* with permission.

Legal Brief

In this text, the term "corporate compliance program" is used because it has purchase in the field. Having said that, it seems to me that "compliance" has a rather tinny and reactive connotation—that is, "OK, we'll comply if we have to."

If I were naming such a program I would prefer a more assertive, good-citizen, we're-on-the-side-of-the-angels term—one that includes words like "integrity," "ethics," and "responsibility," for example.

source of fraud and abuse and the focus of governmental scrutiny.

The CCP concept gained prominence after the publication of the federal government's *Sentencing Guidelines for Organizations*,[49] which is used by federal judges during the sentencing phase of a trial when a corporation has been convicted of a violation of law. The Guidelines are intended to provide a measure of uniformity and predictability in federal criminal sentences.[50] Although criminal violations can relate to many legal topics (such as antitrust, taxation, the environment, employment, and breach of patient confidentiality), the most publicized category of illegal activity in healthcare may be fraud. Federal and state governments crack down on healthcare fraud because by some estimates up to 10 percent of the U.S. annual healthcare spending may result from fraudulent activity or abusive billing practices. (Like other law enforcement agencies, fraud squads "follow the money.") Lawsuits and prosecutions have led to penalties in the hundreds of millions of dollars in individual cases, and fines of hundreds of thousands of dollars are not uncommon (see, for example, Table 12.1).

To protect against this frightening scenario, most providers have established systematic efforts to prevent, detect, report, and correct criminal misconduct and to provide ongoing review of policies, procedures, and operations. Often called "corporate compliance programs," proper CCPs address the healthcare organization's potential vulnerability in all areas of law and ethics, not just fraud and abuse. If the CCP is implemented effectively and is supported and encouraged by its governing board and top management, the program becomes powerful evidence that the organization took steps to prevent violations by its employees and agents. It also demonstrates good faith and moral respectability—critical factors in determining what penalties will be assessed, be they criminal or civil in nature, if a violation is found.

Without a CCP, a convicted organization will incur much stiffer penalties and will usually face a court-imposed compliance program more severe than the Guidelines require. Under the Guidelines, however, an organization with an effective CCP will benefit from penalty reductions of up to 95 percent. Assume that two hospitals, each with 3,000 employees, are convicted of defrauding Medicare through coding errors. (Note that the size of the organization is a factor in the Guidelines's sentencing formula.) Assume further that the frauds resulted in overpayment of $1.6 million to each facility. Hospital A does not have

a CCP; in fact, its management was found "willfully ignorant" of the existence of the fraudulent activity. (Willful ignorance is an aggravating factor in the formula). Hospital B, on the other hand, has an effective CCP, discovered the fraud, and reported it to the authorities immediately. Table 12.2 shows the potential penalties for the two hospitals, according to the formula of the Guidelines.

In addition to reducing the organization's punishment in the event a violation occurs, an effective CCP may also provide early detection of conduct that could lead to governmental enforcement efforts, whistle-blower litigation, or other actions. The CCP's preventive activities allow management to take corrective action before suit is filed and to show due diligence if the matter goes to trial.

Despite the cost of compliance programs, which usually involve a separate executive-level department and budget items, the benefits of a CCP far outweigh the potential disadvantages. In addition to improving the accuracy of billing—the original focus of most programs—a compliance department becomes an internal resource for myriad issues relating to law and ethics. A CCP enables the entity to do the following:

- demonstrate the hospital's strong commitment to honest, ethical, and responsible corporate conduct;
- improve the quality of patient care;
- identify weaknesses in internal systems and management;
- provide an accurate view of employee and contractor behavior relating to fraud and abuse;

TABLE 12.2 Effect of a CCP on Penalty Computations

	Hospital A (no CCP)	Hospital B (with CCP)
Base fine (usually the amount of the overpayment)	$1,600,000	$1,600,000
Culpability score (determined from a table)		
Base score (identical for all defendants)	5	5
Willful ignorance factor (aggravating	4	
Effective CCP factor (mitigating)	0	−3
Self-reporting factor (mitigating)	0	−5
Total culpability score	9	< 0
Culpability multiplier range (CMR) (from a table)	1.8 to 3.6	0.05 to 0.2
Minimum fine (low CMR × base fine)	$2,880,000	$80,000
Maximum fine (high CMR × base fine)	$5,760,000	$320,000

- identify and prevent criminal and unethical conduct;
- create a centralized source for distributing information on healthcare statutes and regulations;
- develop a process that allows employees to report potential problems;
- develop procedures that allow the prompt, thorough investigation of the alleged misconduct;
- initiate immediate and appropriate corrective action; and
- minimize the loss to the government from false claims and thus reduce the hospital's exposure to civil damages and penalties, criminal sanctions, and administrative remedies, such as program exclusion.

The elements of an effective CCP are as follows:

1. *It must contain established compliance standards and procedures.* This requires management to publish standards of conduct outlining legal and ethical requirements in all areas of the organization's operations. Such areas include antitrust, document retention, employment and employee benefits, environmental compliance, Medicare/Medicaid fraud and abuse, occupational safety, patient protection, and taxation.
2. *It must be overseen by high-level personnel.* Most organizations assign the function to an individual who reports to the chief executive officer and has a relationship with the governing board and general counsel.
3. *It must provide that no discretionary authority in the organization may be vested in persons who are known (or should be known) to be likely to engage in criminal conduct.* In effect, this means that the organization must have a mechanism (such as routine criminal background checks) to prevent the hiring of persons who, for example, have previously been convicted of healthcare offenses or who have been excluded from federal healthcare programs.
4. *Its procedures and standards of conduct must be effectively communicated to employees and agents of the organization.* This means that the organization must educate all employees and agents about CCP standards and procedures and must continually publicize the topic in employee newsletters and similar media. In effect, the CCP must have the commitment and understanding of everyone in the organization, including not only the board and senior management but also lower-level employees. Without this level of support, the CCP may be viewed as a sham, which could lead to harsher penalties being assessed.
5. *It must establish reasonable methods to achieve compliance with the standards of conduct.* These methods should include ongoing monitoring activities, periodic audits of various operational departments, and encouragement to employees to report suspicious activities (for example, through "hotlines" or anonymous written reports).

6. *It must provide for, and the organization must carry out, appropriate and consistent discipline*. Discipline includes possible termination of employment for those who violate the standards of conduct or fail to report violations.
7. *It must appropriately and consistently respond to violations that are detected*. This includes having necessary corrective action in place to prevent recurrence of violations.

Healthcare organizations, including their governing boards and senior management, must take seriously the possibility that criminal violations (including fraud and abuse) may occur and that civil liability may arise in the course of their business. Although the cost of developing a CCP is significant, the consequences of not having one can be dire if illegal or unethical activity occurs, and substantial benefits may accrue in the form of reduced exposure to whistleblower lawsuits and other civil actions. Each healthcare organization, as well as each physician practice, should adopt and implement an effective CCP covering their entire operation.

CCPs are an important part of most healthcare organizations' operations. They began with an emphasis on detecting and preventing fraud and abuse and complying with regulations. As they have matured, many have become less reactive and are now more proactive in focusing on the ethical integrity of the corporation through education and sharing of information. The compliance officer should be seen as a valuable resource for questions relating to corporate ethics, conflicts of interest, human subject research, privacy and security of healthcare information, and other subjects from antitrust to zoning.

In addition, because of their auditing and monitoring activities, compliance programs can actually become a revenue center for the facility. The general view, which I share, is that hospitals and physicians probably underbill more often than they overbill. This means that they lose revenue ("leave money on the table") through failure to capture all charges properly. An effective CCP can add to the organization's net revenue while preventing improper billing practices.

Chapter Summary

This chapter deals with one of the most salient issues in healthcare today: the prevention of fraud and abuse in governmental payment programs. Here, the major fraud laws—including the federal FCA, the antikickback statute, and the Stark self-referral laws—are reviewed. The text points out the aggressive enforcement activities of federal and state regulators and the severe monetary and criminal penalties that can be imposed for violations. It also discusses the basics of a CCP, one of the most effective efforts a healthcare organization can undertake to prevent fraud, promote ethical integrity, and improve billing accuracy. Not only are compliance programs

important preventive measures, but they are also valuable resources on a wide range of legal and ethical issues.

Chapter Discussion Questions

1. What factors motivate healthcare organizations to maintain programs aimed at compliance and corporate ethics?
2. What kinds of fraudulent or abusive behavior relating to federal healthcare payment programs can occur in hospital operations?
3. What are the most significant statutes relating to healthcare fraud?
4. What do the terms "kickbacks" and "self-referral" describe in the healthcare setting?

Notes

1. Regarding the cost of healthcare, see Smith, et al., "National Health Spending in 2004," *Health Affairs* 25:1 (2006); regarding the estimate of fraud, see General Accounting Office, Report on Medicare Fraud and Abuse, GAO/HR-95-8 (Feb. 1995).
2. U.S. Dept. of Justice, *Department of Justice Health Care Fraud Report*, Fiscal Year 1994 (Mar. 2, 1995).
3. 768 F. Supp. 1127 (E.D. Pa. 1991).
4. 859 F. Supp. 5 (D. D.C. 1994).
5. 909 F. Supp. 32 (D. D.C. 1995) (memorandum opinion).
6. 31 U.S.C. §§ 3729-3731.
7. See, for example, Rex Trailer Co. v. United States, 350 U.S. 148 (1952) and Fleming v. United States, 336 F.2d 475 (10th Cir. 1964).
8. United States v. Krizek, 111 F.3d 394 (D.C. Cir. 1997).
9. See, for example, United States v. McNinch, 356 U.S. 595 (1958).
10. 31 U.S.C. § 3729(b).
11. S. Rep. No. 345, 99th Cong., 2d Sess. 7.
12. 859 F. Supp. at 13. But see United States v. Nazon, No. 93C5456m (N.D. Ill. Oct. 14, 1993).
13. Pub. L. No. 104–191, § 213, amending 42 U.S.C. § 1320a-7(b)(15).
14. 42 U.S.C. § 1320a-7a(a)(4).
15. 31 U.S.C. § 3733(l)(4).
16. 31 U.S.C. § 3730(h).
17. 317 U.S. 537 (1943); see also United States v. Forster Wheeler Corp., 447 F.2d 100 (2d Cir. 1971)—invoices submitted on contract that was based on inflated cost estimates are false claims; United States v. Veneziale, 268 F.2d 504 (3d Cir. 1959)—fraudulently induced contract may create liability when the contract later results in payment by the government.
18. 797 F.2d 888 (10th Cir. 1986).
19. 760 F. Supp. 1120 (E.D. Pa. 1991).
20. 914 F. Supp. 1507 (M.D. Tenn. 1996).
21. Id. at 1508–1509.
22. Id. at 1513.
23. At least one consent judgment has been entered in a case of this type. In 1994, a company that ran home infusion centers agreed to pay $500,000 in settlement of an FCA case because

it gave physicians incentives to refer patients to the centers. United States v. Medical, Inc., Ga. No. 1:94-CV-2549 (N.D. Ga. Sept. 26, 1994).

24. 18 U.S.C. § 287.
25. 42 U.S.C. § 1320a-7b(b)(1)(A) and (2)(A).
26. Pub. L. No. 104-191, § 204, 110 Stat. 1999, codified at 42 U.S.C. § 1320a-7b(a).
27. 42 U.S.C. § 1320a-7(b)(7).
28. 42 U.S.C. § 1320a-7a(a)(7).
29. 42 U.S.C. § 1320a-7b(b)(3).
30. 42 U.S.C. § 1320a-7b.
31. S. Rep. No. 109, 100th Cong., 1st Sess. 27.
32. 51 F.3d 1390 (9th Cir. 1995).
33. Office of Inspector Gen., U.S. Dept. of Health and Human Servs., Advisory Op. No. 97-6 (Oct. 8, 1997).
34. Levin v. Inspector General, No. CR343 (HHS Dept. App. Bd. Nov. 10, 1994).
35. See 42 U.S.C. §§ 1320a-7b(b)(1)(B) and (2)(B).
36. Unreported decision cited in "Psychiatric Hospital Firm Pleads Guilty to Violating Anti-Kickback Statute," 4 *BNA's Health L. Rep.* 687
37. 42 U.S.C. § 1320a-7a(a)(5).
38. 42 U.S.C. § 1320a-7a(i)(6).
39. Codified at 42 U.S.C. § 1395nn.
40. HCFA Trans. No. AB-95-3 (Jan. 1995), reprinted in *BNA's Health L. & Bus.* Series No. 2400 at 2400–3401, 3402 (1997).
41. Id. at 2400–3403.
42. 42 U.S.C. § 1395nn(b)(2)(A)(i).
43. 42 U.S.C. § 1395nn(b)(2)(B).
44. 42 U.S.C. § 1395nn(b)(2)(A)(ii).
45. 42 U.S.C. § 1395nn(b)(3).
46. 42 U.S.C. § 1395nn(d)(3).
47. 42 U.S.C. § 1395nn(e)(2).
48. See, generally, 42 U.S.C. § 1395nn(c)-(e).
49. 56 Fed. Reg. 22,762–22,786 (May 16, 1991).
50. Although originally considered mandatory, in early 2005 the Supreme Court held (for reasons not relevant here) that the *Sentencing Guidelines* are only "advisory." United States v. Booker and United States v. Fanfan, 543 U.S. 220 (2005). The effect of the Guidelines remains as described in the text.

THE COURT DECIDES

United States v. Greber
760 F.2d 68 (3rd Cir. 1985)

[The defendant was convicted of fraud relating to his durable medical equipment company's billing practices. The company supplied Holter monitors—portable devices worn by patients to record their heartbeats for later interpretation. For this service Dr. Greber's company, Cardio-Med, billed Medicare and remitted a portion of each payment to the referring physician. For this practice he was found guilty of having violated the kickback statute even though the payments were made for consultative services rendered. Dr. Greber was also convicted of submitting false statements concerning how long the monitors were operated (Medicare requires at least eight hours of operation to qualify for payment) and mail fraud (by using the mail to bill for services that were medically unnecessary or were never provided). Only the kickback issue is addressed in the following excerpt.]

On appeal, defendant raises several alleged trial errors. He presses more strongly, however, his contentions that the evidence was insufficient to support the guilty verdict on the Medicare fraud counts, and that the charge to the jury on that issue was not correct....

I. Medicare Fraud

The Medicare fraud statute was amended [in 1977]. Congress, concerned with the growing problem of fraud and abuse in the system, wished to strengthen the penalties to enhance the deterrent effect of the statute. To achieve this purpose, the crime was upgraded from a misdemeanor to a felony.

Another aim of the amendments was to address the complaints of the United States Attorneys who were responsible for prosecuting fraud cases. They informed Congress that the language of the predecessor statute was "unclear and needed clarification."

A particular concern was the practice of giving "kickbacks" to encourage the referral of work. Testimony before the Congressional committee was that "physicians often determine which laboratories would do the test work for their Medicaid patients by the amount of the kickbacks and rebates offered by the laboratory.... Kickbacks take a number of forms including cash, long-term credit arrangements, gifts, supplies and equipment, and the furnishing of business machines."

To remedy the deficiencies in the statute and achieve more certainty, the present version of 42 U.S.C. § 1395nn(b)(2) was enacted. It provides:

> whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly in cash or in kind to induce such person–
>
> ...(B) to purchase, lease, order, or arrange for or recommend purchasing ...or ordering any...service or item for which payment may be made...under this title, shall be guilty of a felony.

[The evidence showed that defendant had paid physicians "interpretation fees" for the doctors' consultation services and for explaining the test results to the patients. Some evidence existed that physicians received "interpretation fees" even though Dr. Greber had actually evaluated the monitoring data. Moreover, the fixed percentage paid to the referring physician was more than Medicare allowed for such

services.]

The district judge instructed the jury that the government was required to prove that Cardio-Med paid...some part of the amount received from Medicare; that defendant caused Cardio-Med to make the payment; and did so knowingly and willfully as well as with the intent to induce Dr. Avallone to use Cardio-Med's services for patients covered by Medicare. The judge further charged that even if the physician interpreting the test did so as a consultant to Cardio-Med, that fact was immaterial if a purpose of the fee was to induce the ordering of services from Cardio-Med.

Defendant contends that the [instruction to the jury] was erroneous. He insists that absent a showing that the only purpose behind the fee was to improperly induce future services, compensating a physician for services actually rendered could not be a violation of the statute.

The government argues that Congress intended to combat financial incentives to physicians for ordering particular services patients did not require.

The language and purpose of the statute support the government's view. Even if the physician performs some service for the money received, the potential for unnecessary drain on the Medicare system remains. The statute is aimed at the inducement factor.

The text refers to "any remuneration." That includes not only sums for which no actual service was performed but also those amounts for which some professional time was expended. "Remunerates" is defined as "to pay an equivalent for service." (*Webster Third New International Dictionary* 1966.) By including such items as kickbacks and bribes, the statute expands "remuneration" to cover situations where no service is performed. That a particular payment was a remuneration (which implies that a service was rendered) rather than a kickback, does not foreclose the possibility that a violation nevertheless could exist.

In *United States v. Hancock* the court applied the term "kickback" found in the predecessor statute to payments made to chiropractors by laboratories which performed blood tests. The chiropractors contended that the amounts they received were legitimate handling fees for their services in obtaining, packaging, and delivering the specimens to the laboratories and then interpreting the results. The court rejected that contention and noted, "The potential for increased costs to the Medicare-Medicaid system and misapplication of federal funds is plain, where payments for the exercise of such judgments are added to the legitimate cost of the transaction.... [T]hese are among the evils Congress sought to prevent by enacting the kick-back statutes...."

Hancock strongly supports the government's position here, because the statute in that case did not contain the word "remuneration." The court nevertheless held that "kickback" sufficiently described the defendants' criminal activity. By adding "remuneration" to the statute in the 1977 amendment, Congress sought to make it clear that even if the transaction was not considered to be a "kickback" for which no service had been rendered, payment nevertheless violated the Act.

We are aware that in *United States v. Porter* the Court of Appeals for the Fifth Circuit took a more narrow view of "kickback" than did the court in *Hancock*. *Porter*'s interpretation of the predecessor statute[,] which did not include "remuneration[,]" is neither binding nor persuasive....

We conclude that the more expansive reading is consistent with the impetus for the 1977 amendments and therefore hold that the district court correctly instructed the jury. If the payments were intended to induce the physician to use Cardio-Med's services, the statute was violated, even if the payments were also intended to com-

United States v. Greber Discussion Questions

1. How, if at all, can you distinguish *Greber* from other instances of payments for professional services? Suppose the percentage Dr. Greber paid to the physicians had not exceeded Medicare's guidelines? Would that payment still amount to prohibited remuneration in this court's eyes?
2. Suppose you were a lawyer or a compliance officer advising a hospital cardiology department. The department has a contract under the terms of which it will pay a certain cardiology group a fixed dollar amount for every electrocardiogram (ECG) it interprets, and the hospital will bill Medicare accordingly. The dollar amount is equal to Medicare's allowable charge for ECGs (less than $10 at this writing), and all readings are medically necessary. You ask why the hospital does not just let the doctors bill Medicare themselves, and the reply is, "Oh, it's such a hassle for them. We already have a billing department, and we can do it for them easily." What is your response, and why?

THE COURT DECIDES

United States v. McClatchey
217 F.3d 823 (10th Cir., 2000)

[Fifteen years after Greber *it was still an open question what intent was required to violate the FCA.* Greber *determined that if any purpose of the remuneration was to induce referrals, the Act was violated even if other purposes were legitimate. The following case excerpt illustrates some of the difficulties of this interpretation.*

The case involved two physicians who were the principals in a group practice (BVMG) that provided care to nursing home patients. In 1984, the physicians approached Baptist Medical Center in Kansas City, Missouri, and proposed that they would move their patients from other hospitals to Baptist if the hospital would buy BVMG. This concept was rejected, but after much negotiation the parties agreed that the physicians would provide various services to the hospital in return for $75,000 each per year. (Among other things, testimony indicated that the fee was determined before the services were agreed on.) The physicians then began admitting their patients to Baptist.

The contractual arrangement continued until 1993 even though as early as 1986 attorneys for Baptist's new owner, the Health Midwest system, were concerned that it did not comply with the "safe harbor" regulations that had since been issued by the U.S. government. Additionally, in late 1991 or early 1992, Baptist learned that the physicians were not performing some of the contractual services, but the fees continued to be paid and the contract was renewed.

The jury convicted the hospital chief executive officer, the two physicians, and Mr. McClatchey of violating the antikickback statute. Two attorneys for Health Midwest who were involved in the negotiations to renew the contract were charged with conspiracy but were found not guilty by the judge on motions for acquittal. The judge also granted Mr. McClatchey's motion for acquittal on the ground that no reasonable jury could find that he deliberately intended to violate the law. Thus, the issue on appeal concerned the type of criminal intent necessary to violate the kickback statute.]

Murphy, Circuit Judge.

....

In Instruction 32, the district court charged the jury as follows:

> In order to sustain its burden of proof against the hospital executives for the crime of violating the Anti-Kickback statute, the government must prove beyond a reasonable doubt that the defendant under consideration offered or paid remuneration with the specific criminal intent "to induce" referrals. To offer or pay remuneration to induce referrals means to offer or pay remuneration with the intent to gain influence over the reason or judgment of a person making referral decisions. The intent to gain such influence must, at least in part, have been the reason the remuneration was offered or paid.
>
> On the other hand, defendants Anderson, Keel, and McClatchey cannot be convicted merely because they hoped or expected or believed that referrals may ensue from remuneration that was designed wholly for other purposes. Likewise, mere oral encouragement to refer patients or the mere creation of an attractive place to which patients can be referred does not violate the law. There must be an offer or payment of remuneration to induce, as I have just defined it.

McClatchey contends this instruction was incorrect and warrants a new trial, because a defendant should not be convicted under the Act when his offer or payment of remuneration was motivated merely in part to induce referrals, but rather the motivation to induce referrals must be the defendant's primary purpose....

Whether the "at least in part" or "one purpose" standard applied in the instant case constitutes a correct interpretation of the Act is an issue of first impression in this Circuit. McClatchey urges this court to reject the test set out in Instruction 32 as too broad, because "[e]very business relationship between a hospital and a physician is based 'at least in part' on the hospital's expectation that the physician will choose to refer patients." This argument, however, ignores the actual instruction given in the instant case, in which the district court specifically informed the jury that "McClatchey cannot be convicted merely because [he] hoped or expected or believed that referrals may ensue from remuneration that was designed wholly for other purposes." According to this instruction, therefore, a hospital or individual may lawfully enter into a business relationship with a doctor and even hope for or expect referrals from that doctor, so long as the hospital is motivated to enter into the relationship for legal reasons entirely distinct from its collateral hope for referrals.

The only three Circuits to have decided this issue have all adopted the "one purpose" test. [One of these was *Greber*, which is set forth earlier.] In *Greber*, a doctor who owned a diagnostic laboratory was convicted of violating the Act because he paid "interpretation fees" to other physicians to induce them to refer Medicare patients to use his laboratory's services. Defendant Greber asserted that these interpretation fees compensated the physicians both for providing initial consultation services and for explaining the test results to the patients. On appeal, Greber argued that a jury instruction much like Instruction 32 was erroneous, because the Act requires the government to prove that the only purpose for the interpretation fees was to induce referrals and that compensation for services actually rendered could not constitute a violation of the Act. Carefully examining the language and purpose of the Act, the Third Circuit rejected Greber's proposed interpretation and instead held that "if one purpose of the payment was to induce

referrals, the [Act] has been violated."...The *Greber* court thus concluded that the "one purpose" test is consistent with the legislative intent behind the amended Act.

This court agrees with the sound reasoning in *Greber* and thus holds that a person who offers or pays remuneration to another person violates the Act so long as one purpose of the offer or payment is to induce Medicare or Medicaid patient referrals. Because the district court accurately informed the jury of the applicable law, McClatchey is not entitled to a new trial based on the jury instructions.

....

This court concludes that the government presented sufficient evidence from which a reasonable jury could infer McClatchey knowingly, voluntarily, and purposefully entered into an agreement with the specific intent to violate the Act.... We therefore REVERSE the judgment of acquittal and the alternative order for a new trial entered by the District Court for the District of Kansas and REMAND to that court with instructions to reinstate the verdict rendered by the jury.

United States v. McClatchey Discussion Questions

1. Determining difficult questions of fact is the jury's job. If you had been a juror in this case and had heard "Instruction 32," where would you have drawn the line between an intent to induce referrals and a mere hope that referrals might ensue?
2. The summary given here leaves out many important facts. What other facts might have been important to you as a juror?
3. Recognizing that physicians are their life blood, hospitals have long provided certain amenities to "keep the docs happy." Among these perqs are preferred parking, free meals, and "professional courtesy" (discounts for care for themselves and their family members). Because the one-purpose test now appears to be the accepted standard under the FCA, and because a purpose of "keeping the docs happy" is to encourage them to refer patients to the facility, are these types of benefits now illegal?

CHAPTER

13

ISSUES OF REPRODUCTION

After reading this chapter, you will

- have a better appreciation for the difficulty of abortion as a legal issue, and understand that abortion will continue to be as controversial in the courtroom as it is in the public policy arena.
- appreciate the difference between "wrongful life" and "wrongful birth" cases; wrongful life cases are rare, but wrongful birth cases are relatively commonplace.
- understand that voluntary sterilization is seldom a vexing legal issue today.
- know what the hospital's role is in reproductive matters.
- be aware of the issues involved in surrogate parenting, in vitro fertilization, and stem-cell technology. Recognize that litigation over stem-cell technology has yet to reach many courtrooms, but it will.

Courts of law are asked to decide many of society's most perplexing problems. The judicial system of this country is asked almost daily to apply Solomonic wisdom to virtually intractable social, moral, and ethical controversies, all of which are presented in the guise of legal principles. Although the system often seems imperfectly constructed to do so, it must make a decision in every justiciable case (see Legal Brief).

Much of the difficult litigation involving issues of reproduction came about because of advances in scientific and medical technology. For example, as doctors developed advanced techniques, such as in vitro fertilization, questions surfaced regarding parental and custodial rights. For lack of any

Legal Brief

"Justiciable" means capable of being settled by a court of law. For a case to be justiciable, there must be an actual controversy between the parties (courts do not issue "advisory opinions"), the issue must not be moot, and the case must not involve questions that are solely political (questions for the other branches of government to resolve).

other effective forums to resolve disputes, the questions often found their way into courtrooms. With the advance of medical technology in such areas as stem-cell research, courts have been and will continue to be asked to reevaluate earlier precedents in light of those developments. The extent to which such decisions can or should be modified remains a continuing source of judicial inquiry.

In this chapter the history and current legal status of abortion and sterilization are reviewed; two torts (wrongful life and wrongful birth) peculiar to reproduction are considered; and surrogate parenting, in vitro fertilization, and stem-cell research are discussed.

Abortion

Before the nineteenth century, English and U.S. laws did not prohibit induced abortion, at least in the early stages of pregnancy. Some scholars maintain that English law never regarded abortion of a quickened fetus (one that has had movements the mother can feel) as a criminal act; others disagree. It is not surprising that American courts deciding cases pursuant to the common law reached differing conclusions. Some held that an abortion of a quickened fetus was criminal, at least a misdemeanor, but others ruled that an abortion, regardless of the stage of pregnancy, was not a crime.[1] In any event, the matter soon became a question solely of statutory law because a generally accepted principle in Anglo-American jurisprudence is that criminal law must be established by statute and not by common-law judicial decision.

The English Parliament enacted the first restrictive abortion statute in 1803.[2] It provided that a willful abortion of a quickened fetus was a capital crime and established lesser penalties for abortions performed during earlier stages of pregnancy. If the surgery was performed in good faith to preserve the life of the mother, however, no criminal act had been committed.[3]

American jurisdictions began to pass restrictive abortion statutes in the early 1800s. Connecticut was the first state to do so when in 1821 it passed a statute that accepted the English distinction between a quickened and unquickened fetus. Similarly, an 1828 New York statute provided that an abortion after quickening was manslaughter but a misdemeanor before then. An exception to manslaughter was made for cases where an abortion was performed to preserve the life of the mother.

By the late 1860s nearly all states had enacted restrictive abortion statutes of some type, and most statutes in time abandoned the distinction between a quickened and unquickened fetus. By the 1960s the various laws generally fell into the following categories:

- those that banned all abortions regardless of the stage of pregnancy and regardless of the reason for the procedure;

- the majority, which permitted termination of pregnancy to preserve the mother's life while prohibiting termination under all other circumstances; and
- some that permitted the surgery to preserve the mother's health, providing that only a physician could perform the procedure and, in some states, only after consulting with other physicians and providing proper medical safeguards.

During the 1960s a trend developed to relax these state laws, and by 1970 approximately one-third of the states had adopted a model abortion law that permitted a licensed physician to terminate a pregnancy when there was "substantial risk that continuance of pregnancy would gravely impair the physical or mental health of the mother or that the child would be born with grave physical or mental defects or that the pregnancy resulted from rape, incest, or other felonious intercourse."[4] Termination of pregnancy under circumstances other than those described was a third-degree felony if performed before the twenty-sixth week (roughly the end of the second trimester), and a first-degree felony if performed thereafter. The law further required that all abortions take place in a licensed hospital, unless an emergency existed and such facilities were not available, and that at least two physicians had to certify in writing the circumstances justifying the surgery. Some jurisdictions added the following additional requirements:

- the patient must be a resident of the state for a specified time before the surgery,
- the attending physician must obtain the concurrence of the hospital's medical staff committee, and
- the hospital where the surgery was to be performed must be accredited by the Joint Commission.

By the end of 1970, liberalization of the law in New York, Washington, Hawaii, and Alaska had gone much further than the model law. These states had adopted in essence the principle of abortion on demand, at least up to a statutorily designated stage of pregnancy. (New York, Hawaii, and Alaska accomplished this change by statute, and Washington did so by public referendum.) These states imposed certain restrictions, for example, that the procedure had to be done by a licensed physician in a licensed or accredited hospital or that the woman must establish a period of residency in the state before she would be eligible for an abortion.

Then came the landmark abortion cases of January 1973. These decisions addressed a broad, fundamental issue of constitutional law: Does a woman have a right to decide for herself, without governmental regulation, whether to bear a child?

The Roe *and* Bolton *Cases*

Roe v. Wade[5] concerned the constitutionality of a very restrictive Texas statute, while the companion case of *Doe v. Bolton*[6] raised issues relevant to Georgia's somewhat more liberal legislation.

Texas law permitted an abortion at any stage of pregnancy, but only to save the life of the mother. The issue for the court was whether the state had a sufficient "compelling interest" to justify the nearly total prohibition of abortion. When fundamental individual rights are involved, a state must convince the court that there is a "compelling interest" to justify the restraint on those rights. Because an individual's right of privacy is a fundamental right, the *Roe* and *Bolton* cases employed the compelling interest test when ruling on the constitutionality of the Texas and Georgia abortion statutes.

In *Roe* the court held that the Texas statute violated the due process clause of the Fourteenth Amendment. A "balancing of interests" between the state, acting to further the general welfare, and the individual seeking an abortion led to the conclusion that the individual's rights of privacy trumped the interests the statute sought to promote. However, the court recognized that the state had two legitimate interests that would justify regulating abortions: protecting the life and health of pregnant women and protecting the "potentiality of human life." These were the interests the court weighed against the woman's right of privacy. The court found that during the first trimester of pregnancy the health risk from abortion was less than the risk of childbirth. Thus, the state's interest in maternal and fetal health did not outweigh the right of privacy. For that reason states may only restrict abortions during the first trimester as they might restrict other surgical procedures—for example, by requiring that they be performed by licensed physicians.[7] Essentially the decision to perform an abortion during the first trimester of pregnancy was solely up to the patient and her physician.

During the second trimester, the court found, the risk to the woman is greater. Under the balancing test, the state's interest in protecting the woman's health becomes compelling, and the state may place restrictions that protect her health, as long as these do not unreasonably interfere with the woman's right to make her own decision. The court held that the state's interest in protecting potential life becomes compelling when the fetus is viable (capable of surviving outside the womb). In 1973 this point was reached about 28 weeks after conception. At that point the state may proscribe abortions altogether, unless they are necessary to protect the life or health of the mother.[8]

In 1973, medical science recognized a relatively clear division of pregnancy: risks inherent in pregnancy increased after the first three months, and fetal viability occurred about the end of the second three months. This

trimester structure was used to determine when the state's interests outweighed those of the woman and, therefore, the point at which the state could place restrictions on abortions.

There are many who question and even dispute the soundness of this legal approach. As pointed out by Justice O'Connor in a case ten years later:

> Just as improvements in medical technology inevitably will move forward the point at which the State may regulate for reasons of maternal health, different technological improvements will move backward the point of viability at which the State may proscribe abortions except when necessary to preserve the life and health of the mother....
>
> The Roe framework, then, is clearly on a collision course with itself. As the medical risks of various abortion procedures decrease, the point at which the State may regulate for reasons of maternal health is moved further forward to actual childbirth. As medical science becomes better able to provide for the separate existence of the fetus, the point of viability is moved further back toward conception.... The Roe framework is inherently tied to the state of medical technology that exists whenever particular litigation ensues.[9]

The *Roe* decision is illustrated in Figure 13.1.

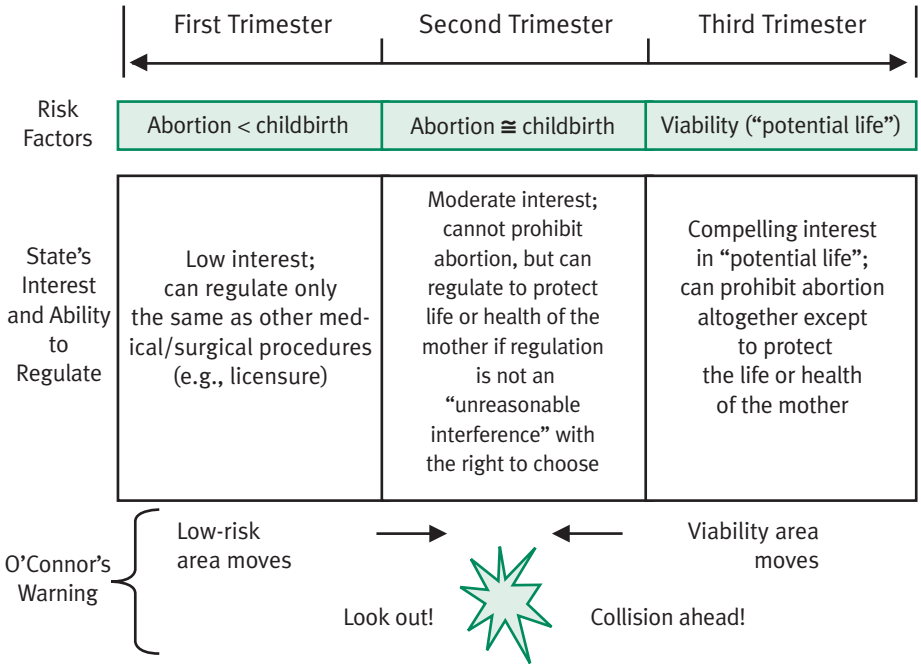


FIGURE 13.1 The Abortion Scenario After *Roe v. Wade* (1973)

A companion case to *Roe*, *Doe v. Bolton*,[10] involved the constitutionality of Georgia's "liberalized" statute patterned after the model law. The law permitted termination of pregnancies whenever continued pregnancy would endanger the woman's life or injure her health; when the baby was likely to be born with grave, permanent handicaps; or when pregnancy was the consequence of rape. In the interest of protecting the patient's health and well-being, however, the law required physicians to exercise their "best clinical judgment" when recommending an abortion. It also required that the procedure be carried out in a hospital accredited by the Joint Commission, that it be approved by an abortion committee comprising members of the hospital's medical staff, and that the judgment of the patient's physician be confirmed by two other independent physicians who had examined the patient. Further, the patient had to establish Georgia residency to be considered eligible for an abortion.

The Supreme Court upheld the statutory requirement that the "best clinical judgment" of the patient's physician be exercised when the need for an abortion is considered. However, it struck down the three procedural requirements and the residency requirement, holding that they unduly restricted the rights of doctors and patients to decide. The court supported its conclusion regarding the procedural matters by noting that Georgia law did not require that other surgical procedures of similar risk take place only in hospitals accredited by the Joint Commission or that they be preceded by consultation with other physicians. Nevertheless, the court specifically recognized that the state might, if it wished, require that abortions after the first trimester be performed at licensed facilities and that the state might also promulgate reasonable standards consistent with its legitimate interest in protecting maternal health.[11] The residency requirement was said to be an invasion of the constitutionally protected right to travel included in the privileges and immunities clause of Article IV of the U.S. Constitution.

The Georgia statute contained a "conscience clause" to permit individuals with moral or religious objections to abortion to decline to participate; this provision was upheld. Whether a conscience clause for hospitals and other healthcare institutions is constitutional is discussed later in this chapter.

State Regulation of Abortion After 1973

In the years since *Roe* and *Bolton*, the Supreme Court issued further guidance on judicial review of state abortion regulation and addressed various state and local abortion regulations that attempted to limit a woman's right to choose. The constitutionality of these regulations has been examined on a case-by-case basis. Restrictions that have been held constitutional include the following:

- a requirement for submission of any tissue removed following an abortion, whether in a hospital or clinic, to a pathologist (because it placed a

"relatively insignificant burden" on a woman's decision on abortion, was "reasonably related to generally accepted medical standards," and furthered "important health-related state concerns";[12]
- requirements for record keeping and reporting—provided that they are not unduly burdensome, that they protect confidentiality, and that the facts are legitimately related to the state's health interest;[13]
- a statute that required that second-trimester abortions be performed in licensed clinics (upheld as a reasonable means of furthering the state's compelling interest in maternal health);[14] and
- a requirement for written informed consent.[15]

Restrictions that have been struck down include the following:

- the Pennsylvania Abortion Control Act's detailed reporting for each abortion performed at any stage of pregnancy;[16]
- an ordinance that required, among other things, that all abortions after the first trimester take place in a hospital (decided in City of Akron);
- a requirement of a waiting period between the woman's consent to an abortion and the abortion itself (decided in City of Akron because there was no legitimate state interest served);
- requirements that certain specific information be given to the woman before obtaining her written consent and that a physician inform a patient that "the unborn child is a human life from the moment of conception" (decided in City of Akron); and
- a requirement that counseling be given only by the attending physician (decided in City of Akron).[17]

The Supreme Court in *Roe* held that a state could criminalize all abortions after the fetus becomes viable, except those necessary to preserve the mother's life or health, because at that point the state's interest in protecting the "potentiality of human life" becomes compelling. The Court observed that "in the medical and scientific community, a fetus is considered viable if it is 'potentially able to live outside the mother's womb, albeit with artificial aid'." The *Roe* court stressed that the "abortion decision in all its aspects is inherently, and primarily, a medical decision," and "left the point [of viability] flexible for anticipated advancements in medical skill."[18]

These advances have occurred, of course. In 1973 a fetus was considered viable at about 28 weeks; since then, medical science has made it possible to save the lives of infants born at 20 weeks or even earlier. Some abortions, however, such as those where genetic diseases or defects are diagnosed, cannot be performed before about 18 to 20 weeks after conception because amniocentesis—the procedure that reveals the disease or defect—is not

always possible before that time. Some abortions performed during the second or third trimester result in live births, although a fetus that survives an abortion may not be capable of living more than momentarily outside the womb.

The question of viability thus raises a number of issues, not all of which have been (or are capable of being) addressed by the legislatures or courts. If abortions are criminal after viability, who determines viability? Who decides whether the abortion was necessary to protect the mother's life or health, and what does "health" encompass? Even if the abortion is medically necessary, must the physician use the method most likely to preserve the life of the fetus? What duty of care is owed to the fetus who survives an abortion?

Some of these issues were addressed by the Supreme Court in *Colautti v. Franklin*.[19] The Pennsylvania Abortion Control Act passed in 1974 provided that

> if the fetus was determined to be viable, the person performing the abortion was required to exercise the same care to preserve the life and health of the fetus as would be required in the case of a fetus intended to be born alive, and was required to adopt the abortion technique providing the best opportunity for the fetus to be aborted alive, so long as a different technique was not necessary in order to preserve the life or health of the mother.[20]

In reviewing this provision, the Supreme Court reiterated the importance of viability as a deciding factor and that the point of viability will "differ with each pregnancy."[21] The Pennsylvania statute imposed a duty on physicians that arises when the child "is" or "may be" viable. The Court found the provision unconstitutional on the ground that it was ambiguous and confusing. "Viable" and "may be viable" appeared to refer to distinct conditions, one of which differed "in some indeterminate way from the definition of viability as set forth in *Roe* and in *Planned Parenthood*."[22] In addition to being unclear, the statute appeared to impose criminal liability without scienter; even physicians who judge in good faith that a fetus is not viable could apparently be found criminally liable if it turned out that the fetus was in fact viable.[23]

Some states seeking to protect the life of the viable fetus have imposed a requirement that a second physician be present to attend to the health of the child at all post-viability abortions. This requirement was upheld by the Supreme Court in *Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft* as reasonably furthering the state's compelling interest in protecting the lives of viable fetuses.[24] However, there must be an exception to the second-physician requirement in case of an emergency that threatens the mother's health. In examining the Pennsylvania statute, the Supreme Court

found no such exception (either express or implied) and thus ruled the provision unconstitutional.[25]

Missouri was the focus of another landmark abortion case, *Webster v. Reproductive Health Services*,[26] decided in 1989. In *Webster* the Court addressed four provisions of a Missouri statute:

1. its preamble, which declared that life begins at conception and that "unborn children have protectable interests in life, health, and well-being";
2. a prohibition on the use of public facilities or employees to perform abortions;
3. a prohibition on public funding of abortion counseling; and
4. a requirement that physicians conduct viability tests before performing abortions.

The Supreme Court declined to wade into the philosophical quagmire of when life begins. Instead, it held the statute's preamble was merely a value judgment favoring childbirth over abortion, a position that the legislature had the authority to express. The Court explained that "the extent to which the preamble's language might be used to interpret other state statutes or regulations is something that only the courts of Missouri can definitively decide." It added that Missouri already protected unborn children in the areas of tort and probate law and that the preamble "can be interpreted to do no more than that."

The Court also upheld the other provisions of the Missouri law. With regard to restrictions on the use of public facilities and employees for abortion, the opinion states, "Nothing in the Constitution requires States to enter or remain in the business of performing abortions. Nor...do private physicians and their patients have some kind of constitutional right of access to public facilities for the performance of abortions." Likewise the prohibition on the use of public funds to support abortions was held not to be an unconstitutional governmental obstacle for a woman who chooses abortion. Finally, the Court upheld the requirement that physicians test for fetal viability before performing an abortion procedure.

The significance of *Webster* was not so much its specific holdings but the language of the opinion, written by Chief Justice Rehnquist, that called *Roe*'s trimester analysis into doubt:

> We think that the doubt cast upon the Missouri statute by these cases is not so much a flaw in the statute as it is a reflection of the fact that the rigid trimester analysis of the course of a pregnancy enunciated in Roe has resulted in subsequent cases making constitutional law in this area a virtual Procrustean bed....

> In the first place, the rigid Roe framework is hardly consistent with the notion of a Constitution cast in general terms as ours is, and usually speaking in general principles, as ours does. The key elements of the Roe framework—trimesters and viability—are not found in the text of the Constitution or in any place else one would expect to find a constitutional principle. Since the bounds of the inquiry are essentially indeterminate, the result has been a web of legal rules that have become increasingly intricate, resembling a code of regulations rather than a body of constitutional doctrine. As Justice White has put it, the trimester framework has left this Court to serve as the country's "ex officio medical board with powers to approve or disapprove practices and standards throughout the United States."
>
> In the second place, we do not see why the State's interest in protecting potential human life should come into existence only at the point of viability, and that there should therefore be a rigid line allowing state regulation after viability but prohibiting it before viability.

Because no clear majority of justices was prepared to overrule *Roe*, the quoted language is dictum. It is dictum, however, that greatly encouraged the antiabortion forces who awaited (and still await) the day when *Roe v. Wade* would be overturned. That opportunity seemed to arise in 1992 in *Planned Parenthood of S.E. Pennsylvania v. Casey*,[27] which involved a Pennsylvania law containing numerous provisions the plaintiffs felt were obstacles to a woman's choice of abortion:

> a requirement that informed consent, accompanied by certain clinical information, be provided at least 24 hours prior to procedure; parental or judicial consent for a minor's abortion; and a narrow definition of "medical emergency" allowing the above requirements to be avoided in certain situations.

Supporters of the law, including the Commonwealth of Pennsylvania and the United States, not only asked that the statute be upheld but urged that *Roe* be reversed. A widely divided Supreme Court declined to do so. The Court upheld the first two provisions, stating that they did not constitute an "undue burden" on a woman's right to choose, but it struck down others as overly burdensome and too narrowly written. (In upholding the provision regarding minors, the court implicitly affirmed the general rule that a state may require parental consent for a minor's abortion if there is also an option for the minor to seek judicial approval if she does not wish to seek or cannot obtain a parent's consent. In the course of announcing the decision, Justice O'Connor's lead opinion now famously declared, "Liberty finds no refuge in a jurisprudence of doubt." From this strong reaffirmation of the principle of stare decisis, it went on to uphold *Roe*'s essential holdings:

> that a woman's right to choose an abortion before viability cannot be unduly interfered with by the State; after viability the State may restrict abortions except in the case of those to protect the mother's life or health; and all throughout pregnancy the State has legitimate interests in protecting the health of the mother and fetus.

But *Roe* did not escape unscathed. In her opinion Justice O'Connor wrote, "We reject the rigid trimester framework of *Roe v. Wade*." Instead of trimesters, the opinion focused on the concept of fetal viability: "[T]he concept of viability…is the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb, so that the independent existence of the second life can in reason and all fairness be the object of state protection that now overrides the rights of the woman." The opinion continued on this point, "The woman's right to terminate her pregnancy before viability is the most central principle of *Roe v. Wade*. It is a rule of law and a component of liberty we cannot renounce."

It is important to note that on the question of rejecting *Roe*'s trimester framework, Justice O'Connor did not speak for a majority of the justices. How can this be? The "judgment of the Court" was announced in the opinion Justice O'Connor authored, which was joined by Justices Kennedy and Souter, but even Justice Kennedy did not concur in the dictum regarding trimesters. Justices Blackmun and Stevens joined in portions of the O'Connor opinion, thus providing the five votes necessary for the particular actions ultimately taken ("affirmed in part" and "reversed in part"), but these two also joined Chief Justice Rehnquist and Justices White, Scalia, and Thomas in dissenting to at least a part of the lead opinion. Furthermore, the latter four members of the Court would have reexamined *Roe*'s principle that abortion is a fundamental right, would have concluded that the choice of an abortion is not a constitutional right at all, and urged that the statute be upheld in its entirety.

Summary of the Abortion Issue

Planned Parenthood v. Casey is an extremely long and complicated decision with numerous written opinions (some of them reflecting almost personal tensions among the justices) and no clear majority position on some of the more significant abortion-related issues. In this respect it mirrors the divisiveness of the public as a whole on the topic of abortion, one of the most difficult and divisive issues the judicial system has ever faced. The issue has been contentious for decades and shows no signs of being resolved any time soon. Its divisiveness is reflected in a passage from the dissenting opinion of Justice Blackmun (author of the majority opinion in *Roe v. Wade*) in the *Casey* case:

> In one sense, the Court's approach [in Casey] is worlds apart from that of the Chief Justice and Justice Scalia [two of the dissenters]. And yet, in

another sense, the distance between the two approaches is short—the distance is but a single vote.

I am 83 years old. I cannot remain on this Court forever, and when I do step down, the confirmation process for my successor well may focus on the issue before us today. That, I regret, may be exactly where the choice between the two worlds will be made.

Despite Justice Blackmun's prediction, the confirmation process for his successor, did not focus overly much on abortion, and ironically it was the new justice, Steven G. Breyer, who summed up the status of abortion law in a decision issued in 2000:

> Aware that constitutional law must govern a society whose different members sincerely hold directly opposing views, and considering the matter in light of the Constitution's guarantees of fundamental individual liberty, this Court, in the course of a generation, has determined and then redetermined that the Constitution offers basic protection to the woman's right to choose.[28]

The Law in Action

As this edition is being prepared, the Supreme Court is considering its first abortion cases in five years. One deals with whether a New Hampshire parental-notification requirement is an "undue burden" on pregnant teenagers; the other concerns the federal statute outlawing "partial birth abortions." These cases do not require the Supreme Court to reconsider its earlier abortion decisions but to resolve issues that are somewhat procedural. The decisions are expected by July 2007.

Thus, stare decisis proved a formidable principle for constancy as the Court once again declined to overrule *Roe* (see The Law in Action).

Sterilization

Sterilization is a surgical procedure intended to end one's ability to procreate. For men the most common procedure is a vasectomy; the operation for women is called a salpingectomy. In a legal analysis one should distinguish between voluntary and involuntary sterilizations and classify them according to their purpose. Voluntary sterilizations are those performed on patients who are competent to understand the nature of the procedure and have given a fully informed consent. Voluntary sterilizations fall into two groups: those performed for the patient's convenience (to prevent conception, for example) and those undertaken as therapeutic measures (where there are sound medical reasons for the procedure).

Involuntary sterilizations—those lacking the informed consent of the patient—may occur because the patient is incompetent to consent or because the state has declared the sterilization to be compulsory. Some involuntary

sterilizations, including those that are compulsory, are called "eugenic" because their purpose is to protect society from inheritable disability. Eugenic sterilizations are now rare. Such procedures must be authorized by statute, and few states have eugenic sterilization statutes. Some states, however, permit the sterilization of incompetent persons for the benefit of the patient.

Voluntary Sterilization

Currently there are no significant legal issues in connection with a legitimate therapeutic procedure that incidentally results in sterility. Such a procedure, such as hysterectomy (removal of the uterus) or orchidectomy (removal of the testes or ovaries) to treat cancer, for example, should probably not even be termed sterilization; it is simply a medical procedure that unavoidably makes one unable to procreate. All states permit such treatment for legitimate medical reasons. The term "sterilization" should be reserved for surgery, the intended purpose of which is to produce sterility.

Contraceptive sterilization has not always been lawful in all jurisdictions. For many years at least two states—Connecticut and Utah—expressly prohibited intentional sterilization and made it a criminal act. In Utah the statutory language seemed to prohibit all sterilizations except those dictated by medical necessity, but when the law was challenged the Utah Supreme Court ruled that it only applied to institutionalized patients because it was part of the Utah Code dealing with state institutions.[29] Voluntary sterilization of other patients was said not to be criminal.

Connecticut's law prohibited use of contraceptives (e.g., prophylactics) and giving advice or assistance in their use. Voluntary contraceptive sterilization was thus prohibited by implication. This statute was declared unconstitutional in the landmark case of *Griswold v. Connecticut* in which the U.S. Supreme Court ruled that the statute invaded a "zone of privacy created by several fundamental constitutional guarantees" that are protected by the due process clause of the Fourteenth Amendment. (As seen in The Law in Action, this viewpoint was not held unanimously.[30]) Another Connecticut statute, which purported to authorize sterilizations only pursuant to statutory provisions for eugenic sterilization, was repealed in 1971.

The Law in Action

"Since 1879 Connecticut has had on its books a law which forbids the use of contraceptives by anyone. I think this is an uncommonly silly law. As a practical matter, the law is obviously unenforceable…. But we are not asked in this case to say whether we think this law is unwise, or even asinine. We are asked to hold that it violates the United States Constitution. And that I cannot do.

…What provision of the Constitution [makes] this state law invalid? The Court says it is the right of privacy 'created by several fundamental constitutional guarantees.' With all deference, I can find no such right of privacy in the Bill of Rights, in any other part of the Constitution, or in any case ever before decided by this Court."

—Justice Stewart, dissenting in *Griswold* (with Justice Black)

Contraceptives aside, in most states the law is and always has been silent on the matter of sterilization. Modern mores and ideas about family planning have now firmly established voluntary sterilization as a matter of personal choice. Thus, there are now no significant legal barriers to sterilization for convenience, although there continues to be significant objection to it from some religious sources, particularly the Roman Catholic Church, on ethical grounds.

That being said, sterilization raises special issues concerning informed consent. Sterilization is a serious and usually permanent operation, forever depriving the patient of the ability to procreate. Patients, especially the young, may not always fully understand the consequences. Certain patients may misunderstand the nature of the operation (its irrevocability, for example) or whether insurance will pay for it. For these reasons, voluntary, informed consent is particularly necessary not only to ensure that the patient fully understands the operation and its consequences but also to make certain that no duress, coercion, or deception has been used.

Federal regulations govern all sterilizations performed under federally financed programs.[31] These rules lay out specific consent requirements so that patients fully understand the consequences of the procedure and are not led to believe that sterilization is related in any way to their right to receive federal assistance. The regulations permit sterilizations only of competent, voluntarily consenting individuals who are at least 21 years old and not institutionalized. They specify the information patients must be given before their consent is obtained: the nature of the procedure, the risks, the alternatives, and the uncertainty of reversing the sterilization procedure. Patients must also be told that they are free to withhold or withdraw consent and that this will not affect their future care or benefits. A 30-day waiting period is required between the written informed consent and the procedure, except in emergencies. The regulations include an approved consent form and information pamphlets. Because regulations are subject to change, hospitals, physicians, and other healthcare providers involved in federally financed sterilizations should keep fully updated on the current federal regulations that govern these procedures. In addition to the federal regulations, some states have laws governing voluntary sterilizations.

Sterilizations, like abortions, differ in some legal respects from other medical procedures. They affect the individual's "right of privacy," which encompasses the right to decide whether to procreate. Actions that deny or interfere with this right, amorphous though it be, may have legal consequences. Healthcare providers must be fully aware of state and federal laws governing sterilizations, and they should set up procedures to ensure compliance. Even in the absence of applicable legislation, the provider's policies and actions should make certain that the patient's consent is fully informed. If the competence or understanding of the patient is at all in doubt, legal and perhaps judicial guidance is advised.

Eugenic Sterilization and Sterilization of Incompetent Persons

Eugenics is the study of hereditary improvement by controlled selective breeding (genetic engineering). Thus, eugenic sterilization means surgery on persons alleged to be unsound or unfit to be parents because of presumably inheritable disabilities.

To be legal, a eugenic sterilization must be based on a state statute that is consistent with the protections of the state and federal constitutions. Approximately half of the states have never enacted statutes authorizing compulsory eugenic sterilization, and in another dozen or so states laws permitting eugenic sterilization have been repealed altogether or in part. In the dozen or so states where statutes remain on the books, the procedure is strongly disfavored and seldom used.

Whether eugenic or otherwise, sterilizations are typically vasectomies and salpingectomies (removal of the Fallopian tubes). Most of the authorized eugenic sterilizations are compulsory because the surgery can be performed without the consent of the patient or guardian (hence their infrequent use today). A few statutes permit only voluntary eugenic sterilization, which requires consent of the patient or the patient's legal representative.

Some statutes apply only to persons confined to state institutions (such as hospitals for the mentally ill, "training schools," or prisons), but some apply to other individuals as well. In any event, the statutes usually identify the persons subject to the law using such terms as "insane," "feeble minded," "habitual criminal," "mentally defective," "sexual psychopath," and similar designations presumably meaningful to medical science at one time but offensive to most observers today.

The constitutionality of these statutes was established by the famous Supreme Court case of *Buck v. Bell*,[32] which was decided in 1927 and is today roundly criticized. Carrie Buck had been duly committed to the state "colony" for epileptics and the "feeble minded." She was the daughter of a "feeble minded" mother who had also been confined to the institution, and at age 17 Carrie had given birth to an illegitimate child (the result of a rape by a relative of her foster parents). Following statutory procedures, a circuit court in Virginia ordered the superintendent of the institution to have a salpingectomy performed on Carrie. The state institution's superintendent engineered the test case in collusion with the law's author and a court-appointed attorney, who by all accounts conducted a purposefully inadequate defense for Carrie. The intent was to ensure that the eugenic sterilization law would be upheld, which it was.

After the trial court and Virginia's highest court upheld the law, it proceeded to the U.S. Supreme Court, where it was again upheld—by an 8-1 vote—in an opinion by Justice Oliver Wendell Holmes, one of the titans of American jurisprudence (see The Law in Action on page 400). By analogy to mandatory vaccination programs, the statute was held to be constitutional under the state's power to regulate the general health and welfare.

The Law in Action

To support his ruling that the state's interest in a "pure" gene pool outweighed the individual's interest in bodily integrity, Justice Holmes wrote:

> "We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. Three generations of imbeciles are enough."[33]

One thing about Justice Holmes, he was not always right, but he was never in doubt!

In fact, Carrie was not mentally handicapped, and her mother was only mildly so. Carrie's daughter was only one month old when she was labeled "mentally defective" by a Red Cross nurse. She died of the measles in 1932 and had by that time completed the second grade. Carrie herself lived into old age, married twice, but of course bore no children.

In contrast to *Buck*, in 1942 the Supreme Court held unconstitutional an Oklahoma statute that authorized sterilization of "habitual criminals" but exempted individuals described as "embezzlers." This it did because the exemption was an unreasonable classification in violation of the equal protection clause of the Fourteenth Amendment—there being no logical difference between embezzlers and other kinds of criminals (see The Court Decides: *Skinner v. Oklahoma ex rel. Attorney General* at the end of this chapter).[34] The Supreme Court also recognized procreation as a fundamental constitutional right, thus subjecting the statute to strict scrutiny regarding equal protection. *Buck v. Bell*, therefore, is no longer a valid precedent, although it has never been explicitly overruled.

As noted earlier, eugenic sterilization statutes have been much criticized. One underlying premise for the procedure—that traits such as mental illness and criminality are hereditary—has been largely discredited by the scientific community.[35] The legal support for the statutes has been attacked, and it is very unlikely that the laws could withstand constitutional scrutiny today.[36] It is just as well that they are ignored.

The "right of privacy" is more and more accepted and is not to be infringed except to serve a compelling state interest. Even then, such infringement must be narrowly drawn and shown to be clearly necessary; if there is any other way of meeting the state's need, that way must be chosen instead. The Minnesota Court of Appeals has observed that sterilization must not be used as a "subterfuge for convenience and relief from the responsibility of supervision."[37]

More than eight decades after *Buck v. Bell*, the disturbing premise of eugenics—that society has the right to decide who will be born and who may become parents—has been totally discredited. According to the New Jersey Supreme Court:

> It cannot be forgotten...that public attitudes toward mental impairment and the handicapped in general have sometimes been very different. We must always remain mindful of the atrocities that people of our own century and culture have committed upon their fellow humans. We cannot adequately express our abhorrence for the kind of ideology that assigns vastly differing value to the lives of human beings because of their innate group characteristics or personal handicaps.[38]

Although eugenic sterilization is all but obsolete in present U.S. law, the sterilization of incompetent persons for other reasons can still take place. It is, however, increasingly regarded as the right of the incompetent person (or guardian), rather than the right of the state, to make the decision. Sterilizations to prevent procreation of "undesirables" and to protect the public pocketbook are thus prohibited.

That being said, some sterilizations of incompetent persons may be morally and legally justified, such as those performed in the best interests of the incompetent person herself. Because the fundamental right of privacy allows competent persons to choose to be sterilized, that same right should be afforded the incompetent (through the guardian). This is the same reasoning used in decisions permitting the withdrawal of life-sustaining treatment for incompetent persons. As in right-to-die cases, the primary legal difficulties lie in how such decisions are made, who makes them, and what standards serve as their basis.

Hospital's Role in Reproductive Issues

Is a particular healthcare institution legally required to make abortion and sterilization services available to potential patients? As is so often the case in the law, the answer is, "it depends."

Some state or federal statutes contain a "conscience clause" that permits hospitals and physicians to refuse to perform abortions on moral or religious grounds. (This was discussed by way of dictum in *Doe v. Bolton*.[39]) In the absence of such a clause, the legal issue is whether the hospital that refuses to provide abortions or sterilizations is acting in the name of the state in denying the patient due process and equal protection of law—and thus violating the Fourteenth Amendment—or whether it is acting "under color of law" and denying civil rights. As emphasized repeatedly in various contexts throughout this book, the Fourteenth Amendment applies to state action; therefore, a state or any institution acting on its behalf may not prevent an individual from exercising constitutional or statutorily protected rights.

It seems to be well settled that a hospital owned and operated by federal, state, or municipal government may not refuse to permit abortions and

sterilizations that are lawful surgical procedures. (Publicly owned hospitals clearly act in the capacity of the government and are hence subject to the Fourteenth Amendment.) A leading decision is *Hathaway v. Worcester City Hospital*.[40] In this litigation the patient's physician recommended that she undergo a therapeutic sterilization because additional pregnancies might well threaten her life. The court ruled that a hospital's policy prohibiting all sterilization procedures denied the patient equal protection of the law.

The matter of whether the law should require a private hospital to furnish reproductive services is somewhat more difficult, but the weight of authority holds that the moral and religious convictions held by the institution should be respected. Thus, a private hospital need not provide abortion or sterilization services, even if it has been funded to a significant extent by federal money and receives such benefits as tax exemption.[41] The leading case is *Doe v. Bellin Memorial Hospital*,[42] decided by a federal court of appeals shortly before *Roe* and *Bolton*. As a private hospital, Bellin Memorial could prevent its staff physicians from performing legally permissible abortions because no state action was involved. Similarly, relying on *Bellin*, *Allen v. Sisters of St. Joseph* held that a Catholic institution could ban a voluntary sterilization procedure.[43]

In *Watkins v. Mercy Medical Center* a physician brought suit against a Catholic hospital that forbade both abortions and sterilizations.[44] The hospital's policy was upheld by a federal district court, which said that state action was not indicated merely by receipt of governmental money, state licensure, or tax exemption. Significant in this decision was that the Health Programs Extension Act of 1973 specifically provides that receipt of Hill-Burton money does not require a hospital to provide abortions or sterilizations as long as refusal is founded on religious beliefs or moral conviction.[45] (Although Mercy Medical Center was not required to permit the plaintiff physician to perform the desired surgical procedure, it could not terminate a medical staff appointment solely on the basis of the physician's personal beliefs.)

In sum, most decisions pertaining to private hospitals have held that no state action is involved under the Fourteenth Amendment and that voluntary institutions that prohibit abortion and sterilization do not act under "color of law" for purposes of the civil rights statutes.[46]

As mentioned, many states have specific conscience clauses to protect institutions' and individuals' moral or religious convictions. Most of these state laws relate only to abortions. They purportedly apply to all hospitals—governmental and private—but some are made applicable only to hospitals owned and operated by churches or religious orders. (The provisions of the Georgia statute discussed earlier were implicitly upheld in the case of *Doe v. Bolton*.[47]) Provisions pertaining to an individual's right of refusal to participate seem clearly constitutional. Perhaps the same can be said of the statutes recognizing the moral and religious convictions of a private sectarian hospital because these are valuable rights to be protected in a free society.[48]

A somewhat related issue is whether a state may deny Medicaid payments for elective or medically necessary abortions rendered to indigent patients. The eponymous Hyde Amendment, the first version of which was passed in 1976 and which has been renewed annually every year since, denies federal funding of abortions except to save the mother's life or in cases of rape or incest. The Supreme Court has ruled that the Medicaid law does not require a state participating in the Medicaid program to fund either elective nontherapeutic abortions[49] or medically necessary abortions[50] as a condition of participation. Because a private hospital need not provide abortion services, hospitalized patients who are refused an abortion or sterilization should be fully informed of their condition and provided with sound medical advice indicating where proper and appropriate care can be obtained.

Additional legal issues concern hospitals that do perform abortions and sterilizations. Most state statutes continue to criminalize third-trimester abortions that are not necessary to preserve the life or health of the mother. A hospital has a duty to prevent criminal acts from occurring on its premises; hence, counsel must carefully advise the hospital and its medical staff about the current legal status of pregnancy terminations. Administrative policies and procedures must be developed to make sure that the institution and its staff perform their duties in a lawful manner.

As it should be evident, issues of informed consent and conformance with the applicable standard of care are no different in the case of abortions than in any other surgical procedures. Quality assurance and risk management programs are just as important in this area as they are in other areas of the hospital.

Wrongful Birth and Wrongful Life

Sometimes sterilization, and even abortion, procedures fail. Rarely have both failed in one sequence of events involving the same couple; however, this is what happened in *Speck v. Finegold*.[51]

Frank Speck suffered from a genetic disease known as neurofibromatosis (see Legal Brief). He fathered two children; both of them also had neurofibromatosis. Fearing that future offspring would be similarly afflicted,

Legal Brief

Neurofibromatosis is a genetic disease characterized by usually benign tumors of the nerve fibers (neurofibromas) on and under the skin and is sometimes accompanied by bone deformity and a predisposition to cancers, especially of the brain. It is also called multiple neurofibroma, neuromatosis, Recklinghausen's disease, and von Recklinghausen's disease.

Joseph Merrick (the "elephant man") was once thought to have been afflicted with neurofibromatosis, but it is now generally believed that Merrick suffered from the very rare Proteus syndrome. (See, for example, National Institutes of Health, "NINDS Neurofibromatosis information page at www.ninds.nih.gov/disorders/neurofibromatosis/neurofibromatosis.htm.)

Mr. and Mrs. Speck decided that they should have no more children and that he should have a vasectomy. Dr. Richard Finegold performed the procedure in early 1974 and then assured Mr. Speck that he "could engage in sexual relations with his wife without contraceptive devices." Mrs. Speck became pregnant anyway. Under her new "right to choose" (*Roe v. Wade* was about a year and a half old) she went to Dr. Henry Schwartz to have an abortion. Afterward Dr. Schwartz told her the abortion was successful. But it was not; she was still pregnant. (The opinion does not explain how a physician could *think* he aborted a pregnancy when in fact he did not.) In April 1975 Mrs. Speck gave birth to a third child, Francine, who also had neurofibromatosis. This led the Specks and Drs. Finegold and Schwartz to the courthouse steps.

The central questions in this bizarre case were these: Were the Specks entitled to bring suit against the physicians who performed the operations? If so, what were their damages? May they recover for mental distress? What about the costs of raising Francine? Would the amount of damages be different if she had been born healthy? (After all, healthy or not the Specks tried to avoid having a third child.) Does Francine herself have a right to recover damages?

Pulling together the decisions of the appellate court and the Commonwealth of Pennsylvania's Supreme Court, the ultimate answers were (a) the existing principles of tort law apply and (b) if negligence were proven, the parents were entitled to recover for the costs of care and treatment of their daughter and for their own mental distress. The issue of whether the child herself had a legally cognizable injury for what has become known as "wrongful life" was left hanging. The court split evenly on the question, saying somewhat turgidly: "The Court being evenly divided on the question of whether an infant plaintiff can bring an action in the circumstances of this case, the Order of the Superior Court that the infant plaintiff's cause of action is not legally cognizable is affirmed."

Many courts before and since *Speck* have addressed wrongful birth and wrongful life cases. The actions have often been labeled "wrongful conception" if the alleged negligence occurred before conception, "wrongful birth" for an action by the parents on their own behalf, and "wrongful life" when the suit is brought on behalf of the child. Not all courts use the same terminology, and "wrongful birth" is sometimes an umbrella term for all such actions. The number of these cases has increased in the last decades of the twentieth century, largely because of two simultaneous developments: (1) the legal recognition of parents' right to decide whether to conceive or abort and (2) the great advances in medical science that make genetic testing and counseling, sterilization, and abortions commonplace medical practices. Legal actions have arisen in various circumstances, including the following:

- unsuccessful contraceptive measures, including negligently performed sterilizations;

- failure to provide genetic counseling or testing;
- failure to diagnose and inform the patient of pregnancy;
- failure to detect and warn the patient of diseases, such as rubella or genetic defects, early enough to permit abortion; and
- negligence in performing an abortion.

Births resulting from these failures may result in either a handicapped or a healthy but unplanned child. These are all examples of traditional medical malpractice, but their unique feature is that if the physician had not been negligent the child would never have been born. Rather than claiming an injury to an already existing person (or in some cases one who would have been born healthy if there had been no negligence), these plaintiffs are claiming that the very existence of the child is the injury. Such cases have caused considerable legal and philosophical angst.

As we know, to succeed in any malpractice case the plaintiff must prove a duty of care, a breach of that duty, an injury proximately caused by the breach, and legally recognized damages. In the wrongful birth and wrongful life arena the courts have had little difficulty discerning duty and breach, but they have struggled with causation and, especially, the measure of damages.

Courts in virtually all jurisdictions have held that physicians owe a duty of care not only to the parents but also to the unborn child. For example, in *Turpin v. Sortini* the parents of a little girl were told she had normal hearing when in fact she was deaf from a hereditary condition.[52] The couple's next child was also deaf. The court held that the professional who tested the first child's hearing had a duty to the second child because it was foreseeable that the parents and their "potential offspring" would be directly affected by the negligent diagnosis.

The physician's duty in these and other medical malpractice cases is, of course, to conform to the generally accepted standards of care exercised by other physicians in similar circumstances at the time of the alleged malpractice. For example, in 1969, a physician allegedly failed to tell his patients of the risk that their baby would be afflicted with cri du chat syndrome (see Legal Brief on page 406), a chromosomal disorder causing severe mental retardation, among other afflictions. He did not perform amniocentesis. The parents sued for damages after their child was born with cri du chat, but their suit was rejected because "on the bases of the patient's medical history and the state of medical knowledge regarding the use of the amniocentesis test in 1969, the defendants' failure to perform the test was no more than a permissible exercise of medical judgment and not a departure from then accepted medical practice."[53]

In contrast, in 1974, a physician was held liable after he failed to advise his 37-year-old pregnant patient of the increased risk for women over age 35 of bearing a child with Down syndrome and did not advise her of the availability

Legal Brief

Cri du chat, which literally means "cry of the cat" in French, is from the distinctive mewing sound made by infants with the disorder. As babies, patients tend to be squirmy with a mewing cry, ascribed to abnormal development of the larynx. The cry becomes less distinctive with age. Individuals with cri du chat syndrome are often underweight at birth. The disorder is characterized by distinctive facial features, small head size (microcephaly), low birth weight, weak muscle tone, a round face, low-set ears, strabismus (a condition in which the eyes do not point in the same direction), and facial asymmetry. Cardiac malformations may occur and affect the vital prognosis. The importance of the whole syndrome seems to vary depending on the amount of lost DNA material.

In terms of development and behavior, severe mental retardation is typical. Expressive language is an area of weakness, and signing is often used. Hypersensitivity to noise is common. In addition, some have autistic traits, such as repetitive behaviors and obsessions with certain objects. Apparently, many enjoy pulling hair. Often they are happy children and sometimes are described as "loving" and sociable (see www.nlm.nih.gov/medlineplus/ency/article/001593.htm).

of amniocentesis to detect the defect. The court reasoned that by then amniocentesis was an accepted medical practice, abortion was recognized as a patient's right, and genetic counseling had become customary.[54] In fact, because genetic testing can now reveal many types of birth defects, the standard of care today requires that prospective parents who risk occurrence of a defect be counseled about available tests and medical alternatives such as abortion, even if the defect cannot be cured and abortion is the only way to prevent the birth.[55] This duty is imposed although it may be against the physician's conscience or morals to recommend abortion. Courts have held that physicians are not required to recommend abortion, but they must at least inform patients of the facts and the available alternatives or refer a patient to another practitioner early enough to allow a choice of solutions.

Liability has been found for other types of negligence in wrongful birth cases. For example, liability has been found not only for negligent sterilizations and unsuccessful abortions but also in cases involving the following:

- a failure to diagnose rubella in a pregnant woman whose child was born with a handicap;[56]
- a failure to diagnose cystic fibrosis in the parents' first child, thus leaving the parents unaware of the risk that a second child would be similarly afflicted;[57]
- the dispensing of tranquilizers instead of birth-control pills;
- a mistake resulting in the birth of a healthy but unwanted child;[58] and
- the failure to inform the patient that the drug she was taking to control her epilepsy could cause birth defects.[59]

Even if a plaintiff has a provable claim of malpractice, the suit must, of course, be brought within the applicable statute of limitations. Histori-

cally the statute for medical malpractice actions began to run at the time of the alleged malpractice (or breach of contract, if the jurisdiction recognizes breach of contract as a cause of action). Hence, the cause of action would be barred when the time, measured from the date of the alleged wrong, had expired. Because pregnancy and birth may occur years after the sterilization procedure, however, the tendency of recent decisions is to hold that the statute will run from the time the tort or breach of contract is discovered or when in the exercise of reasonable care it should have been discovered. In other words, the statute runs from the time the pregnancy was or ought to have been known.[60] (Application of the "discovery rule" to cases of wrongful birth follows the development of the rule in other malpractice situations. At least one court has held that the statute of limitations in a case involving a child with congenital birth defects begins to run from the date of birth.[61])

As noted earlier, courts have had little difficulty with issues of duty and breach in this area, but they have come to widely inconsistent conclusions about causation and damages, especially in wrongful life. Most courts have held in favor of the parents' cause of action, finding proximate cause in the fact that but for the physician's negligence, the child would never have been born. (In certain cases the plaintiff may have to prove that she would have had an abortion or chosen not to conceive.). In at least one case, involving alleged negligence in performing a sterilization, the defendants claimed that the husband's sexual relations with his wife were an "intervening cause" of the pregnancy, thereby relieving the defendants of responsibility. The court was not amused.[62] Courts have also uniformly rejected the claim that the parents have a duty to mitigate damages by obtaining an abortion or placing the child for adoption.[63]

Although the courts recognize that the parents of unwanted or handicapped children have been harmed, they have had trouble determining the proper damages because public policy values life and generally views the birth of a child as a blessing. Virtually all courts that recognize a cause of action for wrongful birth have allowed parents to recover expenses for the pregnancy and childbirth, even when the child was healthy.[64] Other damages, such as lost wages, have also been held recoverable.[65] Damages for the woman's pain and suffering as a result of the pregnancy and birth have been allowed,[66] as well as damages for the husband's loss of consortium.[67] Courts disagree when it comes to damages for the parents' emotional distress. When a child was born with a serious disease or disability, some have permitted compensation for mental distress. For example, in one Virginia case, a man's blood was mislabeled and the couple did not discover that he was a carrier of Tay-Sachs disease (a usually fatal genetic disorder) until their child was born with it. Damages were allowed for the parents' emotional distress over the child's suffering and death.[68] In another case involving Tay-Sachs, however, the

court denied damages for emotional harm arguing that the child suffered the injury, not the parents.[69]

Claims for the expense of raising a disabled child arouse more controversy. Almost all jurisdictions view the birth of a child, even one with disabilities, as an occasion of some benefit and joy to the parents. A traditional rule of tort law, the "benefit rule," requires that any damages awarded to an injured plaintiff be reduced by the value of any benefit that the tort-feasor bestowed upon the plaintiff. Most courts, even those allowing the costs of child rearing in wrongful birth cases, require the jury to offset the damages with the benefits of having the child to the parents.[70] (Some juries find that these benefits outweigh the costs of rearing the child and therefore deny any child-rearing costs,[71] a somewhat surprising finding given the indeterminate and somewhat metaphysical nature of the calculus involved.)

In *Cockrum v. Baumgartner* a negligent sterilization failed to prevent pregnancy, and an unwanted but healthy child was the result.[72] The court recognized the parents' cause of action for wrongful birth because the decision not to have a child is a legally protected right and its violation cannot be ignored. Noting that damage awards are an effective recognition of legal rights, the court allowed the costs of raising the child. It held that the benefit rule applies only if the benefit is to the same interest that was harmed. The court found that the emotional benefits of child rearing are separate from the injured financial interests of the parents. The extraordinary costs of raising a handicapped child—payments for institutional or other specialized care, medical expenses, and special education and training—have generally been allowed. These amounts are arrived at by identifying the extra expenses beyond what would be spent on a healthy child.[73] Even in these cases, however, some courts have held that the advantages of parenthood and the child's own life outweigh the burdens of child rearing.[74]

In contrast to wrongful birth cases, a child's cause of action for wrongful life has been recognized to-date in only a few states. No such action has been allowed on behalf of a healthy child who was unwanted or illegitimate because the courts have found that the child suffered no injury.[75] Even when the child is suffering from a grave disease or birth defect, most courts have repeatedly refused to recognize a cause of action.[76] This refusal has been on several grounds:

- the professional negligence was not the cause of the disease or injury;
- life, even one that is impaired, cannot be seen as a legal injury; and
- damages for an impaired life, as opposed to no life, cannot be determined.

The purpose of compensatory damages is to restore the plaintiffs to the position they would have occupied had there been no negligence. In wrongful

life cases, that position would be nonexistence: But for the defendant's negligence the child would not have been born at all. Most courts have held that no one can determine the value of nonexistence, and therefore such actions must fail, lacking the necessary requirements of proximate cause and legally compensable injury. Courts have also held that there is no fundamental right to be born healthy.[77] Some courts also believe that allowing a cause of action for wrongful birth would diminish the value of human life and would be contrary to society's goal of protecting, preserving, and improving the quality of human existence.[78] A few states, however, have rejected these arguments and have recognized a cause of action for wrongful life. In *Curlender v. Bio-Science Laboratories, Inc.* the plaintiff was a child born with Tay-Sachs disease allegedly as a result of negligent testing to determine whether the parents were carriers.[79] The child was mentally and physically disabled and had a life expectancy of only four years. The California Court of Appeals, finding a "palpable injury" to the child, held that the child could recover damages for pain and suffering and pecuniary loss because of the impaired condition. Costs of care were to be awarded only once, however, not to both the parents and the child.

The California Supreme Court recognized another child's cause of action for wrongful life in *Turpin v. Sortini* and rejected the argument that such actions were against public policy.[80] According to the court it was "hard to see how an award of damages to a severely handicapped or suffering child would 'disavow' the value of life or in any way suggest that the child is not entitled to the full measure of legal and nonlegal rights and privileges accorded to all members of society."[81] According to the court's finding, one could not say as a matter of law that an impaired life is always preferable to no life.

A California statute recognizes the fundamental right of adults to control medical decisions, including the decision to withdraw or withhold life-sustaining procedures.[82] By analogy, the *Turpin* court found that these parents were prevented from making an informed and meaningful choice whether to conceive or bear a handicapped child and that the choice is partly on behalf of the child. Although the court agreed with other opinions that general damages would be impossible to assess, it found that the extraordinary expenses of caring for a disabled child were not speculative. It held that it would be illogical to permit the parents but not the child to recover for the costs of medical care related to the disability. Otherwise, the court stated, the child's receipt of necessary medical expenses would depend on whether the parents sued and recovered damages or whether the expenses were incurred when the parents were still legally responsible for the child's care. (See The Law in Action.)

The Law in Action

In *Turpin* the negligence was failure to adequately diagnose the plaintiffs' first daughter's hereditary deafness. This failure led to the birth of the second daughter who had the same condition. The girls were named Hope and Joy.

The Washington Supreme Court also found that a child should have a cause of action for wrongful life. In *Harbeson v. Parke-Davis, Inc.*, it held that imposing liability for wrongful life would promote social objectives, such as genetic counseling and prenatal testing, and would discourage malpractice.[83] The court had no difficulty finding the requisite proximate cause:

> It is clear in the case before us that, were it not for negligence of the physicians [in not advising the mother of the danger of taking a certain drug during pregnancy], the minor plaintiffs would not have been born, and would consequently not have suffered fetal hydantoin syndrome. More particularly, the plaintiffs would not have incurred the extraordinary expenses resulting from that condition.[84]

The distinction between parents' and children's causes of action is important. Awards to the parents would only cover their expenses during the time they are legally responsible for the child—for example, until majority. The child's own damages, however, could continue throughout life, perhaps many more years beyond the age of majority.

Some states have passed laws concerning actions for wrongful life and wrongful birth. In *Curlender*, discussed earlier, the California Court of Appeals said in dictum that children born with a birth defect should be allowed to sue their parents for their pain and suffering if they foresaw the defect and chose not to abort. The California legislature quickly responded with a statute outlawing such a case lest parents feel pressured to abort or prevent conception.[85] Minnesota went further with legislation prohibiting actions for wrongful birth and wrongful life that claim "but for the alleged negligence a child would have been aborted."[86] (The statute does permit actions for failure of a contraceptive method or a sterilization procedure and for failure to diagnose a disease or defect that could have been prevented or cured if detected early enough. Abortion is not viewed as a prevention or cure, however, and neither the failure nor the refusal of anyone to perform or obtain an abortion constitutes a defense in any action or a consideration in the award of damages.[87])

Wrongful birth and wrongful life cases show that as medical knowledge and technology expand, the duty of the physician also grows, not only to perform tests and procedures with the necessary care but also to provide genetic counseling. In addition to performing all duties carefully, physicians should carefully document in the medical record any discussions with patients about the possible genetic and other risks to the patient's unborn or unconceived children and about the availability of appropriate preconception or prenatal testing, therapies, and alternatives. The documentation should also cover the patient's decision concerning the risks, testing, and alternatives. Recording informed consent for medical treatment is essential in any circumstance, but it is especially so in the important and constitutionally protected matter of procreation.

Other Reproduction Issues

Three other kinds of cases deserve note: surrogate parenting, in vitro fertilization, and the use of stem cells in medical treatment and research. The last of these can be addressed quickly. As of October 2006, only 16 states reported cases in which the phrase "stem cell" appeared in the opinions. All but one involved issues immaterial to this discussion (like insurance coverage) or used the expression in a rather tangential way (such as when stem cell was part of a company name or was the treatment underlying a medical malpractice case). The one even marginally substantive case involved whether the loss or destruction of fertilized eggs by a fertility clinic fell under the ambit of a state's wrongful death statute. The court punted that issue and the question of when life begins to the legislature and discussed stem-cell research only in passing. One can expect to see more litigation directly on issues relating to stem cells—especially stem-cell research—in the future, but for now they occupy but a few folios in the vast legal literature.

Surrogate parenting, on the other hand, has gathered much attention. Surrogacy is the practice of carrying a fetus to term for another woman, generally for a fee. The embryo from which the fetus grows may result from artificial insemination or in vitro fertilization (IVF—fertilizing the egg outside the uterus under laboratory conditions), or it may have been conceived normally and transferred to the surrogate because the natural mother was known to be unable to continue the pregnancy without miscarriage. If either artificial insemination or IVF is used, the sperm may or may not be that of the husband of the egg-bearing woman. In fact, the genetic "parents" (whose identities may or may not be known) can be different than the "parents" for whom the surrogate mother carries the child.

As seen in Legal Brief, there are many permutations of these legal relationships. For example, in *In re Baby M*,[88] the supreme court of New Jersey was asked to determine parental status after a surrogate mother reneged on her contract to surrender the child after birth. The contract was between Mary Beth Whitehead and William Stern, whose wife was infertile. It provided that for a fee of $10,000, Ms. Whitehead would be inseminated with Mr. Stern's sperm, would conceive a child and carry it to term, and then would give the child, Baby M, to Mr. and Mrs. Stern for the latter to adopt.

Legal Brief

Up to seven different people can be involved in IVF:

- sperm donor;
- egg donor;
- spouses of both sperm and egg donors;
- surrogate mother, who has a "womb to rent" and ultimately gives birth;
- surrogate mother's husband, who may or may not be the sperm donor; and
- the baby.

In artificial insemination, the egg donor and surrogate mother are the same, as in the *Baby M* case.

(Mr. Stern, having been the sperm donor, would be recognized as the natural father.) When Ms. Whitehead failed to abide by the contract, the Sterns filed suit. Although the lower court determined that the surrogacy contract was valid, the New Jersey Supreme Court disagreed.

In reaching its conclusion, the court found that the contract conflicted with New Jersey laws prohibiting the use of money in connection with adoptions. According to the court, "The contract's basic premise, that the natural parents can decide in advance of birth which one is to have custody of the child, bears no relationship to the law that the child's best interests shall determine custody." The court continued,

> This is the sale of a child, or, at the very least, the sale of a mother's right to her child, the only mitigating factor being that one of the purchasers is the father. Almost every evil that prompted the prohibition on the payment of money in connection with adoptions exists here.

The court next needed to settle the issue of who should have custody of Baby M. It held that the claims of the genetic father (Mr. Stern) and the natural mother (Ms. Whitehead) are entitled to equal weight and determined that the child's best interests would be the deciding factor. Weighing the personalities, financial situations, and family lives of all the parties, the court concluded that the child's best interests called for custody to be given to the Sterns but that Ms. Whitehead should be allowed visitation rights.

A Kentucky case appears to contradict *Baby M.* In the 1986 decision *Surrogate Parenting Associates, Inc. v. Commonwealth ex rel. Armstrong*,[89] a company that assisted infertile couples by arranging surrogate motherhood was sued by the state attorney general. The suit alleged that the activities of Surrogate Parenting Associates (SPA) violated a state statute prohibiting the sale, purchase, or procurement for sale or purchase of "any child for the purpose of adoption." The court held that SPA's activities did not constitute buying and selling babies because "there are fundamental differences between the surrogate parenting procedure in which SPA participates and the buying and selling of children as prohibited by [law]." (See Legal DecisionPoint.) The court wrote approvingly of SPA's services:

Legal DecisionPoint

How do you think the Kentucky court would have decided if *Baby M* had arisen in that commonwealth?

> [W]e have no reason to believe that the surrogate parenting procedure…will not, in most instances, proceed routinely to the conclusion desired by all of the parties at the outset—a woman who can bear children assisting a childless couple to fulfill their desire for a biologically-related child.

Another example of the kinds of disputes that arise from new reproductive technologies was apparent in *Davis v. Davis*.[90] The case began as a divorce action in which the parties—appellee Junior Lewis Davis and his appellant wife, Mary Sue Davis—agreed on all settlement terms except the disposition of seven frozen embryos that were the product of IVF. Mrs. Davis had asked for custody of the embryos to become pregnant after the divorce. (She later changed her mind and stated that she wanted to donate them to another couple for implantation.) Mr. Davis did not agree. The trial court held that the embryos were "human beings" from the point of conception, and it awarded custody to Mrs. Davis. The court of appeals reversed, holding that Mr. Davis had a constitutional right not to beget a child in this manner and that the state had no compelling interest to overrule either party's wishes.

The supreme court of Tennessee began its consideration by addressing the issue of whether the embryos were "persons" or "property" in the eyes of the law. It concluded that neither Tennessee law nor the U.S. Constitution would consider them "persons," but it also found that the embryos deserved greater respect than that of mere property because of their potential to become human beings. Thus, the court set aside the persons/property issue to focus on the essential dispute of whether the Davises will become parents. In balancing the parties' interests, the court found that to grant Mrs. Davis's wish could result in unwanted fatherhood for Mr. Davis, "with all of its possible financial and psychological consequences." This, the court held, was a greater burden than Mrs. Davis's disappointment of knowing that the IVF procedures she underwent were futile and that the embryos would never become children. Mr. Davis won.

Chapter Summary

Issues relating to reproduction are sensitive and often contentious. This chapter reviews many of the issues relating to abortion, sterilization, wrongful life, wrongful birth, surrogate parenting, in vitro fertilization, and stem-cell research. It also discusses the hospital's role in reproductive issues, such as whether it can be required to provide such services and when it can expect governmental programs to pay for them if they are provided. We conclude with the realization that abortion-related issues will continue to be subjects of judicial review and that the number of cases considering stem-cell research will increase.

Chapter Discussion Questions

1. In *Griswold* Justice Stewart skewered the majority for asserting that the Ninth Amendment of the U.S. Constitution supported their decision to

overturn the Connecticut contraception statute. He wrote, "the idea that a federal court could ever use the Ninth Amendment to annul a law passed by the elected representatives of the people of the State of Connecticut would have caused James Madison no little wonder." What does the Ninth Amendment say, and why would Justice Stewart say that President Madison, in particular, would be perplexed by its use to justify the majority's opinion?

2. Can the *Buck* and *Skinner* decisions be reconciled?
3. In *Turpin v. Sortini* the supreme court of California said it was difficult to understand how awarding damages to a child who would not have been born if not for the defendants' negligence "would disavow the value of life…." "Deprecate" is probably a better word choice in the context of that sentence, so can you construct the moral argument that as a public policy matter such an award would in fact deprecate the value of human life?
4. Summarize the state of the law following the Supreme Court's decision in *Planned Parenthood v. Casey.*
5. What is the difference between a "wrongful life" case and a "wrongful birth" case? What are the differences in the measure of damages in each?
6. Can you predict what kinds of legal issues will be presented in coming years as a result of stem-cell research?

Notes

1. See Roe v. Wade, 410 U.S. 113, notes 27–28 (1973).
2. Lord Ellenborough's Act, 42 Geo. 3, ch. 58. Parliament reversed this position by enacting a liberal abortion bill in 1967.
3. The statutory language of "preserving the life of the mother" was liberally interpreted. In Rex v. Bourne (1939) 1 K.B. 687 (1938), a physician who induced an abortion for a 14-year-old rape victim was acquitted of criminal charges after the judge instructed the jury that a doctor was acting within the law to prevent the patient from becoming a mental or physical "wreck."
4. Model Penal Code § 230.3(2) (1962).
5. 410 U.S. 113 (1973).
6. Doe v. Bolton, 410 U.S. 179 (1973), reh'g denied, 410 U.S. 959 (1973).
7. Such a requirement is clearly constitutional. May v. State of Ark., 254 Ark. 194, 492 S.W.2d 888 (1973), cert. denied, 414 U.S. 1024 (1973). This decision was rendered after the Roe and Bolton cases. See also State v. Norflett, 67 N.J. 268, 337 A.2d 609 (1975).
8. Note that the court in Roe v. Wade did not decide when life begins or when the fetus becomes a "person." Physicians, theologians, and philosophers have long debated these questions. Rhode Island legislation, enacted after the landmark Supreme Court cases, declared that life begins at conception and that accordingly abortion at any stage of pregnancy is criminal. This law was declared unconstitutional, even though the Roe case had sidestepped this particular question. Doe v. Israel, 358 F. Supp. 1193 (D.R.I. 1973), cert. denied, 416 U.S. 993 (1974). Hence, the constitutional right to have an abortion, as articulated by Roe, may not be avoided by a state statute expressing another philosophy or other grounds that attempt to circumvent individual rights. Further, the Roe and Bolton decisions have been held to apply

retroactively. A criminal conviction of a physician under an abortion statute now declared unconstitutional must be vacated even if it preceded the Supreme Court decision. State v. Ingel, 18 Md. App. 514, 308 A.2d 223 (1973).

9. City of Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416 (1983) at 456, 458 (O'Connor, J., dissenting).
10. 410 U.S. 179 (1973).
11. This was taken by many to mean that states could require that second-trimester abortions be performed only in hospitals. However, such a requirement was later found unconstitutional. City of Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416 (1983).
12. Planned Parenthood Ass'n of Kansas City, Mo., Inc. v. Ashcroft, 462 U.S. 476 (1983).
13. See Planned Parenthood of Central Mo. v. Danforth, 428 U.S. 52 (1976).
14. Simopoulos v. Virginia, 462 U.S. 506 (1983).
15. Planned Parenthood of Central Mo. v. Danforth, 428 U.S. 52 (1976).
16. Pa. Cons. Stat. Ann. §§ 3211(a), 3214(h) (Purdon 1983). The statute was ruled unconstitutional in American College of Obstetricians v. Thornburgh, 106 S. Ct. 2169, 2182 (1986). Physicians had to sign and file a report the following month identifying themselves and naming the hospital or clinic; the referring physician, agency, or service; the woman's place of residence, age, race, and marital status; the number of her prior pregnancies; the date of her last menstrual period; the probable gestational age of the unborn child; the "length and weight of the aborted unborn child"; the method of payment for the procedure; and the basis for "any medical judgment that a medical emergency existed" and for the physician's determination "that a child is not viable."
17. Each of the last four points was decided in City of Akron, supra note 9.
18. Colautti v. Franklin, 439 U.S. 379, 387 (1979) (quoting Roe v. Wade, 410 U.S. at 160, 166).
19. 439 U.S. 379 (1979).
20. Id. at 382.
21. Id. at 388–89.
22. Id. at 393.
23. See also Charles v. Daley, 749 F.2d 452 (7th Cir. 1984), appeal dismissed sub nom. Diamond v. Charles, 106 S. Ct. 1697 (1986)—statute that proscribed abortion after viability and prescribed standard of care was unconstitutionally vague.
24. 462 U.S. 476 (1983).
25. American College of Obstetricians v. Thornburgh, 106 S. Ct. 2169 (1986).
26. 492 U.S. 490 (1989).
27. 505 U.S. 833 (1992).
28. Stenberg v. Carhart, 530 U.S. 914, 931 (2000).
29. Parker v. Rampton, 28 Utah 2d 36, 497 P.2d 848 (1972).
30. 381 U.S. 479 (1965). See also Eisenstadt v. Baird, 405 U.S. 438 (1972)—unmarried persons have the same constitutional right to privacy with respect to contraceptive measures as married persons do.
31. 42 C.F.R. §§ 50.201–50.210.
32. 274 U.S. 200 (1927).
33. For more commentary on this case, see Burgdorf and Burgdorf, "The Wicked Witch Is Almost Dead: Buck v. Bell and the Sterilization of Handicapped Persons," 50 *Temple L. Q.* 995 (1977), and R. Posner, *Law and Literature* 273 (1998). Judge Posner says of the opinion, "[It] would be a poorly reasoned, a brutal, and even, to a modern sensibility, a vicious opinion even if Carrie Buck really had been an imbecile. But it is a first-class piece of rhetoric [nonetheless]."
34. Skinner v. Oklahoma, 316 U.S. 535 (1942).
35. See, for example, North Carolina Ass'n for Retarded Children v. State of N.C., 420 F. Supp. 451, 454 (1976), in which the court made a finding of fact that "[m]ost competent geneticists now reject social Darwinism and doubt the premise implicit in Mr. Justice Holmes' incantation that '...three generations of imbeciles is enough.' [P]revalent medical opinion views with distaste even voluntary sterilizations for the mentally retarded and is inclined to sanction it only as a last resort and in relatively extreme cases. In short, the medical and genetical experts are

no longer sold on sterilization to benefit either retarded patients or the future of the Republic."

36. See Burgdorf and Burgdorf, supra note 33.
37. Matter of Welfare of Hillstrom, 363 N.W.2d 871, 876 (Minn. App. 1985)—sterilization was not warranted for a 41-year-old mentally retarded woman who was closely supervised and was not likely to engage in sexual intercourse.
38. In re Grady, 85 N.J. 235, 245, 426 A.2d 467, 472 (1981). See also Burgdorf and Burgdorf, supra note 33.
39. 410 U.S. 179, 197 (1973).
40. 475 F.2d 701 (1st Cir. 1973), appeal for stay of mandate denied, 411 U.S. 929 (1973), reversing the federal district court, which had held that the patient possessed no constitutional right to have a sterilization performed in a city hospital. 341 F. Supp. 1385 (D. Mass. 1972). The decision of the court of appeals was rendered after the Roe and Bolton cases on abortion.
41. Taylor v. St. Vincent's Hosp., 369 F. Supp. 948 (D. Mont. 1973), aff'd, 523 F.2d 75 (9th Cir. 1975), cert. denied, 424 U.S. 948 (1976). The federal district court issued a temporary injunction enjoining a private hospital from enforcing a ban on sterilization on the basis that receipt of governmental funds resulted in "state action." Subsequently the injunction was dissolved and the initial decision was thereby reversed, Taylor v. St. Vincent's Hosp., 369 F. Supp. 948 (D. Mont. 1973), thus upholding the hospital's policy of not permitting surgical sterilization.
42. 479 F.2d 756 (7th Cir. 1973).
43. 361 F. Supp. 1212 (N.D. Tex. 1973), appeal dismissed, 490 F.2d 81 (5th Cir. 1974). Moreover, the district court's decision is not now reviewable by the circuit court of appeals, because the patient in fact obtained sterilization at another hospital. Allen v. Sisters of St. Joseph, 490 F.2d 81 (5th Cir. 1974).
44. 364 F. Supp. 799 (D. Idaho 1973), aff'd, 520 F.2d 894 (9th Cir. 1975).
45. Health Programs Extension Act, 42 U.S.C.A. § 300a-7 (1973). Where nothing in the record proves that a private hospital's policy of prohibiting abortions is based on institutional religious beliefs or moral convictions, the Health Programs Extension Act does not apply. Moreover, a private hospital is engaged in "state action" when it has received Hill-Burton and other governmental funds. Doe v. Charleston Area Medical Center, 520 F.2d 638 (4th Cir. 1975).
46. See also Chrisman v. Sisters of St. Joseph of Peace, 506 F.2d 308 (9th Cir. 1974) (Health Programs Extension Act, 42 U.S.C.A. § 300a-7 is constitutional). Greco v. Orange Memorial Hosp., 374 F. Supp. 227 (E.D. Tex. 1974), aff'd, 513 F.2d 873 (5th Cir. 1975), cert. denied, 423 U.S. 1000 (1975)—a private hospital is not engaged in "state action," even though it receives a significant amount of governmental funds; thus, it may bar abortions. The denial of certiorari by the Supreme Court in effect permits conflicting decisions on "state action" to remain, without resolving the issue on constitutional merits.
47. 410 U.S. 179, 197 (1973).
48. Chrisman v. Sisters of St. Joseph of Peace, 506 F.2d 308 (9th Cir. 1974).
49. Beal v. Ann Doe, 432 U.S. 438 (1977); moreover, the equal protection clause of the Fourteenth Amendment does not require a state participating in the Medicaid program to pay expenses of nontherapeutic abortions for indigent women even though it does pay expenses of childbirth, Maher, Comm'r of Social Servs. of Conn. v. Susan Roe, 432 U.S. 464 (1977).
50. Harris v. McRae, 448 U.S. 297 (1980), reh'g denied, 448 U.S. 917 (1980). The court also held that the Hyde Amendment does not violate due process, equal protection under the Fifth Amendment, or the Establishment Clause of the First Amendment.
51. Speck v. Finegold, 268 Pa. Super. 342, 408 A.2d 496 (1979), modified, 497 Pa. 77, 439 A.2d 110 (1979).
52. 31 Cal. 3d 220, 182 Cal. Rptr. 337, 643 P.2d 954 (1982).
53. Johnson v. Yeshiva Univ., 42 N.Y.2d 818, 820, 396 N.Y.S.2d 647, 648, 364 N.E.2d 1340, 1341 (1977).
54. Becker v. Schwartz, 46 N.Y.2d 401, 413 N.Y.S.2d 895, 386 N.E.2d 807 (1978).
55. Examples of wrongful birth actions for negligence in genetic counseling, testing, or diagnosis include (among others) cases involving Down syndrome—see, for example, Call v. Kezirian,

135 Cal. App. 3d 189, 185 Cal. Rptr. 103 (1982); Berman v. Allen, 80 N.J. 421, 404 A.2d 8 (1979); Azzolino v. Dingfelder, 71 N.C. App. 597, 322 S.E.2d 567 (1984), review granted, 327 S.E.2d 887 (1985); Phillips v. United States, 508 F. Supp. 537 (D.S.C. 1980), 508 F. Supp. 544 (D.S.C. 1981); and Tay-Sachs disease, see, for example, Curlender v. Bio-Science Laboratories, 165 Cal. Rptr. 477, 106 Cal. App. 3d 811 (1980); Goldberg v. Ruskin, 128 Ill. App. 3d 1029, 471 N.E.2d 530 (1984); Gildiner v. Thomas Jefferson Univ. Hosp., 451 F. Supp. 692 (E.D. Pa. 1978).

56. Dumer v. St. Michael's Hosp., 69 Wis. 2d 766, 233 N.W.2d 372 (1975).
57. Schroeder v. Perkel, 87 N.J. 53, 432 A.2d 834 (1981).
58. Troppi v. Scarf, 31 Mich. App. 240, 187 N.W.2d 511 (1971).
59. Harbeson v. Parke-Davis, Inc., 98 Wash. 2d 460, 656 P.2d 483 (1983).
60. Hackworth v. Hart, 474 S.W.2d 377 (Ky. 1971); Hays v. Hall, 488 S.W.2d 412 (Tex. 1972); Vilord v. Jenkins, 226 So. 2d 245 (Fla. Dist. Ct. App. 1969); Teeters v. Currey, 518 S.W.2d 512 (Tenn. 1974).
61. Blake v. Cruz, 108 Idaho 253, 698 P.2d 315 (1984).
62. Custodio v. Bauer, 251 Cal. App. 2d 303, 59 Cal. Rptr. 463 (1967).
63. See, for example, Jones v. Mailinowski, 299 Md. 257, 473 A.2d 429 (1984) and Cockrum v. Baumgartner, 99 Ill. App. 3d 271, 425 N.E.2d 968 (1981), cert. denied, 464 U.S. 846 (1983), rev'd on other grounds, 447 N.E.2d 385 (1983).
64. For example, Nolan v. Merecki, 88 A.D.2d 1021, 451 N.Y.S.2d 914 (1982).
65. See, for example, Troppi v. Scarf, 31 Mich. App. 240, 187 N.W.2d 511 (1971); Ziemba v. Sternberg, 45 A.D.2d 230, 357 N.Y.S.2d 265 (1974).
66. See, for example, Bushman v. Burns Clinic Medical Center, 83 Mich. App. 453, 268 N.W.2d 683 (1978); Sorkin v. Lee, 434 N.Y.S.2d 300, 78 A.D.2d 180 (1980).
67. See, for example, Bushman, supra note 66; James G. and Lurana G. v. Caserta, 332 S.E.2d 872 (Sup. Ct. App. W. Va. 1985); Sorkin v. Lee, 434 N.Y.S.2d 300, 78 A.D.2d 180 (1980).
68. Naccash v. Burger, 223 Va. 406, 290 S.E.2d 825 (1982). Other cases permitting recovery for emotional distress include Berman v. Allen, 80 N.J. 421, 404 A.2d 8 (1979); Blake v. Cruz, 108 Idaho 253, 698 P.2d 315 (1984).
69. Howard v. Lecher, 53 A.D.2d 420, 386 N.Y.S.2d 460 (1976), aff'd, 42 N.Y.2d 109 (1977). See also Becker v. Schwartz, 46 N.Y.2d 401, 413 N.Y.S.2d 895, 386 N.E.2d 807 (1978)—damages for emotional harm would be too speculative; and Goldberg v. Ruskin, 84 Ill. Dec. 1 (1984), modified, 128 Ill App. 3d 1029, 471 N.E.2d 530 (1984)—parents failed to allege that they suffered physical injury and therefore could not recover damages for emotional harm.
70. See, for example, Ochs v. Borelli, 187 Conn. 253, 445 A.2d 883 (1982).
71. See, for example, Rieck v. Medical Protective Co., 64 Wis. 2d 514, 219 N.W.2d 242 (1974)—failure to make a timely diagnosis of pregnancy. Other cases denying costs of raising a healthy child include Wilczynski v. Goodman, 73 Ill. App. 3d 51, 29 Ill. Dec. 216, 391 N.E.2d 479 (1979)—negligent performance of therapeutic abortion; Public Health Trust v. Brown, 388 So. 2d 1084 (Fla. App. 1980)—failed sterilization; Wilbur v. Kerr, 275 Ark. 239, 628 S.W.2d 568 (1982)—husband had not one but two unsuccessful vasectomies; Sorkin v. Lee, 434 N.Y.S.2d 300, 78 A.D.2d 180 (1980)—failed tubal ligation.
72. 99 Ill. App. 3d 271, 425 N.E.2d 968 (1981).
73. See, for example, Blake v. Cruz, 108 Idaho 253, 698 P.2d 315 (1984); Goldberg v. Ruskin, 84 Ill. Dec. 1 (1984), modified, 128 Ill. App. 3d 1029, 471 N.E.2d 530 (1984); Schroeder v. Perkel, 87 N.J. 53, 432 A.2d 834 (1981); Jacobs v. Theimer, 519 S.W.2d 846 (Tex. 1975).
74. See, for example, Berman v. Allen, 80 N.J. 421, 404 A.2d 8 (1979).
75. See, for example, Still v. Gratton, 55 Cal. App. 3d 698, 127 Cal. Rptr. 652 (1976); Zepeda v. Zepeda, 41 Ill. App. 2d 240, 190 N.E.2d 849 (1963), cert. denied, 379 U.S. 945 (1964); Williams v. State, 25 A.D.2d 906, 269 N.Y.S.2d 786 (1966).
76. See, for example, Elliot v. Brown, 361 So. 2d 546 (Ala. 1978); DiNatale v. Lieberman, 409 So. 2d 512 (Fla. App. 1982); Blake v. Cruz, 108 Idaho 253, 698 P.2d 315 (1984); Goldberg v. Ruskin, 84 Ill. Dec. 1 (1984), modified, 128 Ill. App. 3d 1029, 471 N.E.2d 530 (1984); Whit v. United States, 510 F. Supp. 146 (D. Kansas 1981); Eisbrenner v. Stanley, 106 Mich.

App. 357, 308 N.W.2d 209 (1981); Berman v. Allen, 80 N.J. 421, 404 A.2d 8 (1979); Becker v. Schwartz, 46 N.Y.2d 401, 413 N.Y.S.2d 895, 386 N.E.2d 807 (1978); Gildiner v. Thomas Jefferson Univ. Hosp., 451 F. Supp. 692 (E.D. Pa. 1978); Phillips v. United States, 508 F. Supp. 537 (D.S.C. 1980), 508 F. Supp. 544 (D.S.C. 1981); Nelson v. Krusen, 678 S.W.2d 918 (Tex. 1984); Dumer v. St. Michael's Hosp., 69 Wis. 2d 766, 233 N.W.2d 372 (1975).

77. Becker v. N. Schwartz, 46 Y.2d 401, 413 N.Y.S.2d 895, 386 N.E.2d 807 (1978).
78. Blake v. Cruz, 108 Idaho 253, 698 P.2d 315 (1984).
79. 106 Cal. App. 3d 811, 165 Cal. Rptr. 477 (1980).
80. 31 Cal. 3d 220, 182 Cal. Rptr. 337, 643 P.2d 954 (1982).
81. Id. at 233, 182 Cal. Rptr. at 344–45, 643 P.2d at 961–62.
82. Cal. Health & Safety Code § 7186 (Supp. 1986). The court also cited Matter of Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), cert. denied, 429 U.S. 922 (1976); Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977)—recognizing that an individual has the right to decide whether life is preferable to death under certain circumstances.
83. 98 Wash. 2d 460, 656 P.2d 483 (1983).
84. Id. at 483, 656 P.2d at 497. Other cases permitting a wrongful life action include Call v. Kezirian, 135 Cal. App. 3d 189, 185 Cal. Rptr. 103 (1982); Azzolino v. Dingfelder, 71 N.C. App. 289, 322 S.E.2d 567 (1984), review granted, 313 N.C. 327 S.E.2d 887 (1985); Procanik v. Cillo, 97 N.J. 339, 478 A.2d 755 (1984). These cases followed Turpin in permitting special damages for extraordinary expenses but denying general damages.
85. Cal. Civil Code § 43.6(a) (1982): "No cause of action arises against a parent of a child based upon the claim that the child should not have been conceived or, if conceived, should not have been allowed to have been born alive."
86. Minn. Stat. Ann. § 145.424, subds. 1 & 2 (West Supp. 1986). In light of the constitutional right of reproductive freedom, this statute may not be constitutional.
87. Minn. Stat. Ann. § 145.424, subd. 3. The California statute has a similar provision, Cal. Civil Code § 43.6(b) (1982).
88. 109 N.J. 396, 537 A.2d 1227 (1988).
89. 704 S.W.2d 209 (1986).
90. 842 S.W.2d 588 (Tenn. 1992).

THE COURT DECIDES

Skinner v. Oklahoma ex rel. Attorney General
316 U.S. 535 (1942)

Mr. Justice Douglas delivered the opinion of the Court.

This case touches a sensitive and important area of human rights. Oklahoma deprives certain individuals of a right which is basic to the perpetuation of a race—the right to have offspring. Oklahoma has decreed the enforcement of its law against petitioner, overruling his claim that it violated the Fourteenth Amendment. Because that decision raised grave and substantial constitutional questions, we granted the petition for certiorari.

The statute involved is Oklahoma's Habitual Criminal Sterilization Act. That Act defines an "habitual criminal" as a person who, having been convicted two or more times for crimes "amounting to felonies involving moral turpitude," either in an Oklahoma court or in a court of any other State, is thereafter convicted of such a felony in Oklahoma and is sentenced to a term of imprisonment in an Oklahoma penal institution. Machinery is provided for the institution by the Attorney General of a proceeding against such a person in the Oklahoma courts for a judgment that such person shall be rendered sexually sterile. Notice, an opportunity to be heard, and the right to a jury trial are provided. The issues triable in such a proceeding are narrow and confined.

If the court or jury finds that the defendant is an "habitual criminal" and that he "may be rendered sexually sterile without detriment to his or her general health," then the court "shall render judgment to the effect that said defendant be rendered sexually sterile" by the operation of vasectomy in case of a male, and of salpingectomy in case of a female. Only one other provision of the Act is material here, and [it] provides that "offenses arising out of the violation of the prohibitory laws, revenue acts, embezzlement, or political offenses, shall not come or be considered within the terms of this Act."

Petitioner was convicted in 1926 of the crime of stealing chickens, and was sentenced to the Oklahoma State Reformatory. In 1929 he was convicted of the crime of robbery with firearms, and was sentenced to the reformatory. In 1934 he was convicted again of robbery with firearms, and was sentenced to the penitentiary. He was confined there in 1935 when the Act was passed. In 1936 the Attorney General instituted proceedings against him. Petitioner in his answer challenged the Act as unconstitutional by reason of the Fourteenth Amendment. A jury trial was had. The court instructed the jury that the crimes of which petitioner had been convicted were felonies involving moral turpitude, and that the only question for the jury was whether the operation of vasectomy could be performed on petitioner without detriment to his general health. The jury found that it could be. A judgment directing that the operation of vasectomy be performed on petitioner was affirmed by the Supreme Court of Oklahoma by a five to four decision.

Several objections to the constitutionality of the Act have been pressed upon us. It is urged that the Act cannot be sustained as an exercise of the police power, in view of the state of scientific authorities respecting inheritability of criminal traits. It is argued that due process is lacking because, under

this Act, unlike the Act upheld in *Buck v. Bell*, the defendant is given no opportunity to be heard on the issue as to whether he is the probable potential parent of socially undesirable offspring. It is also suggested that the Act is penal in character and that the sterilization provided for is cruel and unusual punishment and [violates] the Fourteenth Amendment. We pass those points without intimating an opinion on them, for there is a feature of the Act [that] clearly condemns it. That is, its failure to meet the requirements of the equal protection clause of the Fourteenth Amendment.

We do not stop to point out all of the inequalities in this Act. A few examples will suffice. In Oklahoma, grand larceny is a felony. Larceny is grand larceny when the property taken exceeds $20 in value. Embezzlement is punishable "in the manner prescribed for feloniously stealing property of the value of that embezzled." Hence, he who embezzles property worth more than $20 is guilty of a felony. A clerk who appropriates over $20 from his employer's till and a stranger who steals the same amount are thus both guilty of felonies. If the latter repeats his act and is convicted three times, he may be sterilized. But the clerk is not subject to the pains and penalties of the Act no matter how large his embezzlements nor how frequent his convictions. A person who enters a chicken coop and steals chickens commits a felony; and he may be sterilized if he is thrice convicted. If, however, he is a bailee of the property and fraudulently appropriates it, he is an embezzler. Hence, no matter how habitual his proclivities for embezzlement are and no matter how often his conviction, he may not be sterilized. Thus, the nature of the two crimes is intrinsically the same and they are punishable in the same manner. [Paragraph break added.]

Furthermore, the line between them follows close distinctions—distinctions comparable to those highly technical ones which shaped the common law as to "trespass" or "taking." There may be larceny by fraud rather than embezzlement even where the owner of the personal property delivers it to the defendant, if the latter has at that time "a fraudulent intention to make use of the possession as a means of converting such property to his own use, and does so convert it." If the fraudulent intent occurs later and the defendant converts the property, he is guilty of embezzlement. Whether a particular act is larceny by fraud or embezzlement thus turns not on the intrinsic quality of the act but on when the felonious intent arose—a question for the jury under appropriate instructions.

It was stated in *Buck v. Bell* that the claim that state legislation violates the equal protection clause of the Fourteenth Amendment is "the usual last resort of constitutional arguments." Under our constitutional system the States in determining the reach and scope of particular legislation need not provide "abstract symmetry." They may mark and set apart the classes and types of problems according to the needs and as dictated or suggested by experience. It was in that connection that Mr. Justice Holmes, speaking for the Court in [another case] stated, "We must remember that the machinery of government would not work if it were not allowed a little play in its joints."

....

But the instant legislation runs afoul of the equal protection clause.... We are dealing here with legislation which involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race. The power to sterilize, if exercised, may have subtle, far-reaching and devastating effects. In evil or reckless hands it can cause races or types which are inimical to the dominant group to wither and disappear. There is no redemption for the individual whom the law touches. Any experiment which the State

conducts is to his irreparable injury. He is forever deprived of a basic liberty. We mention these matters not to re-examine the scope of the police power of the States. We advert to them merely in emphasis of our view that strict scrutiny of the classification which a State makes in a sterilization law is essential, lest unwittingly, or otherwise, invidious discriminations are made against groups or types of individuals in violation of the constitutional guaranty of just and equal laws. The guaranty of "equal protection of the laws is a pledge of the protection of equal laws." When the law lays an unequal hand on those who have committed intrinsically the same quality of offense and sterilizes one and not the other, it has made as invidious a discrimination as if it had selected a particular race or nationality for oppressive treatment. Sterilization of those who have thrice committed grand larceny, with immunity for those who are embezzlers, is a clear, pointed, unmistakable discrimination. Oklahoma makes no attempt to say that he who commits larceny by trespass or trick or fraud has biologically inheritable traits which he who commits embezzlement lacks. [Paragraph break added.]

Oklahoma's line between larceny by fraud and embezzlement is determined, as we have noted, "with reference to the time when the fraudulent intent to convert the property to the taker's own use" arises. We have not the slightest basis for inferring that that line has any significance in eugenics, nor that the inheritability of criminal traits follows the neat legal distinctions which the law has marked between those two offenses. In terms of fines and imprisonment, the crimes of larceny and embezzlement rate the same under the Oklahoma code. Only when it comes to sterilization are the pains and penalties of the law different. The equal protection clause would indeed be a formula of empty words if such conspicuously artificial lines could be drawn. In *Buck v. Bell* the Virginia statute was upheld though it applied only to feeble-minded persons in institutions of the State. But it was pointed out that "so far as the operations enable those who otherwise must be kept confined to be returned to the world, and thus open the asylum to others, the equality aimed at will be more nearly reached." Here there is no such saving feature. Embezzlers are forever free. Those who steal or take in other ways are not. If such a classification were permitted, the technical common law concept of a "trespass" based on distinctions which are "very largely dependent upon history for explanation" could readily become a rule of human genetics.

It is true that the Act has a broad severability clause. But we will not endeavor to determine whether its application would solve the equal protection difficulty. The Supreme Court of Oklahoma sustained the Act without reference to the severability clause. We have therefore a situation where the Act as construed and applied to petitioner is allowed to perpetuate the discrimination which we have found to be fatal. Whether the severability clause would be so applied as to remove this particular constitutional objection is a question which may be more appropriately left for adjudication by the Oklahoma court. That is reemphasized here by our uncertainty as to what excision, if any, would be made as a matter of Oklahoma law. It is by no means clear whether, if an excision were made, this particular constitutional difficulty might be solved by enlarging on the one hand or contracting on the other the class of criminals who might be sterilized.

Reversed.

Skinner v. Oklahoma ex rel. Attorney General Discussion Questions

1. What does "ex rel." mean in the caption of the case?
2. What does Justice Douglas mean when he talks about a "severability clause" in the statute?
3. Note that the opinion takes pains to "distinguish" *Buck v. Bell* from the present case. Are you persuaded by Justice Douglas's discussion, or has he effectively overruled *Buck* without saying so?
4. In the 1930s, "Hereditary Health Courts" were established in Nazi Germany to enforce sterilization laws on individuals suspected of hereditary diseases and other "defects." See, generally, Litton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide*, 22–44 (1986). This kind of policy gave eugenics a bad name, at least in terms of human reproduction, and led to its repudiation in most "enlightened" societies. Should forced sterilization—whether for eugenic reasons or otherwise—ever be allowed? If so, under what circumstances and with what controls?

CHAPTER

14

HEALTH INFORMATION MANAGEMENT

After reading this chapter, you will

- learn that accurate and complete medical records serve many purposes, but the most important is to make quality medical care possible.
- be reminded that health information is highly confidential, but there are many times when the information can and must be disclosed.
- understand that federal and state privacy laws are complex, and it is essential that all healthcare personnel be educated about their requirements.
- know that the HIPAA privacy standards overlie, but rarely replace, other laws on medical record confidentiality.

For most of recorded history medical records have been preserved on paper. This is why we usually think of "medical records" as the folders with color-coded tabs that are kept in our doctor's office. Some of us may also think of the "charts" that physicians and nurses use in a hospital (or on TV shows like *ER* and *House*). These mental images are correct, as far as they go, but medical records represent much more in this electronic age. Records of health information can be stored on various media other than paper—for example, digital photographs, computer and Internet files, CDs, holograms, and handheld devices. We are not yet a "paper*less* society," but we are a *less paper* one.

For this reason, the Health Insurance Portability and Accountability Act (HIPAA) does not use the term "medical records" but refers instead to "health information," which it defines as follows:

> [A]ny information, whether oral or recorded in any form or medium, that:

> 1. is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
> 2. [r]elates to the past, present, or future physical or mental health or condition of an individual; or the past, present, or future payment for the provision of health care to an individual.

Reflect on this definition for a moment, and note how expansive it is. The definition includes, to be sure, the information we usually think of—medical history, current complaints, vital signs, physical findings, the results of diagnostic tests and procedures, medications, diagnosis, prognosis, and plan of care. But does it include any of the following?

- Name, address, and phone number
- Age
- Social security number
- Emergency contact information
- Name(s) of the patient's child(ren)
- Favorite food and favorite color
- Kind of car the patient drives
- Name(s) of the patient's pet(s)

If the information was collected in the process of providing healthcare, the answer is "yes" to *all* of the above.

A New Focus

In previous editions of the book, this chapter was entitled "Medical Records." Recognizing the expanded scope and many purposes of clinical data, we now choose to use the term "health information" wherever possible. Although this text does contain references to "medical records," whenever the context requires it, the reader should understand that the expression means health information as defined by HIPAA.

The primary purpose of medical records is, obviously, to document the care given to patients. A current and complete record is, therefore, indispensable to the practice of medicine. But this is not the only purpose of health information; it is also essential in the following:

- for accurate coding of diagnoses and procedures,
- for billing the patient's insurance or governmental payers,
- to document medical necessity,
- as evidence in criminal trials and civil litigation,

- to support public health efforts and scientific research,
- to conduct peer review and quality assurance programs, and
- to meet accreditation and licensure standards.

Thus, we see that creation of medical records is not a nuisance, although it can seem like one at times, but a critical element in the process of delivering healthcare services. This chapter reviews the three major issues relating to the patient's health information:

1. legal requirements,
2. access, and
3. use in legal proceedings.

Overlying this discussion are the federal privacy standards contained in HIPAA. Rather than devote a discrete section to HIPAA, this chapter considers that law's privacy requirements as supplements to preexisting state and federal standards. Thus, discussion of HIPAA is woven throughout the chapter.

Legal Requirements

Form and Contents

In most states, legal requirements for maintaining medical records are found in the rules and regulations of licensing agencies. Many of these regulations simply require that an "adequate" or "complete" record be maintained; others specify categories of information to be included, leaving it to the professional judgment of physicians, nurses, and other clinicians to decide the details of the record's content and organization. For example, the Florida statute provides:

> Each hospital…shall require the use of a system of problem-oriented medical records for its patients, which system shall include the following elements: basic client data collection; a listing of the patient's problems; the initial plan with diagnostic and therapeutic orders as appropriate for each problem identified; and progress notes, including a discharge summary.[1]

Some states' licensure regulations explicitly authorize an electronic medical record system, as long as the computerized system satisfies the basic requirements for record content. In theory, a computerized record eliminates the need for handwritten or printed documents, improves accuracy, and saves time and money. Although it has these advantages, it also

raises issues like confidentiality, durability, compliance with licensure requirements, and the simple human factor of resistance to change. (As I write this I am reminded that holding a real book is more comforting than looking at words on my computer monitor.)

As is so often the case, the law has not kept pace with technological progress. Most medical record laws were written when paper was the universal medium. If those statutes have not been updated in a particular state, an electronic medical record system might not technically comply with the law. It is important, therefore, to consult with legal counsel if there is doubt about the acceptability of an electronic medical record before implementing such a system.

The Joint Commission has standards for medical records.[2] Failure to comply with them could result in the loss of accreditation and could be evidence of negligence if failure to adhere to recognized record-keeping standards was a cause of injury.[3] The standards of the Joint Commission provide that

- an adequate medical record must be maintained for every person evaluated or treated as an inpatient, an outpatient, an emergency patient, or a patient in a hospital-based home care program.
- the record must contain sufficient information to identify the patient and to support the diagnosis and treatment, and it must furnish accurate documentation of results.
- the records shall be confidential, secure, current, authenticated, legible, and complete. The record department shall be adequately directed, staffed, and equipped, and it shall maintain a system of identification and filing to facilitate prompt location of each record.

The Joint Commission's standards permit hospitals to maintain an automated medical record system. Because some states equate accreditation with qualification for licensure, the Joint Commission's recognition of computerized systems may be a reason that formal regulations have not been updated in many states.

In addition to the general legal requirements for medical record keeping, local laws require certain information to be reported to public authorities for statistical purposes. State statutes commonly require hospitals and physicians to maintain records of births, deaths, autopsies, and similar events of public interest. Local statutes also require that records be kept and reports be made to the appropriate public authority when patients are diagnosed with certain contagious and infectious diseases, when they may have been involved in crimes of violence, when child or elder abuse is suspected, or when public health and welfare are

otherwise at stake. Failure to comply with these laws can have grave consequences for medical personnel and hospitals, not to mention the people the laws are meant to protect.

Both legal regulations and professional standards require that entries in the medical record be signed ("authenticated") by the individual making the entry. A physician's spoken order must be recorded and countersigned later by the doctor. (One physician may not sign for another unless both share responsibility for the patient's care.) Generally entries in the record must be manually authenticated, either by the actual handwriting of the individual or by another form of signature, such as a printed or stamped name or initials. Depending on the language of a local statute or regulation, a "signature" does not necessarily have to be handwritten. In general, however, current law does require a signature of some kind, however that term is defined. Medical staff bylaws and health information management department policies must contain provisions relating to the proper and timely authentication of entries in the patient's chart.

Policies should require that the attending physician keep the record current and complete it within a reasonable time (no more than 30 days) after the patient's discharge.[4] The Joint Commission considers a medical record complete when the medical history, diagnostic and therapeutic orders, all reports of consultations and tests, progress notes, and a clinical resume (discharge summary) are entered and authenticated (signed) by the attending physician. This is consistent with local law and acceptable standards of practice. A physician found to have violated such a policy can be subject to disciplinary measures.

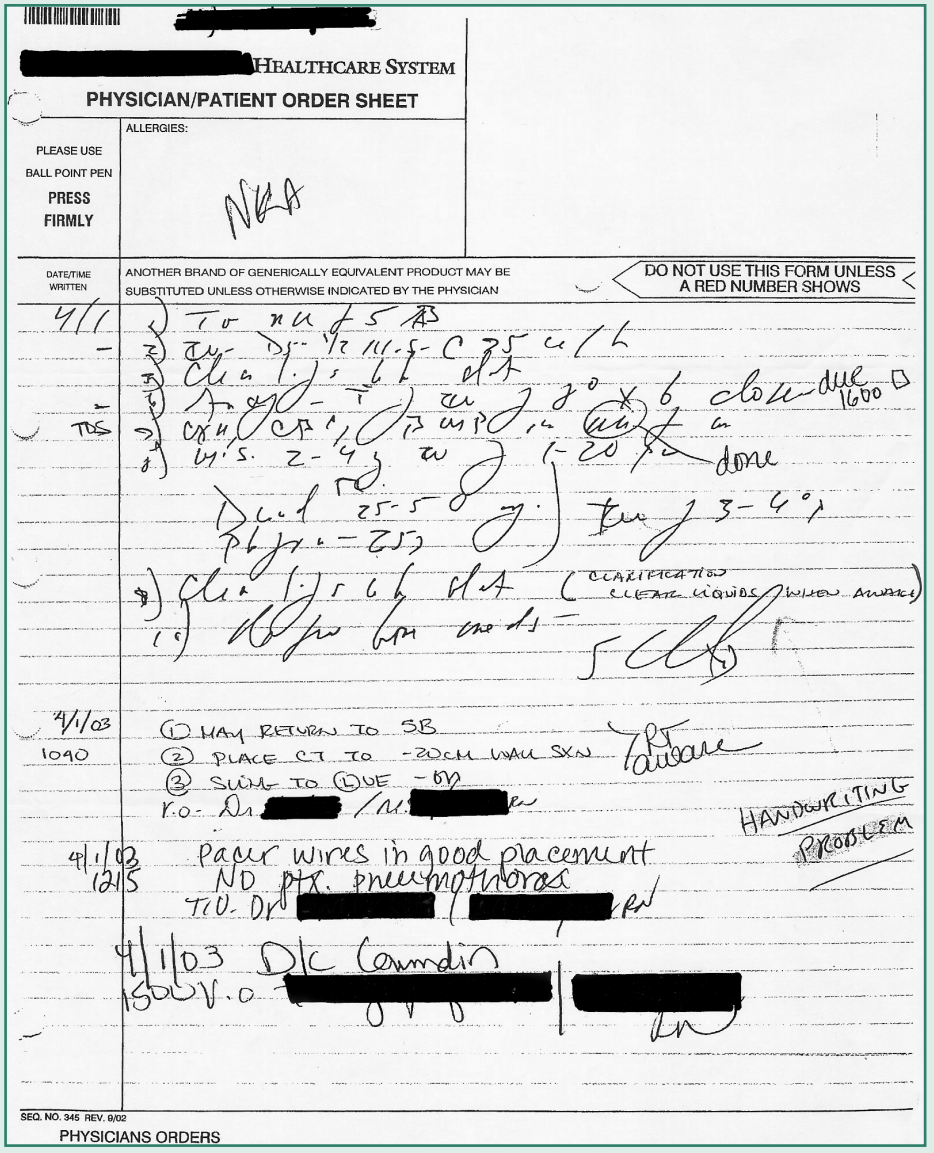
Failure to maintain complete, accurate, and current records can have severe adverse effects for a defendant in civil litigation (see Legal DecisionPoint on page 428). For example, failure of nurses to record observations of the patient's condition can be evidence of negligence for a jury to consider. Medical records are generally admissible as evidence in a malpractice suit, so the absence of appropriate entries in the chart, or the inclusion of inaccurate information, can be the basis for a jury's verdict for the plaintiff.[5] In a New York case a patient was diagnosed as having suffered damage to the liver as a result of an adverse reaction to the anesthetic halothane during foot surgery. No record of the adverse event was made in the chart. A month later the patient had surgery on the other foot, and the same anesthetic was given. This time it caused the patient's death.

The absence of a notation in the medical record was a persuasive factor in the jury's decision favoring the patient's family.[6] Corrections of inaccurate information should also be entered in the medical record at once and in a proper fashion. Erasure or obliteration of medical information,

Legal DecisionPoint

If "a picture is worth a thousand words," consider the following:

1. Look at the first entry. What does it say?
2. An auditor has written, "handwriting problem" in the margin. If an entry is illegible, can it ever be said to be "accurate and complete"?
3. What are some ways to improve the quality of this physician's records?



[redacted] HEALTHCARE SYSTEM

PHYSICIAN/PATIENT ORDER SHEET

ALLERGIES: NKA

PLEASE USE BALL POINT PEN PRESS FIRMLY

DATE/TIME WRITTEN

ANOTHER BRAND OF GENERICALLY EQUIVALENT PRODUCT MAY BE SUBSTITUTED UNLESS OTHERWISE INDICATED BY THE PHYSICIAN

DO NOT USE THIS FORM UNLESS A RED NUMBER SHOWS

4/1 TDS

4/1/03 1090
(1) MAY RETURN TO SB
(2) PLACE CT TO -20CM WALL SXN
(3) SUCTION TO CLOSE - OFF
R.O. Dr [redacted] RN

4/1/03 1215
Pacer wires in good placement
NO PTX. pneumothorax
T.O. Dr [redacted] RN

HANDWRITING PROBLEM

4/1/03 D/C Coumadin
1500 V.O [redacted] RN

SEQ. NO. 345 REV. 9/02
PHYSICIANS ORDERS

even if inaccurate, must *never* be permitted (see The Law in Action). Instead, the person making the change should do the following:

- carefully draw a line through the original entry, leaving the writing legible;
- describe the reason for the change;
- date the corrected entry; and
- authenticate the new entry.

The wisdom of following this practice is illustrated by a Connecticut case in which the court held that the jury was entitled to know that an entry in the chart of a mental patient, who had been left unattended in a locked room for several hours, had been obliterated, rewritten, and falsified. A verdict in the amount of $3.6 million was upheld on appeal.[7]

The Law in Action

A physician had left written orders that the patient should be given a solution of ".3 NS". The decimal point was overlooked, and the patient was given a saline solution ten times the intended concentration. Believing he was not at fault, the physician tried to clarify his original order by going over it in pen to read:

This, of course, only compounded the problem and left the impression that there had been a cover-up. The jury returned a verdict in favor of the plaintiffs.

The adverse implications of an incomplete medical record are seen in *Carr v. St. Paul Fire and Marine Insurance Company*.[8] The patient came to the hospital's emergency department (ED) complaining of severe abdominal pains and vomiting but was examined only by a licensed practical nurse and two "orderlies." (In the first part of the opinion the court points out that the nurse and one of the orderlies were "sweethearts" and later married and that all three were "close friends." The relevance of this fact becomes apparent later.) One of the orderlies took the patient's vital signs, but they were unable to reach the patient's personal doctor, who was out of town. The patient left, saying he would return when his doctor got back. The patient died later that evening after returning to the hospital by ambulance and in even greater distress. The death certificate opined that the decedent had suffered an acute myocardial infarction (a heart attack).

Testimony described the patient's vital signs as "normal" during the first visit, but the three ED personnel "and possibly Dr. Vizant" (who completed the death certificate) were the only ones to see the record of the visit. This is where the friendship among the three ED staff becomes relevant: the record was destroyed that night, after the patient died.

In the resulting lawsuit, the jury was allowed to infer that the documents would probably have revealed a medical emergency necessitating attendance by a physician. The court stated:

> No one knows the effect [destruction of the records] had on the jury, but the jury certainly had a right to infer that the record had it been retained would

have shown that a medical emergency existed and that a doctor should have been called and that more attention should have been given him than was given.

The jury found against the defendants on the ground that hospital personnel had failed to exercise reasonable care under the circumstances.

As this case implies, one of the best "witnesses" in malpractice litigation is a thorough and complete medical record that documents the continued care and treatment of the patient. Such a record is frequently convincing evidence that the patient received reasonable care under all the facts and circumstances. An incomplete or missing record can spell disaster for the defense.

Information in the record must be readily available when the circumstances require it. To illustrate, in *Howlett v. Greenberg* a hospital staff physician examined an automobile accident victim and dictated the results of his examination.[9] This information had not, however, been transcribed and affixed to the patient's chart when Dr. Greenberg performed nonemergency surgery on the patient's wrist, even though he knew that it should have been and that proceeding with surgery in these circumstances was contrary to hospital rules. Adverse results followed the surgery and the patient died.

Liability is established if the patient can show that failure to have relevant medical information readily at hand was the proximate cause of injury. The surgeon could be negligent (a) by performing surgery knowing that the report of the patient's history and physical was not part of the record or (b) by assuming that none was done. The hospital could be liable for not having an effective system of compiling and ensuring the availability of required medical information whenever it is needed.

In contrast to clinical records, "incident reports" are not meant to be part of the medical record and should not be filed there. They are prepared in anticipation of possible litigation and for the hospital's attorneys to use. They often contain information (much of it hearsay) that tends to indicate fault. If they are included in the medical record, they will be available as evidence in a lawsuit. In most states incident reports are considered privileged, are not subject to discovery, and are not admissible. The incident report process is conducted for educational purposes and to improve general standards of patient care and safety. To serve these ends there must be candor and the assurance that such reports will not be available to potential malpractice plaintiffs.

Records Retention Requirements

Hospital policies regarding retention of medical records depend on local law and the standards of professional care appropriate to the type of institution

involved. Accordingly, governing bodies must not only be familiar with applicable legal requirements respecting the length of time that records must be preserved, but they must also analyze their particular medical and administrative needs. For example, to enable epidemiological studies (or for other pedagogic reasons) teaching hospitals and research institutions may wish to retain records longer than typical acute care hospitals do. They might want to keep records for 75 years or more, for example. All institutions will need to retain records long enough to facilitate continuing programs of peer review and quality assurance.

The law on record retention varies widely from state to state on such matters as the length of retention and whether alternative media (such as microfilming or electronic formats) may substitute for records that were originally kept on paper. Medicare's "Conditions of Participation" require records to be maintained for at least five years,[10] but many states specify longer periods. Formats other than paper are generally permitted unless explicitly proscribed, and some items (such as nurses' notes and original x-ray films) may be destroyed earlier than others. To complicate matters, a state's statutes of limitation must be considered. Traditionally, the limitation period for torts did not begin to run against a minor until she reached the age of majority. (If the limitation period was two years and the age of majority was 21, a newborn could technically file suit a day short of his 23rd birthday and have a valid claim.) Some states have changed this common-law rule. Florida, for example, provides "in no event shall the action be commenced later than four years from the date of the incident or occurrence out of which the cause of action accrued, except that this four-year period shall not bar an action brought on behalf of a minor on or before the child's eighth birthday."[11]

In summary, how long the clinical records of patients are retained and in what format will be determined by standards of professional practice, by the operational and medical needs of the particular organization, and by local law in each state. Institutional policies on these questions must be carefully developed and reviewed from time to time with the aid of legal counsel. Private organizations such as the Joint Commission and the American Hospital Association have occasionally published statements of policy on retention and destruction of records. The current policy statement of the American Hospital Association recommends retaining records for at least ten years.

Access to Medical Record Information

Ownership and Control of the Medical Record

The healthcare provider owns the medical record, x-rays, laboratory reports, reports of consultants, and other documents relating to the care

The Law in Action

When I was in the Navy it was common practice for personnel to take their medical records with them to clinic appointments and even when transferring from one duty station to another. This was done for administrative convenience, but I remember thinking how easy it would be for records (or parts of records) to be lost or altered while in the sailor's possession. Speaking as a hospital attorney, I hope this practice has changed.

of patients.[12] The owner of the record has the right to physical possession and control,[13] and the owner should not permit its removal except by court order. Neither a patient nor an authorized representative has a right to physical possession of the original medical records (see The Law in Action).

Ownership and the right of physical control do not mean that the patient and various legitimately interested third parties have no legal right of access to the information the record contains. Most jurisdictions and federal law affirm that patients have a right to view and copy their records and to appoint authorized representatives to examine the documents. Moreover, attending physicians may not prevent disclosure to hospitalized patients of information from the hospital record, with the possible exception of cases in which such disclosure might adversely affect a patient's physical or mental health.[14]

Physicians who retire from practice, those who have been replaced by other doctors selected by their patients, and the estates of deceased physicians are morally and ethically obligated to transfer the medical record or copies of it to the current physician when a patient asks that this be done. Hence, in a New York case the court invalidated a provision in a deceased physician's will that his executor burn all his professional records.[15] The court did recognize, however, that the records belonged to the physician's estate and should not be delivered to the doctor's former patients.

Instead of delivering the entire original record to a newly chosen physician, a former doctor may wish to transfer a copy of the record or whatever excerpts or summaries are necessary for adequate treatment or diagnosis. This would be the normal procedure for hospitals when a patient is transferred to another institution or when a former patient seeks care elsewhere. When a hospital transfers a patient to another hospital—or when a private physician, for example, recommends a consultation with a specialist—the hospital or the physician has a legal and ethical duty to make available to the receiving institution or consultant copies of all medical information that is relevant to and necessary for the appropriate care of the patient. Most hospitals' health information management departments have a contract agency, the full-time job of which is to copy medical records and release the information to other hospitals or physicians on patients' requests.

HIPAA and the Patient's Right to Access Medical Information

Federal law and most states' laws recognize that the patient has a legal right to the information in the medical record, for whatever reason. The long-held assumption that medical records are not to be inspected by the patient or an authorized representative is no longer valid.

With some exceptions, HIPAA gives patients the right to examine and obtain a copy of their own records and to request correction of any errors.[16] The request may be denied for good cause—for example, if disclosure of the information would be likely to endanger the life or physical safety of the patient or another person; if the information is contained in psychotherapy notes; or if it was compiled for use in a civil, criminal, or administrative proceeding. HIPAA also gives patients greater control over how information about them can be used. For example, a signed authorization must be obtained from the patient before health information can be used for marketing or fund-raising purposes.

HIPAA gives patients a right to obtain a listing (an "accounting") of the occasions on which their health information was disclosed to other persons for purposes other than treatment, payment, routine healthcare operations (such as peer review and quality assurance), or at their own request. Accordingly, healthcare facilities and physicians must keep account of disclosures of health information to the following, among others:

- accrediting agencies like the Joint Commission,
- state oversight agencies,
- public health organizations,
- law enforcement agencies,
- funeral directors, and
- tumor registries.

The accounting must indicate the date of the disclosure, the name of the recipient, the information disclosed, and the purpose of the disclosure.[17]

Except to the extent that state law gives patients fewer rights of access to their information, HIPAA does not replace state law protections, and many states already had laws providing for access before HIPAA was passed. For example, a Connecticut statute provides that a patient, her physician, or an authorized attorney may examine the medical record.[18] The right includes access to and copies of the patient's medical history, nursing notes, charts, pictures, and images (e.g., x-rays, scans). In other jurisdictions the statute may extend the right of access *only* to written medical records and notes, thereby excluding images. Laws like this have been "preempted" in part by HIPAA because the federal statute defines health information to mean *any*

information, in whatever form, that is created or received by the healthcare provider and relates to the patient's medical condition, to the provision of care, or to payment for care. Health information, therefore, includes x-rays and other images as well as billing records and the traditional "medical record." A few states allow the medical record to be available to the patient's attorney or representative but not to the patient.[19] These laws have also been preempted by HIPAA.

Most state statutes do not specifically mention either the right of minor patients to obtain information from their medical records or their parents' right to the information. Logically, however, the minor would have the right whenever the relevant jurisdiction has recognized by either legislation or judicial decision that a mature minor can consent for treatment without parental consent. Accordingly, it might follow that a statute simply granting the patient access to information would not grant the parents a right to view the minor's records. On the other hand, if the minor is of tender years or cannot give legal consent for treatment, it would appear that parents should have the right to medical information contained in the minor's chart. HIPAA does not change state law regarding the rights of parents to access their children's medical records.

As noted earlier, in the past physicians and hospitals customarily refused to allow patients access to the medical record. They often based this policy on the belief that records are technical and not understood by laypersons, that revelation of medical information might adversely affect the patient's health, and that the privacy of third parties who may be named in the chart should be protected. Clearly, the first and third of the forgoing reasons are no longer supportable in light of growing social concern—as evidenced by HIPAA—for individuals and their rights to information that directly affects health and welfare. The second reason may still be recognized to the extent that HIPAA allows denial of the right of access where the information would endanger the life or physical safety of the patient or another person.

Hospitals and their medical staffs must reevaluate their policies in light of the new standards of HIPAA. Hospitals and physicians must make the medical record available to anyone the patient designates by presentation of a current written authorization. They must also institute reasonable safeguards to protect healthcare information from unauthorized use and disclosure. Although under the law an attending physician cannot arbitrarily deny a patient access to the record, the doctor should be consulted and should be asked to consent before the patient or a representative examines the record. Not only is this a matter of professional courtesy, but it also protects the patient, whose health or willingness to continue treatment may be adversely affected by revelation of certain information.

Especially important is the moral and legal duty of a hospital or physician to make certain that the patient's authorization is current and

genuine whenever a third party wishes to inspect the record. Healthcare personnel must, therefore, be sensitive to the validity and authenticity of documents that purport to be the patient's authorization to release information to third parties.[20] However, note that HIPAA does not require patient authorization for every release of information, as discussed in the next section.

Release of Information Without the Patient's Consent

To many persons, the concept of confidentiality implies that private information entrusted to another may not be divulged to a third party without the consent of the subject of the information. Because ethical considerations treat medical information as confidential, and because many states have privileged communication statutes pertaining to the physician–patient relationship, it is sometimes believed that release of the information to a third party is prohibited unless the patient consents. As the following discussion shows, this belief oversimplifies the law.

Confidentiality of private information is governed by both state and federal laws. Accordingly, HIPAA's privacy regulations and state statutes and judicial decisions must be consulted to determine reliable answers to the questions that continually arise about the release of medical information.

Disclosure of personal information does not offend the Constitution.[21] Although the Supreme Court has recognized an individual's constitutional right to make certain personal decisions without interference by the government or other third parties,[22] there is no constitutional principle on the confidentiality of information. There are situations, discussed in the next section, where third parties have a legitimate interest in and a legal right to medical information respecting a particular patient. In those cases, release of health information without the patient's consent is permitted and, indeed, sometimes required.

Court Orders and Subpoenas

A valid court order directing that medical records be made available to a third party must be honored, and the patient's consent is not required. Generally the legal process for obtaining medical record information is through a subpoena duces tecum—an order that a witness bring specified documents to a court or other tribunal having jurisdiction over pending litigation.

Note that not all subpoenas amount to a court order. Under most states' rules of procedure, an attorney prosecuting or defending a case may issue a subpoena for records relating to the other party. (The defendant in a malpractice suit, for example, usually subpoenas the plaintiff's medical records to have the case evaluated by a medical expert.) Plaintiffs' attorneys often have supplies of such subpoenas to use on behalf of their clients. Under

HIPAA's privacy standards, however, a healthcare provider can release the patient's records without a court order only (a) if the patient signs an authorization for the release or (b) if the party issuing the subpoena has made a reasonable effort to give the patient notice of the request. If in doubt, the owner of the record can petition the court for a determination of whether the records must be turned over.

Statutory Reports

Certain statutes require hospitals and medical personnel to report information to public authorities. These statutory reporting requirements are permitted by HIPAA, but the disclosures must be accounted for, as noted earlier. The statutes are constitutional as a legitimate exercise of the police power to regulate public health, safety, and welfare.[23] The requirements differ from state to state, and healthcare providers must be familiar with the law of their particular jurisdiction.

Following are some of the kinds of state reporting requirements:

- vital statistics (deaths, births, and fetal deaths),[24]
- abortions,[25]
- sexually transmitted diseases,
- other contagious or infectious diseases,
- injuries that may be the result of criminal acts,[26]
- accidental or self-inflicted wounds,
- drug abuse, and
- child or elder abuse or neglect.

Not all of these reporting duties exist in all jurisdictions, but wherever they do, failure to report to the appropriate public authority may lead to civil liability or criminal penalties.

Duty to Warn Third Parties

Quite apart from statutory duties to report certain medical information to public authorities, if a physician or hospital knows that a patient's psychological condition represents a foreseeable serious risk to a third party, there is a duty to disclose and warn of the danger. HIPAA recognizes the need for such disclosures and specifically permits them when the healthcare provider believes it "is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public" and is made to someone who is able to prevent or lessen the threat.[27]

In a California case with a tragic outcome, a male student was undergoing voluntary outpatient psychiatric treatment at a university hospital as a voluntary outpatient. Several psychotherapists employed by the hospital were aware that he had threatened to kill a particular individual. One of the psychologists determined that the student should be committed to a mental institution and asked the campus police to detain him, which they did. Later,

however, the police released the student, who appeared to be rational, and the chief of psychiatry reversed the psychologist's order for detention.

Two months later the student did in fact kill his intended victim. In *Tarasoff v. Regents of the University of California*—a suit by the parents of the victim—the California court held that under the circumstances the duty to disclose outweighed the duty of holding medical information confidential. According to the court, the psychotherapists and their employer had a duty to exercise reasonable care to give threatened persons a warning that foreseeable dangers could arise from the patient's condition or treatment. Breach of this duty can result in liability for damages. (See The Court Decides: *Tarasoff v. Regents of the University of California* at the end of this chapter.)

The *Tarasoff* doctrine is limited to situations where the physician or psychotherapist knows or should know that the patient represents a serious or imminent threat to a readily identifiable victim. For reasons of policy there is no duty to warn an entire community or neighborhood of a person's generalized threats to unspecified individuals (see Legal Brief). In a later case interpreting *Tarasoff*, the California Supreme Court held that there was no duty to warn the community or the police that a juvenile delinquent released from governmental custody to the home of his mother had exhibited violent propensities toward young children.[28] Hence, there was no liability when the juvenile subsequently caused the death of a five-year-old boy. In the absence of an imminent risk to an identifiable victim, the criminal act causing the death was not a foreseeable event.[29] Fundamentally, these limitations on the duty to warn third parties are the criteria for balancing an individual's right to confidentiality with a third person's right to know that a risk exists. The imminence and probability of the risks must be given weight, along with identification of the probable victim, to justify a conclusion that the third person's interests are paramount to those of the patient.[30] As a practical matter, the professional who must balance these interests is in the unenviable position of having to predict violent behavior despite the fact that current medical knowledge has apparently not advanced to the point where self-injury or injury to others can be accurately forecast (see discussion in Chapter 6).

Legal Brief

"The idea that professionals may be able to [predict] the risk posed by a member of society is very controversial.... A number of studies suggest that such predictions can be made, although the accuracy of such predictions is questionable."

—CourtTV, www.crimelibrary.com/criminal_mind/profiling/danger/2.html

Consistent with the traditional majority approach, the duty to exercise reasonable care in a given instance is typically a matter of law for the court to determine. If a duty of care to a third party is recognized, questions

of breach of duty and proximate cause become matters of fact for a jury to resolve. Thus, foreseeability of harm in a given case is frequently a question for the jury. Hesitation to send this question to the jury may be the reason that some jurisdictions have apparently rejected the rule handed down in *Tarasoff* or at least have distinguished it on its facts and have concluded that the physician–patient privilege prevails.[31] Even California has declined to apply the principle of *Tarasoff* to a situation in which a psychiatrist was allegedly aware of a patient's suicidal tendencies and failed to restrain the patient or warn the parents.[32] The court held that *Tarasoff*'s duty to warn only applies when the risk to be prevented is the danger of violent assault, not when the risk is suicide. HIPAA's duty to warn seems to concur. When the patient is in danger of self-inflicted harm, the proper course would seem to be involuntary commitment.

Peer-Review Statutes

Peer review is a concept under the Medicare statute that is intended to ensure the medical necessity, reasonableness, and quality of care given to Medicare beneficiaries. Under federal regulations,[33] to carry out their responsibilities peer-review organizations have the right to access patient records and other information. The information must be held in confidence and must not be disclosed, except as authorized by law—for example, as aggregate data that do not identify an individual patient or healthcare provider. Compliance with these regulations is recognized and permitted by the HIPAA privacy regulations. (Peer review is discussed more fully in Chapter 7.)

Lien Statutes

A third party's legal right to receive medical information regarding a particular patient is further illustrated by hospital lien statutes, which exist in approximately one-third of the states. In simplest terms, the lien laws grant the healthcare provider a legal claim under which the cost of hospitalization is paid from damages that the patient recovers from the one whose civil wrong necessitated the patient's treatment. In turn, the tort-feasor is entitled access to the patient's medical chart without authorization by the patient to assess the legitimacy of the medical bills.

Legal Brief

"What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about."

—*The Hippocratic Oath: Text, Translation, and Interpretation*, by Ludwig Edelstein. Baltimore, MD: Johns Hopkins Press, 1943

Liability for Unauthorized Disclosure

The Hippocratic Oath requires physicians to hold inviolate and confidential all information entrusted to them by their patients (see Legal Brief). This

ethical obligation may be incorporated in state rules and regulations governing the licensure of physicians and healthcare institutions, and its violation may be a cause for revoking or suspending a license. Whether violation of licensure regulations creates a civil cause of action for damages is a different issue. Clearly, the HIPAA privacy regulations set a standard of care for confidentiality irrespective of other state law.

Under common law there was no doctrine of confidential or privileged communication between patient and physician. The common law recognized a doctrine of privileged communication in only three relationships: attorney–client, husband–wife, and clergy–penitent. Accordingly, neither a doctor nor an institution was obligated under common law to hold medical information about patients confidential.

Most states have now enacted "privileged communication statutes" to correct this situation and establish a confidential relationship between physician and patient. Although these statutes differ somewhat in detail, their essence is to declare that medical practitioners may not disclose any information that they acquire in attending patients in their professional capacity and that was necessary to the care and treatment of their patients. (As noted later, a patient may waive this privilege; in that event the doctor is not prohibited from making such disclosures and could even be compelled to do so by a court order.)

It is important to note that these statutes do not necessarily apply to out-of-court disclosures. They are often applicable only to disclosures made in the course of judicial or quasi-judicial proceedings. Further, they may not apply to institutional providers of care. Hence, an out-of-court disclosure of private medical information might not violate the privileged communication statutes, and as a general rule an aggrieved patient may not base a civil cause of action for damages on an alleged violation of the statutes.[34] A patient bringing an action against a healthcare provider for damages resulting from an unauthorized out-of-court disclosure of information must base the action on a common-law tort or on a theory of contract law. There are at least three theories of action: defamation of character; invasion of privacy; or, as noted in some recent cases, breach of an implied contract to respect confidentiality. Two of these are discussed in the following sections. The contract theory is addressed in Chapter 2.

Defamation

The tort of defamation arises from a written or oral communication to a third party of information about a living person that injures his reputation by diminishing the esteem, respect, or confidence in which the person is held or by exciting adverse or derogatory feelings against that person.[35] (Traditionally a cause of action for defamation did not survive the death of the person whose reputation suffered damage. The modern trend, however, reverses that tradition.[36])

Written defamation is libel; oral defamation is slander. In either event, the communication must be made ("published") to someone other than the aggrieved party. Accordingly, a physician's dictated letter addressed personally

to a nurse suggesting that she may have committed a crime by administering a substitute for a prescribed medicine did not constitute libel.[37] (It might have, however, if a copy of the letter had been sent to a third party.)

In the context of release of information from a medical record, the chances of successful libel or slander suits against physicians and medical care institutions are rather slim. In the first place, the truth of the published statement is a complete defense to either libel or slander in most jurisdictions, even in the absence of any legitimate motive for its publication.[38] The burden of proving the truth of the statement will normally be on the defendant. Even if not true, a published retraction by the defendant or evidence that a defamatory statement was published with a proper motive and a reasonable belief that it was true will generally provide a partial defense that can be considered in mitigation of damages.

Even if a statement published about another without consent is quite untrue and adversely affects the subject's reputation, the law has long recognized two privileges that may afford a defense. There is an absolute privilege related to judicial proceedings and even proceedings by executive or administrative officers of the government. Hence, when a hospital honored a court subpoena and disclosed a medical record indicating the plaintiff was under the influence of alcohol, a statement alleged to be false, there could be no liability based on defamation because the release was absolutely privileged.[39]

A qualified privilege exists where information is transmitted to a third party with proper motive or purpose and with the exercise of reasonable care that the information is true. Information may be published in good faith to protect or advance the legitimate interests of the "publisher" or to protect the interests of an individual recipient or of the public if persons publishing it reasonably believe themselves to be morally obligated to speak and make "fair comment" on matters concerning the public interest.[40] For example, in a Nebraska case, *Simonsen v. Swenson*, a physician disclosed to a hotel that his patient, a resident of the hotel, had a contagious venereal disease. In a suit alleging unwarranted disclosure of confidential information, the court held that, even if the diagnosis had been incorrect, the defendant physician was protected from liability by reason of the qualified privilege. Because the information was transmitted in good faith without malice to a legitimately interested party, with a belief that there was a moral obligation to protect third parties, there was no liability for defamation.[41]

Whether a publication was made in good faith with a reasonable belief and care respecting the truth is a question for the jury. When a publication is motivated by spite or ill will (malice-in-fact), the publisher can be liable for punitive as well as compensatory damages. In a New Mexico case a physician who was examining a patient to determine the reason for her absence from school falsely reported to the school authorities that the 13-year-old girl was pregnant and refused to retract or correct the report after learning it was false. Because a matter of alleged pregnancy is libelous per se when it is false, the plaintiff was

entitled to compensatory damages without proof of actual monetary loss and was also entitled to punitive damages for malice-in-fact.[42]

The question of malice justifying an award for punitive damages is one for the jury, and the proper standard for the jury to consider is whether the publication was made with knowledge of falsity or with reckless disregard for its truth. Because most hospitals and physicians uphold ethical standards and do not as a rule publish information that they know to be false or show a reckless disregard for the truth, the prospect of their being held liable for punitive damages is minimal.

Readers must be aware that the examples of "qualified privilege" cited earlier predate HIPAA by many years. Even if a particular disclosure of information could be justified under traditional defamation law (itself a tenuous proposition), there is no assurance that it could withstand a challenge based on the new federal privacy standards.

Invasion of Privacy

Invasion of privacy—still a controversial subject and not explicitly mentioned in the U.S. Constitution—was recognized as a tort following publication of a famous *Harvard Law Review* article in 1890 (which illustrates the profound influence that legal scholars can have on the process of judicial lawmaking; see Legal Brief).[43] Most courts recognize the tort, but some have imposed limitations to discourage unwarranted litigation and to strike a proper balance between privacy and free speech. A few states have recognized the right of privacy by enacting statutes that carefully set out limitations to the cause of action.

Broadly defined, the so-called right of privacy is the right to carry on one's personal affairs without unreasonable and serious interference that exceeds the limits of decent conduct and is offensive to persons of ordinary sensibilities. With respect to publication of private information to third parties or to the public, there is a legal wrong only when the recipient has no legitimate interest in the information.[44] In contrast to actions based on the law of defamation, the truth of an unwarranted publication is not necessarily a defense to a suit alleging invasion of privacy. On the other hand, of course, express consent to the publication is a defense.

An Ohio court, affirming the principle that an individual has a legally protected right of privacy, defined the right in the case syllabus as follows:

> An actionable invasion of the right of privacy is the unwarranted

Legal Brief

In a *Harvard Law Review* article, cowritten by future U.S. Supreme Court Justice Louis Brandeis and his law partner, Samuel Warren, the authors assert that there is a common-law right of privacy, which they famously described as "the more general right of the individual to be let alone."

—Warren and Brandeis, "The Right to Privacy," 4 *Harvard Law Review* 193 (1890)

> appropriation or exploitation of one's personality, the publicizing of one's private affairs with which the public has no legitimate concern, or the wrongful intrusion into one's private activities in such a manner as to outrage or cause mental suffering, shame or humiliation to a person of ordinary sensibilities.[45]

To succeed in an action for invasion of privacy it is not necessary for the plaintiff to prove monetary loss; damages can be awarded for mental suffering. The right, however, is personal to the individual; the privacy of a deceased person cannot be invaded, and hence surviving relatives have no cause of action when the alleged tort occurs after one's death.[46] Similarly, in contrast to defamation, a corporation or a partnership cannot have its "privacy" invaded; other legal principles, such as copyright and trademark, are used to protect a business entity from unwarranted appropriation of its good name.[47]

Cases of invasion of privacy can be classified into four groups, according to the facts:

1. unauthorized commercial appropriation of the plaintiff's name, personality, professional skills, or photograph;
2. use of plaintiff's name or likeness for the defendant's own purposes or benefit, even though the use was not commercial and even if the benefit to the defendant was not financial;
3. physical intrusion into one's private affairs; and
4. disclosure of private information to those who have no legitimate need to know it.

The Pennsylvania trial court case of *Clayman v. Bernstein* is of the second type.[48] A physician had photographed a patient's facial disfigurement for instructional purposes without consent. The plaintiff succeeded in preventing the use of the photographs to show the effect of the disability.

As already noted, healthcare personnel must be careful when using photographs obtained during treatment. Normally the mere taking of a person's photograph is not an invasion of privacy, just as the mere mention of a name is not a civil wrong. When photographs are taken as a routine part of a patient's care, for the benefit of the patient and in accordance with acceptable professional standards, and when the photographs are then made a part of the medical record, no appreciable legal issue is presented. Like other parts of the record, such photographs can be used by the medical staff of the hospital in evaluating standards and patterns of care and for scientific or research purposes, at least when the patient's anonymity is preserved.[49] To prevent any possible risk of liability, however, in light of *Clayman* and other cases, it is sound administrative practice to have the

patient consent expressly to the photography. Most healthcare providers have a consent form for this purpose.

Photography

Photography that does not accord with professional standards of medical practice or that is done without consent could constitute an invasion of privacy and be within the third category of cases. Moreover, the unauthorized use and publication of the pictures might also fall within the fourth group of privacy cases: where private information is made public to those who have no legitimate concern or interest in the information.[50]

Cases of unauthorized photography have issues that are similar to those involved when unauthorized visitors are present during surgery or medical examinations. Without consent, such a practice is an invasion of a patient's privacy. Teaching hospitals, especially, should make clear to patients that medical students may from time to time accompany treating physicians, and it should be explained that the opportunity to observe is an integral part of the students' education. (These facts should be included in the general consent signed upon admission.)

In cases alleging invasion of privacy, the courts must balance conflicting public policy values: (a) "the right of the individual to be let alone"—to use Justice Brandeis's famous phrase—and (b) the public's "right to know." Obviously, the right to be let alone diminishes as one's fame or notoriety increases. The well-publicized case of attempts to obtain release of NASCAR driver Dale Earnhardt's autopsy photos is a case in point.

Like those of any accident victim in Florida, Mr. Earnhardt's autopsy records were subject to the state's public records laws, and the autopsy report and certain other items were promptly made available to the public. The autopsy photographs, however, were not. When news organizations tried to get copies of the photos, the Earnhardt family objected. The Florida legislature quickly passed an amendment to the public records laws that shielded autopsy photos from disclosure. The media challenged the law. In ruling that the law is constitutional and that the records (the photographs) must not be released, the court looked into "the seriousness of the intrusion into the family's right to privacy." The opinion states:

> The medical examiner testified that the photographs were "gruesome, grisly and highly disturbing," and the physician attending Mr. Earnhardt after the accident confirmed this. The trial court found that such publication would "be an indecent, outrageous, and intolerable invasion, and would cause deep and serious emotional pain, embarrassment, humiliation and sadness to Dale Earnhardt's surviving family members." It is evident from our review of the record that the publication of the nude and dissected body of Mr. Earnhardt would cause his wife and children pain and

Legal DecisionPoint

In its statute protecting autopsy photographs, the Florida legislature noted "that the existence of the World Wide Web and the proliferation of personal computers throughout the world encourages and promotes [sic] the wide dissemination of photographs and video and audio recordings 24 hours a day.... [W]idespread unauthorized dissemination of autopsy photographs and video and audio recordings would subject the immediate family of the deceased to continuous injury."

Readers can recall examples from their own experiences. Do you think current legal standards regarding these kinds of privacy issues are sufficient?

sorrow beyond the poor power of our ability to express in words.

One might be considered justified to believe that the court's "poor power" to express itself in words was quite sufficient, thank you. (See Legal DecisionPoint.)

Release of medical information to persons with a legitimate interest in the information does not ordinarily constitute an invasion of the patient's privacy, even absent an explicit consent to do so.[51] Individuals and organizations having a legitimate interest include attorneys for the patient, insurance carriers, various governmental agencies, bona fide research personnel, and family members (in some circumstances, especially if they are or will be participating in the patient's care and the patient does not object).[52] As mentioned earlier, HIPAA permits release of information for treatment, payment, and healthcare operations (such as quality assurance and peer review) and to healthcare oversight agencies. It permits disclosure to a friend or family member if the patient agrees or, if the patient is unable to consent, if in the patient's best interests.

Persons who consent to publicity or who place themselves in the public eye through their activities and exploits—for example, authors, actors, or candidates for public office—implicitly waive their rights of privacy to the extent that the public has a legitimate interest in newsworthy events.[53] (This principle also applies to persons who are not public figures but who are temporarily in the public eye.) Unless news stories and photographs exceed the bounds of ordinary decent conduct, persons cannot complain when, for example, the press reports an accident that they are involved in, when they commit a crime that is publicized, or when they figure in any other newsworthy event, so long as the publicity is not misleading or the facts are not misrepresented.

Release of information acknowledging an individual's admission to the hospital, naming the physician, and describing the patient's medical condition in general terms ("good," "fair," "critical") usually presents no legal risk of liability for invasion of privacy unless the patient objects.[54] If, however, the mere fact of admission could reveal the presence of mental illness or a disease thought to be shameful and humiliating—as might occur, for example, when the institution in question is known to treat only alcoholics or those suffering from mental illness—then an announcement of admission could lead to

liability, at least if the patient was not a public figure. HIPAA has provisions allowing for the patient to request that no information about his care be released, including the fact that he is in the facility.[55]

Statutory Provisions Mandating Confidentiality

Physicians and hospital personnel must be familiar with state and federal statutes and regulations that create a positive duty not to release medical information in certain circumstances. HIPAA has been mentioned earlier, and many states have "superconfidentiality" laws relating to records of treatment for substance abuse, HIV/AIDS, and mental health. For example, New York's mental hygiene law declares that officials of state mental institutions shall not make case records available, except as provided in the law; violation of this state statute created civil liability to a patient when a hospital director released the record to an adverse attorney.[56]

The Illinois statute is an example of comprehensive legislation that grants mental health patients or a parent/guardian a right of access to mental health records and applies principles of confidentiality to all services related to mental health or developmental disability furnished by physicians, psychiatrists, psychologists, social workers, and nurses in the community at large.[57] The personal notes of a therapist are not held to be a part of the medical record,[58] but no information in the record itself can be disclosed without written consent of the patient, parent, or guardian[59] except to professional colleagues, peer-review committees, and institutions having legal custody of the patient.[60] Furthermore, the statute includes detailed provisions relating to testimonial disclosures in judicial and quasi-judicial proceedings.[61] Violation of these mandated provisions is both a criminal and civil offense; the patient can sue for an injunction and may also seek damages, including recovery of attorney fees.[62]

Federal laws such as the Comprehensive Drug Abuse Prevention and Control Act of 1970[63]; the Drug Abuse Office and Treatment Act of 1972[64]; and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1983[65] impose stringent confidentiality requirements for records of patients receiving treatment for drug dependency and alcoholism under programs supported by federal funds. Underlying these rules is the principle that confidentiality will encourage patients to seek help for drug and alcohol abuse and psychiatric problems.

The legislation applies to all federally assisted healthcare providers, whether the assistance is research on the abuse of drugs or alcohol or through Medicare, Medicaid, or other governmental payment programs. Together, the statutes and attendant regulations[66] provide that medical information is to be disclosed only to those connected with the program. Family members, law enforcement officials, and courts have no access except as specifically provided, unless the patient has given express written consent to the disclosure.

Disclosures without a patient's consent can be made only to personnel in drug or alcohol programs who have a legitimate need to know, to other providers when a medical emergency arises, to organizations conducting research and evaluations (as long as particular patients are not identified), and by special court order based on good cause.[67] These patients may not be identified in any civil, criminal, or administrative procedure, and information cannot be released to law enforcement officials without a specific court order. Normal civil or criminal proceedings and their usual subpoena processes do not justify breach of a substance-abuse or mental-health patient's right to confidentiality. Hospital and medical personnel must, therefore, develop policies to prohibit release of all medical information concerning these patients without a court order.

Courts have ordered release of information in proceedings to revoke criminal probation,[68] in connection with child neglect,[69] and in an investigation by the Internal Revenue Service.[70] In contrast, good cause for a disclosure was not established in a criminal proceeding to determine a person's potential for rehabilitation[71] and when the credibility of a witness was in question.[72] A New York court protected the confidentiality of photographs that had been taken in the waiting room of a methadone treatment clinic and were later sought by law enforcement officials in connection with the investigation of a murder.[73] Where the medical records of a patient in a drug abuse program contained information likely to exonerate a patient from involvement in an alleged crime, however, procedural due process would require disclosure.[74] A judicial "in camera" review is often necessary to determine "good cause" and what portion of the record may be released.

HIPAA Privacy Standards

As has been mentioned, certain provisions of HIPAA now permeate medical records law (see Legal Brief). No one section of a text like this can begin to do justice to the myriad issues that this federal privacy law presents. (The effect of HIPAA's privacy standards would by themselves justify an entire textbook this size.)

Legal Brief

HIPAA is a massive statute, only one part of which relates to the privacy of health information. In our discussion, reference to HIPAA means just those portions that deal with privacy issues. The implementing regulations are also included in the reference. (As is usually the case, the regulations are more detailed than the law itself.)

Until this point, therefore, we address HIPAA's effects only as they might illuminate or be illuminated by the general types of privacy concerns that have existed since Hippocrates. That being said, a decent respect for the significance of this law requires that we consider certain HIPAA-specific provisions regarding the privacy of health information. These regulations are those that

- give patients more control over their health information than before;
- set limits on the use and disclosure of medical records, including billing records;
- establish safeguards to protect the privacy of health information; and
- hold violators accountable through civil and criminal penalties.

HIPAA provides that a person who knowingly and wrongfully obtains or discloses protected health information may be fined up to $50,000, imprisoned for up to one year, or both. If the offense is committed under false pretenses, the penalties increase to $100,000 and five years in prison, and if the offense is committed with the intent to sell or use the information "for commercial advantage, personal gain, or malicious harm," the penalties are $250,000 and ten years in prison.[75]

HIPAA requires health providers and health plans to notify patients of their privacy rights and how their health information will be used. (This is why when you go to the doctor you get something called a "Notice of Privacy Practices" that tells you a lot of things you already knew—and, if you read it carefully, some things you probably didn't—about how information about you will be kept and used.) HIPAA gives patients the right, in many cases, to object to certain uses of the information, such as for marketing, research, and fund-raising. Use of the information for treatment, payment, and healthcare operations is not restricted, and neither are the following:

- disclosures required by law;
- reports about victims of abuse, neglect, or domestic violence;
- uses for healthcare oversight activities;
- disclosures for judicial and administrative proceedings;
- disclosures for law enforcement purposes;
- disclosures to coroners, medical examiners, and funeral directors;
- uses for organ, eye, or tissue donation;
- certain uses for research purposes;
- disclosures to avert a serious threat to health or safety;
- certain disclosures for specialized governmental functions, such as national security; and
- disclosures for workers' compensation.

Use and disclosure of health information for the facility directory or to others (such as family members) who are involved in the patient's care may be made if the patient does not object. Other types of disclosures must be pursuant to the patient's (or her legal representative's) specific written authorization. In any case in which disclosure of health information is permitted or authorized, the organization must "limit the protected health information disclosed to the information reasonably necessary to achieve the purpose for

which the disclosure is sought."[76] For example, if after discharge from the hospital a cardiologist sees a patient for follow-up, it would probably not be appropriate for the hospital to send the cardiologist copies of medical records relating to an earlier admission for a fractured leg; the hospital would limit the information disclosed to the patient's admission for the coronary condition.

HIPAA preempts (supersedes, trumps) state laws that provide (a) less protection for the information or (b) fewer rights of access by the patient. Each state's laws need to be analyzed to determine whether any of its provisions are preempted. In Florida the state hospital association convened a committee of attorneys and compliance officers to review more than 200 state laws and regulations that have some reference to the privacy of healthcare records. The committee found several provisions that conflict with the HIPAA regulations. For example, one section of the Florida mental health law provides that patients may have access to their clinical records unless the physician determines that release would be "harmful to the patient."[77] The HIPAA regulations, however, say that access may be denied only if access is likely to endanger the "life or physical safety" of the patient.[78] To the extent that the Florida statute would permit the physician to deny access for reason of potential emotional harm, not just danger to the patient's life or physical safety, the statute is contrary to HIPAA and is preempted.[79]

To date, precious few court cases on HIPAA's privacy provisions have reached the federal courts of appeals. Those that have done so dealt with fundamental challenges to the provisions' validity. For example, in *South Carolina Medical Association v. Thompson*,[80] the question was whether Congress had unconstitutionally delegated its legislative power to the Executive Branch by giving the secretary of the U.S. Department of Health and Human Services (HHS) broad authority to write privacy regulations. The court held that it had not:

> Because Congress laid out an intelligible principle in HIPAA to guide agency action, we reject appellants' claim that the statute impermissibly delegates the legislative function. We also conclude that regulations promulgated pursuant to HIPAA are not beyond the scope of the congressional grant of authority, and that neither the statute nor the regulations are impermissibly vague.

In *Citizens for Health v. Leavitt*[81] the question was whether the "privacy rule" (the regulation issued by the HHS secretary) is invalid because it allows for the use and disclosure of personal health information for purposes of treatment, payment, and routine healthcare operations without the patient's consent. The court held that the secretary did not abuse his discretion in issuing the regulation and that it does not violate individuals' privacy rights: "[because] the Privacy Rule is permissive and does not compel any uses or disclosures of personal health information by providers, it does not… interfere with any right protected by the First or Fifth Amendments."

In summary, the HIPAA regulations are here to stay. They are lengthy and complicated. Healthcare administrators must ensure that their organizations have proper policies and procedures in place and that appropriate training is available for all members of their workforce.

State Open-Meeting and Public-Records Laws

Most states have statutes requiring governmental agencies to open their meetings to the public and to make minutes and other records available for public inspection. Sometimes these statutes are referred to as "sunshine" laws, connoting that the public is entitled to have daylight shed on the conduct of governmental affairs and has a right to information on governmental decision making.

To ensure compliance, the statutes typically provide that a violation of the public's right to know constitutes a criminal offense punishable by a fine. More significantly, members of the public can usually enforce their statutory rights by seeking a writ of mandamus that compels compliance or an injunction ordering appropriate relief. Depending on the circumstances, a court may be authorized to declare governmental decisions made in violation of the statute to be null and void. In some states the plaintiff's attorney fees can be assessed against the public agency named in the suit or even against individual members of a board or agency.

Governmental hospitals and public hospital authorities are generally covered by these laws,[82] whether at the state, county, or municipal level. Thus, a county-owned hospital in Florida was subject to that state's Public Records Act, and the institution's personnel records were considered to be "public records" subject to inspection.[83] The records were not protected by either a statutory exception or a common-law right of privacy even though they contained information concerning prior felony convictions, drug and alcohol problems, unlisted phone numbers, physical and mental examinations, and communications from third persons who believed the information they furnished was confidential.

In similar fashion the Georgia Supreme Court has held that a county hospital authority is subject to that state's legislation and that a newspaper had the right to access the names, job titles, and salaries of all employees earning more than $28,000.[84] In Florida, *Gadd v. News-Press Publishing Company, Inc.*, held that a newspaper was entitled to view a public hospital's medical staff files and its utilization review documents.[85] The Public Records Act did not provide a specific exception or an exemption for the records of a medical peer-review committee. Although another Florida statute exempts peer-review records and proceedings in an action against a provider of health services from both pretrial discovery and admissibility in evidence during litigation,[86] the *Gadd* court held that the apparent inconsistency between the

two statutory schemes was a matter for the legislature to resolve. These cases are examples of the typical judicial approach to interpret the sunshine statutes liberally in accordance with legislative intent.

Private corporations are not normally subject to open-meeting laws, even if they receive financial support or other assistance from the government. Accordingly, a charitable hospital created by the terms of a private individual's will was not governed by the Massachusetts open-meetings law even though municipal bonds were issued to support the institution, hospital trustees were elected by local voters, and legal title to the hospital's property was vested in the town.[87] The circumstances of each individual case must be compared to the law of the relevant jurisdiction, however, before deciding whether the statutes apply to private organizations that have associations or contracts with the government. When, for example, a private, not-for-profit medical center in Florida leased space from a governmental hospital authority, certain records of the medical center were accessible to the news media.[88] Moreover, whenever a governmental function is delegated to a private organization, the open-meetings statute may apply. For example, in S*eghers v. Community Advancement, Inc.*, a not-for-profit corporation administering a governmental antipoverty program and making policy decisions on the government's behalf was subject to the Louisiana statute.[89] Similarly, a corporation operating a municipal electric utility system could not claim exemption as a private organization because otherwise the city would provide this service directly.[90]

Most of these statutes, of course, have exceptions to the right of public access. Sometimes these exceptions are cast in very general language; some are more specific. A court may also create an exception whenever there is a persuasive reason for limiting the applicability of the legislation. Typically the statutes will except meetings and records relating to pending litigation, negotiations with labor unions, acquisition of capital (such as the purchase of real estate), and disciplinary action against governmental personnel. Illustrating the latter, a New York case held that certain patient records and interviews with various persons, which were used in a statutory disciplinary proceeding against a physician, were exempt from the state's freedom-of-information law.[91] Also in New York a court found that a county medical center need not disclose medical records of patients, even with identifying information removed, because they are embraced within a specific statutory exception and the freedom-of-information statute must be reconciled with the patient's right to confidentiality.[92] The court concluded that it must have been the intent of the legislature to recognize the patient's right as paramount. (Other courts might well disagree.) In California the state's Medi-Cal (Medicaid) agency was permitted to refuse disclosure of a fiscal audit manual sought by the plaintiff hospital. The court felt that the manual contained critical information relating to the state's

audit of Medi-Cal providers and that the interest of the public was best served by nondisclosure.[93]

In contrast to situations in which information access was denied, a public hospital had to release the records of a patient who sued under Washington's Public Disclosure Act, even though the statute exempted personal information from disclosure.[94] A Joint Commission survey report on a governmental hospital was released in a Pennsylvania case.[95] The rationale was that these reports are used by state governments as evidence of qualification for hospital licensure and thus are public records subject to disclosure unless the government received them under an understanding that they would be held in confidence.[96] In Minnesota the Data Privacy Act allowed public access to the names of physicians who received payment for abortion services to state-assisted indigent patients.[97] The court held that neither the patient nor the doctor had a sufficient interest to prevent disclosure of the doctors' names. Similarly, a consumer advocacy group was given access to reports compiled by the Michigan Department of Public Health in the course of granting licenses to nursing homes.[98]

As these examples show, questions involving access to governmental information involve balancing various interests. The outcome of each case will depend on the language of the relevant statute, judicial understanding of legislative intent, the purposes or motives of the one who seeks access, and the countervailing interests of the defendant or third parties.

Medical Records in Legal Proceedings

As mentioned earlier , the common law did not recognize a physician–patient privilege. Hard though it is to believe, and despite the Hippocratic Oath, medical information entrusted to a doctor was not confidential under the common law.[99] Most states, however, now have statutes that prohibit the physician (and perhaps other professional clinical personnel, depending on the particular statute) from disclosing patient information during judicial proceedings unless the patient has consented or waived the privilege. A typical statute reads as follows:

> The following persons shall not testify in certain respects: ...A physician, concerning a communication made to him by his patient in that relation or his advice to his patient, except that the physician may testify by express consent of the patient or, if the patient is deceased, by the express consent of the surviving spouse or the executor or administrator of the estate of the deceased patient and except that, if the patient voluntarily testifies...the physician may be compelled to testify on the same subject, or if the patient, his executor or administrator, files a medical claim...the

Legal Brief

Physician–patient privilege is the legal and ethical duty of a physician to refuse to testify in a trial or other legal proceeding about statements made to him by a patient without the patient's consent.

filing shall constitute a waiver of this privilege with regard to the care and treatment of which complaint is made.[100]

Statutory Privilege of Confidentiality

The purpose of the privilege of confidentiality is to encourage frank communication between the doctor and the patient and thus to facilitate quality medical care (see Legal Brief). The effect is to prevent a physician or other professional person who has confidential information from disclosing it in court or in quasi-judicial proceedings if the patient asserts the privilege. (Note that the statutes generally do not apply to nonjudicial disclosures; those are left to civil remedies such as suits for defamation, invasion of privacy, and the like.)

In addition to courtroom proceedings, these laws apply to pretrial proceedings such as depositions and motions to inspect and discover records. They also apply to investigations conducted by state legislative bodies. As a general rule the privilege survives the patient's death and may be asserted by her estate.[101] To create a privilege of confidentiality, a physician–patient relationship must exist, and the information the physician is asked to disclose must relate to the patient's medical history and treatment. In *State of Washington v. Kuljis* a hospital staff physician drew a sample of a patient's blood to test for intoxication at the request of the police and with the apparent consent of the patient. It was held that there was no physician–patient relationship and that the information the doctor obtained was not for the purpose of treatment. The test results were admissible as evidence in a criminal prosecution.[102]

Modern procedures encourage liberal pretrial discovery practices to gather all possible evidence that may be admissible at trial. Therefore, the parties to a lawsuit can usually be required to give depositions on medical issues arising during litigation, and their medical records are normally subject to subpoena. The question of admissibility will be sorted out later by the judge.

Parties in a lawsuit are usually said to have waived the privilege of confidentiality if they put their medical condition at issue. In contrast, the medical records of one who is not a party to a legal proceeding are not generally subject to pretrial discovery or admissible in evidence. (But there is a trend toward liberalizing this traditional rule, as discussed in the next section.) In essence, the privileged communication statutes protect the confidentiality of the medical records of anyone not a party to a legal proceeding or when medical issues are not relevant to the case being tried.

Admissibility of Medical Records

In states without a privileged communication statute, or when the privilege does not apply or cannot be asserted by the patient, medical records are generally admissible as evidence under one or more of the exceptions to the hearsay rule, which prohibits secondhand evidence. Medical records are hearsay because the information contained in them is compiled by persons not under oath and these persons are not subject to cross-examination.

That being said, the rules of evidence recognize certain exceptions to the hearsay rule, the foremost of which relates to records kept in the normal course of a business and made at or near the time of the matter under scrutiny. Although those records are technically hearsay (because they are out-of-court entries offered into evidence to prove the truth of the matters contained in them), they are admissible as an exception as long as their authenticity is properly established. Medical records maintained by a physician or a hospital fall within the business-record exception.[103] In some jurisdictions legal authority allows records or excerpts from records to be received as evidence only when the person who entered the information in the chart is not available to testify in person. It should also be noted that the parties to the litigation could stipulate to the records' authenticity and agree that they will be received in evidence. In that event the hearsay rule and exceptions to it become irrelevant.

It is sound public policy to admit records in evidence during litigation, subject to the safeguards of materiality and relevance, when no privileged communication statute exists or when the patient has waived the right of confidentiality. The fundamental purpose of litigation should be to ascertain the truth and accomplish justice between the parties in an adversary situation. Records maintained in the regular course of a patient's care will presumably help establish that truth. Because physicians, nurses, and hospitals do not ordinarily falsify information describing the diagnosis and care rendered to a particular patient, courts can be confident that the information accurately reports the facts and medical opinions regarding the case. In addition, the records are frequently more reliable than personal recollections. Witnesses may be forgetful or they may not be available to testify in person. Even if they are available, the entries may have been made by so many different persons that it would be extremely time consuming and expensive if they all had to appear as witnesses. To exclude medical records from evidence because they are hearsay would defeat the legitimate goals of the judicial process.

Extent and Applicability of Statutory Privilege

The privileged communication statutes differ from state to state. All, however, extend the confidential privilege only to the patient, and not to the physician.[104] In other words, the physician may not refuse to testify for personal reasons. Furthermore, as noted earlier, the statutes pertain only to legal

proceedings of one kind or another. Other disclosures do not give the patient a cause of action for violating the privilege statute, but other recourse exists, such as lawsuits for defamation, invasion of privacy, outrage, and violation of contract.

The use of confidential information in court, contrary to the privilege statute, gives rise to a civil cause of action against the medical practitioner who discloses it, at least in the view of the South Dakota Supreme Court. In *Schaffer v. Spicer*[105] a divorced woman and her former husband were engaged in child-custody proceedings. At the husband's request, and without court order, the wife's psychiatrist prepared an affidavit for the husband's attorney in which the doctor disclosed confidential information reflecting unfavorably on the wife's fitness as a mother. The South Dakota Supreme Court held that the privilege statute had been violated because the information had been acquired by the doctor in the course of treating the patient and the patient had not consented to the disclosure or waived her right of privilege. (The information could probably have been obtained with a court order, but this avenue was apparently not explored.)

The privilege generally applies not only to a physician's records but also to those of an institution because those contain information acquired by the physician in the course of treating the patient.[106] Once again, however, the privilege can only be asserted by the patient. Traditionally, a hospital could not assert confidentiality of records on its own behalf when the court proceedings involved third parties. This rule has been greatly affected by HIPAA, of course, and in any event the issue of privilege must be determined by the litigating parties and the court.[107] If the hospital is one of the litigants, the patient will be deemed to have waived the privilege by bringing suit against the hospital.

The privileged status of medical records is exemplified by a California case in which the plaintiff sought damages from the defendant after an automobile accident. During pretrial discovery, the plaintiff admitted to having been involved in an earlier automobile accident, to having attempted suicide in the same year, and to having been under the care of a psychotherapist. The defendant then obtained a subpoena for all of the plaintiff's medical records. The Supreme Court held that under California's statute the records were privileged and not subject to discovery.[108] The plaintiff had not waived the right to confidentiality because the suit against the defendant raised no issue relating to her mental health.

In another case in which an automobile accident victim's estate claimed accidental death benefits, the insurance company was unable to gain access to his medical records to establish, if possible, that the accident was a suicide. Because there was no evidence of suicide other than the accident, the privilege of confidentiality prevailed.[109] In another California case the plaintiff attempted to establish that a minor's parents were aware of their daugh-

ter's violent tendencies and sought her psychiatric medical records to support the claim. The court denied access.[110]

Access to Medical Records of Third Parties

During pretrial discovery some plaintiffs try to obtain information from the medical records of persons who are not parties to the litigation. As noted previously, the medical records of a patient not a party to litigation are generally not discoverable. But attempts to discover records of third parties have been successful in a few circumstances, as noted in the following discussion.

An Arizona case illustrates the traditional approach and an unsuccessful attempt to gain access to the charts of other patients. The plaintiff had filed a malpractice suit against a hospital for complications of childbirth. Her private obstetrician (who was not a defendant) was absent from the delivery room at the time but was allegedly on the hospital premises. Arguing that the hospital had a duty to reach the physician, the plaintiff tried to gain access to the hospital records of another patient to learn what they might reveal about the doctor's actions at the time in question. The trial court granted discovery of the records, but this decision was reversed on appeal. The higher court held that when neither the doctor nor the other patient was a party to the litigation the information was privileged.[111]

Consistent with this view is an Illinois decision denying access to the medical records of nearly 800 persons who, along with the plaintiffs, had allegedly suffered injury following administration of an investigative drug. It was held that the hospital, on behalf of its patients, could claim the records to be privileged because it was highly probable that the identities of individual patients would be disclosed, even if their names were deleted.[112] The court further said that the patients whose records were sought had not waived the privilege.

In other cases, however, the courts have held that certain records revealing information about third parties are not confidential and that a plaintiff is entitled to such information. For example, an Arizona court permitted a malpractice plaintiff to examine the medical records of 24 surgical patients who had received cardiac pacemakers, provided that the patients' names and other identifying information were redacted.[113] The plaintiff's suit against the hospital alleged that implanting a pacemaker in this particular instance was unnecessary and that the institution had been negligent in failing to monitor the surgeon's privileges properly. Because an essential question was whether the hospital was aware or should have been aware of the surgeon's alleged deviations from professional standards, the records of other patients were relevant to the plaintiff's claim.

A malpractice plaintiff has a right to discover the names of other patients who may possess information regarding the alleged negligence or malpractice, and their consent to such disclosure is not necessary.[114] Otherwise the hospital

could seek witnesses favorable to its side while denying the plaintiff the same opportunity. In itself, the release of the names of patients usually does nothing to reveal the nature of their illnesses or the treatment rendered. According to a New York suit against a hospital that allegedly failed to supervise dangerous patients, the victim of an assault by a hospitalized mental patient is entitled to records relating to prior assaults by the same patient.[115] Nonmedical data regarding other assaults by such a patient are clearly discoverable by a plaintiff, such disclosure not being a violation of either the privileged communication statute or New York's mental hygiene law, which provides that the medical records of patients of state mental institutions are confidential.[116]

The Patient's Waiver of Privilege

Patients who file suit for damages and thereby place their physical or mental health in issue are deemed to have waived the privilege of confidentiality, and their medical records will be admissible at trial, subject to the usual rules of evidence. When a person who claimed to have been injured in an automobile accident brought an action against both the state of Vermont and an individual alleging that the defendants' negligence caused the accident, the Supreme Court of Vermont permitted discovery of the medical records compiled by the treating physician.[117] In another suit—one alleging that a hospital was negligent in maintaining its property and thus caused the plaintiff's fall—it was ruled that in bringing suit the plaintiff placed her physical condition at issue and fairness required the hospital to have access to all relevant medical information, including treatment for a preexisting complaint.[118] Another illustration of waiver occurred in New York, where the patient brought suit against the manufacturer of an intrauterine device. In this case the defendant was entitled to discover the patient's record of venereal disease on file with the city health department.[119]

In determining whether information contained in a medical record or possessed by a medical practitioner is subject to pretrial discovery proceedings or is admissible in evidence in judicial or quasi-judicial proceedings, a court must first interpret any local statute that relates to privileged communications and then apply it to the particular circumstances. If no statute exists, or if the statute does not prevent access to medical information, the court must determine the admissibility of the information by applying the general rules of evidence respecting hearsay testimony and their exceptions and then evaluate the authenticity, reliability, credibility, materiality, and relevance of the record.

In jurisdictions with privileged communication statutes, the public policy issue of balancing the patients' rights to confidentiality against the other parties' rights to ascertain the truth and protect their legitimate interests is a sensitive matter. As is evident through this discussion, the courts attempt to deal fairly with these conflicting interests on a case-by-case basis.

The Federal Government's Right of Access to Medical Records

Prior to the enactment of HIPAA there was no statutory privilege of confidentiality under federal law, and state statutes do not apply in cases involving a federal legal issue. HIPAA permits the government, whether federal or state, to have access to medical records for purposes of healthcare oversight and certain other special situations. Situations in which the federal government has been permitted to review medical records without consent of the patient are exemplified in cases initiated by the Internal Revenue Service (IRS) and the National Institute of Occupational Safety and Health (NIOSH). The IRS was granted access, for example, to the medical records of a deceased person to ascertain whether gifts or property during the patient's lifetime were made in contemplation of death and thus subject to the federal estate tax.[120] In another case the IRS was successful in obtaining the surgical records of a physician who had failed to file tax returns.[121] NIOSH may subpoena employees' medical records that employers must maintain under the Occupational Safety and Health Act.[122] In none of these situations did the state's privileged communication statute apply to protect the confidentiality of the records.

In a widely publicized 1983 case, the HHS sought the records of a severely handicapped newborn, contending that failure to perform surgery because the parents refused their consent constituted unlawful discrimination against a handicapped person in violation of federal law. The district court denied the government access to the records, holding that honoring the parents' refusal in the circumstances would not violate the act.[123] The decision was later affirmed by a federal court of appeals but for different reasons. In the view of the appellate court the factual situation was beyond the contemplation and intent of Congress when the legislation prohibiting discrimination against handicapped persons was enacted, and therefore the statute was not relevant.[124] Note that the district court observed in its opinion that disclosure of the records would not have been barred by a state privilege of confidentiality because no statutory privilege exists when a federal question is being decided.[125] An argument that disclosure would offend the patient's constitutional right of privacy was said to be "extremely weak."[126]

In contrast, a few courts have recognized a constitutional right to maintain confidentiality. For example, a district court has held that a federal grand jury investigating allegations that a mental hospital and a physician defrauded certain insurance companies was not entitled to inspect patients' medical records.[127] The court found a privilege of confidentiality, ruling that it was constitutionally based, and held that a physician could assert the privilege on behalf of patients. A similar conclusion was reached in Hawaii. In that state a statute authorized administrative warrants to search the files of psychiatrists who were caring for Medicaid patients upon showing probable cause. The purpose of the legislation, of course, was to aid in finding fraud

and abuse by physicians receiving public funds. Nevertheless, the court issued an injunction prohibiting enforcement of the statute, thereby recognizing a constitutional right of privacy that cannot be interfered with in the absence of a compelling governmental interest.[128] Apparently the court felt that the state had not sufficiently demonstrated a compelling need to inspect the records.

State authorities, like federal administrative agencies, have frequently been successful in gaining information that is necessary to enforce the law and to protect against fraud and abuse of third-party financing arrangements. The U.S. Court of Appeals for the Sixth Circuit has said, for example, that a psychotherapist may be required to disclose the names of patients and the dates of their treatment to a grand jury investigating an alleged scheme to defraud the Michigan Blue Cross/Blue Shield plan.[129] Similarly, a New York court permitted the state's Department of Social Services to review a psychiatrist's records of Medicaid patients when investigating the physician's billing practices.[130] The physician could not claim that the records were privileged. Further, neither the state's privileged communication statute nor a constitutional right of privacy prohibited the access to documents containing medical information relating to patients by a grand jury investigating a death in a hospital's intensive care unit.[131] In California and many other jurisdictions, the agency that is responsible for licensure may review medical records when examining the professional conduct of a physician whose hospital privileges have been revoked, although the law may require that the names of patients be deleted.[132] Information in the hands of a state's medical licensure board is also frequently available to both state and federal agencies investigating possible criminal activities by physicians.

HIPAA and Law Enforcement

As a general proposition, disclosures of protected health information should not be made to law enforcement officials without either the patient's consent, explicit statutory authority, or a court order. HIPAA provides explicit guidance in this area. Institutions should have policies for relationships with law enforcement agencies. The principle behind such guidelines must be consistent with HIPAA and state law and must recognize the need to balance the patient's rights with the community's legitimate interests in preserving public safety and general welfare.[133]

In 2006, the Florida Hospital Association published a handbook ("HIPAA Requirements and Florida Law: Disclosures of Protected Health Information for Law Enforcement Purposes") that contains a comparison of HIPAA and state law plus 28 helpful real-life scenarios that hospitals are likely to encounter. Each scenario is followed by discussion of a possible solution, and each can be used in education on this subject. All healthcare providers are encouraged to find or develop a resource such as this one and to use it as the basis for developing appropriate operational policies.

It is an understatement to say that medical records—that is, all kinds of health information—are necessary for the delivery of quality healthcare services. The premier professional association for health information management professionals puts it this way:

> Quality information is essential to all aspects of today's healthcare system. Health information management is the body of knowledge and practice that ensures the availability of health information to facilitate real-time healthcare delivery and critical health-related decision making for multiple purposes across diverse organizations, settings, and disciplines.[134]

Chapter Summary

This chapter's title reflects a belief that the term "medical records" is passé, because information about a person's health (or payment for health-related services) can be maintained in many types of media other than paper. Regardless of the form in which it is maintained, however, health information must be accurate and its confidentiality must be ensured. The chapter reviews the various ways in which health information is properly used, such as for documentation of treatment, for accurate billing, and as evidence in various legal forums. It also discusses the state and federal laws, including HIPAA, that govern protection of health information. The chapter outlines circumstances in which third parties may properly have access to individuals' health information with and without patient consent, and it points out the pitfalls that one can encounter when that information is improperly disclosed.

Chapter Discussion Questions

1. Describe the different nuances of the terms "medical records" and "health information." Which term is closer to the HIPAA definition, and why?
2. Describe some of the circumstances in which confidential health information can be disclosed without the patient's explicit consent.
3. What is the proper way to make changes to a written medical record?
4. Who owns the physical medical record?
5. In most states, if a physician gossips about a patient has he violated the statutory physician–patient privilege? Why or why not?
6. In the section on the duty to warn third parties, we learned that it is questionable whether healthcare professionals can accurately predict an

individual's danger to society. How can this point be reconciled with the emotional issue of registering convicted sex offenders and preventing them from living in proximity to schools and other places that children frequent?

Notes

1. Fla. Stat. § 395.016.
2. See, for example, the Joint Commission's, *Accreditation Manual for Hospitals.* The Joint Commission has similar accreditation manuals for other types of healthcare organizations. These manuals are updated annually.
3. Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965), cert. denied, 383 U.S. 946 (1966).
4. Supra note 2 at IM 6.10.
5. See, for example, Hansch v. Hackett, 190 Wash. 97, 66 P.2d 1129 (1937)—the hospital was liable for a nurse's negligence in failing to observe and record symptoms of eclampsia.
6. Goldstein v. Madison Ave. Hosp., No. 24212–76 (Kings County, N.Y., May 21, 1981).
7. Pisel v. Stamford Hosp., 430 A.2d 1 (Conn. 1980).
8. 384 F. Supp. 821 (W.D. Ark. 1974).
9. 34 Colo. App. 356, 539 P.2d 491 (1975).
10. 42 C.F.R. § 482.24.
11. Fla. Stat. § 95.11(4)(6).
12. Pyramid Life Ins. Co. v. Masonic Hosp. Ass'n, 191 F. Supp. 51 (W.D. Okla. 1961).
13. McGarry v. J.A. Mercier Co., 272 Mich. 501, 262 N.W. 296 (1935); Flaum v. Medical Arts Center Hosp., 160:36 N.Y.L.J. 2 (Sup. Ct. 1968)—the court would not order the actual hospital x-rays to be sent to a physician; Cannell v. Medical and Surgical Clinic, 21 Ill. App. 3d 383, 315 N.E.2d 278 (1974).
14. Matter of Weiss, 208 Misc. 1010, 147 N.Y.S.2d 455 (Sup. Ct. 1955).
15. In re Culbertson's Will, 57 Misc. 2d 391, 292 N.Y.2d 806 (Sup. Ct. 1968).
16. The regulations implementing the statute are found at 45 C.F.R. Parts 160 and 164.
17. 45 C.F.R. § 164.528.
18. Conn. Gen. Stat. Ann. §§ 4-104, 4-105 (West 1969); see also Ill. Ann. Stat. ch. 110, §§ 8-2001–2004 (Smith-Hurd Supp. 1986)—a patient, physician, or authorized attorney may examine medical records of every private and public hospital, except those of institutions under jurisdiction of the Department of Mental Health and Developmental Disabilities.
19. Cal. Evid. Code § 1158 (West Supp. 1985); Utah Code Ann. § 78-25-25 (1977).
20. Thurman v. Crawford, 652 S.W.2d 240 (Mo. App. 1983)—a hospital may take reasonable precautions to ascertain authenticity of a patient's consent to release medical information and may refuse to honor consent when the date has been altered.
21. Whalen v. Roe, 429 U.S. 589 (1977).
22. Griswold v. Connecticut, 381 U.S. 479 (1965)—state may not prohibit use of contraceptives of advice or assistance in their use; Roe v. Wade, 410 U.S. 113 (1973) and Doe v. Bolton, 410 U.S. 179 (1973) (abortion cases).
23. Robinson v. Hamilton, 60 Iowa 134, 14 N.W. 202 (1882); Planned Parenthood of Central Mo. v. Danforth, 428 U.S. 52 (1976).
24. For example, Iowa Code Ann. § 144.29 (West 1972).
25. Mo. Ann. Stat. § 188.052 (Vernon Supp. 1987); N.Y. Pub. Health Law § 4160 (McKinney 1985); Minn. Stat. Ann. § 145.413 (West Supp. 1987).
26. N.Y. Pub. Health Law § 2101 (McKinney 1985) (communicable disease); N.Y. Penal Law § 265.25 (McKinney 1980) (wounds); Iowa Code § 147.111 (West 1972) (wounds resulting from criminal act).
27. 45 C.F.R. § 164.512(j).
28. Thompson v. County of Alameda, 27 Cal. 3d 741, 614 P.2d 728, 167 Cal. Rptr. 70 (1980).

29. Mangeris v. Gordon, 94 Nev. 400, 580 P.2d 481 (1978). See also Leedy v. Hartnett, 510 F. Supp. 1125 (M.D. Pa. 1981)—Veterans Administration Hospital had no duty to warn of discharged patient's propensity for alcohol-induced violence without a readily identifiable victim; Brady v. Hopper, 570 F. Supp. 1333 (D. Colo. 1983)—the psychiatrist had no duty to warn because the patient, John Hinckley, Jr., who attempted to assassinate President Reagan, had not threatened to shoot anyone; Soutear v. United States, 646 F. Supp. 524 (E.D. Mich. 1986)—physicians were not negligent in releasing a psychiatric patient and not warning the parents when the patient, who killed a mother three months later, had never behaved violently.
30. Mavroudis v. Superior Court for County of San Mateo, 102 Cal. App. 3d 594, 162 Cal. Rptr. 724 (1980); McIntosh v. Milan, 168 N.J. Super. 466, 403 A.2d 500 (1979).
31. For example, Shaw v. Glickman, 45 Md. App. 718, 415 A.2d 625 (1980)—where an estranged husband shot his wife's male friend, psychiatrists were not liable for failure to warn, even if the patient had threatened to harm the plaintiff); Cole v. Taylor, 301 N.W.2d 766 (Iowa 1981)—plaintiff who had been convicted of murdering her former husband could not maintain an action against her psychiatrist alleging negligence in failing to restrain her and warn her victim; Case v. United States, 523 F. Supp. 317 (S.D. Ohio 1981); Hawkins v. King County Dep't of Rehabilitative Servs., 602 P.2d 361 (Wash. App. 1979).
32. Bellah v. Greenson, 81 Cal. App. 3d 614, 146 Cal. Rptr. 535 (1978).
33. 42 C.F.R. Parts 462 and 476.
34. See, for example, Noble v. United Benefit Life Ins. Co., 230 Iowa 471, N.W. 881 (1941) and Simonsen v. Swenson, 104 Neb. 224, 177 N.W. 831 (1920).
35. Prosser and Keeton, Torts § 112 (5th ed. 1984); Restatement (Second) of Torts § 559 (1976).
36. See, for example, MacDonald v. Time, Inc., 554 F. Supp. 1053 (D. N.J. 1983).
37. Farris v. Tvedten, 623 S.W.2d 205 (Ark. 1981).
38. Koudsi v. Hennepin County Medical Center, 317 N.W.2d 705 (Minn. 1982)—the statement that the plaintiff was a patient in a hospital and had given birth was true and could not be defamation.
39. Gilson v. Knickerbocker Hosp., 280 A.D. 690, 116 N.Y.S.2d 745 (1952).
40. Griffin v. Cortland Memorial Hosp., Inc., 85 A.D.2d 837, 446 N.Y.S.2d 430 (1981)—a notation on chart that an outpatient was abusing drugs was protected by qualified privilege.
41. 104 Neb. 224, 177 N.W. 831 (1920); see also Cochran v. Sears Roebuck, 72 Ga. 458, 34 S.E.2d 296 (1945)—no liability was held when a company nurse in good faith and without proved malice mistakenly told the supervisor that an employee had a communicable venereal disease, and the employee was discharged.
42. Vigil v. Rice, 74 N.M. 693, 397 P.2d 719 (1964).
43. Warren and Brandeis, "The Right of Privacy," 4 *Harv. L. Rev.* 193 (1890).
44. Smith v. Doss, 251 Ala. 250, 37 So. 2d 118 (1948).
45. Housh v. Peth, 165 Ohio St. 35, 36, 133 N.E.2d 340, 341 (1956). Posser and Keeton, Torts § 117 (5th ed. 1984)—this identifies four categories of cases: (a) appropriation, for defendant's advantage, of plaintiff's name or likeness; (b) intrusion on plaintiff's seclusion or solitude, or private affairs; (c) public disclosure of embarrassing private facts; and (d) publicity that places plaintiff in a false light in the public eye. My classification of cases will vary somewhat from these.
46. But cf. MacDonald v. Time, Inc., 554 F. Supp. 1053 (D. N.J. 1983)—when a living person is libeled, the claim survives death and is saved from abatement by the New Jersey survival statute.
47. Cf. Chico Feminist Women's Health Center v. Butte Glenn Medical Soc'y, 557 F. Supp. 1190 (E.D. Cal. 1983)—California constitutional law gave an abortion clinic cause of action for invasion of privacy, on behalf of women seeking its service, against hospital, physicians, insurance company, and medical society for statements and activities intended to force the clinic's closure; a corporation did not have cause of action for invasion of privacy in its own right.
48. 38 Pa. D. & C. 543 (1940). See also Estate of Berthiaume v. Pratt, M.D., 365 A.2d 792 (Me. 1976)—photographing a terminally ill patient for research when the patient objects invades the right of privacy.

49. Commonwealth v. Wiseman, 356 Mass. 251, 249 N.E.2d 610 (1969).
50. See Vassiliades v. Garfinckel's, 492 A.2d 580 (D.C. App. 1985)—publication of photographs by the physician without the patient's consent may be a tort.
51. Beth Israel Hosp. and Geriatric Center v. District Court in and for the City and County of Denver, 683 P.2d 343 (Colo. 1984)—the physician may have access to medical records of his patients especially because case names and not patients' names were requested.
52. Knecht v. Vandalia Medical Center, Inc., 14 Ohio App. 3d 129 (1984)—a qualified privilege based on commonality of interest existed when a woman employed by physicians told her son that his friend was examined for venereal disease.
53. But see Sinclair v. Postal Telegraph and Cable Co., 72 N.Y.S.2d 841 (Sup. Ct. 1935)—actors may insist on dignified public presentations of themselves and their work; hence, the defendant's presentation of an actor's picture presenting him in an undignified light, without permission, was wrongful.
54. Koudsi v. Hennepin County Medical Center, 317 N.W.2d 705 (Minn. 1982)—informing a family member that the plaintiff had borne a child in the hospital did not violate any common law or statutory right to confidentiality.
55. 45 C.F.R. § 164.522(b).
56. Munzer v. Blaisdell, 183 Misc. 773, 49 N.Y.S.2d 915 (1944), aff'd, 269 A.D. 970, 58 N.Y.S.2d 359 (1945); N.Y. Mental Hyg. Law § 33. 13 (McKinney Supp. 1987).
57. Mental Health and Developmental Disabilities Confidentiality Act, 117, Ill. Ann. Stat. ch. 911–2 §§ 801–17 (Smith-Hurd 1987). See §§ 804(a) and 802(9).
58. Id. at § 802(7).
59. Id. at § 805(a).
60. Id. at § 809.
61. Id. at § 810.
62. Id. at §§ 815–16.
63. 42 U.S.C.S. § 242(a); 21 U.S.C.S. § 872 (c), (d).
64. 42 U.S.C.S. § 290ee-3.
65. 42 U.S.C.S. § 290dd-3.
66. 42 C.F.R. pt. 2.
67. 42 U.S.C. § 290ee-30(b)(2)(A-C). Information can also be exchanged between the armed forces and the Veterans Administration without violating the statute, 42 U.S.C. § 290ee-3(e).
68. United States v. Hopper, 440 F. Supp. 1208 (N.D. Ill. 1977).
69. Matter of Dwayne G., 97 Misc. 2d 333, 411 N.Y.S.2d 180 (1978).
70. United States v. Providence Hosp., 507 Supp. 519 (E.D. Mich. 1981)—this involved IRS investigation of a physician who filed no taxes for several years.
71. United States v. Fenyo, 6 M.J. 933 (1979).
72. United States v. Graham, 548 F.2d 1302 (8th Cir. 1977).
73. People v. Newman, 32 N.Y.2d 379, 298 N.E.2d 651, 345 N.Y.S.2d 502 (1973), cert. denied, 414 U.S. 1163 (1973).
74. People v. Carr, 190 N.Y.L.J., Nov. 29, 1983, at 13.
75. 42 U.S.C. § 1320d-6
76. 45 C.F.R. § 164.514(3)(ii).
77. Fla. Stat. § 394.4615(10).
78. 45 C.F.R. § 164.524(a)(3).
79. Florida Hospital Association Management Corp., "Florida HIPAA Preemption Analysis" (2002).
80. 327 F.3d 346 (4th Cir. 2003).
81. 428 F.3d. 167 (3d Cir. 2005).
82. The Mississippi statute, Section 25-41-3 (1986), effective in January 1976, however, grants a specific exemption to the boards, committees, and staffs of both "public and private hospitals."
83. Douglas v. Michel, 410 So. 2d 936 (Fla. App. 1982).
84. Richmond County Hosp. Auth. v. Southeastern Newspapers Corp., 311 S.E.2d 806 (Ga. 1984); see also Moberly v. Herboldsheimer, 345 A.2d 855 (Md. App. 1975)—a newspaper may compel a municipal hospital to disclose an administrator's salary and fees paid to legal counsel.
85. 412 So. 2d 894 (Fla. App. 1982).

86. Fla. Stat. § 768.40(4) (1985).
87. District Attorney for N. Dist. v. Board of Trustees of Leonard Morse Hosp., 389 Mass. 729, 452 N.E.2d 208 (1983).
88. Cape Coral Medical Center, Inc. v. News-Press Publishing Co., Inc., 390 So. 2d 1216 (Fla. App. 1980).
89. 357 So. 2d 626 (La. App. 1978).
90. Raton Public Service Co. v. Hobbes, 76 N.M. 535, 417 P.2d 32 (1966).
91. Matter of John P. v. Whalen, 54 N.Y.2d 89, 429 N.E.2d 117, 444 N.Y.S.2d 598 (1981).
92. Matter of Short v. Board of Managers of Nassau County Medical Center, 57 N.Y.2d 399, 442 N.E.2d 1235, 456 N.Y.S.2d 724 (1982).
93. Eskaton Monterey Hosp. v. Myers, 134 Cal. App. 3d 788, 184 Cal. Rptr. 840 (1982).
94. Oliver v. Harborview Medical Center, 94 Wash. 2d 559, 618 P.2d 76 (1980).
95. Patients of Philadelphia State Hosp. v. Commonwealth of Pa., 417 A.2d 805 (Pa. Commw. Ct. 1980).
96. Nassau-Suffolk Hosp. Council v. Whalen, 89 Misc. 2d 304, 390 N.Y.S.2d 995 (1977).
97. Minnesota Medial Ass'n v. State, 274 N.W.2d 84 (Minn. 1978).
98. Citizens for Better Care v. Reizen, 215 N.W.2d 576 (Mich. 1974).
99. Apparently the first exception to the assertion in the text was the appellate court case of Allred v. State. 554 P.2d 411 (Alaska 1976). The Supreme Court of Alaska recognized a common-law privilege respecting communications made in psychotherapeutic treatment by psychiatrists and licensed psychologists. See also In re "B," Appeal of Dr. Loren Roth, 482 Pa. 471, 394 A.2d 419 (1978)—a patient–psychiatrist relationship creates a privilege founded on the patient's constitutional right of privacy.
100. Ohio Rev. Code Ann. § 2317.02(B).
101. Boggess v. Aetna Life Ins. Co., 128 Ga. App. 190, 196 S.E.2d 172 (1973).
102. 70 Wash. 2d 168, 422 P.2d 480 (1967). See also Conyers v. Massa, 512 P.2d 283 (Colo. App. 1973)—privilege does not apply to examinations for third party's benefit.
103. Weis v. Weis, 147 Ohio St. 416, 72 N.E.2d 245 (1947); Sims v. Charlotte Liberty Mutual Ins. Co., 256 N.C. 32, 125 S.E.2d 326 (1962); In re Estate of Searchill, 9 Mich. App. 614, 157 N.W.2d 788 (1968)—when the mental competence of the deceased at the time a contested will was executed was at issue, a hospital's medical records are admissible under the Michigan Business Records Act; Rivers v. Union Carbide Corp., 426 F.2d 633 (3d Cir. 1970)—hospital records disclosing a history of alcoholism and intoxication at the time of an accident are admissible by virtue of Federal Business Records Act, 28 U.S.C. § 1732.
104. In re Lifschutz, 2 Cal. 3d 415, 467 P.2d 557, 85 Cal. Rptr. 829 (1970)—although psychiatrist–patient privilege exists under California statute, the psychiatrist may not assert privilege and refuse to disclose a relationship with a particular patient when sued by the patient for assault; the psychiatrist may be jailed for contempt of court if he refuses to honor a subpoena. See also People v. Williams, 39 Mich. App. 91, 197 N.W.2d 336 (1972)—the state may not claim privilege; in a criminal prosecution for statutory rape, where the victim testified for the prosecution that she became pregnant and gave birth after an alleged assault by the defendant, the state could not prevent the defendant from calling the victim's physician as a witness; Klinge v. Lutheran Medical Center of St. Louis, 518 S.W.2d 157 (Mo. 1974)—although hospital records are within the physician–patient privilege, the hospital medical staff committee may examine medical records of staff physicians' patients without their consent to determine qualifications and competence of such physicians, because the privilege is that of the patient and not the physician.
105. 215 N.W.2d 134 (S.D. 1974).
106. But see State of Iowa v. Bedel, 193 N.W.2d 121 (Iowa 1971)—a blood-alcohol test with consent of a hospitalized patient on request of arresting officer was not privileged when not related to medical diagnoses and treatment; Unick v. Kessler Memorial Hosp., 107 N.J. 121, 257 A.2d 134 (1969). See also Klinge, supra note 104.
107. Hospitals are frequently innocent bystanders when the confidentiality of records is contested. In Nelson v. Grissom, 152 Colo. 362, 382 P.2d 991 (1963), an ex-husband brought an action to prevent his former wife from removing their children from the state. The woman had remarried, and the plaintiff challenged the fitness of the stepfather to care properly for the

children and sought access to medical records bearing on the stepfather's physical and mental condition. In such situations, hospitals should not release the information without a court order; the court will decide the issue of privilege in accordance with local law.

108. Roberts v. Superior Court of Butte County, 9 Cal. 3d 330, 508 P.2d 309, 107 Cal. Rptr. 309 (1973).
109. Grey v. Los Angeles Superior Court, 62 Cal. App. 3d 698, 133 Cal. Rptr. 318 (1976).
110. Grosslight v. Superior Court of Los Angeles County, 72 Cal. App. 3d 502, 140 Cal. Rptr. 278 (1977).
111. Tucson Medical Center, Inc. v. Rowles, 21 Ariz. App. 424, 520 P.2d 518 (1974).
112. Parkson v. Central DuPage Hosp., 105 Ill. App. 3d 850, 435 N.E.2d 140 (1982).
113. Ziegler v. Superior Court in and for the County of Pima, 134 Ariz. 390, 656 P.2d 1251 (1982).
114. Connell v. Washington Hosp. Center, 50 F.R.D. 360 (D.D.C. 1970); King v. O'Connor, 103 Misc. 2d 607, 426 N.Y.S.2d 415 (1980)—the name and address of a patient who was possibly a witness to alleged malpractice is discoverable; Vanadio v. Good Samaritan Hosp., 85 A.D.2d 662, 445 N.Y.S.2d 215 (1981)—the hospital must disclose names and addresses of patients sharing a room with the plaintiff; Lipari v. Center for Reproductive and Sexual Health, Inc., 187 N.Y.L.J. No. 91, May 12, 1982, at 12, col. 5M—the plaintiff is entitled to names, addresses, and records kept by physicians who examined or were consulted by him; Geisberger v. Willuhn, 390 N.E.2d 945 (Ill. App. 1979)—privilege does not apply to patient's name.
115. Mayer v. Albany Medical Center Hosp., 37 A.D.2d 1011, 325 N.Y.S.2d 517 (1971).
116. Katz v. State of N.Y., 41 A.D.2d 879, 342 N.Y.S.2d 906 (1973); Moore v. St. John's Episcopal Hosp., 89 A.D.2d 618, 452 N.Y.S.2d 669 (1982)—although the medical records of a hospitalized patient are privileged in absence of a waiver, the hospital must disclose to malpractice plaintiff nonmedical information reporting prior assaults or violent behavior of another patient.
117. Mattison v. Poulen, 353 A.2d 327 (Vt. 1976).
118. Sklagen v. Greater S.E. Community Hosp., 625 F. Supp. 991 (D.D.C. 1984).
119. Carr v. Schmid, 432 N.Y.S.2d 807 (Sup. Ct. 1980). See also Pennison v. Provident Life and Accident Ins. Co., 154 So. 2d 617 (La. Ct. App. 1963)—a wife's medical records are subject to subpoena in a divorce action if they are relevant to litigated issues.
120. United States v. Kansas City Lutheran Home and Hosp. Ass'n, 297 F. Supp. 239 (W.D. Mo. 1969).
121. United States v. Providence Hosp., 507 F. Supp. 519 (E.D. Mich. 1981). See also United States v. Cherry Hill Women's Center, Inc., 512 F. Supp. 1303 (E.D. Pa. 1981)—IRS may compel an abortion clinic owned by a physician to produce records without the patient's consent.
122. United States v. Westinghouse Electric Corp., 638 F.2d 570 (3d 1980); General Motors Corp. v. Director of NIOSH, 636 F.2d 163 (6th Cir. 1980).
123. United States v. University Hosp. of State Univ. of N.Y. at Stony Brook, 575 F. Supp. 607 (E.D.N.Y. 1983).
124. 729 F.2d 144 (2d Cir. 1984).
125. 575 F. Supp. At 611.
126. Id. at 615–16.
127. In re Michael Artery: A Witness Before Special April 1980 Grand Jury, No. 80 GJ 1435 (N.D. Ill., Aug. 13, 1981).
128. Hawaii Psychiatric Soc'y v. Ariyoshi, 481 F. Supp. 1028 (D.C. Haw. 1979).
129. In re Zuniga, 714 F.2d 632 (6th Cir. 1983).
130. Camperlengo v. Blum 56 N.Y.2d 251, 436 N.E.2d 1299, 451 N.Y.S.2d 697 (1982). Accord, In re Grand Jury Investigation, 441 A.2d 525 (R.I. 1982). See also State of Ill. v. Herbert, 438 N.E.2d 1255 (Ill. App. 1982)—a grand jury may subpoena records of Medicaid patients; privileged communication does not apply because state had the patient's consent; constitutional protection against self-incrimination does not apply because the subpoena was limited to records required by law; In re June 1979 Allegheny County Investigating Grand Jury, 415 A.2d 73 (Pa. 1980)—a grand jury may subpoena a patient's tissue reports.
131. People v. Doe, 116 Misc. 2d 626, 455 N.Y.S.2d 945 (1982).

132. Board of Medical Quality Assurance v. Hazel Hawkins Memorial Hosp., 135 Cal. App. 3d 561, 185 Cal. Rptr. 405 (1982)—a patient's records of disciplinary proceedings, without names, may be subpoenaed; cf. Division of Medical Quality v. Gherardini, 93 Cal. App. 3d 669, 256 Cal. Rptr. 55 (1979)—records of five identified patients are not subject to a subpoena unless state interest overcomes the state's constitutional right of privacy.
133. Several cases illustrate the impropriety of releasing medical information to the police. For example, Matter of Grand Jury Investigation of Onondaga County, 463 N.Y.S.2d 758 (1983)—names and addresses of patients treated for knife wounds during a given period are not discoverable by district attorney investigating a murder; a hospital may assert privilege on behalf of a patient; State of N.J. v. Dyal, 97 N.J. 229, 478 A.2d 390 (1984)—without a subpoena police may not obtain results of a blood-alcohol test made for medical purposes when patient was not in custody or under arrest. See also discussion in Chapter 9, "Consent for Treatment and Withholding Consent."
134. "Quality Healthcare Through Quality Information," American Health Information Management Association, www.ahima.org/about/about.asp.

THE COURT DECIDES

Tarasoff v. Regents of the University of California
17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976)

Tobriner, J.

On October 27, 1969, Prosenjit Poddar killed Tatiana Tarasoff. Plaintiffs, Tatiana's parents, allege that two months earlier Poddar confided his intention to kill Tatiana to Dr. Lawrence Moore, a psychologist employed by the Cowell Memorial Hospital at the University of California at Berkeley. They allege that on Moore's request, the campus police briefly detained Poddar, but released him when he appeared rational. They further claim that Dr. Harvey Powelson, Moore's superior, then directed that no further action be taken to detain Poddar. No one warned plaintiffs of Tatiana's peril.

Concluding that these facts set forth causes of action against neither therapists and policemen involved, nor against the Regents of the University of California as their employer, the superior court sustained defendants' demurrers to plaintiffs' second amended complaints without leave to amend. This appeal ensued.

Plaintiffs' complaints predicate liability on two grounds: defendants' failure to warn plaintiffs of the impending danger and their failure to bring about Poddar's confinement pursuant to the Lanterman-Petris-Short Act *[the California law allowing involuntary, psychiatric admission of persons considered dangerous to themselves or others].* Defendants, in turn, assert that they owed no duty of reasonable care to Tatiana and that they are immune from suit under the California Tort Claims Act of 1963.

We shall explain that defendant therapists cannot escape liability merely because Tatiana herself was not their patient. When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are

reasonably necessary under the circumstances.

In the case at bar, plaintiffs admit that defendant therapists notified the police, but argue on appeal that the therapists failed to exercise reasonable care to protect Tatiana in that they did not confine Poddar and did not warn Tatiana or others likely to apprise her of the danger. Defendant therapists...are public employees. Consequently, to the extent that plaintiffs seek to predicate liability upon the therapists' failure to bring about Poddar's confinement, the therapists can claim immunity under Government Code section 856....[9]

Plaintiffs therefore can amend their complaints to allege that, regardless of the therapists' unsuccessful attempt to confine Poddar, since they knew that Poddar was at large and dangerous, their failure to warn Tatiana or others likely to apprise her of the danger constituted a breach of the therapists' duty to exercise reasonable care to protect Tatiana....

Plaintiffs' Complaints

Plaintiffs, Tatiana's mother and father, filed separate but virtually identical second amended complaints. The issue before us on this appeal is whether those complaints now state, or can be amended to state, causes of action against defendants. We therefore begin by setting forth the pertinent allegations of the complaints.

Plaintiffs' first cause of action, entitled "Failure to Detain a Dangerous Patient," alleges that on August 20, 1969, Poddar was a voluntary outpatient receiving therapy at Cowell Memorial Hospital. Poddar informed Moore, his therapist, that he was going to kill an unnamed girl, readily identifiable as Tatiana, when she returned home from spending the summer in Brazil. Moore, with the concurrence of Dr. Gold, who had initially examined Poddar, and Dr. Yandell, assistant to the director of the department of psychiatry, decided that Poddar should be committed for observation in a mental hospital. Moore orally notified Officers Atkinson and Teel of the campus police that he would request commitment. He then sent a letter to Police Chief William Beall requesting the assistance of the police department in securing Poddar's confinement.

Officers Atkinson, Brownrigg, and Halleran took Poddar into custody, but, satisfied that Poddar was rational, released him on his promise to stay away from Tatiana. Powelson, director of the department of psychiatry at Cowell Memorial Hospital, then asked the police to return

9. § 856. Determinations in accordance with applicable enactments
(a) Neither a public entity nor a public employee acting within the scope of his employment is liable for any injury resulting from determining in accordance with any applicable enactment:
(1) Whether to confine a person for mental illness or addiction.
(2) The terms and conditions of confinement for mental illness or addiction.
(3) Whether to parole, grant a leave of absence to, or release a person confined for mental illness or addiction.
(b) A public employee is not liable for carrying out with due care a determination described in subdivision (a).
(c) Nothing in this section exonerates a public employee from liability for injury proximately caused by his negligent or wrongful act or omission in carrying out or failing to carry out:
(1) A determination to confine or not to confine a person for mental illness or addiction.
(2) The terms or conditions of confinement of a person for mental illness or addiction.
(3) A determination to parole, grant a leave of absence to, or release a person confined for mental illness or addiction.

Moore's letter, directed that all copies of the letter and notes that Moore had taken as therapist be destroyed, and "ordered no action to place Prosenjit Poddar in 72-hour treatment and evaluation facility."

Plaintiffs' second cause of action, entitled "Failure to Warn On a Dangerous Patient," incorporates the allegations of the first cause of action, but adds the assertion that defendants negligently permitted Poddar to be released from police custody without "notifying the parents of Tatiana Tarasoff that their daughter was in grave danger from Posenjit Poddar." Poddar persuaded Tatiana's brother to share an apartment with him near Tatiana's residence; shortly after her return from Brazil, Poddar went to her residence and killed her....

[The court holds that the first cause of action is barred by the principle of governmental immunity. The third and fourth—not summarized in this book—were also held to be invalid.] We direct our attention, therefore, to the issue of whether plaintiffs' second cause of action can be amended to state a basis for recovery.

Plaintiffs can state a cause of action against defendant therapists for negligent failure to protect Tatiana.

The second cause of action can be amended to allege that Tatiana's death proximately resulted from defendants' negligent failure to warn Tatiana or others likely to apprise her of her danger. Plaintiffs contend that as amended, such allegations of negligence and proximate causation, with resulting damages, establish a cause of action. Defendants, however, contend that in the circumstances of the present case they owed no duty of care to Tatiana or her parents and that, in the absence of such duty, they were free to act in careless disregard of Tatiana's life and safety.

In analyzing this issue, we bear in mind that legal duties are not discoverable facts of nature, but merely conclusory expressions that, in cases of a particular type, liability should be imposed for damage done. As stated in *Dillon v. Legg*: "The assertion that liability must * * * be denied because defendant bears no 'duty' to plaintiff 'begs the essential question—whether the plaintiff's interests are entitled to legal protection against the defendant's conduct. * * * [Duty] is not sacrosanct in itself, but only an expression of the sum total of those considerations of policy which lead the law to say that the particular plaintiff is entitled to protection."

In the landmark case of *Rowland v. Christian* (1968), Justice Peters recognized that liability should be imposed "for injury occasioned to another by his want of ordinary care or skill" as expressed in section 1714 of the Civil Code. Thus, Justice Peters, quoting from *Heaven v. Pender* (1883) stated: "'whenever one person is by circumstances placed in such a position with regard to another * * * that if he did not use ordinary care and skill in his own conduct * * * he would cause danger or injury to the person or property of the other, a duty arises to use ordinary care and skill to avoid such danger'."

We depart from "this fundamental principle" only upon the "balancing of a number of considerations"; major ones "are the foreseeability of harm to the plaintiff, the degree of certainty that the plaintiff suffered injury, the closeness of the connection between the defendant's conduct and the injury suffered, the moral blame attached to the defendant's conduct, the policy of preventing future harm, the extent of the burden to the defendant and consequences to the community of imposing a duty to exercise care with resulting liability for breach, and the availability, cost and prevalence of insurance for the risk involved."

The most important of these considerations in establishing duty is foreseeability. As a general principle, a "defendant owes a duty of care to all persons who are foreseeably endangered by his conduct, with

respect to all risks which make the conduct unreasonably dangerous." As we shall explain, however, when the avoidance of foreseeable harm requires a defendant to control the conduct of another person, or to warn of such conduct, the common law has traditionally imposed liability only if the defendant bears some special relationship to the dangerous person or to the potential victim. Since the relationship between a therapist and his patient satisfies this requirement, we need not here decide whether foreseeability alone is sufficient to create a duty to exercise reasonable care to protect a potential victim of another's conduct.

Although, as we have stated above, under the common law, as a general rule, one person owed no duty to control the conduct of another, nor to warn those endangered by such conduct, the courts have carved out an exception to this rule in cases in which the defendant stands in some special relationship to either the person whose conduct needs to be controlled or in a relationship to the foreseeable victim of that conduct. Applying this exception to the present case, we note that a relationship of defendant therapists to either Tatiana or Poddar will suffice to establish a duty of care; as explained in...the Restatement Second of Torts, a duty of care may arise from either "(a) a special relation * * * between the actor and the third person which imposes a duty upon the actor to control the third person" conduct, or (b) a special relation * * * between the actor and the other which gives to the other a right of protection."

Although plaintiffs' pleadings assert no special relation between Tatiana and defendant therapists, they establish as between Poddar and defendant therapists the special relation that arises between a patient and his doctor or psychotherapist. Such a relationship may support affirmative duties for the benefit of third persons. Thus, for example, a hospital must exercise reasonable care to control the behavior of a patient which may endanger other persons. A doctor must also warn a patient if the patient's condition or medication renders certain conduct, such as driving a car, dangerous to others.

Although the California decisions that recognize this duty have involved cases in which the defendant stood in a special relationship both to the victim and to the person whose conduct created the danger, we do not think that the duty should logically be constricted to such situations. Decisions of other jurisdictions hold that the single relationship of a doctor to his patient is sufficient to support the duty to exercise reasonable care to protect others against dangers emanating from the patient's illness. The courts hold that a doctor is liable to persons infected by his patient if he negligently fails to diagnose a contagious disease, or, having diagnosed the illness, fails to warn members of the patient's family.

Since it involved a dangerous mental patient, the decision in *Merchants Nat. Bank & Trust Co. of Fargo v. United States* [1967] comes closer to the issue. The Veterans Administration arranged for the patient to work on a local farm, but did not inform the farmer of the man's background. The farmer consequently permitted the patient to come and go freely during nonworking hours; the patient borrowed a car, drove to his wife's residence and killed her. Notwithstanding the lack of any "special relationship" between the Veterans Administration and the wife, the court found the Veterans Administration liable for the wrongful death of the wife.

In their summary of the relevant rulings [two scholars] conclude that the "case law should dispel any notion that to impose on the therapists a duty to take precautions for the safety of persons threatened by a patient, where due care so requires, is in any way opposed to contemporary ground rules on the duty relationship. On

the contrary, there now seems to be sufficient authority to support the conclusion that by entering into a doctor–patient relationship the therapist becomes sufficiently involved to assume some responsibility for the safety, not only of the patient himself, but also of any third person whom the doctor knows to be threatened by the patient."

Defendants contend, however, that imposition of a duty to exercise reasonable care to protect third persons is unworkable because therapists cannot accurately predict whether or not a patient will resort to violence. In support of this argument amicus representing the American Psychiatric Association and other professional societies cites numerous articles which indicate that therapists, in the present state of the art, are unable reliably to predict violent acts; their forecasts, amicus claims, tend consistently to overpredict violence, and indeed are more often wrong than right. Since predictions of violence are often erroneous, amicus concludes, the courts should not render rulings that predicate the liability of therapists upon the validity of such predictions.

The role of the psychiatrist, who is indeed a practitioner of medicine, and that of the psychologist who performs an allied function, are like that of the physician who must conform to the standards of the profession and who must often make diagnoses and predictions based upon such evaluations. Thus the judgment of the therapist in diagnosing emotional disorders and in predicting whether a patient presents a serious danger of violence is comparable to the judgment which doctors and professionals must regularly render under accepted rules of responsibility.

We recognize the difficulty that a therapist encounters in attempting to forecast whether a patient presents a serious danger of violence. Obviously, we do not require that the therapist, in making that determination, render a perfect performance; the therapist need only exercise "that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of [that professional specialty] under similar circumstances." Within the broad range of reasonable practice and treatment in which professional opinion and judgment may differ, the therapist is free to exercise his or her own best judgment without liability; proof, aided by hindsight, that he or she judged wrongly is insufficient to establish negligence.

In the instant case, however, the pleadings do not raise any question as to failure of defendant therapists to predict that Poddar presented a serious danger of violence. On the contrary, the present complaints allege that defendant therapists did in fact predict that Poddar would kill, but were negligent in failing to warn.

Amicus contends, however, that even when a therapist does in fact predict that a patient poses a serious danger of violence to others, the therapist should be absolved of any responsibility for failing to act to protect the potential victim. In our view, however, once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger. While the discharge of this duty of due care will necessarily vary with the facts of each case, in each instance the adequacy of the therapist's conduct must be measured against the traditional negligence standard of the rendition of reasonable care under the circumstances. As explained in [the same scholars' article]: "* * * the ultimate question of resolving the tension between the conflicting interests of patient and potential victim is one of social policy, not professional expertise. * * * In sum, the therapist owes a legal duty not only to his patient, but also to his patient's would-be victim and

is subject in both respects to scrutiny by judge and jury."

....

We realize that the open and confidential character of psychotherapeutic dialogue encourages patients to express threats of violence, few of which are ever executed. Certainly a therapist should not be encouraged routinely to reveal such threats; such disclosures could seriously disrupt the patient's relationship with his therapist and with the persons threatened. To the contrary, the therapist's obligations to his patient require that he not disclose a confidence unless such disclosure is necessary to avert danger to others, and even then that he do so discreetly, and in a fashion that would preserve the privacy of his patient to the fullest extent compatible with the prevention of the threatened danger.

The revelation of a communication under the above circumstances is not a breach of trust or a violation of professional ethics; as stated in the Principles of Medical Ethics of the American Medical Association (1957), section 9: "A physician may not reveal the confidence entrusted to him in the course of medical attendance * * * unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community." We conclude that the public policy favoring protection of the confidential character of patient–psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins.

Our current crowded and computerized society compels the interdependence of its members. In this risk-infested society we can hardly tolerate the further exposure to danger that would result from a concealed knowledge of the therapist that his patient was lethal. If the exercise of reasonable care to protect the threatened victim requires the therapist to warn the endangered party or those who can reasonably be expected to notify him, we see no sufficient societal interest that would protect and justify concealment. The containment of such risks lies in the public interest. For the foregoing reasons, we find that plaintiffs' complaints can be amended to state a cause of action against defendants Moore, Powelson, Gold, and Yandell and against the Regents as their employer, for breach of a duty to exercise reasonable care to protect Tatiana.

Tarasoff v. Regents of the University of California Discussion Questions

1. This case was before the court on a procedural issue: Whether the trial court was correct to dismiss the complaint before a trial could be held. What do you suppose happened after the case returned to the trial court?
2. What should the defendants have done differently?
3. Why is the board (the Regents) of the University of California a defendant?

GLOSSARY

Ad valorem tax: One imposed in proportion to the value (in Latin, "ad valorem") of the property being assessed.

Admiralty law: The system of law that applies to accidents and injuries at sea, maritime commerce, alleged violations of rules of the sea over shipping lanes and rights of way, and crimes on shipboard. Jurisdiction over all these matters rests exclusively in the federal courts.

Agency by estoppel and apparent agency: Closely related doctrines that if a principal's conduct leads a third party to reasonably believe that a purported agent was in fact authorized to act on the principal's behalf, the third party will be able to hold the principal accountable for the purported agent's actions and will be barred from successfully asserting otherwise.

Allied health professions: Clinical professionals who work with physicians and nurses in providing healthcare. These professions include physical therapy, biomedical engineering, chiropody, dental hygiene, diagnostics, medical laboratory technology, medical coding and billing, medical transcription, health information management (medical records), nutrition and dietetics, occupational therapy, phlebotomy, nuclear medicine technology, nurse practitioners, physician assistants, radiation technology, respiratory therapy, and speech therapy.

Arbitration: An extrajudicial hearing, sometimes used in medical liability cases, held in an attempt to avoid a court trial and conducted by a person or a panel of people who are not necessarily judges.

Assumption of risk: Taking a chance in a situation that is so obviously dangerous that the injured plaintiff knew he could be injured but took the chance anyway.

Cause of action: The basis of a lawsuit; sufficient legal grounds and alleged facts that, if proven, would make up all the requirements for the plaintiff to prevail.

Charity: An organization that exists to help those in need or to provide religious, educational, scientific, or similar aid to the public. Charities are usually corporations established under state law. They require IRS and/or state approval for contributions to them to be tax deductible and for certain of their economic transactions (such as purchases of goods) to be nontaxable.

Common law: The traditional, unwritten law of England, which developed more than a thousand years before the founding of the United States but which was transplanted to the American colonies in the 17th and 18th centuries. Most of this country's legal decisions and statutes are based on common law.

Comparative and contributory negligence: Common-law doctrines relating to allocation of responsibility when the plaintiff was partially at fault. Under comparative negligence, responsibility and damages are based on the relative negligence of every party involved in the accident. Under contributory negligence, if a person's own negligence "contributed" to the accident in any way, she is not entitled to collect any money damages at all from the other party. Contributory negligence is considered so harsh that many juries ignore it.

Consideration: Essentially, payment; a vital element in the law of contracts; something of value (not necessarily money) that is given (or promised) in return for what is received (or promised) in return.

Contract of adhesion: A contract that is so imbalanced in favor of one party that there is a strong implication it was not freely bargained for and that the other party had no choice but to accept all its terms no matter how restrictive. Many commercial contracts, such as those for the purchase of a car, appear to be contracts of adhesion, not because the customer always has the option to "walk away from the deal." By contrast, a poor tenant who cannot afford to move has no choice but to accept all the terms of a landlord's lease renewal, no matter how burdensome they may be.

Corporate charter: The fundamental document (usually Articles of Incorporation) of a corporation's legal authority.

Corporation: An organization formed with governmental approval to act as an artificial person to carry on business (or other activities), which can sue or be sued and (unless it is nonprofit) can issue shares of stock to raise capital. One benefit of incorporation is that the company's liability for damages or debts is limited to its assets, so the shareholders and officers are protected from personal claims, unless they commit fraud.

Defamation: The act of making untrue statements about another that damage his reputation. If the defamatory statement is printed or broadcast over the media, it is libel; if it is oral only, it is slander.

Dictum (plural, dicta): Latin for "remark." A comment in a legal opinion that is not required to reach the decision but may state a related legal principle as the judge understands it.

Due process (of law): A fundamental principle of fairness in legal matters, both civil and criminal. Due process requires that all legal procedures set by statute and court practice must be followed so that no unjust treatment

results. Although it is somewhat indefinite, the term can be gauged by its aim to safeguard both private and public rights against unfairness. The universal guarantee of due process is in the Fifth Amendment to the U.S. Constitution, which provides "No person shall…be deprived of life, liberty, or property, without due process of law." This principle applies to the states by virtue of the Fourteenth Amendment. Many states' constitutions have similar provisions.

Exculpatory/exculpate (in Latin, "ex" is from and "culpa" is guilt): To absolve; to clear of blame.

Fiduciary: A person, including a business like a bank or trust company, who has the power and duty to act for another (the beneficiary) under circumstances that require total trust, good faith, and honesty.

Good Samaritan statute: Provisions of law that provide immunity from liability for persons who provide emergency care at the scene of an accident. For example, "No licensee, who in good faith renders emergency care at the scene of an emergency, shall be liable for any civil damages as a result of any acts or omissions by such person in rendering the emergency care" (Cal. Bus. & Prof. Code § 2395).

Informed consent: Agreement to do something or to allow something to happen only after all the relevant facts are known. Except in emergency cases when patient consent cannot be obtained, to be considered "informed" a patient's consent to a medical procedure must be based on her having been given all relevant information necessary to make a knowing decision.

Intentional tort: A category of torts that describes a civil wrong resulting from an intentional act on the part of the tort-feasor. Examples include murder, assault, battery, defamation (slander or libel), false imprisonment, fraud, and intentional infliction of mental distress (outrage). Intentional torts may also be crimes, and all can occur in the healthcare setting.

Inure: A word used in the federal tax law relating to exempt organizations. Although not defined in the Internal Revenue Code or regulations, it is taken to mean that a charity's assets must be permanently dedicated to exempt purposes and may not be distributed to private interests.

Law: A system of standards to govern the conduct of people in a community, society, or nation.

Liability: Legal responsibility for one's acts or omissions. Failure of a person or entity to live up to one's responsibilities—whether established by law, contract, or the standard of care (q.v.) under the circumstances—leaves him/her/it legally liable for any resulting damages.

Lobbying: Activity intended to influence the outcome of pending legislation. For purposes of federal tax-exemption law, the following are not considered lobbying: (1) publishing nonpartisan research data, (2) providing testimony to a legislative body on issues that will affect the organization itself, and (3) sending communications to a nonlegislative governmental official.

Not-for-profit (also nonprofit): A type of organization in which there are legal and ethical restrictions on the distribution of profits to owners or shareholders. These restrictions fundamentally distinguish not-for-profit organizations from commercial enterprises. Not-for-profit organizations (usually corporations) do not operate for the purpose of generating profit; however, they may accept, hold, and disburse money and other things of value. Their use of profits and assets is usually restricted by state law and the corporate charter. Such organizations are typically funded by donations and often have tax-exempt status. Donations may sometimes be tax deductible.

Parens patriae (Latin for "father of his country"): The doctrine that the government is the ultimate guardian of all people who are under a legal disability, such as minors and the mentally ill.

Physician: For purposes of federal healthcare programs, at least, "physician" includes doctors of medicine (MD), doctors of osteopathy (DO), doctors of dental surgery or dental medicine (DDS or DMD), doctors of podiatric medicine (DPM), doctors of optometry (OD), and chiropractors (DC).

Proximate cause: The legal cause of the damages to the plaintiff; the cause that immediately precedes and produces the effect (as contrasted with a remote or intermediate cause). Sometimes there is an intervening cause that comes between the original negligence of the defendant and the injured plaintiff and that will either reduce the amount of responsibility or, if this intervening cause is the substantial reason for the injury, negate the defendant's liability entirely.

Qui tam (Latin for "who as well") lawsuit: A lawsuit brought by a private citizen (a "relator," "whistle-blower," or "private attorney general") on behalf of the government as well as himself, against a defendant who may have committed fraud or criminal acts in which the government was victimized. Specific statutory authority for such suits must exist, as it does in the False Claims Act, for example. In a qui tam action the government may intervene to take over prosecution of the case, but in any event the plaintiff will be entitled to a percentage of the recovery of any damages awarded.

Res ipsa loquitur (Latin for "the thing speaks for itself"): A rule of law that one is presumed to be negligent if he/she/it had exclusive control of the cause of the injury, even though there is no specific evidence of negligence and if negligence is absent the accident would not have happened.

Respondeat superior (Latin for "let the superior answer"): A doctrine in the law of agency that provides that a principal—the employer (superior)—is responsible for the actions of his/her/its agent (employee) done in the course of employment. For example, if a nurse negligently administers medication to a patient, her employer (a hospital or physician, for example) can be held liable for any resulting injuries. (See also, "vicarious liability.")

School rule: The principle that healthcare practitioners will normally be judged by the standards of their own particular branch of medicine. Thus, podiatrists should be compared to the standards of podiatry, dentists to dentistry, chiropractors to chiropractic, and so on. The various "schools" often overlap, and their borders are blurred. For example, one's feet can be treated not only by podiatrists but also by general practitioners, orthopedists, or general surgeons; thus, determining which standards apply is often difficult.

Scienter (Latin for "having knowledge"): Knowledge by a defendant that his acts were illegal or his statements were fraudulent. In other words, not only knowing what you are doing but knowing that what you are doing is illegal.

Standard of care: The caution and prudence that a reasonable person would exercise in the circumstances. If a person's actions do not meet the standard of care, then her acts are negligent, and any resulting damages may be compensated in a lawsuit brought by the injured party. The proper standard of care to use in judging one's actions is often a subjective issue upon which reasonable people can differ.

Standing: The right to file a lawsuit or petition under the circumstances of the particular case. For example, a hospital trade association will have standing to sue on behalf of its member organizations to challenge a Medicare regulation if its members are affected by the regulation. The issues are the same for all of them, and it would be impractical for each hospital to file its own lawsuit or for a court to deal with all of them. Similarly, a single hospital may have standing to file suit as a representative of all others similarly affected by the regulation.

Stare decisis (Latin for "to stand by a decision"): The principle that a court is bound by decisions of higher courts (precedents) on a particular legal question applicable to the instant case. Reliance on precedents is required until an appellate court changes the rule, even when the lower court believes it is "bad law."

Statute of limitations: A law setting the maximum period one can wait before filing a lawsuit, depending on the type of case or claim. The periods vary by state. Statutory periods may be suspended ("tolled") depending on the status of the plaintiff. For example, a minor's time period might not begin to run until she reaches the age of majority.

Strict liability: Automatic responsibility (without having to prove negligence) for damages as a result of possession and/or use of inherently dangerous equipment such as explosives, wild and poisonous animals, or assault weapons.

Subpoena duces tecum: A court order issued at the request of one of the parties to a suit and requesting a witness to bring to court or to a deposition any relevant documents under the witness's control. A subpoena duces tecum is often fulfilled by delivering the documents to the requesting party rather than appearing in court.

Tort (Latin for "wrong"): A civil offense not founded on contract. A failure to conduct oneself in a manner considered proper under the given circumstances.

Verdict N.O.V. (non obstante veredicto): A verdict "notwithstanding the verdict" entered by the court when a jury's verdict is clearly unsupported by the evidence. It is akin to a directed verdict or summary judgment entered before the case is sent to the jury for deliberation.

Vicarious liability: Attachment of responsibility to a person whose agent caused the plaintiff's injuries. (See also "respondeat superior.")

Writ of certiorari: An order (writ) by a higher court to a lower court to have the case sent to the former for review. Certiorari—Latin for "we wish to be informed"—is most commonly used by the U.S. Supreme Court, which is selective about which cases it will decide. To seek a hearing in the Supreme Court, a litigant must petition (apply) for a writ of certiorari, which the Court grants at its discretion and only if at least four justices agree that the case involves an issue of such importance that Supreme Court scrutiny is warranted. By denying a petition for certiorari the Court does not implicitly affirm the lower decision but says it will let the decision stand, for whatever reason. (Reasons for denying the petition might include that the lower decision conforms to accepted precedents, that the Court wants to see how other jurisdictions will rule in similar cases, or that the legal issue has not yet fully matured into one about which the Court can issue an informed judgment.)

Writ of mandamus: A court order (sometimes called "writ of mandate") requiring a public agency to perform an act required by law when it has neglected or refused to do so.

SUGGESTED READINGS

Judicial Decisions

- Bush v. Gore, 531 U.S. 98 (2001); see especially the dissenting opinions in regard to political versus constitutional issues.
- Lochner v. New York, 198 U.S. 45 (1905), a now discredited opinion on the Fourteenth Amendment and a state government's power to regulate economic activities.
- Marbury v. Madison, 5 U.S. 137 (1803), on the Constitution as the "supreme law of the land" and power of the courts to overrule statutes that conflict with it.
- McCulloch v. Maryland, 17 U.S. 316 (1819), on the "necessary and proper" clause of the Constitution.
- West Coast Hotel Co. v. Parrish, 300 U.S. 379 (1937), the end of the "Lochner era" and the beginning of a much broader view of the government's power to regulate economic activities through minimum-wage and maximum-hour laws.

Law in Literary Works

- C. Dickens, *Bleak House* (various publishers and dates).
- H. Melville, *Billy Budd* (various publishers and dates).
- R. Posner, *Law and Literature* (Rev. ed. 1998).

On the Evolution of the U.S. Healthcare System

- P. Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (1982).

On the Lives of Some Prominent Jurists

- P. Ackroyd, *The Life of Thomas More* (1998). More is the patron saint of lawyers.
- V. Countryman (ed.), *The Douglas Opinions* (1977). An anthology of the opinions of Supreme Court Justice William O. Douglas.
- D. Danelski and J. Tulchin (eds.), *The Autobiographical Notes of Charles Evans Hughes* (1973).
- G. Gunther, *Learned Hand: The Man and the Judge* (1994).
- L. Kalman, *Abe Fortas: A Biography* (1990).

- A. Kaufman, *Cardozo* (1998).
- R. Newman, *Hugo Black: A Biography* (1994).
- S. Novick, *Honorable Justice: The Life of Oliver Wendell Holmes* (1989).

Other Related Texts

- American Bar Association, *Antitrust Health Care Handbook* (2004).
- B. Ashley and K. O'Rourke, *Health Care Ethics: A Theological Analysis,* 4th ed. (1997).
- B. Ashley and K. O'Rourke, *Ethics of Health Care: An Introductory Textbook* (2002).
- S. Brackel and D. Brooks, *Law and Psychiatry in the Criminal Justice System* (2001).
- B. Farrow, et al., *Health Law: Cases, Materials and Problems,* 5th ed. (2005).
- D. Harris, *Contemporary Issues in Healthcare Law and Ethics,* 2nd ed. (2003).
- J. Hendrick, *Law and Ethics in Nursing and Healthcare* (2000).
- D. Kyvig, *Explicit and Authentic Acts* (1996).
- D. Matyas and C. Valiant, *Legal Issues in Healthcare Fraud* (2006).
- R. Miller and R. Hutton, *Problems in Health Care Law* (2004).
- A. Moreczewski and S. Showalter, *Determination of Death: Theological, Medical, Ethical, and Legal Issues* (1982).
- R. Pound, *The Formative Era of American Law* (1938).
- G. Pozgar, *Legal Aspects of Health Care Administration,* 9th ed. (2004).
- W. Roach, Jr., *Medical Records and the Law,* 3rd ed. (2004).
- S. Showalter, "Managing Healthcare Compliance" Self-Study Course (2000).
- S. Showalter, *To Treat or Not to Treat: A Working Document for Making Critical Life Decisions* (1984).
- S. D. Warren and L. D. Brandeis, "The Right to Privacy," 4 *Harvard Law Review* 193 (1890).
- K. Wing, *The Law and the Public's Health,* 6th ed. (2006), and supplemental cases.
- S. Withrow, *Managing Healthcare Compliance* (2001).
- J. Worthley, *Organizational Ethics in the Compliance Context* (1999).

CASE INDEX

C

D

G

H

L

M

Q

R

S

T

INDEX

D

F

G

J

N

O

P

T

ABOUT THE AUTHOR

J. Stuart Showalter, J.D., M.F.S., has spent most of his career dealing with health law issues. He has a law degree from Washington University in St. Louis, Missouri, and a master's degree in forensic science from George Washington University in Washington, DC. He served in the U.S. Navy from 1972 to 1980 in various positions, including as in-house counsel to a 1,000-bed medical center, as malpractice-claims defense attorney, and as counsel to the U.S. Navy Surgeon General.

From 1980 to 1996, Mr. Showalter was vice president and in-house counsel to the Catholic Health Association of the United States, headquartered in St. Louis. Thereafter, he was a partner in a St. Louis law firm, where he specialized in health law and corporate compliance until joining Orlando Regional Health System as director of compliance in March 1998. While in St. Louis, Mr. Showalter taught health law and public policy in the health administration program at Washington University School of Medicine, where he was twice named teacher of the year. He has also held teaching positions at St. Louis University and the University of Central Florida.

Mr. Showalter retired in 2006 and now works full time as an author and pundit.