



# Bioethics and the Law

**Notes, Cases, and Problems**

BROWNE C. LEWIS



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## ABOUT THE AUTHOR

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## PREFACE

In 2020, the world became a different place. A place that will be forever changed. The one major event that impacted the world was the COVID-19 pandemic. By the end of 2020, there had been 84.8 million COVID-19 cases in the world. Almost 2 million people had succumbed to the virus. Despite the development and distribution of a vaccine, in 2021, the death toll continues to increase daily and there is no clear end in sight. The existence of the virus placed the spotlight on the interworkings of hospitals and emergency room departments. The crisis also highlighted several bioethical issues. For example, during the height of the virus, in Italy, healthcare providers were forced to ration healthcare and medical devices. Because of the lack of ventilators, healthcare providers had to decide how to deploy them. For some patients, those ventilators were the difference between life and death. Thus, in some cases, healthcare providers were deciding the fate of their patients. There were no specific laws dictating the actions the healthcare providers had to take under those difficult circumstances. This was one of those situations where healthcare providers were given latitude and trusted to make the right decisions.

The purpose of bioethics is to put forth ethically acceptable solutions to the problems posed by modern medicine. The actions of healthcare providers are governed by the four principles of bioethics: autonomy, non-maleficence, beneficence and justice. Autonomy deals with patient self-determination. It dictates that the healthcare provider respects the wishes of the patient. Non-maleficence requires that the healthcare provider “does no harm.” Thus, the healthcare provider must not take actions that would cause injury to the patient. Beneficence places an affirmative duty on the healthcare provider to only take actions that benefit the patient. The principle of justice mandates that healthcare providers treat their potential patients and patients fairly. The well-documented presence of disparities in the healthcare system indicates that some healthcare providers do not take this principle seriously.

The principles of bioethics are directly connected to legal mandates. The desire to protect patient autonomy led to the enactment of laws designed to protect privacy and liberty. These laws require healthcare providers to obtain informed consent for medical procedures, to avoid medical battery, and to honor the patient’s right to refuse medical treatment. The violation of the principles of non-maleficence or beneficence may lead to the healthcare provider being sued for negligence. Anti-discrimination laws are in place to ensure that healthcare providers adhere to the principle of justice.

The field of bioethics is a relatively new one. It is often taught in philosophy and humanities departments. In Europe, a growing area of the field of bioethics is medical law. Medical law refers to the body of laws concerning the rights and duties of medical professionals and their patients. This book is designed to be used to teach a 2 or 3 credit biomedical ethics and law course or seminar. The number of biomedical ethics issues are vast and beyond the scope of this book. In this book, I will examine the most common duties and rights that arise from the healthcare provider-patient relationship. In selecting the issues to cover, I took a cradle to grave approach because those are the two times where healthcare providers consistently interact with patients. This book is divided into three components. The book is written in a way that permits the professor to use it in whole or in part.

Part I explores the ethical and legal issues surrounding the creation and termination of the healthcare provider-patient relationship. Private hospitals are only obligated to offer treatment to patients in emergency situations. Prior to the enactment of the Affordable Care Act (ACA), many low-income persons received care predominantly from charity/public hospitals. In the age of privatization, very few public hospitals still exist. Hence, the duties to treat placed on private hospitals and physicians are

of the utmost importance. Chapter One in this section analyzes the actions that are necessary to create and to terminate a physician-patient relationship. It also addresses the reasons a physician cannot use to reject a patient. Because inability to pay is one reason why a physician may refuse to treat a patient, the chapter includes a case that explains the provisions and requirements of Emergency Medical Treatment and Active Labor Act (EMTALA), the federal anti-patient dumping statute. The remaining chapters in this Part address the duties that arise once a physician-patient relationship is created. Chapter Two focuses upon the healthcare provider's duty to protect patient information by analyzing the duty of confidentiality. The Chapter also acknowledges that the duty of confidentiality is not absolute and may be breached to protect third parties. The final chapter in this part deals with the physician's duty to obtain informed consent prior to performing procedures on or conducting medical research on a patient or client. During the course of discussing the physician's duty to obtain informed consent, the chapter delves into the kinds of information that a physician must disclose, so that the patient can make an informed decision. The biomedical ethics principles that are relevant to this section of the book are autonomy, non-maleficence, and justice.

Part II of the book transitions from discussing duties to focusing on rights. The chapters in this Part evaluate an individual's right to make reproductive decisions without undue governmental interference. Chapter Four, the first chapter in this Part, dissects an individual's right to procreate. Historically, that right was denied to individuals, including persons of color, persons with disabilities, and persons from low-economic backgrounds, whom the government deemed to possess undesirable traits. The theory was that permitting those types of persons to procreate was unfair to society and to the resulting offspring. This chapter presents a great opportunity to discuss the eugenics movement in the United States. A movement that continues to exist in some form. Chapter Five deals with the most controversial and debated issue in the country—the right to not procreate. That chapter includes a discussion about contraceptives and abortion jurisprudence. In the chapter, I include information on the black anti-abortion movement, a movement that is growing because of the disproportional number of black women who have abortions. The movement gained traction in 2019 when the United States Supreme Court heard *Box v. Planned Parenthood*, a case that challenged a law banning “selective abortions” based on race, gender, or disability. The law also required the fetal remains to be cremated. The Court upheld the state mandate with regards to fetal remains, but neglected to address the constitutionality of the “selective abortions” part of the law. In his concurrence, Justice Clarence Thomas spent almost twenty pages discussing the eugenics movement in the United States. He opined that the “selective abortions” part of the law was intended to prevent what he classified as “eugenic” abortions. Justice Thomas wanted the Court to decide whether a law could be passed prohibiting abortions designed to terminate a fetus from a population deemed to be undesirable. Chapter Six addresses a woman's right to give birth without government dictates. It examines cases where the rights of the mother and the fetus may be in conflict. The biomedical principles of autonomy and fairness play key roles in the cases in this part of the book.

Part III of the book looks at death and dying, an issue that has become important in the last few years for two main reasons: the aging of the population and advances in medicine that make it possible for people to live long lives that may be lacking in quality. The first chapter in this part, Chapter Seven, examines an individual's right to refuse medical treatment even if that refusal might result in death. Because persons in these situations are often incompetent, the chapter spends a great deal of time discussing the role of third-party decision-makers. Chapter Eight addresses medical futility involving situations where the physician decides to stop medical treatment over the objection of the patient or the patient's family members. It discusses federal statutes that limit the state's ability to grant the physician the right to decide when the patient dies. The material in this chapter gives you a good chance to discuss race and dying. Beginning in slavery, the medical

profession put forth the myth that black people have a higher tolerance for pain. In 2016, the result of a survey of 222 white medical students and residents showed that more than half of those individuals believed that blacks feel less pain than whites. See Ike Swetlitz, *Some medical students still think black patients feel less pain than whites*, stanews.com, April 4, 2016. Myths like this are dangerous because they adversely impact the manner in which black patients are treated for pain. A desire for the pain to stop is one of the main reasons patients give for refusing to consent to continued medical treatment. The final chapter of the book, Chapter Nine begins with a discussion of the history of the right to die movement in the United States. Then, it addresses the two U.S. Supreme Court cases concluding that there is technically no right to die based on the United States Constitution, and the Montana case finding that the State's Constitution could be interpreted as giving a person the right to die. The biomedical principles of autonomy, non-maleficence, and beneficence are relevant to the materials in this part.

In addition to cases, the book contains problems, notes, and questions. The cases are designed to give the student a clear understanding of the relevant law. The problems are included to permit the students the opportunity to apply the law. The notes and questions are provided so the students will think critically about the policies behind the law and the outcome of the cases.

## PART I - DUTIES

The healthcare provider owes several duties to the patient. The violation of those duties can result in ethical and legal consequences. The main legal ramification is a medical malpractice claim. That topic is beyond the scope of this book. This section will discuss the duties that the healthcare provider has because of the [oath](#)<sup>1</sup> he or she takes and the legal regulations in place to protect patients.

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<sup>1</sup> Louis Lasagna, *The Hippocratic Oath: Modern Version*, NOVA website, at [https://www.pbs.org/wgbh/nova/doctors/oath\\_modern.html](https://www.pbs.org/wgbh/nova/doctors/oath_modern.html) (last visited July 16, 2021).

# CHAPTER ONE - DUTY TO ACCEPT AND TREAT PATIENTS

Private hospitals have a common law duty to treat patients in severe emergency situations. This duty applies even if the patient is unable to pay for the services. Federal statutes like the Emergency Medical Treatment and Active Labor Act (EMTALA) have codified this duty. Hospitals also have common law and regulatory duties to treat all patients who can pay. However, hospitals are not legally obligated to treat non-emergency patients who cannot pay. Public hospitals are treated differently because they were created to treat the public and funded by the government. These hospitals are referred to as charity hospitals, and very few of these types of hospitals currently exist. Prior to the enactment of the Affordable Care Act (ACA) low-income persons frequently got their healthcare from hospital emergency rooms. In some states, this practice still occurs.

## 1.1 Private Hospital

### *Wilmington General Hosp. v. Manlove, 4 Story 15 (1961)*

SOUTHERLAND, CHIEF JUSTICE.

This case concerns the liability of a private hospital for the death of an infant who was refused treatment at the emergency ward of the hospital. The facts are these:

On January 4, 1959, Darien E. Manlove, the deceased infant, then four months old, developed diarrhea. The next morning his parents consulted Dr. Hershon. They asked whether the medicine they had for him was all right and the doctor said that it was. In the evening of the same day Mrs. Manlove took the baby's temperature. It was higher than normal. They called Dr. Hershon, and he prescribed additional medication (streptomycin), which he ordered delivered by a pharmacy.

Mrs. Manlove stayed up with the child that night. He did not sleep. On the morning of January 6th the parents took the infant to Dr. Hershon's office. Dr. Thomas examined the child and treated him for sore throat and diarrhea. He prescribed a liquid diet and some medicine.

When Mr. Manlove returned home that night, the baby's condition appeared to be the same. His temperature was still above normal, and again he did not sleep during the night.

On the morning of January 7th (a Wednesday) his temperature was still above normal-102. Mr. and Mrs. Manlove determined to seek additional medical assistance. They knew that Dr. Hershon and Dr. Thomas were not in their offices on Wednesdays, and they took their infant to the emergency ward of the Wilmington General Hospital.

There is no real conflict of fact as to what occurred at the hospital. The parents took the infant into the reception room of the Emergency Ward. A nurse was on duty. They explained to the nurse what was wrong with the child, that is, that he had not slept for two nights, had a continuously high temperature, and that he had diarrhea. Mr. Manlove told the nurse that the child was under the care of Dr. Hershon and Dr. Thomas, and showed the nurse the medicines prescribed. The nurse explained to the parents that the hospital could not give treatment because the child was under the care of a physician and there would be danger that the medication of the hospital might conflict with that of the attending physician. The nurse did not examine the child, take his temperature, feel his forehead, or look down his throat.

The child was not in convulsions, and was not coughing or crying. There was no particular area of body tenderness.

The nurse tried to get in touch with Dr. Hershon or Dr. Thomas in the hospital and at their offices, but was unable to do so. She suggested that the parents bring the baby Thursday morning to the pediatric clinic.

Mr. and Mrs. Manlove returned home. Mrs. Manlove made an appointment by telephone to see Dr. Hershon or Dr. Thomas that night at eight o'clock.

At eight minutes past three o'clock in the afternoon the baby died of bronchial pneumonia.

The foregoing facts are taken mainly from the deposition of the plaintiff.

Plaintiff, as administrator, brought suit against the hospital to recover damages for wrongful death. The complaint charged negligence in failing to render emergency assistance, in failing to examine the baby, in refusing to advise the interne about the child or permit the parents to consult him, and in failing to follow reasonable and humane hospital procedure for the treatment of emergency cases. Defendant answered denying negligence and averring that, pursuant to its established rules and community practice, plaintiff was advised by its employee that it was unable to accept the infant for care.

Discovery proceedings were taken by both parties, eliciting the facts set forth above. Defendant then moved for summary judgment, and attached an affidavit from the nurse on duty when the infant was brought to the hospital. Her statement concerning the refusal of treatment is:

'I then told Mr. and Mrs. Manlove that the rules of the hospital provided that in such cases, where a person is under attendance and medication by a private doctor, *and there is no frank indication of emergency*, no treatment or medication may be given by doctors employed by the hospital until the attending doctor has been consulted.' [Emphasis supplied.]

The issues made by the parties below were in effect two:

1. Whether the hospital was under any duty to furnish medical treatment to any applicant for it, even in an emergency;
2. Whether the existence of an apparent emergency was a material fact in dispute.

The holding of the court below may be summarized as follows:

1. The hospital is liable for refusal to furnish medical treatment in an emergency because it is a quasi-public institution, being the recipient of grants of public funds and of tax exemptions.
2. There was some evidence of an apparent emergency because (1) of death following in a few hours, and (2) of the child's symptoms as recited by the nurse.

Hence the court denied the motion. The hospital appeals.

We take a somewhat different view of these questions from that of the learned judge below.

First, as to the status of the defendant hospital.

It was assumed by both parties below that the hospital was a private hospital and not a public one—that is, an institution founded and controlled by private persons and not by public authority. The trial court disagreed, finding a quasi-public status in the receipt of grants of public money and tax exemptions. See, for example, the Act of 1959 (52 Del.L. c. 159) granting certain hospitals, including defendant, the sum of \$550 per bed; and the act authorizing the Levy Court of New Castle County to appropriate public funds to certain hospitals, including defendant, for the care of indigent persons. 9 Del.C. §§ 1801-1806. For the exemption of its property from county taxation see 9 Del.C. § 8103.

Hence, the court concluded, liability may be imposed on the defendant in an emergency case.

We are compelled to disagree with the view that the defendant has become a public (or quasi-public) hospital. It is admitted (although the record does not show it) that it is privately owned and operated. We find no dissent from the rule that such a hospital is a private hospital, and may, at least in the absence of control by the legislature, conduct its business largely as it sees fit.

The question of public or private status has frequently arisen in suits by a physician to compel the hospital to admit him to the use of its facilities. The cases uniformly hold that the receipt of public funds and the exemption from taxation do not convert a private hospital into a public one (citations omitted). We are of opinion that the defendant is a private and not a public hospital, in so far as concerns the right of a member of the public to demand admission or treatment.

What, then, is the liability of a private hospital in this respect?

Since such an institution as the defendant is privately owned and operated, it would follow logically that its trustees or governing board alone have the right to determine who shall be admitted to it as patients. No other rule would be sensible or workable. Such authority as we have found supports this rule.

In *Birmingham Baptist Hospital v. Crews*, 229 Ala. 398, 157 So. 224, 225, it appeared that after giving a child emergency treatment for diphtheria the hospital refused her admission because its regulations did not permit the admission of patients with contagious diseases. The court said:

‘Defendant is a private corporation, and [is] not a public institution, and owes the public no duty to accept any patient not desired by it.’

The above authorities announce a general rule governing the question of admissions to a private hospital. Does that rule apply to the fullest extent to patients applying for treatment at an emergency ward?

Defendant stresses the rule or practice of the hospital to decline to give medical aid to persons already under the care of a physician. This is no doubt entirely reasonable, but we do not think the rule controlling in this case. We are not furnished with a copy of the rule, or with an affidavit explaining it, but it would seem to be applicable to all admissions—not especially to admissions to the emergency ward. Its significance here appears to lie in the fact that it impliedly recognizes that in case of ‘frank’—i.e. unmistakable-emergency there is some duty on the part of the hospital to give help.



We return, then, to the important question: Is there any duty on the part of the hospital to give treatment in an emergency case, i. e., one obviously demanding immediate attention?

It may be conceded that a private hospital is under no legal obligation to the public to maintain an emergency ward, or, for that matter, a public clinic. Cf. *Taylor v. Baldwin*, Mo., 247 S.W.2d 741, 751. But the maintenance of such a ward to render first-aid to injured persons has become a well-established adjunct to the main business of a hospital. If a person, seriously hurt, applies for such aid at an emergency ward, relying on the established custom to render it, is it still the right of the hospital to turn him away without any reason? In such a case, it seems to us, such a refusal might well result in worsening the condition of the injured person, because of the time lost in a useless attempt to obtain medical aid.

Such a set of circumstances is analogous to the case of the negligent termination of gratuitous services, which creates a tort liability. Restatement, Law of Torts, 'Negligence', § 323. But this is not a case in which the hospital assumed to treat the patient. The claim is that it should have treated him, and that the nurse was negligent in failing to have the infant examined by the intern on duty, because an apparent emergency existed.

This leads to the inquiry: What is the duty of a nurse to one applying for admission as an emergency case? Obviously, if an emergency is claimed, someone on behalf of the hospital must make a *prima facie* decision whether it exists. The hospital cannot reasonably be expected to station an intern at all times in the receiving room. It therefore keeps a nurse on duty. If the nurse makes an honest decision that there is no unmistakable indication of an emergency, and that decision is not clearly unreasonable in the light of the nurse's training, how can there be any liability on the part of the hospital?

The only case cited to us involving refusal of treatment at an emergency ward is that of *O'Neill v. Montefiore Hospital*, 11 A.D.2d 132, 202 N.Y.S.2d 436. In that case Mr. and Mrs. John J. O'Neill came early one morning to the hospital emergency ward. O'Neill complained of symptoms of a heart ailment or attack. He was refused admission because he was a member of a Hospital Insurance Plan and the hospital did not take such cases. The nurse called an H I P doctor, and Mr. O'Neill took the telephone and described his symptoms. The nurse then arranged for O'Neill to see that doctor a few hours later. Mrs. O'Neill asked to have a doctor examine him because it was an emergency, but this was not done. The O'Neills returned home, and O'Neill died in a very short time.

In a suit against the doctor and the hospital the trial court found for the defendants. The Appellate Division unanimously reversed as to the doctor. As to the hospital, three judges held there was a question of fact for the jury to decide, that is, whether the nurse's conduct was a personal favor to deceased, or whether her conduct was that of an attaché discharging her duty, and if the latter, whether what she did was adequate. Two judges dissented, pointing out that the doctor called by the nurse did not, after talking to the patient, indicate that any emergency treatment was required, or request that the patient be admitted to the hospital. In these circumstances they found no liability.

The difference of opinion in that case seems to turn on the question whether, by calling a physician for the applicant, the nurse assumed to give him hospital service. The case does not discuss the questions of what constitutes an emergency, and what is the duty of the nurse in such cases.

As to the majority holding that the nurse's telephone call gave rise to liability, we respectfully dissent. We think the minority opinion is the better view.

As above indicated, we are of opinion that liability on the part of a hospital may be predicated on the refusal of service to a patient in case of an unmistakable emergency, if the patient has relied upon a well-established custom of the hospital to render aid in such a case. The hospital rule with respect to applicants already under the care of a physician may be said to be an implied recognition of this duty.

Applying this rule here, we inquire, was there an unmistakable emergency? Certainly the record does not support the view that the infant's condition was so desperate that a layman could reasonably say that he was in immediate danger. The learned judge indicated that the fact that death followed in a few hours showed an emergency; but with this we cannot agree. It is hindsight. And it is to be noted that the attending physician, after prescribing for the child on morning before, did not think another examination that night or the next morning was required. If this case had gone to the jury on the record here made, we would have been required to hold that it was insufficient to establish liability. We cannot agree that the mere recitation of the infant's symptoms was, in itself, evidence of an emergency sufficient to present a question for the jury. Before such an issue could arise there would have to be evidence that an experienced nurse should have known that such symptoms constituted unmistakable evidence of an emergency.

We must keep in mind the fact that this is not the ordinary accident case in which the services of the hospital emergency ward are sought because of a showing of serious physical injury, or of a danger of such injury. It is a case of disease. This is not to say that an emergency could not arise out of a diseased condition; it is only to say that some degree of experience and knowledge is required to make a *prima facie* determination of the existence of such an emergency.

We do not think that the record made below satisfactorily developed the pertinent facts. What is standard hospital practice when an applicant for aid seeks medical aid for sickness at the emergency ward? Is it the practice for the nurse to determine whether or not an emergency exists, or is it her duty to call the interne in every case? Assuming (as seems probable) that it is her duty to make such a determination, was her determination in this case within the reasonable limits of judgment of a graduate nurse, even though mistaken, or was she derelict in her duty, as a graduate nurse, in not recognizing an emergency from the symptoms related to her? To resolve these questions additional evidence, probably expert opinion, would seem to be required.

It may be said that it was the duty of the plaintiff below, when confronted with the motion for summary judgment, to offer additional proof by affidavit or otherwise. This is perhaps so, but the defendant also could have submitted evidence on the questions we have referred to. As it was, the defendant pitched its case on the theory that under no circumstances could it be liable. The possibility that the case might turn on additional evidence respecting the matters we have touched upon was not considered either by the court or counsel.

In the circumstances we think the case should go back for further proceedings. We should add, however, that if plaintiff cannot adduce evidence showing some incompetency of the nurse, or some breach of duty or some negligence, his case must fail. Like the learned judge below, we sympathize with the parents in their loss of a child; but this natural feeling does not permit us to find liability in the absence of satisfactory evidence.

For the reasons above set forth the order denying summary judgment is affirmed, without approving the reasons therefor set forth in the court's opinion.

Judgment reversed.

## 1.2 Physicians

As *Hurley v. Eddingfield* indicates, physicians do not have a common law duty to treat patients even in emergency situations. Thus, a physician can legally stand back and watch a person die without intervening. Some would argue that engaging in that action would be a violation of the bioethics principle of non-maleficence that requires the physician “to do no harm.” This part of the physician’s oath dictates that the physician must avoid harm to the patient. Nevertheless, this ethical principle is only relevant to situations where a physician-patient relationship exists. Likewise, the physician’s legal obligation comes into existence when he or she establishes a relationship with the patient. Once that relationship has been established, the healthcare provider must provide the patient with proper medical care. A commonly litigated issue is whether a physician’s actions are sufficient to create a physician-patient relationship. If that relationship does not exist, the physician does not have to treat the patient. Nonetheless, federal anti-discrimination laws are in place to prevent physicians from refusing a patient treatment because of factors like disability, gender, race, and socio-economic status.

### 1.2.1 General Rule-No Duty

#### *Hurley v. Eddingfield*, 59 N.E. 1058 (1901)

BAKER, J.

The appellant sued appellee for \$10,000 damages for wrongfully causing the death of his intestate. The court sustained appellee’s demurrer to the complaint, and this ruling is assigned as error.

The material facts alleged may be summarized thus: At and for years before decedent’s death appellee was a practicing physician at Mace, in Montgomery County, duly licensed under the laws of the state. He held himself out to the public as a general practitioner of medicine. He had been decedent’s family physician. Decedent became dangerously ill, and sent for appellee. The messenger informed appellee of decedent’s violent sickness, tendered him his fee for his services, and stated to him that no other physician was procurable in time, and that decedent relied on him for attention. No other physician was procurable in time to be of any use, and decedent did rely on appellee for medical assistance. Without any reason whatever, appellee refused to render aid to decedent. No other patients were requiring appellee’s immediate service, and he could have gone to the relief of decedent if he had been willing to do so. Death ensued, without decedent’s fault, and wholly from appellee’s wrongful act. The alleged wrongful act was appellee’s refusal to enter into a contract of employment.

Counsel do not contend that, before the enactment of the law regulating the practice of medicine, physicians were bound to render professional service to everyone who applied. Whart. Neg. § 731. The act regulating the practice of medicine provides for a board of examiners, standards of qualification, examinations, licenses to those found qualified, and penalties for practicing without license. Acts 1897, p. 255; Acts 1899, p. 247. The act is a preventive, not a compulsive, measure. In obtaining the state’s license (permission) to practice medicine, the state does not require, and the licensee does not engage, that he will practice at all or on other terms than he may choose to accept. Counsel’s analogies, drawn from the obligations to the public on the part of innkeepers, common carriers, and the like, are beside the mark. Judgment affirmed.

### *Notes, Questions, and Problems*

1. How would you articulate the reasoning of the Court in *Hurley*?
2. Do you agree with the decision in *Hurley*? What are the possible consequences of the holding in the case?
3. The federal government has designated nearly 80% of rural America as “medically underserved.” As the number of doctors age, the percentage of places classified as a medical desert will continue to increase. Eli Soslow, ‘Out here, it’s just me’: In the medical desert of rural America, one doctor for 11,000 square miles, *The Washington Post*, Sept. 28, 2019.
4. Did the doctor’s conduct in *Hurley* violate any of the principles of bioethics?

### ***Oliver v. Brock*, 342 So.2d 1 (S.C. 1989)**

SHORES, JUSTICE.

Anita Oliver, through her mother, Cathy Oliver, brought suit against Bryan Whitfield Memorial Hospital of Demopolis, Dr. F. S. Whitfield, Dr. Paul Ketcham and Dr. E. C. Brock, alleging that the plaintiffs had retained Drs. Whitfield, Ketcham and Brock to treat her for injuries received as a result of an automobile accident. The allegations are that ‘the Defendant, Ernest C. Brock, was consulted by the Defendants, F. S. Whitfield, and Paul Ketcham, as to the diagnosis of the Plaintiff’s injury, course of care and treatment to the Plaintiff, and the Defendant, Ernest C. Brock, responded by providing technical medical information to the Defendants, F. S. Whitfield and Paul Ketcham, for the diagnosis, care and treatment of the Plaintiff, Anita Oliver.’

The trial court granted Dr. Brock’s motion for summary judgment and the plaintiffs appealed. The motion for summary judgment was supported by three affidavits, Dr. Brock’s own and that of Drs. Whitfield and Ketcham.

Dr. Brock’s affidavit stated:

‘I am Ernest C. Brock, one of the Defendants in the above styled cause; I practice medicine in Tuscaloosa County, Alabama, and have been practicing medicine in Tuscaloosa for several years. I have never seen or talked to Anita Oliver or Cathy Oliver; I have never had Anita Oliver and Cathy Oliver as a patient. I have never been engaged or requested to serve as a consultant in the treatment of Anita Oliver, I was not employed or engaged to consult with the doctors treating Anita Oliver concerning her complaints or medical problems.

‘I have never had Anita Oliver as a patient of mine; there has never been the doctor-patient relationship between Anita Oliver and myself; I have never been employed by

the parents or guardians of Anita Oliver to treat, diagnose, or assist in any way in the care and treatment of Anita Oliver.

‘I have never been employed, or associated by Dr. F. S. Whitfield or Dr. Paul Ketcham of Demopolis, Alabama, to consult with, diagnose or treat Anita Oliver.

‘I know Dr. F. S. Whitfield of Demopolis and I have talked to him on the telephone on occasions in the past. During the year 1974 and the early part of 1975, Dr. Whitfield did not mention Anita Oliver’s name to me on the phone and I was not employed by him to assist in the treatment of Anita Oliver, or to act as a consultant with him in the treatment of Anita Oliver.

‘Anita Oliver has never been my patient, she is not now my patient, I have never been employed or requested to care for or treat Anita Oliver and I have not been employed or requested to advise anyone with regard to her medical problems.’

Dr. Whitfield stated by affidavit:

‘I am F. S. Whitfield, and I am one of the defendants in the above styled cause now pending in the Circuit Court of Tuscaloosa County, Alabama; I treated the plaintiff following an accident on or about October 1, 1974; that during the period plaintiff, Anita Oliver, was confined to the Bryan Whitfield Memorial Hospital as a patient, Affiant 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 of Affiant; that during the course of such conversation, Affiant did describe generally the injuries of plaintiff and the type of treatment Affiant was then giving plaintiff, and Dr. Brock did indicate to Affiant that under the circumstances described he thought the treatment to be correct; Affiant did not disclose to Dr. Brock the name of the patient; Affiant’s discussion with Dr. Brock was gratuitous on his part and for the guidance of Affiant in connection with the treatment of plaintiff; Affiant did not employ Dr. Brock to care for or treat plaintiff and Dr. Brock did not care for or treat plaintiff to the knowledge of Affiant. In the discharge summary dictated by Affiant, Affiant did make note of the telephone conversation with Dr. Brock and of the suggestions made to Affiant by Dr. Brock but did not suggest and does not now suggest that Dr. Brock was in any way employed by him or the plaintiff in connection with the care and treatment of plaintiff or plaintiff’s injuries, and the fact is that Dr. Brock was not so employed and was never employed to care for or treat plaintiff’s said injuries or to advise anyone with regard thereto.’ (Emphasis Supplied)

Dr. Ketcham’s affidavit follows:

‘I am Paul Ketcham, and I am one of the defendants in the above styled cause now pending in the Circuit Court of Tuscaloosa County, Alabama; I treated the plaintiff following an accident on or about October 1, 1974; I had absolutely no contact whatsoever with Dr. Ernest C. Brock, a practicing physician in Tuscaloosa, Alabama, concerning the care and treatment of the plaintiff, Anita Oliver, at any time during the period I participated in her care and treatment; Dr. Brock did not, so far as I am aware, have any contact with the plaintiff while she was a patient at Bryan Whitfield Memorial Hospital following said accident.’

In opposition to the motion for summary judgment, the following affidavit of Cathy Oliver, mother of Anita, was offered:

‘I, Cathy Oliver, being first duly sworn says:

‘That I am the Plaintiff in the lawsuit involving Dr. Ernest C. Brock and that I am the Plaintiff who is suing Dr. Ernest Brock as the mother of Anita Oliver and as the next friend of Anita Oliver. That my daughter, Anita Oliver, was a patient in the Bryan Whitfield Memorial Hospital in October, 1974. While my daughter was a patient at that hospital, I became concerned regarding the care and treatment rendered or done by Dr. Whitfield and Dr. Ketcham. Dr. Whitfield told me that he would call Dr. Brock in Tuscaloosa to get some advise (sic) on how to treat my daughter’s injuries. Dr. Whitfield later told me that he had talked with Dr. Brock and that Dr. Brock told him that Dr. Whitfield was treating the injuries correctly and told him to continue the same treatment.

‘I have reviewed the chart prepared by the Defendants stating the names of the doctors who treated my daughter. On a page marked ‘Discharge Summary’, I have read that Dr. Brock was consulted and assisted in prescribing the treatment for my daughter. I sincerely believe that Dr. Brock took part in the treatment of my daughter and that he is at fault for the serious injuries suffered by my daughter as a result of this treatment.

/s/ Cathy Oliver

CATHY OLIVER

‘Sworn to and subscribed before me this 2 day of June, 1975.

/s/ Dianna Dobbs

NOTARY PUBLIC’

The question before us is whether, based upon the supporting affidavits, Dr. Brock has carried the burden placed upon a movant for summary judgment to demonstrate that there is no genuine issue of material fact and that he is entitled to prevail on the motion as a matter of law. Stated differently, the issue is whether a triable issue exists as opposed to resolution of that issue.

A physician owes his patient the duty of due care in his treatment of that patient. That is not controverted. The question is whether there is any evidence to suggest that a physician-patient relationship was ever created between Dr. Brock and the plaintiff patient. The general rule is stated in 61 Am. Jur.2d, Physicians, Surgeons, and Other Healers, s 96:

‘A physician is under no obligation to engage in practice or to accept professional employment, but when the professional services of a physician are accepted by another person for the purposes of medical or surgical treatment, the relation of physician and patient is created. 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, either general or special, and the rights and liabilities of the parties thereto are governed by the general law of contract, although the existence of the relation does not need to rest on any express contract between the physician and the person treated.

However, the 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.

In the instant case Dr. Brock says that he has never seen Anita Oliver as a patient, or otherwise. He has never been engaged or requested to serve as a consultant in the treatment of Anita Oliver either by her parents or the doctors treating her. Dr. Ketcham concurs in this statement and Dr. Whitfield says that he called Dr. Brock on the telephone about another of his patients and, during the course of conversation, described generally the injuries suffered by Anita and the type treatment he was administering to her. Dr. Whitfield at no time disclosed to Dr. Brock his patient's name, the conversation was completely gratuitous on his part, and he did not attempt to employ Dr. Brock to care for or treat the patient. He did not suggest that Dr. Brock was in any way requested to advise anyone with respect to the treatment being given the plaintiff.

Mrs. Oliver says only that she became concerned about her daughter and that Dr. Whitfield told her he would call Dr. Brock to get some advice as to treatment. She says that he later told her that he had talked with Dr. Brock and that Dr. Brock told him that Dr. Whitfield was treating the injuries correctly.

We fail to see any evidence from which it could be concluded that Dr. Brock has consented to treat the child, or any from which it could be inferred that he consented to act in a consulting capacity. Mrs. Oliver's statements to the effect that Dr. Whitfield told her that Dr. Brock told him that Dr. Whitfield was treating the injuries correctly, and that she believes that Dr. Brock took part in the treatment, falls short of the kind of evidence required by ARCP 56(e). This rule provides that when affidavits are used to support or oppose a motion for summary judgment they shall be made on personal knowledge, shall set forth such facts as would be admissible in evidence, and shall show affirmatively that the affiant is competent to testify to the matters stated therein.

These requirements are mandatory. Mrs. Oliver states in her affidavit that she 'sincerely believes' that Dr. Brock took part in the treatment of her daughter. However, it has been held that belief, no matter how sincere, is not equivalent to knowledge that a statement in an affidavit that the affiant verily believes does not satisfy the requirements of Rule 56(e). *Jameson v. Jameson*, 85 U.S. App. D.C. 176, 176 F.2d 58 (1949). Apart from her belief that Dr. Brock took part in the treatment of her daughter, Mrs. Oliver offers only the hearsay statements of Dr. Whitfield, who told her that Dr. Brock told him that he was treating the child correctly. Dr. Whitfield denies that he ever asked Dr. Brock to take part in the treatment of the child and denies that Dr. Brock did so. He admits making only a casual reference to the condition of this patient in the abstract, without mentioning her name, during the course of a conversation with Dr. Brock about another patient, and that based upon his description of the injury and treatment, Dr. Brock responded that the treatment seemed to be correct. Whether or not a physician-patient relationship exists depends upon the facts in each case, but some facts must be supplied to support a conclusion that the relationship has been created. In this case, there are no facts which can support the conclusion that the relationship ever existed between Dr. Brock and the patient. Mrs. Oliver contends in her affidavit that she has reviewed the chart prepared by the defendant physicians stating the names of the doctors who treated her daughter. She says she has read on the 'discharge summary' that Dr. Brock was consulted and assisted in prescribing the treatment of her daughter. However, that document is not made a part of the record. ARCP 56(e) requires that sworn or certified copies of all papers or parts thereof referred to in an affidavit (in support of or in opposition to a motion for summary judgment) shall be attached thereto or served therewith. This means that if

written documents are relied upon they actually must be exhibited; affidavits that purport to describe a document's substance or an interpretation of its contents are insufficient. Wright & Miller, Federal Practice and Procedure: Civil s 2722.

There is nothing in this record to support the allegation that Dr. Brock took any part in the treatment of Anita Oliver, by way of advising her physicians, or otherwise. The judgment of the trial court in granting motion for summary judgment on his behalf is, therefore, affirmed.

BEATTY, JUSTICE (concurring specially):

The mere discussion between professional people of hypothetical situations cannot be viewed as a basis for liability. To hold otherwise would tend to adversely affect the quality of the services they offer to members of the public. Physicians, lawyers, dentists, engineers, and other professionals, by comparing problem-solving approaches with other members of their disciplines, have the opportunity to learn from one another. Possessing this freedom, they are better positioned to bring theory into practice for the benefit of those whom they serve. Our decision in this case preserves these essential learning situations for all professional people.

### ***Notes, Questions, and Problems***

1. Do you agree with the logic of the concurring opinion in *Oliver v. Brock*?
2. What was the relationship of each defendant to Anita Oliver? Should those interactions have been sufficient to create a doctor-patient relationship?
3. Would the outcome of the case have been different if Dr. Whitfield had called Dr. Brock specifically to consult on Anita Oliver's case?
4. Michael and Max were identical twins. Michael was a primary care physician and Max made his living being a professional clown. When they were younger, the brothers often traded places. Max was hired to perform at the birthday party for the daughter of Samuel Douglas, an influential man. If Samuel liked his performance, he pledged to give Max a generous donation to help him establish his own clown school. On the day of the performance, Max became ill. Because of the importance of the event to his brother, Michael agreed to attend the party in Max's stead. Everyone at the party assumed that the clown was Max, not Michael. When Michael took a break from performing, he encountered Reginald. Michael had treated Reginald five years earlier for hypertension. Michael noticed that Reginald looked unwell. He advised Reginald to drink some water and to sit down. A few minutes later, Reginald collapsed. Samuel asked if there was a doctor in the house. Michael did not want to expose his deception because he did not want to get Max into trouble. Thus, he remained silent and did not offer any assistance to Reginald. Did Michael have a duty to act?



## 1.3 Physician-Patient Relationship

The duty to treat is triggered by the existence of a physician-patient relationship. When determining whether or not such a relationship has been created, courts look at the actions of the parties. The establishment of a physician-patient relationship requires the creation of a contractual relationship. It is a consensual relationship that is created when the physician performs professional services which another person accepts for the purpose of medical treatment. The relationship must be in existence at the time of the facts relevant to the establishment of the duty. That means that the relationship must have been created and not yet terminated. Once a patient recovers from an illness or stops seeking treatment, a new treatment relationship must be formed to invoke a duty of continuing treatment.

### 1.3.1 Creation

#### 1.3.1.1 Scheduling an Appointment

##### *Problem*

Sallie started a new job in February 2020. On April 1, 2021, she received her medical identification card, listing Dr. Walsh as her primary care physician. The health insurance provider told her that she had to schedule the appointment with Dr. Walsh because she had been randomly selected to be her primary care physician. She was informed that it could take up to two weeks to replace Dr. Walsh. Sallie called Dr. Walsh's office to schedule an appointment because she had been having severe migraine headaches. Dr. Walsh's receptionist, Maine Dawson, scheduled the appointment for the next week. Maine was a temporary receptionist, so she did not know that Dr. Walsh had decided to limit her practice to spend more time with her family. When Sallie showed up for the appointment, Gary Theme, Dr. Walsh's permanent receptionist, told Sallie that Dr. Walsh could not see her because she was not accepting new patients. After protesting for several minutes, Sallie was led from the building by security. Sallie died an hour later from a brain aneurysm. Sallie's mom, Denise, plans to sue Dr. Walsh for wrongful death. What is the possible outcome of the case based upon the holdings in the following cases?

##### *Lyons v. Grether, 239 S.E.2d 103 (1977)*

POFF, JUSTICE.

We awarded a writ of error to a final order entered June 2, 1976 sustaining a demurrer to a motion for judgment filed by Magnolia Lyons (plaintiff) against Dr. Eugene R. Grether (defendant).

A demurrer confesses the truth of the facts alleged and accepts all reasonable inferences therefrom. Plaintiff, a blind person, accompanied by her four-year-old son and her guide dog, arrived at defendant's "medical office" on the morning of October 18, 1975, a Saturday, to keep an appointment "for a treatment of a vaginal infection". She was told that defendant would not treat her unless the dog was removed from the waiting room. She insisted that the dog remain because she "was not informed of any steps which would be taken to assure the safety of the guide dog, its care, or availability to her

after treatment.” Defendant “evicted” plaintiff, her son, and her dog, refused to treat her condition, and failed to assist her in finding other medical attention. By reason of defendant’s “wrongful conduct, “plaintiff was “humiliated” in the presence of other patients and her young son, and “for another two days while she sought medical assistance from other sources,” her infection became “aggravated” and she endured “great pain and suffering.” Allying that defendant’s waiting room “is a public place and a place to which the general public is invited and where she had a right to have her guide dog with her pursuant to Virginia Code s 63.1-171.2 Virginia Code s 63.1-171.2,” plaintiff demanded damages resulting from “breach of his duty to treat”.

The order sustaining the demurrer was based upon two grounds. Ruling as matters of law, the trial court held that “the defendant had no duty to treat the plaintiff since he had not accepted her as a patient” and that “defendant’s waiting room is not a public facility or place contemplated by” the White Cane Act. We address the first ruling in our determination whether the motion for judgment was sufficient to allege the creation of a physician-patient relationship and a duty to treat. If we determine that it was, then the trial court’s second ruling bears upon the question whether defendant’s withdrawal from the relationship for the reasons and under the circumstances alleged in plaintiff’s motion excused non-performance of the duty to treat.

Although there is some conflict of authority, the courts are in substantial accord upon the rules concerning the creation of a physician-patient relationship and the rights and obligations arising therefrom (citations omitted). In the absence of a statute, a physician has no legal obligation to accept as a patient everyone who seeks his services. A physician’s duty arises only upon the creation of a physician-patient relationship; that relationship springs from a consensual transaction, a contract, express or implied, general or special, *McNamara v. Emmons*, 36 Cal.App.2d 199, 204-05, 97 P.2d 503, 507 (1939); and a patient is entitled to damages resulting from a breach of a physician’s duty. See 61 Am. Jur.2d Physicians, Surgeons, Etc. s 96 (1972); 70 C.J.S. Physicians and Surgeons ss 37, 38 (1951). Whether a physician-patient relationship is created is a question of fact, turning upon a determination whether the patient entrusted his treatment to the physician and the physician accepted the case (citations omitted).

We consider first whether the facts stated in the motion for judgment, and the reasonable inferences deducible therefrom, were sufficient to allege the creation of a physician-patient relationship and a duty to treat. Standing alone, plaintiff’s allegation that she “had an appointment with defendant” would be insufficient, for it connotes nothing more than that defendant had agreed to see her. But plaintiff alleged further that the appointment she had been given was “for treatment of a vaginal infection.” The unmistakable implication is that plaintiff had sought and defendant had granted an appointment at a designated time and place for the performance of a specific medical service, one within defendant’s professional competence, viz., treatment of a particular ailment. It is immaterial that this factual allegation might have been contradicted by evidence at trial. Upon demurrer, the test of the sufficiency of a motion for judgment is whether it states the essential elements of a cause of action, not whether evidence might be adduced to defeat it. See *Grubbs v. National Life & Co.*, 94 Va. 589, 591, 27 S.E. 464, 465 (1897).

We are of opinion that the motion for judgment was sufficient to allege a consensual transaction giving rise to a physician-patient relationship and a duty to perform the service contemplated, and that the trial court erred in holding as a matter of law that defendant had not accepted plaintiff as a patient.

We consider next how a physician-patient relationship, once created, may be lawfully terminated.

As a general rule, unless the services to be rendered are conditioned or limited by notice or by the terms of employment, the physician-patient relationship continues until the services are no longer needed, *Vann v. Harden*, 187 Va. 555, 565, 47 S.E.2d 314, 319 (1948); however, the relationship may be terminated earlier by mutual consent or by the unilateral action of the patient; and under certain circumstances, the physician has a right to withdraw from a case, provided the patient is afforded a reasonable opportunity to acquire the services he needs from another physician. See Annot., 57 A.L.R.2d 432, 439, s 3 (1958).

Under plaintiff's construction of the White Cane Act, defendant's withdrawal from her case was not justified by the circumstances. She argues that defendant's office was a place "to which the public is invited" within the meaning of Code s 63.1-171.2(b) and that defendant's withdrawal violated the right to which she was entitled under Code s 63.1-171.2(c). Under the trial court's construction, defendant's office was not covered by the Act and plaintiff had no statutory right to take her dog there.

We are persuaded by plaintiff's argument as applied to the facts alleged in this case. It fairly appears from the face of the motion for judgment that defendant's office was a place to which certain members of the public were invited by prior appointment to receive certain treatment at certain scheduled hours. Plaintiff did not allege that defendant's office was a place to which the general public was generally invited to receive general medical services. Accordingly, while we hold that, under the facts alleged here, defendant's office was within the intendment of the White Cane Act and that the trial court erred in ruling otherwise, we believe it would be beyond the issues drawn for us to hold as a matter of law that the Act as presently written covers all physicians' offices under all circumstances.

Even if the trial court had been correct in holding that plaintiff had no statutory right to take her guide dog to defendant's office, the question yet would have remained whether plaintiff's refusal to part with her dog without the assurances she sought constituted a circumstance justifying defendant's withdrawal from her case. Also remaining would have been the other question related to defendant's right to withdraw, viz., whether, as plaintiff expressly alleged, she was denied a reasonable opportunity to acquire the services she needed from another physician. Both questions were questions of fact which, even in the absence of the White Cane Act, were the subjects of proof, and we hold that the trial court erred in sustaining the demurrer.

The judgment is reversed and the case will be remanded with instructions to restore plaintiff's motion for judgment to the docket.

Reversed and remanded.

### ***Notes, Questions, and Problems***

1. What is a demurrer? What are the two reasons the trial court gave for sustaining the demurrer in *Lyons*?
2. Would the outcome of *Lyons* have been different if the appointment was not to be treated for a specific condition? With the exception of annual wellness check-ups, most patients make appointments

with doctors because they have a particular ailment. Consequently, does the holding in *Lyons* place an undue burden on doctors to take on any patient who schedules an appointment with the receptionist?

3. Currently, most patients schedule doctor appointments online using some type of scheduling software, so the patient has no direct contact with the doctor or the staff. Does this fact impact the holding of *Lyons*?

### 1.3.1.2 Limited Consultation

Because of the shortage of physicians, the field of tele-medicine has grown tremendously. Tele-medicine refers to the practice of caring for patients remotely when the provider and patient are not physically present with each other. Modern technology has enabled doctors to consult patients using HIPAA compliant video-conferencing tools. During the global pandemic, most physicians attended to non-emergency patients through tele-medicine. The availability and use of tele-medicine has muddled the water when it comes to determining the establishment of a doctor-patient relationship. States are enacting laws to try and deal with the impact of [tele-medicine](#).<sup>2</sup>

As the following case indicates, courts often look at duration instead of frequency. Thus, a doctor-patient relationship can arise from a single encounter.

### ***White v. Harris*, 36 A.3d 203 (2011)**

REIBER, C.J., DOOLEY, JOHNSON AND SKOGLUND, J.J.

#### **ENTRY ORDER**

Plaintiffs appeal from a superior court order granting summary judgment to defendant Fletcher Allen Health Care, Inc. in this wrongful death action alleging medical malpractice. This case arises from the suicide of plaintiffs' fourteen-year-old daughter. Plaintiffs sued defendant, which employed a psychiatrist who was briefly involved with decedent's case through a telepsychiatry research study. Plaintiffs argue that summary judgment was improperly granted on the issue of the duty owed to decedent by the psychiatrist. We agree, and thus reverse and remand for additional proceedings.

The record indicates the following. Decedent suffered from ongoing mental health problems. On the recommendation of her case manager, she consulted with defendant's psychiatrist through a telepsychiatry research study he was conducting. As part of the study, plaintiffs and decedent completed pre-assessment documentation, and they participated in a one-time, ninety-minute video-conference session with the psychiatrist in August 2006. Following the session, the participants completed a questionnaire about their reaction to using telemedicine. The psychiatrist later completed a consultation evaluation that described decedent and the history of her present illness; it also provided the doctor's diagnostic impression of decedent and set forth recommendations for an initial treatment plan. The evaluation specifically stated that, consistent with the telepsychiatry research protocol, no follow-up services would be provided, and no medication prescriptions would be directly provided by

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<sup>2</sup> *Establishing Doctor-Patient Relationship in Telemedicine*, ortholive, at <https://www.ortholive.com/blog/establishing-doctor-patient-relationship-in-telemedicine/> (Jan 16, 2019).

the doctor. The report further explained that the recommended treatment plan was to be weighed by decedent's treatment team, including her primary care physician, for possible implementation. After sending his evaluation, the psychiatrist had no further interaction with plaintiffs, decedent, or any member of her treatment team.

On June 10, 2007, decedent committed suicide. An autopsy report indicated that she died from the combined effects of ingesting Propoxyphene, opiates, and Citalopram. The psychiatrist had not prescribed or recommended any of these medications.

In June 2009, plaintiffs filed an amended complaint, alleging that defendant, among eight doctors and medical care providers, treated decedent in a manner that "fell below the standard of care required of reasonably skillful, careful, and prudent professionals," and that decedent died as a proximate result. Defendant moved for summary judgment in December 2009, asserting that its doctor had no duty to decedent when she committed suicide because there was no doctor-patient relationship. Alternatively, defendant argued that any such relationship was formally terminated in writing following their one-time interaction. Defendant acknowledged that if the trial court found that a duty existed, its motion would be premature. The trial court also recognized that the motion came at an early stage in the proceedings, but reasoned that if no duty existed, then no additional discovery to show a breach of that duty would be necessary. Ultimately, the trial court agreed that the psychiatrist's contact with decedent was "so minimal as to not establish a physician-patient relationship," and consequently found that no duty existed at the time of decedent's death. Even assuming that a doctor-patient relationship was established, the court concluded that it was terminated following the video-conference and, thus, any duty was extinguished by termination of the relationship and no duty existed at the time of decedent's death. The court thus granted defendant's summary judgment motion. This appeal followed.

Plaintiffs argue that the court erred in finding that the doctor owed no duty to decedent. They maintain that the doctor had a duty to exercise reasonable care to protect decedent from the danger she posed to herself, and that the doctor did not effectively terminate the doctor-patient relationship prior to decedent's death.

We review motions for summary judgment *de novo*, using the same standard of review as the trial court. *Campbell v. Stafford*, 2011 VT 11, ¶ 10, 189 Vt. 567, 15 A.3d 126 (mem.). We afford the nonmoving party "the benefit of all reasonable doubts and inferences," *Doe v. Forrest*, 2004 VT 37, ¶ 9, 176 Vt. 476, 853 A.2d 48, and we will affirm summary judgment orders when there is no genuine issue as to any material fact and a party is entitled to judgment as a matter of law. V.R.C.P. 56(c)(3).

We agree that a duty applies to the service provided. The doctor had a duty of due care in his professional contact with decedent, which was not extinguished by the ministerial act of termination of their professional relationship. See *Endres v. Endres*, 2008 VT 124, ¶ 11, 185 Vt. 63, 968 A.2d 336 (noting that the existence of a legal duty is "central to a negligence claim" and is "primarily a question of law"); see also *Markowitz v. Arizona Parks Bd.*, 146 Ariz. 352, 706 P.2d 364, 366 (1985) (en banc) ("[A] negligence action may be maintained only if there is a duty or obligation, recognized by law, which requires the defendant to conform to a particular standard of conduct in order to protect others against unreasonable risks of harm."). We have defined duty as "an expression of the sum total of those considerations of policy which lead the law to say that the plaintiff is entitled to protection." *Endres*, 2008 VT 124 ¶ 11, 185 Vt. 63, 968 A.2d 336 (quotation omitted). In assessing whether a duty exists, "[t]he question is whether the relationship of the parties was such that the defendant was under an obligation to use some care to avoid or prevent injury to the plaintiff." *Markowitz*, 706 P.2d at 368; see also *Langle v. Kurkul*, 146 Vt. 513, 520, 510 A.2d 1301, 1305 (1986) (in determining whether duty

of care exists, courts consider relationship between parties, nature of the risk (including its foreseeability), and public policy implications of imposing a duty on defendant to protect against the risk). In their analysis of circumstances similar to those here, other courts have considered these factors:

whether the doctor was in a unique position to prevent harm, the burden of preventing harm, whether the plaintiff relied upon the doctor's diagnosis or interpretation, the closeness of the connection between the defendant's conduct and the injury suffered, the degree of certainty that the plaintiff has or will suffer harm, the skill or special reputation of the actors, and public policy.

*Stanley v. McCarver*, 208 Ariz. 219, 92 P.3d 849, 853 (2004).

The facts here disclose a consultation of limited duration. Decedent and her mother signed an informed consent form, and the doctor stated in writing that the scope of his services was limited. At the same time, however, there is no dispute that the doctor performed a psychiatric evaluation of decedent, following which the doctor offered recommendations for decedent's treatment. And the record reveals the parties' expectation that the doctor would aid in decedent's treatment through his expertise, regardless of the mechanism of doctor-patient contact. In requesting a consultation with the doctor, decedent's treatment team specifically sought recommendations about decedent's medication, particularly given the increase in decedent's angry and aggressive behavior and self-mutilation. They also sought the doctor's diagnostic impression and recommendations about the role that Attention-Deficit Hyperactivity Disorder might play in decedent's behavior. While decedent's medical records may not have been provided to the doctor, the doctor was provided with a very recent medical evaluation of decedent performed by another doctor, which was supplemented by additional information about decedent from decedent's treatment team. This included information that decedent had a history of depressive behavior and had recently exhibited an increase in angry, aggressive behavior, along with more frequent cutting behavior. All of this information bears on the scope of the professional relationship from which defendant's duty arose and it helps to frame the applicable standard of care. We find it sufficient to support the existence of a duty here.

A professional consultation may arise in many different circumstances. Defendant's involvement here was limited, but that does not mean it was nonexistent. It may be analogized to cases in which a doctor is asked to perform an independent medical examination (IME) of a patient as part of a legal investigation or an insurance claim. As in the current case, an IME doctor usually does not see a patient again or maintain an ongoing relationship with the patient; rather he or she performs a limited analysis of the patient's condition that is provided to a third party. See *Ritchie v. Krasner*, 221 Ariz. 288, 211 P.3d 1272, 1279-81 (Ct. App.2009) (considering existence of duty where insurance carrier asked defendant doctor to conduct IME); *Harris v. Kreutzer*, 271 Va. 188, 624 S.E.2d 24, 29-32 (2006) (considering medical malpractice claim against doctor retained to conduct a court-ordered IME). Many courts addressing IME cases have concluded that an IME creates a doctor-patient relationship that "imposes fewer duties on the examining physician than does a traditional physician-patient relationship," but "still requires that the examiner conduct the examination in such a way as not to cause harm." *Dyer v. Trachtman*, 470 Mich. 45, 679 N.W.2d 311, 316 (2004); see also *Ritchie*, 211 P.3d at 1280 ("[A]n IME doctor has a duty to conform to the legal standard of reasonable conduct in the light of the apparent risk." (quotation omitted)); *Harris*, 624 S.E.2d at 32 (holding that "a cause of action for malpractice may lie for the negligent performance of a [court-ordered medical examination]," but that the examining physician's "duty is limited solely to the exercise of due care consistent with the applicable standard of care so as not to cause harm to the patient in actual conduct of the examination").

Here, the relationship between doctor and patient was even more direct than a third-party-retained IME doctor. The defendant became involved on referral from decedent's treatment team and reported to them his findings and recommendations after evaluation. We hold that the ninety-minute consultation performed in this case created a doctor-patient relationship. We acknowledge that the tele-psychiatry research study conducted by the doctor provided no treatment component directly to decedent, other than recommendations to her treatment team. However, through this consultation, a limited doctor-patient relationship was established, and we conclude that a duty of due care applies. Through this consultation, defendant's doctor assumed a duty to act in a manner consistent with the applicable standard of care so as not to harm decedent through the consultation services provided.

Defendant argues that submission of the psychiatrist's consultation evaluation to decedent's treatment team terminated any doctor-patient relationship that ever existed, and defendant equates the ending of this relationship with the termination of any "further duty to the patient." We hold, however, that even if doctor-patient contact had ended, this does not terminate the doctor's responsibility for the consequences of any lapses in his duty to provide services consistent with the applicable standard of care for the consultation. Under 12 V.S.A. § 1908(1), a doctor must exercise "the degree of care ordinarily exercised by a reasonably skillful, careful, and prudent health care professional engaged in a similar practice under the same or similar circumstances." A doctor may be liable for malpractice if "as a proximate result of the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred." *Id.* § 1908 (3). Under this statute, whether or not a doctor has ceased treating a patient is irrelevant to whether he or she may be held liable for injuries resulting from his or her failure to exercise the proper degree of care *while treating* the patient. It is the doctor's responsibility for the services provided that is significant here, and not simply the duration of the doctor-patient relationship itself.

On these facts, however, the scope of defendant's duty and the standard of care cannot yet be determined. In evaluating the standard of care, we must not conflate the existence of a duty with the appropriate standard of care, an issue that takes us beyond the limited facts in the record before us and was not properly raised below. See *W. Keeton et al., Prosser and Keeton on the Law of Torts* § 53, at 356 (5th ed. 1984).

The issue of standard of care was not raised by defendant in its motion for summary judgment, nor decided by the trial court. It is not the role of this Court to set that standard or to evaluate whether it was breached at this stage of the proceedings. Expert testimony is required. See *Senesac v. Assocs. in Obstetrics & Gynecology*, 141 Vt. 310, 313, 449 A.2d 900, 902 (1982) (in medical malpractice action, plaintiff must ordinarily produce "expert medical testimony setting forth: (1) the proper standard of medical skill and care; (2) that the defendant's conduct departed from that standard; and (3) that this conduct was the proximate cause of the harm complained of"); see also *Ritchie*, 211 P.3d at 1279 (noting that, aside from duty, the remaining "elements of negligence are factual issues, and are generally within the province of the jury").

This is a lawsuit in its formative stages. The motion for summary judgment was filed six months after the complaint was filed and raised the sole question of the duty of care of this consulting doctor. The remaining elements of plaintiffs' claim have not yet been fully developed, and defendant did not move for summary judgment on these elements. See *State v. Therrien*, 2003 VT 44, ¶ 23 n. 3, 175 Vt. 342, 830 A.2d 28 (recognizing "general rule that summary judgment should not be granted on an issue not raised in the summary judgment motion unless the party against whom summary judgment is granted

is given full and fair notice and opportunity to respond to the issue prior to the entry of summary judgment”). Given our conclusion that a duty exists, we reverse and remand for additional proceedings.

Reversed and remanded.

### **1.3.1.3 Telephone Consultation**

#### ***Reynolds v. Decatur Memorial Hosp.*, 277 Ill. App. 3d 80 (Ill. App. Ct. 1996)**

JUSTICE MCCULLOUGH delivered the opinion of the court:

Plaintiffs Kevin Thomas Reynolds, a minor (born July 14, 1988), by Barbara Reynolds, his mother and next friend, and Charles W. and Barbara Reynolds, individually, appeal from a summary judgment entered by the circuit court of Macon County in favor of defendant Dr. Thomas Fulbright in this medical malpractice action based on a negligence theory. Although this case remains pending as to other defendants, the trial court made a finding pursuant to Supreme Court Rule 304(a) (155 Ill.2d R. 304(a)) and this appeal ensued.

The only issue is whether, as a matter of law, a telephone conference between treating pediatrician Dr. Sharon Bonds and Fulbright concerning Kevin’s condition created a physician-patient relationship between Kevin and Fulbright so as to raise a duty which is enforceable in a medical malpractice action in light of the standards of protocol of the hospital at which Kevin was being treated and in which both physicians were allowed to practice. The trial court found there was no physician-patient relationship and, therefore, no duty was owed by Fulbright to plaintiffs. We affirm.

Taken with the case was defendant’s motion to strike the statement of facts in plaintiffs’ brief. The plaintiffs have filed an objection to the motion.

The statement of facts in the plaintiffs’ brief appears to be an attempt to appeal to the sympathy of the members of this court in favor of plaintiffs. The respondent’s objection to this has merit. The statement of facts is not presented fairly without argument or comment, a violation of Supreme Court Rule 341(e)(6) (155 Ill.2d R. 341(e)(6)). Nevertheless, the motion to strike the entire statement of facts is denied. The parties are assured that this court has considered only those relevant facts which appear of record in rendering a decision in this case.

Plaintiffs claim Kevin’s quadriplegia resulted from the medical malpractice of defendants. The facts relevant to this appeal appear undisputed, although the legal consequences of those facts are in dispute.

At about 10:45 p.m. on November 29, 1990, Kevin was seen in the emergency room of Decatur Memorial Hospital by Dr. Terry Balagna. The history given indicated he was injured at 8:30 or 9 p.m. by falling while jumping on the couch in the family living room. Upon examination, an abnormal breathing pattern was observed. Tests were conducted to discover the possibility of an infection or an electrolyte or metabolic problem. Cervical spine X rays were taken at about 1:05 a.m. which appeared normal. Nevertheless, Kevin was admitted to the hospital. Balagna called Bonds, a pediatrician, to examine him.



Bonds arrived at the hospital at about 1:45 a.m. on November 30, 1990. At that time, Kevin's temperature was 102 degrees Fahrenheit. Bonds made a quick assessment of plaintiff and took a history from Barbara, which indicated Kevin had jumped off the couch, landed on his arm, walked to his mother, and gradually became limp after that. Bond noticed the child's breathing difficulties and that he was flaccid. She reviewed the emergency room records and X-ray reports, conducted reflex tests, and noticed he was moving his head. His neck was not tender. Among the possible reasons for his condition which Bonds considered were neurologic, traumatic, metabolic, infectious, or post-infectious problem. Because of the fever, she was leaning toward the infectious process diagnosis, and she did not consider a spinal cord injury. A history of a two-foot fall with a normal 2 ½ -year-old child did not indicate to her the existence of a cervical cord injury from trauma.

At 2:05 a.m., Bonds telephoned Fulbright at his home. She advised Fulbright that Kevin walked following the fall, he had an elevated temperature and was flaccid and responsive, and the cervical spine X rays were negative. She probably told him the child was flaccid from the neck down, including all four extremities. Fulbright inquired if the child had a stiff neck. Bonds said she did not know, went to check Kevin's neck, and returned to inform Fulbright that his neck was stiff. At the end of the conversation, Fulbright suggested a spinal tap to determine whether meningitis, encephalitis, or something similar was involved. Bonds did not ask Fulbright to treat Kevin, nor did Fulbright commit himself to further involvement with Kevin. Bonds was under the impression that Fulbright would see Kevin if she contacted him and requested that he treat Kevin.

Fulbright's recollection of his telephone conversation was as follows:

"Dr. Bonds called me regarding Kevin Reynolds. She related to me that the patient had presented with a history of a fall, I believe from a couch. The height estimated to be less than two feet. She related that the child was listless, and that the child was febrile with a fever of—on the order of 102 degrees Fahrenheit.

I questioned Dr. Bonds regarding the history. My first concern was the veracity of the history. My major concern here was the question of child abuse. There was some report on her part that the history had been somewhat inconsistent. That in itself is a hallmark of abuse. I questioned her specifically as to whether or not she felt abuse was operative in this case. She stated relatively emphatically that she did not think that it was.

She did not think that the fall was overly significant because of it's [*sic*] apparently benign nature, that is, a fall from a low height of a young child as happens to every young child.

The question of the cause of the fever and the possible neurological causes of the fever was raised. The question of meningitis was discussed. The question of an ascending neuritis was discussed. The performance of a lumbar puncture was discussed. The conclusion was that Dr. Bonds would perform the lumbar puncture and let me know if she wanted me to see the child thereafter. I offered to make myself physically available if she wished. We elected to proceed with the plan of her performing the lumbar puncture and letting me know if she needed me there."

He often received informal inquiries from other doctors asking questions and seeking suggestions. These inquiries do not include a request to see a patient, review a patient, or render an opinion, but only to discuss the case. He considered this a courtesy service for which he did not bill. He offered to

make himself available because the other physician may be inhibited about asking him to see the patient due to the late hour or the marginal neurosurgical nature of the case.

At 3:30 a.m. on November 30, 1990, Bonds performed the spinal tap. Before leaving the hospital, she told a nurse to write an order in Kevin's chart "to consult with Fulbright to see in early a.m." That note was posted to the chart, and the message was taken off the chart at 4:05 a.m. The usual practice was for the ward clerk or nurse to notify the operator who would place the message in the appropriate area. The message was never received by Fulbright. At 8 a.m., Bonds realized Fulbright had not received the message, attempted to locate him, and was told he was in surgery performing a very long procedure. Fulbright stated he did not receive another call from Bonds or anyone else at the hospital with regard to Kevin's condition or treatment. Kevin's family never asked Fulbright to treat Kevin, and he never saw, examined, or came to a diagnosis as to Kevin's condition. Fulbright did not bill for any services to Kevin.

When Kevin was transferred to St. John's Hospital (St. John's) at 12 p.m. on November 30, 1990, Bonds' diagnosis was an infectious process called Guillain-Barre syndrome. At St. John's, a spinal cord injury was diagnosed.

According to the affidavit of Dr. John Oldershaw, a neurosurgeon, the medical staff rules of Decatur Memorial Hospital relating to consultations state:

"4.1 Appropriate consultation shall be obtained by practitioners in cases in which the patient is not a good medical or surgical risk and in cases in which the diagnosis is obscure, where there is doubt as to the best therapeutic measure to be utilized, or where the treatment is difficult and especially in cases with probable disorders or complications lying within a field other than the one in which the attending physician is primarily qualified.

4.2 A consultant must be well qualified to give an opinion in the field where his opinion is sought. A satisfactory consultation must include the examination of the patient and the record. A written opinion signed by the consultant must be included in the medical record. When operations are involved, the consultation note, except in emergency, shall be recorded prior to the operation."

According to Oldershaw, the failure of Fulbright to examine Kevin and the records before making a recommendation and failing to follow through after being consulted violated the hospital rules and generally accepted standards of practice in the medical community.

"The determination of whether a duty exists—whether the defendant and the plaintiff stood in such a relationship to one another that the law imposed upon the defendant an obligation of reasonable conduct for the benefit of the plaintiff—is an issue of law to be determined by the court." *Kirk v. Michael Reese Hospital & Medical Center* (1987), 117 Ill.2d 507, 525, Ill. Dec. 944, 953, 513 N.E.2d 387, 396.

Where a question of law is determinative of a case, summary judgment is a proper remedy. (*National Underground Construction Co. v. E.A. Cox Co.* (1991), 216 Ill.App.3d 130, 134, 159 Ill. Dec. 614, 617, 576 N.E.2d 283, 286 (construction of a contract as a matter of law).) Even if the question presented would ordinarily be a question of fact, if only one conclusion may be drawn from the undisputed facts,

then a question of law is presented which may be appropriately dispensed with by summary judgment. (citations omitted).

In a negligence action for medical malpractice, there must be a duty owed by defendant to the plaintiff, a breach of duty, an injury proximately caused by the breach, and resultant damages. (citations omitted) The determination of whether the parties stood in such a relationship to one another that the law would impose on defendant a duty of reasonable conduct for the benefit of the plaintiff is a question of law. That policy determination is based on consideration of the likelihood of injury, the magnitude of the burden of guarding against it, and the consequences of placing that burden on the defendant. (Kirk, 117 Ill.2d at 525-26, 111 Ill. Dec. at 952-53, 513 N.E.2d at 395-96.) A physician's duty is limited to those situations in which a direct physician-patient relationship exists or there is a special relationship such as when an infant sues for prenatal injuries foreseeably caused by the physician's negligent care of the mother prior to conception. Kirk, 117 Ill.2d at 531, 111 Ill. Dec. at 956, 513 N.E.2d at 399; *Renslow v. Mennonite Hospital* (1977), 67 Ill.2d 348, 357, 10 Ill. Dec. 484, 489, 367 N.E.2d 1250, 1255.) In this case, there was no special relationship as in *Renslow*, and there was no direct physician-patient relationship, and hence no duty owed to plaintiffs by Fulbright. This determination was properly made as a matter of law.

The relationship of physician and patient is one of trust and confidence. It is a consensual relationship in which the patient knowingly seeks the physician's assistance and the physician knowingly accepts the person as a patient. (70 C.J.S. *Physicians and Surgeons* § 58, at 448 (1987). A consensual relationship can exist where other persons contact the physician on behalf of the patient, but this is not a case in which Fulbright was asked to provide a service for Kevin, conduct laboratory tests, or review test results. Fulbright did nothing more than answer an inquiry from a colleague. He was not contacted again and he charged no fee. A doctor who gives an informal opinion at the request of a treating physician does not owe a duty of care to the patient whose case was discussed. (*Lopez v. Aziz*. (Tex.Ct.App.1993), 852 S.W.2d 303, 306; see *Flynn v. Bausch* (1991), 238 Neb. 61, 66, 469 N.W.2d 125, 128029; *Hill v. Kokosy* (1990), 186 Mich.App. 300, 304, 463 N.W.2d 265, 267; *Ingher v. Kandler* (1987), 128 A.D.2d 591, 592, 513 N.Y.S.2d 11, 11 (memorandum decision); *Oliver v. Brock* (Ala. 1976), 342 So.2d 1,4.) This is not a case in which Fulbright had accepted a referral of the patient. (See *Davis v. Weiskopf* (1982), 108 Ill.App.3d 505, 511-13, 64 Ill. Dec. 131, 135-36, 439 N.E.2s 60, 64-65.) Nor is this a case in which a physician undertook to direct the actions of hospital employees in a telephone conversation with an emergency room nurse. See *Wheeler v. Yettie Kersting Memorial Hospital* (Tex.Ct.App.1993), 866 S.W.2d 32, 39-40.

The affidavit of Oldershaw does not help plaintiffs. Whether Fulbright owed a duty to Bonds, and ultimately to plaintiffs, is a question of law, not a question of medicine. The proffered opinion of plaintiffs' expert transcends the bounds of his competence and intrudes on the exclusive province of the court. Plaintiffs may not, in the guise of offering expert medical opinion, arrogate to themselves a judicial function and obviate a ruling on the existence of or extent of a legal duty which might be owed by a physician to a patient. *Sawh v. Schoen* (N.Y.App.Div.1995), 215 A.D.2d 291, 292-293, 627 N.Y.S.2d 7,9 (memorandum decision).

For the same reasons, the rules of Decatur Memorial Hospital are not dispositive of this case. Such rules are more appropriately considered in determining whether the standard of care was met. (See *Darling v. Charleston Community Memorial Hospital* (1965), 33 Ill.2d 326, 331-32, 211 N.E.2d 253,257.) Such considerations only arise after a physician-patient relationship imposing a duty has been found to exist.

Plaintiffs also argue that, since the telephone conversation breached the hospital rules, Fulbright breached his contract with Decatur Memorial Hospital. Plaintiffs' complaint in this case did not present a theory of recovery on behalf of plaintiffs as third-party beneficiary of any contract between the hospital and Fulbright. This issue is not presented by the pleadings.

The rules of Decatur Memorial Hospital in this case cannot, as a matter of law, require a physician to enter into a physician-patient relationship with every person treated in the hospital whose treating physician might make an informal inquiry about that case.

Plaintiffs suggest that what needs to be done is to find a physician-patient relationship to result from every such conversation. The consequence of such a rule would be significant. It would have a chilling effect upon practice of medicine. It would stifle communication, education and professional association, all to the detriment of the patient. The likely effect in adopting plaintiff's argument also would be that such informal conferences would no longer occur. To reiterate, this would inhibit the exchange of information and expertise among physicians and would not benefit the medical profession or persons seeking treatment. Lopez, 852 S.W.2d at 307.

Agreeing with the trial court that there was no physician-patient relationship between plaintiffs and Fulbright, and therefore no duty owed by Fulbright to plaintiffs, the summary judgment of the circuit court of Macon County is affirmed.

Affirmed.

#### **1.3.1.4 On-Call Physician**

##### ***Anderson v. Houser*, 523 S.E. 2d 342 (1999)**

RUFFIN, JUDGE.

Mariam Anderson was admitted to the Southwest Hospital emergency room on February 29, 1996, for a suspected drug overdose. On March 1, 1996, she was discharged and transferred to Georgia Regional Hospital. She later sued Southwest Hospital and several physicians, including Dr. John W. Houser, for medical malpractice, alleging that they negligently failed to diagnose an esophageal perforation. Although not specified in her complaint, she also contended that the hospital transferred her to Georgia Regional Hospital when she was not stable. Dr. Houser never met or treated Anderson and was out of town during her hospital stay. However, Anderson contended that Dr. Houser owed her a duty of care because he was the scheduled on-call physician when she was admitted to the emergency room. The trial court granted summary judgment to Houser, holding that he owed Anderson no duty because there was no physician-patient privity. For reasons discussed below, we affirm.

Dr. Houser testified that he was an attending physician on the staff of Southwest Hospital. In February 1996, Dr. Houser was listed as an on-call physician for family practice at the hospital. The hospital bylaws required staff members to provide on-call services for patients who came to the emergency room without a physician. The hospital would distribute a schedule listing the days each doctor was assigned on-call duty. On any given day, one doctor would be the designated on-call doctor for family practice patients. Dr. Houser testified that, if a doctor was unable to be on call when scheduled, it was his responsibility to find someone to take his place. However, Dr. Houser also testified that "the

hospital bylaws provide for a redundant system. In other words, if I'm not available, there's someone else; and if that person is not available, there's somebody else. But on the schedule, there's only one name." Another doctor, Dr. Frank Cook, testified that

there's a chain of command that is supposed to be followed [when an on-call doctor is unavailable]. There are rules and regs governing according to the medical staff bylaws, that there are certain steps you go through if you can't find the attending physician. They go to the person's partner or associate, number one. If there is not or if that's not available, they go to the chief of the service. If that person is not available, they go to the chief of staff. If that person is not available, they go to the hospital administrator.

Dr. David Blake testified that, if a resident is unable to contact the on-call family practice doctor, there is a family practice attending physician on call at all times to whom he could turn for assistance.

Dr. Houser admitted that he was the scheduled on-call family practice physician from 8:00 a.m. on February 29, 1996, until 8:00 a.m. on March 1, 1996, during which time Anderson was admitted to the emergency room. He also admitted that he was out of town during this period, but claimed that he arranged for Dr. Cook to cover for him. Dr. Cook denied that he agreed to cover for Dr. Houser on February 29, when Anderson was admitted, claiming that his coverage period was not to begin until March 1.

Dr. Cook testified that he did not receive any medical information or give any advice regarding Anderson during her hospital stay. However, Dr. Shaun Brownlee, a resident who treated Anderson at the hospital, testified that he consulted with Dr. Cook regarding Anderson's treatment after learning that Dr. Houser was out of town. Dr. Brownlee testified that, although Dr. Cook said he was not supposed to start covering for Dr. Houser until the weekend, he nevertheless agreed to let Dr. Brownlee present Anderson's case to him. According to Dr. Brownlee, Dr. Cook approved his suggested orders and gave him additional orders for treatment. Dr. Brownlee testified that there was no doubt in his mind that Dr. Cook was available throughout the remainder of his shift for consultation regarding Anderson. Dr. Cook, however, testified that he told Dr. Brownlee he was not covering for Dr. Houser and that he refused to provide any input as to Anderson's diagnosis or treatment. Nurse Sarah Hardy testified that Dr. Cook personally authorized Anderson's transfer to Georgia Regional Hospital, although Dr. Cook denied doing so. The trial court found that the evidence was conflicting as to whether Dr. Houser had properly arranged for a substitute on-call physician and assumed for summary judgment purposes that Dr. Houser did not make proper arrangements.

1. The sole question on appeal is whether Dr. Houser owed Anderson a duty of care, even though he never met Anderson, was never consulted about her condition, and was not aware of her existence. In considering this issue, we must start from the

well-settled principle of Georgia law that there can be no liability for malpractice in the absence of [a] physician-patient relationship. [D]octor-patient privity is essential because it is this relation which is a result of a consensual transaction that establishes the legal duty to conform to a standard of conduct. (citation omitted) relationship is considered consensual where the patient knowingly seeks the assistance of the physician and the physician knowingly accepts him as a patient.

The parties do not cite, and we are not aware of, any Georgia cases dealing with the precise issue in this case. However, cases in other jurisdictions have taken differing approaches to determining when

an on-call doctor may be liable for failing to provide services to a patient he has never met. In *Hiser v. Randolph*, after a patient with acute diabetes arrived at the emergency room in a semi-comatose condition, the emergency room nurse contacted the on-call physician, Dr. Randolph. Dr. Randolph refused to attend or treat the patient and advised the nurse to call Dr. Arnold, the patient's regular physician, who had treated her in the emergency room the day before. The nurse subsequently advised Dr. Randolph that Dr. Arnold would not come to the hospital, and Dr. Randolph again refused to attend the patient. The patient died the next day, and her husband later sued Dr. Randolph for malpractice.

In reversing a grant of summary judgment in favor of Dr. Randolph, the Arizona Court of Appeals held that he had a duty to treat the emergency room patient. The court noted that (1) state law required a hospital providing emergency room services to provide those services to everyone in need of them; (2) the hospital's bylaws stated a purpose that "all patients treated in the Emergency Room receive the best possible care"; (3) the hospital's rules and regulations stated that "[i]n case of emergency [a] provisional diagnosis shall be stated as soon after admission as possible"; (4) all members of the medical staff were required to sign the bylaws and rules and regulations; and (5) Dr. Randolph was paid \$100 per day to be the doctor on call in charge of the emergency room. Although the court recognized the general rule that a doctor can refuse to treat a patient even in emergency situations, it held that

[i]n our opinion, Dr. Randolph, by assenting to these bylaws, and rules and regulations, and accepting payment from the hospital to act as the emergency room doctor "on call," personally became bound "to insure that all patients treated in the Emergency Room receive the best possible care," and agreed to insure "in the case of emergency the provisional diagnosis shall be started as soon after admission as possible." [T]he obviously intended effect of the bylaws and rules and regulations was to obligate the emergency room doctor "on call" to provide emergency treatment to the best of the doctor's ability to any emergency patient of the hospital. Under these circumstances, the lack of a consensual physician-patient relationship before a duty to treat can arise has been waived by the signatory doctors.

The court in *Hiser* did not address whether the patient was an intended third-party beneficiary of the contract between the hospital and Dr. Randolph so as to create a doctor-patient relationship. Nor did it hold that there *was* a consensual doctor-patient relationship between the patient and Dr. Randolph. Rather, it held that by agreeing to the hospital's bylaws and rules and regulations, Dr. Randolph assumed a duty to treat emergency room patients notwithstanding the lack of a consensual doctor-patient relationship.

The Ohio Court of Appeals took a different approach to this issue in *McKinney v. Schlatter*. In that case, the patient's emergency room doctor telephoned an on-call cardiologist and described the patient's x-ray, electrocardiogram, and other test results. The cardiologist said that he did not believe the patient's problem was cardiac in nature and suggested that the emergency room doctor repeat the electrocardiogram. After the patient died of an aortic aneurysm, his executor sued the on-call cardiologist and others for malpractice. The Ohio Court of Appeals held that

a physician-patient relationship can exist by implication between an emergency room patient and an on-call physician who is consulted by the patient's physician but who has never met, spoken with, or consulted the patient when the on-call physician (1) participates in the diagnosis of the patient's condition, (2) participates in or prescribes a course of treatment for the patient, and (3) owes a duty to the hospital, staff or patient

for whose benefit he is on call. Once an on-call physician who has a duty to the hospital, its staff, or patients is contacted for the benefit of an emergency room patient, and a discussion takes place between the patient's physician and the on-call physician regarding the patient's symptoms, a possible diagnosis and course of treatment, a physician-patient relationship exists between the patient and the on-call physician.

Applying this three-prong test, the Court of Appeals held that the trial court erred in granting the on-call doctor's motion for directed verdict.

The Michigan Court of Appeals considered a similar situation in *Oja v. Kin*. The facts in that case were similar to those in *McKinney*, except that the on-call physician, when contacted on several occasions by the resident on duty, refused to offer any assistance and suggested that the resident should contact another doctor for assistance. The Court of Appeals expressed approval of *McKinney's* recognition that "a physician's on-call status alone is insufficient to warrant a finding that the physician impliedly consented to a physician-patient relationship." The court then went on to analyze the issue as follows:

A physician-patient relationship is contractual and requires the consent, express or implied, of both the doctor and the patient. The consent of the patient is generally implied. The question is, [u]nder what circumstances can the doctor's consent be implied? [M]erely listening to another physician's description of a patient's problem and offering a professional opinion regarding the proper course of treatment is not enough. Under those circumstances, a doctor is not agreeing to enter into a contract with the patient. Instead, she is simply offering informal assistance to a colleague. At the other end of the spectrum, a doctor who is on call and who, on the phone or in person, receives a description of a patient's condition and then essentially directs the course of that patient's treatment, has consented to a physician-patient relationship. The difficulty arises in determining where, between these two extremes, a physician-patient relationship (and thus a duty) arises. This inquiry is necessarily conducted case by case, but we do not believe that a physician's on-call status alone is enough to support an implied consent to a physician-patient relationship. Thus, we conclude that an implied consent to a physician-patient relationship may be found only where a physician has done something, such as participate in the patient's diagnosis and treatment, that supports the implication that she consented to a physician-patient relationship. We conclude that such participation is necessary for, but by itself does not establish, an implied physician-patient relationship.

The court in *Oja* held that, because the on-call physician did not provide any care, treatment, or advice regarding the patient's condition, he did not consent to the creation of a physician-patient relationship. In so holding, the court rejected the contention that the physician's contract with the hospital created such a relationship:

Plaintiff argues that Dr. Kin's contractual relationship with the hospital, combined with the hospital by-laws, imposed a duty on Dr. Kin to come to the hospital when he was called, or to arrange for coverage. Dr. Kin may very well have owed such a duty to the hospital. However, a contract between the hospital and Dr. Kin does not necessarily create rights in third-parties such as the decedent.

The court rejected the proposition that the patient was an intended third-party beneficiary of the contract between the hospital and the on-call physician, noting that under Michigan law, "[w]here the

contract in question is primarily for the benefit of the parties thereto, the fact that a third person is incidentally benefited does not give that person rights as a third-party beneficiary.”

We believe that the approach taken in Oja is the preferable approach. Georgia law clearly provides that no duty can arise in the absence of a consensual doctor-patient relationship. A consensual relationship is established when “the patient knowingly seeks the assistance of the physician and the physician knowingly accepts him as a patient.” As Oja recognized, an individual presenting herself to the emergency room may generally be assumed to have consented to treatment by any physician associated with the hospital who offers such treatment. Therefore, the key question in determining the existence of a doctor-patient relationship is whether the physician has knowingly accepted such individual as his patient.

Although a doctor who has agreed to be on-call makes himself available to be consulted regarding a patient’s condition, that fact alone does not indicate that the doctor has agreed to establish a doctor-patient relationship with any patient who presents herself to the hospital for diagnosis and treatment. Indeed, there may be many circumstances where an on-call physician who is consulted about a particular patient does not feel competent to diagnose and treat the patient. Clearly, in those circumstances, the mere fact that the doctor has agreed to be on call for consultation does not establish a consensual doctor-patient relationship.

Although the issue becomes more complicated when the doctor has a contract or agreement with the hospital requiring him to be on call during a certain period, we do not believe this fact necessarily implies the existence of a consensual relationship between the doctor and any patient who presents herself at the hospital. The issue is not whether the doctor has a duty to the hospital, but whether he has a duty to the patient. It is axiomatic that one who is not a party to a contract has no standing to enforce the contract unless she is an intended third-party beneficiary thereof. Clearly, therefore, a patient cannot rely on a contract between a doctor and a hospital to create a consensual relationship between herself and the doctor, unless she is an intended third-party beneficiary of the contract with enforceable rights thereunder.

OCGA § 9-2-20(b) provides that “[t]he beneficiary of a contract made between other parties for his benefit may maintain an action against the promisor on the contract.” However,

[i]n order for a third party to have standing to enforce a contract under OCGA § 9-2-20(b) it must clearly appear from the contract that it was intended for his or her benefit. The mere fact that the third party would benefit from performance of the agreement is not alone sufficient.

In this case, there is no evidence that any agreement between Dr. Houser and the hospital requiring him to provide on-call services was intended for the benefit of the patient as opposed to the hospital. Although a patient admitted to an emergency room may expect that the hospital has made adequate staffing arrangements to provide necessary emergency room services, she does not have any reason to expect that any particular doctor will provide treatment. To the extent that a hospital is required to provide emergency services to patients, the precise manner in which it chooses to meet its staffing needs is an administrative matter for the hospital. In this case, although the hospital required staff members to serve specified periods on call, it also provided a redundant system in the event the scheduled on-call doctor could not be reached. In other words, the system put in place by the hospital allowed emergency room physicians to obtain the necessary consultations whether or not the scheduled on-call doctor was available. The existence of this redundant system shows that the practice of



designating a particular doctor to be on call for a particular day was intended for the benefit of the hospital and was not intended to give a patient an enforceable right to be diagnosed or treated by any particular doctor. The fact that the system may not have functioned properly in this particular case does not change the result, since what is important is the intent of the contracting parties.

The potential ramifications of imposing liability upon an on-call doctor under the circumstances in this case are far-reaching. There would be no logical reason to limit such a holding to situations involving on-call doctors. Suppose a neurologist on staff is required by the terms of his agreement with the hospital to provide consultations when requested by another physician, but is late returning from lunch one day. Another doctor seeking a consultation is unable to locate the neurologist and consults a different physician who incorrectly diagnoses the patient's condition. Can the patient sue the neurologist for malpractice, claiming that she had a consensual doctor-patient relationship with him by virtue of his employment agreement with the hospital? Although such a result would appear absurd, there is no principled way to distinguish it from the on-call scenario.

Because there is no evidence that Anderson was an intended third-party beneficiary of any on-call agreement between Dr. Houser and the hospital, the trial court correctly concluded that the on-call agreement did not give rise to a consensual doctor-patient relationship between Dr. Houser and Anderson.

2. Dr. David Blake, a third-year resident at the hospital, testified that on occasion Dr. Houser would ask him to visit his patients at the hospital when Dr. Blake was off duty and Dr. Houser was unavailable. Dr. Houser would pay Dr. Blake a fee for visiting his patients. Dr. Blake testified that, because he was not an attending physician and could not admit or discharge patients, he could not be the sole physician responsible for covering for Dr. Houser. Rather, he would visit Dr. Houser's patients to assist whoever was covering for Dr. Houser.

Anderson contends that, if Dr. Blake covered for Dr. Houser in connection with her treatment, then he must be considered Dr. Houser's agent or employee, rendering Dr. Houser liable for his actions. However, there is no evidence that Dr. Blake in fact ever treated Anderson. Dr. Blake testified that he did not recall treating Anderson, and Anderson's hospital records do not indicate that he was involved in any way with her treatment. The only evidence of any involvement by Dr. Blake with Anderson is that he refused to sign her discharge papers when summoned by another resident who believed he was covering for Dr. Houser. Because there is no evidence that Dr. Blake took part in Anderson's care or treatment, Anderson has not shown how his relationship with Dr. Houser has any relevance to the issue of Dr. Houser's duty to Anderson.

Judgment affirmed.

### ***Questions and Problems***

1. Describe the approaches the *Anderson* court discussed with regards to the duty of on-call doctors. What are the pros and cons of each approach?

2. Dr. Armstrong was an on-call physician at Regent's Hospital. Betty Davis was brought into the emergency room suffering flu-like symptoms on a night where Dr. Armstrong was the on-call physician. Dr. Scott, the ED physician who treated Betty told the nurses to give her fluids. While Dr. Scott was on break, he ran into Dr. Armstrong at the vending machine. The men had a conversation about the weather and sports. At the end of the conversation, Dr. Scott stated, "I just saw a patient who has the weirdest flu symptoms." Dr. Armstrong asked questions about the patient's ages and symptoms. Then, he said, "It sounds like she has the flu, so you should just send her home, and tell her to drink plenty of fluids." Dr. Scott followed Dr. Armstrong's advice and discharged Betty. Two days later, Betty was re-admitted to the hospital and placed on a ventilator. Dr. Floss, the ED physician on duty at that time, immediately ordered a COVID-19 test that came back positive. Betty died a few days later, and her family sued for wrongful death. Dr. Armstrong claims that he did not owe a duty to Betty because he was not her doctor. Does a doctor-patient relationship exist under the rule established in *McKinney v. Schlatter*? In *Oja v. Kin*?

3. Explain the agency argument the plaintiff makes in the *Anderson* case. What facts would have to change to make her argument a successful one?

***Tomeh v. Bohannon*, 765 S.E. 2d 743 (2014)**

MILLER, JUDGE.

Alikina Bohannon, individually and on behalf of her deceased son, Xavier Bohannon, sued Dr. Mohammad Tomeh, South Fulton Medical Center ("South Fulton"), and numerous other medical providers, alleging that the hospital and its staff committed malpractice prior to and during Bohannon's labor and delivery, resulting in Xavier's death shortly after he was born prematurely. Dr. Tomeh, a pediatrician, filed a motion for summary judgment, arguing that no doctor-patient relationship existed between him and either Bohannon or Xavier. Following a hearing, the trial court denied Dr. Tomeh's motion, and this Court subsequently granted Dr. Tomeh's application for interlocutory review. On appeal, Dr. Tomeh contends that it is undisputed that no doctor-patient relationship existed between himself and Bohannon or Xavier. We agree and reverse.

The evidence shows that Bohannon first sought prenatal care from obstetrician Dr. Gabriel Nassar when she was approximately 25 weeks pregnant. Bohannon was of [advanced maternal age](#)<sup>3</sup> and suffered from insulin-dependent diabetes and hypertension. Her baby's estimated due date was July 25, 2011. On June 22, 2011, Bohannon arrived at South Fulton's labor and delivery unit, complaining of pain and leaking fluid. Bohannon underwent fetal monitoring and was discharged a few hours later with instructions to rest and drink water.

Bohannon alleged in her complaint that at approximately midnight on June 26, 2011, she called 911 complaining of contractions, pain and vaginal bleeding and was taken to South Fulton by ambulance. She arrived at the hospital at around 1:15 a.m. on June 27 and was examined by Dr. Nassar an hour later. At 3:19 a.m., Dr. Nassar delivered Xavier by cesarean section.

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<sup>3</sup> Charles Patrick Davis, MD, PhD, *Medical Definition of Advanced Maternal Age*, MedicineNet, at [https://www.medicinenet.com/advanced\\_maternal\\_age/definition.htm](https://www.medicinenet.com/advanced_maternal_age/definition.htm) (March 29, 2021).

Immediately after birth, Xavier was blue and limp. Medical personnel intubated Xavier and attempted to resuscitate him, but he died around 3:44 a.m. The handwritten notations on Xavier's medical records show that a respiratory therapist intubated Xavier and neonatal nurse practitioner Sara Posley oversaw his treatment. Nurse practitioner Posley was overseen by Dr. Babatunde Onasanya. The intraoperative record, as well as the handwritten records, show that Dr. Nassar, nurse practitioner Posley, an anesthesiologist, a respiratory therapist, a scrub tech, and several nurses were present in the operating room during Xavier's birth. Under South Fulton's written policies, a neonatologist, nurse practitioner, physician's assistant, or respiratory therapist is responsible for the intubation of high-risk newborns.

Prior to delivery, Bohannon had not chosen a pediatrician for Xavier. Dr. Tomeh just happened to be the on-call pediatrician at South Fulton on June 27, 2011. As an on-call pediatrician, Dr. Tomeh treated infants in the normal nursery but did not treat infants in the neonatal intensive care unit, and he did not intubate or resuscitate infants immediately following delivery. According to South Fulton's policies, a pediatrician trained in resuscitation and capable of intubation was to be present, upon request, during cesarean sections and high-risk vaginal deliveries. Xavier's computer-generated admission records from South Fulton list Dr. Tomeh as Xavier's admitting and attending doctor. Dr. Tomeh is also listed on an automatically-generated coding summary as the provider who intubated Xavier and performed resuscitation efforts.

In his affidavit in support of his motion for summary judgment, Dr. Tomeh averred that he never consulted with nor provided treatment for Xavier or Bohannon. Dr. Tomeh further averred that he was not consulted about Xavier; he was not called or asked to treat Xavier at any point; he did not refuse to treat Xavier; he was not present at South Fulton on June 27, 2011; and he was not required to be present at that time. Dr. Tomeh also averred that he had never met Bohannon or Xavier, he did not charge Bohannon or her insurance for any treatment, and he accepted no payment for any alleged treatments. Specifically, Dr. Tomeh denied that he participated in the efforts to intubate or resuscitate Xavier.

In his sole enumeration of error, Dr. Tomeh contends that the trial court erred in denying his motion for summary judgment because there was no doctor-patient relationship between him and Xavier or Bohannon. We agree.

It is well settled Georgia law that proof of three essential elements is required to establish liability in a medical malpractice action: "(1) the duty inherent in the doctor-patient relationship; (2) the breach of that duty by failing to exercise the requisite degree of skill and care; and (3) that this failure be the proximate cause of the injury sustained." (Citation and punctuation omitted.) *Zwiren v. Thompson*, 276 Ga. 498, 499, 578 S.E.2d 862 (2003); see also OCGA § 51-1-27. Additionally,

[d]octor-patient privity is [an essential element] because it is this relation which is a result of a consensual transaction that establishes the legal duty to conform to a standard of conduct. The relationship is considered consensual where the patient knowingly seeks the assistance of the physician and the physician knowingly accepts him as a patient.

*Anderson v. Houser*, 240 Ga.App. 613, 615(1), 523 S.E.2d 342 (1999); see also *Herrington v. Gaulden*, 294 Ga. 285, 286, 751 S.E.2d 813 (2013) (plaintiff in medical malpractice case must usually prove the existence of a doctor-patient relationship).

(a) The evidence does not show the existence of a doctor-patient relationship between Dr. Tomeh and Bohannon or Xavier.

Dr. Tomeh, by his affidavit, presented a plethora of evidence that he did not treat Bohannon or Xavier. Moreover, the director of medical records at South Fulton in her affidavit averred that when a baby is born alive at the hospital, a medical chart is created and an admitting and attending physician must be assigned to the baby. Where, as here, the parent has not selected a pediatrician for the child, the pediatrician who is on call at the time of the baby's birth is assigned automatically as the admitting and attending physician in the child's chart. The director of medical records specifically averred, "If the baby dies in the operating room and prior to the transfer to the nursery, the on-call pediatrician will still be listed as the admitting and attending physician in the baby's medical records, even if the pediatrician never treated the baby."

The director of medical records also averred that South Fulton's patient software system automatically creates a coding summary, which lists the name of each patient's attending physician in conjunction with all the treatment rendered to the patient, regardless of whether the attending physician actually performed the treatment. The coding summary is not a billing document and does not necessarily reflect the services billed by the hospital. Accordingly, even though the medical records listed Dr. Tomeh as Xavier's pediatrician and the coding summary indicated that Dr. Tomeh provided certain treatments to Xavier, those records do not necessarily establish that Dr. Tomeh treated Xavier. Accordingly, Dr. Tomeh presented evidence negating an essential element of Bohannon's claim—the existence of a doctor-patient relationship—and the burden then shifted to Bohannon to point to specific evidence giving rise to a triable issue. *Cowart*, supra, 287 Ga. at 623(1)(a), 697 S.E.2d 779. Bohannon failed to do so.

Notably, in response to Dr. Tomeh's motion for summary judgment, Bohannon did not address Dr. Tomeh's affidavit, nor that of the director of medical records. Bohannon also did not address the handwritten hospital records showing that Dr. Tomeh was not present in the operating room at Xavier's birth and did not participate in the efforts to save Xavier. Instead, in opposition to Dr. Tomeh's motion for summary judgment and on appeal, Bohannon relies solely on the coding summary from South Fulton and on the fact that Dr. Tomeh is listed on Xavier's computer-generated medical records as his attending and admitting physician.

Here, the circumstantial evidence, such as the coding summary and the computer-generated medical records, which were shown to sometimes be inaccurate, cannot rebut Dr. Tomeh's direct testimony that he did not treat Xavier or Bohannon. Since the burden shifted to Bohannon and she failed to point to any specific evidence giving rise to a triable issue, the trial court erred in denying Dr. Tomeh's motion for summary judgment.

(b) Moreover, the mere fact that Dr. Tomeh was the on-call pediatrician at the time of Xavier's birth does not establish a doctor-patient relationship.

"Although a doctor who has agreed to be on-call makes himself available to be consulted regarding a patient's condition, that fact alone does not indicate that the doctor has agreed to establish a doctor-patient relationship with any patient who presents herself to the hospital for diagnosis and treatment." *Anderson*, supra, 240 Ga.App. at 619(1), 523 S.E.2d 342.

Here, although Dr. Tomeh was the on-call pediatrician at the time of Xavier's birth, he presented affidavit evidence showing that he did not diagnose or treat Xavier, consult on his care, or even meet

him. A doctor who is merely on call, but who renders no treatment nor care to a patient does not have a doctor-patient relationship. See *Anderson*, supra, 240 Ga.App. at 615-619 (1), 523 S.E.2d 342 (no doctor-patient relationship existed where on-call doctor did not consult with or treat patient); *Minster v. Pohl*, 206 Ga.App. 617, 520(1), 426 S.E.2d 204 (1992) (no doctor-patient relationship existed where on-call doctor merely reviewed patient's x-ray at nurse's request); compare *Rindsberg v. Neacsu*, 317 Ga.App. 269, 274, 730 S.E.2d 525 (2012) (question of fact remained as to whether doctor-patient relationship existed where on-call doctor asked nurse about patient's status, spoke to patient's family, and refused family's request to examine patient).

A plaintiff has to show more than that a doctor was the on-call physician at the time of the patient's injury. Georgia law requires some evidence of an actual doctor-patient relationship. In this case, that Dr. Tomeh was the on-call pediatrician at the time of Xavier's birth alone cannot give rise to any liability for malpractice, and since Bohannon has failed to come forward with any evidence to contradict Dr. Tomeh's sworn statement that he did not treat her or Xavier, the trial court erred in denying Dr. Tomeh's motion for summary judgment.

## **1.4 Termination**

There are several ways for the physician-patient relationship to be terminated. The relationship ends at the cessation of the necessary medical treatment which gave rise to the relationship. The patient can discharge the physician. The physician can withdraw from the case as long as he or she gives the patient reasonable notice, so the patient will be able to secure other medical assistance. The physician and patient mutually agree to end the relationship.

### ***Ricks v. Budge*, 64 P.2d 208 (1937)**

EPHRAIM HANSON, JUSTICE.

This is an action for malpractice against the defendants who are physicians and surgeons at Logan, Utah, and are copartners doing business under the name and style of the "Budge Clinic." The complaint contains two causes of action. The first alleges that the defendants were negligent in failing to properly treat and care for plaintiff and were negligent in discharging him from the hospital before his condition warranted such discharge. For the second cause of action plaintiff alleges that he was suffering from an infected right hand and was in immediate need of medical and surgical care and treatment, and there was danger of his dying unless he received such treatment; that defendants for the purpose of treating plaintiff sent him to the Budge Memorial Hospital at Logan, Utah; that while at the hospital and while he was in need of medical and surgical treatment, defendants refused to treat or care for plaintiff and abandoned his case. At the conclusion of the evidence defendants moved for and the court granted a directed verdict as to each cause of action. To review the rulings of the court granting these motions, plaintiff appeals to this court.

We shall deal with each cause of action separately. The evidence shows that on or about March 8, 1935, plaintiff caught the middle finger of his right hand on a barbed wire. Soon thereafter the finger and hand began to swell and became reddened. In the early morning of March 11th, plaintiff went to the Budge Memorial Hospital to seek treatment from the defendants. Dr. S. M. Budge, one of the defendants, was performing an emergency operation at the hospital at the time plaintiff arrived.

Immediately on finishing the operation, he made an examination of plaintiff to determine the nature and extent of plaintiff's injury and the treatment necessary therefor. Dr. Budge made two lateral incisions in the finger, waited a few hours to see the result, and then later the same morning deepened the incisions in order to reach the pus, which he believed had developed. A gauze wick was then put in each incision for the purpose of drainage.

The plaintiff remained in the hospital from March 11th until March 15th, during which time he was under the care of Dr. S. M. Budge. Plaintiff received while in the hospital the usual care and treatment given for such an injury, and under that treatment made favorable progress towards recovery. On the morning of March 15th, plaintiff told the nurse and Dr. Budge that he intended leaving the hospital that morning. Dr. Budge advised plaintiff against leaving, but notwithstanding the protests of Dr. Budge, plaintiff left the hospital after paying the amount that was due at that time.

There is no evidence whatever to show that the treatment which plaintiff received from Dr. Budge was not proper in every respect. We have examined the record carefully and are unable to find any evidence that even tends to show that the defendants were negligent as alleged in the first cause of action. As to the claim that plaintiff was discharged from the hospital before his condition warranted such discharge, there is no merit whatever. The evidence shows that plaintiff believed his condition to be such that he could take care of himself at home and save the hospital expense; that he was advised by Dr. Budge to remain in the hospital until his condition was further improved, but instead of doing so, over the objection of Dr. Budge, he left the hospital and returned to his home. Under the evidence the trial court was justified in directing a verdict in favor of the defendants in the first cause of action.

The second cause of action, however, presents a more serious question. As to that cause of action the evidence shows that when plaintiff left the hospital on March 15th, Dr. Budge advised him to continue the same treatment that had been given him at the hospital, and that if the finger showed any signs of getting worse at any time, plaintiff was to return at once to Dr. Budge for further treatment; that on the morning of March 17th, plaintiff telephoned Dr. Budge, and explained the condition of his hand; that he was told by the doctor to come to his office, and in pursuance of the doctor's request, plaintiff reported at the doctor's office at 2 p. m. of that day. Dr. Budge again examined the hand and told plaintiff the hand was worse; he called in Dr. D. C. Budge, another of the defendants, who examined the hand, scraped it some, and indicated thereon where the hand should be opened. Dr. S. M. Budge said to plaintiff: "You have got to go back to the hospital." Plaintiff said he would like a different room from the one he had before, but the doctor told him he would have to take the same room. Plaintiff left immediately for the hospital. Upon arriving there, he was assigned by the matron to the same room he had before, and went to bed at once. The nurse who previously had charge of plaintiff, brought a boric acid solution in which plaintiff began to soak his hand. Within a short time after the arrival of plaintiff, Dr. S. M. Budge arrived at the hospital. Plaintiff testified: "He [meaning Dr. S. M. Budge] came into my room and said, 'You are owing us. I am not going to touch you until that account is taken care of.'" (The account referred to was, according to plaintiff, of some years' standing and did not relate to any charge for services being then rendered.) Plaintiff testified that he did not know what to say to the doctor, but that he finally asked the doctor if he was going to take care of him, and the doctor replied: "No, I am not going to take care of you. I would not take you to the operating table and operate on you and keep you here thirty days, and then there is another \$30.00 at the office, until your account is taken care of." Plaintiff replied: "If that is the idea, if you will furnish me a little help, I will try to move."

Plaintiff testified that this help was furnished, and that after being dressed, he left the Budge Memorial Hospital to seek other treatment. At that time, it was raining. He walked to the Cache Valley Hospital, a few blocks away, and there met Dr. Randall, who examined the hand. Dr. Randall testified that when

the plaintiff arrived at the Cache Valley Hospital, the hand was swollen with considerable fluid oozing from it; that the lower two-thirds of the forearm was red and swollen from the infection which extended up in the arm, and that there was some fluid also oozing from the back of the hand, and that plaintiff required immediate surgical attention; that immediately after the arrival of plaintiff at the hospital he made an incision through the fingers and through the palm of the hand along the tendons that led from the palm and followed those tendons as far as there was any bulging, and opened it up thoroughly all the way to the base of the hand and put drain tubes in. Plaintiff remained under the care of Dr. Randall for approximately a month. About two weeks after the plaintiff entered the Cache Valley Hospital, it became necessary to amputate the middle finger and remove about an inch of the metacarpal bone.

Dr. S. M. Budge testified that at the time he sent the plaintiff to the Budge Memorial Hospital on March 17th, plaintiff was in a dangerous condition and needed immediate surgical and medical attention; that the reason for sending him to that hospital was in order to give him the necessary immediate surgical and medical attention. There can be no question that both Dr. S. M. Budge and Dr. D. C. Budge, on the examination of plaintiff's hand at their office on March 17th, decided that immediate surgical intervention thereon was necessary. The plaintiff testified that at the time he was sent to the hospital by the defendants on March 17th, his hand was badly swollen; that he was unable to move any of his fingers on that hand; that the hand was full of blisters which had broken and were oozing; and that blood was dripping from the places scraped by Dr. D. C. Budge. Dr. S. M. Budge arrived at the hospital a short time after the arrival of plaintiff for the purpose of giving plaintiff such medical and surgical attention as he deemed necessary. There can be no question from the evidence that it was the intention of Dr. S. M. Budge to operate at once on plaintiff's hand.

Defendants contend: (1) That there was no contract of employment between plaintiff and defendants and that defendants in the absence of a valid contract were not obligated to proceed with any treatment; and (2) that if there was such a contract, there was no evidence that the refusal of Dr. S. M. Budge to operate or take care of plaintiff resulted in any damage to plaintiff. We cannot agree with either of these propositions. The evidence shows that plaintiff had been under the care and treatment of the defendants at the Budge Memorial Hospital from March 11th to March 15th; that when he left that hospital on March 15th, Dr. S. M. Budge said to him: "If you are going home, you had better follow out the treatment at home just as near as you can the same as you were doing here. Here is another thing I want to tell you, if you see any signs of that finger getting worse at any time, you come in and see me immediately." On March 17th, plaintiff, realizing that his condition was getting worse, telephoned Dr. S. M. Budge and was told by that doctor to come to the doctor's office, which plaintiff did; that there both Dr. S. M. Budge and Dr. D. C. Budge examined the hand; that Dr. D. C. Budge indicated on it where it should be opened; and that under the instructions of these doctors, plaintiff was returned to the hospital for no other purpose than having his hand operated upon at once.

Under this evidence, it cannot be said that the relation of physician and patient did not exist on March 17th. It had not been terminated after its commencement on March 11th. When the plaintiff left the hospital on March 15th, he understood that he was to report to Dr. S. M. Budge if the occasion required and was so requested by the doctor. Plaintiff's return to the doctor's office was on the advice of the doctor. While at the doctor's office, both Dr. S. M. Budge and Dr. D. C. Budge examined plaintiff's hand and they ordered that he go at once to the hospital for further medical attention. That plaintiff was told by the doctor to come to the doctor's office and was there examined by him and directed to go to the hospital for further treatment would create the relationship of physician and patient. That the relationship existed at the time the plaintiff was sent to the hospital on March 17th cannot be seriously questioned.

We believe the law is well settled that a physician or surgeon, upon undertaking an operation or other case, is under the duty, in the absence of an agreement limiting the service, of continuing his attention, after the first operation or first treatment, so long as the case requires attention. The obligation of continuing attention can be terminated only by the cessation of the necessity which gave rise to the relationship, or by the discharge of the physician by the patient, or by the withdrawal from the case by the physician after giving the patient reasonable notice so as to enable the patient to secure other medical attention. A physician has the right to withdraw from a case, but if the case is such as to still require further medical or surgical attention, he must, before withdrawing from the case, give the patient sufficient notice so the patient can procure other medical attention if he desires (citations omitted).

*Mucci v. Houghton*, 80 Iowa 608, 57 N.W. 305, 306, the court announces the law as follows: “If a physician or surgeon be sent for to attend a patient, the effect of his responding to the call, in the absence of a special agreement, will be an engagement to attend the case as long as it needs attention, unless he gives notice of his intention to discontinue his services, or is dismissed by the patient; and he is bound to exercise reasonable and ordinary care and skill in determining when he should discontinue his treatment and services.”

The Maine court in *Ballou v. Prescott*, 64 Me. 305, said:

“The care and skill which a professional man guarantees to his employer are elements of the contract to which he becomes a party on accepting a proffered engagement. They are implied by the law as resulting from that engagement, though it be but verbal, and nothing said in relation to such elements. So continued attention to the undertaking so long as attention is required in the absence of any stipulation to the contrary, is equally an inference of the law. If a counsellor at law undertakes the management of a cause, nothing more being said or done than simply an offer and acceptance of a retainer for that purpose, it will hardly be denied that an abandonment of the cause before its close would be as much a violation of the contract with the client as a neglect to use the requisite care and skill in its prosecution, and the duty of continued attention is equally an implication of the law as that of exercising the required care and skill.

That the same principles apply to the employment of a physician or surgeon there can be no doubt. If he is called to attend in the usual manner, and undertakes to do so by word or act, nothing being said or done to modify this undertaking, it is quite clear as a legal proposition that not only reasonable care and skill should be exercised, but also continued attention so long as the condition of the patient might require it, in the exercise of an honest and properly educated judgment, and certainly any culpable negligence in this respect would render him liable in an action. *Barbour v. Martin*, 62 Me. 536; *Shearman & Redfield on Negligence*, § 441.”

“A physician who leaves a patient, at a critical stage of the disease, without reason, or sufficient notice to enable the party to procure another medical attendant, is guilty of a culpable dereliction of duty.” *Barbour v. Martin*, 62 Me. 536.

“When a physician is employed to attend upon a sick person, his employment continues while the sickness lasts, unless put to an end by the assent of the parties, or revoked by the express dismissal of the physician. In the absence of special agreement, his engagement is to attend the case as long as it requires attention, unless he gives notice of his intention to discontinue his visits, or is dismissed, as aforesaid; and he is bound to exercise reasonable and ordinary care and skill in determining when his



attendance should cease.” *Lawson v. Conaway*, 37 W.Va. 159, 16 S.E. 564, 18 L.R.A. 627, 38 Am.St.Rep. 17. When a physician is employed to attend upon a sick person, his employment, as well as the relation of physician and patient, continues, in the absence of a stipulation to the contrary, as long as attention is required; and the physician or surgeon must exercise reasonable care in determining when the attendance may be properly and safely discontinued.” *Dashiell v. Griffith*, 84 Md. 363, 35 A. 1094, 1096.

We have briefly reviewed the evidence showing the urgent need of plaintiff for medical and surgical attention at the time Dr. S. M. Budge refused plaintiff further treatment. As the case stands on the record before us, we must consider the evidence in the most favorable light of which it is reasonably susceptible in behalf of plaintiff. The evidence warrants the inference that plaintiff was being prepared for an operation when Dr. S. M. Budge arrived at the hospital and told the plaintiff that he would give him no further medical attention until something was done about the old account.

We cannot say as a matter of law that plaintiff suffered no damages by reason of the refusal of Dr. S. M. Budge to further treat him. The evidence shows that from the time plaintiff left the office of the defendants up until the time that he arrived at the Cache Valley Hospital his hand continued to swell; that it was very painful; that when he left the Budge Memorial Hospital he was in such condition that he did not know whether he was going to live or die. That both his mental and physical suffering must have been most acute cannot be questioned. While the law cannot measure with exactness such suffering and cannot determine with absolute certainty what damages, if any, plaintiff may be entitled to, still those are questions which a jury under proper instructions from the court must determine.

Inasmuch as the views heretofore expressed require us to remand the case for a new trial, it becomes our duty to consider certain other specifications of error. We think it is immaterial and irrelevant as to how many children plaintiff might have and, therefore, the objection to such question was properly sustained.

A question propounded to plaintiff by his own attorney as to whether he was at the time Dr. Budge came to the hospital prepared for another operation was objected to, and the objection sustained, as being leading and calling for a conclusion. This we think was error. It would seem to relate wholly to his readiness and convenience to have the operation performed at that time. We think the ruling erroneous, although not prejudicial. Plaintiff was further asked to compare the treatment he gave his hand while at home with the treatment he had received at the hospital. Objection thereto was sustained and we think erroneously. Inasmuch as plaintiff, before he left the hospital, had been directed quite specifically how to treat his hand while at home, it would seem to be most obvious for him to be permitted to state just how he treated his hand during the time he was at home. Nor do we see any reason why plaintiff should not be permitted to state what treatment was given to his hand after the operation, during the time he remained at the hospital. We think the objection thereto was erroneously sustained.

For the reasons stated, the judgment of the lower court is reversed, and the cause is remanded to the district court of Cache county for a new trial. Appellant to recover his costs.

WOLFE, JUSTICE (concurring).

If there was any evidence which was competent to go to the jury on the first cause of action, there certainly was no evidence of damage suffered. Up to the time plaintiff left the hospital against the advice of the doctors on the 15th of March, he was rapidly improving. He complains: (a) That his hand

was bathed in water of improper temperature; (b) that respondents failed to lance the finger deep enough properly to drain the pus; (c) that respondents failed to remove a piece of metal from the finger; (d) that gauze was inserted in the incision too tightly to permit drainage; and (e) that respondents failed to examine the incisions frequently enough. There is no expert testimony as to (b) and (d). A layman's opinion on these matters would not be sufficient. There may be acts of commission or omission which a jury of intelligent laymen could say were negligence. I doubt if (a) or (e) are of this character, but even if there is evidence of such acts which could go to the jury without expert testimony that it did not constitute the treatment usually employed by skilled and competent physicians in that locality, there certainly was no evidence that it did any harm. As to (c) there is no evidence that there was any metal in the finger to take out. Dr. Randall testified that he found none. If there was any negligence, the patient improved because or in spite of it—most of us would be satisfied with treatment that brought recovery. I concur in the findings of the prevailing opinion that the directed verdict for the defendants on the first cause of action was proper. On the 15th of March the relationship of doctor and patient was terminated by the acts of plaintiff. Any advice the doctors gave him prior to his departure was because of their solicitation for his future. Such ministrations, if according to standard, cannot be converted into a basis of liability.

I concur with the findings of that opinion that the directed verdict on the second cause of action was improperly directed, but for a different reason. We must assume the evidence in its most favorable light for the plaintiff in testing this motion. I think there was sufficient evidence to go to the jury on the question as to whether the defendants reassumed the relationship of doctor and patient on March 17th. The plaintiff was told to come to the doctor's office; Dr. S. M. Budge examined the hand; Dr. D. C. Budge scraped it and indicated that it would have to be opened. They thereupon sent the patient to what was, to all intents and purposes of this case, their hospital. The jury might well come to the conclusion that they sent him to their hospital only on the assumption that they intended to treat him. If the jury should find that the relationship of doctor and patient had been resumed on March 17th, which it well might, they would next have to determine whether the doctors abandoned that relationship with too peremptory a notice under such circumstances as would make the plight of the plaintiff more dangerous and in such a way as not to give him opportunity to procure other medical aid in order to make the transition from one doctor to another without substantial hazard. I think there was evidence to go to the jury on this issue.

As to whether the several hours' delay and plaintiff's having to walk out in the rain aggravated the danger or made recovery more difficult, or resulted in the loss of the finger which might have been otherwise saved, is for the jury if there is evidence to go to it on that point. While I have some doubt as to whether there is competent evidence on this point, I think the doubt must be resolved in favor of plaintiff and that it was for the jury. There certainly may have been prolonged suffering by the delay and on that element the jury may find him entitled to some damages.

### *Notes, Questions, and Problems*

1. Explain the position of the concurring justice.
2. What are the ways to terminate the doctor-patient relationship? In which of the following cases should the relationship be deemed to have been terminated?

- a) LaToya, a trans woman, had been a patient of Dr. Jamieson for five years. She became angry after a rude encounter with one of Dr. Jamieson's nurses who misgendered her. Thus, she wrote him a letter stating that if he did not require his staff to take sensitivity training, she would take her business elsewhere. Dr. Jamieson responded by stating that he did not plan to require his staff to take any type of political correctness training. Has the doctor-patient relationship been terminated?
- b) Dr. Green's nurse tested positive for COVID-19, but he did not want to share that information with his patients. Instead, he mailed out letters to his patients stating that he was thinking about reducing his hours of operation because of COVID-19. Mario, a long-term patient, responded to Dr. Green's letter with one of his own. In his letter, Mario stated, "If anyone in your office gets COVID, count me out." Has the doctor-patient relationship been terminated?
- c) Dr. Garcia conducted a physical examination on Jennifer, so she could get cleared to run a marathon. During the physical examination, Dr. Garcia discovered that Jennifer had a blood disorder. When Dr. Garcia informed Jennifer of his findings, she thanked him and left the office. The next day, Jennifer sought the services of a faith healer. Has the doctor-patient relationship been terminated?
- d) Jessica Holmes was a long-time patient of Dr. Weatherson, a dermatologist. Dr. Weatherson was treating Jessica for a rare skin disorder. One night, Dr. Weatherson came home to find Jessica in bed with Peter Weatherson, Dr. Weatherson's husband. The next day, Dr. Weatherson had her assistant mail all of Jessica's medical records to Jessica's house. Has the doctor-patient relationship been terminated?

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

GRODIN, ASSOCIATE JUSTICE.

Occasionally a case will challenge the ability of the law, and society, to cope effectively and sensitively with fundamental problems of human existence. This is such a case. Appellant, Brenda Payton, is a 35-year-old black woman who suffers from a permanent and irreversible loss of kidney function, a condition known as chronic end stage renal disease. To stay alive, she must subject herself two or three times a week to hemodialysis (dialysis), a process in which the patient's circulatory system is connected to a machine through which the blood is passed. Using salts and osmotic membranes, artificial kidneys in the machine drain the blood of excess liquids and accumulated impurities. Without such treatment, the volume of liquids in the patient's system will increase dangerously; liquid will begin to fill the lungs, making breathing difficult and possibly leading to heart failure. The resulting toxic waste build-up and chemical imbalances can also threaten the function of the heart and other organs.

Brenda has other difficulties. Unable to care for her children, she lives alone in a low-income housing project in West Oakland, subsisting on a \$356 per month Social Security check. She has no family support; one brother is in prison and another is a mental patient. She confesses that she is a drug addict, having been addicted to heroin and barbiturates for over 15 years. She has alcohol problems, weight problems and, not surprisingly, emotional problems as well.

Despite these difficulties Brenda appears from the record to be a marvelously sympathetic and articulate individual who in her lucid moments possesses a great sense of dignity and is intent upon preserving her independence and her integrity as a human being. At times, however, her behavior is such as to make extremely difficult the provision of medical care which she so desperately requires.

The other principal figure in this case is respondent John C. Weaver, Jr., a physician specializing in kidney problems. He conducts his practice through respondent Biomedical Application of Oakland, Inc. (BMA), which operates an outpatient dialysis treatment unit on the premises of respondent Providence Hospital.

Dr. Weaver began treating Brenda in 1975 when, after the birth of Brenda's twin daughters, her system rejected a transplanted kidney. He has been treating her ever since. To her, "Dr. Weaver is and was and still is the man between me and death other than God, I don't think of nobody higher than I do Dr. Weaver."

On December 12, 1978, Dr. Weaver sent Brenda a letter stating he would no longer permit her to be treated at BMA because of her "persistent uncooperative and antisocial behavior over more than three years her persistent refusal to adhere to reasonable constraints of hemodialysis, the dietary schedules and medical prescriptions the use of barbiturates and other illicit drugs and because all this resulted in disruption of our program at BMA."

In the latter part of 1978, Brenda applied for admission to the regular dialysis treatment programs operated by respondents Alta Bates and Herrick hospitals, and was refused.

For several months Dr. Weaver continued to provide Brenda with necessary dialysis on an emergency basis, through Providence. On April 23, 1979, he again notified her by letter that he would no longer treat her on an outpatient basis. This letter led to Brenda's filing of a petition for mandate to compel Dr. Weaver, BMA, and Providence to continue to provide her with outpatient dialysis services. That litigation was settled by a stipulated order which called for continued treatment provided Brenda met certain conditions: that she keep all appointments at their scheduled time; that she refrain from use of alcohol and drugs; that she maintain prescribed dietary habits; and that she "in all respects cooperate with those providing her care and abide by her physician's prescribed medical regimen." Later, a sixth stipulation was added: that Brenda would "enter into and participate in good faith in a program of regular psychotherapy and/or counselling."

Dr. Weaver and BMA continued treatment of Brenda as an outpatient pursuant to the stipulation, but on March 3, 1980, Dr. Weaver, contending that Brenda had failed to fulfill any part of the bargain, again notified her that treatment would be terminated. He provided her with a list of dialysis providers in San Francisco and the East Bay, and volunteered to work with her counsel to find alternative care.

Brenda then instituted a second proceeding, again in the form of a petition for writ of mandate, this time naming Herrick and Alta Bates hospitals as respondents, along with Dr. Weaver, BMA and Providence. As pertinent here, the petition alleges that all respondents have "wrongfully failed and refused and continue to fail and refuse to provide Petitioner with regular hemodialysis treatment and medical supervision as required by her chronic end-stage kidney condition"; and, more specifically, that the refusal by Herrick and Alta Bates to admit her as an outpatient to their dialysis treatment programs violated their obligations under Health and Safety Code section 1317 to provide "emergency" treatment. The petition also contained allegations that Herrick and Alta Bates had

discriminated against her on grounds of race and indigency, in violation of the Civil Rights Act of 1968 and the Hill-Burton Act (42 U.S.C. § 291), but the trial court found these allegations to be unsupported, and they are not at issue here.

The trial court, after a lengthy evidentiary hearing, found that Brenda had violated each and every condition which she had accepted as part of the stipulated order providing for continued treatment, and that finding is basically undisputed. There was evidence that Brenda continued, after the stipulated order, to buy barbiturates from pushers on the street at least twice a week; that she failed to restrict her diet, gaining as much as 15 kilograms between dialysis treatments; that she continued to be late and/or miss appointments; that due primarily to missed appointments she had 30 emergencies requiring hospitalization in the 11 months preceding trial; that she would appear for treatment in an intoxicated condition; that she discontinued her program of counseling after a brief period; and, as the trial court found, she displayed in general “gross non-cooperation with her treating physician, BMA of Oakland and Providence Hospital.” The trial court found that her behavior in these respects was “knowing and intentional.”

Brenda’s behavior was found to affect not only Dr. Weaver but the other patients and the treating staff as well. Dialysis treatment is typically provided to several patients at a time, all of them connected to a single dialysis machine. There was evidence that Brenda would frequently appear for treatment late or at unscheduled times in a drugged or alcoholic condition, that she used profane and vulgar language, and that she had on occasion engaged in disruptive behavior, such as bothering other patients, cursing staff members with obscenities, screaming and demanding that the dialysis be turned off and that she be disconnected before her treatment was finished, pulling the dialysis needle from the connecting shunt in her leg causing blood to spew, and exposing her genitals in a lewd manner. The trial court found that during the times she has sought treatment “her conduct has been disruptive, abusive, and unreasonable such as to trespass upon the rights of other patients and to endanger their rights to full and adequate treatment,” and that her conduct “has been an imposition on the nursing staff.” The court determined that, on balance, the rights and privileges of other patients endangered by Brenda’s conduct were superior to the rights or inequities which Brenda claimed.

The court also found, contrary to Brenda’s contentions, that Dr. Weaver had given sufficient notice to Brenda, and that Dr. Weaver was not responsible for Brenda being refused dialysis by any other respondent. It concluded that Dr. Weaver had “discharged all obligations imposed by the patient-physician relationship” with Brenda.

As to Alta Bates and Herrick hospitals the court found that they had not refused Brenda “emergency” treatment in violation of Health and Safety Code section 1317. In late 1978, after receiving notification from Dr. Weaver that he would no longer treat her, Brenda made application to the *regular outpatient dialysis programs* at these two hospitals and was refused—for reasons, as the trial court found, that did not include her race, her indigency, or any actions on the part of Dr. Weaver. It concluded, on the basis of reasoning which we shall discuss later in this opinion, that Brenda’s chronic kidney disease did not itself constitute an “emergency” within the meaning of that section.

Finally, the trial court found that Brenda “has freedom of several choices available by which she can be kept away from dangerous drugs and alcohol, helped to stay on a proper dietary regimen, and in all other ways caused to cooperate with those attempting to provide her with care,” so that she is “not without means to arrange for her own care.” It concluded, after a weighing of the equities, that Brenda “has no legal right to compel medical service from any of the Respondents for chronic or regular care of her kidney problems through dialysis,” and so denied her petition for writ of mandate. At the same

time, however, the court stayed execution of its judgment and continued in effect its temporary order requiring Dr. Weaver, and BMA, to provide hemodialysis to Brenda on a regular basis pending appeal.

### Discussion

We begin our analysis by considering the trial court's conclusion that Dr. Weaver and the clinic with which he is associated have no present legal obligation to continue providing Brenda with dialysis treatment. Brenda does not claim that Dr. Weaver has any such obligation on the basis of the stipulated order that was entered in the prior proceeding, nor could she reasonably do so. The trial court found that she was estopped from so claiming by her frequent violations of the conditions contained in that order, and that finding is amply supported by the evidence.

Rather, Brenda relies upon the general proposition that a physician who abandons a patient may do so "only after due notice, and an ample opportunity afforded to secure the presence of other medical attendance." (citations omitted)

The trial court found, however, that Dr. Weaver gave sufficient notice to Brenda, and discharged all his obligations in that regard, and that finding, also, is amply supported. Dr. Weaver supplied Brenda with a list of the names and telephone numbers of all dialysis providers in San Francisco and the East Bay, and it is apparent from the record that nothing would have pleased him more than to find an alternative facility for her, but there is no evidence that there is anything further he could have done to achieve that goal under the circumstances.

During the proceedings, the trial court observed that Dr. Weaver "is one of the most sensitive and honest physicians that I have been exposed to either in a courtroom or out of a courtroom," that he was "in fact sensitive to [Brenda's] needs, that he has attempted to assist her to the best of his medical abilities, that he continues to have concern for her as a person and has continued to serve her medical needs," and that "[t]he man has the patience of Job." It appears that Dr. Weaver has behaved according to the highest standards of the medical profession, and that there exists no basis in law or in equity to saddle him with a continuing sole obligation for Brenda's welfare. The same is true of the clinic, the BMA.

We turn now to Brenda's contention that Herrick and Alta Bates hospitals violated their obligations under Health and Safety Code section 1317, the text of which is set forth in the margin, by denying her admission to their regular out-patient dialysis programs in late 1978. The trial court found that at the time Brenda applied for admission to these programs she was not in an "emergency condition," by which the court obviously meant that she was in no imminent physical danger on the day she applied. Brenda contends, however, that her illness is itself "a chronic/acute emergency which requires that she receive medical treatment every third day to avoid death," and that such a condition qualifies for mandated service under section 1317.

The trial court, in response to Brenda's contention, found that a patient with end stage renal disease "will not become a medical emergency if that person obeys medical orders, avoids drug abuse and appears for and has regularly scheduled hemodialysis treatments," and that regular outpatient dialysis treatment requires expertise and equipment not normally found in emergency rooms. It concluded that a chronic requirement for continued dialysis treatment does not constitute a need for "emergency" services or care within the meaning of section 1317. It declared, in that connection, that should Brenda present herself at any emergency department of any of the respondent health care providers claiming a need for emergency care, "a determination shall be made at that time by qualified physicians to see

whether her condition constitutes an emergency” and, if so, she would be entitled to medical services under section 1317. Since that was not the situation at the time of Brenda’s application to the two hospitals, the court found no liability.

We agree with the trial court’s conclusion. While end stage renal disease is an extremely serious and dangerous disease, which can create imminent danger of loss of life if not properly treated, the need for continuous treatment as such cannot reasonably be said to fall within the scope of section 1317. There are any number of diseases or conditions which could be fatal to the patient if not treated on a continuing basis. If a patient suffering from such a disease or condition were to appear in the emergency room of a hospital in need of immediate life-saving treatment, section 1317 would presumably require that such treatment be provided. But it is unlikely that the Legislature intended to impose upon whatever health care facility such a patient chooses the unqualified obligation to provide continuing preventive care for the patient’s lifetime.

It does not necessarily follow that a hospital, or other health care facility, is without obligation to patients in need of continuing medical services for their survival. While it has been said that “[a] private hospital owes the public no duty to accept any patient not desired by it, and it is not necessary to assign any reason for its refusal to accept a patient for hospital service” (41 C.J.S. Hospitals § 8, 345; see *Birmingham Baptist Hospital v. Crews* (1934) 229 Ala. 398, 157 So. 224, 225; cf. *Wilmington General Hospital v. Manlove* (Sup. Ct. Del. 1961) 174 A.2d 135), it is questionable whether a hospital which receives public funding under the Hill-Burton Act (42 U.S.C. § 291), and perhaps from other sources, can reasonably be said to be “private” in that sense. (Cf. *Ascherman v. Saint Francis Memorial Hosp.* (1975) 45 Cal.App.3d 507, 512-513, 119 Cal.Rptr. 507.) Rather, where such a hospital contains a unique, or scarce, medical resource needed to preserve life, it is arguably in the nature of a “public service enterprise,” and should not be permitted to withhold its services arbitrarily, or without reasonable cause. And, while disruptive conduct on the part of a patient may constitute good cause for an individual hospital to refuse continued treatment, since it would be unfair to impose serious inconvenience upon a hospital simply because such a patient selected it, it may be that there exists a *collective* responsibility on the part of the providers of scarce health resources in a community, enforceable through equity, to *share* the burden of difficult patients over time, through an appropriately devised contingency plan.

Whatever the merits of such an approach might be in a different factual context, however--and we recognize that it poses difficult problems of administration and of relationship between hospitals and physicians--it cannot serve as a basis for imposition of responsibility upon these respondents under the circumstances present here. Apart from the fact that the record does not demonstrate to what extent respondent hospitals are the sole providers of dialysis treatment in the area accessible to Brenda, her present behavior, as found by the trial court, is of such a nature as to justify their refusal of dialysis treatment on either an individual or collective basis. Whatever collective responsibility may exist, it is clearly not absolute, or independent of the patient’s own responsibility.

What we have said to this point is analytically sufficient to dispose of Brenda’s legal arguments, and thus to sustain the trial court’s ruling, but the circumstances are such that we cannot responsibly avoid confronting the more fundamental question posed by Brenda’s challenge, and considered at some length by the parties in their briefs and at oral argument, namely: what alternatives exist for assuring that Brenda does not die from lack of treatment as a result of her uncooperative and disruptive behavior.

One possibility which has been considered is an involuntary conservatorship under the Lanterman-Petris-Short (LPS) Act (Welf & Code, § 5350 et seq.). Such a conservatorship is appropriate in the

case of persons “gravely disabled as a result of mental disorder or impairment by chronic alcoholism” (§5350). The County of Alameda has apparently determined, however, that the conditions of that statute cannot be met in Brenda’s case.

A second possibility is an involuntary conservatorship under the provisions of Probate Code section 1801 et seq. Under section 1801, subdivision (a), “[a] conservator may be appointed for a person who is unable properly to provide for his or her personal needs for physical health, food, clothing, or shelter.” Such a conservator “may consent to medical treatment to be performed upon the conservatee, and may require the conservatee to receive such medical treatment, in any case which the conservator determines in good faith based upon medical advice that the case is an emergency case in which the medical treatment is required.” (Prob.Code § 2354, subd. (c); see also § 2354, subd. (a).) This possibility remains a viable alternative.

A third possibility, and the one which appears from recent developments to be the most promising, is a voluntary conservatorship under Probate Code section 1802. While Brenda has heretofore resisted consenting to such a conservatorship, her attorneys advise us in a post-argument declaration that they are willing to use their influence to persuade Brenda to consent and that they believe they can arrange for her placement in a private, closed psychiatric facility. They suggest that we remand the matter to the superior court for the institution of appropriate proceedings. Respondents also appear to consider a voluntary conservatorship the best approach.

We have no authority to “remand” for the institution of a voluntary conservatorship, as Brenda’s attorneys suggest. The trial court’s order requiring Dr. Weaver to provide dialysis treatment to Brenda pending appeal will, however, remain in effect until our decision becomes final. If, during that period, Brenda institutes proceedings for a voluntary conservatorship, and a conservator is appointed, it will be that person’s obligation to arrange for continued treatment under statutory authority, and subject to such conditions as the court may impose. The judgment is affirmed.

### ***Wells v. Jochenning*, 378 N.E. 2d 878 (Ohio App. 1989)**

PER CURIAM.

Plaintiffs James J. and Marian Wells appeal from a judgment entry which granted the motion for summary judgment of defendants Paul Jochenning, M.D., and Forsythe, Stueber & Jochenning, M.D., Inc. For the reasons set forth below, we reverse.

The record indicates that James Wells suffered from recurrent prostatitis for two years before defendant Paul Jochenning operated on him for this condition on May 6, 1985. Due to post-surgical complications, Jochenning subsequently performed additional surgery on Wells on May 17, 1985. Following these additional procedures, Wells was incontinent of urine, and he continued to treat with Jochenning for the next several months in order to alleviate this problem.

Wells’ last appointment with Jochenning was on January 8, 1986. Wells did not keep a follow-up appointment scheduled for March 12, 1986, however. Thereafter, on February 5, 1987, Wells’ attorney notified Jochenning that Wells was contemplating filing a malpractice action against Jochenning. Wells subsequently filed this action against Jochenning, Forsythe, Stueber & Jochenning, M.D., Inc., and three other defendants on July 23, 1987.



On March 7, 1988, defendants Paul Jochenning and Forsythe, Stueber & Jochenning, Inc., moved for summary judgment contending that the action was not filed within the statute of limitations set forth in R.C. 2305.11(A), because, defendants argued, the statute commenced to run on January 8, 1986, the date on which Jochenning last treated Wells.

Plaintiffs subsequently filed a brief in opposition, supported by an affidavit from Wells, which indicated that at the January 8, 1986 office visit, Jochenning gave Wells a prescription for medication and also discussed other methods and procedures which could be employed to alleviate Wells' incontinence. Wells further indicated in his affidavit that he needed time to consider these treatment options, and, at Jochenning's request, scheduled a follow-up appointment with Jochenning for March 12, 1986. Thereafter, according to Wells' affidavit, he decided to obtain a second opinion and subsequently met with Timothy Sidor, M.D., on March 5, 1986. Finally, Wells indicated, he considered his professional relationship with Jochenning to be in effect until he failed to keep the March 12, 1986 appointment.

The trial court subsequently granted defendants' motion for summary judgment, and this appeal was commenced.

## II

For their sole assignment of error, plaintiffs contend that the trial court erred in granting defendants' motion for summary judgment because the parties contemplated that the March 12, 1986 appointment would be a follow-up to the January 8, 1986 appointment, and because medication was prescribed at this appointment. These two facts, plaintiffs argue, caused the physician-patient relationship to continue beyond January 8, 1986. As we find that reasonable minds could conclude that the physician-patient relationship did continue until Wells failed to appear for the March 12, 1986 appointment, we find that summary judgment was improvidently granted, and we reverse.

Pursuant to R.C. 2305.11 (A), an action for medical malpractice must be commenced within one year after the cause of action occurs. If, however, prior to the expiration of this one-year limitation period, the claimant gives written notice to the physician that he is considering bringing an action for malpractice, the action may be commenced within one hundred eighty days after the notice is given. R.C. 2305.11(B).

The time at which the cause of action accrues, and the statute of limitations commences to run, is (a) when the patient discovers or in the exercise of reasonable care and diligence, should have discovered the resulting injury, or (b) when the physician-patient relationship is terminated, whichever occurs later. *Fryinger v. Leech* (1987), 32 Ohio St.3d 38, 512 N.E.2d 337, paragraph one of the syllabus.

Where, as in this case, a surgery patient has a date for an appointment with his physician for post-operative care and fails to keep that appointment, and declines to ever see his physician again, the physician-patient relationship is finally terminated no later than the day of the appointment which the patient failed to keep. *Millbaugh v. Gilmore* (1972), 30 Ohio St.2d 319, 59 O.O.2d 383, 285 N.E.2d 19, paragraph one of the syllabus. In this situation, the precise point at which the physician-patient relationship terminates will be the point where the patient refuses to submit to further treatment by the physician, see *Buckley v. Jefferies* (Jan. 27, 1983), Cuyahoga App. No. 44724, unreported, 1983 WL 5706, or the point at which either party takes affirmative steps to terminate the relationship. See *Smales v. Portman* (Nov. 5, 1981), Franklin App. No. 81AP-522, unreported, 1981 WL 3576. Absent such

action, the relationship is terminated by the patient's failure to keep the next scheduled appointment. *Id.*

Where there is a continuing course of treatment, however, the physician-patient relationship may be found to be in effect beyond the date of the missed appointment. Cf. *Ishler v. Miller* (1978), 56 Ohio St.2d 447, 457, 10 O.O.3d 539, 544, 384 N.E.2d 296, 303. A continuing course of treatment will be found, for example, where the patient is taking prescribed medication with the knowledge of the physician and under his supervision. *Id.*; *Kraus v. Cleveland Clinic* (N.D. Ohio 1977), 442 F. Supp. 310, 314.

In light of the foregoing, the point of the termination of the physician-patient relationship, and the point at which the statute of limitations may commence to run pursuant to *Frysinger v. Leech*, *supra*, is dependent upon the conduct of the particular parties involved, and is, accordingly, a question of fact. *Accord Fields v. Nilavar* (June 7, 1982), Clark App. No. CA 1672, unreported; *Wenning v. Syntex Corp.* (July 27, 1981), Montgomery App. No. CA 6749, unreported.

In this case, construing the evidence most strongly in favor of plaintiffs as required by Civ. R. 56 (C), we find that reasonable minds could reach divergent conclusions as to whether Wells refused to submit to further treatment with defendants or took any affirmative steps to terminate his relationship with defendants until he missed the appointment scheduled for March 12, 1986. Since Wells does not indicate that he actually took the medication *Johenning* prescribed on January 8, 1986, but rather indicated that he only considered this and the other treatment options discussed at this appointment, reasonable minds could not conclude that the physician-patient relationship continued beyond the missed appointment by a continuing course of treatment, however. Cf. *Kraus v. Cleveland Clinic*, *supra*.

In light of the foregoing, we find that the trial court improvidently granted defendants' motion for summary judgment, and we reverse. Cf. Civ.R. 56(C); *Viocck v. Stone-Woodward Co.* (1983), 13 Ohio App.3d 7, 15, 13 OBR 8, 16, 467 N.E.2d 1378, 1387.

Judgment reversed and cause remanded.

### ***Questions and Problems***

1. Why did the court conclude that the physician in *Payton* had properly terminated his relationship with the patient?
2. What are the options that the court put forth to assist Brenda? What are the pros and cons of each of those options? What are other possible options?
3. In the *Payton* case, the doctor tried several times to get the patient to comply. Was there a way for the doctor to terminate the relationship without going to such great lengths to assist the patient?

4. A doctor can terminate the doctor-patient relationship. However, the doctor cannot abandon the patient without consequence. Patient abandonment is a type of medical malpractice. The elements of such a claim are as follows: (1) the physician unilaterally severs the relationship with the patient; (2) the physician does not give the patient reasonable notice or provide the patient with adequate alternative medical care; and (3) the physician's actions occur at a time when it is necessary to continue the medical care. *Granek v. Texas State Bd. of Medical Examiners*, 172 S.W. 3d. 761 (Tex. App.-Austin 2005, no pet.). In which of the following situations is the court likely to find that the patient has been abandoned?

(a) When Lynne went into labor, she called her OBGYN Dr. Wilson. Dr. Wilson advised Lynne to proceed to Mercy Hospital and promised to meet her there. Dr. Wilson arrived at the hospital and examined Lynne, and left the hospital shortly thereafter to pick up her husband from the airport. Although Lynne was placed on a fetal monitor, she began the labor process on her own until the baby's head had partially traveled outside the birth canal and she was holding it in the palm of her hands. At that point, her wife ran out and called in an unidentified doctor standing in the hallway who, along with several nurses, completed the delivery.

(b) Maggie began treatment with Drs. Robinson and Stein for infertility. The doctors had a falling out and Dr. Robinson left to form her own practice. Dr. Robinson was prohibited from treating Maggie because of a temporary restraining order issued in a suit to enforce a non-compete agreement between Dr. Robinson and Dr. Stein. Eventually, Maggie tried to intervene in the non-compete case or to obtain relief from the effect of the injunction. The court agreed to allow Dr. Robinson to treat Maggie, but she could not do so at any hospital listed in the non-compete agreement. Maggie wished to be treated at Peace Hospital which was on the prohibited hospital list.

(c) The army informed Dr. Dylan that he would be deployed in two weeks. Because he was going on a secret mission, Dr. Dylan was told that he could not notify anyone until the Army gave him approval. Three days before he was to be deployed, the Army gave Dr. Dylan permission to notify his patients. In response, Dr. Dylan entered the information into his patients' MyChart accounts and posted it on the practice's social media page. Dr. Dylan was treating 78-year-old Robert Jackson for hypertension. Robert had a MyChart account, but he never logged into it and he was not active on social media. Two weeks after Dr. Dylan left for his deployment, Robert called his office to schedule an appointment. At that time, he was told that Dr. Dylan's practice was shut down indefinitely. Robert needed his blood pressure medicine, so he tried to find another doctor. Unfortunately, he could not find a doctor in his area that was accepting new patients. Robert suffered a massive stroke.

(d) Bonnie Sims was a patient of Dr. Little Flower for over ten years. Dr. Little Flower was treating Bonnie for anxiety and depression. Dr. Little Flower decided to move to Iceland for a month to be with her husband who had accepted a fellowship at Iceland University. Dr. Little Flower temporarily transferred her patients to Dr. Matthews, a psychiatrist in her office building. When Bonnie showed up for her appointment, she was told that Dr. Matthews was seeing Dr. Little Flower's patients. Because of the trauma she had suffered, Bonnie was not comfortable seeing Dr. Matthews who was a man. Thus, she left the appointment.

(e) 87-year-old Grant Steward was the father of two children, Gary Steward and Karen Steward. Grant suffered from rheumatoid arthritis. He had been a patient of Dr. Chin for almost twenty years. One day, Karen accompanied Grant to his doctor's appointment. When she saw that Grant's

doctor was of Asian descent, Karen demanded another physician. She stated that she was afraid that her father would be exposed to COVID if treated by Dr. Chin. Grant objected and told Karen that she was being ignorant. Dr. Chin asked Karen and Grant to leave the office. The next day, Grant received a letter from Dr. Chin stating that he would no longer be Grant's physician.

### 1.4.1 Illegal Reasons to Not Treat

The foregoing discussion has made it clear that physicians, like other professionals, have the right to accept or refuse to treat patients. There are three general contexts in which it is permissible and sometimes obligatory to refuse care: when doctors are subjected to abusive treatment, when the treatment requested is outside a doctor's scope of practice, or when providing the requested treatment would otherwise violate one's duties as a physician, such as the Hippocratic mandate to "first do no harm." A consensus exists among legal and bioethics experts that doctors can refuse to provide treatment in certain situations. For example, courts have ruled that doctors may refuse to treat violent or intransigent patients as long as they give proper notice so that those patients can find alternative care. Forcing doctors to treat such patients, courts have said, would violate the 13th Amendment's prohibition on involuntary servitude.

The American Medical Association, as an organization, has not yet taken a definitive position on the issue of a physician's right to refuse to treat patients. According to the organization's code of ethics, physicians have a responsibility "to place patients' welfare above their own self-interest." However, the organization acknowledges that doctors are individuals with the right to free choice, stating that "physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities." At the same time, that freedom, the code says, "is not unlimited."<sup>4</sup>

Physicians can decide not to perform certain procedures based on their religious belief. Former President Trump announced a new rule, issued by the Department of Health and Human Services, that would have permitted doctors, hospitals, insurers, and other healthcare providers to refuse to deliver or fund services like abortion, assisted suicide, or procedures for transgender patients that they say violate their religious belief.<sup>5</sup> The rule was successfully challenged in court because it had the potential to discriminate against members of marginalized groups.<sup>6</sup> Nonetheless, federal legislation still allows physicians to decline treatment that is incompatible with their religious or moral beliefs. For instance, gynecologists may refuse to perform abortions on those grounds.<sup>7</sup>

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<sup>4</sup> American Medical Association (AMA), *Physician Exercise of Conscience*, Code of Medical Ethics Opinion 1.17, at <https://www.ama-assn.org/delivering-care/ethics/physician-exercise-conscience> (last visited April 5, 2021).

<sup>5</sup> Reuters: KHN Morning Briefing, *Trump Administration Expanded Conscience Rule Will Allow Medical Professionals to Refuse to Provide Health Care Services*, at <https://khn.org/morning-breakout/trump-administrations-expanded-conscience-rule-will-allow-medical-professionals-to-refuse-to-provide-health-care-services/> (May 3, 2019).

<sup>6</sup> Selena Simmons-Duffin and Colin Dwyer, *Judge Scraps 'Conscience' Rule Protecting Doctors Who Deny Care For Religious Reasons*, NPR, at <https://khn.org/morning-breakout/trump-administrations-expanded-conscience-rule-will-allow-medical-professionals-to-refuse-to-provide-health-care-services/> (Nov. 6, 2019).

<sup>7</sup> Linda Carroll, *Most states protect doctors who refuse to do abortions because of religion*, Reuters, at <https://www.reuters.com/article/us-health-abortion-access/most-states-protect-doctors-who-refuse-to-do-abortions-because-of-religion-idUSKBN1XT2HA> (Nov. 19, 2019).

Conscientious objection by physicians may limit a patient's right to self-determination. Patients do have the option of finding doctors who are willing to render treatment to them; however, that action can lead to potentially dangerous delays, especially in areas with limited resources. Conscientious objection may also be used to mask implicit bias and outright discrimination. For example, some Christian medical associations have asserted that providing medical treatment to transgender individuals may be perceived as condoning their behavior and/or lifestyle. The law does not recognize a physician's right to discriminate in the selection of patients.

#### **1.4.1.1 Race As a Pretext**

##### ***Walker v. Pierce*, 560 F.2d 609 (4th Cir. 1977)**

ALBERT V. BRYAN, SENIOR CIRCUIT JUDGE:

Violation of their civil rights was laid, in this action for damages and declaratory and injunctive relief by Virgil Walker and Shirley Brown, black females, to Clovis H. Pierce, the attending obstetrician at the Aiken County Hospital in South Carolina for sterilizing them, or threatening to do so, solely on account of their race and number of their children, while they were receiving medical assistance under the Medicaid program.<sup>2</sup> The other defendants, the Chairman of the Board of Trustees of the Hospital, its Administrator, the Director of the Department of Social Services of Aiken County, the State Commissioner of the Department of Social Services of South Carolina and the Hospital, are charged with conspiring or acting in concert with Dr. Pierce in the unlawful acts imputed to him.

Verdicts, those directed and those returned by the jury, went for the defendants except Pierce, against whom the jury assessed damages of \$5.00 in favor of Shirley Brown. Judgments were passed accordingly, including denial of declaratory and injunctive relief. On plaintiffs' appeals we affirm; on the obstetrician's we reverse.

#### **The Complaint**

As faultlessly put in the plaintiffs' brief: "The essence of the complaint was that Medicaid recipients were being required to consent to undergo a tubal ligation if they were delivering a third living child." Centering the controversy is the policy previously announced and constantly pursued in practice by the doctor, testified to by him as follows:

"My policy was with people who were unable to financially support themselves, whether they be on Medicaid or just unable to pay their own bills, if they were having a third child, to request they voluntarily submit to sterilization following the delivery of the third child. If they did not wish this as a condition for my care, then I requested that they seek another physician other than myself."

There is no question of his professional qualifications or experience. As drawn by the plaintiffs, he is the arch-offender. The accusation is incursion upon their Constitutional rights of privacy, due process of law and equal protection of the law as well as of their statutory privileges against discrimination on account of their race and color, all by subjecting or threatening the plaintiffs as citizens of the United States with involuntary sterilization. These deprivations, they further say, are the result of the effectuation of Pierce's policy under color of State law, that is, under the Medicaid program

administered by South Carolina. His codefendants, to repeat, are impleaded for conspiring and acting in concert with him, and for acquiescing in his unlawful conduct. 42 U.S.C. ss 1981, 1983, 1985(3) and 2000d. Personal injury has been suffered, each plaintiff asserts, as a direct consequence of acts of the defendants under this policy.

Now to follow are the facts as elicited by the plaintiffs from their evidence, but denied by the defendants as inculpatations of them.

#### Plaintiff Walker

Virgil Walker had completed the seventh grade, was separated from her husband and was receiving Aid to Families with Dependent Children and Medicaid benefits. Expecting her fourth child, she first went to Pierce on January 7, 1972. During this consultation, he discussed family planning and his sterilization policy. Walker refused to consent. The issue again came up at the second visit and she again declined. Walker testified that Pierce threatened to have her State assistance terminated unless she cooperated. She called another doctor, but he was not taking new patients.

On February 4, 1972, Spears, a Department of Social Services caseworker assigned to Walker, received a note from Pierce's office asking that he talk with Walker about sterilization. Thereupon, Spears, according to his testimony, spoke with her on February 17th, offering to get her a second doctor. On the other hand, Walker stated that Spears had said there was nothing he could do. Then she returned to Pierce and subsequently signed a consent form for sterilization.

Her fourth child was delivered at the Aiken County Hospital April 16, 1972 by Dr. Billy Burke, an obstetrician who substituted for Pierce on occasion. Burke discussed tubal ligation with Walker. Her response was that she did not want additional children and understood that it would be a permanent sterilization. Two more consent forms were then signed. Pierce performed the operation April 17, 1972. She protested no further because, she said, it would have been futile.

Walker's hospital bills and doctor's fees were paid by Medicaid. Under the South Carolina plan operated by the Department of Social Services, the patient-physician relationship is one of free choice for both parties. The physician, under no contract with the State, simply submits his bill when treatment is concluded to the Medicaid insurance carrier instead of the patient.

#### Plaintiff Brown

Shirley Brown consulted Pierce regarding her third pregnancy. She, too, was separated from her husband and had taken job maternity leave from Seminole Mills. On her initial visit, Brown paid Pierce \$50.00. Sterilization was not discussed. A \$250.00 balance due on his fee was satisfied in part by Brown and her husband and partially by the health insurance plan at the mill.

At the end of August 1973, Brown qualified for Medicaid benefits. She was delivered of her third child at the Hospital September 2, 1973 by a doctor other than Pierce. The hospital bills, not Pierce's fees, were to be paid by Medicaid. After the delivery, Pierce requested his nurse to obtain Brown's consent to sterilization. Brown refused. Upon word of her refusal, Pierce saw no necessity for further hospitalization and ordered her discharge and release from the Hospital.

Her mother intervened, offering to pay the hospital bill, but Brown left September 3, 1973, "afraid something might happen to her." Protest was made to the defendant Nesbit, Hospital Administrator,

who suggested she file a complaint with the Board of Trustees since he had no control over a doctor's discharge of patients. At trial, Brown's attorney conceded that she sustained no actual damages in leaving the Hospital.

### The Defendants

Defendant Nesbit stated that he first learned of Pierce's policy in July, 1973 from newspaper accounts appearing in the local papers. He reported it to the Chief of Obstetrics and Gynecology at the Hospital but at that time he received no answer as to anything he should do.

Defendant Poore, Director of the Aiken County Department of Social Services since March 23, 1972, testified that he also originally learned of Pierce's policy from press items on July 17, 1973. He called a staff meeting and arranged for a doctor in Augusta, Georgia to see obstetric patients. Transportation for them was provided by the Department.

Defendant Ellis, State Commissioner of DSS, became aware of the sterilization policy through July, 1973 news accounts. He fixed a meeting for July 26 between Pierce, a Medicaid deputy and a State attorney general. An investigation included a review of records of Pierce's patients and interviews with Medicaid recipients sterilized at the Hospital in the first six months of 1973. Early September, Ellis and a State attorney general met with Pierce and his attorney. Ellis asked Pierce to sign an affidavit stating that he would not discriminate against Medicaid patients. Pierce declined. Finally, Ellis wrote Pierce September 27, 1973 that his continued refusal to sign the affidavit forced the Department to impose a non-payment sanction for Pierce's submitted Medicaid bills. Pierce no longer treated Medicaid patients. From January 1, 1972 to June 30, 1973 the doctor had received \$60,000 in Medicaid fees.

### The Verdicts and Judgments

The claims against Poda, Chairman of the Board of the Hospital, were withdrawn. In the Walker action under section 1981 verdicts were directed for all of the defendants except Dr. Pierce, Nesbit individually and as Administrator of the Hospital and the Hospital itself, but the jury returned a verdict for the latter defendants; in the Walker action under section 1983, verdicts were directed for all defendants except Dr. Pierce and Nesbit, but the verdict acquitted these two. In Brown's action under section 1981, directed verdicts were granted for all defendants except Pierce, Poore and the Hospital, but the jury found for them. In Brown's action under section 1983, verdicts were instructed for all defendants except Dr. Pierce and Poore. However, the jury found for Poore but against Dr. Pierce assessing damages at \$5.00 "Nominal Damages."

As weighed by the Court, the evidence was not sufficient to permit a finding of a conspiracy under section 1985(3), and, therefore, the case was not submitted to the jury on that count, directed verdicts going for all the defendants. Judgments, with costs, went accordingly. Motions for new trials were denied, as was a motion for judgment n. o. v. by Dr. Pierce. Previously the Court had denied plaintiffs' request for a class action under Rule 23(a), (b)(1) and (b)(2) F.R.Civ.P.

The claim for a class action was not argued before the court but the plaintiffs noted that they reserved the point. The Court did not abuse its discretion in refusing the request and the record confirms the soundness of this resolution. Nor is error apparent in the directed verdicts. The proof was not adequate to establish discrimination, racial or otherwise, conspiracy, or recklessness or want of good faith, as to those favored by the directions, and the jury found none save against Pierce under 1983. Therefore,

without further discussion we affirm as to all defendants in each case save as to the verdict against Dr. Pierce.<sup>5</sup> In his instance we reverse and enter final judgment.

#### The Case Against Dr. Pierce

We perceive no reason why Dr. Pierce could not establish and pursue the policy he has publicly and freely announced. Nor are we cited to judicial precedent or statute inhibiting this personal economic philosophy. Particularly is this so when all persons coming to him as patients are seasonably made fully aware of his professional attitude toward the increase in offspring and his determination to see it prevail. At no time is he shown to have forced his view upon any mother. Indeed, quite the opposite appears. In the single occasion in this case of a sterilization by this doctor, not just one but three formal written consents were obtained the first before delivery of the fourth child and two afterwards.

But if his conduct is nevertheless to be judged by the factors of section 1983, Dr. Pierce was not a violator. He was not acting under color of State law when treating the only successful plaintiff, Brown. His fee for her delivery was paid by her and her employer's insurance plan; there was no use of Medicaid money. Incidentally, he did not sterilize her; the tort charged to him is his discharge and release of her from the Hospital, an accepted procedure there. Receipt by the Hospital of Hill-Burton funds, 42 U.S.C. 291 et seq. did not convert Dr. Pierce into a participant in a Federal program and thus in State action. *Ascherman v. Presbyterian Hospital*, 507 F.2d 103, 1105 (9 Cir. 1974). No decision has been advanced holding that a physician by simply practicing in such an institution acts under color of State law. Certainly the Fourth Circuit did not do so in its line of decisions on the question terminating in *Doe v. Charleston Area Medical Center, Inc.*, 529 F.2d 638 (1975).

The judgments of the District Court are affirmed except that granted Shirley Brown against Clovis H. Pierce, which is reversed with final judgment for the defendant. Affirmed in part; reversed in part; and final judgment.

BUTZNER, CIRCUIT JUDGE, concurring in part and dissenting in part:

I join in affirming the judgments in favor of the hospital, its officers, and the state and county officials. The evidence did not prove them to be willful participants in Dr. Pierce's practice of sterilizing Medicaid patients.

I dissent from the reversal of the judgment against Dr. Pierce. The facts and the law fully justify the district judge's ruling that Dr. Pierce was acting under color of state law within the meaning of 42 U.S.C. s 1983. At the outset, it is necessary to note the distinction between Dr. Pierce's professional role as a physician treating Medicaid patients and his role as a participant in the fiscal and administrative aspects of the Medicaid program. Title 42 U.S.C. s 1396a, dealing with state plans for the Medicaid program, is designed to avoid governmental intrusion in the doctor-patient relationship. "(T)he very heart of the congressional scheme is that the physician and patient should have complete freedom to choose those medical procedures for a given condition which are best suited to the needs of the patient." *Beal v. Doe*, 432 U.S. 438, ---, 97 S.Ct. 2366, 2374, 53 L.Ed.2d 464 (1977) (Brennan, J., dissenting). Thus, a physician paid by Medicaid does not act as an agent of the state or under color of its laws when he decides what medical care and services his patient's health requires. Cf. *Byrne v. Kysar*, 347 F.2d 734, 736 (7<sup>th</sup> Cir. 1965); *Duzynski v. Nosal*, 324 F.2d 924, 929 (7<sup>th</sup> Cir. 1963). Consequently, it is necessary to ascertain whether Dr. Pierce's policy of sterilizing Medicaid patients was based on considerations of their health.



When Dr. Pierce treated a patient who could pay for delivery of her child, he did not exact consent for sterilization regardless of the number of her children. If, however, the patient already had more than two children and her bill was to be paid by Medicaid, he refused to treat her unless she consented to sterilization.

Dr. Pierce's policy of requiring sterilization of Medicaid patients is also illustrated by his treatment of Mrs. Shirley Brown. As long as it appeared that her expenses were being paid from private funds, Dr. Pierce was content to accept her as a patient without conditioning either his services or her hospitalization on her consent to sterilization. When he learned from hospital records that her hospital bill was being paid by Medicaid, he directed a nurse to obtain her consent to sterilization. Upon Mrs. Brown's refusal, he ordered her discharged from the hospital.

Had Dr. Pierce's decisions to sterilize his patients been based on their medical needs, he would not have acted under color of state law within the meaning of s 1983. See, e. g., *Byrne v. Kysar*, 347 F.2d 73 (7<sup>th</sup> Cir. 1965); *Duzynski v. Nosal*, 324 F.2d 924 (7<sup>th</sup> Cir. 1963). However, the foregoing evidence establishes beyond doubt that Dr. Pierce's policy pertaining to sterilization was based on economic factors instead of the health of his Medicaid patients. It is clear that he undertook to grant or deny Medicaid benefits for reasons unrelated to his patients' health. It therefore becomes necessary to determine next whether Dr. Pierce's policy of sterilization for economic reasons establishes that he was acting under color of state law.

There is no litmus test for ascertaining whether an ostensibly private person is in fact acting under color of state law. "Only by sifting facts and weighing circumstances can the nonobvious involvement of the State in private conduct be attributed its true significance." *Burton v. Wilmington Parking Authority*, 365 U.S. 715, 722, 81 S.Ct. 856, 860, 6 L.Ed.2d 45 (1961). This inquiry must determine "whether there is a sufficiently close nexus between the State and the challenged action of (the person under scrutiny) so that the action of the latter may be fairly treated as that of the State itself." *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 351, 95 S.Ct. 449, 453, 42 L.Ed.2d 477 (1974). Action under color of law may be found when (A) the state is involved in the questioned activity, or (B) the private actor has assumed a state or public function. See *Greco v. Orange Memorial Hospital Corp.*, 513 F.2d 873, 878 (5<sup>th</sup> Cir. 1975). Among the significant factors to be considered are the private person's operation as an integral part of a comprehensive governmental program and his consequent receipt of substantial public funds. *Sams v. Ohio Valley General Hospital Assoc.*, 413 F.2d 826, 828 (4<sup>th</sup> Cir. 1969); *Simkins v. Moses H. Cone Memorial Hospital*, 323 F.2d 959, 967 (4<sup>th</sup> Cir. 1963). Applying these principles, I believe Dr. Pierce acted under color of state law.

In this case, the state's involvement is readily apparent. The questioned activity is the grant or denial of Medicaid benefits for fiscal reasons unrelated to a patient's health. Under the Medicaid statute, the state is responsible for ascertaining which women are entitled to receive Medicaid benefits for the delivery of their children. Because the state is involved in the activity under scrutiny, one criterion for applying s 1983 is satisfied.

Furthermore, the evidence discloses that Dr. Pierce assumed a state function. South Carolina does not contract directly with physicians to participate in Medicaid; rather, qualified doctors are free to accept Medicaid patients, if they choose. Under this arrangement, a pregnant woman can select a participating doctor of her choice, and the doctor can accept or reject the patient. Freedom of choice on the part of both physician and patient is assured as an essential part of the program. When a physician accepts a Medicaid patient, the state is not made aware of the relationship until the doctor's bill is presented to the state's agent (a private insurance company) for processing and payment. By these procedures the

state delegates much of its administrative responsibility for the operation of the Medicaid program to individual doctors. Therefore, a doctor who represents himself to the public as a qualified Medicaid practitioner assumes a state or public administrative function when he conditions the grant or denial of Medicaid benefits on requirements not connected with the patient's health.

Dr. Pierce was free to decline to treat any or all persons dependent on Medicaid. He opted to participate in the program and accepted patients entitled to receive Medicaid. He undertook an administrative function when he insisted for economic reasons unrelated to health that a patient otherwise entitled to the delivery of her child by the physician of her choice at Medicaid expense should be sterilized. Finally, as further indication of his operation as an integral part of a comprehensive governmental program, Medicaid paid Dr. Pierce more than \$60,000 during the time when the events giving rise to this suit occurred.

These facts and circumstances fully warrant the district judge's conclusion that Dr. Pierce was acting under color of state law. The nexus between the state and Dr. Pierce was sufficient to establish that his sterilization of Medicaid patients for economic reasons not related to their health can be fairly treated as the action of the state. In fact, Dr. Pierce was his patients' most important contact with the state program. Therefore, I would affirm the district judge's ruling that Dr. Pierce was acting under color of law within the meaning of 42 U.S.C. § 1983.

### ***Questions***

1. Why did the majority fail to find state action in *Walker*? What was the position of the dissenting justice on this issue? Which decision makes the most sense based on ethics and public policy?

2. Did the women in the *Walker* case really have a choice?

#### **1.4.1.2 Socio-Economic Status**

For a long time, [patient dumping](#)<sup>8</sup> was the dirty little secret practiced by hospitals. Patient dumping refers to the release of low-income patients prior to treatment to avoid being stuck with the cost of their care. Even though federal and state laws have been put in place to solve the problem, [hospitals continue to engage](#)<sup>9</sup> in the practice. If caught, they simply pay the fine. The next case gives a good explanation of how the anti-patient dumping statute was meant to function.

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<sup>8</sup> Andrea K. McDaniels, *What is patient dumping? Incident with woman at Baltimore hospital is hardly new*, The Baltimore Sun, at <https://www.baltimoresun.com/health/bs-hs-what-is-patient-dumping-20180111-story.html> (January 11, 2018).

<sup>9</sup> Gaby Galvin, *'Patient Dumping' Still a Problem Despite Law*, U.S. News & World Report, at <https://www.usnews.com/news/health-news/articles/2019-04-01/patient-dumping-still-a-problem-despite-federal-law> (April 1, 2019).



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***Owens v. Nacogdoches County Hosp. Dist.*, 741 F.Supp. 1269 (E.D. Tex. 1990)**

JUSTICE, DISTRICT JUDGE.

On August 3, 1987, Rebecca Owens, a sixteen-year-old indigent resident of Nacogdoches County whose pregnancy was full term, began to experience labor pains. She went to the emergency room at Memorial Hospital in Nacogdoches at approximately 3:00 p.m. After initial processing, she was taken to the Labor and Delivery room, where she was examined by Dr. Bruce Thompson, who was under contract with Memorial Hospital to provide obstetric and gynecological care to indigent pregnant women. After approximately one-half hour, Dr. Thompson discharged Ms. Owens with instructions that she go to John Sealy Hospital in Galveston, Texas—a facility approximately two hundred miles and four hours driving time away—to deliver her baby. On the night of August 3, this court, upon the petition of Rebecca Owen’s mother and next friend Betty Owens, issued a temporary restraining order enjoining Memorial Hospital from refusing to admit Rebecca Owens for the purpose of delivering her baby. On August 7, 1987, four days after the issuance of the temporary restraining order, Rebecca Owens was admitted to Memorial Hospital, where Dr. Bruce Thompson delivered her baby. Plaintiff has brought suit against the hospital and its board of directors in their official capacities, seeking damages, and declaratory and injunctive relief pursuant to 42 U.S.C. § 1395dd, the Emergency Medical Treatment and Active Labor Act, which forms part of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA).

It is clear beyond peradventure first, that no attempt was made by defendant hospital to comply with the transfer requirements of § 1395dd; second, that the sole reason for the instruction to Rebecca

<sup>10</sup> 2 *Investigators: Patient 'Dumping,'* CBS Chicago, at <https://www.youtube.com/watch?v=v7d8msvghUY> (Oct. 27, 2017).

Owens to go to John Sealy Hospital was that she was without funds; third, that this action constituted “dumping,” the very evil which § 1395dd was designed to prevent; fourth, that this incident was not an isolated one, but part of a pattern of dumpings of indigent patients that continued virtually until the time of trial in this civil action—a pattern caused by the unwillingness of defendant hospital to take the steps requisite for adequate performance of its statutory responsibilities for the care of indigent patients under both federal and state law; and finally, that what occurred to Rebecca Owens is capable of repetition, yet might evade review. Accordingly, judgment in this civil action will be entered for plaintiff, damages and attorney’s fees in accordance with the stipulation of the parties will be awarded to her, and defendant hospital will be permanently enjoined from refusing her delivery in any future pregnancy in violation of 42 U.S.C. § 1395dd.

## I Background—42 U.S.C. § 1395dd

### II

The Emergency Medical Treatment and Active Labor Act, sometimes referred to as the Anti-Dumping Act, was enacted by Congress as part of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), and codified at 42 U.S.C. 42 U.S.C. § 1395dd. The Act was a response to a national epidemic of “dumping,” the practice by hospitals of refusing emergency care to indigent patients outright or of transferring such patients, without regard to the necessity for stabilizing their condition, to other—typically public—hospitals (citations omitted).

The extent and severity of patient dumping has been increasing in recent years, and the act is the latest governmental attempt to deal with the phenomenon. Other attempts have been made both by Congress—notably in the Hill-Burton Act, which requires hospitals which have received certain Federal funds to provide necessary emergency care to all residents of the community served by the hospitals—and by various state legislatures, including that of the State of Texas.

The rationale behind the bill is plainly explained in the legislative history by the Report of the House Committee on the Judiciary:

In recent years there has been a growing concern about the provision of adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured. Although at least 22 states have enacted statutes or issued regulations requiring the provision of limited medical services whenever an emergency situation exists, and despite the fact that many state court rulings impose a common law duty on doctors and hospitals to provide necessary emergency care, some are convinced that the problem needs to be addressed by federal sanctions.

1986 U.S.Code Cong.Admin.News Vol. 3, p. 728.

To address these problems, 42 U.S.C. § 1395dd. requires that any hospital with an emergency room must provide a medical screening examination to any patient who appears complaining of an emergency medical condition. It further provides that such patients cannot be transferred to another facility in an unstable condition, and requires that such a transfer be “appropriate.” The guidelines for an appropriate transfer are that the physician certify in writing that the benefits of such transfer outweigh the risk, that the transferring hospital provide the medical treatment necessary to minimize the risk to the health of the patient (which includes, in the case of a woman in labor, the health of the child as well as the mother), that the transferring hospital send the relevant records in its possession

with the patient, that the transferring hospital obtain the assurance of the receiving hospital that the receiving hospital has space and facilities for the patient and has accepted the transfer, and that the transfer “is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures.”

In order to make clear what the responsibilities of the physician and the transferring hospital are, the act includes definitional sections which establish what is meant by an “emergency medical condition” and “active labor.” For the purpose of this civil action, the relevant section is 42 U.S.C. § 1395dd(e)(2), and particularly 42 U.S.C. § 1395dd(e)(2)(C):

(2) The term “active labor” means labor at a time at which—

(A) delivery is imminent,

(B) there is inadequate time to effect safe transfer to another hospital prior to delivery,  
or

(C) a transfer may pose a threat to the health or safety of the patient or the unborn child.

The definitional section of the act clearly establishes the basis for judging the acts of the physician and hospital. That is, the physician cannot, by a mere assertion that in his judgment neither an emergency medical situation nor active labor exists, evade or negate the plain intent of the statute. To hold otherwise would render the statutory scheme merely precatory, which, as the above citation of the history of the act makes clear, is not what Congress intended.

The act provides for a variety of sanctions to enforce its provisions, including termination or suspension of the defendant hospital’s Medicare provider agreement, civil monetary penalties, and the establishment of causes of action for both patients who are dumped and hospitals which receive dumped patients. The basis for this civil action is the first of the civil enforcement sections, § 1395dd(d)(3)(A):

(A) Personal harm. Any individual who suffers personal harm as a direct result of a participating hospital’s violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

The cause of action established by this section is plainly a Federal one, cognizable in a United States District Court. *Bryant v. Riddle Memorial Hospital*, 689 F. Supp. 490 (E.D.Pa. 1988); *Stewart v. Myrick*, 731 F. Supp. 433 (Kansas 1990). The statute permits a patient injured by dumping to recover for her own injuries, and essentially to vindicate the purpose of the statute, which as it was described by Judge Newcomer in his scholarly discussion of Congressional intent, is to “establish a series of federal guidelines which Medicare hospitals having emergency medical care must follow to prevent the problem of patient dumping.” *Bryant v. Riddle Memorial Hospital*, 689 F. Supp. 490, 493 (E.D.Pa.1988). Accordingly, this court has federal question jurisdiction over this civil action, and Rebecca Owens has standing to maintain it.

## II Narrative of Events

Rebecca Owens, a sixteen-year-old indigent female resident of Nacogdoches County, was pregnant with her first child in 1987. During the course of her pregnancy she received pre-natal care and

counseling from the East Texas Health Services Clinic in Lufkin, Texas, under the auspices of the Maternal and Infant Health Improvement Act (M.I.H.I.A.) program, a program established by the State of Texas to provide such services for indigent, and especially adolescent, expectant mothers.

All pertinent records concerning Rebecca's pre-natal care were turned over to the Owens family by the clinic at the end of July, 1987. Further, the East Texas Health Services clinic advised the Owensens "from day one that [Rebecca] could go to any county hospital," to deliver her child. Testimony of Betty Owens.

On the afternoon of August 3, 1987, Rebecca Owens began to experience labor pains. At approximately 3:00 p.m., she went to the emergency room at Memorial Hospital. After initial processing, she was taken to the Labor and Delivery room, where she was examined by Dr. Bruce Thompson.

There are two factual controversies about this interview. Rebecca Owens asserted in her testimony that she gave the physician her M.I.H.I.A. records, and that she never indicated a desire to go to John Sealy Hospital to deliver her child. Testimony of Rebecca Owens. Dr. Thompson testified that no records were given him, and that Rebecca Owens gave him to understand that she intended to drive to John Sealy Hospital and "was coming to the hospital for me to make a determination on whether or not it would be relatively safe for her to go" to Galveston. Deposition of Dr. Bruce Thompson, p. 73. Certain hospital records were also introduced which would seem to support Dr. Thompson's version of events, as would the testimony of Barbara Davidson, the admitting nurse. However, since, as noted *infra*, a grave suspicion attaches to the authenticity of one of these hospital records and to Ms. Davidson's credibility, since Rebecca Owens's actions are entirely inconsistent with Dr. Thompson's version of the conversation and entirely consistent with her own version, and since—considering their relative claims in the light of the consistency of their testimony and their respective demeanor—the court finds Rebecca Owens a more credible witness than Dr. Thompson, the court finds it established as a matter of fact that the M.I.H.I.A. records were given to the hospital, and that Rebecca Owens asked not to be shipped two hundred miles to Galveston, but rather to be admitted to deliver her baby at the hospital at which she presented herself.

In the course of his examination, Dr. Thompson relied upon the notes of the nurse who had made the preliminary examination for his conclusion that her water bag had not burst and her membranes were intact. He did not check this conclusion by performing an acidity test, a test which by his testimony would have taken "minutes" and cost "a few dollars." Deposition of Dr. Bruce Thompson, pp. 195, 253. The whole of his instruction to Rebecca Owens was to go to Galveston, to the University of Texas Medical Branch at John Sealy Hospital, and not to speed getting there.

Dr. Thompson's diagnosis on August 3, 1987, was that Rebecca Owens was in early, latent labor. Deposition of Dr. Bruce Thompson, p. 145. Under cross-examination, Dr. Thompson repeatedly admitted that Rebecca Owens was not in false labor. Deposition of Dr. Bruce Thompson, pp. 242, 244.

Dr. Thompson did not call John Sealy Hospital to alert them that Rebecca Owens was on her way, and to make certain that John Sealy had a bed for her and was willing to accept her. He did not write a transfer memo, listing in writing his reasons for judging that the transfer's benefits outweighed its risks. He did not provide any medical treatment to minimize the risks to the mother and baby, unless one counts as medical treatment his advice that Rebecca Owens not speed to Galveston. He did not offer, or provide, an ambulance and crew or any other necessary and medically appropriate life support measures. Indeed, when asked how she was to transport herself to Galveston, he shrugged his shoulders. He does not appear to have provided her with the medical records to give John Sealy

Hospital, which, even were one to accept his claim that he did not have the M.I.H.I.A. records, would have included those records generated in the emergency and labor and delivery room at Memorial on August 3, 1987.

After being told that she would not be admitted to the hospital, Rebecca Owens was in a state of some fear and confusion. She sat in the hallway at the hospital until approximately 5:30 p.m., when a nurse came up to her and told her she was supposed to be on her way to Galveston. At that point, she walked across the street to her mother's place of employment. According to Betty Owens, her daughter was "doubled over in pain." Testimony of Betty Owens. Thereafter she went to the office of East Texas Legal Services where she filled out some papers, including an application for pregnancy care. She then went to her mother's house, and subsequently to the home of Gary Dempsey, the father of her child. At some point during the afternoon, she and Geneva Dempsey, Gary Dempsey's aunt, timed her contractions. According to their calculations, the contractions were approximately 3 minutes apart.

That evening, Rebecca Owens and Gary Dempsey, who were apparently unaware that the efforts of East Texas Legal Services to obtain a temporary restraining order in this civil action were bearing fruit, went to the home of Gary Dempsey's grandfather, from whom they borrowed \$100.00 for the trip to Galveston, and departed for John Sealy Hospital in the middle of the night in a 1976 Pinto in bad condition. They arrived on the morning of August 4, 1987. At John Sealy, according to Rebecca Owens's testimony, the doctors examined her to see the extent of her dilation and had her walk around. She was told she would not be admitted because she was not dilated to three centimeters. The medical records of John Sealy Hospital reflect that she was in early labor, and that the fundal height of her baby—one of the measures by which the size of the baby in the womb is determined—was thirty-three centimeters.

While Rebecca Owens and Gary Dempsey were driving to Galveston, the temporary restraining order enjoining Memorial Hospital from refusing to deliver her child already referred to was issued. Dr. Thompson became aware of the temporary restraining order at midnight on August 3, but did not look at it until the following day. Deposition of Dr. Bruce Thompson, p. 151. He was, as a result of seeing the temporary restraining order, fearful of the possibility of a malpractice suit. He did not want to deliver Rebecca Owens. He admits to anger at the prospect of having to deliver Rebecca Owens. Deposition of Dr. Bruce Thompson, pp. 151–152.

Rebecca Owens became aware of the temporary restraining order after her return from Galveston. Her bag of water ruptured on August 7. She returned to Memorial that afternoon. Dr. Thompson administered Oxytocin to speed her contractions, and Christopher Dempsey was born at 5:52 p.m. on August 7, 1987. When Christopher was born, the records indicate a nuchal cord—that is, the umbilical cord was wrapped around his neck. According to Dr. Thompson, it is not certain whether the cord was around the baby's neck on August 3. Deposition of Dr. Bruce Thompson, p. 255.

According to the testimony of Rebecca Owens and Mamie Dempsey, the mother of Gary Dempsey, Dr. Thompson engaged in an abusive tirade against Rebecca Owens in the delivery room, denouncing her for involving a lawyer and a federal court. Dr. Thompson does not deny that the incident occurred, but avers that he has no memory of it. Deposition of Dr. Bruce Thompson, pp. 175–176. Considering the weight of the evidence and the relative credibility of the parties, the court finds it established as a matter of fact that Dr. Bruce Thompson engaged in the abusive and vilificatory language alleged.

As a result of the acts of Memorial Hospital and Dr. Bruce Thompson, Rebecca Owens asserts that she suffered great mental anguish and fear, both on the night of August 3 and 4 of 1987, during the birth

of her child, and thereafter, and remains gravely concerned as to whether she can deliver future children at Memorial Hospital. The court accepts the testimony of Rebecca Owens, and finds as a matter of fact that sending Rebecca Owens, a sixteen-year-old girl pregnant with her first child who was experiencing labor pains, to a hospital two hundred miles away in a 1976 Ford Pinto, did occasion her great fear, mental anguish, and emotional distress.

### III Transfer Requirements Under 42 U.S.C. § 1395dd

Defendants urge that Rebecca Owens was not “transferred” within the meaning of 42 U.S.C. § 1395dd. At first glance, this argument conflicts with the statutory language. The definitional section of the Anti-Dumping Act defines “transfer” as follows:

(5) The term “transfer” means the movement (including the discharge) of a patient outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly with) the hospital, but does not include such a movement of a patient who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

The contractual affiliation of Dr. Bruce Thompson and Memorial Hospital is uncontested. Dr. Thompson admits that he directed Rebecca Owens to go to Galveston, and the records so indicate. Rebecca Owens is not dead, and did not leave Memorial Hospital without permission on the night of August 3, 1987. That the order to go to Galveston constituted a transfer appears plain.

Defendants, however, appear to be of a different view. They contend that because Rebecca Owens was a M.I.H.I.A. patient, and because the University of Texas–Medical Branch at John Sealy Hospital in Galveston had, as Memorial Hospital did not, a contract to provide delivery services under M.I.H.I.A., Rebecca Owens was a patient of John Sealy Hospital; hence, they argue that the direction to go to John Sealy cannot be a transfer. The logic of the argument is best expressed in a colloquy between defendants’ counsel and Dr. Thompson:

Q. Was this transfer the night of August 3, 1987 a medical transfer?

A. Not—I felt—no, I don’t feel like it was.

Q. Whose patient was she the night of August 3, 1987?

A. She was a patient of the MIHIA program and a patient of John Sealy Hospital, Galveston.

Q. Well, you can’t transfer a patient from John Sealy Hospital to John Sealy Hospital, can you?

A. No, not technically, you can’t.

Deposition of Dr. Bruce Thompson, p. 226.

Contrary to defendants’ assertions, however, Rebecca Owens was not a patient of John Sealy Hospital on August 3, 1987. She had not presented herself for admission to John Sealy Hospital. She had come to Nacogdoches Memorial Hospital. She was obviously Memorial’s patient, and defendants’ artful quibbling on this point avails them nothing. The definition of “transfer” unquestionably encompasses the direction to proceed to Galveston.

This is yet clearer when one considers that Rebecca Owens had never been a patient of John Sealy Hospital. She had received no treatment or care at John Sealy Hospital. All her pre-natal care had



occurred at the East Texas Health clinic in Lufkin, Texas. The blanket equation that a M.I.H.I.A. patient was a high risk patient to be sent to Galveston on which Dr. Thompson relied had no necessary warrant in her case, and was, as he admitted, not based on his examination of her. Deposition of Dr. Bruce Thompson, p. 100.

Indeed, according to the written deposition of plaintiffs' expert witness Dr. David Smith, Chief Executive Officer and Medical Director for the community oriented primary care program at Parkland Memorial Hospital in Dallas, Texas, "the fact that Galveston, the University of Texas Medical Branch was the contractor under M.I.H.I.A. for the area around Nacogdoches does not justify a blanket statement that an individual must go to Galveston for delivery." Deposition of Dr. David Smith, p. 4. (It is found that Dr. Smith's testimony is particularly credible because he was involved in the effort to enact M.I.H.I.A., and has been associated with M.I.H.I.A. providers both in Brownsville, Texas and at Parkland.) Written Deposition of Dr. David Smith, p. 3.

Given that the order to go to Galveston was a transfer order, it is apparent that it violated all the standards set down for a transfer in the act, as the narrative of events has already noted. Dr. Thompson was, by his own admission, aware of the procedural and substantive requirements for a transfer, though uncertain that those were legal requirements. Deposition of Dr. Bruce Thompson, p. 171. He knew he was supposed to call the receiving hospital to get permission for the transfer. He knew he was supposed to make copies of the relevant records. He did, as a matter of routine, write a memorandum outlining the benefits versus the risks of a transfer. Yet he drafted no such transfer memorandum in the case of Rebecca Owens. Deposition of Dr. Bruce Thompson, p. 173. Nor does the record reflect that he took any other action which was required by 42 U.S.C. § 1395dd.

As to the requirement of providing adequate transportation for the transfer, it is uncontroverted that no transport was provided. At best, the defendants rely on a document which asserts that according to Rebecca Owens, she had a car. Even were one willing to accept the assertions of this document, a 1976 Ford Pinto with no medical equipment, whose only other occupant besides the patient is her boyfriend, is not the equivalent of an ambulance for the purposes of the Antidumping Act.

Dr. Pamela Schute, a board-certified obstetrician and gynecologist practicing at the Kaiser Permanente Health Maintenance Organization in Dallas, Texas, with previous experience in indigent health care in Alameda County, California, testified that the standard of care for appropriate transfer if a patient is suspected of being in labor would require a sterile delivery set and a person able to deliver the baby in an ambulance. Deposition of Dr. Pamela Schute, p. 19. This testimony is corroborated by Dr. Smith, who described the transport as "an inappropriate transport, which I can't even characterize as a medical transport. The best term is the one you've used legislatively, it's dumping." Oral Deposition of Dr. David Smith, p. 33. This testimony is found credible.

#### IV Reasons for the Transfer

Defendants offer two arguments as reasons for the transfer of Rebecca Owens on August 3, 1987. First, they argue that Rebecca Owens announced that it was her intent to go to John Sealy Hospital when she came to Memorial. Second, they argue that it was preferable for Rebecca Owens, because she was a M.I.H.I.A. patient, to deliver at John Sealy Hospital since it is a Level-III hospital with a neonatal unit. Neither of these arguments is availing.

Rebecca Owens, in both her direct and her cross-examination, repeatedly and strenuously denied having told anyone at Memorial Hospital that she was on her way to Galveston. Nor, despite the

assertions of defense counsel, is her testimony inconsistent with the previous deposition testimony. Deposition of Rebecca Owens, p. 25. Moreover, her testimony is entirely consistent with her actions on August 3. Had Rebecca Owens intended to go to Galveston, it would not have made sense for her to remain in the hallway of Memorial Hospital for two hours or to go to East Texas Legal Services to get an attorney, who first attempted to negotiate with the hospital and then sought a temporary restraining order. Hence, her testimony is deemed truthful. Under cross-examination, Dr. Bruce Thompson admitted that such actions indicated a desire to deliver at Memorial. Deposition of Dr. Bruce Thompson, pp. 73–74. He further admitted that it is not “a typical desire for a woman in labor to drive four hours away to deliver their baby.” Deposition of Dr. Bruce Thompson, p. 75. Rebecca Owens’s testimony is corroborated by that of her mother, to which reference has already been made, and that of Gary Dempsey.

Many of the defendants’ claims that—despite her testimony, the testimony of her mother and Gary Dempsey, and the inferences any person of ordinary common sense would make based on her actions on August 3, 1987—Rebecca Owens in fact wished to go to Galveston and asserted that she had adequate transportation to go to Galveston are based on a document labelled as an “OB outpatient observation record” for Rebecca Owens on August 3, 1987 and listed as part of Defendants’ Exhibit 1. (The same record is also listed as part of Plaintiff’s Exhibit 2.) However, as the cross examination of the nurse who alleged that she had prepared the document demonstrated, there are clear indications that the statements on which the defense relies were written in after the fact, and a very strong suggestion attaches that statements in this document were deliberately fabricated for the purposes of this litigation. Cross-examination of Barbara Davidson, R.N. Accordingly, the court gives no credence to the document, to the testimony which sought to authenticate it, or to any testimony based upon it.

Given the relative credibility of the witnesses and the inferences that may be drawn from the behavior of Rebecca Owens on August 3, 1987, the court finds that as a matter of fact, Rebecca Owens expressed no intent to go to Galveston, Texas to deliver her child, but rather requested that she be delivered at Memorial Hospital.

Defendants’ other principal argument is that the decision to send Rebecca Owens to Galveston was justified in light of the fact that the facilities of John Sealy Hospital, particularly the neo-natal unit, were more appropriate for Rebecca Owen’s delivery than those of Memorial Hospital. According to the testimony of Dr. Bruce Thompson, it was for this reason that he felt the benefits of sending Rebecca Owens to Galveston outweighed the risks of sending her.

Dr. Thompson testified that his conclusion that there were high risks associated with Rebecca Owens’s delivery was based on the fact that she had been a M.I.H.I.A. patient. Deposition of Dr. Bruce Thompson, p. 72. He further testified that had she not been a M.I.H.I.A. patient, he would not have sent her to Galveston. Deposition of Dr. Bruce Thompson, pp. 88–89.

When asked to list the risks he thought possible on the basis of the fact that Rebecca Owens was a M.I.H.I.A. patient which would have justified in sending her to Galveston, Dr. Thompson, after some hesitation, was able to list four problems: that there were problems that might be associated with poor nutrition; that there was a potential for Rebecca Owens to have a growth-retarded baby; that there was a possibility that Rebecca Owens might require a Caesarean section; and that it was possible that Rebecca Owens might have a sexually transmitted disease such as Acquired Immune Deficiency Syndrome (AIDS). Deposition of Dr. Bruce Thompson, pp. 96–98. Under further questioning, however, Dr. Thompson admitted that poor nutrition was not corrigible during labor. Deposition of Dr. Bruce Thompson, p. 100. He further agreed that he was fully capable of performing a Caesarean

section, had Rebecca Owens required one. Deposition of Dr. Bruce Thompson, pp. 103–104. He testified that, if a woman whom he thought likely to require a Caesarean section were to go into labor, it “would not be the thing to do” to have her drive to a hospital four hours away, because there were serious risks that, should the mother give birth on the road in such a situation, either the mother or the child, or both, could die. Deposition of Dr. Bruce Thompson, pp. 106, 111–112.

Dr. Thompson further admitted that he had no reason on August 3, 1987, to suspect that Rebecca Owens had AIDS, and knew of no reason related to AIDS to transfer Rebecca Owens. Deposition of Dr. Bruce Thompson, pp. 110–111. He finally relied on one possible risk which would justify a transfer to John Sealy Hospital—the possibility that Rebecca Owens’s child was a growth-retarded, or small for gestational age (SGA) baby. On further examination, however, Dr. Thompson testified that Memorial Hospital could have provided the nutrition necessary to counteract growth retardation, and that he could have competently delivered an SGA baby at Memorial. Deposition of Dr. Bruce Thompson, pp. 103, 116. He further testified that it would be better for an SGA baby to be born at Memorial Hospital than in a car bound for Galveston. Deposition of Dr. Bruce Thompson, p. 247. He stated at least twice that SGA was “not a concern of [his] back August 3rd” and was not a medical reason to transport on August 3, 1987. Deposition of Dr. Bruce Thompson, pp. 131, 133. Finally, he admitted that in fact Rebecca Owens had not required the services of the neo-natal clinic at John Sealy Hospital. Deposition of Dr. Bruce Thompson, p. 252.

Weighed against Dr. Thompson’s claim of the benefit of transfer, which boils down to a statement that John Sealy Hospital “had a little bit more to offer” than Memorial, are the risks identified by Drs. Schute, Smith, and F. Barry Roberts as well as Dr. Thompson himself. Deposition of Dr. Bruce Thompson, p. 164.

As Dr. Thompson testified, “You don’t want [women] delivering in the car if you can help it.” Deposition of Dr. Bruce Thompson, p. 183. According to Dr. Smith, the risks of in-travel delivery include separation of the placenta, drop in fetal heart rate, aspiration by the fetus of the meconium or stool, and nuchal cords. Deposition of Dr. David Robert Smith, pp. 17–18. Dr. Pamela Schute testified that there were also such dangers as cord prolapse and hemorrhaging. Deposition of Dr. Pamela Schute, p. 12. Dr. Thompson agreed that in-transit delivery would pose such risks as hemorrhaging, cord prolapse, separation of the placenta, and the death of both mother and child. Deposition of Dr. Bruce Thompson, pp. 176–177. Dr. F. Barry Roberts, Dr. Schute, and Dr. Smith all testified that the risks of a private car transport from Nacogdoches to Galveston far outweighed any possible benefit of the transfer. Deposition of Dr. F. Barry Roberts, pp. 56–57; Deposition of Dr. Pamela Schute, pp. 10, 12–13, 16, 66, 72; Oral Deposition of Dr. David Robert Smith, pp. 16–18, 33. Dr. Smith analogized sending a woman in the situation of Rebecca Owens on August 3, 1987 to a hospital four hours away to playing Russian Roulette. Oral Deposition of Dr. David Robert Smith, p. 18. The court concurs, and finds this analogy apt.

The explanations proffered by Dr. Thompson for the transfer are best described as inadequate, stumbling, and incredible. The assertion that the risks associated with sending a frightened adolescent girl on a four-hour trip by private car are markedly less severe than those of admitting her for delivery, when the only serious medical risk the physician identifies is stunted growth—a risk which, under further questioning, he then admits was not his concern at the time—is entirely unworthy of credence.

The relevant standard to be considered in judging whether the actions of Dr. Thompson as an agent of Memorial Hospital violated the Antidumping Act is the definitional section already cited herein, 42 U.S.C. § 1395dd(e)(2)(C), whether “a transfer may pose a threat to the health or safety of the patient

or unborn child,” since according to the testimony of Dr. Bruce Thompson, Rebecca Owens was in early or latent labor when he saw her on August 3, 1987. Deposition of Dr. Bruce Thompson, p. 145. Dr. Thompson repeatedly agreed that Rebecca Owens’s condition was labor, not false labor. Deposition of Dr. Bruce Thompson, pp. 242, 244.

Much of the defendants’ case rests on the fact that Rebecca Owens did not deliver her child for four days. It is, however, clear from the context of Dr. Schute’s testimony that she means that the birth of Rebecca Owens’s child was not imminent. As the court attempted to make clear to the defense in denying its motion for summary judgment, imminent childbirth does not exhaust the statutory meaning of active labor pursuant to 42 U.S.C. § 1395dd. When it is established, as it is by Dr. Thompson’s testimony, that the woman was in labor, the inquiry turns to the questions of whether there was sufficient time for a transfer, and most pertinently to the question of whether the transfer posed undue risk to mother and child.

In this case, the risks of the transportation were severe. According to the testimony of all the medical witnesses, including Dr. Thompson, there was a risk that, had the baby been born on the side of the road, both mother and child might have died. The transfer was wholly without supervision; so far as can be determined, nobody in the 1976 Pinto knew the faintest thing, in the familiar words of Prissie, “about birthing babies.” See M. Mitchell, *Gone With The Wind*. Had the child been born in the car, and had the cord been wrapped around its neck on August 3, as it was on August 7, Christopher Dempsey might well have strangled at birth.

There is no reason to recite yet again the dangers which all the physicians agreed would have attended a birth somewhere on the two hundred miles of highway between Nacogdoches and Galveston. They are all a matter of record. Not even Dr. Thompson, when pressed, denies that they exist. It is found that, as a matter of fact, the transfer by private car of plaintiff Rebecca Owens from Nacogdoches to Galveston while she was undergoing labor pains on the night of August 3, 1987, did pose significant and wholly unnecessary risks to both Rebecca Owens and her unborn child.

Moreover, it is transparent that the sole reason for the illegal transfer was Rebecca Owens’s indigency. Dr. Thompson repeatedly admitted that, had Rebecca Owens not been a M.I.H.I.A. patient, she would not have been sent to Galveston. Deposition of Dr. Bruce Thompson, pp. 88–89. He was aware that Rebecca Owens’s status as a M.I.H.I.A. patient indicated her indigency. Deposition of Dr. Bruce Thompson, p. 80. He contended that her status as a M.I.H.I.A. patient gave him a medical basis for his determination that she was a high-risk patient who ought to be sent to Galveston. Deposition of Dr. Bruce Thompson, p. 72. However, when he was pressed, his reasons became flimsier and flimsier, as already noted. He admits that he has never transferred a paying patient by private car. Deposition of Dr. Bruce Thompson, pp. 154–156.

In her deposition, Dr. Pamela Schute asked, “What was it about Rebecca Owens that she had to go four hours away?” Deposition of Dr. Pamela Schute, p. 67. It is found, as a matter of fact, that the reason for the transfer was that Rebecca Owens was without funds. The flimsiness of the pretense that there was any reason other than her poverty to send the plaintiff to Galveston is apparent.

Further, since under substantive Texas personal injury law, which governs pursuant to 42 U.S.C. § 1395dd, proof of physical injury is not a prerequisite for recovery for negligent infliction of mental anguish, *St. Elizabeth Hospital v. Garrard*, 730 S.W.2d 649 (Tex. 1987), and since it has already been found that the decision to transfer her to Galveston caused Rebecca Owens severe mental anguish, it

is found that the violation of the Antidumping Act by Memorial Hospital through its agents Dr. Bruce Thompson caused Rebecca Owens personal injury within the meaning of the statute.

Pursuant to the joint stipulation of the parties regarding damages entered into on the morning trial commenced, the court assesses against Memorial Hospital the sum of \$25,000.00 in damages and the sum of \$25,000.00 in attorneys' fees.

#### V Declaratory and Injunctive Relief

By its terms, the Anti-Dumping Act provides not only for damages for personal injury, but also for "such equitable relief as is appropriate." Accordingly, plaintiff Rebecca Owens has moved for injunctive relief as well as declaratory relief pursuant to the 28 U.S.C. § 2201.

Defendants demur, arguing that the relief sought is based upon speculation, and that there is no "real or immediate threat" of future injury by the defendants. *City of Los Angeles v. Lyons*, 461 U.S. 95, 103 S.Ct. 1660, 75 L.Ed.2d 675 (1982). The defendants argue that, since Rebecca Owens is not now pregnant, she has no standing to maintain her claims and there is no justiciable controversy in this regard.

Defendants' argument is unavailing. As plaintiff correctly points out, the appropriate standard here is whether the complained of acts are capable of repetition, yet may evade review. Given that the wrongs sought to be addressed by the Antidumping Act are precisely not continuing but episodic, since that is the nature of emergency medical conditions and of childbirth, it simply does not make sense to assert that Rebecca Owens ceased to have standing for equitable relief when she gave birth. To so hold would render the inclusion of equitable relief in the statute mere surplusage. *See Maziarka v. St. Elizabeth Hospital*, 1989 WL 13195, 1989 U.S. Dist. Lexis 1536.

In any event, defendants are wrong as a matter of fact regarding the claim that plaintiff has not shown a real and immediate threat of future injury. Plaintiff's evidence demonstrates a long-standing pattern of patient dumping, caused by staffing policies that in the opinion of a series of medical experts would inevitably lead to standards of care at Memorial Hospital that patently did not meet state or federal statutory requirements. Bluntly stated, Memorial Hospital has callously and negligently allowed a situation to develop in which all emergency obstetric and gynecological services to indigent patients—an enormous and ever-increasing load—have been left to on-call private physicians like Dr. Thompson, and the dumping of pregnant women has been the inevitable result.

Plaintiff's counsel introduced testimony from Vera Brown, Lacrete Mergerson, Wanda Saxton, and Werdner Simmons which indicated a long-standing pattern of dumping from 1984 on; that testimony was essentially unrefuted by Memorial Hospital. The rebuttal testimony of Elaine Salisbury, who first became aware of this civil action during the course of its trial, indicated that this practice continued through 1989. There was no serious contest as to the credibility of these witnesses, and their statements are accepted as true. It is found, as a fact, that for at least five years, Memorial Hospital has flagrantly been engaged in patient dumping.

The evidence given by plaintiff's expert Dr. F. Barry Roberts, who practiced for nine and one-half years at Memorial Hospital, that Memorial has been continuously obstructionist whenever physicians attempted to bring the problem of indigent health care to the attention of the Board, is also found credible. Deposition of Dr. F. Barry Roberts, pp. 12–17, 24, 25, 27, 29–30, 47. The weight of the evidence—especially considering the fact that when this civil action came on for trial, a private

practitioner was the only OB–GYN delivering poor babies at Memorial—convincingly establishes a disturbing pattern of negligent behavior on the part of the administrators of Memorial Hospital which has inevitably led to the pattern of patient dumping. Deposition of Dr. F. Barry Roberts, p. 27; Cross–Examination of Ronnie Horn.

In the light of this pattern of either negligent or deliberate flouting by Memorial Hospital of its obligations under the Antidumping Act, plaintiff Rebecca Owens has amply demonstrated that she has standing, and that there is a real threat of injury to her. The complained of acts are capable of repetition, and indeed have been repeated. Plaintiff is awarded permanent injunctive relief to prevent these egregious acts from evading review in the future.

## VI Conclusion

The purpose of the Anti–Dumping Act is to end the national scandal, as Senator Durenberger described it, of “rejecting indigent patients in life threatening situations for economic reasons alone,” 131 Cong.Rec. at 513903 (daily ed. October 23, 1985), *cited in* Stewart v. Myrick, 731 F.Supp. 433 (Kansas 1990); see also Bryant v. Riddle Memorial Hospital, 689 F.Supp. 490 (E.D.Pa. 1988).

By terms of the Antidumping Act, hospitals with emergency facilities cannot deny those facilities to the poor. They cannot shrug their shoulders and send children in rickety cars on four-hour drives, simply because they do not make the same money for treating such children as they do for paying customers. They may not wantonly turn their backs on the indigent.

## FINAL JUDGMENT

In accordance with the findings of fact and conclusions of law set forth in the memorandum opinion filed contemporaneously herewith, it is hereby

### 1.4.1.3 EMTALA

EMTALA requires that a patient must be screened in order to determine if the patient has an emergency medical condition or is in active labor. An emergency medical condition is 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 one of the following: (1) placing the patient’s health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. Active labor refers to labor at a time when there is inadequate time to effect safe transfer to another hospital prior to delivery or a transfer may pose a threat to the health and safety of the patient or the unborn child. A patient diagnosed with an emergency medical condition or active labor must be treated or transferred. Prior to transferring the patient, the healthcare provider must stabilize the patient by providing such medical treatment of the condition as may be necessary to assure, within a reasonable probability, that no material deterioration of the condition is likely to result from a transfer. The patient can be transferred without being stable if the patient requires the transfer or the physician certifies in writing that the medical benefits of the transfer outweigh the increased risks to the patients and the receiving hospital is capable of providing the needed treatment and has agreed to the transfer. The transfer must occur with appropriate personnel and transportation, including appropriate life support measures.

### *Notes, Questions, and Problems*

1. What is the rationale behind the Emergency Medical Treatment and Active Labor Act (EMTALA)?
2. What are the requirements of EMTALA?
3. What are the guidelines for an appropriate transfer under EMTALA?
4. Which of the following incidents would trigger EMTALA?
  - a) Peggy is six months pregnant. She cannot afford prenatal care, so she goes to the hospital to seek treatment.
  - b) Danna's water breaks while she is shopping for groceries and the ambulance brings her to the hospital.
  - c) Mary is five months pregnant and she shows up at the hospital with severe bleeding.
  - d) Jackie arrives at the hospital with mild contractions.
5. What are the sanctions for violating EMTALA? Is there a private cause of action available?
6. What are the factual controversies that were present in the case?
7. How is transfer defined under EMTALA? Why did the defendants argue that the plaintiff was not transferred under the provisions of the statute? What arguments do the defendants make as reasons for the transfer? What did the court conclude was the sole reason for the transfer?

#### **1.4.1.4 Disability**

##### ***Howe v. Hull***

JOHN W. POTTER, DISTRICT JUDGE.

This cause was brought by the plaintiff as representative of the Estate of Fred Charon under the Americans with Disabilities Act (ADA), 42 U.S.C. § 12101 et. Seq., the Federal Rehabilitation Act of 1973 (FRA), and the Emergency Medical Treatment and Active Labor Act (EMTALA). Plaintiff also brought supplemental state law claims of intentional and negligent infliction of emotional distress. This Court, by a Memorandum and Order dated May 26, 1994, granted defendant Hull's motion for summary judgment on plaintiff's EMTALA and negligent infliction of emotional distress claims, and

denied the motion as to the ADA, FRA and intentional infliction of emotional distress claims. In that same order, the Court granted defendant Memorial Hospital's motion for summary judgment on plaintiff's negligent infliction of emotional distress claim, and denied the motion as to plaintiff's ADA, FRA, EMTALA, and intentional infliction of emotional distress claims.

A trial was held between May 31, 1994 and June 14, 1994. Plaintiff's remaining FRA, EMTALA, and intentional infliction of emotional distress claims were tried to a jury, and plaintiff's ADA claims were tried to the bench by stipulation of the parties and pursuant to the applicable provisions of the ADA. On June 14, the jury returned a special verdict in favor of the defendants on the EMTALA and intentional infliction of emotional distress claims and against both defendants on the FRA claim, awarding plaintiff \$62,000.00 compensatory damages. The jury also awarded punitive damages in the amount of \$150,000.00 against defendant Hull and \$300,000.00 against defendant Memorial Hospital.

Plaintiff brought suit in this action alleging that, on April 17, 1992, the defendants refused to provide him medical treatment because he was infected with HIV. The original plaintiff in this case, Fred L. Charon, is deceased, and plaintiff Howe was substituted as the representative of Mr. Charon's estate on June 10, 1993. Defendant Memorial Hospital is the facility where plaintiff sought treatment, and defendant Hull was the on-call admitting physician at Memorial Hospital when plaintiff sought treatment.

On April 17, 1992, Charon and Howe were travelling through Ohio, on their way to vacation in Wisconsin. Mr. Charon, a resident of Portland, Maine, was HIV-positive and had AIDS at the time. At approximately 9:00 on the morning of the April 17, Charon took a prescription medication called floxin which he had not taken before.

Charon had a severe reaction to the floxin. Charon vomited, began feeling light-headed, had difficulty grasping objects, and suffered from a high fever, a rash, and extreme redness of the skin. Howe and Charon exited the highway due to Charon's condition. After consulting via the telephone with Charon's treating physician in Maine, they sought the nearest hospital. Howe conversed with Memorial Hospital personnel on the telephone and then drove Charon to Memorial Hospital and sought treatment in the emergency room.

Dr. Mark Reardon examined Charon in the emergency room. Dr. Reardon found that Charon was suffering from fever, severe erythema (redness of the skin) over virtually his entire body; erythematous conjunctivae; hot, painful and tender skin; arthralgia (painful joints); testicular pain; and headache. Dr. Reardon determined that Charon was suffering from a very serious allergic drug reaction and that he should be admitted to Memorial Hospital.

Dr. Reardon worried that this very severe drug reaction may ultimately develop into toxic epidermal necrolysis (TEN). Despite the fact that Dr. Reardon at the time only considered TEN to be a possibility, he ultimately entered "probable toxic epidermal necrolysis" into Charon's medical record. Although Memorial Hospital had the capability to effectively treat a severe allergic drug reaction and, in fact, did treat patients suffering from allergic drug reactions on a fairly routine basis, Memorial Hospital had neither the necessary equipment nor medical specialists necessary to effectively treat TEN.

After determining that Charon needed to be admitted to Memorial Hospital, Dr. Reardon telephoned Dr. Hull to obtain the necessary approval for Charon's admission. Dr. Hull, a physician with staff privileges at Memorial, was the hospital's on-call admitting physician. As the on-call admitting physician, Dr. Hull was in a position of authority at Memorial Hospital and was responsible for



determining whether patients could be admitted from the emergency room into the hospital. Dr. Hull had the authority and discretion to admit Mr. Charon to Memorial Hospital for treatment.

Dr. Reardon told Dr. Hull that Charon was HIV-positive and was suffering from a severe allergic drug reaction. Dr. Reardon also told Dr. Hull that this condition was not related to Charon's HIV or AIDS status. An argument ensued between the two physicians over whether Charon's condition had progressed from HIV-positive to full-blown AIDS. Dr. Hull was concerned that Charon had progressed to AIDS, because he felt that patients with AIDS should be treated in special AIDS programs.

Dr. Reardon told Dr. Hull that Charon's condition was "not related to AIDS or HIV infection in any way." Despite this, Dr. Hull remained primarily concerned about Charon's AIDS/HIV status. Dr. Hull never asked Dr. Reardon why he was concerned about the possibility of TEN. During the course of their discussion, Dr. Hull told Dr. Reardon that "[i]f you get an AIDS patient in the hospital, you will never get him out." Dr. Reardon subsequently recorded this statement in Charon's medical records.

Dr. Hull ultimately refused to admit Charon to Memorial Hospital. Dr. Reardon could have attempted to contact other physicians with staff privileges at Memorial Hospital in order to get Charon admitted; however, since it was a Friday evening, Reardon doubted whether he could promptly locate an admitting physician who was not "on-call." Due to the severity of Charon's drug reaction, Reardon felt he had to get the patient admitted to a hospital for care quickly. Consequently, acting on the suggestion of Dr. Hull, Dr. Reardon contacted the Medical College of Ohio (MCO) and arranged to have Charon transferred and admitted to that facility.

Dr. Reardon called Dr. Chris Lynn at MCO and asked if Lynn would accept admission of a patient with a severe drug reaction. Dr. Reardon never mentioned to Dr. Lynn that Charon possibly had the very rare TEN or that TEN was the reason for the transfer. Dr. Reardon also did not ask Dr. Lynn whether MCO had the capability to treat TEN. Dr. Reardon did tell Dr. Lynn that he had to transfer Charon because he "could not find a physician who was able to do it, to admit the patient and the concern was raised because he was HIV positive, that was the reason he could not be admitted to Memorial Hospital."

When Dr. Reardon returned from his conversations with Dr. Hull and Dr. Lynn, he explained to Charon and Howe that Charon would have to be transferred to MCO. Dr. Reardon never mentioned the possibility that Charon might have TEN, nor told Charon that TEN was the reason for the transfer. Dr. Reardon did state to Charon and Howe that "this is a small community and the admitting doctor does not feel comfortable admitting him."

At the end of his shift in the emergency room, Dr. Reardon recorded Dr. Hull's statement about AIDS patients in the official emergency room records. Dr. Reardon also recorded that Mr. Charon's allergic drug reaction was "not related to AIDS or HIV infection in any way."

Dr. Hull did not come to the Memorial Hospital emergency room, a four-mile trip from his home, until after Dr. Reardon's shift had ended and arrangements for Charon's transfer had been made. When Dr. Hull did eventually come to the emergency room, he neither examined Charon, looked at him nor reviewed his chart, despite the fact that he knew that Charon was waiting in the emergency room and had not yet been transferred to MCO.

While at MCO, Charon was examined by Dr. Roger MacArthur, an infectious disease specialist. Dr. MacArthur testified that Charon suffered from "a very simple drug reaction." Dr. MacArthur was

“surprised” that he was even consulted on the case because Charon’s condition was very “straightforward.” Dr. MacArthur further stated that “[s]imply because [Charon] was HIV-positive doesn’t mandate a consult from an infectious disease specialist.”

Dr. Hull testified that the appropriate treatment for someone with TEN was at a hospital with a specialized burn unit, and that a TEN patient should be under the care of a dermatologist. Memorial Hospital had neither a burn unit nor a staff dermatologist. However, MCO, the hospital Dr. Hull recommended transferring Charon to, also did not have a burn unit. Charon was also never examined by a dermatologist during the course of his treatment at MCO.

When treated at MCO, Charon was treated for a simple, albeit severe, allergic drug reaction. Mr. Charon did not have TEN. He had a simple allergic drug reaction that was unrelated to and uncomplicated by his HIV/ AIDS status. Memorial Hospital had the capability on April 17, 1992 to treat patients suffering from allergic drug reactions and did routinely treat patients suffering from allergic drug reactions.

In this order, the Court will make its findings of fact and conclusions of law. Since the FRA the ADA claims share common factual questions, the Court is bound by the jury’s determination on those common factual issues as memorialized on the special verdict forms. In re Lewis, 845 F.2d 624 (6<sup>th</sup> Cir. 1988) The Court observes that, had this case been tried solely to the bench, it would independently make these same factual findings. In accordance with Fed.R.Civ.P. 52(a), the Court has considered and weighed all of the evidence and resolved any conflicts therein and now makes its independent findings of fact and conclusions of law.

#### Findings of Fact

1. Defendant Memorial Hospital is a hospital that employed more than 25 employees and had gross receipts of more than \$1,000,000.00 for each year from 1991 to 1994.
2. Memorial Hospital delegated to Dr. Hull the authority to admit or not admit patients to Memorial Hospital.
3. On April 17, 1992, defendant Hull was a physician with staff privileges at Memorial Hospital. Defendant Hull’s refusal to admit Charon was within the ambit of his discretion as on-call admitting physician. The refusal to admit Charon was not a result of an institutional policy of refusing to treat AIDS patients; it was, however, within the scope of his authority as on-call admitting physician.
4. Charon did not have, nor was he ever diagnosed with, TEN. Charon had a simple, albeit severe, allergic drug reaction. The articulated reason for the refusal to admit, the possible TEN “diagnosis,” was a pretext.
5. Memorial Hospital had the capability to treat Charon’s allergic drug reaction.
6. Fred Charon had AIDS on April 17, 1992. AIDS is a fatal disease which substantially limits one or more major life activities.
7. On April 17, 1992, the defendants refused to admit Charon for treatment to Memorial Hospital.

8. Charon's AIDS/HIV status was the motivating factor in the defendants' refusal to admit and treat him at Memorial Hospital.

### Conclusions of Law

1. This Court has federal question jurisdiction over this action brought under the Americans with Disabilities Act (ADA). 28 U.S.C. § 1331; 42 U.S.C. § 12101 et. seq.

2. The ADA prohibits discrimination based upon disability by places of public accommodation:

No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to) or operates a place of public accommodation.

42 U.S.C. § 12182(a).

3. Fremont Memorial Hospital, as a public accommodation that employed more than 25 employees and had gross receipts in excess of \$1,000,000.00 in 1992, was subject to the ADA on April 17, 1992.

4. An individual may be subject to personal liability under the ADA. Given the broad language and remedial purposes of the ADA, allowing individual liability in some circumstances under 42 U.S.C. § 12182(a) is consistent with both the plain language of the statute and congressional intent. To hold differently would allow individuals with both the authority and the discretion to make decisions based on a discriminatory animus to violate the ADA with a degree of impunity not envisioned by Congress. See *United States v. Morvant*, 843 F.Supp. 1092 (E.D.La.1994) (allowing individual liability for the operator of a dental office under the ADA); *EEOC v. AIC Security Investigations, Ltd.*, No. 92C7330; 1993 WL 427454 at 9 (N.D.Ill. Oct. 21 1993) (“[a]bsent a clear and express statutory directive to the contrary, this court does not believe that the remedial purposes of the ADA were intended to relieve from personal liability those supervisory employees committing discriminatory acts”); *Vakharia v. Swedish Covenant Hospital*, 824 F.Supp. 769, 784-86 (N.D.Ill. 1993) (personal liability must be based on individual acts distinct from institutional procedure).

5. This Court holds that, under 42 U.S.C. § 12182(a), an individual may be liable as an operator of a public accommodation where (a) he or she is in a position of authority; (b) within the ambit of this authority he or she has both the power and discretion to perform potentially discriminatory acts; and (c) the discriminatory acts are the result of the exercise of the individual's own discretion, as opposed to the implementation of institutional policy or the mandates of superiors. See *Memorandum and Order* of this Court of May 26, 1994, pp. 12–14. See also *Caparts Distribution Center, Inc., v. Automotive Wholesaler's Ass'n of New England, Inc.*, 37 F.3d 12, 15-19 (1<sup>st</sup> Cir. 1994) (broadly interpreting Title I & III of the ADA, and holding that, under Title I, a health insurer may be an “employer” under the ADA where the insurer functions as an employer by controlling an important aspect of employment or where insurer existed solely for the purpose of allowing employer to delegate potentially discriminatory decisions to the insurer).

6. On April 17, 1992, Dr. Hull “operated” Memorial Hospital within the meaning of the ADA. He was in a position of authority at Memorial; he was a Vice–Chief of Staff; the Medical Director of Special Services; and, as the on-call admitting physician, had the authority and discretion to admit Charon to

Memorial for treatment. Further, Dr. Hull's decision regarding Charon was not the implementation of an institutional policy at Memorial.

7. Memorial Hospital is liable under the ADA for Dr. Hull's actions on April 17, 1992 because it explicitly delegated the authority of on-call admitting physician to him. *See Clark v. Southview Hospital*, 68 Ohio St.3d 435, 628 N.E.2d 46 (1994).

8. Dr. Hull's actions in operating Memorial Hospital on April 17, 1992 are governed by the effective date applicable to Memorial Hospital. Therefore, Dr. Hull was subject to the ADA's non-discrimination mandate on April 17, 1992.

9. The fact that Dr. Reardon did not attempt to find another physician who might have been willing to admit Charon to Memorial Hospital is irrelevant to this action. Given the circumstances, Dr. Reardon felt that his chosen course of action would get Charon admitted to and treated by a hospital most expeditiously. Under the emergency room circumstances, Dr. Reardon did not have to conduct a plebiscite of Memorial Hospital physicians. Further, this suit is between plaintiff and the defendants, not plaintiff and Dr. Reardon.

10. There are three criteria plaintiff must meet in order to establish a prima facie case of discrimination under the ADA:

- a) the plaintiff has a disability;
- b) the defendant discriminated against the plaintiff;
- c) the discrimination was on the basis of the disability.

42 U.S.C. § 1282(a) & 42 U.S.C. § 12182(b).

11. A disability is defined as "a physical or mental impairment that substantially limits the person in one or more major life activities." 42 U.S.C. § 12102(2)(A). AIDS and HIV infection are both disabilities within the meaning of the ADA. *T.E.P. v. Leavitt*, 840 F.Supp. 110, 111 (D.Utah 1993); 28 C.F.R. § 36.104(1)(B)(ii).

12. Discrimination in public accommodation can take the form of the denial of the opportunity to receive medical treatment, segregation unnecessary for the provision of effective medical treatment, unnecessary screening or eligibility requirements for treatment, or provision of unequal medical benefits based upon the disability. 42 U.S.C. § 12182 (b)(1)(A)(i), § 12182(b)(1)(A)(iii), § 12182(b)(2)(A)(i), § 12182(b)(1)(A)(ii).

13. The ADA's public accommodation provision prohibits discrimination "on the basis of disability." 42 U.S.C. § 12182 (a). To prove that the discrimination was "on the basis of" Charon's disability, plaintiff must prove that Charon's disability was a motivating factor in the decision not to admit him to Memorial Hospital. *See Wessel v. AIC Security Investigations, Ltd.*, No. 92 C7330, 1993 WL 22687 (jury instructions) (N.D.Ill.1993), *reprinted in* 31 Illinois Labor and Employment Law Bulletin (Sept.1993) (jury required to find that plaintiff's "disability was a motivating factor in the decision to discharge him."). *See also* H.R.Rep. No. 485 (II), 101st Cong., 2nd Sess. 86 (1990), U.S. Code Cong. & Admin. News 1990, pp. 267, 368 ("[t]he existence of non-disability related factors does not immunize defendants in the ADA cases and the entire procedure must be reviewed to determine if the disability was improperly considered") (citations omitted).

14. Nothing in the ADA compels a health care provider to treat an individual who requires care beyond the provider's ability or expertise. A provider may refer an individual with a disability to another health care provider if, in the normal course of its operations, "the referring provider would make a similar referral for an individual without a disability who seeks or requires the same treatment or services." 28 C.F.R. § 36.302(b)(1).

The ADA is not a medical malpractice statute. The test, whether the referring provider would similarly refer an individual without a disability, implies a contemporaneous analysis of the referring provider's subjective belief at the time of the referral. Thus, a provider who believes that a disabled individual requires treatment beyond the provider's capability for a medical condition that is unrelated to the disability, may refer that individual to another provider if the provider would likewise refer an individual without a disability in the same fashion.<sup>2</sup>

15. On April 17, 1992, Charon had a disability as defined by the ADA.

16. Dr. Hull's refusal to admit Charon constituted a denial of the opportunity to receive medical treatment as defined by the ADA. 42 U.S.C. § 12182(b)(1)(A)(i). In light of this conclusion and the conclusions that follow, the Court need not reach the issue of whether the refusal to admit Charon to Memorial Hospital and the subsequent transfer to MCO also constituted segregation unnecessary for the provision of effective medical treatment, use of unnecessary screening criteria, or provision of unequal medical benefits. 42 U.S.C. § 12182(b)(1)(A)(iii), § 12182(b)(2)(A)(i), § 12182(b)(1)(A)(ii).

17. The defendants offered a valid reason, the TEN diagnoses, for refusing to admit Charon. Because that reason was a pretext, however, plaintiff rebutted the proffered reason. Charon was diagnosed as suffering from a simple drug reaction which did not require treatment beyond defendants' capabilities.

18. Defendant Hull improperly considered Charon's disability in refusing to admit Charon to Memorial Hospital. The Court's finding, that Charon's AIDS/HIV status was the motivating factor in Dr. Hull's refusal to admit him to Memorial Hospital, requires the conclusion that defendants' discriminatory action was on the basis of Charon's disability. 42 U.S.C. § 12182. This is consistent with the jury's finding that, under the FRA, the defendants discriminated against Charon solely on the basis of disability.

19. Defendants' actions on April 17, 1992 constituted a discriminatory denial of the opportunity to participate in or benefit from a public accommodation and, as such, violated the Americans with Disabilities Act.

20. The ADA provides for injunctive relief as a remedy in private civil suits brought for violations of its public accommodations provision. 42 U.S.C. § 12188(b)(2)(A)(i).

THEREFORE, for the foregoing reasons, good cause appearing, it is

ORDERED that judgment be, and hereby is, entered in favor of plaintiff; and it is

FURTHER ORDERED that defendants are permanently enjoined from any further violations of the Americans with Disabilities Act.

### ***Notes, Questions, and Problems***

1. What are the three criteria that a plaintiff has to meet to establish a prima facie case of discrimination under the ADA?
2. Which of the following would qualify as a disability under the ADA?
  - a) A severe case of the flu.
  - b) A positive COVID-19 test.
  - c) Pregnancy
3. Why did the court find an ADA violation in this case? Would the outcome of this case have been different if it involved a physician instead of a hospital?
4. In an ADA case, the plaintiff must prove that he was otherwise qualified for the medical procedure; the defendant must show that the disability disqualified the plaintiff; and the plaintiff must show the defendant's reason was a pretext or the reason encompassed unjustified consideration of the disability.

#### **1.4.1.5 Marital Status**

##### ***Moon v. Michigan Reproductive & IVF Center, P.C., 810 N.W.2d 919 (2011)***

PER CURIAM.

Plaintiff Alison Moon contacted Grand Rapids Fertility & IVF, P.C. (GRFI), and Michigan Reproductive & IVF Center, P.C. (MRIC), and specifically asked if the clinics would provide in vitro fertilization (IVF) services to a single woman. Both facilities responded that they did not provide IVF services to single women. Moon filed suit against both, alleging a single count of discrimination based on marital status under the Civil Rights Act (CRA), MCL 37.2101 et. seq. The circuit court dismissed Moon's discrimination action, stating that, under the common law, a doctor could refuse to enter into a doctor-patient relationship with any individual for any reason or no reason at all. Accordingly, the court concluded that the common law permitted a doctor to reject a potential patient even for discriminatory reasons.

Under the circuit court's reasoning, a doctor could refuse to treat any patient based solely on a characteristic protected under the CRA, including race, and yet avoid legal liability. Because such a result certainly was not contemplated by the Legislature, we reverse and remand for further proceedings.

#### **I FACTUAL AND PROCEDURAL HISTORY**

Moon began receiving IVF treatments from the University of Michigan Health System in Ann Arbor, but she desired to continue her treatments closer to her home in Portage. On July 3, 2008, Moon sent an e-mail to GRFI and specifically inquired if the facility provided IVF treatment to single women. Dr. Douglas Daly responded via e-mail that while GRFI provided various fertility treatments to all women, it did not provide insemination services to single women. Dr. Daly referred Moon to another clinic that is not a party to this suit. Dr. Daly's response stated in full:

We provided [sic] medically indicated treatment for all women. However, the state of Michigan [sic], like most states, does not have adequate statutory or case law for reproductive health. All children have the right to child support (the basis of paternity payments) but in the case of donor insemination (or any conception outside a marriage) the law does not provide any definition for paternity. By contract the donor is protected by the company processing the sperm. The company is protected by the legal agreement with the MD. The inseminated woman can NOT sign away the right to child support for the child, therefore in the absence of any controlling law or legal precedent [sic] the child may be able to claim child support from the MD involved. And make that claim retroactively until 21 yrs. of age (maybe longer)—similar to the precedent set by malpractice litigation.

Until I feel there is adequate law I will not be providing insemination services to single individuals. While the issue is somewhat different there is an IVF program in Boston Ma (a terribly conservative state) that has been ordered to pay 1.2M in child support—no one believed (except me) when the case was filed [sic] there was any chance the plaintiff [sic] would win. I am not willing to gamble my financial future on this issue. If you only need insemination—contact [another clinic]—we supply them with all medical treatment for the patient—other than IVF.

Moon queried whether the recommended clinic would similarly deny her treatment. Dr. Daly responded that the recommended clinic might deny her treatment. However, he indicated:

They are not as jaded regarding the legal profession as I am and since they are not an IVF program they have a much lower profile. They have been providing this service for many years—and I have provided any necessary infertility based medical evaluation and treatment—other than the actual inseminations.

Dr. Daly and Moon subsequently exchanged two more e-mails discussing her chances of pregnancy and multiple pregnancy using different types of fertility drugs.

In August 2008, Moon falsely informed MRIC that she was in a relationship in order to secure an initial consultation. When Moon ultimately informed Dr. James Young that she was single, the doctor informed her that MRIC does not provide IVF services for single women. Dr. Young referred Moon to a nurse practitioner who could perform the artificial inseminations. Upon meeting Moon, however, the nurse practitioner felt that Moon was "emotionally unstable" and informed Dr. Young that Moon intended to file suit against him. Accordingly, Dr. Young and MRIC refused to treat Moon. As a result of GRFI's and MRIC's denial of treatment, Moon travelled to Ypsilanti, over two hours away from her home, to receive IVF treatment.

Moon filed suit against GRFI and MRIC on May 20, 2010, alleging a single count of discrimination based on marital status under MCL 37.2302 of the CRA. GRFI filed a motion for summary disposition,

citing the statute's express exception to the antidiscrimination legislation: discrimination is prohibited "[e]xcept where permitted by law" GRFI asserted that the creation of a doctor-patient relationship is consensual under the common law and "a physician is not required to render services to anyone." Accordingly, GRFI contended that the CRA was inapplicable to the doctor-patient relationship. Rather, the CRA was intended to prevent discrimination in more informal relationships, such as those between a retail store and its customer or a common carrier and its passengers.

Moon responded that, in light of the comments made by Dr. Daly in his e-mails, GRFI had refused to provide IVF treatment to her solely because she is a single woman. Moon conceded that GRFI was not required to enter into a doctor-patient relationship with her. However, Moon argued that the decision to accept or deny her as a patient had to be for legitimate, nondiscriminatory reasons.

The circuit court granted GRFI's motion for summary disposition under MCR 2.116(C)(8) and additionally under MCR 2.116(C)(10). The circuit court agreed with GRFI that, under the Michigan common law:

[A] physician-patient relationship is voluntary and consensual, and a physician may refuse to enter into such a relationship for any reason or no reason at all. This Court does not believe the [CRA] was intended to function so as to force professionals to enter into relationships with clients. That is likely one reason why MCL 37.2302 begins with the phrase "[e]xcept where permitted by law." [Third alteration in original.]

Although the circuit court dismissed Moon's complaint for failure to state a legally cognizable claim, the court further noted that it would have dismissed Moon's claim on the merits as well. Specifically, the court treated Moon's claim as presenting indirect evidence of disparate treatment, and ruled that GRFI could avoid liability by providing a legitimate, nondiscriminatory reason for refusing treatment. The circuit court believed that Dr. Daly had provided such a legitimate reason—"potential financial liability given the lack of regulation and case law in Michigan regarding IVF services."

## II STANDARD OF REVIEW

We review de novo a trial court's decision on a motion for summary disposition. *Coblentz v. City of Novi*, 475 Mich. 558, 567, 719 N.W.2d 73 (2006). A motion under MCR 2.116(C)(8) "tests the legal sufficiency of the claim on the pleadings alone to determine whether the plaintiff has stated a claim on which relief may be granted." *Spiek v. Dep't of Transp.*, 456 Mich. 331, 337, 572 N.W.2d 201 (1998). We review de novo underlying issues of statutory interpretation. *Eggleston v. Bio-Med. Applications of Detroit, Inc.*, 468 Mich. 29, 32, 658 N.W.2d 139 (2003). goal of statutory interpretation is to discern the intent of the Legislature from the language of the statute. "If the statutory language is clear and unambiguous, judicial construction is neither required nor permitted, and courts must apply the statute as written." *Rose Hill Ctr., Inc. v. Holly Twp.*, 224 Mich.App. 28, 32, 568 N.W.2d 332 (1997). If a statute is ambiguous, however, judicial construction is permitted. *Detroit City Council v. Detroit Mayor*, 283 Mich.App. 442, 449, 770 N.W.2d 117 (2009).

## III A PLAINTIFF MAY FILE SUIT AGAINST A "PROFESSIONAL" UNDER THE CRA

First and foremost, we reject the circuit court's conclusion that a professional, such as a doctor, may reject a patient or client for any reason, including discriminatory animus toward a protected characteristic. This runs afoul of the very purpose of all antidiscrimination legislation and cannot be supported.



Marital status occupies a coequal place in the catalog of protected characteristics identified in the CRA. MCL 37.2102(1) provides:

The opportunity to obtain employment, housing and other real estate, *and the full and equal utilization of public accommodations*, public service, and educational facilities without discrimination because of religion, race, color, national origin, age, sex, height, weight, familial status, or *marital status* as prohibited by this act, is recognized and declared to be a civil right. [Emphasis added.]

The Michigan Supreme Court defined “marital status” under the CRA in *Miller v. C.A. Muer Corp.*, 420 Mich. 355, 362-363, 362 N.W.2d 650 (1984), as referring simply to whether an individual is married or not.

MCL 37.2301 (a) defines a “place of public accommodation” as “a business, or health facility whose goods, services, facilities, privileges, advantages, or accommodations are extended, offered, sold, or otherwise made available to the public.” MCL 37.2302 prohibits discrimination by a place of public accommodation as follows:

Except where permitted by law, a person shall not:

(a) Deny an individual the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of a place of public accommodation or public service because of religion, race, color, national origin, age, sex, or marital status. [Emphasis added.]

For purposes of summary disposition, GRFI stipulated that it is a place of public accommodation to which the statutory prohibition of discrimination applies. The parties disagree whether GRFI was able to “[d]eny [Moon] the full and equal enjoyment of” its services because the denial was otherwise “permitted by law.” *Id.*

This Court has previously held that the phrase “[e]xcept where permitted by law” in MCL 37.2302 encompasses the common law and constitutional law, as well as statutory law. *People v. Walker*, 135 Mich.App. 267, 278, 354 N.W.2d 312 (1984); *Cheesman v. American Multi-Cinema, Inc.*, 108 Mich.App. 428, 433, 310 N.W.2d 408 (1981). Compare *Dep’t of Civil Rights ex rel. Forton v. Waterford Twp. Dep’t of Parks & Recreation*, 425 Mich. 173, 189, 387 N.W.2d 821 (1986) (declining to answer the query whether the phrase “except as permitted by law” includes “constitutional and common law as well as statutory law”). Assuming *arguendo* that the statutory exception includes discrimination permitted under the common law, we disagree with the circuit court’s overly broad interpretation of the consensual and voluntary nature of the doctor-patient relationship.

GRFI correctly notes that a doctor-patient relationship is contractual and may only be established voluntarily and through the consent, either express or implied, of both the doctor and the patient. *Oja v. Kim*, 229 Mich. App. 184, 581 N.W.739 (1998), citing *Hill v. Kokosky*, 186 Mich.App. 300, 463 N.W.2d 265 (1999), *St. John v. Pope*, 901 S.W.2d 420 (Tex. 1995), and *McKinney v. Schlatter*, 118 Ohio App.3d 328, 692 N.E.2d 1045 (1997). However, the cases cited by GRFI describe the creation of a doctor-patient relationship in establishing the necessary elements of a medical-malpractice claim. The cited cases absolve a doctor of medical-malpractice liability if the doctor did not explicitly or implicitly consent to enter into a doctor-patient relationship with the plaintiff. GRFI has not cited a

single case in which a doctor was allowed to use the consensual nature of the doctor-patient relationship to discriminate against potential patients based on protected characteristics such as race or marital status.

The CRA certainly serves to prohibit doctors and medical facilities from refusing to form a doctor-patient relationship based solely on the patient's protected status. A contrary interpretation would allow a doctor to follow his or her personal prejudices or biases and deny treatment to a patient merely because the patient is African-American, Jewish, or Italian. Rather, following this state's enactment of the CRA, a doctor may only deny his or her consent to enter into a doctor-patient relationship with a potential patient based on legally permissible, nondiscriminatory reasons.

We find *Lyons v. Grether*, 218 Va. 630, 239 S.E.2d 103 (1977), instructive in this regard. In *Lyons*, 218 Va. At 631, 239 S.E.2d 103, the plaintiff was a blind patient who had entered a physician's waiting room with her guide dog. The doctor refused to treat the plaintiff unless she removed her dog from the office. Under Virginia law, the blind are "entitled to full and equal accommodations" and "privileges of places of public accommodation" and also have "the right to be accompanied by a dog guide." *Id.* At 632 n. 1, 239 S.E.2d 103, quoting former Va Code Ann 63.1-171.2. The Virginia Supreme Court acknowledged that, under the common law, "a physician has no legal obligation to accept as a patient everyone who seeks his services" and that the creation of the doctor-patient relationship is consensual and contractual. *Id.* At 632-633, 239 S.E.2d 103. However, the court determined that there was a remaining issue of material fact whether the defendant doctor discriminatorily terminated his relationship with the plaintiff patient because she exercised her rights under the state's "White Cane Act." *Id.* At 634-635, 239 S.E.2d 103. The current case poses the similar question of whether a doctor may refuse to enter into a doctor-patient relationship with a patient based on discriminatory factors in violation of the CRA. The answer to that question clearly is no. Accordingly, the circuit court erred by dismissing Moon's discrimination claim pursuant to MCR 2.116(C)(8).

#### IV MOON PRESENTED DIRECT EVIDENCE OF DISCRIMINATION AND THE CIRCUIT COURT IMPROPERLY DISMISSED HER CLAIM ON THE MERITS

We further reject the circuit court's conclusion that Moon failed to create a genuine issue of material fact that GRFI discriminatorily rejected her as a patient.

In order to state a claim under MCL 37.2302(a), plaintiff must establish four elements: (1) discrimination based on a protected characteristic (2) by a person, (3) resulting in the denial of the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations (4) of a place of public accommodation. [*Haynes v. Neshewat*, 477 Mich. 29, 35, 729 N.W.2d 488 (2007).]

Moon clearly established that she was denied the enjoyment of the goods, services, facilities, privileges, advantages, or accommodations offered by GRFI, which stipulated to being a place of public accommodation for purposes of summary disposition. The only question remaining is whether she created a genuine issue of material fact that GRFI discriminated against her based on marital status. In this regard, Moon argues that she was given disparate treatment from married women.

In a discrimination action based on disparate treatment, the plaintiff has the initial burden to establish the existence of illegal discrimination, either through direct or indirect evidence. *Hazle v. Ford Motor Co.*, 464 Mich. 456, 462-463, 628 N.W.2d 515 (2001). "[P]roof of discriminatory motive is required in order to establish a *prima facie* case" of disparate treatment. *Dep't of Civil Rights ex rel. Peterson*

v. Brighton Area Schools, 171 Mich.App. 428, 439, 431 N.W.2d 65 (1988); see also Farmington Ed. Ass'n v. Farmington Ed. Ass'n v. Farmington School Dist., 133 Mich.App. 566, 572, 351 N.W.2d 242 (1984). Direct evidence is “evidence which, if believed, requires the conclusion that unlawful discrimination was at least a motivating factor in the” decision-maker’s actions. Hazle, 464 Mich. At 462, 628 N.W.2d 515, quoting Jacklyn v. Schering-Plough Healthcare Prod. Sales Corp., 176 F.3d 921, 926 (C.A.6, 1999).

Moon proffered direct evidence of discrimination, specifically, the e-mail messages that she received from Dr. Daly, indicating that GRFI did not provide IVF treatment to single women. Dr. Daly’s statement, “Until I feel there is adequate law I will not be providing insemination services to single individuals,” tends to establish “that unlawful discrimination was at least a motivating factor” in Dr. Daly’s decision to deny Moon IVF services. Hazle, 464 Mich. At 462, 628 N.W.2d 515 (citation omitted). When a plaintiff presents direct evidence of discrimination, “the case should proceed as an ordinary civil matter.” DeBrow v. Century 21 Great Lakes, Inc. (After Remand), 463 Mich. 530, 620 N.W.2d 836 (2001), quoting DeBrow v. Century 21 Great Lakes, Inc., unpublished opinion of the Court of Appeals, issued August 12, 1996 (Docket No. 161048), 1996 WL 33360653 (YOUNG, J., dissenting) (*DeBrow I*). As an ordinary civil matter, the circuit court should have denied GRFI’s motion for summary disposition on the merits and proceeded through discovery and to trial if necessary.

We note that the circuit court’s error stemmed from its application of the shifting burdens standard of McDonnell Douglas Corp. v. Green, 411 U.S. 792, 93 S.Ct. 1817, 36 L.Ed.2d 668 (1973), to Moon’s discrimination claim. “The shifting burdens of proof described in McDonnell Douglas are not applicable if a plaintiff can cite direct evidence of unlawful discrimination.” DeBrow (After Remand), 463 Mich. at 539, 620 N.W.2d 836. As Moon presented *direct evidence* of discrimination, she was not required to “present a rebuttable prima facie case from which a factfinder could infer” discriminatory animus. Hazle, 464 Mich. at 462, 628 N.W.2d 515 (quotation marks, citation, and emphasis omitted). Further, it was irrelevant at the summary disposition phase whether GRFI had rebutted Moon’s discrimination claim by articulating “a legitimate, nondiscriminatory reason for its” actions. *Id.* at 46, 628 N.W.2d 515. Rather, the credibility of GRFI’s claimed motive for denying IVF treatment to Moon (fear of financial liability for the child conceived) is a question for the fact-finder. And, “[n]either this Court nor the trial court can make factual findings or weigh credibility in deciding a motion for summary disposition.” DeBrow (After Remand), 463 Mich. at 540, 620 N.W.2d 836, quoting DeBrow I.

Reversed and remanded for further proceedings consistent with this opinion. We do not retain jurisdiction.

### ***Ethics Consultation One***

Dr. Brian Moses has been practicing medicine for over 25 years. Dr. Moses is a primary care physician. One day, Dr. Moses was in the locker room at his fitness center talking to his best friend, Danny. Twenty-five-year-old graduate student, Anthony Martin was also in the locker room. Anthony was extremely overweight. Anthony mentioned to Dr. Moses that he had just started a weight loss program. Dr. Moses told Anthony that he should make sure to stay hydrated and to take frequent breaks. Anthony asked Dr. Moses if he should start out on the treadmill or the exercise bike. Dr. Moses advised Anthony that he should walk on the treadmill at a speed of about 2.5 MPH.

Anthony planned to walk on the treadmill for 30 minutes. When Anthony had been walking for about 15 minutes, he fell off of the treadmill and placed his hand on his chest. The woman on the treadmill next to Anthony yelled, “Is there a doctor in the room?” Dr. Moses decided not to get involved because he is not a cardiologist. Danny turned to Dr. Moses and said, “Brian, aren’t you gonna do something?” In response, Dr. Moses left the room. Danny followed him into the locker room and said, “You’re a doctor man. How can you just walk away?” Dr. Moses felt bad, so he headed back into the exercise area. By that time, the EMTs had arrived. Dr. Moses told them that he thought Anthony had suffered a heart attack. He recommended treatment and told them to take Anthony to Sisters of Peace Hospital-Main (Sisters of Peace I) where he had admitting and surgical privileges. Dr. Moses rode in the ambulance with Anthony and tried to revive him. When Anthony arrived at Sisters of Peace I, the emergency room doctor pronounced him dead. The emergency room doctor stated that Anthony may have survived had he received medical intervention earlier. Anthony’s wife, Polly, and his daughters, Rebecca and Tina, plan to sue Dr. Moses and Sisters of Peace because Dr. Moses failed to intervene when Anthony first collapsed at the fitness center.

After Anthony’s death, Polly was overcome with grief. Polly was a diabetic, so Rebecca was worried that Polly was not taking proper care of herself. The evening after Anthony’s funeral, Rebecca found Polly sitting on the sofa staring at the television. Polly was slurring her words, sweating, and acting disoriented. Instead of waiting for an ambulance, Rebecca drove Polly to Sisters of Peace I, the closest hospital. Sisters of Peace had a policy that persons suspected of drinking or doing drugs were not permitted on hospital premises. Rebecca dropped Polly off in front of the hospital while she went to park. When Polly walked into the hospital she was staggering. Oscar, the security guard on duty, suspected that Polly was intoxicated. Thus, he refused to let Polly enter the hospital. When Rebecca arrived, she found Polly collapsed in the parking lot. Rebecca ran into the emergency room and got help for Polly. By the time Polly was placed on the gurney, she was in a diabetic coma. As a result, Polly suffered permanent brain damage and is in a vegetative state. Rebecca plans to sue Sisters of Peace for failing to promptly treat Polly.

Tina struggled with schizophrenia most of her life. One night, Tina ran out of her apartment because she thought that aliens were trying to eat her brain. After receiving a 911 call, EMTs picked Tina up in the middle of the street. The EMTs transported Tina to Sisters of Peace East (Sisters of Peace II), a small rural hospital that was a satellite campus of Sisters of Peace I. Sisters of Peace II did not have a psychiatric floor. However, Sisters of Peace II had a contract with Carver County Mental Institute (Mental Institute), a psychiatric hospital located 25 miles away from Sisters of Peace II. Sisters of Peace II admitted Tina to the hospital, so that the hospital would be paid for the ambulance transport. After Tina was admitted, the nurses gave her a bath and put her in restraints. The next morning, Sisters of Peace II arranged for Tina to be transported to Mental Institute. Doctors at Sisters of Peace II never saw Tina and never gave her any medicine. On the way to Mental Institute, the ambulance had a flat tire. While the EMTs were trying to figure out what to do about the flat tire, Tina got out of the restraints and jumped out of the ambulance. Before the EMTs could stop her, Tina ran in the road and was hit by a car. Tina was killed instantly. Rebecca plans to sue Sisters of Peace for wrongful death.

### ***Problem***

Your law firm represents Sisters of Peace. Please prepare a memorandum analyzing the relevant legal issues and discussing the possible outcomes of the three cases.

## CHAPTER TWO - DUTY TO PROTECT PATIENT INFORMATION AND THIRD PARTIES

### 2.1 Health Insurance Portability and Accountability Act (HIPAA)

Patients share highly sensitive and personal information with their doctors. That exchange of information is critically important to ensure that the physician has the information needed to provide the patient with the best care possible. Thus, there are rules and regulations in place to make sure that any information a patient shares with a physician is kept confidential. Initially, patients relied on state tort laws to enforce their rights of privacy and confidentiality. Those laws were deemed to be insufficient. Hence, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) of 1996. That law contains several complex provisions. It is primarily designed to improve the manner in which health insurance is sold and the patient's ability to transfer health insurance between employers. For the purposes of this chapter, we will concentrate on the impact HIPAA has on patient privacy.

HIPAA's Privacy Rule mandates that certain "[covered entities](#)"<sup>11</sup> maintain the confidentiality of enumerated types of "[protected health information](#)"<sup>12</sup> (PHI). Covered entities refer to health insurers, claim processing clearinghouses, and health care providers. 45 C.F.R. 160.102(a). Those organizations must take the following actions: (1) enact internal procedures to protect the privacy of protected health information; (2) educate employees about those privacy procedures; (3) appoint a privacy officer; (4) protect patient records that contain protected information; and (5) develop and enforce agreements with certain third-party "[business associates](#)"<sup>13</sup> to make sure that they maintain privacy protection for patient information to which they have access. The HITECH Act of 2009 expanded the scope of the Act by imposing many of the Privacy Rule's mandates on business associations. 45 C.F.R. 160.102(b).

The Privacy Rule does not explicitly create a private cause of action for people harmed by disclosures. Moreover, the Privacy Rule contains important preemption rules that reinforce the role states play in establishing and enforcing strict privacy protections. The HIPAA preemption only applies to state laws that provide weaker protections of privacy. Thus, states can adopt and enforce more protective regimes. 45 C.F.R. 160.201-205. This means that harmed individuals can pursue whatever remedies they may have under state law.

A patient's right to confidentiality is not absolute. There are several types of situations that warrant the disclosure of patient medical information. A patient's medical information may be disclosed for the purposes of treatment. For example, to provide proper treatment of patients, physicians must have the freedom to share patient information with other healthcare providers, including nurses, pharmacists, lab technicians, and other healthcare personnel. To facilitate this process, patients are usually required to sign release forms prior to being treated. Physicians may also disclose patient information to ensure that they receive payment for their services. For instance, when seeking payment from health insurance

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<sup>11</sup> *Covered Entities and Business Associates*, U.S. Department of Health & Human Services Office for Civil Rights (OCR), at <https://www.hhs.gov/hipaa/for-professionals/covered-entities/index.html> (June 16, 2017).

<sup>12</sup> Steve Alder, *What is Protected Health Information?* HIPAA Journal, at <https://www.hipaajournal.com/what-is-protected-health-information/> (Jan. 10, 2021).

<sup>13</sup> Maggie Hales, *Business Associates 101*, The HIPAA E-Tool, at <https://thehipaaetool.com/business-associates-101/> (June 25, 2019).

providers, physicians must describe the treatments they have delivered. In fulfilling that obligation, physicians may have to disclose information from their patients' medical files. Moreover, the disclosure of patient medical information may be necessary for the benefit of the public. During the A.I.D.S. crisis, some physicians had to disclose patient health information under a public health mandate. As of the writing of this book, the United States has passed 12 million COVID-19 cases. To prevent the spread of the deadly virus and to assist with [contact tracing](#),<sup>14</sup> patient health information may need to be disclosed. Lastly, in some cases, healthcare providers are legally mandated to disclose patient health information to protect a third party. This type of disclosure falls under the duty to warn doctrine that will be discussed in the second part of this chapter.

## 2.2 Protecting Patient Privacy

### 2.2.1 Unauthorized Disclosure

*Miguel M. v. Barron*, 950 N.E. 2d 107 (N.Y.S.2d 2011)

SMITH, J.

We hold that the Privacy Rule adopted by the federal government pursuant to the Health Insurance Portability and Accountability Act (HIPAA) prohibits the disclosure of a patient's medical records to a state agency that requests them for use in a proceeding to compel the patient to accept mental health treatment, where the patient has neither authorized the disclosure nor received notice of the agency's request for the records.

#### I

Dr. Charles Barron, as designee of the New York City Department of Health and Mental Hygiene, applied for an order under Mental Hygiene Law § 9.60 requiring "assisted outpatient treatment" (AOT) for Miguel M. The petition alleged that Miguel was suffering from a mental illness; that he was unlikely to survive safely in the community without supervision; that he had a history of failing to comply with treatment; that he was unlikely to participate in necessary treatment voluntarily; and that he needed, and would benefit from, AOT to prevent a relapse or deterioration of his mental status, which would be likely to result in serious harm to Miguel or to others.

At the hearing on the petition, Barron offered in evidence records from two hospitals relating to three occasions on which Miguel was hospitalized. A witness called by Barron testified that the hospitals had furnished the records in response to a request—a request made, it is clear from the record, without notice to Miguel. The witness acknowledged that Miguel had not authorized the release of the records, and that no court order for their disclosure had been sought or obtained.

The records were received in evidence over Miguel's objection and Barron's witness described their contents. After the hearing, Supreme Court directed that Miguel "receive and accept assisted outpatient

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<sup>14</sup> *Contact tracing slows the spread of COVID-19*, National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases, at <https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/contact-tracing.html> (Feb. 25, 2021).

treatment” for a period of six months. The Appellate Division affirmed. We granted leave to appeal and now reverse.

## II

The six-month duration of Supreme Court’s order expired before the Appellate Division decided this case, and the immediate controversy is therefore moot. Neither party challenges, however, the Appellate Division’s conclusion that the case presents a novel and substantial issue that is likely to recur and likely to evade review, and that therefore the exception to the rule against deciding moot disputes applies here. We agree, and proceed to the merits.

Mental Hygiene Law § 9.60, known as “Kendra’s Law,” was enacted in 1999. It is named for Kendra Webdale, who was killed by a mentally ill man who pushed her off a subway platform. It says that, on a proper showing, a mentally ill person whose lack of compliance with treatment has, twice within the last 36 months, caused him or her to be hospitalized may be the subject of AOT pursuant to a plan stated in a court order. Public officials identified as “directors of community services” are given the duty of enforcing Kendra’s Law and a petition to require AOT may be filed by a director of community services or his or her designee. Mental Hygiene Law § 33.13(c) (12) permits disclosure of medical records to a director of community services who requests it in the exercise of his or her duties. Thus, the disclosure of a patient’s medical records for purposes of an AOT proceeding is permitted by state law, unless the applicable state law is preempted. Miguel argues that it is.

Miguel says that preemption is found in HIPAA Pub. L. 104-191, 110 U.S. Stat. 1936 [codified in various titles of the United States Code]) and the Privacy Rule (45 CFR parts 160, 164) promulgated by the United States Department of Health and Human Services under authority granted by HIPAA § 264(c)(1) (*see* Historical and Statutory Notes following 42 USCA § 1320d-2). The Privacy Rule prohibits disclosure of an identifiable patient’s health information without the patient’s authorization, subject to certain exceptions (45 CFR 164.508[a][1]). HIPAA § 264(c)(2) (*see* Historical and Statutory Notes following 42 USCA § 1320d-2) and the Privacy Rule (45 CFR 160.203 [b]) say that contrary state laws are preempted unless they offer privacy protections that are “more stringent” than those of the federal law; New York does not offer any more stringent protection that is relevant here. The preemption issue thus comes down to whether the disclosure of Miguel’s medical records was permitted by one of the exceptions to the Privacy Rule.

Barron relies on two exceptions, those permitting disclosure for purposes of “public health” and “treatment.” It is possible to read the language of both exceptions as covering the disclosure now at issue, but in both cases the reading is strained. Considering the apparent purposes of these two exceptions, we conclude that neither fits these facts.

The public health exception permits disclosure of protected information to:

“A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions” (45 CFR 164.512[b][1][i]).

Barron reasons that disclosure of a mentally ill person’s hospital records for purposes of requiring that person to accept AOT protects the public health, because mentally ill people might kill or injure other

people—like Kendra Webdale—who, of course, are members of the public. Thus Barron, a person designated to enforce Kendra’s Law, would be a “public health authority,” collecting information for the “purpose of preventing injury,” and his action to require AOT in Miguel’s case could be called a public health intervention. We are not convinced, however, that the authors of the Privacy Rule meant “public health” in this literal, but counterintuitive, sense.

The apparent purpose of the public health exception is to facilitate government activities that protect large numbers of people from epidemics, environmental hazards, and the like, or that advance public health by accumulating valuable statistical information. To disclose private information about particular people, for the purpose of preventing those people from harming themselves or others, effects a very substantial invasion of privacy without the sort of generalized public benefit that would come from, for example, tracing the course of an infectious disease. The disclosure to Barron of Miguel’s hospital records was not within the scope of the public health exception.

The treatment exception permits disclosure of protected health information “for treatment activities of a health care provider” (45 CFR 164.506[c][2]). “Treatment” is defined as:

“the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another” (45 CFR 164.501).

Again, Barron’s argument is literalistic: AOT—assisted outpatient treatment—is literally “treatment”—“the provision of health care by one or more health care providers.” But the thrust of the treatment exception is to facilitate the sharing of information among health care providers working together. We see no indication that the authors of the regulation meant to facilitate “treatment” administered by a volunteer “provider” over the patient’s objection. Disclosure for that purpose is a more serious invasion of privacy than, for example, the transmission of medical records from a patient’s primary care physician to a specialist—the sort of activity for which the treatment exception seems primarily designed. The treatment exception is inapplicable here.

We find support for our conclusion that the two exceptions Barron relies on are inapposite in the existence of other exceptions that Barron might have invoked but did not. The Privacy Rule authorizes disclosure of health information, subject to certain conditions, “in the course of any judicial or administrative proceeding,” in response to either “an order of a court or administrative tribunal” (45 CFR 164.512[e][1][i]) or “a subpoena, discovery request, or other lawful process” (45 CFR 164.512[e][1][ii]). Thus, Barron could have pursued Miguel’s records either by seeking a court order or by serving a subpoena. To do so in compliance with the Privacy Rule, however, Barron would have had to give notice to Miguel of his request for the records. He could not, absent extraordinary circumstances, have obtained a court order requiring disclosure without giving such notice. And the Privacy Rule’s exception for subpoenas and the like is conditioned on “satisfactory assurance” from the person seeking the information to the entity providing it either “that reasonable efforts have been made to ensure that the individual who is the subject of the protected health information has been given notice of the request” (45 CFR 164.512[e][1][ii][A]), or that an order protecting the confidentiality of the information has been sought (45 CFR 164.512 [e][1][ii] [B]). In a case, like this one, to which the patient is a party, a request for a protective order would require notice to the patient.



We can see no reason, and Barron has suggested none, why notice should not have been given here. It may well be, in this case as in many others, that no valid ground for withholding the records exists; courts ruling on disclosure issues will surely be conscious, as we are, of the strong public interest in seeing that mentally ill people who might otherwise be dangerous receive necessary treatment. But it seems only fair, and no great burden on the public agencies charged with enforcing Kendra's Law, to give patients a chance to object before the records are delivered.

We emphasize that it is far from our purpose to make the enforcement of Kendra's Law difficult. It may often be possible to avoid all disclosure problems by getting the patient to authorize the disclosure in advance; surely many mentally ill people will, while they are under proper care, recognize that disclosure is very much in their own interest. When there is no advance authorization, patients who are given notice that their records are being sought often may not object; when they do object, their objections may often be overruled. We hold only that unauthorized disclosure without notice is, under circumstances like those present here, inconsistent with the Privacy Rule.

### III

Barron argues in the alternative that, even if the disclosure of the records to him was unlawful—as we have held it was—Supreme Court did not err by admitting the records into evidence at the AOT hearing. HIPAA, as Barron points out, contains its own remedies for violations: civil penalties (HIPAA § 262[a], adding 42 USCA § 1320d-5) and, for the knowing and wrongful disclosure of individually identifiable health information, fines and imprisonment (HIPAA § 262[a], adding 42 USCA § 1320d-6). Neither exclusion of the records from evidence nor suppression of evidence obtained by use of the records is among the remedies listed. Barron cites decisions from other states holding that evidence obtained as a result of a HIPAA violation need not be suppressed in a criminal case (citations omitted).

We assume it is correct that, in a criminal case, a HIPAA or Privacy Rule violation does not always require the suppression of evidence. Indeed, we have held that suppression is not required in such a case where evidence was obtained as a result of a violation of New York's physician-patient. But this case is different. It is one thing to allow the use of evidence resulting from an improper disclosure of information in medical records to prove that a patient has committed a crime; it is another to use the records themselves, or their contents, in a proceeding to subject to unwanted medical treatment a patient who is not accused of any wrongdoing. Using the records in that way directly impairs, without adequate justification, the interest protected by HIPAA and the Privacy Rule: the interest in keeping one's own medical condition private. We therefore hold that medical records obtained in violation of HIPAA or the Privacy Rule, and the information contained in those records, are not admissible in a proceeding to compel AOT.

Accordingly, the order of the Appellate Division should be reversed, with costs, and the case remitted to Supreme Court for further proceedings in accordance with this opinion.

### *Notes, Questions, and Problems*

1. In January of 1999, Kendra Webdale died after being pushed in front of a New York City subway train by a man with a history of mental illness and hospitalizations.

2. In *Miguel M.*, on which two exceptions to the Privacy Rule did Barron rely? Why did the court reject his arguments?

3. In *Miguel M.*, what legitimate ways could Barron have used to get the medical records that he needed?

4. Rev. Sherry Watson was a long-time patient of Dr. Lin. Rev. Watson came to Dr. Lin's office complaining of flu-like symptoms. Dr. Lin had Sherry take a COVID-19 test. The test came back positive. That evening, while he was watching the news Dr. Lin learned that Rev. Watson planned to host a gathering of 5000 church members in the park the next day. What would you advise Dr. Lin to do?

5. Carla Benson was a long-time patient of Dr. Wilson. During a routine physical examination, Carla tested positive for COVID-19. She informed Dr. Wilson that she was spending the weekend with her boyfriend, Jeff, and his three children. What would you advise Dr. Wilson to do?

6. Paula Stevens was a long-time patient of Dr. Benson. Paula was on the list to get a new liver transplant. One day Paula came to Dr. Benson's office intoxicated. Afterward, Dr. Benson told Dr. Davis, Paula's transfer doctor, that because she was drinking, Paula was not in compliance with the transplant mandates. Consequently, Dr. Benson removed Paula from the transplant list. Paula approached you asking if she had any remedies. What would you advise?

***Henry v. Community Healthcare System Community Hospital*, 134 N.E.3d 435 (Ind.Ct.App. 2019)**

BAKER, JUDGE.

Amanda Henry appeals the trial court's order dismissing the complaint she filed against Community Healthcare System Community Hospital (Community) after a Community employee allegedly provided Henry's medical records to the employee's spouse, who happened to be Henry's employer. Henry argues that (1) while HIPAA does not contain a private right of action, it can form the basis of a duty and/or standard of care; (2) the trial court erroneously found that Indiana does not recognize the tort of public disclosure of private information; and (3) dismissal was improper where there were multiple viable negligence-based claims implicated by the complaint. Finding that Henry has one or more claims that should have survived dismissal, we reverse and remand for further proceedings.

Facts

On March 1, 2018, Henry received medical treatment at Community Hospital in Munster. As part of her treatment, she underwent radiographic imaging. Three days later, Henry's employer showed her digital images of her X-rays on the employer's cell phone. Henry later learned that her employer is married to the radiologic technician who performed her radiographic imaging.

On October 24, 2018, Henry filed a complaint against Community. The relevant portions of the complaint read as follows:

3. On March 1, 2018, plaintiff received medical care at Community.
  4. Community owes a duty to protect the privacy, security, and confidentiality of health records generated or maintained by providers within its network.
  5. At some point between March 1, 2018 and March 4, 2018, a Community workforce member shared plaintiff's protected health information with the workforce member's spouse.
  6. On March 4, 2018, the workforce member's spouse showed plaintiff digital images (contained in the spouse's cellular telephone) of plaintiff's March 1, 2018 x-ray films.
- \* \* \*
11. As a direct and proximate result of the above-described acts of Community and of Community's workforce member, plaintiff has suffered damages for which Community is liable.

Appellant's App. Vol. II p. 10-11 (emphases omitted). Community filed an answer denying the allegations.

On April 17, 2019, Community moved to dismiss the complaint pursuant to Indiana Trial Rule 12(B)(6). Henry responded the same day. The trial court held a hearing on the motion to dismiss on June 3, 2019, and entered an order dismissing the complaint the next day. The trial court found that because the motion to dismiss was filed after the pleadings were closed, the motion should be treated as a motion for judgment on the pleadings pursuant to Trial Rule 12(C). In relevant part, the trial court found as follows:

Here, the question is quite simple: Does Henry have a right of action against Community on the facts she alleges?

It has long been held that no private action exists under HIPAA, found at 42 U.S.C. § 1320(d), and its implementing regulations[.]

As to Henry's claim under the Public Disclosure Privacy Act, the very recent case of [F.B.C. v. MDwise, Inc., 122 N.E.3d 834 (Ind. Ct. App. Apr. 16, 2019), *trans. pending*,] held:

[t]he tort of Disclosure has not yet been recognized in Indiana. In Doe v. Methodist Hospital, the Indiana Supreme Court declined to adopt [the tort of private disclosure of public facts ("Disclosure")], which is a sub-tort of invasion of privacy, as an actionable claim. 690 N.E.2d 681, 693 (Ind. 1997).

The Court recognized that while neighboring states have adopted a more liberal Disclosure standard, it was not persuaded to adopt Disclosure as a cognizable claim in Indiana. Id. at 692-93. *See also* Felsher v. University of Evansville, 755 N.E.2d 589, 593 (Ind. 2001).

It is therefore ordered, adjudged and decreed by the Court as follows:

1. The Motion to Dismiss of [Community] is granted.

2. This case is ordered dismissed with prejudice.

Appealed Order p. 2-3 (emphasis and citation in original omitted). Henry now appeals.

### Discussion and Decision

As noted above, the trial court treated Community's motion to dismiss as a motion for judgment on the pleadings pursuant to Indiana Trial Rule 12(C). We apply a de novo standard of review to a ruling on a motion for judgment on the pleadings. *Murray v. City of Lawrenceburg*, 925 N.E.2d 728, 731 (Ind. 2010). When evaluating such a motion, we must accept as true the well-pleaded material facts alleged in the complaint. *Consol. Ins. Co. v. Nat'l Water Servs., LLC*, 994 N.E.2d 1192, 1196 (Ind. Ct. App. 2013). A Rule 12(C) motion is granted only where it is clear from the face of the complaint that under no circumstances could relief be granted. *Id.* A complaint will withstand a motion for judgment on the pleadings if it states any set of allegations, no matter how inartfully pleaded, upon which the trial court could have granted relief. *Tony v. Elkhart Cty.*, 851 N.E.2d 1032, 1035 (Ind. Ct. App. 2006).

Community attempts to frame this case under the Health Insurance Portability and Accountability Act (HIPAA) and the Indiana Access to Health Care Records Statute (IAHRS), arguing that there is no private right of action under either statute. This framing is a red herring, however, inasmuch as Henry agrees that there is no private right of action and is not attempting to assert one.

Instead, Henry argues that HIPAA may be used to establish the standard of care in a common law negligence action. To ensure that litigants are not enabled to make an end-run around the lack of a private right of action under HIPAA, Community argues that there must first be a common law duty. We agree.

There is an age-old recognition that medical providers owe a duty of confidentiality to their patients. While this duty is now codified by statute in Indiana, that does not change the historical recognition of the duty at common law. *See Schlarb v. Henderson*, 211 Ind. 1, 4, 4 N.E.2d 205, 206 (1936) (acknowledging, in the context of doctor-patient privilege, that there was a "common-law rule before the statute" to ensure open communication "without the danger of publicity concerning such private and intimate affairs"); *Springer v. Byram*, 137 Ind. 15, 36 N.E. 3561, 363 (1894) (observing that communications made by a patient to a doctor are "intended to be private and confidential, and can never be divulged without the consent of the patient"). This common law duty finds support in the ethical rules governing the medical profession. *See Canfield v. Sandock*, 563 N.E.2d 526, 529 and 529 n.2 (Ind. 1990) (observing that "the ethical rules of the medical profession prohibit disclosure of confidential information in non-judicial settings" and that the "Hippocratic Oath imposes on physicians a duty to maintain confidences acquired in their professional capacity"); *see also* Am. Med. Ass'n, Code of Medical Ethics Opinion 3.2.1, <https://www.ama-assn.org/delivering-care/ethics/confidentiality> (stating that physicians "have an ethical obligation to preserve the confidentiality of information gathered in association with the care of the patient"); *Vargas v. Shepherd*, 903 N.E.2d 1026, 1031-32 (Ind. Ct. App. 2009) (acknowledging argument that medical providers assume a duty to abide by ethical guidelines, including obtaining patient consent before disclosing any medical information, and assuming without deciding that such a duty exists).

We have little trouble concluding, based on the above authority, that there is—and, in modern times, always has been—a common law duty of confidentiality owed by medical providers to their patients. And it is necessarily true that if a duty exists, a breach of that duty is also possible. Indeed, this Court has more than once considered a claim that a medical provider negligently or recklessly disseminated

a patient's confidential information, finding that such a claim sounds in ordinary negligence rather than in medical malpractice (citations omitted).

Having found that a common law duty exists, we have little trouble agreeing with a sister court that "HIPAA and its implementing regulations may be utilized to inform the standard of care" in tort claims related to alleged breaches of the duty of confidentiality owed by medical providers to their patients. *Byrne v. Avery Ctr. For Obstetrics & Gynecology, P.C.*, 314 Conn. 433, 102 A.3d 32, 49 (Conn. 2014).

Under Indiana's liberal notice pleading standard, we find that Henry's complaint includes the operative facts necessary to make a negligence-based claim against Community. *See ARC Constr. Mgmt., LLC v. Zelenak*, 962 N.E.2d 692, 697 (Ind. Ct. App. 2012) (holding that "[u]nder Indiana's notice pleading system, a pleading need not adopt a specific legal theory of recovery to be adhered to throughout the case"). Specifically, the complaint alleged a duty to protect the privacy, security, and confidentiality of her health records, a breach of that duty by Community's employee when the employee shared Henry's x-rays with employee's spouse, and resulting damages, if any. Under these circumstances, it was erroneous to grant Community's motion for judgment on the pleadings because it is *not* clear from the face of the complaint that under no circumstances could relief be granted.

The judgment of the trial court is reversed and remanded for further proceedings.

***Byrne v. Avery Center for Obstetrics and Gynecology*, 175 A.3d 1 (Conn. 2018)**

EVELEIGH, J.

The plaintiff, Emily Byrne, appeals from the judgment of the trial court rendered in favor of the defendant, Avery Center for Obstetrics and Gynecology, P.C., on two counts of the operative complaint alleging, respectively, negligence and negligent infliction of emotional distress. On appeal, the plaintiff asserts that the trial court incorrectly granted summary judgment in favor of the defendant on these counts because it incorrectly concluded that the defendant, as a health care provider, owed the plaintiff no common-law duty of confidentiality. We agree with the plaintiff and, accordingly, reverse the judgment of the trial court.

This case returns to us for a second time. The facts and procedural history are set forth in this court's prior decision. *See Byrne v. Avery Center for Obstetrics & Gynecology, P.C.*, 314 Conn. 433, 436-44, 102 A.3d 32 (2014). "Before July 12, 2005, the defendant provided the plaintiff [with] gynecological and obstetrical care and treatment. The defendant provided its patients, including the plaintiff, with notice of its privacy policy regarding protected health information and agreed, based on this policy and on law, that it would not disclose the plaintiff's health information without her authorization.

In May, 2004, the plaintiff began a personal relationship with Andro Mendoza, which lasted until September, 2004. In October, 2004, she instructed the defendant not to release her medical records to Mendoza. In March, 2005, she moved from Connecticut to Vermont where she presently lives. On May 31, 2005, Mendoza filed paternity actions against the plaintiff in Connecticut and Vermont." (Footnote in original; internal quotation marks omitted.) *Id.*, at 437, 102 A.3d 32. Thereafter, the defendant received a subpoena instructing the custodian of its records to appear before the issuing attorney on July 8, 2005, at the New Haven Regional Children's Probate Court and to produce "all medical records" pertaining to the plaintiff. "The defendant did not alert the plaintiff of the subpoena,

file a motion to quash it or appear in court. Rather, the defendant mailed a copy of the plaintiff's medical file to the court around July 12, 2005. In September, 2005, [Mendoza] informed [the] plaintiff by telephone that he reviewed [the] plaintiff's medical [record] in the court file. On September 15, 2005, the plaintiff filed a motion to seal her medical file, which was granted. The plaintiff alleges that she suffered harassment and extortion threats from Mendoza since he viewed her medical records.

The plaintiff subsequently brought this action against the defendant. Specifically, the operative complaint in the present case alleges that the defendant: (1) breached its contract with her when it violated its privacy policy by disclosing her protected health information without authorization; (2) acted negligently by failing to use proper and reasonable care in protecting her medical file, including disclosing it without authorization in violation of General Statutes § 52-146o and the [federal] regulations implementing [the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. § 1302d et seq.], (3) made a negligent misrepresentation, upon which the plaintiff relied to her detriment, that her medical file and the privacy of her health information would be protected in accordance with the law; and (4) engaged in conduct constituting negligent infliction of emotional distress. After discovery, the parties filed cross motions for summary judgment.” (Footnotes altered; internal quotation marks omitted.) *Byrne v. Avery Center for Obstetrics & Gynecology, P.C.*, supra, 314 Conn. At 437-39, 102 A.3d 32.

With respect to the plaintiff's negligence based claims in counts two and four of the complaint, the trial court agreed with the defendant's contention that ‘HIPAA preempts “any action dealing with confidentiality/privacy of medical information,”’ which prompted the court to treat the summary judgment motion as one seeking dismissal for lack of subject matter jurisdiction. In its memorandum of decision, the trial court first considered the plaintiff's negligence claims founded on the violations of the regulations implementing HIPAA. The court first observed the ‘well settled’ proposition that HIPAA does not create a private right of action, requiring claims of violations instead to be raised through administrative channels. The trial court then relied on *Fisher v. Yale University*, Superior Court, judicial district of New Haven, Complex Litigation Docket, Docket No. X10-CV-04-4003207-S, 2006 EL 1075035 (April 3, 2006), and *Meade v. Orthopedic Associates of Windham County*, Superior Court, judicial district of Windham Docket No. CV-06-4005043-S, 2007 WL 4755001 (December 27, 2007), and rejected the plaintiff's claim that she had not utilized HIPAA as the basis of her cause of action, but rather, relied on it as ‘“evidence of the appropriate standard of care” for claims brought under state law, namely, negligence.’ Emphasizing that the courts cannot supply a private right of action that the legislature intentionally had omitted, the trial court noted that the ‘plaintiff has labeled her claims as negligence claims, but this does not change their essential nature. They are HIPAA claims.’ The trial court further determined that the plaintiff's statutory negligence claims founded on a violation of § 52-146o were similarly preempted because the state statute had been superseded by HIPAA, and thus the plaintiff's state statutory claim ‘amount[ed] to a claim for a HIPAA violation, a claim for which there is no private right of action.’

The trial court concluded similarly with respect to the plaintiff's common-law negligence claims, observing that, under the regulatory definitions implementing HIPAA's preemption provision. to ‘the extent that common-law negligence permits a private right of action for claims that amount to HIPAA violations, it is a contrary provision of law and subject to HIPAA's preemption rule. Because it is not more stringent, according to the definition of 45 C.F.R. § 160.202, the preemption exception does not apply.’ For the same reasons, the trial court dismissed count four of the complaint, claiming negligent infliction of emotional distress.

With respect to the remainder of the pending motions, the trial court first denied, on the basis of its previous preemption determinations, the plaintiff's motion for summary judgment, which had claimed that the defendant's conduct in responding to the subpoena violated the HIPAA regulations, specifically 45 C.F.R. § 164.512(e), as a matter of law. The trial court denied, however, the defendant's motion for summary judgment with respect to the remaining counts of the complaint, namely, count one alleging breach of contract and count three alleging negligent misrepresentation, determining that genuine issues of material fact existed with respect to contract formation through the defendant's privacy policy, and whether the plaintiff had received and relied upon that policy. Thus, the trial court denied the defendant's motion for summary judgment as to counts one and three of the complaint, and dismissed counts two and four of the complaint for lack of subject matter jurisdiction." (Citations omitted; footnotes added and omitted.) *Byrne v. Avery Center for Obstetrics & Gynecology, P.C.*, supra, 314 Conn. At 439-44, 102 A.3d 32.

Thereafter, pursuant to Practice Book § 61-4, the plaintiff obtained permission to file an appeal from the judgment of the trial court dismissing counts two and four of the complaint to the Appellate Court. The appeal was subsequently transferred to this court pursuant to General Statutes § 51-199(c) and Practice Book § 65-1. On appeal to this court, the plaintiff asserted that the trial court improperly concluded that her state law claims for negligence and negligent infliction of emotional distress were preempted by HIPAA. *Id.*, at 436, 102 A.3d 32. In examining the plaintiff's claim, this court explained: "We note at the outset that whether Connecticut's common law provides a remedy for a health care provider's breach of its duty of confidentiality, including in the context of responding to a subpoena, is not an issue presented in this appeal. Thus, assuming, without deciding, that Connecticut's common law recognizes a negligence cause of action arising from health care providers' breaches of patient privacy in the context of complying with subpoenas, we agree with the plaintiff and conclude that such an action is not preempted by HIPAA and, further, that the HIPAA regulations may well inform the applicable standard of care in certain circumstances." (Footnote omitted.) *Id.*, at 446-47, 102 A.3d 32.

This court concluded that, "to the extent that Connecticut's common law provides a remedy for a health care provider's breach of its duty of confidentiality in the course of complying with a subpoena, HIPAA does not preempt the plaintiff's state common-law causes of action for negligence or negligent infliction of emotional distress against the health care providers in this case and, further, that regulations of the Department of Health and Human Services (department) implementing HIPAA may inform the applicable standard of care in certain circumstances." *Id.*, at 436, 102 A.3d 32. Accordingly, this court reversed the judgment of the trial court and remanded the case to that court for further proceedings. *Id.*, at 436, 102 A.3d 32.

On remand, the defendant filed a motion for summary judgment on the counts of the operative complaint alleging negligence and negligent infliction of emotional distress. As grounds for its motion, the defendant claimed that no Connecticut court had ever recognized a common-law cause of action against a health care provider for breach of its duty of confidentiality for its response to a subpoena. The trial court granted the defendant's motion for summary judgment, determining that "no courts in Connecticut, to date, recognized or adopted a common-law privilege for communications between a patient and physicians. Any recognition of this cause of action is best addressed to our Supreme and Appellate Courts or the legislature. Accordingly, the motion for summary judgment is granted as to counts two and four of the plaintiff's operative complaint." This appeal followed. See footnote 2 of this opinion.

We begin with general principles and the standard of review. "Practice Book § 17-49 provides that summary judgment shall be rendered forthwith if the pleadings, affidavits and any other proof

submitted show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. In deciding a motion for summary judgment, the trial court must view the evidence in the light most favorable to the nonmoving party. The party moving for summary judgment has the burden of showing the absence of any genuine issue of material fact and that the party is, therefore, entitled to judgment as a matter of law. Our review of the trial court's decision to grant the defendant's motion for summary judgment is plenary." (Internal quotation marks omitted.) *Bozelko v. Papastavros*, 323 Conn. 275, 282, 147 A.3d 1023 (2016).

In the present appeal, the plaintiff asserts that the trial court incorrectly granted summary judgment in favor of the defendant on the counts of the operative complaint alleging negligence and negligent infliction of emotional distress. Specifically, the plaintiff asserts that Connecticut's common law recognizes a duty of confidentiality arising from the physician-patient relationship and that this duty extends to compliance with a subpoena. The plaintiff further asserts that recognition of such a duty is supported by public policy considerations, as reflected in § 52-146o and HIPAA, and case law from other jurisdictions. In response, the defendant asserts that there is no common-law duty of confidentiality between a health care provider and a patient in the context of responding to a subpoena. The defendant further asserts that such a duty is not supported by public policy considerations or recognized in other jurisdictions. We conclude that recognizing a cause of action for the breach of the duty of confidentiality in the physician-patient relationship by the disclosure of medical information is not barred by § 52-146o or HIPAA and that public policy, as viewed in a majority of other jurisdictions that have addressed the issue, supports that recognition.

The dispositive issue in this appeal is whether a patient has a civil remedy against a physician if that physician, without the patient's consent, discloses confidential information obtained in the course of the physician-patient relationship. Although we have not had the opportunity to address this question before, this court has recognized that "[t]he principle of confidentiality lies at the heart of the physician-patient relationship." *Jarmie v. Troncale*, 306 Conn. 578, 607, 50 A.3d 802 (2012) "Physician-patient confidentiality is described as a 'privilege.' When that confidentiality is diminished to any degree, it necessarily affects the ability of the parties to communicate, which in turn affects the ability of the physician to render proper medical care and advice." *Id.*, at 608-609, 50 A.3d 802. "[T]he purpose of the privilege is to give the patient an incentive to make full disclosure to a physician in order to obtain effective treatment free from the embarrassment and invasion of privacy which could result from a doctor's testimony." *State v. White*, 169 Conn. 223, 234-35, 363 A.2d 143, cert. denied, 423 U.S. 1025, 96 S.Ct. 469, 46 L.Ed. 2d 399 (1975), citing *C. McCormick*, *Evidence* (2d Ed. 1972) § 98, p. 213. Additionally, the Appellate Court has recognized the fiduciary nature of the physician-patient relationship, which is based on trust and confidence that develops as medical service is provided. *Rosenfield v. Rogin, Nassau, Caplan, Lassman & Hirtle, LLC*, 69 Conn. App. 151, 163, 795 A.2d 572 (2002) ("There is a marked resemblance between the continuous treatment of a patient's condition by a physician and the continuous representation of a client by an attorney. In both situations, the relationship between the parties is demarcated by the fiduciary relationship of trust and confidence, which continues to develop as the service is provided." [Citations omitted.]).

The importance of confidentiality in the physician-patient relationship has been recognized by courts in numerous jurisdictions throughout the country. Courts have repeatedly used the common law to recognize "a patient's valid interest in preserving the confidentiality of medical facts relayed to a physician." *Bratt v. International Business Machines Corp.*, 392 Mass. 508, 522, 467 N.E.2d 126 (1984). "A patient should be entitled to freely disclose his symptoms and condition to his doctor in order to receive proper treatment without fear that those facts may become public property. Only thus can the purpose of the relationship be fulfilled." *Hague v. Williams*, 37 N.J. 328, 336, 181 A.2d 345



(1962). “The benefits which inure to the relationship of physician-patient from the denial to a physician of any right to promiscuously disclose such information are self-evident. On the other hand, it is impossible to conceive of any countervailing benefits which would arise by according a physician the right to gossip about a patient’s health.” *Id.*, at 335-336, 181 A.2d 345. “Notwithstanding the concern that application of the patient-physician privilege may bar the admissibility of probative testimony, there is a clear recognition that, in general, a physician does have a professional obligation to maintain the confidentiality of his patient’s communications. This obligation to preserve confidentiality is recognized as part of the Hippocratic Oath.” (Citation omitted.) *Stemper v. Speidell*, 100 N.J. 368, 375, 495 A.2d 857 (1985).

Indeed, this court has explained that “[t]he principle of confidentiality lies at the heart of the physician-patient relationship and has been recognized by our legislature. [Section] 52-146o was enacted in 1990; see Public Acts 1990, No. 90-177; to address the need ‘to protect the confidentiality of communications in order to foster the free exchange of information from patient to physician.’” *Jarmie v. Troncale*, *supra*, 306 Conn. At 607-608 50 A.3d 802.

Section 52-146o (a) provides: “Except as provided in sections 52-146c to 52-146j, inclusive, sections 52-146p, 52-146q and 52-146s, and subsection (b) of this section, in any civil action or any proceeding preliminary thereto or in any probate, legislative or administrative proceeding, a physician or surgeon, licensed pursuant to section 20-9, or other licensed health care provider, shall not disclose (1) any communication made to him or her by, or any information obtained by him or her from, a patient or the conservator or guardian of a patient with respect to any actual or supposed physical or mental disease or disorder, or (2) any information obtained by personal examination of a patient, unless the patient or that patient’s authorized representative explicitly consents to such disclosure.”

Subsection (b) of § 52-146o further provides as follows: “Consent of the patient or the patient’s authorized representative shall not be required for the disclosure of such communication or information (1) pursuant to any statute or regulation of any state agency or the rules of court, (2) by a physician, surgeon or other licensed health care provider against whom a claim has been made, or there is a reasonable belief will be made, in such action or proceeding, to the physician’s, surgeon’s or other licensed health care provider’s attorney or professional liability insurer or such insurer’s agent for use in the defense of such action or proceeding, (3) to the Commissioner of Public Health for records of a patient of a physician, surgeon or health care provider in connection with an investigation of a complaint, if such records are related to the complaint, or (4) if child abuse, abuse of an elderly individual, abuse of an individual who is physically disabled or incompetent or abuse of an individual with intellectual disability is known or in good faith suspected.”

At the outset, we recognize that, although § 52-146o creates an evidentiary privilege arising from the physician-patient relationship, it does not explicitly provide a cause of action or any other remedy for improper disclosure of the confidential communications obtained in the course of that relationship. Contrary to HIPAA, which “expressly provides a method for enforcing its prohibition upon use or disclosure of [an] individual’s health information—the punitive imposition of fines and imprisonment for violations”; (internal quotation marks omitted) *Byrne v. Avery Center for Obstetrics & Gynecology, P.C.*, *supra*, 314 Conn. At 452, 102 A.3d 32; § 52-146o does not provide for any penalty for its violation.

An exhaustive search of Connecticut case law reveals no hard and fast test that courts apply when determining whether to recognize new causes of action. We do have the inherent authority, pursuant to the state constitution, to create new causes of action. Moreover, it is beyond dispute that we have

the power to recognize new tort causes of action, whether derived from a statutory provision or rooted in the common law.” (Citation omitted.) *ATC Partnership v. Coats North America Consolidated, Inc.*, 284 Conn. 537, 552-53, 935 A.2d 115 (2007). “When we acknowledge new causes of action, we also look to see if the judicial sanctions available are so ineffective as to warrant the recognition of a new cause of action. To determine whether existing remedies are sufficient to compensate those who seek the recognition of a new cause of action, we first analyze the scope and applicability of the current remedies under the facts alleged by the plaintiff. Finally, we are mindful of growing judicial receptivity to the new cause of action, but we remain acutely aware of relevant statutes and do not ignore the statement of public policy that such statutes represent.” (Citations omitted.) *Id.*, at 553, 935 A.2d 115.

We begin by examining the currently available judicial sanctions. In *Byrne v. Avery Center for Obstetrics & Gynecology, P.C.*, *supra*, 314 Conn. At 433, 102 A.3d 32, this court undertook a thorough analysis of the criminal and civil sanctions provided by HIPAA. “It is by now well settled that the statutory structure of HIPAA precludes implication of a private right of action. [Section] 1320d–6 [of title 42 of the United States Code] expressly provides a method for enforcing its prohibition upon use or disclosure of individual’s health information—the punitive imposition of fines and imprisonment for violations.” (Footnote omitted; internal quotation marks omitted.) *Id.*, at 451-52, 102 A.3d 32. In that case, we further explained that “one commenter during the rulemaking process had raised the issue of whether a private right of action is a greater penalty, since the proposed federal rule has no comparable remedy.” *Id.*, at 453, 102 A.3d 32. “[HIPAA] provides for only two types of penalties: fines and imprisonment. Both types of penalties could be imposed in addition to the same type of penalty imposed by a state law, and should not interfere with the imposition of other types of penalties that may be available under state law. Thus, we think it is unlikely that there would be a conflict between state and federal law in this respect.” *Id.*, at 453 n. 19, 102 A.3d 32, quoting Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82, 462, 82,462, 82,582 (Dec. 28, 2000).

As explained previously in this opinion, when acknowledging new causes of action, “we are mindful of growing judicial receptivity to the new cause of action, but we remain acutely aware of relevant statutes and do not ignore the statement of public policy that such statutes represent.” *ATC Partnership v. Coats North America Consolidated, Inc.*, *supra*, 284 Conn. At 553, 935 A.2d 115. Therefore, we next turn to federal law and law from other jurisdictions regarding the duty of health care providers to maintain the confidentiality of medical records.

Federal law regarding the privacy of medical information is codified in HIPAA. As we explained in *Byrne*, “[r]ecognizing the importance of protecting the privacy of health information in the midst of the rapid evolution of health information systems, Congress passed HIPAA in August 1996. Within the Administrative Simplification section, Congress included another provision outlining a two-step process to address the need to afford certain protections to the privacy of health information maintained under HIPAA. First, [Congress] directed [the department] to submit within twelve months of HIPAA’s enactment detailed recommendations on standards with respect to the privacy of individually identifiable health information. Second, if Congress did not enact further legislation pursuant to these recommendations within thirty-six months of the enactment of HIPAA, [the department] was to promulgate final regulations containing such standards. Because Congress ultimately failed to pass any additional legislation, the department’s final regulations implementing HIPAA, known collectively as the Privacy Rule, were promulgated in February 2001, with compliance phased in over the next few years.” (Citations omitted; internal quotation marks omitted.) *Byrne v. Avery Center for Obstetrics & Gynecology, P.C.*, *supra*, 314 Conn. at 448-49, 102 A.3d 32; see also *South Carolina Medical Assn. v.*

Thompson, 327 F.3d 346, 348 (4<sup>th</sup> Cir.), cert. denied, 540 U.S. 981, 124 S.Ct. 464, 157 L.Ed. 2d 371 (2003).

In *Byrne v. Avery Center for Obstetrics & Gynecology, P.C.*, supra, 314 Conn. at 448-59, 102 A3d 32, this court “conclude[d] that, if Connecticut’s common law recognizes claims arising from a health care provider’s alleged breach of its duty of confidentiality in the course of complying with a subpoena, HIPAA and its implementing regulations do not preempt such claims. We further conclude that, to the extent it has become the common practice for Connecticut health care providers to follow the procedures required under HIPAA in rendering services to their patients, HIPAA and its implementing regulations may be utilized to inform the standard of care applicable to such claims arising from allegations of negligence in the disclosure of patients’ medical records pursuant to a subpoena.” Therefore, this court has previously concluded that recognition of a private cause of action for breach of the duty of confidentiality of medical records is not preempted by, or inconsistent with, HIPAA.

Indeed, this court further explained that “[t]he availability of such private rights of action in state courts, to the extent that they exist as a matter of state law, do not preclude, conflict with, or complicate health care providers’ compliance with HIPAA. On the contrary, negligence claims in state courts support at least one of HIPAA’s goals by establishing another disincentive to wrongfully disclose a patient’s health care record.” (Internal quotation marks omitted.) *Id.*, at 459, 102 A.3d 32; see also *Yath v. Fairview Clinics, N.P.*, 767 N.W.2d 34, 49-50 (Minn. App. 2009) (concluding that state statutory cause of action for improper disclosure of medical records was not preempted by HIPAA because, “[a]lthough the penalties under the two laws differ, compliance with [the Minnesota statute] does not exclude compliance with HIPAA,” and “[r]ather than creating an ‘obstacle’ to HIPAA, [the Minnesota statute] supports at least one of HIPAA’s goals by establishing another disincentive to wrongfully disclose a patient’s health care record”). Therefore, we conclude that the federal law regarding privacy and confidentiality of medical records supports our recognition of a common-law cause of action for breach of the duty of confidentiality of medical records by a health care provider.

Although the question of whether to recognize a common-law cause of action for breach of the duty of confidentiality of medical records by a health care provider is one of first impression in this court, many other jurisdictions have addressed this question. A review of case law from other jurisdictions that have addressed this issue demonstrates that a majority of jurisdictions have recognized a common-law cause of action for breach of the confidentiality of medical records by health care providers. “Although the common law did not bestow a privilege on the doctor-patient relationship and no cause of action existed for divulgence of any confidences, the clear modern consensus of the case law has imposed a legal duty of confidentiality or a fiduciary duty under the common law’s continuing power and competence to answer novel questions of law arising under ever changing conditions of the society.” (Footnotes omitted; internal quotation marks omitted.) D. Elder, *Privacy Torts* (2017) § 5:2; see also annot., 48 A.L.R. 4<sup>th</sup> 668, § 2 (a) (1986) (“Although at common law neither the patient nor the physician has the privilege that a communication of one to the other not be disclosed to a third party, courts have generally upheld or recognized the right of a patient to recover damages from a physician for unauthorized disclosure concerning the patient on the ground that such disclosure constitutes an actionable invasion of the patient’s privacy. Another basis of a physician’s liability for unauthorized disclosure of confidential information about a patient is breach of the physician-patient confidential relationship. Although a few jurisdictions have refused to recognize this cause of action it generally has been held or recognized that a patient may have such a cause of action against the physician.” [Footnotes omitted.]).

A review of cases from other jurisdictions reveals that courts have recognized causes of action for breach of confidentiality of medical records by health care providers on a variety of bases. The most common basis for recognizing such a cause of action is that health care providers enjoy a special fiduciary relationship with their patients and that recognition of the privilege is necessary to ensure that this bond remains.

For instance, the Court of Appeals of New York explained that “in New York, the special relationship akin to a fiduciary bond, which exists between the physician and patient, is reflected in the statute. The basis of the evidentiary privilege is that patients will be forthcoming and encouraged to provide complete data to assist a medical provider in diagnosis and treatment. An additional motivation for the existence of the privilege is the avoidance of a Hobson’s choice for physicians: choosing between honoring their professional obligation with respect to their patients’ confidences or their legal duty to testify truthfully. By law and by oath, a physician warrants that any confidential medical information obtained through the relationship will not be released without the patient’s permission. The physician-patient relationship thus operates and flourishes in an atmosphere of transcendent trust and confidence and is infused with fiduciary obligations.” (citation omitted.) *Aufrichtig v. Lowell*, 85 N.Y.2d 540, 546, 650 N.E.2d 401, 626 N.Y.S.2d 743 (1995).

Similarly, the Massachusetts Supreme Judicial Court addressed whether a patient has a nonstatutory, civil remedy against a physician for the disclosure of confidential medical information without the patient’s consent in *Alberts v. Devine*, 395 Mass. 59, 479 N.E.2d 113, cert. denied sub nom. *Carroll v. Alberts*, 474 U.S. 1013, 106 S.Ct. 546, 88 L.Ed. 2d 475 (1985). In that case, the court recognized that “[f]ew cases consider the out-of-court physician-patient privilege. That is undoubtedly due to the fact that the confidentiality of the relationship is a cardinal rule of the medical profession, faithfully adhered to in most instances, and thus has come to be justifiably relied upon by patients seeking advice and treatment. Of the courts that have considered the question, most have held that a patient can recover damages if the physician violates the duty of confidentiality that plays such a vital role in the physician-patient relationship.” (Citation omitted; internal quotation marks omitted.) *Id.*, at 66, 479 N.E.2d 113.

The Massachusetts Supreme Judicial Court reasoned as follows: “We continue to recognize a patient’s valid interest in preserving the confidentiality of medical facts communicated to a physician or discovered by the physician through examination. The benefits which inure to the relationship of physician-patient from the denial to a physician of any right to promiscuously disclose such information are self-evident. On the other hand, it is impossible to conceive of any countervailing benefits which would arise by according a physician the right to gossip about a patient’s health. To foster the best interest of the patient and to insure a climate most favorable to a complete recovery, men of medicine have urged that patients be totally frank in their discussions with their physicians. To encourage the desired candor, men of law have formulated a strong policy of confidentiality to assure patients that only they themselves may unlock the doctor’s silence in regard to those private disclosures. The result which these joint efforts of the two professions have produced has been urged or forecast in *una voce* by commentators in the field of medical jurisprudence.” (Citation omitted; internal quotation marks omitted.) *Id.*, at 65-66, 479 N.E.2d 113.

In considering whether to recognize the new cause of action, the Massachusetts Supreme Judicial Court reasoned as follows: “[T]he [l]egislature has demonstrated its recognition of a policy favoring confidentiality of medical facts by enacting [statutes] to limit the availability of hospital records. Furthermore, [the legislature has also created] an evidentiary privilege as to confidential communications between a psychotherapist and a patient. The fact that no such statutory privilege obtains with respect to physicians generally and their patients does not dissuade us from declaring that

in this Commonwealth all physicians owe their patients a duty, for violation of which the law provides a remedy, not to disclose without the patient's consent medical information about the patient, except to meet a serious danger to the patient or to others." (citation omitted.) *Id.*, at 67-68, 479 N.E.2d 113.

The foregoing cases from other jurisdictions reveal that a majority of jurisdictions that have considered the question have recognized a cause of action against a physician for the unauthorized disclosure of confidential medical information obtained in the context of the physician-patient relationship. "In the absence of express legislation, courts have found the basis for a right of action for wrongful disclosure in four main sources: (1) state physician licensing statutes, (2) evidentiary rules and privileged communication statutes which prohibit a physician from testifying in judicial proceedings, (3) [common-law] principles of trust, and (4) the Hippocratic Oath and principles of medical ethics which proscribe the revelation of patient confidences. The jurisdictions that recognize the duty of confidentiality have relied on various theories for the cause of action, including invasion of privacy, breach of implied contract, medical malpractice, and breach of a fiduciary duty or a duty of confidentiality." (citation omitted; footnote omitted.) *McCormick v. England*, *supra*, 328 S.C. at 636-37, 494 S.E.2d 431.

Other jurisdictions that have considered the issue have continued to allow state law causes of action arising from the breach of patient confidentiality by health care providers after the enactment of HIPAA. These cases rely on the premise that "such state-law claims compliment HIPAA by enhancing the penalties for its violation and thereby encouraging HIPAA compliance." *R.K. v. St. Mary's Medical Center, Inc.*, 229 W.Va. 712, 721, 735 S.E.2d 715 (2012), cert. denied, 569 U.S. 905, 133 S.Ct. 1738, 185 L.Ed. 2d 788 (2013).

In a case with very similar facts to the present case, the Appellate Division of the Superior Court of New Jersey allowed a plaintiff to proceed with a common-law civil action seeking to recover damages against her physician for the disclosure of certain medical records to her husband's attorney in response to a subpoena in the absence of the plaintiff's authorization or a notice to the plaintiff or her attorney. *Crescenzo v. Crane*, 350 N.J. Super. 531, 534-35, 796 A.2d 283 (App. Div.), cert. denied, 174 N.J. 364, 807 A.2d 196 (2002). The court rejected the doctor's claim that the subpoena itself was a determination by the court that would authorize disclosure without consent because it commanded him to produce the documents and he was subject to a contempt citation if he did not comply. *Id.*, at 540-41, 796 A.2d 283. In reaching this conclusion, the court reasoned as follows: "That a physician may find himself in a difficult position when confronted with the imposing language of a subpoena does not warrant a resolution of the problem by simply providing the records without a release or further inquiry, especially when regulatory provisions governing a doctor's conduct recognize and are designed to preserve the confidentiality of a patient's records. We have identified practical alternatives to simply yielding the records—a release, contact with the patient or contact with the attorney—none of which impose[s] a significant or undue burden on the doctor when confidentiality is at stake. We hold that [the] plaintiff may proceed with her cause of action against the doctor." *Id.*, at 542, 796 A.2d 283.

Although many jurisdictions had recognized an independent tort for the unauthorized disclosure of medical information to a third party prior to the enactment of HIPAA, the trend toward recognition of the cause of action and allowance of such claims has continued after its enactment in 1996. See *Sorensen v. Barbuto*, 143 P.3d 295, 300 (Utah App. 2006) (holding that "ex parte communication between a physician and opposing counsel constitutes a breach of the physician's fiduciary duty of confidentiality" and concluding that "the trial court erred in dismissing [the plaintiff's] claim for breach of confidentiality [and, because] we have determined that a duty exists, the trial court [also] erred in

dismissing [the plaintiff's] claim for negligence"); see also, e.g., *Biddle v. Warren General Hospital*, 86 Ohio St.3d 395, 401, 715 N.E.2d 518 (1999) ("[w]e hold that in Ohio, an independent tort exists for the unauthorized, unprivileged disclosure to a third party of nonpublic medical information that a physician or hospital has learned within a physician-patient relationship").

Our research reveals four jurisdictions that have declined to recognize a cause of action for breach of the physician's duty of confidentiality. See annot., 48 A.L.R.4th, supra, § 7, pp. 691–92. ("[i]n a few jurisdictions, the courts have held that liability for a physician's unauthorized disclosure of confidential information about a patient cannot be based upon a breach of the confidential relationship of physician and patient, where the particular jurisdiction follows the common-law rule that neither patient nor physician has a privilege that a communication of one to the other not be disclosed to a third party, and has no statute providing for such a privilege"); see also *Mikel v. Abrams*, 541 F.Supp. 591, 599 (W.D. 1982) (refusing to follow cases from other states and declining to recognize cause of action for breach of confidential or privileged relationship because no Missouri case had recognized cause of action before), *aff'd*, 716 F.2d 907 (8<sup>th</sup> Cir. 1983); *Logan v. District of Columbia*, 447 F.Supp. 1328 (D.D.C. 1978) (noting that "[o]ther jurisdictions have recognized a cause of action for unauthorized disclosure of information obtained through the physician-patient relationship" but concluding that plaintiff had failed to persuade court "that such a cause of action should or would be recognized by the courts of this jurisdiction" and that plaintiff's invasion of privacy claim was "sufficient to redress any breach of the confidentiality of the physician-patient relationship"); *Collins v. Howard*, 156 F.Supp. 322, 324 (S.D.Ga. 1957) (The court refused to recognize a cause of action for breach of confidentiality, concluding as follows: "There is no confidential relationship between doctor and patient or hospital and patient in Georgia. The [common-law] rule is followed and no statute has been enacted creating the relationship. In the absence of a statute providing for such privilege, none exists." [Citation omitted.]); *Quarles v. Sutherland*, 215 Tenn. 651, 655-57, 389 S.W.2d 249 (1965) (declining to recognize cause of action for breach of confidentiality where state had no common-law or statutory privilege for communications between patient and physician).

We conclude that a duty of confidentiality arises from the physician-patient relationship and that unauthorized disclosure of confidential information obtained in the course of that relationship for the purpose of treatment gives rise to a cause of action sounding in tort against the health care provider, unless the disclosure is otherwise allowed by law.

In the present case, there is a genuine issue of material fact as to whether the defendant violated the duty of confidentiality by the manner in which it disclosed the plaintiff's medical records in response to the subpoena. Accordingly, we conclude that the trial court incorrectly granted summary judgment in favor of the defendant in the present case.

The judgment is reversed and the case is remanded for further proceedings in accordance with this opinion.

## *Questions*

1. What is the two-step process under HIPPA mentioned in the *Byrne* case?

2. What are the theories the *Byrne* court discusses to justify a cause of action for breach of confidentiality?
3. According to the *Byrne* court, what are the four main sources for finding a cause of action for breach of confidentiality?
4. What is the rule adopted in the *Byrne* case?
5. What would you have advised the *Byrne* defendant to do when he received the subpoena?

HIPAA has been the subject of a lot of criticism since its inception.<sup>15</sup> One group claims that the law does not go far enough because it cannot contend with the impact that technology has on the healthcare system. For instance, people regularly use fitness apps to track sensitive health information. However, those entities are not subject to HIPAA regulations. Other experts contend that the law goes too far because it makes it difficult for healthcare providers to work together to assist patients and it places an undue burden on patients who try to gain access to their healthcare information.

### ***HIPAA and COVID-19***

The COVID-19 pandemic highlighted some of the problems with HIPAA. The United States Department of Health and Human Services Office for Civil Rights (OCR), the agency that enforces HIPAA, issued several guidance pertaining to the manner in which health information may be used and disclosed in response to the global pandemic. The agency reacted to the crisis by loosening the mandates of HIPAA to give healthcare providers more flexibility. For instance, OCR issued a Notice of Enforcement Discretion permitting healthcare providers to deliver tele-health remote communications to patients using apps like FaceTime, Skype, and Zoom. In addition, OCR released a guidance that empowered first responders to gain access to protected health information about individuals who tested positive or were exposed to COVID-19 in order to help keep both first responders and the public safe. Another OCR guidance document contained information explaining how health care providers could share information with the Centers for Disease Control (CDC), family members of patients, and others, to help prevent the spread of COVID-19. One of the biggest flaws that was exposed is HIPAA's inability to respond to the impact that technology is having on the healthcare industry.

### ***HIPAA and Technology***

As healthcare providers migrate more data to the cloud, the probability that patient health information will be compromised by hackers increases. One of the greatest threats to entities that control patient

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<sup>15</sup> Nick Biernat, *Now 2 decades old, does HIPAA have the muscle to protect patient rights?* HealthChampion, at <https://myhealthchampion.com/now-two-decades-old-does-hipaa-have-the-muscle-to-protect-patient-rights/> (May 22, 2020).

health data is ransomware.<sup>16</sup> Ransomware enables hackers to gain control of protected health information and threaten to publish personally identifiable information if the healthcare institution refuses to pay the ransom. In a report published in 2020, the Department of Health and Human Services claimed that it found that the majority of healthcare providers do not conduct the required risk assessments and risk management procedures. A report issued by ForgeRock contains some troubling statistics. In 2020, the healthcare industry was impacted by 43% of the data breaches in the country, making it the most targeted industry. Medical details were the most sought-after information.<sup>17</sup>

### ***Proposed Changes to the HIPAA Privacy Rule***

In December 2020, OCR announced the following proposed new HIPAA regulations to address some of the deficiencies in the law.

- Patients would be permitted to review their protected health information (PHI) in person and to take notes or pictures of those records.
- Healthcare providers would have to give patients access to PHI within 15 days instead of 30 days.
- Patients would only be permitted to have the electronic protected health information (ePHI ) maintained in an electronic health record (EHR) transferred to a third party.
- Individuals would be permitted to have their PHI transferred to a personal health application.
- The regulations would state when individuals should be provided with ePHI at no cost.
- Covered entities would be required to let individuals know that they have the right to receive or to request that copies of their PHI be sent to a third party when a summary PHI is offered instead of a copy.
- HIPAA-covered entities would be required to place estimated fee schedules on their webpages for PHI access and disclosures.
- HIPAA-covered entities would be required to give customized estimates of the fees they charge for providing an individual with a copy of their own PHI.
- The regulations would create a pathway for individuals to request that their PHI maintained in an EHR be shared among covered entities.
- Under the HIPAA Right of Access, individuals will be able to permit covered healthcare providers and health plans to request their PHI.

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<sup>16</sup> Danny Palmer, *Ransomware attacks now to blame for half of healthcare data breaches*, ZDNet, at <https://www.zdnet.com/article/ransomware-attacks-now-to-blame-for-half-of-healthcare-data-breaches/> (Jan. 15, 2021).

<sup>17</sup> See ForgeRock Consumer Identity Breach Report 2020, at <https://www.forgerock.com> (last visited April 5, 2021).



- HIPAA-covered entities would no longer be required to obtain written confirmation that a Notice of Privacy practices form has been provided.
- Currently, HIPAA-covered entities are permitted to disclose PHI to avert a threat to health and safety when harm is “serious and imminent.” The new regulations would allow the information to be disclosed when harm is “seriously and reasonably foreseeable.”
- HIPAA-covered entities would be allowed to make certain uses and disclosures of PHI relying on their good faith belief that it is in the individual’s best interest.
- The definition of healthcare operations would be broadened to cover care coordination and case management.
- The Armed Forces would be given broader permission to use or disclose PHI to all uniformed services.
- Electronic health record would be defined.

### **2.2.2 Duty to Disclose and Warn**

The duty to warn finds its origin in common law. This obligation poses a problem for physicians. On the one hand, the physician owes a duty to protect the confidentiality of the patient. On the other hand, the physician may be obligated to protect a third party. In contract law, the third-party beneficiary theory provides protections for a third party who may be adversely impacted or benefitted by the terms of the contract. The key to that protection is foreseeability. The primary parties to the contract must foresee that it will have an impact on someone other than them.

#### ***Bradshaw v. Daniel*, 854 S.W.2d 865 (1993)**

ANDERSON, JUSTICE.

We granted this appeal to determine whether a physician has a legal duty to warn a non-patient of the risk of exposure to the source of his patient’s non-contagious disease—Rocky Mountain Spotted Fever. The trial court denied the defendant physician’s motion for summary judgment, but granted an interlocutory appeal on the issue of the physician’s legal duty. The Court of Appeals limited the record and held that the facts were insufficient to show that the risk to the non-patient of contracting Rocky Mountain Spotted Fever was such that a legal duty arose on the part of the physician. We disagree and conclude, for the reasons stated herein, that the physician had a legal duty to warn the non-patient of the risk of exposure to the source of the patient’s non-contagious disease.

#### **Background**

On July 19, 1986, Elmer Johns went to the emergency room at Methodist Hospital South in Memphis, Tennessee, complaining of headaches, muscle aches, fever, and chills. He was admitted to the hospital under the care and treatment of the defendant, Dr. Chalmers B. Daniel, Jr. Dr. Daniel first saw Johns

on July 22, 1986, at which time he ordered the drug Chloramphenicol, which is the drug of choice for a person in the latter stages of Rocky Mountain Spotted Fever. Johns' condition rapidly deteriorated, and he died the next day, July 23, 1986. An autopsy was performed, and the Center for Disease Control in Atlanta conclusively confirmed, in late September 1986, that the cause of death was Rocky Mountain Spotted Fever. Although Dr. Daniel communicated with Elmer Johns' wife, Genevieve, during Johns' treatment, he never advised her of the risks of exposure to Rocky Mountain Spotted Fever, or that the disease could have been the cause of Johns' death.

A week after her husband's death, on August 1, 1986, Genevieve Johns came to the emergency room of Baptist Memorial Hospital in Memphis, Tennessee, with similar symptoms of chills, fever, mental disorientation, nausea, lung congestion, myalgia, and swelling of the hands. She was admitted to the hospital and treated for Rocky Mountain Spotted Fever, but she died three days later, on August 4, 1986, of that disease. It is undisputed that no patient-physician relationship existed between Genevieve Johns and Dr. Daniel.

The plaintiff, William Jerome Bradshaw, is Genevieve Johns' son. He filed this suit alleging that the defendant's negligence in failing to advise Genevieve Johns that her husband died of Rocky Mountain Spotted Fever, and in failing to warn her of the risk of exposure, proximately caused her death. The defendant filed a motion to dismiss for failure to state a cause of action on the grounds that the physician owed Genevieve Johns no legal duty because of the absence of a patient-physician relationship. The trial judge denied the motion.

Later, the defendant filed a motion for summary judgment on the same grounds, supported by the affidavit of Dr. Michael S. Gelfand. Dr. Gelfand testified that the medical standard of care did not require a physician treating a patient infected with, or suspected of being infected with, Rocky Mountain Spotted Fever to treat the family of the patient in contact with him, or to warn them of the risk of exposure to the disease or the risk of exposure to ticks or tick bites. The plaintiff responded with the affidavit of Dr. Burt Prater. Dr. Prater testified that because of the clustering effect of the disease, the medical standard of care required that a physician treating a patient with symptoms of Rocky Mountain Spotted Fever advise the family of the patient as to the incubation period, the symptoms of the disease, and the need for immediate medical attention upon manifestation of the symptoms. Dr. Prater further testified that the defendant, Dr. Daniel, negligently failed to diagnose Elmer Johns' fatal disease of Rocky Mountain Spotted Fever and failed to warn his wife, Genevieve Johns, of the incubation period of the disease, the symptoms, and the need to seek medical treatment upon manifestation of the symptoms. He also testified that the disease, if untreated, has a 40 percent mortality rate, but if treated promptly, has a 4 percent mortality rate. Based on the affidavits, the defendant's motion for summary judgment was denied.

The case was then transferred to another judge and tried before a jury, which returned a verdict of \$50,000 against the defendant. Thereafter, the plaintiff filed a motion for a new trial or additur on the grounds of inadequate damages, and the defendant filed a motion notwithstanding the verdict on the grounds, among others, that no legal duty existed. The plaintiff's motion for a new trial was granted, and the defendant's motion was overruled.

After the new trial was granted, the defendant again filed a motion for summary judgment contending that he owed no legal duty to his patient's wife, Genevieve Johns. In support of the motion, the defendant relied upon the pleadings, the affidavit of Dr. Michael Gelfand, and the "entire record in this cause." The plaintiff filed no written response but, during oral argument on the motion, stated that he

relied on the entire record in the original trial. The trial judge again denied the motion; however, he granted the defendant an interlocutory appeal.

The Court of Appeals also granted the defendant's application for interlocutory appeal. *See* Tenn. R.App.P. 9. The plaintiff filed a designation of the record on appeal, listing, among other things, the defendant's testimony at the first trial, which had not been transcribed at the time of the hearing on the motion for summary judgment. The defendant moved to strike portions of the plaintiff's designation of the record on appeal, including the trial testimony of the defendant. The trial judge ordered that the defendant's trial testimony be included in the record on appeal.

The Court of Appeals refused to consider the defendant's trial testimony in its determination of the substantive issue of legal duty. The intermediate court then granted the motion for summary judgment, concluding that the record did not contain sufficient facts to establish a risk to Genevieve Johns which would give rise to a legal duty. We granted the plaintiff's application for permission to appeal and now reverse for the reasons set out herein.

### Record on Appeal

In this case, the trial judge ruled that the defendant's testimony at the first trial was properly includable in the record on appeal. The defendant, Dr. Daniel, testified at trial that he did not see his patient, Elmer Johns, for the first three days he was hospitalized, but communicated with another physician about him. On the fourth day of his hospitalization, Dr. Daniel examined him, recognized that Rocky Mountain Spotted Fever could be one of the causes of his symptoms, and prescribed a strong drug with significant side effects—which was the drug of choice for Rocky Mountain Spotted Fever victims. He also testified that although he was in communication with Genevieve Johns, he did not warn her that Rocky Mountain Spotted Fever could be causing her husband's symptoms, nor did he advise her of the incubation period, the need to be on the lookout for similar symptoms, and the need to seek immediate treatment if such symptoms occurred. Dr. Daniel conceded that there is a medical, but not a legal, duty to educate the family and provide information when a patient is diagnosed as having Rocky Mountain Spotted Fever. The Court of Appeals refused to consider this testimony, opining that since it was not transcribed at the time of the hearing on the motion, it was not before the trial judge when he ruled on the motion.

The general policy of the Tennessee Rules of Appellate Procedure is to “disregard technicality in form in order that a just, speedy, and inexpensive determination of every appellate proceeding on its merits may be obtained.” Tenn.R.App. 1 advisory commission comments.

The content of the record on appeal is governed by Tenn.R.App.P. 24, which is designed to ensure that the record on appeal conveys “a fair, accurate and complete account of what transpired with respect to those issues that are the bases of appeal.” The procedure for correction or modification of the record is set forth in subsection (e) of Rule 24 which provides:

If any matter properly includable is omitted from the record, is improperly included, or is misstated therein, the record may be corrected or modified to conform to the truth. Any differences regarding whether the record accurately discloses what occurred in the trial court shall be submitted to and settled by the trial court regardless of whether the record has been transmitted to the appellate court. Absent extraordinary circumstances, the determination of the trial court is conclusive. If necessary, the appellate or trial court may direct that a supplemental record be certified and transmitted.

The procedure for correction or modification of the record reflects the policy of avoiding technicality and expediting a just resolution on the merits by according deference to the trial court's decision on which matters are properly includable in the record, thereby avoiding additional litigation on that subject alone. The specific purpose of Rule 24 is accommodated as well, since the trial judge is in the best position to determine which matters are necessary to "convey a fair, accurate and complete account of what transpired with respect to those issues that are the bases of appeal." *See also Artrip v. Crilley*, 688 S.W.2d 451, 453 (Tenn.App.1985). While Rule 24(e) grants an appellate court authority to direct that a supplemental record be certified and transmitted, absent extraordinary circumstances, an appellate court does not have the authority to refuse to consider matters that are determined by the trial court judge to be appropriately includable in the record.

Here, the first trial had been held and a new trial had been granted to the plaintiff. The defendant had filed a second motion for summary judgment on essentially the same grounds as his earlier motions to dismiss, for summary judgment, and notwithstanding the verdict. He relied on the Gelfand affidavit and the entire record in the cause, which included all his earlier motions and affidavits filed before and during the first trial, including the affidavit of the defendant. The plaintiff, in response, also relied on the entire record. The trial judge who ruled on the motion for summary judgment presided over the trial and heard the live testimony of the defendant. By allowing the testimony to be included in the record on appeal, the trial judge agreed that he considered the testimony when he denied the motion for summary judgment. Based on these facts, there were no "extraordinary circumstances" which would justify disregarding the defendant's testimony.

The defendant argues that the Court of Appeals' refusal to consider the testimony should be upheld because the plaintiff did not file a written response to the motion stating that he was relying on the first trial testimony. While we agree with the defendant that it would have been better practice for the plaintiff to have filed a written response, rather than stating it orally, this technical defect does not justify disregarding a portion of the record that the trial judge deemed necessary to reflect a fair, accurate and complete account of what transpired in the trial court. *See* Tenn.R.App.P.1 advisory commission comments; Tenn.R.App.P. 24.

Accordingly, in determining whether the defendant owed Genevieve Johns a legal duty, we will consider the entire record on appeal.

### Legal Duty

The defendant physician argues that he owed his patient's wife no legal duty because first, there was no physician-patient relationship, and second, Rocky Mountain Spotted Fever is not a contagious disease and, therefore, there is no duty to warn of the risk of exposure.

We begin our analysis by examining how we determine when a legal duty may be imposed upon one for the benefit of another. While duty was not part of the early English common law jurisprudence of tort liability,<sup>1</sup> it has since become an essential element in negligence cases. No claim for negligence can succeed in the absence of any one of the following elements: (1) a duty of care owed by the defendant to the plaintiff; (2) conduct falling below the applicable standard of care amounting to a breach of that duty; (3) an injury or loss; (4) causation in fact; and (5) proximate, or legal cause (citations omitted). In determining the issue, a court should consider

whether, upon the facts in evidence, such a relation exists between the parties that the

community will impose a legal obligation upon one for the benefit of others—or, more simply, whether the interest of the plaintiff which has suffered invasion was entitled to legal protection at the hands of the defendant. This is entirely a question of law to be determined by reference to the body of statutes, rules, principles and precedents which make up the law; and it must be determined only by the court. A decision by the court that, upon any version of the facts, there is no duty, must necessarily result in judgment for the defendant. A decision that if certain facts are found to be true, a duty exists, leaves open the other questions now under consideration [concerning the existence of negligence].

*Lindsey*, 689 S.W.2d at 859, quoting Prosser, § 37 at 236. Thus, the imposition of a legal duty reflects society's contemporary policies and social requirements concerning the right of individuals and the general public to be protected from another's act or conduct. Prosser, *Palsgraf Revisited*, 52 Mich.L.Rev. 1, 15 (1953); *Kirk v. Reese Hospital & Medical Ctr.*, 117 Ill.2d 507, 111 Ill.Dec. 944, 953-54, 513 N.E.2d 387, 396-97 (1987). Indeed, it has been stated that 'duty' is not sacrosanct in itself, but is only an expression of the sum total of those considerations of policy which lead the law to say that the plaintiff is entitled to protection. Prosser, § 53 at 358. Our determination of this question of law is *de novo* upon the record, viewing the evidence in a light most favorable to the plaintiff, the non-moving party, allowing all reasonable inferences and discarding all countervailing evidence. *Byrd v. Hall*, 847 S.W.2d 208, 210 (Tenn. 1993); *Cowden v. Sovran Bank/Central South*, 816 S.W.2d 741, 744 (Tenn. 1991).

The defendant contends that the absence of a physician-patient relationship negates the existence of a duty in this case. While it is true that a physician-patient relationship is necessary to the maintenance of a medical malpractice action, it is not necessary for the maintenance of an action based on negligence, and this Court has specifically recognized that a physician may owe a duty to a non-patient third party for injuries caused by the physician's negligence, if the injuries suffered and the manner in which they occurred were reasonably foreseeable. *Wharton Transport Corp. v. Bridges*, 606 S.W.2d 521, 526 (Tenn. 1980) (physician owed duty to third party injured by disabled truck driver's negligence, where the physician was negligent both in his physical examination and certification of the truck driver for the employer).

Here, we are asked to determine whether a physician has an affirmative duty to warn a patient's family member about the symptoms and risks of exposure to Rocky Mountain Spotted Fever, a non-contagious disease. Insofar as we are able to determine, there is no reported decision from this or any other jurisdiction involving circumstances exactly similar to those presented in this case.

We begin by observing that all persons have a duty to use reasonable care to refrain from conduct that will foreseeably cause injury to others. See *Doe v. Linder*, 845 S.W.2d 173, 178 (Tenn. 1992); Restatement (Second) of Torts § 314 (1964).

In determining the existence of a duty, courts have distinguished between action and inaction. Professor Prosser has commented that the reason for the distinction may be said to lie in the fact that by 'misfeasance' the defendant has created a new risk of harm to the plaintiff, while by 'nonfeasance' he has at least made his situation no worse, and has merely failed to benefit him by interfering in his affairs. Prosser, § 56 at 373; *Lindsey*, supra, 689 at 859.

Because of this reluctance to countenance nonfeasance as a basis of liability, as a general rule, under the common law, one person owed no affirmative duty to warn those endangered by the conduct of

another. Prosser, § 56 at 374; *Tarasoff v. Regents of University of California*, 17 Cal.3d 425, 131 Cal.Rptr. 14, 23, 551 P.2d 334, 343 (1976).

To mitigate the harshness of this rule, courts have carved out exceptions for cases in which the defendant stands in some special relationship to either the person who is the source of the danger, or to the person who is foreseeably at risk from the danger. Lindsey, 689 S.W.2d at 859; *Tarasoff*, 551 P.2d at 343; Restatement (Second) of Torts § 315 (1964). Accordingly,

while an actor is always bound to prevent his acts from creating an unreasonable risk to others, he is under the affirmative duty to act to prevent another from sustaining harm only when certain socially recognized relations exist which constitute the basis for such legal duty.

Harper & Kime, *The Duty to Control the Conduct of Another*, 43 Yale L.J. 886, 887 (1934).

One of the most widely known cases applying that principle is *Tarasoff*, supra, in which the California Supreme Court held that when a psychotherapist determines or, pursuant to the standards of his profession, should determine that his patient presents a serious danger of violence to another, the therapist has an affirmative duty to use reasonable care to protect the intended victim against such danger, and the duty may require the physician to warn the intended victim of the danger. 551 P.2d at 340. The special relationship of the patient to his psychotherapist supported imposition of the affirmative duty to act for the benefit of third persons. 551 P.2d at 340-44.

Decisions of other jurisdictions have employed the same analysis and held that the relationship of a physician to his patient is sufficient to support the duty to exercise reasonable care to protect third persons against foreseeable risks emanating from a patient's physical illness. Specifically, other courts have recognized that physicians may be liable to persons infected by a patient, if the physician negligently fails to diagnose a contagious disease, or having diagnosed the illness, fails to warn family members or others who are foreseeably at risk of exposure to the disease. See *Gammil v. United State*, 727 F.2d 950, 954 (10<sup>th</sup> Cir. 1984) (physician may be found liable for failing to warn a patient's family, treating attendants, or other persons likely to be exposed to the patient of the nature of the disease and the danger of exposure); *Davis v. Rodman*, 147 Ark. 385, 227 S.W. 612, 614 (1921) (physician has a duty to exercise reasonable care to prevent the spread of infectious diseases); *Jones v. Stanko*, 118 Ohio St. 147, 160 N.E. 456, 458 (1928) (physician liable for injuries incurred by third person who contracted smallpox as result of physician's failure to warn) (citations omitted).

Returning to the facts of this case, first, it is undisputed that there was a physician-patient relationship between Dr. Daniel and Elmer Johns. Second, here, as in the contagious disease context, it is also undisputed that Elmer Johns' wife, who was residing with him, was at risk of contracting the disease. This is so even though the disease is not contagious in the narrow sense that it can be transmitted from one person to another. Both Dr. Daniel and Dr. Prater, the plaintiff's expert, testified that family members of patients suffering from Rocky Mountain Spotted Fever are at risk of contracting the disease due to a phenomenon called clustering, which is related to the activity of infected ticks who transmit the disease to humans. Dr. Prater also testified that Dr. Daniel negligently failed to diagnose the disease and negligently failed to warn his patient's wife, Genevieve Johns, of her risk of exposure to the source of disease. Dr. Daniel's expert disputed these conclusions, but Dr. Daniel conceded there is a medical duty to inform the family when there is a diagnosis of the disease. Thus, this case is analogous to the *Tarasoff* line of cases adopting a duty to warn of danger and the contagious disease cases adopting a

comparable duty to warn. Here, as in those cases, there was a foreseeable risk of harm to an identifiable third party, and the reasons supporting the recognition of the duty to warn are equally compelling here.

We, therefore, conclude that the existence of the physician-patient relationship is sufficient to impose upon a physician an affirmative duty to warn identifiable third persons in the patient's immediate family against foreseeable risks emanating from a patient's illness. Accordingly, we hold that under the factual circumstances of this case, viewing the evidence in a light most favorable to the plaintiff, the defendant physician had a duty to warn his patient's wife of the risk to her of contracting Rocky Mountain Spotted Fever, when he knew, or in the exercise of reasonable care, should have known, that his patient was suffering from the disease. Our holding here is necessarily limited to the conclusion that the defendant physician owed Genevieve Johns a legal duty. We express no opinion on the other elements which would be required to establish a cause of action for common-law negligence in this case.

Accordingly, the judgment of the Court of Appeals granting the defendant's motion for summary judgment is reversed, and this cause is remanded to the trial court for proceedings consistent with this opinion. The costs of this appeal are taxed against the defendant.

***Tarasoff v. Regents of University of California*, 551 P.2d 334 (Cal.3d 1976)**

TOBRINER, JUSTICE.

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 (Welf. & Inst.Code, s 5000ff.) 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 (Gov.Code, s 810ff.).

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, however, 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. No specific statutory provision, however, shields them from liability based upon failure to warn Tatiana or others likely to apprise her of the danger, and Government Code section 820.2 does not protect such failure as an exercise of discretion.

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, however, plead no relationship between Poddar and the police defendants which would impose upon them any duty to Tatiana, and plaintiffs suggest no other basis for such a duty. Plaintiffs have, therefore, failed to show that the trial court erred in sustaining the demurrer of the police defendants without leave to amend.

#### 1. 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 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.



Plaintiffs' third cause of action, entitled 'Abandonment of a Dangerous Patient,' seeks \$10,000 punitive damages against defendant Powelson. Incorporating the crucial allegations of the first cause of action, plaintiffs charge that Powelson 'did the things herein alleged with intent to abandon a dangerous patient, and said acts were done maliciously and oppressively.'

Plaintiffs' fourth cause of action, for 'Breach of Primary Duty to Patient and the Public,' states essentially the same allegations as the first cause of action, but seeks to characterize defendants' conduct as a breach of duty to safeguard their patient and the public. Since such conclusory labels add nothing to the factual allegations of the complaint, the first and fourth causes of action are legally indistinguishable.

As we explain in part 4 of this opinion, plaintiffs' first and fourth causes of action, which seek to predicate liability upon the defendants' failure to bring about Poddar's confinement, are barred by governmental immunity. Plaintiffs' third cause of action succumbs to the decisions precluding exemplary damages in a wrongful death action. (See part 6 of this opinion.) We direct our attention, therefore, to the issue of whether plaintiffs' second cause of action can be amended to state a basis for recover.

2. 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* (1968) 68 Cal.2d 728, 734, 69 Cal.Rptr. 72, 76, 441 P.2d 912, 916: '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.' (Prosser, *Law of Torts* (3d ed. 1964) at pp. 332—333.)'

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 (citations omitted). 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 (*Rest.2d Torts*, *supra*,

s 314, *com. c Prosser, Law of Torts* (4th ed. 1971) s 56, p. 341), 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 (see *Rest.2d Torts*, *supra*, ss 315-320). 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 section 315 of 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’s 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. (*Hofmann v. Blackmon* (Fla.App. 1970) 241 So.2d 752), or, having diagnosed the illness, fails to warn members of the patient’s family (citations omitted).

Since it involved a dangerous mental patient, the decision in *Merchants Nat. Bank & Trust Co. of Fargo v. United States* (D.N.D.1967) 272 F.Supp. 409 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 Fleming and Maximov 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.’ (Fleming & Maximov, *The Patient or His Victim: The Therapist’s Dilemma* (1974) 62 Cal.L.Rev. 1025, 1030.)

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' (citations omitted). See 4 Witkin, Summary of Cal.Law (8th ed. 1974) Torts, s 514 and cases cited.) 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. (Accord *Cobbs v. Grant* (1972) 8 Cal.3d 229, 243, 104 Cal.Rptr. 505, 502 p.2d 1.) explained in *Fleming and Maximov, The Patient or His Victim: The Therapist's Dilemma* (1974) 62 Cal.L.Rev. 1025, 1067: '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.'

The issue in the present context is not whether the patient should be incarcerated, but whether the therapist should take any steps at all to protect the threatened victim; some of the alternatives open to the therapist, such as warning the victim, will not result in the drastic consequences of depriving the patient of his liberty. Weighing the uncertain and conjectural character of the alleged damage done the patient by such a warning against the peril to the victim's life, we conclude that professional inaccuracy in predicting violence cannot negate the therapist's duty to protect the threatened victim.

The risk that unnecessary warnings may be given is a reasonable price to pay for the lives of possible victims that may be saved. We would hesitate to hold that the therapist who is aware that his patient

expects to attempt to assassinate the President of the United States would not be obligated to warn the authorities because the therapist cannot predict with accuracy that his patient will commit the crime.

Defendants further argue that free and open communication is essential to psychotherapy that unless a patient is assured that information (revealed by him) can and will be held in utmost confidence, he will be reluctant to make the full disclosure upon which diagnosis and treatment depends. (Sen.Com. on Judiciary, comment on Evid.Code, s 1014. The giving of a warning, defendants contend, constitutes a breach of trust which entails the revelation of confidential communications.

We recognize the public interest in supporting effective treatment of mental illness and in protecting the rights of patients to privacy (See *In re Lifschutz*, supra, 2 Cal.3d at p. 432, 85 Cal.Rptr. 829, 467 P.2d 557) and the consequent public importance of safeguarding the confidential character of psychotherapeutic communication. Against this interest, however, we must weigh the public interest in safety from violent assault. The Legislature has undertaken the difficult task of balancing the countervailing concerns. In evidence Code section 1014, it established a broad rule of privilege to protect confidential communications between patient and psychotherapist. In Evidence Code section 1024, the Legislature created a specific and limited exception to the psychotherapist-patient privilege: 'There is no privilege . . . if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger.'

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. (See Fleming & Maximov, *The Patient or His Victim: The Therapist's Dilemma* (1974) 62 Cal.L.Rev. 1025, 1065—1066.)

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.' (Emphasis added.) 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.

Finally, we reject the contention of the dissent that the provisions of the Lanterman-Petris-Short Act which govern the release of confidential information prevented defendant therapists from warning Tatiana. The dissent's contention rests on the assertion that Dr. Moore's letter to the campus police constituted an 'application in writing' within the meaning of Welfare and Institutions Code section 5150, and thus initiates proceedings under the Lanterman-Petris-Short Act. A closer look at the terms of section 5150, however, will demonstrate that it is inapplicable to the present case.

Section 5150 refers to a written application only by a professional person who is '(a) member of the attending staff of an evaluation facility designated by the county,' or who is himself 'designated by the county' as one authorized to take a person into custody and place him in a facility designated by the county and approved by the State Department of Mental Hygiene. The complaint fails specifically to allege that Dr. Moore was so empowered. Dr. Moore and the Regents cannot rely upon any inference to the contrary that might be drawn from plaintiff's allegation that Dr. Moore intended to 'assign' a 'detention' on Poddar; both Dr. Moore and the Regents have expressly conceded that neither Cowell Memorial Hospital nor any member of its staff has ever been designated by the County of Alameda to institute involuntary commitment proceedings pursuant to section 5150.

Furthermore, the provisions of the Lanterman-Petris-Short Act defining a therapist's duty to withhold confidential information are expressly limited to 'information and records Obtained in the course of providing services under Division 5 (commencing with Section 5000), Division 6 (commencing with Section 6000), or Division 7 (commencing with Section 7000)' of the Welfare and Institutions Code (Welf. & Inst. Code, s 5328). (Emphasis added.) Divisions 5, 6 and 7 describe a variety of programs for treatment of the mentally ill or retarded. The pleadings at issue on this appeal, however, state no facts showing that the psychotherapy provided to Poddar by the Cowell Memorial Hospital falls under any of these programs. We therefore conclude that the Lanterman-Petris-Short Act does not govern the release of information acquired by Moore during the course of rendition of those services.

Neither can we adopt the dissent's suggestion that we import wholesale the detailed provisions of the Lanterman-Petris-Short Act regulating the disclosure of confidential information and apply them to disclosure of information Not governed by the act. Since the Legislature did not extend the act to control all disclosures of confidential matter by a therapist, we must infer that the Legislature did not relieve the courts of their obligation to define by reference to the principles of the common law the obligation of the therapist in those situations not governed by the act.

Turning now to the police defendants, we conclude that they do not have any such special relationship to either Tatiana or to Poddar sufficient to impose upon such defendants a duty to warn respecting Poddar's violent intentions (citations omitted). Plaintiffs suggest no theory, and plead no facts that give rise to any duty to warn on the part of the police defendants absent such a special relationship. They have thus failed to demonstrate that the trial court erred in denying leave to amend as to the police defendants (citations omitted).

We address the issue of whether defendant therapists are protected by governmental immunity for having failed to warn Tatiana or those who reasonably could have been expected to notify her of her peril. We postulate our analysis on section 820.2 of the Government Code. That provision declares, with exceptions not applicable here, that 'a public employee is not liable for an injury resulting from his act or omission where the act or omission was the result of the exercise of the discretion vested in him, whether or not such discretion (was) abused.'

Noting that virtually every public act admits of some element of discretion, we drew the line in *Johnson v. State of California* (1968) 69 Cal.2d 782, 73 Cal.Rptr. 240, 447 P.2d 352, between discretionary policy decisions which enjoy statutory immunity and ministerial administrative acts which do not. We concluded that section 820.2 affords immunity only for ‘basic policy decisions.’ (Emphasis added.) (citations omitted).

We also observed that if courts did not respect this statutory immunity, they would find themselves ‘in the unseemly position of determining the propriety of decisions expressly entrusted to a coordinate branch of government.’ (*Johnson v. State of California*, supra, 69 Cal.2d at p. 793, 73 Cal.Rptr. at p. 248, 447 P.2d at p. 360.) It therefore is necessary, we concluded, to ‘isolate those areas of quasi-legislative policy-making which are sufficiently sensitive to justify a blanket rule that courts will not entertain a tort action alleging that careless conduct contributed to the governmental decision.’ After careful analysis we rejected, in *Johnson*, other rationales commonly advanced to support governmental immunity and concluded that the immunity’s scope should be no greater than is required to give legislative and executive policymakers sufficient breathing space in which to perform their vital policymaking functions.

Relying on *Johnson*, we conclude that defendant therapists in the present case are not immune from liability for their failure to warn of Tatiana’s peril. *Johnson* held that a parole officer’s determination whether to warn an adult couple that their prospective foster child had a background of violence ‘present(ed) no reasons for immunity’ was ‘at the lowest, ministerial rung of official action’ (*Id.*, at 796, 793, 73 Cal.Rptr. at p. 250, 447 P.2d at p. 362), and indeed constituted ‘a classic case for the imposition of tort liability.’ *Id.*, p. 797, 73 Cal.Rptr. p. 251, 447 P.2d at p. 363; cf. *Morgan v. County of Yuba*, supra, 230 Cal.App.2d 938, 942-943, 41 Cal.Rptr. 508.). Although defendants in *Johnson* argued that the decision whether to inform the foster parents of the child’s background required the exercise of considerable judgmental skills, we concluded that the state was not immune from liability for the parole officer’s failure to warn because such a decision did not rise to the level of a ‘basic policy decision.’

We conclude, therefore, that the therapist defendants’ failure to warn Tatiana or those who reasonably could have been expected to notify her of her peril does not fall within the absolute protection afforded by section 820.2 of Government Code. We emphasize that our conclusion does not raise the specter of therapists employed by the government indiscriminately being held liable for damage despite their exercise of sound professional judgment. We require of publicly employed therapists only that quantum of care which the common law requires of private therapists. The imposition of liability in those rare cases in which a public employee falls short of this standard does not contravene the language or purpose of Government Code section 820.2.

For the reasons stated, we conclude that plaintiffs can amend their complaints to state a cause of action against defendant therapists by asserting that the therapists in fact determined that Poddar presented a serious danger of violence to Tatiana, or pursuant to the standards of their profession should have so determined, but nevertheless failed to exercise reasonable care to protect her from that danger.

The judgment of the superior court in favor of defendants Atkinson, Beall, Brownrigg, Hallernan, and Teel is affirmed. The judgment of the superior court in favor of defendants Gold, Moore, Powelson, Yandell, and the Regents of the University of California is reversed, and the cause remanded for further proceedings consistent with the views expressed herein.

MOSK, JUSTICE (concurring and dissenting).

I concur in the result in this instance only because the complaints allege that defendant therapists did in fact predict that Poddar would kill and were therefore negligent in failing to warn of that danger. Thus the issue here is very narrow: we are not concerned with whether the therapists, pursuant to the standards of their profession, 'should have' predicted potential violence; they allegedly did so in actuality. Under these limited circumstances I agree that a cause of action can be stated.

Whether plaintiffs can ultimately prevail is problematical at best. As the complaints admit, the therapists did notify the police that Poddar was planning to kill a girl identifiable as Tatiana. While I doubt that more should be required, this issue may be raised in defense and its determination is a question of fact.

I cannot concur, however, in the majority's rule that a therapist may be held liable for failing to predict his patient's tendency to violence if other practitioners, pursuant to the 'standards of the profession,' would have done so. The question is, what standards? Defendants and a responsible amicus curia, supported by an impressive body of literature discussed at length in our recent opinion in *People v. Burnick* (1975) 14 Cal.3d 306, 121 Cal.Rptr. 488, 535 P.2d 352, demonstrate that psychiatric predictions of violence are inherently unreliable.

The majority confidently claim their opinion is not offensive to *Burnick*, on the stated ground that *Burnick* involved proceedings to commit an alleged mentally disordered sex offender and this case does not. I am not so sanguine about the distinction. Obviously the two cases are not factually identical, but the similarity in issues is striking: in *Burnick* we were likewise called upon to appraise the ability of psychiatrists to predict dangerousness, and while we declined to bar all such testimony (*Id.* at pp. 327-328, 121 Cal.Rptr. 488, 535 P.2d 352) we found it so inherently untrustworthy that we would permit confinement even in a so-called civil proceeding only upon proof beyond a reasonable doubt.

I would restructure the rule designed by the majority to eliminate all reference to conformity to standards of the profession in predicting violence. If a psychiatrist does in fact predict violence, then a duty to warn arises. The majority's expansion of that rule will take us from the world of reality into the wonderland of clairvoyance.

CLARK, JUSTICE (dissenting).

Until today's majority opinion, both legal and medical authorities have agreed that confidentiality is essential to effectively treat the mentally ill, and that imposing a duty on doctors to disclose patient threats to potential victims would greatly impair treatment. Further, recognizing that effective treatment and society's safety are necessarily intertwined, the Legislature has already decided effective and confidential treatment is preferred over imposition of a duty to warn.

The issue whether effective treatment for the mentally ill should be sacrificed to a system of warnings is, in my opinion, properly one for the Legislature, and we are bound by its judgment. Moreover, even in the absence of clear legislative direction, we must reach the same conclusion because imposing the majority's new duty is certain to result in a net increase in violence.

Generally, a person owes no duty to control the conduct of another. (*Richards v. Stanley* (1954) 43 Cal.2d 60, 65, 271 P.2d 23; *Wright v. Arcade School Dist.* (1964) 230 Cal.App.2d 272, 277, 40 Cal.Rptr. 812; *Rest.2d Torts* (1965) s 315.) Exceptions are recognized only in limited situations where (1) a special relationship exists between the defendant and injured party, or (2) a special relationship

exists between defendant and the active wrongdoer, imposing a duty on defendant to control the wrongdoer's conduct. The majority does not contend the first exception is appropriate to this case.

Policy generally determines duty. (*Dillon v. Legg* (1968) 68 Cal.2d 728, 734, 69 Cal.Rptr. 72, 441 P.2d 912.) Principal policy considerations include foreseeability of harm, certainty of the plaintiff's injury, proximity of the defendant's conduct to the plaintiff's injury, moral blame attributable to defendant's conduct, prevention of future harm, burden on the defendant, and consequences to the community. Overwhelming policy considerations weigh against imposing a duty on psychotherapists to warn a potential victim against harm. While offering virtually no benefit to society, such a duty will frustrate psychiatric treatment, invade fundamental patient rights and increase violence.

The importance of psychiatric treatment and its need for confidentiality have been recognized by this court. (*In re Lifschutz* (1970) 2 Cal.3d 415, 421-422, 85 Cal.Rptr. 829, 467 P.2d 558.) 'It is clearly recognized that the very practice of psychiatry vitally depends upon the reputation in the community that the psychiatrist will not tell.' (*Slovenko, Psychiatry and a Second Look at the Medical Privilege* (1960) 6 Wayne L.Rev. 175, 188.)

Assurance of confidentiality is important for three reasons.

First, without substantial assurance of confidentiality, those requiring treatment will be deterred from seeking assistance. (See Sen. Judiciary Com. comment accompanying s 1014 of Evid.Code; *Slovenko, Supra*, 6 Wayne L.Rev. 175, 187—188; *Goldstein & Katz, Psychiatrist-Patient Privilege: The GAP Proposal and the Connecticut Statute* (1962) 36 Conn.Bar J. 175, 178.) It remains an unfortunate fact in our society that people seeking psychiatric guidance tend to become stigmatized. Apprehension of such stigma—apparently increased by the propensity of people considering treatment to see themselves in the worst possible light—creates a well-recognized reluctance to seek aid. (*Fisher, The Psychotherapeutic Professions and the Law of Privileged Communications* (1964) 10 Wayne L.Rev. 609, 617; *Slovenko, Supra*, 6 Wayne L.Rev. 175, 188; see also *Rappeport, Psychiatrist-Patient Privilege* (1963) 23 Md.L.J. 39, 46—47.) This reluctance is alleviated by the psychiatrist's assurance of confidentiality.

Second, the guarantee of confidentiality is essential in eliciting the full disclosure necessary for effective treatment. (*In re Lifschutz, supra*, 2 Cal.3d 415, 431, 85 Cal.Rptr. 829, 467 P.2d 557; *Taylor v. United States* (1955), 95 U.S.App.D.C. 373, 222 F.2d 398, 401; *Goldstein & Katz, Supra*, 36 Conn.Bar J. 175, 178; *Heller, Some Comments to Lawyers on the Practice of Psychiatry* (1957) 30 Temp.L.Q. 401; *Guttmacher & Weihofen, Privileged Communications Between Psychiatrist and Patient* (1952) 28 Ind.L.J. 32, 34.) The psychiatric patient approaches treatment with conscious and unconscious inhibitions against revealing his innermost thoughts. 'Every person, however well-motivated, has to overcome resistances to therapeutic exploration. These resistances seek support from every possible source and the possibility of disclosure would easily be employed in the service of resistance.' (*Goldstein & Katz, Supra*, 36 Conn.Bar J. 175, 179; see also, 118 Am.J.Psych. 734, 735.) Until a patient can trust his psychiatrist not to violate their confidential relationship, 'the unconscious psychological control mechanism of repression will prevent the recall of past experiences.' (*Butler, Psychotherapy and Griswold: Is Confidentiality a Privilege or a Right?* (1971) 3 Conn.L.Rev. 599, 604.)

Third, even if the patient fully discloses his thoughts, assurance that the confidential relationship will not be breached is necessary to maintain his trust in his psychiatrist—the very means by which treatment is affected. '(T) he essence of much psychotherapy is the contribution of trust in the external



world and ultimately in the self, modelled upon the trusting relationship established during therapy.’ (Dawidoff, *The Malpractice of Psychiatrists*, 1966 Duke L.J. 696, 704.) Patients will be helped only if they can form a trusting relationship with the psychiatrist. (Id. at p. 704, fn. 34; Burham, *Separation Anxiety* (1965) 13 Arch.Gen. Psychiatry 346, 356; Heller, *supra*, 30 Temp.L.Q. 401, 406.) All authorities appear to agree that if the trust relationship cannot be developed because of collusive communication between the psychiatrist and others, treatment will be frustrated. (See, e.g., Slovenko (1973) *Psychiatry and Law*, p. 61; Cross, *Privileged Communications Between Participants in Group Psychotherapy* (1970) *Law and the Social Order*, 191, 199; Hollender, *The Psychiatrist and the Release of Patient Information* (1960) 116 Am.J. Psychiatry 828, 829.)

Given the importance of confidentiality to the practice of psychiatry, it becomes clear the duty to warn imposed by the majority will cripple the use and effectiveness of psychiatry. Many people, potentially violent—yet susceptible to treatment—will be deterred from seeking it; those seeking it will be inhibited from making revelations necessary to effective treatment; and, forcing the psychiatrist to violate the patient’s trust will destroy the interpersonal relationship by which treatment is affected.

By imposing a duty to warn, the majority contributes to the danger to society of violence by the mentally ill and greatly increases the risk of civil commitment—the total deprivation of liberty—of those who should not be confined. The impairment of treatment and risk of improper commitment resulting from the new duty to warn will not be limited to a few patients but will extend to a large number of the mentally ill. Although under existing psychiatric procedures only a relatively few receiving treatment will ever present a risk of violence, the number making threats is huge, and it is the latter group—not just the former—whose treatment will be impaired and whose risk of commitment will be increased.

Both the legal and psychiatric communities recognize that the process of determining potential violence in a patient is far from exact, being fraught with complexity and uncertainty. In fact, precision has not even been attained in predicting who of those having already committed violent acts will again become violent, a task recognized to be of much simpler proportions. (Kozol, Boucher & Garofalo, *Supra*, 18 *Crime & Delinquency* 371, 384.)

This predictive uncertainty means that the number of disclosures will necessarily be large. As noted above, psychiatric patients are encouraged to discuss all thoughts of violence, and they often express such thoughts. However, unlike this court, the psychiatrist does not enjoy the benefit of overwhelming hindsight in seeing which few, if any, of his patients will ultimately become violent. Now, confronted by the majority’s new duty, the psychiatrist must instantaneously calculate potential violence from each patient on each visit. The difficulties researchers have encountered in accurately predicting violence will be heightened for the practicing psychiatrist dealing for brief periods in his office with heretofore nonviolent patients. And, given the decision not to warn or commit must always be made at the psychiatrist’s civil peril, one can expect most doubts will be resolved in favor of the psychiatrist protecting himself.

Neither alternative open to the psychiatrist seeking to protect himself is in the public interest. The warning itself is an impairment of the psychiatrist’s ability to treat, depriving many patients of adequate treatment. It is to be expected that after disclosing their threats, a significant number of patients, who would not become violent if treated according to existing practices, will engage in violent conduct as a result of unsuccessful treatment. In short, the majority’s duty to warn will not only impair treatment of many who would never become violent but worse, will result in a net increase in violence.

The second alternative open to the psychiatrist is to commit his patient rather than to warn. Even in the absence of threat of civil liability, the doubts of psychiatrists as to the seriousness of patient threats have led psychiatrists to overcommit to mental institutions. This over-commitment has been authoritatively documented in both legal and psychiatric studies. This practice is so prevalent that it has been estimated that ‘as many as twenty harmless persons are incarcerated for everyone who will commit a violent act.’ (Steadman & Coccozza, Stimulus/Response: We Can’t Predict Who is Dangerous (Jan. 1975) 8 Psych. Today 32, 35.) Given the incentive to commit created by the majority’s duty, this already serious situation will be worsened, contrary to Chief Justice Wright’s admonition ‘that liberty is no less precious because forfeited in a civil proceeding than when taken as a consequence of a criminal conviction.’ (In re W. (1971) 5 Cal.3d 296, 307, 96 Cal.Rptr. 1, 9, 486 P.2d 1201, 1209.)

The tragedy of Tatiana Tarasoff has led the majority to disregard the clear legislative mandate of the Lanterman-Petris-Short Act. Worse, the majority impedes medical treatment, resulting in increased violence from—and deprivation of liberty to—the mentally ill. We should accept legislative and medical judgment, relying upon effective treatment rather than on indiscriminate warning.

The judgment should be affirmed.

***Santa Rosa Health Care Corp. v. Garcia*, 964 S.W.2d 940 (Tex. App-Dallas 2006)**

SPECTORS, JUSTICE, delivered the opinion for a unanimous Court.

In this case, we consider whether Santa Rosa had a duty to notify Linda Garcia that she was at risk of contracting the HIV virus. The court of appeals held that Santa Rosa had a duty to notify Garcia and that a fact issue existed whether it breached that duty. We reverse and render judgment that Garcia take nothing.

I.

Adalberto Balderas met Linda Garcia in 1987, and the two married in March 1988. The couple divorced in 1990, after Balderas was diagnosed HIV-positive in December 1989. Balderas, a hemophiliac, had become infected with the HIV virus from injections of the blood-clotting agent Factor VIII he received in the 1970s and 1980s. He died of AIDS in 1993. While Garcia twice tested negative for HIV in 1989 and 1990, she has not been tested since for fear of testing positive.

Santa Rosa Health Care Corporation participates in the South Texas Regional Hemophilia Center. The Center provides facilities for administering Factor VIII to patients, and provides information about and assists patients with acquiring Factor VIII when patients cannot come to the Center. Balderas first came in contact with Santa Rosa in the late 1970s, when he sought Factor VIII after suffering an injury. Over the next few years, he contacted Santa Rosa for Factor VIII on two or three other occasions. Although Santa Rosa referred Balderas to other facilities to receive Factor VIII, he never received any Factor VIII directly from Santa Rosa. After April 1980, Balderas did not contact Santa Rosa about receiving any more Factor VIII. Santa Rosa never tested Balderas for HIV or AIDS, and Balderas did not know he had the virus until another doctor diagnosed him as having HIV in 1989. Balderas never claimed that Santa Rosa negligently infected him with the HIV virus.

At some point in the mid-1980s, Santa Rosa became aware that some of the nation's blood supply before the 1980s was contaminated with HIV and that Balderas may, therefore, have been exposed to the virus. However, Santa Rosa did not know Balderas was HIV-positive until he was diagnosed in December 1989. Between 1986 and 1989, Santa Rosa sent seven written notices to Balderas's home asking him to come in for annual appointments. These notices stated that Santa Rosa would test Balderas's blood for exposure to several viral illnesses, including HTLV-3 (HIV). The last six of these notices also indicated that Balderas should bring his wife or any steady girlfriend with him. Shortly before Balderas and Garcia were married, Santa Rosa called Balderas's residence to schedule an appointment. Although Garcia answered the call, Santa Rosa did not mention that she was at risk of contracting HIV from Balderas. Balderas never attended any of the annual appointments.

In 1991, Balderas and Garcia sued Santa Rosa for negligent, grossly negligent, reckless, or intentional breach of its duty to notify them of Balderas's possible exposure to HIV/AIDS. Balderas alleged that Santa Rosa in all likelihood knew that he was HIV-positive and that his life could have been extended had he known to seek medical attention at the time Santa Rosa became aware of this potential infection. Garcia alleged that Santa Rosa's negligent failure to notify her of Balderas's potential condition exposed her to the virus and caused her emotional distress. *See generally* Lauren J. Camillo, Comment, *Adding Fuel to the Fire: Realistic Fears or Unrealistic Damages in AIDS Phobia Suits?*, 35 S. TEX. L.REV. 331 (1994) (discussing whether the simple fear of exposure to AIDS, absent an HIV-positive test result, is compensable).

Santa Rosa moved for summary judgment on the grounds that it breached no duty to notify the plaintiffs of Balderas's possible exposure to HIV, and that the claims nevertheless were barred by the statute of limitations. The trial court granted Santa Rosa's motion on all claims, and Garcia appealed.

The court of appeals reversed, holding that Santa Rosa owed a duty to notify Garcia and that a fact issue existed whether Santa Rosa had reasonably warned Balderas and Garcia of the possible exposure to HIV.

## II.

The issue we must decide is whether Santa Rosa had a duty to notify Garcia that she was at risk of exposure to the HIV virus from contact with Balderas. This case is governed by the applicable statute.

### A. The 1987 Act

In 1983, the Legislature enacted the Communicable Disease Prevention and Control Act (CDPCA). Act of May 13, 1983, 68th Leg., R.S., ch. 255, 1983 Tex. Gen. Laws 1116. The Act's purpose was to prevent and control the spread of communicable diseases in Texas by implementing reporting requirements, testing guidelines, and other measures. Four years later, the Legislature added sections specifically covering HIV and AIDS. *See* Act of June 1, 1987, 70th Leg., R.S., ch. 543, 1987 Tex. Gen. Laws 2176, 2185.

To protect confidentiality, the Legislature listed in the Act the persons to whom an HIV or AIDS "test result" could be disclosed. § 9.03(a) ("A test result is confidential."). The Act defined "test result" as "any statement or assertion that any identifiable individual is positive, negative, *at risk*, or any other statement that indicates that an identifiable individual has or has not been tested for AIDS or HIV infection."

In her original petition, Garcia claimed that Santa Rosa “failed to advise [her] of the possibility of the HIV infection.” If Santa Rosa had advised Garcia that she could possibly be exposed to the HIV virus by contact with Balderas, the notice logically would have had to include a statement or assertion that Balderas was at risk of having the virus, or that he had not yet been tested for the virus. Either way, the notice falls within the statutory definition of a test result. Therefore, we must next consider whether Santa Rosa could lawfully have released Balderas’s test results to Garcia.

The 1987 version of the statute comprehensively listed those persons to whom test results could be released, regarding the spouse of the person tested. A test result could be released to the spouse of a person tested only if “the person tests positive for AIDS or HIV infection.” The record is clear that, in spite of its repeated efforts to set up appointments with Balderas to do so, Santa Rosa never tested Balderas for the HIV virus. As Santa Rosa had not tested Balderas for HIV, and therefore did not know whether he had tested positive or not, it was prohibited from notifying Garcia that she was at risk. In fact, if Santa Rosa had released the results to Garcia, it would have been subject to civil or criminal sanctions.

#### B. The 1989 Act

In 1989, the Legislature repealed the CDPCA and re-enacted it as part of the Texas Health and Safety Code. Act of May 18, 1989, 71st Leg., R.S., ch. 678, § 1, 1989 Tex. Gen. Laws 2305. Section 81.101 (5) now defines “test result” as “*any statement that indicates that an identifiable individual has or has not been tested for AIDS or HIV infection, including a statement or assertion that the individual is positive, negative, [or] at risk*” Tex. Health & Safety Code § 81.101(5) (emphasis ours). This definition is substantially the same as the old version; therefore, any similar notice to Garcia would still be a test result.

Section 81.103 (a) states that, “A test result is confidential. A person that possesses or has knowledge of a test result may not release or disclose the test result or allow the test result to become known except as provided by this section.” Tex. Health & Safety Code § 81.103(a). Section 81.103 (b) lists the only persons to whom tests results may be released. Id. § 81.103(b). While the new section no longer precludes a cause of action for failure to notify a spouse, it maintains the requirement that before the results can be released to a spouse, the patient must first test positive. Id. § 81.103(b)(7) (“A test result may be released to: (7) the spouse of the person tested *if the person tests positive for AIDS or HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS.*”) (emphasis ours).

Balderas was diagnosed HIV-positive in December 1989. Before this date, neither he nor Santa Rosa knew he was HIV-positive. The record is clear that all seven notices from Santa Rosa to Balderas urging him to come in for annual evaluation and testing were sent before December 1989. The statute is clear that before test results can be released to a spouse, the patient must have tested positive. Because Balderas had not tested positive by the time the notices were sent, Garcia was not within a class of persons to whom his test results could have been released. Finally, as Santa Rosa logically could not notify Garcia that she was at risk of contracting the HIV virus from Balderas without informing her of his test results, under the 1989 statute Santa Rosa had no duty to, and in fact was prohibited from, giving Garcia the notice to which she claims she was entitled. *See* Id. § 81.103(j) (stating possible criminal liability for wrongful release or disclosure of test results).

Finally, in the trial court, Garcia argued that Santa Rosa had a common-law duty to notify her that she was at risk of contracting the HIV virus from Balderas. As we have stated, any such notice would

violate the statute. Accordingly, we hold that Santa Rosa had no common-law duty to notify Garcia that she was at risk of contracting HIV from Balderas.

### III.

We hold that Santa Rosa had no statutory or common-law duty to notify Garcia that she was at risk of contracting the HIV virus from Balderas. Accordingly, we reverse the judgment of the court of appeals and render judgment that Garcia take nothing.

#### ***Molloy v. Meier*, 679 N.W.2d 711 (Minn. 2004)**

MEYER, JUSTICE.

Kimberly Molloy (Molloy) and her husband, Glenn Molloy, brought a medical malpractice action against appellants Dr. Diane Meier, Dr. Reno Backus, and Dr. Kathryn Green, claiming they were negligent in failing to diagnose a genetic disorder in Molloy's daughter and their negligence caused Molloy to conceive another child with the same genetic disorder. The district court denied the appellants' motion for summary judgment and concluded that a physician who performs genetic tests on a child owes a duty to the biological parents of that child; that the action did not accrue until the time of conception and, therefore, was not time-barred; and that the action was not barred by Minn. Stat. § 145.424 (2002), which prohibits causes of action for wrongful birth and wrongful life. The court of appeals answered three certified questions and upheld the denial of summary judgment. We granted review and now affirm the court of appeals.

This case arises out of the medical treatment of S.F., the daughter of Kimberly Molloy and her ex-husband, Robert Flomer. As a young girl, S.F. was treated by appellant Dr. Diane M. Meier at Partners in Pediatrics (formerly Oakdale Pediatrics). When S.F. was three years old, Dr. Meier noted during a check-up that S.F. was developmentally delayed. Dr. Meier ordered a number of tests, but the results did not reveal the source of S.F.'s difficulties. On May 18, 1992, Dr. Meier met with Molloy, Robert Flomer, and S.F. to discuss the possible causes for S.F.'s developmental delays, including the possibility of a genetic cause. Molloy told Dr. Meier about Molloy's mentally retarded half-brother and asked Dr. Meier to conduct genetic tests on S.F. to determine whether S.F. had inherited any abnormalities from Molloy.

In her notes from the May 18 visit, Dr. Meier wrote "? Chromosomes + fragile X," which meant she intended to order chromosomal testing and testing for Fragile X syndrome. In May of 1992, a Fragile X chromosomal test capable of diagnosing the disorder with 70 to 80 percent accuracy was in widespread use. A parent who is a carrier of Fragile X has up to a 50 percent chance of giving birth to a child with the condition. Although physicians can treat the symptoms of Fragile X, the condition itself is incurable. Dr. Meier conceded that "it was appropriate to test [S.F.] for [F]ragile X in keeping with accepted standards of pediatric practice on May 18, 1992." According to Molloy, Dr. Meier told her that if S.F. tested positive for a genetic disorder, Molloy should be tested herself.

On June 17, 1992, the chromosome testing ordered by Dr. Meier was performed at North Memorial Medical Center. On July 18, 1992, North Memorial's laboratory reported normal chromosome testing for S.F. Dr. Meier received the test results, telephoned the Flomers and informed them that the test results were negative; i.e., normal. However, Dr. Meier failed to mention that Fragile X testing had not

been performed. The Flomers then informed Molloy that the test results were “normal.” Based on the fact that Dr. Meier had mentioned Fragile X in her discussion of chromosomal testing, Molloy assumed that the negative test results included a negative result for Fragile X.

Meanwhile, on June 23, 1992, S.F. was referred by Dr. Meier to the Minneapolis Clinic of Neurology where she was seen by Dr. Reno Backus. Dr. Backus testified in his deposition that his role was to evaluate S.F. and report back to Dr. Meier, the referring physician. Dr. Backus met with S.F., Molloy, and the Flomers, and diagnosed S.F. with a pervasive developmental delay of unknown origin. Molloy inquired about her chances of conceiving another child with S.F.’s defect. According to Molloy, Dr. Backus responded that S.F.’s problems were not genetic in origin and the risk that Molloy might give birth to another child like S.F. was extremely remote, especially with a father other than Robert Flomer. Dr. Backus was aware that chromosomal testing had been done but he made his assessment before the test results were known.

Several years later S.F. was referred to Dr. Kathryn Green, who was an employee of the Minneapolis Clinic of Neurology. When Dr. Green saw S.F. on April 30, 1996, she had the office chart of Minneapolis Clinic, including Dr. Backus’s 1992 report. There were no Fragile X testing results in the chart because the testing had never been done. Dr. Green knew of Molloy’s mentally retarded half-brother who had exhibited problems similar to S.F.’s. Despite having this information, Dr. Green did not order or recommend Fragile X testing. Dr. Green testified that she recognized the importance of Fragile X testing in general, but she assumed such tests had already been performed on S.F. and had come back negative, as S.F. had already seen three physicians.

In the meantime, Molloy remarried and gave birth to M.M. on June 30, 1998. M.M. showed signs of the same developmental difficulties as S.F., so his pediatrician, Dr. David Tilstra, ordered Fragile X testing for him. The Fragile X test results were positive; i.e., M.M. carried the Fragile X genetic disorder. When Dr. Tilstra received the positive results, he counseled Kimberly and Glenn Molloy about Fragile X syndrome and recommended that they and other potentially affected family members receive testing. Based on Dr. Tilstra’s recommendation, S.F. and Kimberly Molloy were tested for Fragile X, and it was discovered that they both carried the genetic disorder.

Molloy commenced this lawsuit on August 23, 2001, alleging that Drs. Meier, Backus, and Green and their employers were negligent in the care and treatment rendered to S.F., Kimberly Molloy, and Glenn Molloy by failing to order Fragile X testing on S.F., failing to properly read those lab tests that were performed, mistakenly reporting that S.F. had been tested for Fragile X, and failing to provide counseling to Kimberly and Glenn Molloy regarding the risk of passing an inheritable genetic abnormality to future children. Molloy claimed she would not have conceived M.M. if Drs. Meier, Backus, and Green had correctly diagnosed S.F. with Fragile X and informed Molloy of the diagnosis.

Drs. Meier, Backus, and Green and their employers moved for summary judgment, arguing that they did not owe a duty to the family of a patient and that, in any event, Molloy’s action was barred by the four-year statute of limitations for medical malpractice claims. In opposition, Molloy presented expert testimony of a pediatrician and a pediatric neurologist who described the prevailing standard of care in the medical community with respect to testing and counseling for genetic disorders. The experts indicated that a patient who exhibits the symptoms of this disorder with a family history of mental retardation should be tested for Fragile X. Further, a physician who identifies the possibility of Fragile X has a responsibility to follow up to confirm that the tests are performed. Finally, the physician of a child with Fragile X has an obligation to provide genetic counseling to the child’s family.

In deposition testimony, the appellants each somewhat confirmed the standard of care described by Molloy's expert witnesses. Dr. Meier admitted that her practice is to communicate the results of Fragile X testing to the child's "primary" parents and inform them that the condition may be inherited. Dr. Backus acknowledged that Fragile X testing would have been appropriate for a child such as S.F. and that diagnoses of diseases such as Fragile X have implications for the entire family. Dr. Green conceded that a physician should share the genetic implications of positive genetic test results with the parents of a child diagnosed with an inheritable disorder.

The district court denied summary judgment, concluding that the defendants owed a duty to the biological parents of the child, the cause of action was not barred by the four-year statute of limitations, and a claim for wrongful conception was permitted under Minn. Stat. §145.424. Subsequently, the district court certified the following question to the court of appeals as "important and doubtful" under Minn. R. Civ.App.P. 103.03(i).

(a) Does a physician who allegedly fails to test for and diagnose a genetic disorder in an existing child leading to the birth of a subsequent child with that disorder owe a legal duty to the child's parents?

The court of appeals answered the certified question in the affirmative: the appellants owed a legal duty to Molloy because appellants "should have foreseen that negligently rendering care to S.F. or erroneously reporting genetic test results to S.F.'s biological parents could result in the birth of another child with fragile X." The court of appeals answered the second certified question by concluding that the statute of limitations began to run at the time of M.M.'s conception, the point at which Molloy could establish damages and a viable cause of action in tort. In answering the third certified question, the court concluded that Molloy's action was not barred by Minn. Stat. §145.424 because she did not claim that, but for the negligence of the appellants, M.M. would have been aborted.

## I.

We begin by addressing the first certified question, whether the appellants owed a duty to Molloy regarding the genetic testing and diagnosis of S.F. for Fragile X syndrome. When we review certified questions arising from the denial of summary judgment, we must decide "whether there are any genuine issues of material fact and whether the lower courts erred in their application of the law" (citations omitted). The existence of a duty in a negligence case is a question of law. *Funchess v. Cecil Newman Corp.*, 632 N.W.2d 666, 672 (Minn. 2001). We consider the evidence in the light most favorable to the nonmoving party. *Gradjelick v. Hance*, 646 N.W.2d 225, 231 (Minn. 2002).

Molloy advances two legal theories. She first argues that a physician-patient relationship existed between her and the appellants that gave rise to a legal duty to warn her about the risks of becoming pregnant as a carrier of Fragile X. Additionally, citing *Skillings v. Allen*, 143 Minn. 323, 173 N.W. 663 (1919), Molloy urges this court to hold that even if a physician-patient relationship cannot be established, a physician's duty to warn others of a patient's genetic disorder arises from the foreseeability of injury.

The appellants argue that their duty is owed only to S.F., the person with whom they had a physician-patient relationship. The appellants claim that they met with S.F. solely for S.F.'s own benefit and not for the benefit of her family. If any duty extended beyond the minor patient, the appellants argue that it should reach only those parties who have a contractual relationship with the physician, in this case the Flomers, S.F.'s custodial parents.

The question of whether a physician owes a duty to inform a child's family about the genetic implications of a child's genetic disorder is one of first impression in Minnesota. A medical malpractice action is based on principles of tort liability for negligence; the existence of a duty running to the plaintiff is a prerequisite to a finding of negligence. See *Plutshack v. Univ. of Minn. Hosps.*, 316 N.W.2d 1, 8 (Minn. 1982).

We begin our analysis by observing that a duty to a third party who is not a patient of the physician has been recognized in only a few Minnesota cases. See *Lundgren v. Fultz*, 354 N.W.2d 25, 28-29 (Minn. 1984) (psychiatrist owed duty to third party where patient threatens foreseeable harm to that party and psychiatrist has the ability to control the risk of harm); *Cairl v. State*, 323 N.W.2d 20, 25 n. 7, 26 (Minn. 1982) (treatment facility may owe duty to warn identifiable third parties of violent propensities of a mentally disabled youth whom it released if that youth poses a specific threat to those parties). We also recognized a physician's duty to third parties in *Skillings v. Allen*, 143 Minn. 323, 325-26, 173 N.W. 663, 664 (1919). In that case, a minor child was hospitalized with scarlet fever. *Id.* at 324, 173 N.W. at 663. When the parents asked the child's physician about the nature of the disease and the danger of infection, the physician negligently informed them that they could safely visit their daughter in the hospital and take her home, even though the disease was in its most contagious stage. *Id.* We held that the doctor owed a duty to the parents, reasoning that "one is responsible for the direct consequences of his negligent acts whenever he is placed in such a position with regard to another that it is obvious that if he does not use due care in his own conduct he will cause injury to that person." *Id.* at 325, 173 N.W. at 663-64. We declined to label the duty contractual or non-contractual, noting that under either construct, liability extends to the parents because the physician had an obligation to use due care in a situation where it was likely known that the parents would rely on the advice. See *Id.* at 326, 173 N.W. at 664.

Similarly, we noted in an attorney malpractice case, *Togstad v. Vesely, Otto, Miller & Keefe*, that an attorney-client relationship existed "under circumstances which made it reasonably foreseeable to [the defendant] that [the plaintiff] would be injured if the advice were negligently given." 291 N.W.2d 686, 693 (Minn. 1980). Our decision in *Togstad* derived from the professional relationship. The plaintiff in that case consulted with the attorney defendant to discuss the medical treatment of her husband, whom she believed suffered permanent brain damage as a result of a hospital's negligence. *Id.* at 689-90. After taking notes and asking questions of the plaintiff, the defendant told her that she did not have a case for medical malpractice. *Id.* at 690. In reliance on these statements, the plaintiff did not pursue her case further until the statute of limitations for medical malpractice had run. See *id.* The plaintiff obtained expert testimony that a competent attorney would, at a minimum, obtain medical records and consult with an expert in the field before informing a client that she did not have a case. *Id.* at 691-92. We held that there was sufficient evidence to support an attorney-client relationship because it was reasonably foreseeable that negligent advice would injure the plaintiff. *Id.* at 693. We declined to adopt either tort or contract theory in resolving the case because under either legal theory the evidence established that the plaintiff "sought and received legal advice under circumstances which made it reasonably foreseeable to [the attorney] that [the plaintiff] would be injured if the advice were negligently given." *Id.*

Only a few other jurisdictions have addressed the question of whether a physician owes a legal duty to the family of a patient who received negligent care in the field of genetics. In a case most analogous to the instant one, the New Jersey Supreme Court held that a physician owes a duty to members of the patient's immediate family who might be injured by the physician's breach of duty to the patient. The court held that liability could extend to the patient's family where a doctor's failure to diagnose a first-



born child with cystic fibrosis led to the birth of a second child with that disorder and it was foreseeable that the parents would rely on the diagnosis.

The Supreme Court of Florida has also held that a duty exists where “the prevailing standard of care creates a duty that is obviously for the benefit of certain identified third parties and the physician knows of the existence of those third parties.” *Pate v. Threlkel*, 661 So.2d 278, 282 (Fla.1995). In *Pate*, the defendant physician diagnosed the plaintiff’s mother with medullary thyroid carcinoma, a genetically inheritable disease. *Id.* at 279. When the plaintiff learned that she also carried the disease, she sued, alleging that the defendant should have known of the inheritable nature of the disease and owed a duty to inform her mother that the plaintiff may have carried it as well. *Id.* The plaintiff presented expert testimony that the prevailing standard of care required physicians to inform patients of the genetically transferable nature of their conditions. *Id.* at 281. The Florida Supreme Court noted that the standard of care was developed for the benefit of third parties and therefore held that a physician owes a duty to those third parties of whom the physician has knowledge. *Id.* at 282.

Other courts have drawn upon the prevailing standard of care to define the duties physicians owe in the context of genetic counseling. For example, the California Court of Appeals found no duty to parents to disclose the possibility of having a child with Tay-Sachs disease when the physicians did not have any reason to suspect that the parents were in a high-risk group for the disease. *Munro v. Regents of Univ. of Cal.*, 215 Cal.App.3d 977, 263 Cal.Rptr. 878, 882 (1989). That court recognized that it was impossible to test all patients and relied on expert testimony that the prevailing standard of care required testing only when parents had specific ethnic backgrounds. *Id.* Similarly, the New Jersey Court of Appeals relied upon “the presumed medical knowledge at the time [of treatment]” to find a duty to warn the patient’s immediate family of a patient’s genetically transferable condition. *Safer v. Estate of Pack*, 291 N.J. Super. 619, 677 A.2d 1188, 1192 (App.Div.1996).

Cases such as *Safer*; *Munro*, and *Pate* recognize that the field of genetic counseling is rapidly evolving as new methods of testing become more practical and reliable, and the legal duty of physicians will be driven, at least in part, by the standard of care in the medical profession. As this occurs, it is unlikely that the medical community will adopt a standard of care that is either unduly burdensome or unbeneficial to patients.

Our decision today is informed by the practical reality of the field of genetic testing and counseling; genetic testing and diagnosis does not affect only the patient. Both the patient and her family can benefit from accurate testing and diagnosis. And conversely, both the patient and her family can be harmed by negligent testing and diagnosis. *Molloy’s* experts indicate that a physician would have a duty to inform the parents of a child diagnosed with Fragile X disorder. The appellants admit that their practice is to inform parents in such a case. The standard of care thus acknowledges that families rely on physicians to communicate a diagnosis of the genetic disorder to the patient’s family. It is foreseeable that a negligent diagnosis of Fragile X will cause harm not only to the patient, but to the family of the patient as well. This is particularly true regarding parents who have consulted the physicians concerning the patient’s condition and have been advised of the need for genetic testing.

We therefore hold that a physician’s duty regarding genetic testing and diagnosis extends beyond the patient to biological parents who foreseeably may be harmed by a breach of that duty. In this case, the patient suffered from a serious disorder that had a high probability of being genetically transmitted and for which a reliable and accepted test was widely available. The appellants should have foreseen that parents of childbearing years might conceive another child in the absence of knowledge of the genetic disorder. The appellants owed a duty of care regarding genetic testing and diagnosis, and the resulting

medical advice, not only to S.F. but also to her parents. In recognizing this duty, we apply the principles of negligence law set forth in *Skillings and Togstad* and conclude that the duty arises where it is reasonably foreseeable that the parents would be injured if the advice is negligently given. “[T]he risk reasonably to be perceived defines the duty to be obeyed, and risk imports relation; it is risk to another or to others within the range of apprehension.” *Connolly v. Nicollet Hotel*, 254 Minn. 373, 381, 95 N.W.2d 657, 664 (1959) (quoting *Palsgraf v. Long Island R. Co.*, 248 N.Y. 339, 162 N.E. 99, 100 (1928)).

Under our standard of review for summary judgment, there is sufficient evidence in the record to indicate that each of the appellants was on notice that S.F. displayed symptoms of Fragile X but that the testing was never carried out. Drs. Meier and Backus met face-to-face with Molloy and were aware of her specific need for accurate genetic information. Dr. Green did not meet face-to-face with Molloy but that does not relieve her of her duty of reasonable care to the patient and the patient’s biological parents to provide accurate genetic testing results. We find sufficient evidence in the record to submit the negligence of each physician to a jury for a determination on whether one or more of the physicians breached the standard of care.

Appellants suggest that recognizing a duty to Molloy would extend a physician’s duty to an unreasonable extent, requiring the physician to seek out and inform distant relatives. The court of appeals held that the “physician must notify a biological parent” to discharge his or her duty. Molloy concedes that the appellants could have discharged their duty by informing an appropriate contact person, who in this case would be Robert Flomer or Randine Flomer, the custodial parents, or Molloy, the noncustodial biological parent. In light of this concession, the facts of this case, and the limitation of the certified question to whether a duty extends to a minor patient’s parents, we need not, and do not, address whether the duty recognized here extends beyond biological parents who foreseeably will rely on genetic testing and diagnosis and therefore foreseeably may be injured by negligence in discharging the duty of care.

Affirmed.

***Hardee v. Bio-Medical Applications of South Carolina, Inc.*, 636 S.E.2d 629 (S.C. 2009)**

CHIEF JUSTICE TOAL

This appeal arises out of the trial court’s decision to grant summary judgment in favor of Conway Dialysis Center (Respondent). The trial court held that Respondent was not liable for injuries Respondent’s patient, Danny Tompkins (Patient), caused to be inflicted on Allene and Kathleen Hardee (Appellants) because South Carolina law does not recognize a duty running from a medical provider to a third party non-patient. We reverse.

Factual/Procedural Background

Appellants were badly injured in an accident which occurred in January of 1998. Appellants were traveling through the intersection of Highways 701 and 319 in Conway when Patient’s automobile struck Appellants’ automobile. The accident occurred minutes after Respondent administered dialysis treatment to Patient.

Patient is a Type 1 Insulin dependent diabetic whose diabetic condition is deemed “brittle.” Patient took hemodialysis treatment three times a week and each treatment lasted almost four hours. The dialysis treatment required that Patient’s blood be taken out of his system, run into a dialysis machine to be cleaned, and then returned to Patient’s body.

After the completion of the dialysis treatment, Patient was released to go home. During the drive home, Patient lost control of his vehicle, and ultimately collided with Appellants. The accident resulted in Patient’s death and devastating injuries to Appellants.

Following the accident, Appellants filed this suit against Respondent for negligence related to the treatment of Patient in the administration of dialysis treatment. Specifically, Appellants alleged that Respondent did not warn Patient of the ill effects that could result from his dialysis treatment, that Patient was experiencing insulin shock or suffering from low blood sugar at the time he left Respondent’s facilities, and that Respondent did not perform the normal post-treatment tests or monitoring prior to releasing Patient. Respondent filed a motion for summary judgment, which the trial court initially denied. Respondent requested that the trial court alter or amend its decision, however, and after further consideration, the trial court granted Respondent’s motion for summary judgment.

At this point, Respondent forwarded a proposed order to Appellants’ counsel for comment. Appellants’ counsel advised Respondent of a number of problems with the proposed order, however, prior to Appellants’ counsel having the opportunity to present these comments to the trial court, the court signed the order. Appellants made a motion to alter or amend the order to correctly reflect the facts in the case. The trial court denied Appellants’ motion, and this appeal followed.

The following issue is before the Court for review:

Did the trial court err in determining that a medical provider does not owe a duty to a third party (non-patient), even if the medical provider negligently fails to warn a patient of the risks related to driving immediately following a medical procedure and the failure to warn the patient results in harm to the third party?

### Standard of Review

When reviewing the trial court’s decision to grant summary judgment, an appellate court applies the same standard applied by the trial court. *Lanham Blue Cross and Blue Shield of South Carolina, Inc.*, 349 S.C. 356, 361, 563 S.E.2d 331, 333 (2002). A grant of summary judgment is proper when “there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.” Rule 56(c), SCRCP; *Tupper v. Dorchester Country*, 326 S.C. 318, 325, 487 S.E.2d 187, 191 (1997). Because the trial court’s order granting summary judgment focused only upon whether Respondent owed Appellants any duty of care, we limit our analysis accordingly.

### Law/Analysis

Appellant argues that the trial court erred in determining that, as a matter of law, a medical provider never owes a duty to a third-party non-patient as a result of actions or omissions the provider takes in regard to a patient’s treatment. We agree.

Although this Court has never addressed this issue directly, we have decided similar cases. Generally, an action against a doctor can only be maintained by the patient. *Bishop v. South Carolina Dep’t of*

Mental Health, 331 S.C. 79, 91, 502 S.E.2d 78, 84 (1998). However, this Court recognized in *Bishop* that a physician-patient relationship is not a requirement in every legal action against a medical provider. *Id.* at 92, 502 S.E.2d at 84. In that case, the Court stated that a physician's malpractice in treating a patient may form the basis of a negligence action against the physician by a third party in limited circumstances. *Id.* This Court has never defined what constitutes the limited circumstances in which a third party can maintain suit against a medical provider as outlined in *Bishop*.

At the outset, it is important to characterize the precise nature of the cause of action to which this statement in *Bishop* alluded. As we noted in *Bishop*, a medical malpractice action is instituted by a patient and is predicated upon a physician's deviation from accepted standards of professional care in treating that patient. Not every cause of action asserted against a medical provider, however, is an action for medical malpractice. Thus, our statement in *Bishop* affirms the validity of the general rule prescribing the class of permissible plaintiffs in medical malpractice actions, but also recognizes that causes of action may accrue in other contexts by virtue of a medical provider's actions or omissions.

In this case, Appellants argue Respondent knew that the medical procedure it performed on Patient could have substantial detrimental effects on Patient's ability to operate a motor vehicle. Thus, Appellants argue that if Respondent did not warn Patient of the risks of operating a motor vehicle, Respondent breached a duty a medical provider owes to those persons in the general field of danger (that is, the motoring public) which should reasonably have been foreseen by Respondent when it administered the treatment.

We believe South Carolina tort law ought to recognize such a duty. Generally, a medical provider has a duty to warn of the dangers associated with medical treatment. Thus, a medical provider who provides treatment which it knows may have detrimental effects on a patient's capacities and abilities owes a duty to prevent harm to patients and to reasonably foreseeable third parties by warning the patient of the attendant risks and effects before administering the treatment. Therefore, if Respondent knew that Patient could experience ill effects following dialysis treatment, Respondent owed Appellants a duty to warn Patient of the risks of driving.<sup>3</sup>

We note that this is a very narrow holding that carves out an exception to the general rule that medical providers do not owe a duty to third party non-patients. Importantly, this duty owed to third parties is identical to the duty owed to the patient, i.e., a medical provider must warn a patient of the attendant risks and effects of any treatment. Thus, our holding does not hamper the doctor-patient relationship.

Accordingly, we reverse the trial court's decision granting summary judgment and remand the case for proceedings consistent with this opinion.

Based on the above cited authority, we reverse the trial court's decision granting summary judgment and hold that the trial court erred in determining that a medical provider never owes a duty to a third party non-patient as a result of actions or omissions the provider takes in regard to a patient's treatment.

***Safer v. Estate of Pack*, 677 A.2d 1188 (N.J. Super 1996)**

KESTIN, J.A.D.

Plaintiffs appeal from the trial court's order dismissing their complaint and denying their cross-motion for partial summary judgment as to liability only. We reverse that portion of the order dismissing the complaint and affirm the denial of plaintiffs' motion.

Donna Safer's claim arises from the patient-physician relationship in the 1950s and 1960s between her father, Robert Batkin, a resident of New Jersey, and Dr. George T. Pack, also a resident of New Jersey, who practiced medicine and surgery in New York City and treated Mr. Batkin there. It is alleged that Dr. Pack specialized in the treatment and removal of cancerous tumors and growths.

In November 1956, Mr. Batkin was admitted to the hospital with a pre-operative diagnosis of retroperitoneal cancer. A week later, Dr. Pack performed a total colectomy and an ileosigmoidectomy for multiple polyposis of the colon with malignant degeneration in one area. The discharge summary noted the finding in a pathology report of the existence of adenocarcinoma developing in an intestinal polyp, and diffuse intestinal polyposis "from one end of the colon to the other." Dr. Pack continued to treat Mr. Batkin postoperatively.

In October 1961, Mr. Batkin was again hospitalized. Dr. Pack performed an ileoabdominal perineal resection with an ileostomy. The discharge summary reported pathology findings of "ulcerative adenocarcinoma of colon Grade II with metastases to Levels II and III" and "adenomatous polyps." Dr. Pack again continued to treat Mr. Batkin postoperatively. He also developed a physician-patient relationship with Mrs. Batkin relative to the diagnosis and treatment of a vaginal ulcer.

In December 1963, Mr. Batkin was hospitalized once again at Dr. Pack's direction. The carcinoma of the colon had metastasized to the liver with secondary jaundice and probable retroperitoneal disease causing pressure on the sciatic nerve plexus. After some treatment, Mr. Batkin died on January 3, 1964, at forty-five years of age. Donna was ten years old at the time of her father's death. Her sister was seventeen.

In February 1990, Donna Safer, then thirty-six years of age and newly married, residing in Connecticut, began to experience lower abdominal pain. Examinations and tests revealed a cancerous blockage of the colon and multiple polyposis. In March, Ms. Safer underwent a total abdominal colectomy with ileorectal anastomosis. A primary carcinoma in the sigmoid colon was found to extend through the serosa of the bowel and multiple polyps were seen throughout the entire bowel. Because of the detection of additional metastatic adenocarcinoma and carcinoma, plaintiff's left ovary was also removed. Between April 1990 and mid-1991, Ms. Safer underwent chemotherapy treatment.

In September 1991, plaintiffs obtained Robert Batkin's medical records, from which they learned that he had suffered from polyposis. Their complaint was filed in March 1992, alleging a violation of duty (professional negligence) on the part of Dr. Pack in his failure to warn of the risk to Donna Safer's health.

Plaintiffs contend that multiple polyposis is a hereditary condition that, if undiscovered and untreated, invariably leads to metastatic colorectal cancer. They contend, further, that the hereditary nature of the disease was known at the time Dr. Pack was treating Mr. Batkin and that the physician was required,

by medical standards then prevailing, to warn those at risk so that they might have the benefits of early examination, monitoring, detection and treatment, that would provide opportunity to avoid the most baneful consequences of the condition.

The summary judgment proceeding in the trial court was based upon a scanty record, largely comprised of hospital records. Dr. Pack himself had died in 1969; none of his individual records were before the court. The reports of the parties' medical experts and a deposition of plaintiffs' expert were submitted. Ida Batkin, Donna Safer's mother, had also given a deposition in which she testified, among other details, that neither her husband nor Dr. Pack had ever told her that Mr. Batkin suffered from cancer; and that, throughout the courses of surgery and treatment, Dr. Pack advised her that he was treating a "blockage" or an unspecified "infection". On the one or two occasions when Mrs. Batkin inquired of Dr. Pack whether the "infection" would affect her children, she was told not to worry.

In dismissing, the trial court held that a physician had no "legal duty to warn a child of a patient of a genetic risk[.]" In the absence of any evidence whether Dr. Pack had warned Mr. Batkin to provide information concerning his disease for the benefit of his children, the motion judge "assume[d] that Dr. Pack did not tell Robert Batkin of the genetic disease."

The motion judge's reasoning proceeded from the following legal premise: "[i]n order for a doctor to have a duty to warn, there must be a patient/physician relationship or circumstances requiring the protection of the public health or the community [at] large." Finding no physician-patient relationship between Dr. Pack and his patient's daughter Donna, the court then held genetically transmissible diseases to differ from contagious or infectious diseases or threats of harm in respect of the duty to warn, because "the harm is already present within the non-patient child, as opposed to being introduced, by a patient who was not warned to stay away. The patient is taking no action in which to cause the child harm."

The motion judge relied on *Pate v. Threlkel*, 640 So.2d 183 (Fla. Dist. Ct. App. 1994), as the only "on point" authority respecting genetically transmissible disease. In holding that a physician owed the patient's child no duty to warn, the Florida Court of Appeals had expressly rejected the general approach of the New Jersey Supreme Court in *Schroeder v. Perkel*, 87 N.J. 53, 63-65, 432 A.2d 834 (1981), on related questions of foreseeability and duty.

The Florida Supreme Court has since dealt with the issue, reaching a contrary conclusion. *Pate v. Threlkel*, 661 So.2d 278 (1995). Because the case had initially been decided on defendants' motions to dismiss the complaint for failure to state a cause of action, the Supreme Court was required to

accept as true the [plaintiffs'] allegations that pursuant to the prevailing standard of care, the health care providers were under a duty to warn [the patient] of the importance of testing her children for [the genetically transmissible] carcinoma.

[Id. at 281.]

Our holding should not be read to require the physician to warn the patient's children of the disease. In most instances the physician is prohibited from disclosing the patient's medical condition to others except with the patient's permission. *See* §455.241(2), Fla.Stat.(1989). Moreover, the patient ordinarily can be expected to pass on the warning. To require the physician to seek out and warn various members of the patient's family would often be difficult or impractical and would place too heavy a burden upon the physician. Thus, we emphasize that in any circumstances in which the physician has a duty to warn

of a genetically transferable disease, that duty will be satisfied by warning the patient. [Pate v. Threlkel, *supra*, 661 So.2d at 282]

Because the issue before us arose on a motion for summary judgment, we, too, are obliged to accept plaintiffs' proffer through their medical expert that the prevailing standard of care at the time Dr. Pack treated Mr. Batkin required the physician to warn of the known genetic threat. The legal standard of care, knowledge and skill is that which is "ordinarily possessed and exercised in similar situations by the average member of the profession practicing in the field." Schueler v. Strelinger, 43 N.J. 330, 344, 204 A.2d 577 (1964). Whether the conduct of a practitioner in established circumstances at a particular time comported with prevailing standards of care is preeminently a question to be determined by the finder of fact, not an issue of law to be resolved by the court. Campo v. Tama, 133 N.J. 123, 133, 627 A.2d 135 (1993); Lopez v. Swyer, 115 N.J. Super. 237, 251, 279 A.2d 116 (App.Div.1971), *aff'd*, 62 N.J. 267, 300 A.2d 563 (1973). Where, as here, a genuine issue of fact in this regard is presented, the matter is not amenable to resolution on summary judgment. *R. 4:46-2*; Brill v. Guardian Life Ins. Co. of America, 142 N.J. 520, 528-30, 536-37, 666 A.2d 146 (1995); Judson v. Peoples Bank & Trust Co. of Westfield, 17 N.J. 67, 73-77, 110 A.2d 24 (1954).

Whether a legal duty exists is, however, a matter of law. Strawn v. Canuso, 271 N.J. Super. 88, 100, 638 A.2d 141 (App.Div.1994), *aff'd*, 140 N.J. 43, 657 A.2d 420 (1995). We see no impediment, legal or otherwise, to recognizing a physician's duty to warn those known to be at risk of avoidable harm from a genetically transmissible condition. In terms of foreseeability especially, there is no essential difference between the type of genetic threat at issue here and the menace of infection, contagion or a threat of physical harm (citations omitted). The individual or group at risk is easily identified, and substantial future harm may be averted or minimized by a timely and effective warning.

The motion judge's view of this case as one involving an unavoidable genetic condition gave too little significance to the proffered expert view that early monitoring of those at risk can effectively avert some of the more serious consequences a person with multiple polyposis might otherwise experience. We cannot conclude either, as the trial court did, that Dr. Pack breached no duty because avoidable harm to Donna was not foreseeable, *i.e.*, "that Dr. Pack's conduct did not create a 'foreseeable zone of risk.'" Such a determination would ignore the presumed state of medical knowledge at the time. It would also tend to undervalue the concepts that inform our case law establishing a cause of action for increased risk of harm, as well as the underlying rationale of our rules of law on foreseeability, heretofore held to be specifically applicable in professional negligence cases involving genetic torts (citations omitted).

Although an overly broad and general application of the physician's duty to warn might lead to confusion, conflict or unfairness in many types of circumstances, we are confident that the duty to warn of avertible risk from genetic causes, by definition a matter of familial concern, is sufficiently narrow to serve the interests of justice. Further, it is appropriate, for reasons already expressed by our Supreme Court, that the duty be seen as owed not only to the patient himself but that it also "extend[s] beyond the interests of a patient to members of the immediate family of the patient who may be adversely affected by a breach of that duty." We need not decide, in the present posture of this case, how, precisely, that duty is to be discharged, especially with respect to young children who may be at risk, except to require that reasonable steps be taken to assure that the information reaches those likely to be affected or is made available for their benefit. We are aware of no direct evidence that has been developed concerning the nature of the communications between physician and patient regarding Mr. Batkin's disease: what Dr. Pack did or did not disclose; the advice he gave to Mr. Batkin, if any, concerning genetic factors and what ought to have been done in respect of those at risk; and the conduct

or expressed preferences of Mr. Batkin in response thereto. There may be enough from Mrs. Batkin's testimony and other evidence for inferences to be drawn, however.

We decline to hold as the Florida Supreme Court did in that, in all circumstances, the duty to warn will be satisfied by informing the patient. It may be necessary, at some stage, to resolve a conflict between the physician's broader duty to warn and his fidelity to an expressed preference of the patient that nothing be said to family members about the details of the disease. We cannot know presently, however, whether there is any likelihood that such a conflict may be shown to have existed in this matter or, if it did, what its qualities might have been. As the matter is currently constituted, it is as likely as not that no such conflict will be shown to have existed and that the only evidence on the issue will be Mrs. Batkin's testimony, including that she received no information, despite specific inquiry, that her children were at risk. We note, in addition, the possible existence of some offsetting evidence that Donna was rectally examined as a young child, suggesting that the risk to her had been disclosed.

This case implicates serious and conflicting medical, social and legal policies, many aptly identified in Sonia M. Suter, *Whose Genes Are These Anyway? Familial Conflicts Over Access to Genetic Information*, 91 Mich. L.Rev. 1854 (1993) and in other sources, including some referred to by the motion judge. Some such policy considerations may need to be addressed in ultimately resolving this case. For example, if evidence is produced that will permit the jury to find that Dr. Pack received instructions from his patient not to disclose details of the illness or the fact of genetic risk, the court will be required to determine whether, as a matter of law, there are or ought to be any limits on physician-patient confidentiality, especially after the patient's death where a risk of harm survives the patient, as in the case of genetic consequences. *See generally* Janet A. Kobrin, *Confidentiality of Genetic Information* 30 UCLA L.Rev. 1283 (1983).

Issues of fact remain to be resolved, as well. What was the extent of Donna's risk, for instance? We are led to understand from the experts' reports that the risk of multiple polyposis was significant and that, upon detection, an early full colectomy, *i.e.*, an excision of her entire colon, may well have been the treatment of choice to avoid resultant cancer—including metastasis, the loss of other organs and the rigors of chemotherapy. Full factual development may, however, cast a different light on these issues of fact and others.

Difficult damage issues portend also. Not the least of these will involve distinguishing between the costs of the medical surveillance that would have followed a timely and effective warning, and the costs of medical care attributable to any breach of duty that may be found to have occurred. *See Lanzet v. Greenberg*, 126 N.J. 168, 188, 594 A.2d 1309 (1991). Because of the necessarily limited scope of our consideration, we have highlighted only a few of the potentially troublesome issues presented by this case. Such questions are best conceived and considered in the light of a fully developed record rather than in the abstract.

The order of the trial court dismissing the complaint is reversed. For similar reasons, the trial court's order denying plaintiffs' motion for summary judgment on liability is affirmed. The matter is remanded to the trial court for further proceedings.



***Pate v. Threlkel*, 661 So.2d 278 (Fla. 1995)**

WELLS, JUSTICE.

We have for review the following question certified to be of great public importance: Does a physician owe a duty of care to the children of a patient to warn the patient of the genetically transferable nature of the condition for which the physician is treating the patient? We answer the question in the affirmative provided the children of the patient first establish that pursuant to the prevailing standard of care set forth in section 766.102, Florida Statutes (1989), a reasonably prudent physician would give such warning to his or her patient in light of all relevant circumstances.

In March 1987, Marianne New received treatment for medullary thyroid carcinoma, a genetically transferable disease. In 1990, Heidi Pate, New's adult daughter, learned that she also had medullary thyroid carcinoma. Consequently, Pate and her husband filed a complaint against the physicians who initially treated New for the disease as well as the physicians' respective employers. Pate and her husband alleged that the physicians knew or should have known of the likelihood that New's children would have inherited the condition genetically; that the physicians were under a duty to warn New that her children should be tested for the disease; that had New been warned in 1987, she would have had her children tested at that time; and if Pate had been tested in 1987, she would have taken preventative action, and her condition, more likely than not, would have been curable. Pate claimed that as a direct and proximate cause of the physicians' negligence, she suffers from advanced medullary thyroid carcinoma and its various damaging effects.

The respondent health care providers moved to dismiss the complaint for failure to state a cause of action. Specifically, the respondents alleged that Pate did not demonstrate the existence of a professional relationship between her and respondents and thus failed to establish that respondents owed her a duty of care. The trial court granted the motion and dismissed the Pates' complaint with prejudice, finding that the plaintiffs were not patients of the respondents and that they did not fit within any exception to the requirement that there be a physician-patient relationship between the parties as a condition precedent to bringing a medical malpractice action.

The district court affirmed the trial court's dismissal. The court rejected the Pates' argument that it should, based upon past decisions recognizing a doctor's duty to inform others of a patient's contagious disease, extend a physician's duty to cover the child of a patient who suffers from an inheritable disease.

In rejecting the Pates' claim, the district court focused upon the legal issue of duty. To define the concept of duty the court relied on our decision in *McCain v. Florida Power Corp.*, 593 So.2d 500 (Fla.1992). In *McCain*, we stated, "Florida, like other jurisdictions, recognizes that a legal duty will arise whenever a human endeavor creates a generalized and foreseeable risk of harming others." *Id.* at 503. A duty is thus established when the acts of a defendant in a particular case create a foreseeable zone of risk. Having defined when a duty arises, we went on to state that "each defendant who creates a risk is required to exercise prudent foresight whenever others may be injured as a result." *Id.* Relying on *McCain*, the district court recognized the existence of a physician's duty. The court, however, declined to extend the boundaries of that duty to include Heidi Pate. Specifically, the court held, "we feel constrained by the circumstances of this case and the law as it exists to hold that appellees' conduct in treating Marianne New did not create a foreseeable zone of risk encompassing Heidi Pate, and that

the general rule of privity would apply to affirm the trial court's dismissal of the cause." Pate, 640 So.2d at 185.

We agree with the district court's focus on duty. We conclude that to answer the certified question we must consider two questions related to duty. First, we must determine whether New's physicians had a duty to warn New of the genetically transferable nature of her disease. We find that to make this determination we must apply section 766.102, Florida Statutes (1989), which defines the legal duty owed by a health care provider in a medical malpractice case. That section provides in part:

(1) In any action for recovery of damages based on the death or personal injury of any person in which it is alleged that such death or injury resulted from the negligence of a health care provider as defined in s. 768.50(2)(b), the claimant shall have the burden of proving by the greater weight of evidence that the alleged actions of the health care provider represented a breach of the prevailing professional standard of care for that health care provider. The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

§ 766.102, Fla.Stat. (1989). In applying this statute to the instant case, we conclude that a duty exists if the statutory standard of care requires a reasonably prudent health care provider to warn a patient of the genetically transferable nature of the condition for which the physician was treating the patient.

In medical malpractice cases, the standard of care is determined by a consideration of expert testimony. Because this case comes to us on appeal from an order granting the physicians' motion to dismiss, the record has yet to be developed in respect to such testimony. However, the court's dismissal requires us to assume that the factual allegations in the complaint are true (citations omitted). Accordingly, we must accept as true the Pates' allegations that pursuant to the prevailing standard of care, the health care providers were under a duty to warn New of the importance of testing her children for medullary thyroid carcinoma. Whether these allegations are supported by the statutorily required expert medical authority will have to be determined as the action progresses. We do note, however, that the plaintiffs have pled good-faith compliance with section 766.104, Florida Statutes (1989).

The second question we must address in answering the certified question is to whom does the alleged duty to warn New of the nature of her disease run? The duty obviously runs to the patient who is in privity with the physician. In the past, courts have held that in order to maintain a cause of action against a physician, privity must exist between the plaintiff and the physician. See *Joseph v. Shafey*, 580 So.2d 160 (Fla. 3d DCA 1990), *review denied*, 592 So.2d 681 (Fla.1991), *Boynton v. Burglass*, 590 So.2d 446 (Fla. 3d DCA 1991). In other professional relationships, however, we have recognized the rights of identified third party beneficiaries to recover from a professional because that party was the intended beneficiary of the prevailing standard of care. In such cases, we have determined that an absence of privity does not necessarily foreclose liability (citations omitted). We conclude that this analysis recognizing that privity is not always needed to establish liability should apply to the professional relationship between a patient's child and a health care provider.

Here, the alleged prevailing standard of care was obviously developed for the benefit of the patient's children as well as the patient. We conclude that when the prevailing standard of care creates a duty that is obviously for the benefit of certain identified third parties and the physician knows of the existence of those third parties, then the physician's duty runs to those third parties. Therefore, in

accord with our decision in *Baskerville–Donovan Engineers*, we hold that privity does not bar Heidi Pate’s pursuit of a medical malpractice action. Our holding is likewise in accord with *McCain* because under the duty alleged in this case, a patient’s children fall within the zone of foreseeable risk.

Though not encompassed by the certified question, there is another issue which should be addressed in light of our holding. If there is a duty to warn, to whom must the physician convey the warning? Our holding should not be read to require the physician to warn the patient’s children of the disease. In most instances the physician is prohibited from disclosing the patient’s medical condition to others except with the patient’s permission. See § 455.241(2), Fla.Stat. (1989). Moreover, the patient ordinarily can be expected to pass on the warning. To require the physician to seek out and warn various members of the patient’s family would often be difficult or impractical and would place too heavy a burden upon the physician. Thus, we emphasize that in any circumstances in which the physician has a duty to warn of a genetically transferable disease, that duty will be satisfied by warning the patient.

Accordingly, we conclude that the trial court erred by dismissing the complaint with prejudice. Whether the Pates can recover for medical malpractice depends upon the prevailing standard of care pursuant to section 766.102. The pleadings were prematurely terminated based upon the trial court’s conclusion that a lack of privity prevented the Pates from stating a cause of action. We therefore quash the decision of the district court affirming the dismissal of the complaint with prejudice and remand for further proceedings in accord with this opinion.

It is so ordered.

### *Notes, Questions, and Problems*

1. From a public policy perspective, what limits should the court place on a physician’s duty to warn? In the cases above, it seems that the courts placed the rights of the third parties above the patients’ right to feel comfortable sharing information with their physicians.

2. Calvin Matthews was injured in a football game. Dr. Jason Dunkin prescribed oxycodone to Calvin. He told Calvin’s coach to make sure that Calvin only took one pill a day. The coach wanted to ensure that Calvin was ready for the big game, so he encouraged Calvin to take two pills a day. When Calvin ran out of pills, Dr. Dunkin gave him a refill. Eventually, Calvin became addicted to oxycodone. Calvin’s parents sued Dr. Dunkin for failing to warn Calvin that he could become addicted to oxycodone. What is the possible outcome of the case?

3. Jamie had a history of depression and suicide attempts. Jamie’s girlfriend, Kate, encouraged him to see her therapist. Thus, Jamie started seeing Dr. Mark Scott on a regular basis. Kate drove Jamie to and from his sessions. On January 10, Jamie told Dr. Scott that he was thinking about killing himself on his birthday, so he could be reincarnated as an eagle. In response, Dr. Scott prescribed anti-depression medication and told Jamie to call him if he was really feeling suicidal. The medicine seemed to be working and Jamie said that he wanted to live to a ripe old age. On March 12, Jamie’s birthday, Kate was driving Jamie home from his therapy session. When they were near a cliff, Jamie grabbed the wheel and turned the car towards the cliff. Kate unsuccessfully tried to regain control of the car.

The car went over the cliff and burst into flames. Both Jamie and Kate were killed. Katie's parents sued Dr. Scott for failing to warn Kate that Jamie planned to kill himself. What is the possible outcome of the case?

4. Janice and Sam planned a wedding for about 100 guests. The day before the wedding Janice tested positive for COVID-19. She told Dr. Lee Jackson, her dad who was also her doctor, about the positive test. Dr. Jackson did not want to ruin his daughter's wedding, so he did not share the information with anyone. The day after the wedding, 70 of the guests tested positive for COVID-19. Anna Green, an 85-year-old wedding attendee, died from COVID-19. Anna's family found out that Dr. Jackson knew that his daughter had tested positive prior to the wedding, and sued him. What is the possible outcome of the case?

5. Henry started seeing Dr. Will Green because he was suffering from depression. Throughout his therapist sessions, Henry insisted that his mother, Henrietta, had ruined his life because she spoiled him as a child. One day the following conversation occurred in Dr. Green's office when Dr. Cateson was filling in for Dr. Green who was on vacation. Henry said, "My mama ruined me for life. She let me think we were rich." Dr. Cateson responded, "How did she do that?" Henry answered, "She gave me everything I asked for as a child. She treated me like I was a young Bill Gates." Dr. Cateson said, "Sounds like she was just trying to be a good mother." Henry stood and shook his head, "That bitch wants me to get a job because her lazy ass left her job to live off of a retirement check." Henry laughed, "She is gonna be real surprised when she no longer has her check." Dr. Cateson asked, "Why would she no longer have her retirement check?" Henry gave Dr. Cateson a disgusted look before saying, "Because I stole her identification and set up a new bank account in her name. The check will be directly deposited into the new account." Does Dr. Green or Dr. Cateson have a duty to warn Henry's mother?

### ***Bioethics Consultation Two***

Gail suffered from an anxiety disorder and was being treated by Dr. Glenn Miller. During an appointment with Dr. Miller, Gail asked him to give her a prescription for Drug A. Dr. Miller told her that he did not prescribe Drug A to his patients because it caused bad side effects, including hearing voices and thoughts of suicide. In response, Gail told Dr. Miller that she was concerned because her brother, Jeff was taking Drug A. Gail also mentioned that Jeff was having hallucinations. Dr. Miller stated, "Aren't you glad that you're my patient?" That evening, when Dr. Miller was having dinner with his wife, Betty, he mentioned his conversation with Gail. Betty was surprised that Jeff was taking Drug A because he was running for mayor of their small city.

The next day, Betty and her best friend, Judy, went to the spa. The ladies consumed several glasses of champagne. While they were getting a pedicure, a political ad featuring Jeff came on the television. Judy said, "I think I'm gonna vote for that guy. He makes sense." Betty laughed and said, "As long as he takes his medicine, I guess he will be okay." Then, Betty repeated the conversation she had with Dr. Miller. Wanda, the woman giving Betty her pedicure, overheard the conversation. Wanda's brother, Mitchell, was running against Jeff for mayor. When she left work, Wanda told Mitchell that Jeff was on Drug A.

The next morning, Mitchell confronted Dr. Miller outside of his office. Mitchell said, “My sister told me that your wife said that you are giving Drug A to Jeff Green. You should be ashamed of yourself. How can you sit by and let a crazy person run for mayor of the city? You have a duty to the people who live here.”

Dr. Miller was surprised by Mitchell’s statement. He said, “You’re mistaken, Mr. Green is not my patient.”

Mitchell shrugged. “It doesn’t matter. Tonight at the debate I’m gonna make sure that everybody knows that Jeff is a crazy person.” Dr. Miller was furious. He planned to tell Betty about her loose lips and the misinformation that she spread. That night, during the debate, Mitchell announced that Jeff was taking Drug A. In response, Jeff ran out of the debate. Later that night, Jeff committed suicide.

Gail was totally devastated by Jeff’s death. She went to Dr. Miller for treatment. She blamed herself for Jeff’s death because she did not warn him about the adverse side effects of Drug A. Dr. Miller told Gail that it was not her fault that Jeff killed himself. Gail said, “You’re right. It’s Mitchell Coleman’s fault. I’m gonna find that son of a b\*\*\*h and blow his brains out.” Dr. Miller tried to calm Gail down, but he did not tell her that his wife had revealed Jeff’s secret. Two days later, while Mitchell was making a speech, Gail shot him in the head. Mitchell is in the hospital in a vegetative state.

You have received a request to issue an opinion with regards to Dr. Miller’s behavior. The Ethics Board is concerned about any legal or ethical violations that may have occurred in this case. Please draft the opinion.

## CHAPTER THREE - DUTY TO OBTAIN INFORMED CONSENT

The purpose of informed consent is to ensure that the patient understands and consents to treatment by the healthcare provider. Therefore, informed consent statutes place a duty on the healthcare provider to obtain a patient's informed consent. To be considered proper, the consent must be informed. That means that the healthcare provider must supply the patient with all the information the person needs to make a competent decision. The physician must tell the patient not only about the options that he or she recommends, but also about all medically reasonable alternatives known to the physician. To successfully plead an informed consent case, the patient must prove the following: (1) the medical procedure carried a specific risk that was not disclosed; (2) the physician violated the applicable standard of disclosure; (3) the undisclosed risk materialized; and (4) the failure to disclose the information caused the patient's injury.

There are several theories of the standard that should be used to evaluate if the patient has received enough information to make an informed decision. One standard is the professional malpractice approach. Under that theory, healthcare providers are required to disclose to patients that information which would have been disclosed by the reasonable, minimally competent physician. This approach is not patient-friendly because it requires the patient to put forth expert testimony to prevail. It is difficult to get a physician to second guess another physician in these types of cases. Another standard is the reasonable patient approach. According to that theory, physicians are required to disclose the risks that a reasonable patient would consider material in deciding whether or not to undergo the procedure. This standard is meant to be objective. A third standard is referred to as the particular patient approach. That theory requires physicians to disclose the information that a particular patient would have wanted to know to make his or her decision. Because the focus is on the desires of a specific patient, this standard is deemed to be subjective. A trending informed consent standard is the fiduciary theory that requires physicians to disclose all the information the patient needs to know to make an informed decision. This theory permits the physician to be paternalist.

There are limits on the physician's duty to disclose. Those restrictions focus upon the type of information involved in the situation. The physician is not required to disclose information classified as common knowledge or patient knowledge. Common knowledge refers to information a person of average sophistication should know. An example of common knowledge is that any medical procedure may result in death. Patient knowledge is the information that the patient already knows. For instance, if the patient knows that he or she has a pre-existing condition that might make the condition more dangerous.

Traditionally, the failure to obtain a patient's informed consent to an invasive procedure like surgery was treated as a medical battery. The physician's obligation to obtain the consent of the patient to surgery derived from the patient's right to reject a non-consensual touching. As you will recall from your first-year Tort Law class, a battery is an intentional tort that involves an offensive touching. Consequently, initially, a patient only had to give consent to an invasive procedure that involved some type of physician contact. For example, a physician did not have to obtain a patient's consent before prescribing something like "bed rest." Examples of conduct that rise to the level of medical battery are the following: (1) the patient has not consented to be treated at all; (2) the physician performs a completely different procedure than the one for which consent was given; (3) the physician performs a procedure on the wrong area of the body; or (4) a different, unconsented-to provider performs the procedure. Eventually, some courts determined that the need for a patient's consent derived from the

patient's right to self-determination. Self-determination refers to the right to intelligently decide whether to choose or decline a particular medical procedure.

### **3.1 Disclosure of Information About the Procedure**

#### ***Canterbury v. Spence*, 464 F2d 772 (1972)**

SPOTTSWOOD W. ROBINSON, III, CIRCUIT JUDGE:

This appeal is from a judgment entered in the District Court on verdicts directed for the two appellees at the conclusion of plaintiff-appellant Canterbury's case in chief. His action sought damages for personal injuries allegedly sustained as a result of an operation negligently performed by appellee Spence, a negligent failure by Dr. Spence to disclose a risk of serious disability inherent in the operation, and negligent post-operative care by appellee Washington Hospital Center. On close examination of the record, we find evidence which required submission of these issues to the jury. We accordingly reverse the judgment as to each appellee and remand the case to the District Court for a new trial.

#### **I**

The record we review tells a depressing tale. A youth troubled only by back pain submitted to an operation without being informed of a risk of paralysis incidental thereto. A day after the operation he fell from his hospital bed after having been left without assistance while voiding. A few hours after the fall, the lower half of his body was paralyzed, and he had to be operated on again. Despite extensive medical care, he has never been what he was before. Instead of the back pain, even years later, he hobbled about on crutches, a victim of paralysis of the bowels and urinary incontinence. In a very real sense this lawsuit is an understandable search for reasons.

At the time of the events which gave rise to this litigation, appellant was nineteen years of age, a clerk-typist employed by the Federal Bureau of Investigation. In December, 1958, he began to experience severe pain between his shoulder blades. He consulted two general practitioners, but the medications they prescribed failed to eliminate the pain. Thereafter, appellant secured an appointment with Dr. Spence, who is a neurosurgeon.

Dr. Spence examined appellant in his office at some length but found nothing amiss. On Dr. Spence's advice appellant was x-rayed, but the films did not identify any abnormality. Dr. Spence then recommended that appellant undergo a myelogram—a procedure in which dye is injected into the spinal column and traced to find evidence of disease or other disorder—at the Washington Hospital Center.

Appellant entered the hospital on February 4, 1959. The myelogram revealed a “filling defect” in the region of the fourth thoracic vertebra. Since a myelogram often does no more than pinpoint the location of an aberration, surgery may be necessary to discover the cause. Dr. Spence told appellant that he would have to undergo a laminectomy—the excision of the posterior arch of the vertebra—to correct what he suspected was a ruptured disc. Appellant did not raise any objection to the proposed operation nor did he probe into its exact nature.

Appellant explained to Dr. Spence that his mother was a widow of slender financial means living in Cyclone, West Virginia, and that she could be reached through a neighbor's telephone. Appellant called his mother the day after the myelogram was performed and, failing to contact her, left Dr. Spence's telephone number with the neighbor. When Mrs. Canterbury returned the call, Dr. Spence told her that the surgery was occasioned by a suspected ruptured disc. Mrs. Canterbury then asked if the recommended operation was serious and Dr. Spence replied "not any more than any other operation." He added that he knew Mrs. Canterbury was not well off and that her presence in Washington would not be necessary. The testimony is contradictory as to whether during the course of the conversation Mrs. Canterbury expressed her consent to the operation. Appellant himself apparently did not converse again with Dr. Spence prior to the operation.

Dr. Spence performed the laminectomy on February 11 at the Washington Hospital Center. Mrs. Canterbury traveled to Washington, arriving on that date but after the operation was over, and signed a consent form at the hospital. The laminectomy revealed several anomalies: a spinal cord that was swollen and unable to pulsate, an accumulation of large tortuous and dilated veins, and a complete absence of epidural fat which normally surrounds the spine. A thin hypodermic needle was inserted into the spinal cord to aspirate any cysts which might have been present, but no fluid emerged. In suturing the wound, Dr. Spence attempted to relieve the pressure on the spinal cord by enlarging the dura—the outer protective wall of the spinal cord—at the area of swelling.

For approximately the first day after the operation appellant recuperated normally, but then suffered a fall and an almost immediate setback. Since there is some conflict as to precisely when or why appellant fell, we reconstruct the events from the evidence most favorable to him. Dr. Spence left orders that appellant was to remain in bed during the process of voiding. These orders were changed to direct that voiding be done out of bed, and the jury could find that the change was made by hospital personnel. Just prior to the fall, appellant summoned a nurse and was given a receptacle for use in voiding, but was then left unattended. Appellant testified that during the course of the endeavor he slipped off the side of the bed, and that there was no one to assist him, or side rail to prevent the fall.

Several hours later, appellant began to complain that he could not move his legs and that he was having trouble breathing; paralysis seems to have been virtually total from the waist down. Dr. Spence was notified on the night of February 12, and he rushed to the hospital. Mrs. Canterbury signed another consent form and appellant was again taken into the operating room. The surgical wound was reopened and Dr. Spence created a gusset to allow the spinal cord greater room in which to pulsate.

Appellant's control over his muscles improved somewhat after the second operation but he was unable to void properly. As a result of this condition, he came under the care of a urologist while still in the hospital. In April, following a cryptoscopic examination, appellant was operated on for removal of bladder stones, and in May was released from the hospital. He reentered the hospital the following August for a 10-day period, apparently because of his urologic problems. For several years after his discharge he was under the care of several specialists, and at all times was under the care of a urologist. At the time of the trial in April, 1968, appellant required crutches to walk, still suffered from urinal incontinence and paralysis of the bowels, and wore a penile clamp.

In November, 1959 on Dr. Spence's recommendation, appellant was transferred by the F.B.I. to Miami where he could get more swimming and exercise. Appellant worked three years for the F.B.I. in Miami, Los Angeles and Houston, resigning finally in June, 1962. From then until the time of the trial, he held a number of jobs, but had constant trouble finding work because he needed to remain seated and close



to a bathroom. The damages appellant claims include extensive pain and suffering, medical expenses, and loss of earnings.

## II

Appellant filed suit in the District Court on March 7, 1963, four years after the laminectomy and approximately two years after he attained his majority. The complaint stated several causes of action against each defendant. Against Dr. Spence it alleged, among other things, negligence in the performance of the laminectomy and failure to inform him beforehand of the risk involved. Against the hospital the complaint charged negligent post-operative care in permitting appellant to remain unattended after the laminectomy, in failing to provide a nurse or orderly to assist him at the time of his fall, and in failing to maintain a side rail on his bed. The answers denied the allegations of negligence and defended on the ground that the suit was barred by the statute of limitations.

Pretrial discovery—including depositions by appellant, his mother and Dr. Spence—continuances and other delays consumed five years. At trial, disposition of the threshold question whether the statute of limitations had run was held in abeyance until the relevant facts developed. Appellant introduced no evidence to show medical and hospital practices, if any, customarily pursued in regard to the critical aspects of the case, and only Dr. Spence, called as an adverse witness, testified on the issue of causality. Dr. Spence described the surgical procedures he utilized in the two operations and expressed his opinion that appellant's disabilities stemmed from his pre-operative condition as symptomized by the swollen, non-pulsating spinal cord. He stated, however, that neither he nor any of the other physicians with whom he consulted was certain as to what that condition was, and he admitted that trauma can be a cause of paralysis. Dr. Spence further testified that even without trauma paralysis can be anticipated "somewhere in the nature of one percent" of the laminectomies performed, a risk he termed "a very slight possibility." He felt that communication of that risk to the patient is not good medical practice because it might deter patients from undergoing needed surgery and might produce adverse psychological reactions which could preclude the success of the operation.

At the close of appellant's case in chief, each defendant moved for a directed verdict and the trial judge granted both motions. The basis of the ruling, he explained, was that appellant had failed to produce any medical evidence indicating negligence on Dr. Spence's part in diagnosing appellant's malady or in performing the laminectomy; that there was no proof that Dr. Spence's treatment was responsible for appellant's disabilities; and that notwithstanding some evidence to show negligent post-operative care, an absence of medical testimony to show causality precluded submission of the case against the hospital to the jury. The judge did not allude specifically to the alleged breach of duty by Dr. Spence to divulge the possible consequences of the laminectomy.

We reverse. The testimony of appellant and his mother that Dr. Spence did not reveal the risk of paralysis from the laminectomy made out a prima facie case of violation of the physician's duty to disclose which Dr. Spence's explanation did not negate as a matter of law. There was also testimony from which the jury could have found that the laminectomy was negligently performed by Dr. Spence, and that appellant's fall was the consequence of negligence on the part of the hospital. The record, moreover, contains evidence of sufficient quantity and quality to tender jury issues as to whether and to what extent any such negligence was causally related to appellant's post-laminectomy condition. These considerations entitled appellant to a new trial.

Elucidation of our reasoning necessitates elaboration on a number of points. In Parts III and IV we explore the origins and rationale of the physician's duty to reasonably inform an ailing patient as to the

treatment alternatives available and the risks incidental to them. In Part V we investigate the scope of the disclosure requirement and in Part VI the physician's privileges not to disclose. In Part VII we examine the role of causality, and in Part VIII the need for expert testimony in non-disclosure litigation. In Part IX we deal with appellees' statute of limitations defense and in Part X we apply the principles discussed to the case at bar.

### III

Suits charging failure by a physician adequately to disclose the risks and alternatives of proposed treatment are not innovations in American law. They date back a good half-century, and in the last decade they have multiplied rapidly. There is, nonetheless, disagreement among the courts and the commentators on many major questions, and there is no precedent of our own directly in point. For the tools enabling resolution of the issues on this appeal, we are forced to begin at first principles.

The root premise is the concept, fundamental in American jurisprudence, that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body." True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision. From these almost axiomatic considerations springs the need, and in turn the requirement, of a reasonable divulgence by physician to patient to make such a decision possible.<sup>15</sup>

A physician is under a duty to treat his patient skillfully but proficiency in diagnosis and therapy is not the full measure of his responsibility. The cases demonstrate that the physician is under an obligation to communicate specific information to the patient when the exigencies of reasonable care call for it. Due care may require a physician perceiving symptoms of bodily abnormality to alert the patient to the condition. It may call upon the physician confronting an ailment which does not respond to his ministrations to inform the patient thereof. It may command the physician to instruct the patient as to any limitations to be presently observed for his own welfare, and as to any precautionary therapy he should seek in the future. It may oblige the physician to advise the patient of the need for or desirability of any alternative treatment promising greater benefit than that being pursued. Just as plainly, due care normally demands that the physician warn the patient of any risks to his well-being which contemplated therapy may involve.

The context in which the duty of risk-disclosure arises is invariably the occasion for decision as to whether a particular treatment procedure is to be undertaken. To the physician, whose training enables a self-satisfying evaluation, the answer may seem clear, but it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie. To enable the patient to chart his course understandably, some familiarity with the therapeutic alternatives and their hazards becomes essential.

A reasonable revelation in these respects is not only a necessity but, as we see it, is as much a matter of the physician's duty. It is a duty to warn of the dangers lurking in the proposed treatment, and that is surely a facet of due care. It is, too, a duty to impart information which the patient has every right to expect. The patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms' length transactions. His dependence upon the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject. As earlier noted, long before the instant litigation arose, courts had recognized that the physician had the

responsibility of satisfying the vital informational needs of the patient. More recently, we ourselves have found “in the fiducial qualities of [the physician-patient] relationship the physician’s duty to reveal to the patient that which in his best interests it is important that he should know.” We now find, as a part of the physician’s overall obligation to the patient, a similar duty of reasonable disclosure of the choices with respect to proposed therapy and the dangers inherently and potentially involved.

This disclosure requirement, on analysis, reflects much more of a change in doctrinal emphasis than a substantive addition to malpractice law. It is well established that the physician must seek and secure his patient’s consent before commencing an operation or other course of treatment. It is also clear that the consent, to be efficacious, must be free from imposition upon the patient. It is the settled rule that therapy not authorized by the patient may amount to a tort—a common law battery—by the physician. And it is evident that it is normally impossible to obtain a consent worthy of the name unless the physician first elucidates the options and the perils for the patient’s edification. Thus the physician has long borne a duty, on pain of liability for unauthorized treatment, to make adequate disclosure to the patient. The evolution of the obligation to communicate for the patient’s benefit as well as the physician’s protection has hardly involved an extraordinary restructuring of the law.

#### IV

Duty to disclose has gained recognition in a large number of American jurisdictions, but more largely on a different rationale. The majority of courts dealing with the problem have made the duty depend on whether it was the custom of physicians practicing in the community to make the particular disclosure to the patient. If so, the physician may be held liable for an unreasonable and injurious failure to divulge, but there can be no recovery unless the omission forsakes a practice prevalent in the profession. We agree that the physician’s noncompliance with a professional custom to reveal, like any other departure from prevailing medical practice, may give rise to liability to the patient. We do not agree that the patient’s cause of action is dependent upon the existence and nonperformance of a relevant professional tradition.

There are, in our view, formidable obstacles to acceptance of the notion that the physician’s obligation to disclose is either germinated or limited by medical practice. To begin with, the reality of any discernible custom reflecting a professional consensus on communication of option and risk information to patients is open to serious doubt. We sense the danger that what in fact is no custom at all may be taken as an affirmative custom to maintain silence, and that physician-witnesses to the so-called custom may state merely their personal opinions as to what they or others would do under given conditions. We cannot gloss over the inconsistency between reliance on a general practice respecting divulgence and, on the other hand, realization that the myriad of variables among patients makes each case so different that its omission can rationally be justified only by the effect of its individual circumstances. Nor can we ignore the fact that to bind the disclosure obligation to medical usage is to arrogate the decision on revelation to the physician alone. Respect for the patient’s right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves.

More fundamentally, the majority rule overlooks the graduation of reasonable-care demands in Anglo-American jurisprudence and the position of professional custom in the hierarchy. The caliber of the performance exacted by the reasonable-care standard varies between the professional and non-professional worlds, and so also the role of professional custom. “With but few exceptions,” we recently declared, “society demands that everyone under a duty to use care observe minimally a general standard.” “Familiarly expressed judicially,” we added, “the yardstick is that degree of care which a

reasonably prudent person would have exercised under the same or similar circumstances.” “Beyond this,” however, we emphasized, “the law requires those engaging in activities requiring unique knowledge and ability to give a performance commensurate with the undertaking.” Thus physicians treating the sick must perform at higher levels than non-physicians in order to meet the reasonable care standard in its special application to physicians— “that degree of care and skill ordinarily exercised by the profession in [the physician’s] own or similar localities.” And practices adopted by the profession have indispensable value as evidence tending to establish just what that degree of care and skill is.

We have admonished, however, that “[t]he special medical standards are but adaptations of the general standard to a group who are required to act as reasonable men possessing their medical talents presumably would.” There is, by the same token, no basis for operation of the special medical standard where the physician’s activity does not bring his medical knowledge and skills peculiarly into play. And where the challenge to the physician’s conduct is not to be gauged by the special standard, it follows that medical custom cannot furnish the test of its propriety, whatever its relevance under the proper test may be. The decision to unveil the patient’s condition and the chances as to remediation, as we shall see, is oft times a non-medical judgment and, if so, is a decision outside the ambit of the special standard. Where that is the situation, professional custom hardly furnishes the legal criterion for measuring the physician’s responsibility to reasonably inform his patient of the options and the hazards as to treatment.

The majority rule, moreover, is at war with our prior holdings that a showing of medical practice, however probative, does not fix the standard governing recovery for medical malpractice. Prevailing medical practice, we have maintained, has evidentiary value in determinations as to what the specific criteria measuring challenged professional conduct are and whether they have been met, but does not itself define the standard. That has been our position in treatment cases, where the physician’s performance is ordinarily to be adjudicated by the special medical standard of due care. We see no logic in a different rule for nondisclosure cases, where the governing standard is much more largely divorced from professional considerations. And surely in nondisclosure cases the factfinder is not invariably functioning in an area of such technical complexity that it must be bound to medical custom as an inexorable application of the community standard of reasonable care.

Thus, we distinguished, for purposes of duty to disclose, the special and general-standard aspects of the physician-patient relationship. When medical judgment enters the picture and for that reason the special standard controls, prevailing medical practice must be given its just due. In all other instances, however, the general standard exacting ordinary care applies, and that standard is set by law. In sum, the physician’s duty to disclose is governed by the same legal principles applicable to others in comparable situations, with modifications only to the extent that medical judgment enters the picture. We hold that the standard measuring performance of that duty by physicians, as by others, is conduct which is reasonable under the circumstances.

## V

Once the circumstances give rise to a duty on the physician’s part to inform his patient, the next inquiry is the scope of the disclosure the physician is legally obliged to make. The courts have frequently confronted this problem but no uniform standard defining the adequacy of the divulgence emerges from the decisions. Some have said “full” disclosure, a norm we are unwilling to adopt literally. It seems obviously prohibitive and unrealistic to expect physicians to discuss with their patients every risk of proposed treatment—no matter how small or remote—and generally unnecessary from the

patient's viewpoint as well. Indeed, the cases speaking in terms of "full" disclosure appear to envision something less than total disclosure, leaving unanswered the question of just how much.

The larger number of courts, as might be expected, have applied tests framed with reference to prevailing fashion within the medical profession. Some have measured the disclosure by "good medical practice," others by what a reasonable practitioner would have bared under the circumstances, and still others by what medical custom in the community would demand. We have explored this rather considerable body of law but are unprepared to follow it. The duty to disclose, we have reasoned, arises from phenomena apart from medical custom and practice. The latter, we think, should no more establish the scope of the duty than its existence. Any definition of scope in terms purely of a professional standard is at odds with the patient's prerogative to decide on projected therapy himself. That prerogative, we have said, is at the very foundation of the duty to disclose, and both the patient's right to know and the physician's correlative obligation to tell him are diluted to the extent that its compass is dictated by the medical profession.

In our view, the patient's right of self-decision shapes the boundaries of the duty to reveal. That right can be effectively exercised only if the patient possesses enough 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 the information material to the decision. Thus, the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked. And to safeguard the patient's interest in achieving his own determination on treatment, the law must itself set the standard for adequate disclosure.

Optimally for the patient, exposure of a risk would be mandatory whenever the patient would deem it significant to his decision, either singly or in combination with other risks. Such a requirement, however, would summon the physician to second-guess the patient, whose ideas on materiality could hardly be known to the physician. That would make an undue demand upon medical practitioners, whose conduct, like that of others, is to be measured in terms of reasonableness. Consonantly with orthodox negligence doctrine, the physician's liability for nondisclosure is to be determined on the basis of foresight, not hindsight; no less than any other aspect of negligence, the issue on nondisclosure must be approached from the viewpoint of the reasonableness of the physician's divulgence in terms of what he knows or should know to be the patient's informational needs. If, but only if, the fact-finder can say that the physician's communication was unreasonably inadequate is an imposition of liability legally or morally justified.

Of necessity, the content of the disclosure rests in the first instance with the physician. Ordinarily it is only he who is in position to identify particular dangers; always he must make a judgment, in terms of materiality, as to whether and to what extent revelation to the patient is called for. He cannot know with complete exactitude what the patient would consider important to his decision, but on the basis of his medical training and experience he can sense how the average, reasonable patient expectably would react. Indeed, with knowledge of, or ability to learn, his patient's background and current condition, he is in a position superior to that of most others—attorneys, for example—who are called upon to make judgments on pain of liability in damages for unreasonable miscalculation.

From these considerations we derive the breadth of the disclosure of risks legally to be required. The scope of the standard is not subjective as to either the physician or the patient; it remains objective with due regard for the patient's informational needs and with suitable leeway for the physician's situation. In broad outline, we agree that "[a] risk is thus material when a reasonable person, in what the physician

knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy."

The topics importantly demanding a communication of information are the inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the results likely if the patient remains untreated. The factors contributing significance to the dangerousness of a medical technique are, of course, the incidence of injury and the degree of the harm threatened. A very small chance of death or serious disablement may well be significant; a potential disability which dramatically outweighs the potential benefit of the therapy or the detriments of the existing malady may summons discussion with the patient.

There is no bright line separating the significant from the insignificant; the answer in any case must abide a rule of reason. Some dangers—infection, for example—are inherent in any operation; there is no obligation to communicate those of which persons of average sophistication are aware. Even more clearly, the physician bears no responsibility for discussion of hazards the patient has already discovered, or those having no apparent materiality to patients' decision on therapy. The disclosure doctrine, like others marking lines between permissible and impermissible behavior in medical practice, is in essence a requirement of conduct prudent under the circumstances. Whenever nondisclosure of particular risk information is open to debate by reasonable-minded men, the issue is for the finder of the facts.

## VI

Two exceptions to the general rule of disclosure have been noted by the courts. Each is in the nature of a physician's privilege not to disclose, and the reasoning underlying them is appealing. Each, indeed, is but a recognition that, as important as is the patient's right to know, it is greatly outweighed by the magnitudinous circumstances giving rise to the privilege. The first comes into play when the patient is unconscious or otherwise incapable of consenting, and harm from a failure to treat is imminent and outweighs any harm threatened by the proposed treatment. When a genuine emergency of that sort arises, it is settled that the impracticality of conferring with the patient dispenses with need for it. Even in situations of that character the physician should, as current law requires, attempt to secure a relative's consent if possible. But if time is too short to accommodate discussion, obviously the physician should proceed with the treatment.

The second exception obtains when risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view. It is recognized that patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient. Where that is so, the cases have generally held that the physician is armed with a privilege to keep the information from the patient, and we think it clear that portents of that type may justify the physician in action he deems medically warranted. The critical inquiry is whether the physician responded to a sound medical judgment that communication of the risk information would present a threat to the patient's well-being.

The physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself. The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs. That attitude presumes instability or perversity for even the normal patient, and runs counter to the foundation principle that

the patient should and ordinarily can make the choice for himself. Nor does the privilege contemplate operation save where the patient's reaction to risk information, as reasonable foreseen by the physician, is menacing. And even in a situation of that kind, disclosure to a close relative with a view to securing consent to the proposed treatment may be the only alternative open to the physician.

## VII

No more than breach of any other legal duty does nonfulfillment of the physician's obligation to disclose alone establish liability to the patient. An unrevealed risk that should have been made known must materialize, for otherwise the omission, however unpardonable, is legally without consequence. Occurrence of the risk must be harmful to the patient, for negligence unrelated to injury is nonactionable. And, as in malpractice actions generally, there must be a causal relationship between the physician's failure to adequately divulge and damage to the patient.

A causal connection exists when, but only when, disclosure of significant risks incidental to treatment would have resulted in a decision against it. The patient obviously has no complaint if he would have submitted to the therapy notwithstanding awareness that the risk was one of its perils. On the other hand, the very purpose of the disclosure rule is to protect the patient against consequences which, if known, he would have avoided by foregoing the treatment. The more difficult question is whether the factual issue on causality calls for an objective or a subjective determination.

It has been assumed that the issue is to be resolved according to whether the factfinder believes the patient's testimony that he would not have agreed to the treatment if he had known of the danger which later ripened into injury. We think a technique which ties the factual conclusion on causation simply to the assessment of the patient's credibility is unsatisfactory. To be sure, the objective of risk-disclosure is preservation of the patient's interest in intelligent self-choice on proposed treatment, a matter the patient is free to decide for any reason that appeals to him. When, prior to commencement of therapy, the patient is sufficiently informed on risks and he exercises his choice, it may truly be said that he did exactly what he wanted to do. But when causality is explored at a post-injury trial with a professedly uninformed patient, the question whether he actually would have turned the treatment down if he had known the risks is purely hypothetical: "Viewed from the point at which he had to decide, would the patient have decided differently had he known something he did not know?" And the answer which the patient supplies hardly represents more than a guess, perhaps tinged by the circumstance that the uncommunicated hazard has in fact materialized.

In our view, this method of dealing with the issue on causation comes in second-best. It places the physician in jeopardy of the patient's hindsight and bitterness. It places the factfinder in the position of deciding whether a speculative answer to a hypothetical question is to be credited. It calls for a subjective determination solely on testimony of a patient-witness shadowed by the occurrence of the undisclosed risk.

Better it is, we believe, to resolve the causality issue on an objective basis: in terms of what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance. If adequate disclosure could reasonably be expected to have caused that person to decline the treatment because of the revelation of the kind of risk or danger that resulted in harm, causation is shown, but otherwise not. The patient's testimony is relevant on that score of course but it would not threaten to dominate the findings. And since that testimony would probably be appraised congruently with the factfinder's belief in its reasonableness, the case for a wholly objective standard for passing

on causation is strengthened. Such a standard would in any event ease the fact-finding process and better assure the truth as its product.

## VIII

In the context of trial of a suit claiming inadequate disclosure of risk information by a physician, the patient has the burden of going forward with evidence tending to establish *prima facie* the essential elements of the cause of action, and ultimately the burden of proof—the risk of non-persuasion—on those elements. These are normal impositions upon moving litigants, and no reason why they should not attach in nondisclosure cases is apparent. The burden of going forward with evidence pertaining to a privilege not to disclose, however, rests properly upon the physician. This is not only because the patient has made out a *prima facie* case before an issue on privilege is reached, but also because any evidence bearing on the privilege is usually in the hands of the physician alone. Requiring him to open the proof on privilege is consistent with judicial policy laying such a burden on the party who seeks shelter from an exception to a general rule and who is more likely to have possession of the facts.

As in much malpractice litigation, recovery in nondisclosure lawsuits has hinged upon the patient's ability to prove through expert testimony that the physician's performance departed from medical custom. This is not surprising since, as we have pointed out, the majority of American jurisdictions have limited the patient's right to know to whatever boon can be found in medical practice. We have already discussed our disagreement with the majority rationale. We now delineate our view on the need for expert testimony in nondisclosure cases.

There are obviously important roles for medical testimony in such cases, and some roles which only medical evidence can fill. Experts are ordinarily indispensable to identify and elucidate for the factfinder the risks of therapy and the consequences of leaving existing maladies untreated. They are normally needed on issues as to the cause of any injury or disability suffered by the patient and, where privileges are asserted, as to the existence of any emergency claimed and the nature and seriousness of any impact upon the patient from risk-disclosure. Save for relative infrequent instances where questions of this type are resolvable wholly within the realm of ordinary human knowledge and experience, the need for the expert is clear.

The guiding consideration our decisions distill, however, is that medical facts are for medical experts and other facts are for any witnesses—expert or not—having sufficient knowledge and capacity to testify to them. It is evident that many of the issues typically involved in nondisclosure cases do not reside peculiarly within the medical domain. Lay witness testimony can competently establish a physician's failure to disclose particular risk information, the patient's lack of knowledge of the risk, and the adverse consequences following the treatment. Experts are unnecessary to a showing of the materiality of a risk to a patient's decision on treatment, or to the reasonably, expectable effect of risk disclosure on the decision. These conspicuous examples of permissible uses of non-expert testimony illustrate the relative freedom of broad areas of the legal problem of risk nondisclosure from the demands for expert testimony that shackle plaintiffs' other types of medical malpractice litigation.

Reversed and remanded for a new trial.



### *Notes, Questions, and Problems*

1. When Brenda was working in her garden, she got stung by a wasp. Brenda's face started swelling. Brenda drove to the urgent care center that was five minutes from her house. Brenda made it to the check-in desk and collapsed. While she was unconscious, Dr. Gail Peterson injected Brenda with a new drug that was designed to reduce the likelihood that Brenda would suffer such a bad reaction to a wasp bite in the future. After Brenda woke up and discovered that she had been given a new drug instead of the drug that was traditionally used, she was upset. When she discovered that a possible side effect of the drug was seizure-syndrome, Brenda claimed that she should not have been given the drug without her consent. Thus, she plans to sue the clinic. What is the possible outcome of the case?
2. Physicians prescribe billions of pills to patients annually. At the time the medication is prescribed, the physician usually does not disclose any information about the medication. If a patient is lucky, the pharmacy might attach some information about the drug to the bag. One of the main complaints from persons who become addicted to pain medication is that they were never told that addiction was possible. Should physicians be required to get informed consent before prescribing medication? What are the pros and cons of mandating such an action?
3. What standard of care did the *Canterbury* court adopt?
4. According to the *Canterbury* court, when is a risk considered to be material? Under that standard, which of the following risks might be considered material?
  - a. An 89-year-old woman is having surgery and one risk of that surgery is that it causes infertility.
  - b. A Jehovah's Witness is having surgery and one risk of the technique the surgery is using is severe blood loss.
  - c. A model is having surgery and one risk of the surgery is that she could develop scar tissue.
  - d. An opera singer is having surgery and one risk of the surgery is loss of motor functions.
5. Gina went to the emergency room complaining of stomach pain. The doctor had to perform an emergency appendectomy. During the surgery, the doctor noticed a tear in the small intestine. The doctor decided that, since they had her open, they might as well repair the tear. While repairing the tear, the doctor accidentally scraped an artery. Consequently, Gina had to have a blood transfusion. Gina is a member of a religious group opposed to blood transfusion. Thus, she was upset when she discovered that she had been given a blood transfusion without her consent. Gina plans to sue the hospital and the doctor. What is the possible outcome of the case?
6. Dr. Morris was the personal physician of Alberto Garcia from 1995 to 1999. In 1999, another physician discovered that Mr. Garcia had advanced colon cancer. Mr. Garcia died in 2000, at the age

of 60. His children sued Dr. Morris for failing to perform a colonoscopy on Mr. Garcia between 1995 and 1999. Trial testimony indicated that: (1) if the colonoscopy had been performed during that time period, Mr. Garcia's condition would have been discovered at an earlier stage and he probably would have lived; (2) medical practice required physicians to inform patients of the purpose of a colonoscopy; and (3) Dr. Morris repeatedly advised Mr. Garcia to undergo the test but did not specifically explain the possible consequence of his refusal. Consider this case under the professional and material risk standards of disclosure. What arguments can you raise on behalf of Mr. Garcia's children? What arguments or defenses might you raise on behalf of Dr. Morris?

### **3.2 Disclosure of Information About the Physician**

#### ***Howard v. University of Medicine and Dentistry of New Jersey, 800 A.2d 73 (2002)***

LAVECCHIA, J.

In this appeal we consider what causes of action will lie when a plaintiff contends that a physician misrepresented his credentials and experience at the time he obtained the plaintiff's consent to surgery.

#### **I.**

Plaintiff, Joseph Howard, came under the care of defendant, Dr. Robert Heary, in February 1997 for neck pain and related complaints. He had a history of cervical spine disease. Following a car accident in 1991, he was diagnosed with spondylosis, with spinal cord compression extending from the C3 to C7 cervical discs. According to various doctors who examined him at that time he had severe cervical spine stenosis, and he was advised to undergo a "decompressive cervical laminectomy because of the extent of his cervical pathology." Although the condition was "worsening progressively," plaintiff decided to forego surgery.

In January 1997, another automobile accident caused plaintiff injuries that included a cerebral concussion, cervical syndrome with bilateral radiculopathies, and low back syndrome with bilateral radiculopathies. Plaintiff sought the care of Dr. Boston Martin, who had treated him after the 1991 accident. Dr. Martin concluded that plaintiff's spinal condition had worsened significantly and recommended that plaintiff be seen at the University of Medicine and Dentistry of New Jersey (UMDNJ) by Dr. Heary, a Professor of Neurosurgery and the Director of UMDNJ's Spine Center of New Jersey.

Dr. Heary had two pre-operative consultations with plaintiff. In the first consultation, Dr. Heary determined that plaintiff needed surgery to correct a cervical myelopathy secondary to cervical stenosis and a significantly large C3 C4 disc herniation. Because of the serious nature of the surgery, Dr. Heary recommended that plaintiff's wife attend a second consultation. The doctor wanted to explain again the risks, benefits, and alternatives to surgery, and to answer any questions concerning the procedure.

Plaintiff returned with his wife for a second consultation, but what transpired is disputed. An "Office Note" written by Dr. Heary detailing the contents of the consultation states that "[a]ll alternatives have been discussed and patient elects at this time to undergo the surgical procedure, which has been scheduled for March 5, 1997." Dr. Heary asserts that he informed plaintiff and his wife that the surgery entailed significant risks, including the possibility of paralysis. Plaintiffs dispute that they were

informed of such risks. Further, they contend that during the consultation plaintiff's wife asked Dr. Heary whether he was Board Certified and that he said he was. Plaintiffs also claim that Dr. Heary told them that he had performed approximately sixty corpectomies in each of the eleven years he had been performing such surgical procedures. According to Mrs. Howard, she was opposed to the surgery and it was only after Dr. Heary's specific claims of skill and experience that she and her husband decided to go ahead with the procedure.

Dr. Heary denies that he represented that he was Board Certified in Neurosurgery. He also denies that he ever claimed to have performed sixty corpectomies per year for the eleven years he had practiced neurosurgery.

Dr. Heary performed the surgical procedure on March 5, 1997, but it was unsuccessful. A malpractice action was filed alleging that Mr. Howard was rendered quadriplegic as a result of Dr. Heary's negligence.

During pretrial discovery, Dr. Heary and Mr. and Mrs. Howard were deposed. Plaintiffs claim that they learned from Dr. Heary's deposition that he had misrepresented his credentials and experience during the pre-surgery consultation. In his deposition Dr. Heary stated that he was not Board Certified at the time of the surgery, and that he had performed approximately "a couple dozen" corpectomies during his career. Based on that allegedly new information, plaintiffs moved unsuccessfully to amend their original complaint to add a fraud count.

In denying the motion, the trial court reasoned that "the plaintiff can get before the jury everything that is necessary without clouding the issue [with] is there a fraud here against the doctor. I have to agree with counsel for defendant that that, in essence, is not the nexus of malpractice." The court added that the fraud count would be duplicative, because if it were true that the doctor had misrepresented his credentials and experience plaintiffs still would be required to prove that Dr. Heary deviated from the acceptable standard of care to be entitled to recovery.

On leave to appeal the interlocutory order, the Appellate Division reversed and remanded with direction to the trial court to permit amendment of the complaint to include a "deceit based claim." *Howard v. University of Medicine and Dentistry*, 338 N.J. Super. 33, 39, 768 A.2d 195 (2001). Rejecting the contention that the amended complaint caused undue prejudice to defendant, the Appellate Division held that the denial of the motion for leave to amend did not comport with the interests-of-justice standard. *Id.* at 38, 768 A.2d 195. In respect of the merits of the newly pled claim based on deceit, the panel disagreed that plaintiff would be required to prove negligent performance of the surgery in order to recover damages. *Ibid.* The Appellate Division likened the claim for fraudulent misrepresentation to a claim for battery, when a doctor, other than the one authorized under principles of informed consent, performs the surgery. *Id.* at 39, 768 A.2d 195. In such circumstances, proof of negligent performance by the doctor would not be required. *Ibid.*

We granted defendant's motion for leave to appeal.

## II.

Presently, a patient has several avenues of relief against a doctor: (1) deviation from the standard of care (medical malpractice); (2) lack of informed consent; and (3) battery. *Colucci v. Oppenheim*, 326 N.J. Super 166, 180, 749 A.2d 1101 (App.Div.1999), *certif. denied*, 163 N.J. 395, 749 A.2d 369 (2000) (citations omitted). Although each cause of action is based on different theoretical underpinnings, "it

is now clear that deviation from the standard of care and failure to obtain informed consent are simply sub-groups of a broad claim of medical negligence.” *Teilhafer v. Greene*, 320 N.J. Super. 453, 727 A.2d 518 (App. Div. 1999) (citations omitted). The original complaint in this case alleged a standard medical malpractice claim of deviation from the standard of care. Plaintiffs’ motion to amend the complaint to add a fraud claim raises the question whether a patient’s consent to surgery obtained through alleged misrepresentations about the physician’s professional experience and credentials is properly addressed in a claim of lack of informed consent, or battery, or whether it should constitute a separate and distinct claim based on fraud.

A.

We focus first on the distinction between lack of informed consent and battery as they are recognized in New Jersey. The doctrine of informed consent was tied initially to the tort of battery, but its evolution has firmly established it as a negligence concept. See *Largey v. Rothman*, 110 N.J. 204, 207-08, 540 A.2d 504 (1988) (tracing history of theory of informed consent). Early cases recognized a cause of action for an “unauthorized touching” or “battery” if a physician did not obtain consent to perform a medical procedure. See, e.g., *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12, 14-15 (1905) (finding physician liable for operating on left ear when permission given only for surgery on right ear). Because doctors ordinarily lacked the “intent” to harm normally associated with the tort of battery, however, courts examining the nuances of the doctor-patient relationship realized that conceptually a cause of action based on lack of patient consent fit better into the framework of a negligence cause of action (citations omitted).

By the mid-twentieth century, as courts began to use a negligence theory to analyze consent causes of action, the case law evolved from the notion of consent to *informed* consent, balancing the patient’s need for sufficient information with the doctor’s perception of the appropriate amount of information to impart for an informed decision (citations omitted). The doctrine of informed consent continued to be refined (citations omitted). Eventually, the “prudent patient,” or “materiality of risk” standard was introduced. *Canterbury v. Spence*, 464 F.2d 772, 786-99 (D.C.Cir.1972), cert. denied, 409 U.S. 1064, 93 S.Ct. 560, 34 L.Ed.2d 518 (1972). That patient-centered view of informed consent stresses the patient’s right to self-determination, and the fiduciary relationship between a doctor and his or her patients. *Id.* at 781-82. The standard balances the patient’s need for material information with the discretion to be exercised by the doctor, and requires a physician to disclose material information to the patient even if the patient does not ask questions. *Ibid.* “A risk would be deemed ‘material’ when a reasonable patient, in what the physician knows or should know to be the patient’s position, would be ‘likely to attach significance to the risk or cluster of risks’ in deciding whether to forgo the proposed therapy or to submit to it.” *Largey*, supra, 110 N.J. at 211-212, 540 A.2d 504 (quoting *Canterbury*, supra, 464 F.2d at 787).

In New Jersey, as in most jurisdictions, informed consent is “a negligence concept predicated on the duty of a physician to disclose to a patient information that will enable him to ‘evaluate knowledgeably the options available and the risks attendant upon each’ before subjecting that patient to a course of treatment.” *Perna v. Pirozzi*, 92 N.J. 446, 459, 457 A.2d 431 (1983) (quoting *Canterbury*, supra, 464 F.3d at 780). Although we originally followed the “professional” standard for assessing claims of informed consent, that standard was replaced by the “prudent patient” standard set forth in *Canterbury*. *Largey*, supra, 110 N.J. at 216, 540 A.2d 504.

Thus, to sustain a claim based on lack of informed consent, the patient must prove that the doctor withheld pertinent medical information concerning the risks of the procedure or treatment, the

alternatives, or the potential results if the procedure or treatment were not undertaken. Perna, *supra*, 92 N.J. at 460, 457 A.2d 431 (citation omitted). The information a doctor must disclose depends on what a reasonably prudent patient would deem significant in determining whether to proceed with the proposed procedure. Largey, *supra*, 110 N.J. at 211-212; 540 A.2d 504.

A plaintiff seeking to recover under a theory of lack of informed consent also must prove causation, *Id.* at 215, 540 A.2d 504, thereby requiring a plaintiff to prove that a reasonably prudent patient in the plaintiff's position would have declined to undergo the treatment if informed of the risks that the defendant failed to disclose. *Canesi v. Wilson*, 158 N.J. 490, 504-05, 730 A.2d 805 (1999) (citation omitted). If the plaintiff would have consented to the proposed treatment even with full disclosure, the burden of proving causation is not met. Largey, *supra*, 110 N.J. at 215-216, 540 A.2d 504. Accordingly,

[t]o establish a *prima facie* case for medical negligence premised on a theory of liability for lack of informed consent, a plaintiff must show “(1) the physician failed to comply with the [reasonably–prudent–patient] standard for disclosure; (2) *the undisclosed risk occurred and harmed the plaintiff*; (3) a reasonable person under the circumstances would not have consented and submitted to the operation or surgical procedure had he or she been so informed; and (4) *the operation or surgical procedure was a proximate cause of plaintiff's injuries.*”

[Teilhaver, *supra*, 320 N.J. Super. at 465, 727 A.2d 518 (citations omitted) (emphasis added).]

The damages analysis in an informed consent case involves a comparison between the condition a plaintiff would have been in had he or she been properly informed and not consented to the risk, with the plaintiff's impaired condition as a result of the risk's occurrence. *Canesi, supra*, 158 N.J. at 505, 730 A.2d 805 (citations omitted) (noting that “there must be medical causation [from the procedure], that is, a causal connection between the undisclosed risk [of the procedure performed] and the injury ultimately sustained”). Our case law does not require a plaintiff to prove that the physician deviated from the standard of care in performing the operation or procedure; the physician's negligence is in the inadequate disclosure and the damages claimed derive from the harm to the patient caused by a procedure that would not have occurred if the disclosure had been adequate. *Id.* at 506, 730 A.2d 805 (analyzing causation requirements of informed consent and wrongful birth actions; although both require disclosure of risks that reasonably prudent patient would consider material, informed consent action requires plaintiff to demonstrate that undisclosed risk materialized and injury to patient resulted from treatment provided).

## B.

Our common law also authorizes a medical battery cause of action where a doctor performs a surgery without consent, rendering the surgery an unauthorized touching. Perna, *supra*, 92 N.J. at 460-61, 457 A.2d 431. Because battery is an intentional tort, it is reserved for those instances where either the patient consents to one type of operation but the physician performs a substantially different one from that for which authorization was obtained, or where no consent is obtained. *Matthies, supra*, 160 N.J. at 35, 733 A.2d 456 (citing 3 David W. Louisell & Harold Williams, *Medical Malpractice* §§ 22.02, 22.03 (1999)); *Samoilov v. Raz*, 222 N.J. Super. 108, 119, 536 A.2d 275 (App.Div. 1987).

In circumstances where the surgery that was performed was authorized with arguably inadequate information, however, an action for negligence is more appropriate. *Tonelli v. Khanna*, 238 N.J. Super. 121, 126-27, 569 A.2d 282 (App.Div.), *certif. denied*, 121 N.J. 657, 583 A.2d 344 (1990). Battery

actions are less readily available in part because of the severity of their consequences. In an action for battery, a patient need not prove that the physician deviated from either the applicable standard for disclosure or the standard for performance of the operation. *Perna*, supra, 92 N.J. at 460-61, 457 A.2d 431. Accordingly, “[a]n operation undertaken without [any] consent (battery) even if perfectly performed with good medical results may entitle a plaintiff to at least nominal and even punitive damages.” *Whitley-Woodford v. Jones* 253 N.J. Super. 7, 11, 600 A.2d 946 (App.Div. 1992) (citations omitted).

The decision in *Perna* represents the unusual circumstance where the consent granted was vitiated, rendering the circumstances the equivalent of an unauthorized touching—in other words, a battery. In that matter, the defendant urologists were part of a medical group that operated as a self-described “team.” *Perna*, supra, 92 N.J. at 451, 457 A.2d 431. Their method of operation included a decision made immediately prior to a surgical procedure designating the specific member of the group who was to perform the surgery. Unaware of that practice, the plaintiff entered the hospital on the advice of his family physician for tests and a urological consultation. In the hospital, the plaintiff was examined by one physician member of the practice group who previously had treated the plaintiff for a bladder infection. *Ibid.* The doctor recommended the removal of kidney stones and the plaintiff signed a consent form naming that physician as the surgeon. The operation ultimately was performed by two other physicians from the practice group, both of whom were unaware that only the original doctor’s name appeared on the consent form. *Id.* at 452, 457 A.2d 431. Post-surgical complications developed and the plaintiff became aware of the substitution of doctors. *Ibid.*

Plaintiff sued based on lack of informed consent. *Perna*, supra, 92 N.J. at 452, 457 A.2d 431. The court instructed the jury that the plaintiff could recover only if the substitution of surgeons caused his damages. *Id.* at 452, 457 A.2d 431. The jury found for the defendants, and on appeal the Appellate Division affirmed. *Id.* at 450, 457 A.2d 431. On certification to this Court, the matter was reversed and remanded. *Id.* at 465-66, 457 A.2d 431. The Court referred to the substitution of surgeons as “ghost surgery” because the doctor to whom informed consent was given was not the surgeon who performed the surgery. In that circumstance, the Court concluded that that surgeon did not have the plaintiff’s informed consent. *Id.* at 463 n. 3, 464-465, 457 A.2d 431 (citing *Judicial Council of the American Medical Ass’n*, Op. 8.12 (1982)). Denominating the matter a battery, the Court held that the plaintiff was entitled to “recover for all injuries proximately caused by the mere performance of the operation, whether the result of negligence or not.” *Perna*, supra, 92 N.J. at 460-61, 457 A.2d 431. The Court held that if the patient suffers no injuries except those that may be foreseen from the operation, he then is entitled at least to nominal damages and, in an appropriate case, may be entitled to damages for mental anguish resulting from the belated knowledge that the operation was performed by a doctor to whom he had not given consent. *Id.* at 461, 457 A.2d 431.

Thus, although a claim for battery will lie where there has been “ghost surgery” or where no consent has been given for the procedure undertaken, if consent has been given for the procedure only a claim based on lack of informed consent will lie. A claim based on lack of informed consent properly will focus then on the adequacy of the disclosure, its impact on the reasonable patient’s assessment of the risks, alternatives, and consequences of the surgery, and the damages caused by the occurrence of the undisclosed risk. See W. Page Keeton, et al., *Prosser and Keeton on Torts* § 32 at 190 (5th ed.1984).

### III.

#### A.

In finding that a deceit-based claim was appropriate in this matter, the Appellate Division analogized the allegations concerning Dr. Heary's misrepresentations about his credentials and experience to the "ghost surgery" situation discussed in *Perna*. At the outset, we note that this case is not factually analogous to *Perna* where a different person from the one to whom consent was given actually performed the procedure. 92 N.J. at 451-52, 457 A.2d 431. Nor is this a case where someone impersonating a doctor actually touched a patient. See *Taylor v. Johnston*, 985 P.2d 460, 465 (Alaska 1999) (noting that "battery claim may lie if a person falsely claiming to be a physician touches a patient, even for the purpose of providing medical assistance"). Here, defendant explained the procedure, its risks and benefits, and the alternatives to the surgery. He then performed the procedure; another person did not operate in his stead as in the "ghost surgery" scenario. See *Thomas Lundmark, Surgery by an Unauthorized Surgeon as a Battery*, 10 J.L. & Health 287 (1995-1996) (defining ghost surgery as "surgery by a surgeon [to whom] the patient has not consented"). The facts in *Perna* simply are not helpful here.

Few jurisdictions have confronted the question of what cause of action should lie when a doctor allegedly misrepresents his credentials or experience. Research has revealed only one jurisdiction that has allowed a claim based on lack of informed consent under similar circumstances. See *Johnson v. Kokemoor*, 199 Wis.2d 615, 545 N.W.2d 495, 498 (Wis. 1996) (analyzing doctor's affirmative misrepresentation as claim for lack of informed consent and finding that reasonable person would have considered information regarding doctor's relative lack of experience in performing surgery to have been material in making intelligent and informed decision). Although some suggest that a claim based in fraud may be appropriate if a doctor actively misrepresents his or her background or credentials, we are aware of no court that has so held. See, e.g., *Bethea v. Coralli*, 248 Ga.App. 853, 546 S.E.2d 542, 544 (Ga.Ct.App.2001)(holding that patient may not bring claim for fraud independent of claim of medical malpractice); *Ditto v. McCurdy*, 86 Hawaii 84, 947 P.2d 952, 958 (Hawaii 1997) (holding that failure to disclose lack of board certification as plastic surgeon, as opposed to other board certifications possessed, did not violate requirements for informed consent or render doctor liable for fraud); *Paulos v. Johnson*, 597 N.W.2d 316, 320 (Minn.Ct.App.1999)(allegation of misrepresentation is not actionable as independent fraud claim); *Spinosa v. Weinstein*, 168 A.D.2d 32, 571 N.Y.S.2d 747, 751-54 (N.Y.App.Div.1991) (holding that fraudulent representations made to plaintiff did not render her consent to foot surgery equivalent to absence of consent; rather, claim had to do with whether there was failure to obtain informed consent); cf. *Duttry v. Patterson*, 565 Pa. 130, 771 A.2d 1255, 1259 (Pa.2001)(holding that alleged affirmative misstatement of credentials does not support claim for lack of informed consent, but suggesting that claim for misrepresentation may be appropriate).

The thoughtful decision of the Appellate Division notwithstanding, we are not convinced that our common law should be extended to allow a novel fraud or deceit-based cause of action in this doctor-patient context that regularly would admit of the possibility of punitive damages, and that would circumvent the requirements for proof of both causation and damages imposed in a traditional informed consent setting. We are especially reluctant to do so when plaintiff's damages from this alleged "fraud" arise exclusively from the doctor-patient relationship involving plaintiff's corpectomy procedure. See *Spinosa*, supra, 571 N.Y.S.2d at 753 (citations omitted) (holding that concealment or failure to disclose doctor's own malpractice does not give rise to claim of fraud or deceit independent of medical malpractice, and noting that intentional tort of fraud actionable "only when the alleged fraud occurs separately from and subsequent to the malpractice and then only where the fraud claim gives rise to damages separate and distinct from those flowing from the malpractice"). Accordingly, we hold that a fraud or deceit-based claim is unavailable to address the wrong alleged by plaintiff. We next consider whether a claim based on lack of informed consent is the more appropriate analytical basis for the amendment to the complaint permitted by the Appellate Division.

B.

Our case law never has held that a doctor has a duty to detail his background and experience as part of the required informed consent disclosure; nor are we called on to decide that question here. See *In re Conroy*, 98 N.J. 321, 346, 486 A.2d 1209 (1985) (stating that informed consent doctrine anticipates “a patient’s consent, obtained after explanation of the nature of the treatment, substantial risks, and alternative therapies.”) (quoting Norman L. Cantor, *A Patient’s Decision to Decline Life Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 *Rutgers L.Rev.* 228, 346 (1973)); Matthies, *supra*, 160 N.J. at 36-41, 733 A.2d 456. See generally 3 David W. Louisell & Harold Williams, *Medical Malpractice* § 22.04(3)(a) (1998) (noting that ordinary scope of disclosure involves “information concerning (1) the diagnosis; (2) the general nature of the contemplated procedure; (3) the risks involved; (4) the prospects of success; (5) the prognosis if the procedure is not performed; and (6) alternative medical treatments”). Courts generally have held that claims of lack of informed consent based on a failure to disclose professional-background information are without merit. See, e.g., *Ditto*, *supra*, 947 P.2d at 958 (holding that informed consent does not require doctor to “affirmatively disclose his or her [professional] qualifications or lack thereof to a patient”); *Foard v. Jarman*, 326 N.C. 24, 387 S.E.2d 162, 167 (N.C.1990) (finding that because informed consent statute imposed no affirmative duty to discuss experience, facts presented “no genuine issue regarding defendant’s experience which [bore] on the issue of informed consent”).

Although personal credentials and experience may not be a required part of an informed consent disclosure under the current standard of care required of doctors, the question raised in this appeal is whether significant misrepresentations concerning a physician’s qualifications can affect the validity of consent obtained. The answer obviously is that they can.

In certain circumstances, a serious misrepresentation concerning the quality or extent of a physician’s professional experience, viewed from the perspective of the reasonably prudent patient assessing the risks attendant to a medical procedure, can be material to the grant of intelligent and informed consent to the procedure. See 1 Dan B. Dobbs, *The Law of Torts*, § 251 at 660–61 (2001) (citing *Kokemoor*, *supra*, and discussing that some authority has begun to suggest that patient is entitled to information concerning doctor’s experience in performing specific surgery). In *Kokemoor*, *supra*, the Supreme Court of Wisconsin reviewed a case in which the plaintiff alleged that her surgeon did not obtain her informed consent to perform a surgical procedure because he had misrepresented his experience in response to a direct question during a pre-operative consultation. 545 N.W.2d at 505. At trial, evidence was introduced suggesting that the type of surgery performed—basilar bifurcation aneurysm—was “among the most difficult in all of neurosurgery.” *Ibid.* The court found that evidence of the defendant’s lack of experience was relevant to an informed consent claim because “[a] reasonable person in the plaintiff’s position would have considered such information material in making an intelligent and informed decision about the surgery.” *Ibid.* See also *Bethea*, *supra*, 546 S.E.2d at 544 (recognizing that fraudulent misrepresentation of facts material to consent may support claim based on lack of informed consent); *Paulos*, *supra*, 597 N.W.2d at 320 (suggesting misrepresentation by doctor that he was board certified in plastic surgery may present issue of informed consent).

The allegation here is that defendant’s misrepresentations concerning his credentials and experience were instrumental in overcoming plaintiff’s reluctance to proceed with the surgery. The theory of the claim is not that the misrepresentation induced plaintiff to proceed with unnecessary surgery. See *Tonelli*, *supra*, 238 N.J. Super. at 128, 569 A.2d 282 (noting that plaintiff alleged that doctor performed unnecessary surgery for personal gain). Rather, plaintiff essentially contends that he was misled about



material information that he required in order to grant an intelligent and informed consent to the performance of the procedure because he did not receive accurate responses to questions concerning defendant's experience in performing corpectomies and whether he was "Board Certified." Plaintiff allegedly was warned of the risk of paralysis from the corpectomy procedure; however, he asserts that if he had known the truth about defendant's qualifications and experience, it would have affected his assessment of the risks of the procedure. Stated differently, defendant's misrepresentations induced plaintiff to consent to a surgical procedure, and its risk of paralysis, that he would not have undergone had he known the truth about defendant's qualifications. Stripped to its essentials, plaintiff's claim is founded on lack of informed consent.

As noted earlier, a patient-specific standard of what is material to a full disclosure does not apply in a claim based on lack of informed consent. Thus, plaintiff's subjective preference for a Board Certified physician, or one who had performed more corpectomies than defendant had performed, is not the actionable standard. Nonetheless, assuming the misrepresentations are proved, if an objectively reasonable person could find that physician experience was material in determining the medical risk of the corpectomy procedure to which plaintiff consented, and if a reasonably prudent person in plaintiff's position informed of the defendant's misrepresentations about his experience would not have consented, then a claim based on lack of informed consent may be maintained.

Modern advances in medicine coupled with the increased sophistication of medical consumers require an evolving notion of the reasonably prudent patient when assessing a claim based on lack of informed consent. See Schultz, *supra*, 95 Yale L.J. at 221-22. That said, most informed consent issues are unlikely to implicate a setting in which a physician's experience or credentials have been demonstrated to be a material element affecting the risk of undertaking a specific procedure. The standard requires proof on which an objectively reasonable person would base a finding that physician experience could have a causal connection to a substantial risk of the procedure. Largey, *supra*, 110 N.J. at 213-15, 540 A.2d 504; David W. Louisell & Harold Williams, *Medical Malpractice* § 22.05(3) (2001).

The alleged misrepresentations in this case about "physician experience" (credentials and surgical experience) provide a useful context for demonstrating the difficulty inherent in meeting the materiality standard required in order for physician experience to have a role in an informed consent case. We recognize that a misrepresentation about a physician's experience is not a perfect fit with the familiar construct of a claim based on lack of informed consent. The difficulty arises because physician experience is not information that directly relates to the procedure itself or one of the other areas of required medical disclosure concerning the procedure, its substantial risks, and alternatives that must be disclosed to avoid a claim based on lack of informed consent. But the possibility of materiality is present. If defendant's true level of experience had the capacity to enhance substantially the risk of paralysis from undergoing a corpectomy, a jury could find that a reasonably prudent patient would not have consented to that procedure had the misrepresentation been revealed. That presumes that plaintiff can prove that the actual level of experience possessed by defendant had a direct and demonstrable relationship to the harm of paralysis, a substantial risk of the procedure that was disclosed to plaintiff. Put differently, plaintiff must prove that the additional undisclosed risk posed by defendant's true level of qualifications and experience increased plaintiff's risk of paralysis from the corpectomy procedure.

The standard for causation that we envision in such an action will impose a significant gatekeeper function on the trial court to prevent insubstantial claims concerning alleged misrepresentations about a physician's experience from proceeding to a jury. We contemplate that misrepresented or exaggerated physician experience would have to significantly increase a risk of a procedure in order

for it to affect the judgment of a reasonably prudent patient in an informed consent case. As this case demonstrates, the proximate cause analysis will involve a two-step inquiry.

The first inquiry should be, assuming a misrepresentation about experience, whether the more limited experience or credentials possessed by defendant could have substantially increased plaintiff's risk of paralysis from undergoing the corpectomy procedure. We envision that expert testimony would be required for such a showing. The second inquiry would be whether that substantially increased risk would cause a reasonably prudent person not to consent to undergo the procedure. If the true extent of defendant's experience could not affect materially the risk of paralysis from a corpectomy procedure, then the alleged misrepresentation could not cause a reasonably prudent patient in plaintiff's position to decline consent to the procedure. The court's gatekeeper function in respect of the first question will require a determination that a genuine issue of material fact exists requiring resolution by the factfinder in order to proceed to the second question involving an assessment by the reasonably prudent patient. Further, the trial court must conclude that there is a genuine issue of material fact concerning both questions in order to allow the claim to proceed to trial.

Finally, to satisfy the damages element in a claim based on lack of informed consent, a plaintiff typically has to show a causal connection between the inadequately disclosed risk of the procedure and the injury sustained. *Canesi*, supra, 158 N.J. at 505, 730 A.2d 805. If that risk materialized and harmed plaintiff, damages for those injuries are awarded. *Ibid*. Here, if successful in his claim based on lack of informed consent, plaintiff may receive damages for injuries caused by an inadequately disclosed risk of the corpectomy procedure. However, as noted, to be successful plaintiff must prove that defendant's allegedly misrepresented qualifications and experience can satisfy the stringent test for proximate causation that is required for physician experience to be material to the substantial risk of the procedure that occurred (paralysis) and injured plaintiff. If he can, then plaintiff may be compensated for that injury caused by the corpectomy irrespective of whether defendant deviated from the standard of care in performing the surgical procedure.

In conclusion, plaintiff's medical malpractice action will address any negligence in defendant's performance of the corpectomy procedure. We hold that in addition plaintiff may attempt to prove that defendant's alleged misrepresentation about his credentials and experience presents a claim based on lack of informed consent to the surgical procedure, consistent with the requirements and limitations that we have imposed on such a claim.

#### IV.

We reverse that portion of the decision below that would permit a separate action for fraud in view of our conclusion that misrepresentations concerning a physician's credentials and experience ordinarily are to be cognizable in a claim based on lack of informed consent. All aspects of plaintiff's complaint against defendant arise out of plaintiff's consent to a medical procedure and defendant's performance of that procedure. Permitting a cause of action based on lack of informed consent, in addition to the malpractice action, is all that is required and appropriate to address plaintiff's allegations.

The judgment of the Appellate Division is affirmed in part, and reversed in part. The matter is remanded to the trial court to allow plaintiff the opportunity to amend his complaint to allege lack of informed consent, consistent with the requirements for prevailing on that claim as set forth in this opinion.

## *Notes, Questions, and Problems*

1. In 2019, [Malachi Love-Robinson](#),<sup>18</sup> a 22-year-old Florida man, was arrested for impersonating a doctor while he was a teenager. He was also charged with stealing from one of his patients.
2. How does a claim for medical battery differ from a claim for lack of informed consent? Which of those causes of action is appropriate in the following cases?
  - a. The physician neglected to tell the patient that his nurse was a recovering addict prior to operating on the patient.
  - b. The patient consented to having her left leg removed and the doctor accidentally removed the right leg.
  - c. The patient consented to have Dr. A. perform her surgery and Dr. B. performed the surgery instead.
  - d. A person pretending to be a doctor operated on the patient.
  - e. The doctor did not tell the patient that he had a financial interest in the medicine he prescribed for her.
3. How much information should a doctor have to share with the patient? What is the justification for the doctor having to share information about himself like he has to do about the procedure?
4. Nelson, an African American who was assigned female at birth, but lives as a man, fell and badly injured his leg. He was rushed to County Hospital where he saw Dr. Demon. Nelson desperately wanted to save his leg, but Dr. Demon recommended amputation. Dr. Demon is a member of a secret society that believes that black people, trans people, and non-binary people should be eliminated from the earth. Does Dr. Demon have to disclose his membership in the organization to Nelson?

### **3.3 Informed Consent and the Standard of Care**

One of the most litigated elements deals with the correct standard of disclosure that the courts should apply to the situation. There are two disclosure standards—the professional malpractice standard and the reasonable patient standard. Under the professional standard, the physician is required to disclose to patients that information which would have been disclosed by the reasonable, minimally competent physician. This approach favors the healthcare provider because the patient has to engage an expert to give testimony to prove that the healthcare provider’s conduct fell below the applicable standard of

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<sup>18</sup> Associated Press, 'Dr. Love': Florida man who faked being a teen doctor freed from prison, USA Today, at <https://www.usatoday.com/story/news/nation/2019/09/25/dr-love-malachi-love-robinson-fake-florida-doctor-free/2439309001/> (Sept. 25, 2019).

care. The reasonable patient standard mandates that physicians disclose the risks that a reasonable patient would consider material in making a medical treatment decision. This is an objective standard, so expert testimony is not needed. There are two other theories upon which some states rely. The particular patient standard is a subjective standard that requires physicians to disclose the information that a specific patient would have wanted to know prior to making the medical decision. Reliance on the fiduciary standard, courts require physicians to disclose all the information the patient needs to make an informed decision.

***Culbertson v. Mernitz*, 602 N.E.2d 98 (1992)**

KRAHULIK, JUSTICE.

Roland B. Mernitz, M.D., (Appellee-Defendant) seeks transfer from the Court of Appeals' reversal of a summary judgment entered in his favor. The issue squarely presented in this petition is whether expert medical testimony is required to establish the standard of care of health care providers on the issue of informed consent. Because this Court has not previously written on this subject, we accept transfer.

The facts of the case are as follows. Dr. Mernitz first saw Patty Jo Culbertson on March 28, 1988. Her chief complaint was that of uncontrollable leakage of urine and discharge from the vagina. After performing a physical examination, Dr. Mernitz determined that she was suffering from urinary stress incontinence due to a mild cystocele, which is a bulging of the bladder into the vagina. Additionally, he determined that she had cervicitis, which was causing the vaginal discharge. Thirdly, he found that she had multiple fibroid tumors of the uterus. His recommendation was that she should undergo a surgical procedure known as a MMK procedure in order to suspend the bladder and either a hysterectomy or cryosurgery to freeze the infected tip of the cervix. Dr. Mernitz contends that he advised her of the general risks of any surgery, viz. infection, bleeding, and death, and that, with respect to the bladder suspension, he explained to her the risk that the procedure could fail and the possibility that she would be unable to void. Additionally, with respect to the cryosurgery he contends he told her that she would have severe vaginal discharge for two weeks and a milder discharge for six weeks thereafter. Mrs. Culbertson, on the other hand, denies that any of these risks were explained to her. Both parties, however, agree that Dr. Mernitz did not advise her of a risk that the cervix could become adhered to the wall of the vagina.

Following this office visit, Mrs. Culbertson decided to proceed with the bladder suspension and cryosurgery. She was admitted to the hospital and underwent these procedures. Post-surgically, Mrs. Culbertson's cervix adhered to the wall of her vagina. Dr. Mernitz prescribed medication for this condition, but Mrs. Culbertson became dissatisfied with his care and saw another surgeon who eventually performed a total abdominal hysterectomy, bilateral salpingo-oophorectomy which involves the removal of both ovaries, and another bladder suspension.

Following this surgery, Mr. and Mrs. Culbertson filed a proposed complaint against Dr. Mernitz with the Indiana Department of Insurance in four counts. Count I alleged that the adherence of the cervix to the vagina was caused by negligent cautery of the cervix. Count II alleged that Dr. Mernitz failed to inform Mrs. Culbertson of the alternatives to surgery and the inherent risks and complications of surgery. Count III alleged that Dr. Mernitz refused to treat and abandoned Mrs. Culbertson. And Count IV alleged a claim for loss of consortium by Mr. Culbertson.

A medical review panel was convened and, after submission of evidence to it, issued its written opinion. On Count I the panel unanimously found that there was no evidence to support the allegation that the surgery had been negligently performed. Similarly, it found no evidence to support the allegation in Count III that Dr. Mernitz had abandoned Mrs. Culbertson. With respect to the informed consent issue alleged in Count II, the panel ruled:

The Panel determines that [Dr. Mernitz] did not advise [Mrs. Culbertson] of the complication of cervical adhesion to the vagina; the Panel further determines that such non-disclosure does not constitute a failure to comply with the appropriate standard of care, as such complication is not considered a risk of such surgery requiring disclosure to the patient.

The Culbertsons filed their civil action in a complaint that mirrored the allegations of the proposed complaint. After answering this complaint, Dr. Mernitz moved for summary judgment relying on the expert opinion issued by the medical review panel. The Culbertsons did not file an affidavit or other evidence in opposition to the motion for summary judgment, but argued to the trial court that the “prudent patient” standard should be utilized in evaluating informed consent claims. The trial court entered summary judgment on all four counts. The Culbertsons appealed to the Court of Appeals on the informed consent issue and argued that expert medical testimony is not necessary to make a *prima facie* case of lack of informed consent because the “prudent patient” standard is the law in this State and such standard does not contemplate the necessity of expert medical testimony.

The Court of Appeals agreed with the Culbertsons that the trial court had erroneously entered summary judgment on Counts II and IV because an issue of fact remained as to whether the risk of cervical adhesion to the vagina was a “material risk”. The court further held that that issue was a question for the jury which does not require expert testimony as to materiality, although expert testimony might be required to establish the existence and extent of the risk. *Id.* Judge Hoffman disagreed and filed a dissenting opinion in which he set forth his belief that a physician must disclose those risks which a reasonably prudent physician would disclose under the circumstances. *Id.* at 1043. He further reasoned that the situation in the instant case was clearly outside the realm of a layperson’s comprehension, and that expert testimony was required to establish whether the disclosure was reasonable. He concluded that Culbertson’s failure to present any expert testimony contrary to the panel’s express findings on this issue made entry of summary judgment in favor of Dr. Mernitz proper. Because of the divergence of opinions in the Court of Appeals on this precise issue, we must determine the role, if any, played by expert medical opinion in resolving claims of medical malpractice premised upon a failure to obtain an informed consent.

The courts, historically, have established the standard of care required of physicians when treating patients. The law requires that a physician treating a patient possess and exercise that degree of skill and care ordinarily possessed and exercised by a physician treating such maladies in the same or similar locality. *Worster v. Caylor* (1953), 231 Ind. 625, 110 N.E.2d 337 (overruled on other grounds). In order for a lay jury to know whether a physician complied with the legally prescribed standard of care, expert testimony has generally been held to be required. This requirement was premised on the logical belief that a non-physician could not know what a reasonably prudent physician would or would not have done under the circumstances of any given case. Therefore, an expert familiar with the practice of medicine needed to establish what a reasonably prudent physician would or would not have done in treating a patient in order to set before the jury a depiction of the reasonably prudent physician against which to judge the actions of the defendant physician. An exception was created in cases of *res ipsa loquitur* on the premise that in such cases a lay jury did not need guidance from a physician familiar

with medical practice as to what was required of a reasonably prudent physician because the deficiency of practice “spoke for itself.” *Kranda v. Houser-Norborg Med. Corp.* (1981), Ind. App., 419 N.E.2d 1024, 1042. This was the settled law of most American jurisdictions, including Indiana, prior to the early 1970’s when two cases on the opposite coasts carved out an additional exception to the requirement of expert medical testimony in the area of “informed consent”.

In *Cobbs v. Grant* (1972), 8 Cal.3d 229, 104 Cal.Rptr. 505, 502 P.2d 1, the California Supreme Court held that expert testimony is not required to establish a physician’s duty to disclose risks of a proposed treatment. The premise of this opinion was that placing unlimited discretion in the medical community to determine what risks to disclose was irreconcilable with the basic right of a patient to make the ultimate informed decision regarding a course of treatment. The court reasoned that a physician is in the best position to appreciate the risks inherent in the proposed procedure, the risks inherent in deciding not to undergo the proposed procedure, as well as the chances of a successful outcome. The court held that once this information had been disclosed, however, the expert function of the physician had been performed and the decisional task of weighing the positive benefits of the proposed procedure against the negative possibilities inherent in the procedure passed solely and exclusively to the patient. Finally, the court opined that a jury is in the best position to determine whether the physician gave the patient the information needed by the patient to weigh the alternatives and make the ultimate decision of whether to proceed with the proposed treatment.

In the same year, the Court of Appeals for the District of Columbia decided *Canterbury v. Spence* (1972), 464 D.2d 772, *cert. den.*, 409 U.S. 1064, 93 S.Ct. 560, 34 L.Ed.2d 518. In *Canterbury*, the court also held that expert testimony was not required to establish a physician’s duty to disclose risks of a proposed treatment. It reasoned that while an expert may be required to identify for the jury the risks of the proposed treatment and the risks of non-treatment, a jury did not need expert guidance on whether a particular risk was material to a patient’s ultimate decision. The court held that “a risk is thus material when a reasonable person, in what the physician knows or should know to be the patient’s position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.” 464 F.2d at 787. With that as the standard of care in informed consent cases, the court concluded that a lay jury was in as good a position as a physician to determine whether the physician had informed the patient of the facts such a patient would “need to know” in order to arrive at a decision

### Informed Consent in Indiana Jurisprudence

In the first reported Indiana case to discuss the doctrine of informed consent, the Court of Appeals declined to determine either the extent of a physician’s duty to disclose or the exceptions to such duty, because that determination was not necessary to the resolution of the case at hand. *Joy v. Chau* (1978), 177 Ind.App. 29, 377 N.E.2d 670. The *Joy* court, however, did hold:

It is clear that Indiana must recognize the duty of a physician to make a reasonable disclosure of material facts relevant to the decision which the patient is requested to make. The duty arises from the relationship between the doctor and patient, and is imposed as a matter of law as are most legal duties.

177 Ind.App. at 39, 377 N.E.2d at 676-77 (citations omitted). This discussion of informed consent was next taken up and directly decided in *Revord v. Russell* (1980), Ind.App., 401 N.E.2d 763. In *Revord*, the Court of Appeals affirmed the trial court’s granting of a motion for judgment on the evidence in favor of Dr. Russell over the plaintiff’s assertion that an issue of fact requiring a jury’s resolution

existed, even though no expert medical testimony had been presented. In discussing this issue, the *Revord* court quoted from both *Cobbs*, 104 Cal.Rptr. 505, 502 P.2d 1, and *Canterbury*, 464 F.2d 772, as well as from 52 A.L.R.3d 1084. The court specifically held, however, as follows:

In the instant case, the Revords offered no expert medical testimony, and laymen would have no way of determining whether under the circumstances Mary Revord's parents had sufficient information to allow them to make an intelligent decision. Brain surgery is not a matter within the common knowledge or experience of laymen, and we hold that medical testimony was required of the Revords to establish a *prima facie* case under their informed consent theory. No expert medical evidence was offered by the Revords that a reasonable neurosurgeon, in the same or similar circumstances, would have told them of the risk of injury suffered here or that the disclosures made by Russell did not meet the standard of what a reasonable neurosurgeon would have disclosed under the same or similar circumstances. Thus the trial court properly granted a directed verdict in Russell's favor.

401 N.E.2d at 767 (citations and footnote omitted). It is clear from the above-quoted holding that the *Revord* court, although recognizing the discussion of *Cobbs* and *Canterbury*, continued to hold the view that expert medical testimony was necessary to prove a *prima facie* case of medical malpractice under the informed consent doctrine.

This view was continued in *Searcy v. Manganhas* (1981), Ind.App., 415 N.E.2d 142. In affirming the trial court's entry of judgment on the evidence, the *Searcy* court cited *Revord* and held that judgment on the evidence was appropriate because the plaintiff patient had offered no expert medical testimony to establish what risks the defendant physicians had a duty to disclose. Therefore, the *Searcy* court held that the patient's evidence lacked at least one essential element necessary to establish a *prima facie* case and the trial court properly granted the motion for judgment on the evidence in the physician's favor. *Id.* at 145. This same rule of law was restated in *Ellis v. Smith* (1988), Ind.App., 528 N.E.2d 826, where the Court of Appeals upheld the entry of summary judgment in favor of a physician. In so doing, the court reiterated its previous holdings:

The general rule is that expert medical opinion testimony is required to establish the content of "reasonable disclosure" unless the situation is clearly within the realm of laymen's comprehension, as where disclosure is so obvious that laymen could recognize the necessity of such disclosure.

In the present case, the reasonable disclosure and informed consent necessary for elective foot surgery on a muscular dystrophy patient is not clearly within a layman's realm of comprehension. Plaintiffs were required to come forward with expert medical opinion contrary to the unanimous finding of the medical review panel. The question of an appropriate standard of care may not be resolved without resort to expert testimony. 528 N.E.2d at 828 (citations omitted).

This rule was followed in *Payne v. Marion General Hospital* (1990), Ind.App., 549 N.E.2d 1043, where the Court of Appeals reversed a summary judgment entered in favor of the physicians in a case involving the physician's order to not resuscitate, or "no code", a patient without discussing the matter with the patient. The *Payne* court held that the situation involved in that case was within the realm of the ordinary layman's comprehension. *Id.* at 1050. The court specifically held that a jury would not be called upon to weigh a disclosure to determine if it met the requisite standard of care as is typically the

case undertaken by the jury in informed consent cases. *Id.* The court held that this was true because in the case at bar, no disclosure whatsoever had been made and no effort had been undertaken by the physician to determine if the patient was competent prior to entering the “no code” order over the telephone. *Id.* The court continued, however, to follow the general rule: “As a general rule, expert medical testimony is required to establish whether the disclosure by the physician is reasonable. However, if the situation is clearly within the realm of laymen’s comprehension, expert medical testimony is not required. *Ellis, supra; Searcy, supra; Revord, supra.*” *Id.*

The Culbertsons urge that the Indiana Court of Appeals arguably adopted the “prudent patient” standard of care as discussed in *Canterbury* in the case of *Spencer v. Christiansen* (1990), Ind.App., 549 N.E.2d 1090. They are mistaken. The *Spencer* court, in a one paragraph review of the general law, stated that Indiana recognized the duty of a physician to “make a reasonable disclosure of material facts relevant to the decision which the patient is requested to make” and that, as a general rule, “expert medical testimony is required to establish the content of the ‘reasonable disclosure’.” *Id.* at 1091. The court, however, then continued and stated that “whether the required disclosure occurred and its adequacy is an issue of fact that does not require medical expertise; accordingly medical expert opinion on the jury issue is inappropriate.” *Id.* As was recently recognized in *Dickey v. Long* (1992), Ind., 591 N.E.2d 1010, much of the language contained in *Spencer* was merely dicta because the specific holding in *Spencer* was that a medical review panel had not resolved a disputed fact and, consequently, the issue of whether that case required expert medical opinion was not decided. *Spencer* is not, therefore, support for the proposition advocated by the Culbertsons.

Finally, in *Griffith v. Jones* (1991), Ind.App., 577 N.E.2d 258, the Court of Appeals for the first time departed from its previous holdings and concluded that “the weight of authority supports the trial court’s determination that the prudent patient standard of care in informed consent cases, as articulated in *Canterbury*, *supra*, has been adopted in Indiana.” *Id.* at 264. Simply stated, our reading of the prior cases, as set forth above, does not support this statement and, to the contrary, leads us to conclude that expert medical testimony is necessary to establish whether a physician’s disclosure of risks comports with what a reasonably prudent physician would have disclosed. Because the court in the case at issue here relied on its previous holding in *Griffith* to reverse the summary judgment entered in favor of Dr. Mernitz, it erred. We hold that pursuant to the precedent discussed above, the trial court properly entered summary judgment in favor of Dr. Mernitz.

Resolution of the issue of the necessity of expert medical testimony in informed consent cases depends on whether the issue is viewed through the eyes of the physician or the patient. When viewed through the eyes of the physician, it is easy to see that a physician should not be required to guess or speculate as to what a hypothetical “reasonably prudent patient” would “need to know” in order to make a determination. A physician should only be required to do that which he is trained to do, namely, conduct himself as a reasonably prudent physician in taking a history, performing a physical examination, ordering appropriate tests, reaching a diagnosis, prescribing a course of treatment, and in discussing with the patient the medical facts of the proposed procedure, including the risks inherent in either accepting or rejecting the proposed course of treatment. From a physician’s viewpoint, he should not be called upon to be a “mind reader” with the ability to peer into the brain of a prudent patient to determine what such patient “needs to know,” but should simply be called upon to discuss medical facts and recommendations with the patient as a reasonably prudent physician would.

On the other hand, from the patient’s viewpoint, the physician should be required to give the patient sufficient information to enable the patient to reasonably exercise the patient’s right of self-decision in a knowledgeable manner. Viewed from this vantage point, the patient does not want the medical



profession to determine in a paternalistic manner what the patient should or should not be told concerning the course of treatment. Thus, such a patient would view the reasonably prudent physician standard as destroying the patient's right of self-decision and, impliedly, placing such decision under the exclusive domain of the medical profession. While this viewpoint may or may not have been justified in 1972 when *Canterbury*, and *Cobbs*, were decided, a review of medical ethics standards of care in 1992 should assuage this fear.

The 1992 Code of Medical Ethics, as prepared by the Council on Ethical and Judicial Affairs of the American Medical Association, sets forth the medical profession's standard on informed consent. It reads as follows:

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his own determination on treatment. The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for his care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a basic social policy for which exceptions are permitted (1) where the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent; or (2) when risk-disclosure poses such a serious psychological threat of detriment to the patient as to be medically contraindicated. Social policy does not accept the paternalistic view that the physician may remain silent because divulgence might prompt the patient to forego needed therapy. Rational, informed patients should not be expected to act uniformly, even under similar circumstances, in agreeing to or refusing treatment.

We recognize this statement as a reasonable statement on the issue of informed consent. There is no need to change Indiana law on this issue. We therefore hold that, except in those cases where deviation from the standard of care is a matter commonly known by lay persons, expert medical testimony is necessary to establish whether a physician has or has not complied with the standard of a reasonably prudent physician.

In the present case we cannot say that the risk of the adherence of the cervix to the vaginal wall is a matter commonly known to lay persons. Therefore, the Culbertsons needed to provide expert medical testimony to refute the unanimous opinion issued by the medical review panel in order to present a material issue of fact as to what a reasonably prudent physician would have discussed concerning this proposed surgery. Without the presentation of such expert medical opinion, the trial court could only conclude that there was no genuine issue of material fact and that summary judgment should be entered for Dr. Mernitz.

We affirm the entry of summary judgment in this case.

### **3.4 Informed Consent and Research on Human Subjects**

The negative impact of COVID-19 had companies scrambling to find ways to slow the spread of the deadly virus. It was quickly evident that a COVID-19 vaccine needed to be manufactured. Like any

other drug, the vaccine had to go through several phases before the Food and Drug Administration (FDA) would approve it for human consumption. Before it can put a new drug on the market, the manufacturer must test the new drug in three phases of clinical trials. The purpose of the clinical trials is to test the drug's safety and effectiveness. The manufacturer cannot gather all the information it needs by just testing on animals and conducting other tests in the laboratory. Consequently, the drug must be eventually tested on human subjects. Companies rely on human research volunteers to assist in their tests. In phase I, the new drug is administered to the healthy human volunteers to determine whether it is safe for human consumption. Then, in phase II, the drug is given to persons with the target disease to decide if it will be an effective treatment. In phase III, patients receive the drug to ascertain the risks and benefits associated with the drug. After completing phase III trials, the manufacturer can submit the research results to the FDA for approval. The clinical trial process indicates that tests on human subjects are necessary to help companies discover treatments for diseases and disorders. Nonetheless, the world has an ugly history of [conducting research of human subjects](#).<sup>19</sup> As a result, people are hesitant to participate in clinical trials because of the possible adverse side effects of a new drug.

One way to encourage people to participate in clinical trials is to put in safety measures. One of those safeguards is the necessity of informed consent. In 1949, the Nuremberg tribunal accepted and published *Permissible Medical Experiments*. A key assertion in that document was “the voluntary consent of the human subject is absolutely essential.” The Nuremberg Code required more than informed consent. It also established requirements that focused on the experiment, on the welfare of the human subject, and on the conduct of the researcher. The Code established the foundation for informed consent, but it does not have much relevance in modern times. Research on human subjects is regulated by several federal laws and regulations. The most important regulation impacting research on human subjects is the Institutional Review Board approval process. Institutional Review Boards (IRBs) provide peer review of proposed experiments that involve human subjects. A key mandate of IRBs is that the research subject gives informed consent.

### 3.4.1 Involuntary Participation

At times, a person may become a research subject without giving consent. In those cases, it does not matter if the research is being done to benefit the patient or to benefit the greater good. The courts tend to give more scrutiny to situations involving non-therapeutic research. Therapeutic research provides the chance of benefit to the research subject. An example of therapeutic research is when a cancer patient enters a clinical trial for an experimental treatment. Because the subject has the potential of gaining some benefit from the research, some risk to the subject might be tolerated so long as it's outweighed by the anticipated benefit and other criteria are met. Non-therapeutic research does not offer a benefit to the subject. For instance, when a healthy college student is paid to participate in a clinical trial that is considered to be non-therapeutic research. Non-therapeutic research cannot proceed unless the risks to the subject are deemed to be minimal. In the *Grimes* case, the children were experimented on without their consent. As the *Moore* case illustrates, research that starts out therapeutic may end up being non-therapeutic without the participant's consent.

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<sup>19</sup> Anthony Wrigley, *Human experiments – the good, the bad, and the ugly*, The Conversation, at <https://theconversation.com/human-experiments-the-good-the-bad-and-the-ugly-39876> (June 8, 2015).

***Grimes v. Kennedy Krieger Institute, Inc.*, 782 A.2d 807 (Md. 2001)**

CATHELL, JUDGE.

**Prologue**

We initially note that these are cases of first impression for this Court. For that matter, precious few courts in the United States have addressed the issues presented in the cases at bar. In respect to nontherapeutic research using minors, it has been noted that “consent to research has been virtually unanalyzed by courts and legislatures.” Robert J. Katerberg, *Institutional Review Boards, Research on Children, and Informed Consent of Parents: Walking the Tightrope Between Encouraging Vital Experimental and Protecting Subjects’ Rights*, 24 J.C. & U.L. 545, 562, quoting National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, *Report and Recommendations [National Commission]: Research Involving Children* 79–80 (1977). Our research reveals this statement remains as accurate now as it was in 1977.

In these present cases, a prestigious research institute, associated with Johns Hopkins University, *based on this record*, created a nontherapeutic research program whereby it required certain classes of homes to have only partial lead paint abatement modifications performed, and in at least some instances, including at least one of the cases at bar, arranged for the landlords to receive public funding by way of grants or loans to aid in the modifications. The research institute then encouraged, and in at least one of the cases at bar, required, the landlords to rent the premises to families with young children. In the event young children already resided in one of the study houses, it was contemplated that a child would remain in the premises, and the child was encouraged to remain, in order for his or her blood to be periodically analyzed. In other words, the continuing presence of the children that were the subjects of the study was required in order for the study to be complete. Apparently, the children and their parents involved in the cases *sub judice* were from a lower economic strata and were, at least in one case, minorities.

The purpose of the research was to determine how effective varying degrees of lead paint abatement procedures were. Success was to be determined by periodically, over a two-year period of time, measuring the extent to which lead dust remained in, or returned to, the premises after the varying levels of abatement modifications, and, as most important to our decision, by measuring the extent to which the theretofore healthy children’s blood became contaminated with lead, and comparing that contamination with levels of lead dust in the houses over the same periods of time. In respect to one of the protocols presented to the Environmental Protection Agency and/or the Johns Hopkins Joint Committee on Clinical Investigation, the Johns Hopkins Institutional Review Board (IRB), the researchers stated: “To help insure that study dwellings are occupied by families with young children, City Homes will give priority to families with young children when renting the vacant units following R & M [Repair and Maintenance] interventions.”

The same researchers had completed a prior study on abatement and partial abatement methods that indicated that lead dust remained and/or returned to abated houses over a period of time. In an article reporting on that study, the very same researchers said: “Exposure to lead-bearing dust is particularly hazardous for children because hand-to-mouth activity is recognized as a major route of entry of lead into the body and because absorption of lead is inversely related to particule size.” Mark R. Farfel & J. Julian Chisolm, *Health and Environmental Outcomes of Traditional and Modified Practices for Abatement of Residential Lead-Based Paint*, —80 *American Journal of Public Health*—1240, 1243

(1990). After publishing this report, the researchers began the present research project in which children were encouraged to reside in households where the possibility of lead dust was known to the researcher to be likely, so that the lead dust content of their blood could be compared with the level of lead dust in the houses at periodic intervals over a two-year period.

Apparently, it was anticipated that the children, who were the human subjects in the program, would, or at least might, accumulate lead in their blood from the dust, thus helping the researchers to determine the extent to which the various partial abatement methods worked. There was no complete and clear explanation in the consent agreements signed by the parents of the children that the research to be conducted was designed, at least in significant part, to measure the success of the abatement procedures by measuring the extent to which the children's blood was being contaminated. It can be argued that the researchers intended that the children be the canaries in the mines but never clearly told the parents. (It was a practice in earlier years, and perhaps even now, for subsurface miners to rely on canaries to determine whether dangerous levels of toxic gasses were accumulating in the mines. Canaries were particularly susceptible to such gasses. When the canaries began to die, the miners knew that dangerous levels of gasses were accumulating.)

The researchers and their Institutional Review Board apparently saw nothing wrong with the search protocols that anticipated the possible accumulation of lead in the blood of otherwise healthy children as a result of the experiment, or they believed that the consents of the parents of the children made the research appropriate. Institutional Review Boards (IRB) are oversight entities within the institutional family to which an entity conducting research belongs. In research experiments, an IRB can be required in some instances by either federal or state regulation, or sometimes by the conditions attached to governmental grants that are used to fund research projects. Generally, their primary functions are to assess the protocols of the project to determine whether the project itself is appropriate, whether the consent procedures are adequate, whether the methods to be employed meet proper standards, whether reporting requirements are sufficient, and the assessment of various other aspects of a research project. One of the most important objectives of such review is the review of the potential safety and the health hazard impact of a research project on the human subjects of the experiment, especially on vulnerable subjects such as children. Their function is *not* to help researchers seek funding for research projects.

In the instant case, as is suggested by some commentators as being endemic to the research community as a whole, *infra*, the IRB involved here, the Johns Hopkins University Joint Committee on Clinical Investigation, in part, abdicated that responsibility, instead suggesting to the researchers a way to miscast the characteristics of the study in order to avoid the responsibility inherent in nontherapeutic research involving children.

While the suggestion of the IRB would not make this experiment any less nontherapeutic or, thus, less regulated, this statement shows two things: (1) that the IRB had a partial misperception of the difference between therapeutic and nontherapeutic research and the IRB's role in the process and (2) that the IRB was willing to aid researchers in getting around federal regulations designed to protect children used as subjects in nontherapeutic research. An IRB's primary role is to assure the safety of human research subjects—not help researchers avoid safety or health-related requirements. The IRB, in this case, misconceived, at least partially, its own role.

The provisions or conditions imposed by the federal funding entities, pursuant to federal regulations, are conditions attached to funding. As far as we are aware, or have been informed, there are no federal or state (Maryland) statutes that mandate that all research be subject to certain conditions. Certain international "codes" or "declarations" exist (one of which is supposedly binding but has never been

so held) that, at least in theory, establish standards. We shall describe them, *infra*. Accordingly, we write on a clean slate in this case. We are guided, as we determine what is appropriate, by those international “codes” or “declarations,” as well as by studies conducted by various governmental entities, by the treatises and other writings on the ethics of using children as research subjects, and by the duties, if any, arising out of the use of children as subjects of research.

Otherwise healthy children, in our view, should not be enticed into living in, or remaining in, potentially lead-tainted housing and intentionally subjected to a research program, which contemplates the probability, or even the possibility, of lead poisoning or even the accumulation of lower levels of lead in blood, in order for the extent of the contamination of the children’s blood to be used by scientific researchers to assess the success of lead paint or lead dust abatement measures. Moreover, in our view, parents, whether improperly enticed by trinkets, food stamps, money or other items, have no more right to intentionally and unnecessarily place children in potentially hazardous nontherapeutic research surroundings, than do researchers. In such cases, parental consent, no matter how informed, is insufficient.

While the validity of the consent agreement and its nature as a contract, the existence or nonexistence of a special relationship, and whether the researchers performed their functions under that agreement pursuant to any special relationships are important issues in these cases that we will address, the very inappropriateness of the research itself cannot be overlooked. It is apparent that the protocols of research are even more important than the method of obtaining parental consent and the extent to which the parents were, or were not, informed. If the research methods, the protocols, are inappropriate then, especially when the IRB is willing to help researchers avoid compliance with applicable safety requirements for using children in nontherapeutic research, the consent of the parents, or of any consent surrogates, in our view, cannot make the research appropriate or the actions of the researchers and the Institutional Review Board proper.

The research relationship proffered to the parents of the children the researchers wanted to use as measuring tools, should never have been presented in a nontherapeutic context in the first instance. Nothing about the research was designed for treatment of the subject children. They were presumed to be healthy at the commencement of the project. As to them, the research was clearly nontherapeutic in nature. The experiment was simply a “for the greater good” project. The specific children’s health was put at risk, in order to develop low-cost abatement measures that would help all children, the landlords, and the general public as well.

The research project at issue here, and its apparent protocols, differs in large degree from, but presents similar problems as those in the Tuskegee Syphilis Study conducted from 1932 until 1972 (*The Tuskegee Syphilis Study*, 289 New England Journal of Medicine 730 (1973)), the intentional exposure of soldiers to radiation in the 1940s and 50s (*Jaffee v. United States*, 663 F.2d 1226 (3d Cir. 1981), *cert. denied*, 456 U.S. 972, 102 S.Ct. 2234, 72 L.Ed.2d 845 (1982)), the tests involving the exposure of Navajo miners to radiation (*Begay v. United States*, 591 F.Supp. 991 (1984), *aff’d*, 768 F.2d 1059 (9<sup>th</sup> Cir. 1985) and the secret administration of LSD to soldiers by the CIA and the Army in the 1950s and 60s (*United States v. Stanley*, 483 U.S. 669, 107 S.Ct. 3054, 97 L.Ed.2d 550 (1987)); *Central Intelligence Agency v. Sims*, 471 U.S. 159, 105 S.Ct. 1881, 85 L.Ed.2d 173 (1985)). The research experiments that follow were also prior instances of research subjects being intentionally exposed to infectious or poisonous substances in the name of scientific research. They include the Tuskegee Syphilis Study, aforesaid, where patients infected with syphilis were not subsequently informed of the availability of penicillin for treatment of the illness, in order for the scientists and researchers to be able to continue research on the effects of the illness, the Jewish Hospital study, and several other post-

war research projects. Then there are the notorious use of “plague bombs” by the Japanese military in World War II where entire villages were infected in order for the results to be “studied”; and perhaps most notorious, the deliberate use of infection in a nontherapeutic project in order to study the degree of infection and the rapidity of the course of the disease in the Rose and Mrugowsky typhus experiments at Buchenwald concentration camp during World War II. These programs were somewhat alike in the vulnerability of the subjects; uneducated African–American men, debilitated patients in a charity hospital, prisoners of war, inmates of concentration camps and others falling within the custody and control of the agencies conducting or approving the experiments. In the present case, children, especially young children, living in lower economic circumstances, albeit not as vulnerable as the other examples, are nonetheless, vulnerable as well.

It is clear to this Court that the scientific and medical communities cannot be permitted to assume sole authority to determine ultimately what is right and appropriate in respect to research projects involving young children free of the limitations and consequences of the application of Maryland law. The Institutional Review Boards, IRBs, are, primarily, in-house organs. In our view, they are not designed, generally, to be sufficiently objective in the sense that they are as sufficiently concerned with the ethicality of the experiments they review as they are with the success of the experiments. This has been the subject of comment in a constitutional context, in dissent, in a case involving the use of psychiatric medication on mental patients without their consent.

As can be seen from the letter from the Johns Hopkins University Joint Committee on Clinical Investigation, *supra*, to the researchers in this case, Justice Steven’s doubts as to the effectiveness of such in-house review to assess the ethics of research were warranted. Here, the IRB, whose primary function was to insure safety and compliance with applicable regulations, encouraged the researchers to misrepresent the purpose of the research in order to bring the study under the label of “therapeutic” and thus under a lower safety standard of regulation. The IRB’s purpose was ethically wrong, and its understanding of the experiment’s benefit incorrect.

The conflicts are inherent. This would be especially so when science and private industry collaborate in search of material gains. Moreover, the special relationship between research entities and human subjects used in the research will almost always impose duties.

In respect to examining that special relationship, we are obliged to further examine its nature and its ethical constraints. In that regard, when contested cases arise, the assessment of the legal effect of research on human subjects must always be subject to judicial evaluation. One method of making such evaluations is the initiation of appropriate actions bringing such matters to the attention of the courts, as has been done in the cases at bar. It may well be that in the end, the trial courts will determine that no damages have been incurred in the instant cases and thus the actions will fail for that reason. In that regard, we note that there are substantial factual differences in the Higgins and in the Grimes cases. But the actions, themselves, are not defective on the ground that no legal duty can, according to the trial courts, possibly exist. For the reasons discussed at length in the main body of the opinion, a legal duty normally exists between researcher and subject and in all probability exists in the cases at bar. Moreover, as we shall discuss, the consents of the parents in these cases under Maryland law constituted contracts creating duties. Additionally, under Maryland law, to the extent parental consent can ever be effective in research projects of this nature, the parents may not have been sufficiently informed and, therefore, the consents ineffective and, based on the information contained in the sparse records before this court, the research project, may have invaded the legal rights of the children subjected to it.

## II. Facts & Procedural Background

### A. *The Research Study*

The research study was sponsored jointly by the EPA and the Maryland Department of Housing and Community Development (DHCD). It was thus a joint federal and state project. The Baltimore City Health Department and Maryland Department of the Environment also collaborated in the study. It appears that, because the study was funded and sponsored in part by a federal entity, certain federal conditions were attached to the funding grants and approvals. There are certain uniform standards required in respect to federally funded or approved projects. We, however, are unaware of, and have not been directed to, any federal or state statute or regulation that imposes limits on this Court's powers to conduct its review of the issues presented. None of the parties have questioned this Court's jurisdiction in these cases. Moreover, 45 Code Federal Regulations (CFR) 46.116(e) specifically provides: "The informed consent requirements in this policy are not intended to preempt any applicable federal, state, or local laws which require additional information to be disclosed in order for informed consent to be legally effective." Those various federal or state conditions, recommendations, etc., may well be relevant at a trial on the merits as to whether any breach of a contractual or other duty occurred, or whether negligence did, in fact, occur; but have no limiting effect on the issue of whether, at law, legal duties, via contract or "special relationships" are created in Maryland in experimental nontherapeutic research involving Maryland children.

The research study included five test groups, each consisting of twenty-five houses. The first three groups consisted of houses with a considerable amount of lead dust present therein and each group received assigned amounts of maintenance and repair. The fourth group consisted of houses, which at one time had lead present in the form of lead based paint but had since received a supposedly complete abatement of lead dust. The fifth group consisted of modern houses, which had never had a presence of lead dust. The aim of the research study was to analyze the effectiveness of different degrees of partial lead paint abatement in reducing levels of lead dust present in these houses. The ultimate aim of the research was to find a less than complete level of abatement that would be relatively safe, but economical, so that Baltimore landlords with lower socio-economical rental units would not abandon the units. The research study was specifically designed, in part, to do less than comprehensive lead paint abatement in order to study the potential effectiveness, if any, over a period of time, of lesser levels of repair and maintenance on the presence of lead dust by measuring the presence of lead in the blood of theretofore (as far as the record of the cases reveals) healthy children. In essence, the study at its inception was designed not only to test current levels of lead in the blood of the children, but the increase or decrease in future lead levels in the blood that would be affected by the various abatement programs. It appears that this study was also partially motivated, as we have indicated, *supra*, by the reaction of property owners in Baltimore City to the cost of lead dust abatement. The cost of full abatement of such housing at times far exceeded the monetary worth of the property—in other words, the cost of full abatement was simply too high for certain landlords to be able to afford to pay or be willing to pay. As a result, some lower level rental properties containing lead based paint in Baltimore had been simply abandoned and left vacant. The study was attempting to determine whether a less expensive means of rehabilitation could be available to the owners of such properties.

One way the study was designed to measure the effectiveness of such abatement measures was to measure the lead dust levels in the houses at intervals and to compare them with the levels of lead found, at roughly the same intervals, in the blood of the children living in the respective houses. The project required that small children be present in the houses. To facilitate that purpose, the landlords agreeing to permit their properties to be included in the studies were encouraged, if not required, to

rent the properties to tenants who had young children. In return for permitting the properties to be used and in return for limiting their tenants to families with young children, KKI assisted the landlords in applying for and receiving grants or loans of money to be used to perform the levels of abatement required by KKI for each class of home.

In summary, KKI conducted a study of five test groups of twenty-five houses each. The first three groups consisted of houses known to have lead present. The amount of repair and maintenance conducted increased from Group 1 to Group 2 to Group 3. The fourth group consisted of houses, which had at one time lead present but had since allegedly received a complete abatement of lead dust. The fifth group consisted of modern houses, which had never had the presence of lead dust. The twenty-five homes in each of the first three testing levels were then to be compared to the two control groups: the twenty-five homes in Group 4 that had previously been abated and the 25 modern homes in Group 5. The research study was specifically designed to do less than full lead dust abatement in some of the categories of houses in order to study the potential effectiveness, if any, of lesser levels of repair and maintenance.

If the children were to leave the houses upon the first manifestation of lead dust, it would be difficult, if not impossible, to test, over time, the rate of the level of lead accumulation in the blood of the children attributable to the manifestation. In other words, if the children were removed from the houses before the lead dust levels in their blood became elevated, the tests would probably fail, or at least the data that would establish the success of the test—or of the abatement results, would be of questionable use. Thus, it would benefit the accuracy of the test, and thus KKI, the compensated researcher, if children remained in the houses over the period of the study even after the presence of lead dust in the houses became evident.

Pursuant to the plans of the research study, KKI collected dust samples in the Monroe Street property on March 9, 1993, August 23, 1993, March 9, 1994, September 19, 1994, April 18, 1995, and November 13, 1995. The March 9, 1993 dust testing revealed what the researchers referred to as “hot spots” where the level of lead was “higher than might be found in a completely renovated [abated] house.” This information about the “hot spots” was not furnished to Ms. Hughes until December 16, 1993, more than nine months after the samples had been collected and, as we discuss, *infra*, not until after Ericka Grimes’s blood was found to contain elevated levels of lead.

KKI drew blood from Ericka Grimes for lead content analysis on April, 9, 1993, September 15, 1993, and March 25, 1994. Unlike the lead concentration analysis in dust testing, the results of the blood testing were typically available to KKI in a matter of days. KKI notified Ms. Hughes of the results of the blood tests by letters dated April 9, 1993, September 29, 1993, and March 28, 1994, respectively. The results of the April 9, 1993 test found Ericka Grimes blood to be less than 9 Pg/dL, which placed her results in the “normal” range according to classifications established by the Centers for Disease Control (CDC). However, on two subsequent retests, long after KKI had identified “hot spots,” but before KKI informed Ms. Hughes of the “hot spots,” Ericka Grimes’s blood lead level registered Class III—32  $\mu$ g/dL on September 15, 1993 and 22  $\mu$ g/dL on March 25, 1994. Ms. Hughes and her daughter vacated the Monroe Street property in the Summer of 1994, and, therefore, no further blood samples were obtained by KKI after March 25, 1994.

In her Complaint filed in the Circuit Court for Baltimore City, Ms. Hughes sought to hold KKI liable for negligence for failing to warn of, or abate, lead-paint hazards that KKI allegedly discovered in the Monroe Street property during the research study.



On appeal, appellant seeks review of the Circuit Court's decision granting KKI summary judgment. She contends that KKI owed a duty of care to appellant based on the nature of its relationship with appellant and her mother arising out of: (1) a contract between the parties; (2) a voluntary assumption by KKI; (3) a "special relationship" between the parties; and (4) a Federal regulation. She argues that KKI's failure to notify her of the lead dust hazards in the Monroe Street property until after more than nine months had passed since the samples had been collected, and until after Ericka Grimes's blood was found to be lead poisoned, constituted negligence on the part of KKI in the performance of its duties to Ericka arising out of the nature of the relationship between the parties.

KKI filed a Motion for Summary Judgment on the grounds that it did not owe any duty to appellant. On April 5, 2000, the Circuit Court granted KKI's motion and entered judgment in favor of KKI. On May 4, 2000, appellant filed a Motion to Reconsider, which the Circuit Court denied on May 25, 2000. Appellant dismissed the claims against Polakoff, Chase Management and CFOD-2 Limited Partnership and filed a Notice of Appeal on July 20, 2000. On February 8, 2001, prior to consideration by the Court of Special Appeals, we issued a Writ of Certiorari.

### **III. Discussion**

#### *A. Standard of Review*

We resolve these disputes in the context of the trial court's granting of the appellee's motions for summary judgment. The threshold issues before this Court are whether appellee, KKI, was entitled to summary judgment as a matter of law on the basis that no contract existed and that there is inherently no duty owed to a research subject by a researcher. Perhaps even more important is the ancillary issue of whether a parent in Maryland, under the law of this State, can legally consent to placing a child in a nontherapeutic research study that carries with it any risk of harm to the health of the child. We shall resolve all of these primary issues.

"In reviewing a grant of a summary judgment, we are first concerned with whether a genuine dispute of material fact exists" and then whether the movant is entitled to summary judgment as a matter of law (citations omitted). "A material fact is a fact the resolution of which will somehow affect the outcome of the case" (citations omitted). "[A] dispute as to facts relating to grounds upon which the decision is not rested is not a dispute with respect to a *material* fact and such dispute does not prevent the entry of summary judgment." *Salisbury Beauty Schs. v. State Bd. of Cosmetologists*, 268 Md. 32, 40, 300 A.2d 367, 374 (1973).

#### *B. General Discussion*

Initially, we note that we know of no law, nor have we been directed to any applicable in Maryland courts, that provides that the parties to a scientific study, because it is a scientific, health-related study, cannot be held to have entered into special relationships with the subjects of the study that can create duties, including duties, the breach of which may give rise to negligence claims. We also are not aware of any general legal precept that immunizes nongovernmental "institutional volunteers" or scientific researchers from the responsibility for the breaches of duties arising in "special relationships." Moreover, we, at the very least, hold that, under the particular circumstances testified to by the parties, there are genuine disputes of material fact concerning whether a special relationship existed between KKI and Ericka Grimes. Concerning this issue, the granting of the summary judgment motions was clearly inappropriate. When a "special relationship" can exist as a matter of law, the issue of whether, given certain facts, a special relationship does exist, when there is a dispute of material fact in that

respect, is a decision for the finder of fact, not the trial judge. We shall hold initially that the very nature of nontherapeutic scientific research on human subjects can, and normally will, create special relationships out of which duties arise. Since World War II the specialness or nature of such relationships has been frequently of concern in and outside of the research community.

As a result of the atrocities performed in the name of science during the Holocaust, and other happenings in the World War II era, what is now known as The Nuremberg Code evolved. Of special interest to this Court, the Nuremberg Code, at least in significant part, was the result of legal thought and legal principles, as opposed to medical or scientific principles, and thus should be the preferred standard for assessing the legality of scientific research on human subjects. Under it, duties to research subjects arise.

“Following the Doctors’ Trial (the ‘Medical Case’), which included charges of conducting lethal studies of the effects of high altitude and extreme cold, the action of poisons, and the response to various induced infections, the court issued ‘The Nuremberg Code’ *as a summary of the legal requirements for experimentation on humans*. The Code requires that the informed, voluntary, competent, and understanding consent of the research subject be obtained. Although this principle is placed first in the Code’s ten points, the other nine points must be satisfied before it is even appropriate to ask the subject to consent.

The Nuremberg Code is the ‘most complete and authoritative statement of the law of informed consent to human experimentation.’ It is also ‘part of international common law and may be applied, in both civil and criminal cases, by state, federal and municipal courts in the United States.’ However, even though the courts in the United States may use the Nuremberg Code to set criminal and civil standards of conduct, none have used it in a criminal case and only a handful have even cited it in the civil context. Even where the Nuremberg Code has been cited as authoritative, it has usually been in dissent, and no United States court has ever awarded damages to an injured experimental subject, or punished an experimenter, on the basis of a violation of the Nuremberg Code. There have, however, been very few court decisions involving human experimentation. It is therefore very difficult for a ‘common law’ of human experimentation to develop. This absence of judicial precedent makes codes, especially judicially-crafted codes like the Nuremberg Code, all the more important.” [Footnotes omitted.] [Emphasis added.]

“Why wasn’t the Nuremberg Code immediately adopted by United States courts as setting the minimum standard of care for human experimentation? One reason, perhaps, is that there was little opportunity. As remains true today, almost no experiments resulted in lawsuits in the 1940’s, 50’s, and 60’s. A second reason may be that the Nazi experiments were considered so extreme as to be seen as irrelevant to the United States. This may explain why our own use of prisoners, the institutionalized retarded, and the mentally ill to test malaria treatments during World War II was generally hailed as positive, making the war ‘everyone’s war.’ Likewise, in the late 1940’s and early 1950’s, the testing of new polio vaccines on institutionalized mentally retarded children was considered appropriate. Utilitarianism was the ethic of the day. Noting that the Code applied primarily to the type of outrageous nontherapeutic experiments conducted during the war, physician groups tended to find the Code too ‘legalistic’ and irrelevant to their therapeutic experiments, and set about to develop an alternative code to guide medical researchers. The most successful and influential has been the World Medical Association’s (WMA) Declaration of Helsinki.” [*see infra*.]

*Mengele's Birthmark, supra*, at 24 (footnotes omitted).

Karine Morin in her article, *The Standard of Disclosure in Human Subject Experimentation*, 19 *Journal of Legal Medicine* 157 (June 1998), after discussing the history of informed consent as it developed in medical practice, describes nontherapeutic experimental research, differentiating it from therapeutic medical treatment. She stated that “any manipulation, observation, or other study of a human being—or of anything related to that human being that might subsequently result in manipulation of that human being—done with the intent of developing new knowledge and which differs in any form from customary medical (or other professional) practice.” *Id.* at 166 (quoting from a paper by Robert Levine to the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research). She then states further: “Research is usually described in a formal protocol that sets forth an objective and a set of procedures designed to reach that objective.” *Id.* at 167.

In arguing that a fuller disclosure should be made when consent is sought for nontherapeutic research, as opposed to therapeutic research, Morin notes:

“Furthermore, as long as courts continue to interpret the doctrine of informed consent in experimentation as it applies in the context of treatment, the uniqueness of the protection needed for human research subjects will be overlooked. Failing to recognize that subjects who volunteer for the sake of the advancement of science are differently situated from the patients who stand to benefit from treatment results in an analysis that misconceives the purpose of disclosure. Beyond informing the patient as to means available to treat him or her, a subject must become a voluntary and willing participant in an endeavor that may yield no direct benefit to him or her, or worse, that may cause harm.”

*Id.* at 220.

Because of the way the case sub judice has arrived, as appeal from the granting of summary judgment, there is no complete record of the specific compensation of the researchers involved. Although the project was funded by the EPA, at the request of KKI the EPA has declined to furnish such information to the attorney for one of the parties, who requested it under the federal Freedom of Information Act. Whether the research’s character as a co-sponsored state project opens the records under the Maryland Public Information Act has apparently not been considered. Neither is there in the record any development of what pressures, if any, were exerted in respect to the researchers obtaining the consents of the parents and conducting the experiment. Nor, for the same reason, is there a sufficient indication as to the extent to which the Institute has joined with commercial interests, if it has, for the purposes of profit, that might potentially impact upon the researcher’s motivations and potential conflicts of interest—motivations that generally are assumed, in the cases of prestigious entities such as John Hopkins University, to be for the public good rather than a search for profit.

We do note that the institution involved, the respondent here, like the Wendell Johnson Speech and Hearing Center, is a highly respected entity, considered to be a leader in the development of treatments, and treatment itself, for children infected with lead poisoning. With reasonable assurance, we can note that its reputation alone might normally suggest that there was no realization or understanding on the Institute’s part that the protocols of the experiment were questionable, except for the letter from the IRB requesting that the researchers mischaracterize the study.

We shall further address both the factual and legal bases for the findings of the trial courts, holding, ultimately, that the respective courts erred in both respects.

### *C. Negligence*

It is important for us to remember that appellants allege that KKI was negligent. Specifically, they allege that KKI, as a medical researcher, owed a duty of care to them, as subjects in the research study, based on the nature of the agreements between them and also based on the nature of the relationship between the parties. They contend specifically that KKI was negligent because KKI breached its duty to: (1) design a study that did not involve placing children at unnecessary risk; (2) inform participants in the study of results in a timely manner; and (3) to completely and accurately inform participants in the research study of all the hazards and risks involved in the study.

In order to establish a claim for negligence under Maryland law, a party must prove four elements: “(1) that the defendant was under a duty to protect the plaintiff from injury, (2) that the defendant breached that duty, (3) that the plaintiff suffered actual injury or loss and (4) that the loss or injury proximately resulted from the defendant’s breach of the duty.” (Emphasis added) (Citations omitted). (Because this is a review of the granting of the summary judgment based solely on the grounds that there was no legal duty to protect the children, we are primarily concerned with the first prong-whether KKI was under a duty to protect appellant from injury.)

Perhaps among these the factor deemed most important is foreseeability. See *id.* However, ‘foreseeability’ must not be confused with ‘duty.’ The fact that a result may be foreseeable does not itself impose a duty in negligence terms.” [Some alterations in original.] Furthermore, as we stated in *Almaraz*, 329 Md. At 449, 620 A.2d at 333, “legal scholars have long agreed that the seriousness of potential harm, as well as its probability, contributes to a duty to prevent it.”

The relationship that existed between KKI and appellant in the case at bar was that of medical researcher and research study subject. Though not expressly recognized in the Maryland Code or in our prior cases as a type of relationship which creates a duty of care, evidence in the record suggests that such a relationship involving a duty or duties would ordinarily exist, and certainly could exist, based on the facts and circumstances of each of these individual cases. Once we have determined that the facts and circumstances of the present case, considered in a light most favorable to the nonmoving parties, are susceptible to inferences supporting the position of the party opposing summary judgment, we are mandated to hold that the granting of summary judgment in the lower court was improper. In addition to the trial courts’ erroneous conclusions on the law, the facts and circumstances of both of these cases are susceptible to inferences that a special relationship imposing a duty or duties was created in the arrangements in the cases sub judice, and, ordinarily, could be created in similar research programs involving human subjects.

## **IV. The Special Relationships**

### *A. The Consent Agreement Contract*

Both sets of appellants signed a similar Consent Form prepared by KKI in which KKI expressly promised to: (1) financially compensate (however minimally) appellants for their participation in the study; (2) collect lead dust samples from appellants’ homes, analyze the samples, discuss the results with appellants, and discuss steps that could be taken, which could reduce exposure to lead; and (3) collect blood samples from children in the household and provide appellants with the results of the

blood tests. In return, appellants agreed to participate in the study, by: (1) allowing KKI into appellants' homes to collect dust samples; (2) periodically filling out questionnaires; and (3) allowing the children's blood to be drawn, tested, and utilized in the study. If consent agreements contain such provisions, and the trial court did not find otherwise, and we hold from our own examination of the record that such provisions were so contained, mutual assent, offer, acceptance, and consideration existed, all of which created contractual relationships imposing duties by reason of the consent agreement themselves (as well, as we discuss elsewhere, by the very nature of such relationships).

By having appellants sign this Consent Form, both KKI and appellants expressly made representations, which, in our view, created a bilateral contract between the parties. At the very least, it suggests that appellants were agreeing with KKI to participate in the research study with the expectation that they would be compensated, albeit, more or less, minimally, be informed of all the information necessary for the subject to freely choose whether to participate, and continue to participate, and receive promptly any information that might bear on their willingness to continue to participate in the study. This includes full, detailed, prompt, and continuing warnings as to all the potential risks and hazards inherent in the research or that arise during the research. KKI, in return, was getting the children to move into the houses and/or to remain there over time, and was given the right to test the children's blood for lead. As consideration to KKI, it got access to the houses and to the blood of children that had been encouraged to live in a "risk" environment. In other words, KKI received a measuring tool—the children's blood. Considerations existed, mainly money, food coupons, trinkets, bilateral promises, blood to be tested in order to measure success. "Informed consent" of the type used here, which imposes obligation and confers consideration on both researcher and subject (in these cases, the parents of the subjects) may differ from the more one-sided "informed consent" normally used in actual medical practice. Researcher/subject consent in nontherapeutic research can, and in this case did, create a contract.

### *B. The Sufficiency of the Consent Form*

The consent form did not directly inform the parents of the fact that it was contemplated that some of the children might ingest lead dust particles, and that one of the reasons the blood of the children was to be tested was to evaluate how effective the various abatement measures were.

A reasonable parent would expect to be clearly informed that it was at least contemplated that her child would ingest lead dust particles, and that the degree to which lead dust contaminated the child's blood would be used as one of the ways in which the success of the experiment would be measured. The fact that if such information was furnished, it might be difficult to obtain human subjects for the research, does not affect the need to supply the information, or alter the ethics of failing to provide such information. A human subject is entitled to all material information. The respective parent should also have been clearly informed that in order for the measurements to be most helpful, the child needed to stay in the house until the conclusion of the study. Whether assessed by a subjective or an objective standard, the children, or their surrogates, should have been additionally informed that the researchers anticipated that, as a result of the experiment, it was possible that there might be some accumulation of lead in the blood of the children. The "informed" consent was not valid because full material information was not furnished to the subjects or their parents.

### *C. Special Relationship*

In Case Number 128, Ms. Hughes signed a Consent Form in which KKI agreed to provide her with "specific blood-lead results" and discuss with her "a summary of house test results and steps that [she]

could take to reduce any risks of exposure.” She contends that this agreement between the parties gave rise to a duty owed by KKI to provide her with that information in a timely manner. She signed the Consent Form on March 10, 1993. The project began almost simultaneously. KKI collected dust samples in the Monroe Street property on March 9, 1993, August 23, 1993, March 9, 1994, September 19, 1994, April 18, 1995, and November 13, 1995. The March 9, 1993 dust testing revealed what the researchers referred to as “hot spots,” where the level of lead was “higher than might be found in a completely renovated house.” As we indicated, *supra*, this information was not furnished to Ms. Hughes until December 16, 1993, more than nine months after the samples had been collected and not until after Ericka Grimes’s blood was found to contain elevated levels of lead. She contends that not only did KKI have a duty to report such information in a timely manner but that it breached this duty by delaying to such a time that her daughter was allowed to contract lead poisoning. Looking at the relevant facts of Case Number 128, they are susceptible to inferences supporting the position of appellant, Ericka Grimes, and, moreover, that, if true, would create a “special relationship” out of which duties would be created. Therefore, for this reason alone, the grant of summary judgment was improper.

In Case Number 129, Ms. Higgins also signed a Consent Form in which KKI agreed to provide her with “specific blood-lead results” in respect to her child and to discuss with her “a summary of house test results and steps that [she] could take to reduce any risks of exposure.” She contends that this agreement between the parties gave rise to a duty owed by KKI to provide her with complete and accurate information. Pursuant to the plans of the research study, KKI collected dust samples in the Federal Street property on May 17, 1994, July 25, 1994, and November 3, 1994. KKI informed Ms. Higgins of the dust sample results by letters dated June 24, 1994, September 14, 1994, and February 7, 1995, respectively. Although KKI had recorded high levels of lead concentration in the dust samples collected by the Cyclone vacuum during the May 17, 1994 visit, KKI failed to disclose this information to Ms. Higgins in the letter dated June 24, 1994. Instead, KKI relied on the results obtained from the dust wipe samples collected and informed her that there was no area in her house where the lead level was higher than what might have been found in a completely renovated house.

Ms. Higgins contends that KKI knew of the presence of high levels of lead-based paint and dust in the Federal Street property as early as December of 1993, that even after Level II intervention such high levels still existed as of June of 1994, and that it was not until she received a letter dated September 14, 1994 that KKI specifically informed Ms. Higgins of the fact that her house had elevated lead levels. This was after her child, Myron, was diagnosed with elevated levels of lead in his blood.

Specifically, Ms. Higgins contends that KKI was negligent in its failure to inform her of its knowledge of the high levels of lead dust recorded by both XRF testing in December 1993 and from the samples collected via the Cyclone vacuum in May 1994 and that this withholding of information combined with KKI’s letter dated June 24, 1993, informing her solely of the lower results of the samples collected by dust wipe methodology, was misleading to her as a participant in the study. KKI does not argue the facts as appellant presents them. Instead, it argues that no duty to inform existed because although the Cyclone readings were high, they were not an indication of a potential hazard because the clearance levels were based on dust wipe methodology and the dust wipe results were not above the clearance levels. Looking at the relevant facts of Case Number 129, they are susceptible to inferences supporting the position of appellant, Ms. Higgins. Accordingly, for this reason alone, the grant of summary judgment was improper.

As we indicated earlier, the trial courts appear to have held that special relationships out of which duties arise cannot be created by the relationship between researchers and the subjects of the research.

While in some rare cases that may be correct, it is not correct when researchers recruit people, especially children whose consent is furnished indirectly, to participate in nontherapeutic procedures that are potentially hazardous, dangerous, or deleterious to their health. As opposed to compilation of already extant statistics for purposes of studying human health matters, the creation of study conditions or protocols or participation in the recruitment of otherwise healthy subjects to interact with already existing, or potentially existing, hazardous conditions, or both, for the purpose of creating statistics from which scientific hypotheses can be supported, would normally warrant or create such special relationships as a matter of law.

It is of little moment that an entity is an institutional volunteer in a community. If otherwise, the legitimacy of the claim to noble purpose would always depend upon the particular institution and the particular community it is serving in a given case. As we have indicated, history is replete with claims of noble purpose for institutions and institutional volunteers in a wide variety of communities.

Institutional volunteers may intend to do good or, as history has proven, even to do evil and may do evil or good depending on the institution and the community they serve. Whether an institutional volunteer in a particular community should be granted exceptions from the application of law is a matter that should be scrutinized closely by an appropriate public policy maker. Generally, but not always, the legislative branch is appropriately the best first forum to consider exceptions to the tort laws of this State—even then it should consider all ramifications of the policy—especially considering the general vulnerability of subjects of such studies—in this case, small children. In the absence of the exercise of legislative policymaking, we hold that special relationships, out of which duties arise, the breach of which can constitute negligence, can result from the relationships between researcher and research subjects.

#### *D. The Federal Regulations*

A duty may be prescribed by a statute, or a special relationship creating duties may arise from the requirement for compliance with statutory provisions. Although there is no duty of which we are aware prescribed by the Maryland Code in respect to scientific research of the nature here present, federal regulations have been enacted that impose standards of care that attach to federally funded or sponsored research projects that use human subjects. See 45 C.F.R. Part 46 (2000). 45 C.F.R. Part 46, Subpart A, is entitled “Basic HHS Policy for Protection of Human Research Subjects” and Subpart D of the regulation is entitled “Additional Protections for Children Involved as Subjects in Research.” 45 C.F.R. section 46.101(a) (2000).

As we discussed, *supra*, this study was funded, and co-sponsored, by the EPA and presumably was therefore subject to these federal conditions. These conditions, if appropriate administrative action has been taken, require fully informed consent in any research using human subjects conducted, supported, or otherwise subject to any level of control or funding by any federal department or agency.

Clearly, KKI, as a research institution, is required to obtain a human participant’s fully informed consent, using sound ethical principles. It is clear from the wording of the applicable federal regulations that this requirement of informed consent continues during the duration of the research study and applies to new or changing risks. In this case, a special relationship out of which duties might arise might be created by reason of the federally imposed regulations. The question becomes whether this duty of informed consent created by federal regulation, as a matter of state law, translates into a duty of care arising out of the unique relationship that is researcher-subject, as opposed to doctor-patient.

We answer that question in the affirmative. In this State, it may, depending on the facts, create such a duty.

Additionally, the Nuremberg Code, intended to be applied internationally, and never expressly rejected in this country, inherently and implicitly, speaks strongly to the existence of special relationships imposing ethical duties on researchers who conduct nontherapeutic experiments on human subjects. The Nuremberg Code specifically requires researches to make known to human subjects of research “all inconveniences and hazards reasonably to be expected, and the effects upon his health or person which may possibly come from his participation in the experiment.” (Emphasis added.) The breach of obligations imposed on researchers by the Nuremberg Code, might well support actions sounding in negligence in cases such as those at issue here. We reiterate as well that, given the facts and circumstances of both of these cases, there were, at the very least, genuine disputes of material facts concerning the relationship and duties of the parties, and compliance with the regulations.

### **V. The Ethical Appropriateness of the Research**

The World Medical Association in its Declaration of Helsinki included a code of ethics for investigative researchers and was an attempt by the medical community to establish its own set of rules for conducting research on human subjects.

The determination of whether a duty exists under Maryland law is the ultimate function of various policy considerations as adopted by either the Legislature, or, if it has not spoken, as it has not in respect to this situation, by Maryland courts. In our view, otherwise healthy children should not be the subjects of nontherapeutic experimentation or research that has the potential to be harmful to the child. It is, first and foremost, the responsibility of the researcher and the research entity to see to the harmlessness of such nontherapeutic research. Consent of parents can never relieve the researcher of this duty. We do not feel that it serves proper public policy concerns to permit children to be placed in situations of potential harm, during nontherapeutic procedures, even if parents, or other surrogates, consent. Under these types of circumstances, even where consent is given, albeit inappropriately, policy considerations suggest that there remains a special relationship between researchers and participants to the research study, which imposes a duty of care. This is entirely consistent with the principles found in the Nuremberg Code.

Researchers cannot ever be permitted to completely immunize themselves by reliance on consents, especially when the information furnished to the subject, or the party consenting, is incomplete in a material respect. A researcher’s duty is not created by, or extinguished by, the consent of a research subject or by IRB approval. The duty to a vulnerable research subject is independent of consent, although the obtaining of consent is one of the duties a researcher must perform. All of this is especially so when the subjects of research are children. Such legal duties, and legal protections, might additionally be warranted because of the likely conflict of interest between the goal of the research experimenter and the health of the human subject, especially, but not exclusively, when such research is commercialized. There is always a potential substantial conflict of interest on the part of researchers as between them and the human subjects used in their research. If participants in the study withdraw from the research study prior to its completion, then the results of the study could be rendered meaningless. There is thus an inherent reason for not conveying information to subjects as it arises, that might cause the subjects to leave the research project. That conflict dictates a stronger reason for full and continuous disclosure.



A special relationship giving rise to duties, the breach of which might constitute negligence, might also arise because, generally, the investigators are in a better position to anticipate, discover, and understand the potential risks to the health of their subjects. Practical inequalities exist between researchers, who have superior knowledge, and participants “who are often poorly placed to protect themselves from risk.” *Id.* at 3. “[G]iven the gap in knowledge between investigators and participants and the inherent conflict of interest faced by investigators, participants cannot and should not be solely responsible for their own protection.” *Id.* at 3–4.

This duty requires the protection of the research subjects from unreasonable harm and requires the researcher to completely and promptly inform the subjects of potential hazards existing from time to time because of the profound trust that participants place in investigators, institutions, and the research enterprise as a whole to protect them from harm. “Faced with seemingly knowledgeable and prestigious investigators engaged in a noble pursuit, participants may simply assume that research is socially important or of benefit to them individually; they may not be aware that participation could be harmful to their interests.” *Id.*

While we acknowledge that foreseeability does not necessarily create a duty, we recognize that potential harm to the children participants of this study was both foreseeable and potentially extreme. A “special relationship” also exists in circumstances where such experiments are conducted.

## **VI. Parental Consent for Children to Be Subjects of Potentially Hazardous Nontherapeutic Research**

The issue of whether a parent can consent to the participation of her or his child in a nontherapeutic health-related study that is known to be potentially hazardous to the health of the child raises serious questions with profound moral and ethical implications. What right does a parent have to knowingly expose a child not in need of therapy to health risks or otherwise knowingly place a child in danger, even if it can be argued it is for the greater good? The issue in these specific contested cases does not relate primarily to the authority of the parent, but to the procedures of KKI and similar entities that may be involved in such health-related studies. The issue of the parents’ right to consent on behalf of the children has not been fully presented in either of these cases, but should be of concern not only to lawyers and judges, but to moralists, ethicists, and others. The consenting parents in the contested cases at bar were not the subjects of the experiment; the children were. Additionally, this practice presents the potential problems of children initiating actions in their own names upon reaching majority, if indeed, they have been damaged as a result of being used as guinea pigs in nontherapeutic scientific research. Children, it should be noted, are not in our society the equivalent of rats, hamsters, monkeys, and the like. Because of the overriding importance of this matter and this Court’s interest in the welfare of children—we shall address the issue.

Most of the relatively few cases in the area of the ethics of protocols of various research projects involving children have merely assumed that a parent can give informed consent for the participation of their children in nontherapeutic research. The single case in which the issue has been addressed, and resolved, a case with which we agree, will be discussed further, *infra*.

It is not in the best interest of a specific child, in a nontherapeutic research project, to be placed in a research environment, which might possibly be, or which proves to be, hazardous to the health of the child. We have long stressed that the “best interests of the child” is the overriding concern of this Court in matters relating to children. Whatever the interests of a parent, and whatever the interests of the general public in fostering research that might, according to a researcher’s hypothesis, be for the good

of all children, this Court's concern for the particular child and particular case, over-arches all other interests. It is, simply, and we hope, succinctly put, not in the best interest of any healthy child to be intentionally put in a nontherapeutic situation where his or her health may be impaired, in order to test methods that may ultimately benefit all children.

To think otherwise, to turn over human and legal ethical concerns solely to the scientific community, is to risk embarking on slippery slopes, that all too often in the past, here and elsewhere, have resulted in practices we, or any community, should be ever unwilling to accept.

We have little doubt that the general motives of all concerned in these contested cases were, for the most part, proper, albeit in our view not well thought out. The protocols of the research, those of which we have been made aware, were, in any event, unacceptable in a legal context. One simply does not expose otherwise healthy children, incapable of personal assent (consent), to a nontherapeutic research environment that is known at the inception of the research, might cause the children to ingest lead dust. It is especially troublesome, when a measurement of the success of the research experiment is, in significant respect, to be determined by the extent to which the blood of the children absorbs, and is contaminated by, a substance that the researcher knows can, in sufficient amounts, whether solely from the research environment or cumulative from all sources, cause serious and long term adverse health effects. Such a practice is not legally acceptable.

When it comes to children involved in nontherapeutic research, with the potential for health risks to the subject children in Maryland, we will not defer to science to be the sole determinant of the ethicality or legality of such experiments. The reason, in our view, is apparent from the research protocols at issue in the case at bar. Moreover, in nontherapeutic research using children, we hold that the consent of a parent alone cannot make appropriate that which is innately inappropriate.

The Nuremberg Code explicitly recognized the need to place non-paternalistic limits on the scope of experiments. The Code asks more of an experiment, a researcher, or society than mere consent.” Id. at 494–97. Based on the record before us, no degree of parental consent, and no degree of furnished information to the parents could make the experiment at issue here, ethically or legally permissible. It was wrong in the first instance.

## **VII. Conclusion**

We hold that in Maryland a parent, appropriate relative, or other applicable surrogate, cannot consent to the participation of a child or other person under legal disability in nontherapeutic research or studies in which there is any risk of injury or damage to the health of the subject.

We hold that informed consent agreements in nontherapeutic research projects, under certain circumstances can constitute contracts; and that, under certain circumstances, such research agreements can, as a matter of law, constitute “special relationships” giving rise to duties, out of the breach of which negligence actions may arise. We also hold that, normally, such special relationships are created between researchers and the human subjects used by the researchers. Additionally, we hold that governmental regulations can create duties on the part of researchers towards human subjects out of which “special relationships” can arise. Likewise, such duties and relationships are consistent with the provisions of the Nuremberg Code.

The determination as to whether a “special relationship” actually exists is to be done on a case by case basis. See Williams, 359 Md. At 150, 753 A.2d at 68. The determination as to whether a special

relationship exists, if properly pled, lies with the trier of fact. We hold that there was ample evidence in the cases at bar to support a fact finder's determination of the existence of duties arising out of contract, or out of a special relationship, or out of regulations and codes, or out of all of them, in each of the cases.

We hold that on the present record, the Circuit Courts erred in their assessment of the law and of the facts as pled in granting KKI's motions for summary judgment in both cases before this Court. Accordingly, we vacate the rulings of the Circuit Court for Baltimore City and remand these cases to that court for further proceedings consistent with this opinion.

RAKER, JUDGE, dissenting.

I respectfully dissent from the order denying the motions for reconsideration. I adhere to the views previously expressed in my concurring opinion filed herein on August 16, 2001.

The majority's discussion of the ability of a parent or guardian to consent to the participation of a minor child in a nontherapeutic research study and the discussion regarding the ethics of the research conducted in these cases involve serious public policy considerations. The statements are a declaration of public policy that, in the posture of this case, are best left to the General Assembly. See *Gaver v. Harrant*, 316 Md. 17, 28-29, 557 A.2d 210, 217 (1989); *Harrison v. Mont. Co. Bd. of Educ.*, 295 Md. 442, 460, 456 A.2d 894, 903 (1983). Inasmuch as these issues were never raised by the pleadings or the parties below, this Court had no basis to address these very complex issues; if a change is to be made in the State's policy of regulating research studies, unless clearly presented to the court, it should be made by legislative enactment. See *Md. Nat'l Bk. V. United Jewish App.*, 286 Md. 274, 407 A.2d 1130 (1979).

### ***Questions and Problems***

1. Why did the *Grimes* court conclude that the IRB acted unethically? What actions should the IRB have taken?
2. It is clear that a physician has a special relationship with the patient that obligates the physician to meet a certain standard of care. In cases involving a medical researcher and a research subject the existence of that relationship is not so clear. In the *Grimes* case, why did the court find a special relationship between the researcher and the research subjects?
3. The defendant presented an informed consent form signed by the children's parents. Why did the *Grimes* court determine that the informed consent form was invalid? How did the informed consent process in this case differ from ones between physicians and patients?
4. The *Grimes* court seemed to indicate that even if the parents had given proper informed consent, the research would have been unethical. Why did the court reach that conclusion?

***Moore v. Regents of University of California*, 793 P.2d 479 (1990)**

PANELLI, JUSTICE.

We granted review in this case to determine whether plaintiff has stated a cause of action against his physician and other defendants for using his cells in potentially lucrative medical research without his permission. Plaintiff alleges that his physician failed to disclose preexisting research and economic interests in the cells before obtaining consent to the medical procedures by which they were extracted. The superior court sustained all defendants' demurrers to the third amended complaint, and the Court of Appeal reversed. We hold that the complaint states a cause of action for breach of the physician's disclosure obligations, but not for conversion.

II. Facts

Our only task in reviewing a ruling on a demurrer is to determine whether the complaint states a cause of action. Accordingly, we assume that the complaint's properly pleaded material allegations are true and give the complaint a reasonable interpretation by reading it as a whole and all its parts in their context. (*Phillips v. Desert Hospital Dist.* (1989) 49 Cal.3d 699, 702, 263 Cal.Rptr. 119, 780 P.2d 349; *Blank v. Kirwan* (1985) 39 Cal.3d 311, 418, 216 Cal.Rptr. 718, 703 P.2d 58; *Tameny v. Atlantic Richfield Co.* (1980) 27 Cal.3d 167, 170, 164 Cal.Rptr. 839, 610 P.2d 1330). We do not, however, assume the truth of contentions, deductions, or conclusions of fact or law. (*Daar v. Yellow Cab. Co.* (1967) 67 Cal.2d 695, 713, 63 Cal.Rptr. 724, 433 P.2d 732.) For these purposes we briefly summarize the pertinent factual allegations of the 50-page complaint.

The plaintiff is John Moore (Moore), who underwent treatment for hairy-cell leukemia at the Medical Center of the University of California at Los Angeles (UCLA Medical Center). The five defendants are: (1) Dr. David W. Golde (Golde), a physician who attended Moore at UCLA Medical Center; (2) the Regents of the University of California (Regents), who own and operate the university; (3) Shirley G. Quan, a researcher employed by the Regents; (4) Genetics Institute, Inc. (Genetics Institute); and (5) Sandoz Pharmaceuticals Corporation and related entities (collectively Sandoz).

Moore first visited UCLA Medical Center on October 5, 1976, shortly after he learned that he had hairy-cell leukemia. After hospitalizing Moore and "withdr[awing] extensive amounts of blood, bone marrow aspirate, and other bodily substances," Golde confirmed that diagnosis. At this time all defendants, including Golde, were aware that "certain blood products and blood components were of great value in a number of commercial and scientific efforts" and that access to a patient whose blood contained these substances would provide "competitive, commercial, and scientific advantages."

On October 8, 1976, Golde recommended that Moore's spleen be removed. Golde informed Moore "that he had reason to fear for his life, and that the proposed splenectomy operation was necessary to slow down the progress of his disease." Based upon Golde's representations, Moore signed a written consent form authorizing the splenectomy.

Before the operation, Golde and Quan "formed the intent and made arrangements to obtain portions of [Moore's] spleen following its removal" and to take them to a separate research unit. Golde gave written instructions to this effect on October 18 and 19, 1976. These research activities "were not intended to have any relation to [Moore's] medical care." However, neither Golde nor Quan informed Moore of their plans to conduct this research or requested his permission. Surgeons at UCLA Medical

Center, whom the complaint does not name as defendants, removed Moore's spleen on October 20, 1976.

Moore returned to the UCLA Medical Center several times between November 1976 and September 1983. He did so at Golde's direction and based upon representations "that such visits were necessary and required for his health and well-being, and based upon the trust inherent in and by virtue of the physician-patient relationship." On each of these visits Golde withdrew additional samples of "blood, blood serum, skin, bone marrow aspirate, and sperm." On each occasion Moore travelled to the UCLA Medical Center from his home in Seattle because he had been told that the procedures were to be performed only there and only under Golde's direction.

"In fact, [however,] throughout the period of time that [Moore] was under [Golde's] care and treatment, the defendants were actively involved in a number of activities which they concealed from [Moore]." Specifically, defendants were conducting research on Moore's cells and planned to "benefit financially and competitively [by exploiting the cells] and [their] exclusive access to [the cells] by virtue of [Golde's] on-going physician-patient relationship."

Sometime before August 1979, Golde established a cell line from Moore's T-lymphocytes. On January 30, 1981, the Regents applied for a patent on the cell line, listing Golde and Quan as inventors. "[B]y virtue of an established policy, [the] Regents, Golde, and Quan would share in any royalties or profits arising out of [the] patent." The patent issued on March 20, 1984, naming Golde and Quan as the inventors of the cell line and the Regents as the assignee of the patent. (U.S. Patent No. 4,438,032 (Mar. 20, 1984).

The Regent's patent also covers various methods for using the cell line to produce lymphokines. Moore admits in his complaint that "the true clinical potential of each of the lymphokines [is] difficult to predict, [but] competing commercial firms in these relevant fields have published reports in biotechnology industry periodicals predicting a potential market of approximately \$3.01 Billion Dollars by the year 1990 for a whole range of [such lymphokines]."

With the Regents' assistance, Golde negotiated agreements for commercial development of the cell line and products to be derived from it. Under an agreement with Genetics Institute, Golde "became a paid consultant" and "acquired the rights to 75,000 shares of common stock." Genetics Institute also agreed to pay Golde and the Regents "at least \$330,000 over three years, including a pro-rata share of [Golde's] salary and fringe benefits, in exchange for exclusive access to the materials and research performed" on the cell line and products derived from it. On June 4, 1982, Sandoz "was added to the agreement," and compensation payable to Golde and the Regents was increased by \$110,000. "[T]hroughout this period, Quan spent as much as 70 [percent] of her time working for [the] Regents on research" related to the cell line.

Based upon these allegations, Moore attempted to state 13 causes of action. Each defendant demurred to each purported cause of action. The superior court, however, expressly considered the validity of only the first cause of action, conversion. Reasoning that the remaining causes of action incorporated the earlier, defective allegations, the superior court sustained a general demurrer to the entire complaint with leave to amend. In a subsequent proceeding, the superior court sustained Genetics Institute's and Sandoz's demurrers without leave to amend on the grounds that Moore had not stated a cause of action for conversion and that the complaint's allegations about the entities' secondary liability were too conclusory. In accordance with its earlier ruling that the defective allegations about conversion

rendered the entire complaint insufficient, the superior court took the remaining demurrers off its calendar.

With one justice dissenting, the Court of Appeal reversed, holding that the complaint did state a cause of action for conversion. The Court of Appeal agreed with the superior court that the allegations against Genetics Institute and Sandoz were insufficient, but directed the superior court to give Moore leave to amend. The Court of Appeal also directed the superior court to decide “the remaining causes of action, which [had] never been expressly ruled upon.”

### III. DISCUSSION

#### *A. Breach of Fiduciary Duty and Lack of Informed Consent*

Moore repeatedly alleges that Golde failed to disclose the extent of his research and economic interests in Moore’s cells before obtaining consent to the medical procedures by which the cells were extracted. These allegations, in our view, state a cause of action against Golde for invading a legally protected interest of his patient. This cause of action can properly be characterized either as the breach of a fiduciary duty to disclose facts material to the patient’s consent or, alternatively, as the performance of medical procedures without first having obtained the patient’s informed consent.

Our analysis begins with three well-established principles. First, “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.” (Cobbs v. Grant (1972) 8 Cal.3d 229, 242 [104 Cal.Rptr. 505, 502 P.2d 1].) Second, “the patient’s consent to treatment, to be effective, must be an informed consent.” (Cobbs v. Grant, supra, 8 Cal.3d at p. 242, 104 Cal.Rptr. 505, 502 P.2d 1.) Third, in soliciting the patient’s consent, a physician has a fiduciary duty to disclose all information material to the patient’s decision (citations omitted).

These principles lead to the following conclusions: (1) a physician must disclose personal interests unrelated to the patient’s health, whether research or economic, that may affect the physician’s professional judgment; and (2) a physician’s failure to disclose such interests may give rise to a cause of action for performing medical procedures without informed consent or breach of fiduciary duty.

To be sure, questions about the validity of a patient’s consent to a procedure typically arise when the patient alleges that the physician failed to disclose medical risks, as in malpractice cases, and not when the patient alleges that the physician had a personal interest, as in this case. The concept of informed consent, however, is broad enough to encompass the latter. “The scope of the physician’s communication to the patient must be measured by the patient’s need, and that need is whatever information is material to the decision.” (Cobbs v. Grant, supra, 8 Cal.3d at p. 245, 104 Cal.Rptr. 505, 502 P.2d 1.)

Indeed, the law already recognizes that a reasonable patient would want to know whether a physician has an economic interest that might affect the physician’s professional judgment. As the Court of Appeal has said, “[c]ertainly a sick patient deserves to be free of any reasonable suspicion that his doctor’s judgment is influenced by a profit motive.” (Magan Medical Clinic v. Cal. State Bd. Of Medical Examiners (1967) 249 Cal.App.2d 124, 132, 57 Cal.Rptr. 256.) The desire to protect patients from possible conflicts of interest has also motivated legislative enactments. Among these is Business and Professions Code section 654.2. Under that section, a physician may not charge a patient on behalf of, or refer a patient to, any organization in which the physician has a “significant beneficial interest,

unless [the physician] first discloses in writing to the patient, that there is such an interest and advises the patient that the patient may choose any organization for the purposes of obtaining the services ordered or requested by [the physician].” (Bus. & Prof.Code § 654.2 subd. (a). See also Bus. & Prof.Code § 654.1 [referrals to clinical laboratories].) Similarly, under Health and Safety Code section 24173, a physician who plans to conduct a medical experiment on a patient must, among other things, inform the patient of “[t]he name of the sponsor or funding source, if any, and the organization, if any, under whose general aegis the experiment is being conducted.” (Health & Saf.Code, § 24173, subd. (c)(9).)

It is important to note that no law prohibits a physician from conducting research in the same area in which he practices. Progress in medicine often depends upon physicians, such as those practicing at the university hospital where Moore received treatment, who conduct research while caring for their patients.

Yet a physician who treats a patient in whom he also has a research interest has potentially conflicting loyalties. This is because medical treatment decisions are made on the basis of proportionality—weighing the benefits *to the patient* against the risks *to the patient*. As another court has said, “the determination as to whether the burdens of treatment are worth enduring for any individual patient depends upon the facts unique in each case,” and “the patient’s interests and desires are the key ingredients of the decision-making process.” (Barber v. Superior Court (1983) 147 Cal.App.3d 1006, 1018-1019, 195 Cal.Rptr. 484.) A physician who adds his own research interests to this balance may be tempted to order a scientifically useful procedure or test that offers marginal, or no, benefits to the patient. The possibility that an interest extraneous to the patient’s health has affected the physician’s judgment is something that a reasonable patient would want to know in deciding whether to consent to a proposed course of treatment. It is material to the patient’s decision and, thus, a prerequisite to informed consent. (See Cobbs v. Grant, supra, 8 Cal.3d at p. 245, 104 Cal.Rptr. 505, 502 P.2d 1.)

Golde argues that the scientific use of cells that have already been removed cannot possibly affect the patient’s medical interests. The argument is correct in one instance but not in another. If a physician has no plans to conduct research on a patient’s cells at the time he recommends the medical procedure by which they are taken, then the patient’s medical interests have not been impaired. In that instance the argument is correct. On the other hand, a physician who does have a preexisting research interest might, consciously or unconsciously, take that into consideration in recommending the procedure. In that instance the argument is incorrect: the physician’s extraneous motivation may affect his judgment and is, thus, material to the patient’s consent.

We acknowledge that there is a competing consideration. To require disclosure of research and economic interests may corrupt the patient’s own judgment by distracting him from the requirements of his health. But California law does not grant physicians unlimited discretion to decide what to disclose. Instead, “it is the prerogative of the patient, not the physician, to determine for himself the direction in which he believes his interests lie.” (Cobbs v. Grant, supra, 8 Cal.3d at p. 242, 104 Cal.Rptr. 505, 502 P.2d 1.) “Unlimited discretion in the physician is irreconcilable with the basic right of the patient to make the ultimate informed decision.” (Id., at p. 243, 104 Cal.Rptr. 505, 502 P.2d 1.)

Accordingly, we hold that a physician who is seeking a patient’s consent for a medical procedure must, in order to satisfy his fiduciary duty and to obtain the patient’s informed consent, disclose personal interests unrelated to the patient’s health, whether research or economic, that may affect his medical judgment.

## 1. Dr. Golde

We turn now to the allegations of Moore's third amended complaint to determine whether he has stated such a cause of action. We first discuss the adequacy of Moore's allegations against Golde, based upon the physician's disclosures prior to the splenectomy.

Moore alleges that, prior to the surgical removal of his spleen, Golde "formed the intent and made arrangements to obtain portions of his spleen following its removal from [Moore] in connection with [his] desire to have regular and continuous access to, and possession of, [Moore's] unique and rare Blood and Bodily Substances." Moore was never informed prior to the splenectomy of Golde's "prior formed intent" to obtain a portion of his spleen. In our view, these allegations adequately show that Golde had an undisclosed research interest in Moore's cells at the time he sought Moore's consent to the splenectomy. Accordingly, Moore has stated a cause of action for breach of fiduciary duty, or lack of informed consent, based upon the disclosures accompanying that medical procedure.

We next discuss the adequacy of Golde's alleged disclosures regarding the postoperative takings of blood and other samples. In this context, Moore alleges that Golde "expressly, affirmatively and impliedly represented that these withdrawals of his Blood and Bodily Substances were necessary and required for his health and well-being." However, Moore also alleges that Golde actively concealed his economic interest in Moore's cells during this time period. "[D]uring each of these visits, and even when [Moore] inquired as to whether there was any possible or potential commercial or financial value or significance of his Blood and Bodily Substances, or whether the defendants had discovered anything which was or might be related to any scientific activity resulting in commercial or financial benefits, the defendants repeatedly and affirmatively represented to [Moore] that there was no commercial or financial value to his Blood and Bodily Substances and in fact actively discouraged such inquiries."

Moore admits in his complaint that defendants disclosed they "were engaged in strictly academic and purely scientific medical research." However, Golde's representation that he had no financial interest in this research became false, based upon the allegations, at least by May 1979, when he "began to investigate and initiate the procedures for [obtaining] a patent" on the cell line developed from Moore's cells.

In these allegations, Moore plainly asserts that Golde concealed an economic interest in the postoperative procedures. Therefore, applying the principles already discussed, the allegations state a cause of action for breach of fiduciary duty or lack of informed consent.

We thus disagree with the superior court's ruling that Moore had not stated a cause of action because essential allegations were lacking. We discuss each such allegation. First, in the superior court's view, Moore needed but failed to allege that defendants knew his cells had potential commercial value *on October 5, 1976* (the time blood tests were first performed at UCLA Medical Center) and had *at that time* already formed the intent to exploit the cells. We agree with the superior court that the absence of such allegations precludes Moore from stating a cause of action based upon the procedures undertaken on October 5, 1976. But, as already discussed, Moore clearly alleges that Golde had developed a research interest in his cells by October 20, 1976, when the splenectomy was performed. Thus, Moore can state a cause of action based upon Golde's alleged failure to disclose that interest before the splenectomy.

The superior court also held that the lack of essential allegations prevented Moore from stating a cause of action based on the splenectomy. According to the superior court, Moore failed to allege that the



operation lacked a therapeutic purpose or that the procedure was totally unrelated to therapeutic purposes. In our view, however, neither allegation is essential. Even if the splenectomy had a therapeutic purpose, it does not follow that Golde had no duty to disclose his additional research and economic interests. As we have already discussed, the existence of a motivation for a medical procedure unrelated to the patient's health is a potential conflict of interest and a fact material to the patient's decision.

## 2. The Remaining Defendants

The Regents, Quan, Genetics Institute, and Sandoz are not physicians. In contrast to Golde, none of these defendants stood in a fiduciary relationship with Moore or had the duty to obtain Moore's informed consent to medical procedures. If any of these defendants is to be liable for breach of fiduciary duty or performing medical procedures without informed consent, it can only be on account of Golde's acts and on the basis of a recognized theory of secondary liability, such as respondeat superior. The procedural posture of this case, however, makes it unnecessary for us to address the sufficiency of Moore's secondary-liability allegations.

As already mentioned, the superior court addressed only the purported cause of action for conversion. Because the superior court found that Moore had not stated such a cause of action, it had no occasion to address the sufficiency of Moore's allegation that the Regents and Quan were acting as Golde's "agent[s]" and "joint venturer[s]." In a later proceeding, however, the superior court did find that the same allegations were too conclusory to state a cause of action against Genetics Institute and Sandoz.

The Court of Appeal did not hold, explicitly or implicitly, that Moore's secondary-liability allegations were sufficient as against any defendant. The court did hold that Moore had stated a cause of action against the Regents and Quan. However, the court did not reach that conclusion on the basis of secondary liability. Instead, drawing no distinctions between the defendants, the court held simply that each defendant was primarily liable for conversion. Because no court has yet addressed the Regents' and Quan's secondary liability and because the superior court will need to consider other issues on remand, there is no need to address these issues at this time.

With respect to Genetics Institute and Sandoz, the situation is slightly different. The Court of Appeal mentioned Moore's secondary-liability allegations against these defendants but expressed no opinion as to their sufficiency. Instead, as to these defendants the court merely reversed the superior court's order "for failure to grant leave to amend." Our affirmance of this part of the Court of Appeal's decision will leave Moore free to attempt, once again, to allege that Genetics Institute and Sandoz are secondarily liable for Golde's torts.

## ***Bioethics Consultation***

Greenie Johnson was a long-time patient of Dr. Heather Grey. Greenie started having headaches that lasted for days. Dr. Grey ordered an MRI that showed a small tumor on Greenie's brain. Dr. Heather Grey referred Greenie to neurosurgeon Dr. Paul Williams. Dr. Williams ran some tests and concluded that, even though the tumor was not life-threatening, it made sense to have it removed. Dr. Williams wanted to do the surgery because he felt it would be a great case study to include in a book that he was writing. Dr. Williams did not share that information with Greenie prior to the surgery. Greenie's daughter, Maxie, was concerned about her mother having brain surgery because of the information she

had read on the internet. Greenie asked Dr. Williams to speak with Maxie to reassure her about the surgery. During his meeting with Maxie, Dr. Williams told Maxie that stress could make Greenie's condition worse. Thus, he asked Maxie to stop sharing information she discovered on the internet with Greenie. In response, Maxie asked, "You don't think that she should know that the surgery could leave her hearing impaired? Dr. Williams assured Maxie that the risk of Greenie losing her hearing was so small that it was not worth burdening her with information about that risk. He also stated that because Greenie made her living as a voice coach, she may refuse to have the surgery if she thought her hearing was at risk. Maxie agreed that they should not share that information with Greenie. After a few meetings to discuss Greenie's condition, Dr. Williams and Max started having a sexual relationship. Maxie gave her blessings and encouraged Greenie to have the surgery. Dr. Williams told Greenie that the only risks involved with the surgery were those typically involved in any surgery, including infection, hemorrhaging, and death. Greenie signed an informed consent form and Dr. Williams performed the surgery. A few days after the surgery, Greenie lost 85% of her hearing. Because of her disability, Greenie is no longer able to work as a voice coach. Greenie plans to sue Dr. Williams for lack of informed consent. What is the possible outcome of the case?

## PART II - RIGHT TO MAKE REPRODUCTION CHOICES

Although respected, the right to make reproductive choices is not an absolute one. For various reasons, the government has put restrictions on the right to make reproductive choices. In the United States, incest laws ban intimate relations and marriage between children and parents, brothers and sisters, and grandchildren and grandparents. In some states, those activities are banned between aunts, uncles, nieces, nephews, and cousins. A key justification for those laws is a mistaken belief that they are needed to prevent the birth of children with deformities. Thus, by enacting such laws, the states are indirectly placing restrictions on reproductive choices. The same logic holds true when reflecting on the rationale behind laws preventing interracial couples from marrying.<sup>20</sup>

Recently, courts have attempted to link the ability to reproduce with behaviors society deems to be unacceptable. For instance, a judge told 35-year-old Asim Taylor that he could not have any more children for at least five years until he could prove that he was financially providing for the four children he already had fathered. At that time, Asim owed almost \$100,000 in back child support for his four children.<sup>21</sup> This ruling was later upheld by that state appellate court. Several other state courts have made similar rulings.<sup>22</sup> The constitutionality of the rulings has not yet been challenged in the United States Supreme Court. Some women who used drugs while pregnant have been arrested for child abuse/neglect. As a condition of probation on those matters, some courts have required the women to agree not to have any more children.<sup>23</sup> At least 23 states define prenatal substance exposure as civil child maltreatment.<sup>24</sup> In this part, we will discuss an individual's right to make reproductive choices. We start with a chapter that looks at cases involving the government's attempt to prevent women and men from procreating because of the belief that they would produce undesirable offspring. Then, we move to an analysis of the right to decide not to procreate. Currently, most of the cases involving reproductive rights involve circumstances where a person is trying not to get pregnant.

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<sup>20</sup> See *Loving v. Virginia*, 388 U.S. 1 (1967).

<sup>21</sup> Erica Ho, *Judge orders Man Owing \$96K Child Support To Stop Having Kids*, TIME, at <https://newsfeed.time.com/2013/01/28/judge-orders-man-owing-96k-in-child-support-to-stop-having-kids/> (Jan. 28, 2013).

<sup>22</sup> Carissa Woytach, *Abstention order struck down Ohio Supreme Court reverses, remands case of Lorain man ordered not to father children as a condition of probation*, The Chronicle, at <https://chroniclet.com/news/245381/abstention-order-struck-down-ohio-supreme-court-reverses-remands-case-of-lorain-man-ordered-not-to-father-children-as-a-condition/> (Dec. 18, 2020).

<sup>23</sup> Emma Coleman, *As the opioid epidemic surges, states have been cracking down on pregnant addicted women*, The Center for Child Health Policy, at <https://www.vumc.org/childhealthpolicy/news-events/many-states-prosecute-pregnant-women-drug-use-new-research-says-thats-bad-idea> (Dec. 5, 2019).

<sup>24</sup> Elizabeth Brico, *North Carolina Wants to Penalize Prenatal Substance Exposure*, Center for American Progress, at <https://talkpoverty.org/2020/02/13/north-carolina-prenatal-substance-exposure-crime/> (Feb. 13, 2020).

## CHAPTER FOUR - RIGHT TO PROCREATE WITHOUT GOVERNMENTAL INTERFERENCE

The right to procreate is often seen as a natural right. However, at the height of the eugenics movement, the United States government decided that the survival of the nation required the elimination of persons who had traits deemed to be undesirable. To accomplish that goal, states passed laws permitting persons possessing those traits to be involuntarily sterilized. Women like Carrie Buck who had children out of wedlock were deemed to be feeble-minded and committed to institutions. That label made them prime candidates for forced sterilization. The rationale behind the law was that persons who possessed undesirable traits passed those characteristics on to their children. To prevent the country from being overrun with “undesirable” people, the government had to ensure that those people did not procreate. The holding in *Buck v. Bell* occurred at a time when members of marginalized communities in the United States were being forcibly sterilized. It also contributed to the spread of the American eugenics movement.

### ***Buck v. Bell*, 47 S.Ct. 584**

Mr. JUSTICE HOLMES delivered the opinion of the Court.

This is a writ of error to review a judgment of the Supreme Court of Appeals of the State of Virginia, affirming a judgment of the Circuit Court of Amherst County, by which the defendant in error, the superintendent of the State Colony for Epileptics and Feeble Minded, was ordered to perform the operation of salpingectomy upon Carrie Buck, the plaintiff in error, for the purpose of making her sterile.<sup>143</sup> Va. 310, 130 S.E. 516. The case comes here upon the contention that the statute authorizing the judgment is void under the Fourteenth Amendment as denying to the plaintiff in error due process of law and the equal protection of the laws.

Carrie Buck is a feeble-minded white woman who was committed to the State Colony above mentioned in due form. She is the daughter of a feeble-minded mother in the same institution, and the mother of an illegitimate feeble-minded child. She was eighteen years old at the time of the trial of her case in the Circuit Court in the latter part of 1924. An Act of Virginia approved March 20, 1924 (Laws 1924, c. 394) recites that the health of the patient and the welfare of society may be promoted in certain cases by the sterilization of mental defectives, under careful safeguard, etc.; that the sterilization may be effected in males by vasectomy and in females by salpingectomy, without serious pain or substantial danger to life; that the Commonwealth is supporting in various institutions many defective persons who if now discharged would become a menace but if incapable of procreating might be discharged with safety and become self-supporting with benefit to themselves and to society; and that experience has shown that heredity plays an important part in the transmission of insanity, imbecility, etc. The statute then enacts that whenever the superintendent of certain institutions including the above named State Colony shall be of opinion that it is for the best interest of the patients and of society that an inmate under his care should be sexually sterilized, he may have the operation performed upon any patient afflicted with hereditary forms of insanity, imbecility, etc., on complying with the very careful provisions by which the act protects the patients from possible abuse.

The superintendent first presents a petition to the special board of directors of his hospital or colony, stating the facts and the grounds for his opinion, verified by affidavit. Notice of the petition and of the time and place of the hearing in the institution is to be served upon the inmate, and also upon his

guardian, and if there is no guardian the superintendent is to apply to the Circuit Court of the County to appoint one. If the inmate is a minor notice also is to be given to his parents, if any, with a copy of the petition. The board is to see to it that the inmate may attend the hearings if desired by him or his guardian. The evidence is all to be reduced to writing, and after the board has made its order for or against the operation, the superintendent, or the inmate, or his guardian, may appeal to the Circuit Court of the County. The Circuit Court may consider the record of the board and the evidence before it and such other admissible evidence as may be offered, and may affirm, revise, or reverse the order of the board and enter such order as it deems just. Finally, any party may apply to the Supreme Court of Appeals, which, if it grants the appeal, is to hear the case upon the record of the trial in the Circuit Court and may enter such order as it thinks the Circuit Court should have entered. There can be no doubt that so far as procedure is concerned the rights of the patient are most carefully considered, and as every step in this case was taken in scrupulous compliance with the statute and after months of observation, there is no doubt that in that respect the plaintiff in error has had due process at law.

The attack is not upon the procedure but upon the substantive law. It seems to be contended that in no circumstances could such an order be justified. It certainly is contended that the order cannot be justified upon the existing grounds. The judgment finds the facts that have been recited and that Carrie Buck 'is the probable potential parent of socially inadequate offspring, likewise afflicted, that she may be sexually sterilized without detriment to her general health and that her welfare and that of society will be promoted by her sterilization,' and thereupon makes the order. In view of the general declarations of the Legislature and the specific findings of the Court obviously we cannot say as matter of law that the grounds do not exist, and if they exist they justify the result. 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. *Jacobson v. Massachusetts*, 197 U.S. 11, 25 S.Ct. 358, 49 L.Ed. 643, 3 Ann. Cas. 765. Three generations of imbeciles are enough.

But, it is said, however it might be if this reasoning were applied generally, it fails when it is confined to the small number who are in the institutions named and is not applied to the multitudes outside. It is the usual last resort of constitutional arguments to point out shortcomings of this sort. But the answer is that the law does all that is needed when it does all that it can, indicates a policy, applies it to all within the lines, and seeks to bring within the lines all similarly situated so far and so fast as its means allow. Of course 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.

Judgment affirmed.

***Skinner v. Oklahoma*, 316 U.S. 535**

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. et seq.; L.1935, p. 94 et seq. 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. s 173. 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. ss 176, 177. Notice, an opportunity to be heard, and the right to a jury trial are provided. ss 177-181. 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' s 182, by the operation of vasectomy in case of a male and of salpingectomy in case of a female. s 174. Only one other provision of the Act is material here and that is which 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 Bell*, 274 U.S. 200, 47 S.Ct. 584, 71 L.Ed. 1000, 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. See *Davis v. Berry*, D.C., 216 F. 413; *Williams v. Smith*, 190 Ind. 526, 131 N.E. 2. It is also suggested that the Act is penal in character and that the sterilization provided for is cruel and unusual punishment and violative of the Fourteenth Amendment. See *Davis v. Berry*, supra. Cf. *State v. Feilen*, 70 Wash. 65, 126 P. 75, 41 L.R.A., N.S., 418, Ann.Cas.1914B, 512; *Mickle v. Henrichs*, D.C., 262 F. 687. We pass those points without intimating an opinion on them, for there

is a feature of the Act which 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. Okl.St. Ann. Tit. 21, s 1705 (s5). Larceny is grand larceny when the property taken exceeds \$20 in value. Id. S 1704. Embezzlement is punishable 'in the manner prescribed for feloniously stealing property of the value of that embezzled.' Id. 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. Id. 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. 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'. Bishop, Criminal Law, 9th Ed., Vol. 2, ss 760, 799, et seq. 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'. *Bivens v. State*, 6 Okl. Cr. 521, 529, 120 P. 1033, 1036. If the fraudulent intent occurs later and the defendant converts the property, he is guilty of embezzlement. *Bivens v. State*, supra; *Flohr v. Territory*, 14 Okl. 477, 78 P. 565. 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. *Bivens v. State*, supra

It was stated in *Buck v. Bell*, supra, that the claim that state legislation violates the equal protection clause of the Fourteenth Amendment is 'the usual last resort of constitutional arguments.' 272 U.S. page 208, 47 S.Ct. page 585, 71 L.Ed. 1000. Under our constitutional system the States in determining the reach and scope of particular legislation need not provide 'abstract symmetry.' *Patsone v. Pennsylvania*, 232 U.S. 138, 144, 34 S.Ct. 281, 282, 58 L.Ed. 539. They may mark and set apart the classes and types of problems according to the needs and as dictated or suggested by experience. See *People of State of New York ex rel. Bryant v. Zimmerman*, 278 U.S. 63, 49 S.Ct. 61, 3 L.Ed. 184, 62 A.L.R. 785, and cases cited. It was in that connection that Mr. Justice Holmes, speaking for the Court in *Bain Peanut Co. v. Pinson*, 282 U.S. 499, 501, 51 S.Ct. 228, 229, 75 L.Ed. 482, stated, 'We must remember that the machinery of government would not work if it were not allowed a little play in its joints.' Only recently we reaffirmed the view that the equal protection clause does not prevent the legislature from recognizing 'degrees of evil' (*Truax v. Raich*, 239 U.S. 33, 43, 36 S.Ct. 7, 11, 60 L.Ed. 131, L.R.A. 1916D, 545, Ann. Cas. 1917B, 283) by our ruling in *Tigner v. Texas*, 310 U.S. 141, 147, 60 S.Ct. 879, 882, 84 L.Ed. 1124, 130 A.L.R. 1321, that 'the Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same.' And see *Nashville, Chattanooga & St. Louis Ry. v. Browning*, 310 U.S. 362, 60 S.Ct. 968, 84 L.Ed. 1254. Thus, if we had here only a question as to a State's classification of crimes, such as embezzlement or larceny, no substantial federal question would be raised. See *Moore v. Missouri*, 159 U.S. 673, 16 S.Ct. 179, 40 L.Ed. 301; *Hawker v. New York*, 170 U.S. 189, 18 S.Ct. 573, 42 L.Ed. 1002; *Finley v. California*, 222 U.S. 28, 32 S.Ct. 13, 56 L.Ed. 75; *Patsone v. Pennsylvania*, supra. For a State is not constrained in the exercise of its police power to ignore experience which marks a class of

offenders or a family of offenses for special treatment. Nor is it prevented by the equal protection clause from confining 'its restrictions to those classes of cases where the need is deemed to be clearest'. *Miller v. Wilson*, 236 U.S. 373, 384, 35 S.Ct. 342, 344, 59 L.Ed. 628, L.R.A. 1915F, 829. And see *McLean v. Arkansas*, 211 U.S. 539, 29 S.Ct. 206, 53 L.Ed. 315. As stated in *Buck v. Bell*, supra, 274 U.S. page 208, 47 S.Ct. page 585, 71 L.Ed. 1000, '\* \* \* the law does all that is needed when it does all that it can, indicates a policy, applies it to all within the lines, and seeks to bring within the lines all similarly situated so far and so fast as its means allow.'

But the instant legislation runs afoul of the equal protection clause, though we give Oklahoma that large deference which the rule of the foregoing cases requires. 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 reexamine 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.' *Yick Wo. V. Hopkins*, 118 U.S. 356, 369, 6 S.Ct. 1064m 1070, 30 L.Ed. 220. 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 an invidious a discrimination as if it had selected a particular race or nationality for oppressive treatment. *Yick Wo v. Hopkins*, supra; *Gaines v. Canada*, 305 U.S. 337, 59 S.Ct. 232, 83 L.Ed. 208. 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. 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. *Riley v. State*, supra, 64 Okl.Cr. page 189, 78 P.2d page 715. 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. See *Smith v. Wayne Probate Judge*, 231 Mich. 409, 420, 421, 204 N.W. 140, 40 A.L.R. 515. In *Buck v. Bell*, supra, 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.' 274 U.S. page 208, 47 S.Ct. page 585, 71 L.Ed. 1000. 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' (*Bishop, Criminal Law*, 9th Ed., vol. 1, ss 566, 567) based on distinctions which are 'very largely dependent upon history for explanation' (*Holmes, The Common Law*, p. 73) 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. *Dorchy v. Kansas*, 264 U.S. 286, 44 S.Ct. 323, 68 L.Ed. 686. That is reemphasized here by our uncertainty as to what excision, if any, would be made as a matter of Oklahoma law. Cf. *Smith v. Cahoon*, 283 U.S. 553, 51 S.Ct. 582, 75 L.Ed. 1264. 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 (cf. Mr. Justice Brandeis dissenting, *National Life Insurance Co. v. United States*, 277 U.S. 508, 534, 535, 48 S.Ct. 591, 598, 72 L.Ed. 968) the class of criminals who might be sterilized.

Reversed.

### ***Notes, Questions, and Problems***

1. There was no evidence that Carrie Buck or her mother was feeble-minded or that either woman suffered from any kind of mental defect. Further, Carrie's child was presumed to be feeble-minded without any type of medical diagnosis. In fact, Carrie's pregnancy was a result of a rape by the nephew of her employers.

2. What were the objections to the constitutionality of the law in the *Skinner* case? The court focused on the Equal Protection arguments. What did the court say were the equalities caused by the law?

3. Why was the outcome in *Skinner* different from the one in *Buck v. Bell*?

4. Chief Justice Stone concurred in *Skinner*. A judge usually concurs when he or she agrees with the outcome, but disagrees with the manner in which the majority reaches the outcome. The majority opinion in *Skinner* focused on the unfairness of the application of the law. According to Justice Stone, the law, as applied, punished chicken thieves, but gave embezzlers a pass. Thus, the law violated the Equal Protection clause by treating similarly-situated people differently. Justice Stone agreed that the law was unconstitutional, but he did not think an Equal Protection analysis was appropriate. He determined that the law was flawed because it did not afford the persons impacted adequate due process. The law required a hearing to be held to determine if the sterilization could be safely performed. To satisfy the Due Process Clause, Justice Douglas concluded that a hearing should have been required to decide whether criminal tendencies of habitual offenses are inheritable.

5. The declaration that a person has a right to procreate is not quite accurate. The right that is protected is the right to procreate without undue governmental interference. The government does not have an obligation to assist people who want to procreate, but cannot for some reason. That is one of the reasons why the availability and use of assisted reproductive technology (ART) is not heavily regulated. The regulations that are in place are designed to restrict, not expand, the use of ART to procreate. For example, in most states traditional surrogacy is illegal and gestational surrogacy is heavily regulated.

**6. Posthumous Reproduction:** The technology now exists to procreate using the gametes of a person who is dead or in a permanent vegetative state. Most of the cases involve spouses or significant others using sperm or eggs to produce after-death children. However, recently, parents have sought to use the gametes of their dead children to create grandchildren. What do you see are some of the ethical consequences of that practice? For more information, See Browne Lewis, *The Ethical and Legal Consequences of Posthumous Reproduction: Arrogance, Avarice and Anguish* (London: Routledge Press, 2016).

## CHAPTER FIVE - THE RIGHT TO NOT PROCREATE

The majority of this chapter will be spent on abortion because it continues to be the hotbed issue. The predominance of abortion as an issue in the United States is evidenced by the fact that, over the last few decades, presidents have selected United States Supreme Court Justices based upon their stance on abortion. For example, former President Donald Trump vowed to only appoint Justices who promised to overturn *Roe v. Wade*. Likewise, federal and state elections have turned on whether the candidate has been deemed to be “pro-life” or “pro-choice.” There are literally hundreds of laws passed every year designed to severely restrict a woman’s ability to have an abortion. Thus, there is usually a pending abortion case on the docket of the U.S. Supreme Court. The first restrictions on reproductive freedom were designed to regulate people’s attempt not to procreate. Then, the law progressed to make sure that women who became pregnant remained that way until they give birth.

### 5.1 Contraception

#### *Griswold v. Connecticut*, 381 U.S. 479

Mr. JUSTICE DOUGLAS delivered the opinion of the Court.

Appellant Griswold is Executive Director of the Planned Parenthood League of Connecticut. Appellant Buxton is a licensed physician and a professor at the Yale Medical School who served as Medical Director for the League at its Center in New Haven—a center open and operating from November 1 to November 10, 1961, when appellants were arrested.

They gave information, instruction, and medical advice to *married persons* as to the means of preventing conception. They examined the wife and prescribed the best contraceptive device or material for her use. Fees were usually charged, although some couples were serviced free.

The statutes whose constitutionality is involved in this appeal are ss 53-32 and 54-196 of the General Statutes of Connecticut (1958 rev.). The former provides:

‘Any person who uses any drug, medicinal article or instrument for the purpose of preventing conception shall be fined not less than fifty dollars or imprisoned not less than sixty days nor more than one year or be both fined and imprisoned.’

Section 54-196 provides:

‘Any person who assists, abets, counsels, causes, hires or commands another to commit any offense may be prosecuted and punished as if he were the principal offender.’

The appellants were found guilty as accessories and fined \$100 each, against the claim that the accessory statute as so applied violated the Fourteenth Amendment. The Appellate Division of the Circuit Court affirmed. The Supreme Court of Errors affirmed that judgment. 151 Conn. 544, 200 A.2d 479. We noted probable jurisdiction. 379 U.S. 926, 85 S.Ct. 328, 13 L.Ed.2d 339.

We think that appellants have standing to raise the constitutional rights of the married people with whom they had a professional relationship. *Tileston v. Ullman*, 318 U.S. 44, 63 S.Ct. 493, 87 L.Ed.

603, is different, for there the plaintiff seeking to represent others asked for a declaratory judgment. In that situation we thought that the requirements of standing should be strict, lest the standards of ‘case or controversy’ in Article III of the Constitution become blurred. Here those doubts are removed by reason of a criminal conviction for serving married couples in violation of an aiding-and-abetting statute. Certainly the accessory should have standing to assert that the offense which he is charged with assisting is not, or cannot constitutionally be a crime.

This case is more akin to *Truax v. Raich*, 239 U.S. 33, 36 S.Ct. 7, 60 L.Ed. 131, where an employee was permitted to assert the rights of his employer; to *Pierce v. Society of Sisters*, 268 U.S. 510, 45 S.Ct. 571, 69 L.Ed. 1070, where the owners of private schools were entitled to assert the rights of potential pupils and their parents; and to *Barrows v. Jackson*, 346 U.S. 249, 73 S.Ct. 1031, 97 L.Ed. 1586, where a white defendant, party to a racially restrictive covenant, who was being sued for damages by the covenantors because she had conveyed her property to Negroes, was allowed to raise the issue that enforcement of the covenant violated the rights of prospective Negro purchasers to equal protection, although no Negro was a party to the suit (citations omitted). The rights of husband and wife, pressed here, are likely to be diluted or adversely affected unless those rights are considered in a suit involving those who have this kind of confidential relation to them.

Coming to the merits, we are met with a wide range of questions that implicate the Due Process Clause of the Fourteenth Amendment. Overtones of some arguments suggest that *Lochner v. State of New York*, 198 U.S. 45, 25 S.Ct. 539, 49 L.Ed. 937, should be our guide. But we decline that invitation as we did in *West Coast Hotel Co. v. Parrish*, 300 U.S. 379, 57 S.Ct. 578, 81 L.Ed. 703. We do not sit as a super-legislature to determine the wisdom, need, and propriety of laws that touch economic problems, business affairs, or social conditions. This law, however, operates directly on an intimate relation of husband and wife and their physician’s role in one aspect of that relation.

The association of people is not mentioned in the Constitution nor in the Bill of Rights. The right to educate a child in a school of the parents’ choice—whether public or private or parochial—is also not mentioned. Nor is the right to study any particular subject or any foreign language. Yet the First Amendment has been construed to include certain of those rights.

By *Pierce v. Society of Sisters*, *supra*, the right to educate one’s children as one chooses is made applicable to the States by the force of the First and Fourteenth Amendments. By *Meyer v. State of Nebraska*, *supra*, the same dignity is given the right to study the German language in a private school. In other words, the State may not, consistently with the spirit of the First Amendment, contract the spectrum of available knowledge. The right of freedom of speech and press includes not only the right to utter or to print, but the right to distribute, the right to receive, the right to read (*Martin v. City of Struthers*, 319 U.S. 141, 143, 63 S.Ct. 862, 863, 87 L.Ed. 1313) and freedom of inquiry, freedom of thought, and freedom to teach (see *Wieman v. Updegraff*, 344 U.S. 183, 195, 73 S.Ct. 215, 220, 97 L.Ed. 216) indeed the freedom of the entire university community. *Sweezy v. State of New Hampshire*, 354 U.S. 234, 249-250, 261-263, 77 S.Ct. 1203, 1211, 1217-1218, 1 L.Ed.2d 1311; *Barenblatt v. United States*, 360 U.S. 109, 112, 79 S.Ct. 1081, 1085, 3 L.Ed.2d 1115; *Baggett v. Bullitt*, 377 U.S. 360, 369, 84 S.Ct. 1163, 1321, 12 L.Ed.2d 377. Without those peripheral rights the specific rights would be less secure. And so we reaffirm the principle of the *Pierce* and the *Meyer* cases.

In *NAACP v. State of Alabama*, 357 U.S. 449, 462, 78 S.Ct. 1163, 1172, we protected the ‘freedom to associate and privacy in one’s associations,’ noting that freedom of association was a peripheral First Amendment right. Disclosure of membership lists of a constitutionally valid association, we held, was invalid ‘as entailing the likelihood of a substantial restraint upon the exercise by petitioner’s members

of their right to freedom of association.’ Ibid. In other words, the First Amendment has a penumbra where privacy is protected from governmental intrusion. In like context, we have protected forms of ‘association’ that are not political in the customary sense but pertain to the social, legal, and economic benefit of the members. *NAACP v. Button*, 371 U.S. 415, 430-431, 83 S.Ct. 328, 336-337. In *Schwartz v. Board of Bar Examiners*, 353 U.S. 232, 77 S.Ct. 752, 1 L.Ed.2d 796, we held it not permissible to bar a lawyer from practice, because he had once been a member of the Communist Party. The man’s ‘association with that Party’ was not shown to be ‘anything more than a political faith in a political party’ (Id., at 244, 77 S.Ct. at 759) and was not action of a kind proving bad moral character. Id., at 245-246, 77 S.Ct. at 759-760.

Those cases involved more than the ‘right of assembly’ — a right that extends to all irrespective of their race or ideology. *De Jonge v. State of Oregon*, 299 U.S. 353, 57 S.Ct. 255, 81 L.Ed. 278. The right of ‘association,’ like the right of belief (*West Virginia State Board of Education v. Barnette*, 319 U.S. 624, 63 S.Ct. 1178), is more than the right to attend a meeting; it includes the right to express one’s attitudes or philosophies by membership in a group or by affiliation with it or by other lawful means. Association in that context is a form of expression of opinion; and while it is not expressly included in the First Amendment its existence is necessary in making the express guarantees fully meaningful.

The foregoing cases suggest that specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance. See *Poe v. Ullman*, 367 U.S. 497, 516-522, 81 S.Ct. 1752, 6 L.Ed.2d 989 (dissenting opinion). Various guarantees create zones of privacy. The right of association contained in the penumbra of the First Amendment is one, as we have seen. The Third Amendment in its prohibition against the quartering of soldiers ‘in any house’ in time of peace without the consent of the owner is another facet of that privacy. The Fourth Amendment explicitly affirms the ‘right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures.’ The Fifth Amendment in its Self-Incrimination Clause enables the citizen to create a zone of privacy which government may not force him to surrender to his detriment. The Ninth Amendment provides: ‘The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.’

The Fourth and Fifth Amendments were described in *Boyd v. United States*, 116 U.S. 616, 630, 6 S.Ct. 524, 532, 29 L.Ed. 746, as protection against all governmental invasions ‘of the sanctity of a man’s home and the privacies of life.’ We recently referred in *Mapp v. Ohio*, 367 U.S. 643, 656, 81 S.Ct. 1684, 1692, 6 L.Ed.2d 1081, to the Fourth Amendment as creating a ‘right to privacy, no less important than any other right carefully and particularly reserved to the people.’ See *Beane, The Constitutional Right to Privacy*, 1962 Sup.Ct.Rev. 212; *Griswold, The Right to be Let Alone*, 55 Nw.U.L.Rev. 216 (1960).

The present case, then, concerns a relationship lying within the zone of privacy created by several fundamental constitutional guarantees. And it concerns a law which, in forbidding the use of contraceptives rather than regulating their manufacture or sale, seeks to achieve its goals by means having a maximum destructive impact upon that relationship. Such a law cannot stand in light of the familiar principle, so often applied by this Court, that a ‘governmental purpose to control or prevent activities constitutionally subject to state regulation may not be achieved by means which sweep unnecessarily broadly and thereby invade the area of protected freedoms.’ *NAACP v. Alabama*, 377 U.S. 288, 307, 84 S.Ct. 1302, 1314, 12 L.Ed.2d 325. Would we allow the police to search the sacred precincts of marital bedrooms for telltale signs of the use of contraceptives? The very idea is repulsive to the notions of privacy surrounding the marriage relationship.

We deal with a right of privacy older than the Bill of Rights—older than our political parties, older than our school system. Marriage is a coming together for better or for worse, hopefully enduring, and intimate to the degree of being sacred. It is an association that promotes a way of life, not causes; a harmony in living, not political faiths; a bilateral loyalty, not commercial or social projects. Yet it is an association for as noble a purpose as any involved in our prior decisions.

Reversed.

### *Notes*

1. The court recognized the right of a single person to not procreate in *Eisenstadt v. Baird*, 405 U.S. 438, 92 S. Ct. 1029 (1972). The holding in *Carey v. Population Services International*, 431 U.S. 678, 97 S.Ct. 2010 (1977) affirmed the right of minors to avoid procreation by using contraception.

2. The availability and use of assisted reproductive technology has changed the reproductive landscape. Nonetheless, courts still honor a person's right to not procreate. The court hearing *Davis v. Davis*, 842 S.W.2d 588 (1992) had to decide whether to permit the egg donor to donate the pre-embryos or to allow the sperm donor to have the pre-embryos destroyed. The court ruled in favor of the sperm donor deciding that he had a right to not procreate. That right outweighed the egg donor's desire to permit someone else to use the pre-embryos to create a child.

3. Emergency contraception (EC) can prevent pregnancy when taken up to five days following sexual intercourse. The Centers for Disease Control and Prevention, National Center for Health Statistics estimates approximately 10 percent of women in the United States have used emergency contraception. Emergency contraception pills are estimated to be 75 to 90 percent effective at preventing pregnancy.

## **5.2 Abortion**

[Abortion jurisprudence](#)<sup>25</sup> involves three sets of rights that the courts have to balance when evaluating cases dealing with the subject. The first right the courts have to consider is the woman's right to have control of her body. This boils down to the ethics of treating a woman like an incubator. The second right the courts have to look at in their deliberations is the right of the man who contributed the sperm used to conceive the child. The state's rights are impacted because the state seeks to be the voice of the unborn child. For persons who believe that life begins at conception, the "child's" rights are tantamount to those of the woman. The U.S. Supreme Court has taken steps to balance those rights. Nonetheless, *Roe v. Wade* remains in jeopardy of being overruled as the Court becomes more and more conservative. Which of these rights do you think should be given precedence?

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<sup>25</sup> Carrie N. Baker, *The History of Abortion Law in the United States*, Our Bodies Ourselves, at <https://www.ourbodiesourselves.org/book-excerpts/health-article/u-s-abortion-history/> (Sept. 14, 2020).

## ***Roe v. Wade*, 410 U.S. 113**

Mr. JUSTICE BLACKMUN delivered the opinion of the Court.

This Texas federal appeal and its Georgia companion, *Doe v. Bolton*, 410 U.S. 179, 93 S.Ct. 739, 35 L.Ed.2d 201, present constitutional challenges to state criminal abortion legislation. The Texas statutes under attack here are typical of those that have been in effect in many States for approximately a century. The Georgia statutes, in contrast, have a modern cast and are a legislative product that, to an extent at least, obviously reflects the influences of recent attitudinal change, of advancing medical knowledge and techniques, and of new thinking about an old issue.

We forthwith acknowledge our awareness of the sensitive and emotional nature of the abortion controversy, of the vigorous opposing views, even among physicians, and of the deep and seemingly absolute convictions that the subject inspires. One's philosophy, one's experiences, one's exposure to the raw edges of human existence, one's religious training, one's attitudes toward life and family and their values, and the moral standards one establishes and seeks to observe, are all likely to influence and to color one's thinking and conclusions about abortion.

In addition, population growth, pollution, poverty, and racial overtones tend to complicate and not to simplify the problem.

Our task, of course, is to resolve the issue by constitutional measurement, free of emotion and of predilection. We seek earnestly to do this, and, because we do, we have inquired into, and in this opinion place some emphasis upon, medical and medical-legal history and what that history reveals about man's attitudes toward the abortion procedure over the centuries.

### I

The Texas statutes that concern us here are Arts. 1191-1194 and 1196 of the State's Penal Code, Vernon's Ann.P.C. These make it a crime to 'procure an abortion,' as therein defined, or to attempt one, except with respect to 'an abortion procured or attempted by medical advice for the purpose of saving the life of the mother.' Similar statutes are in existence in a majority of the States.

Texas first enacted a criminal abortion statute in 1854. Texas Laws 1854, c. 49, s 1, set forth in 3 H. Gammel, Laws of Texas 1502 (1898). This was soon modified into language that has remained substantially unchanged to the present time. See Texas Penal Code of 1857, c. 7, Arts. 531-536; G. Paschal, Laws of Texas, Arts. 2192-2197 (1866); Texas Rev.Stat., c. 8, Arts. 536-541 (1879); Texas Rev.Crim.Stat., Arts. 1071-1076 (1911). The final article in each of these compilations provided the same exception, as does the present Article 1196, for an abortion by 'medical advice for the purpose of saving the life of the mother.'

### II

Jane Roe, a single woman who was residing in Dallas County, Texas, instituted this federal action in March 1970 against the District Attorney of the county. She sought a declaratory judgment that the Texas criminal abortion statutes were unconstitutional on their face, and an injunction restraining the defendant from enforcing the statutes.

Roe alleged that she was unmarried and pregnant; that she wished to terminate her pregnancy by an abortion ‘performed by a competent, licensed physician, under safe, clinical conditions’; that she was unable to get a ‘legal’ abortion in Texas because her life did not appear to be threatened by the continuation of her pregnancy; and that she could not afford to travel to another jurisdiction in order to secure a legal abortion under safe conditions. She claimed that the Texas statutes were unconstitutionally vague and that they abridged her right of personal privacy, protected by the First, Fourth, Fifth, Ninth, and Fourteenth Amendments. By an amendment to her complaint Roe purported to sue ‘on behalf of herself and all other women’ similarly situated.

James Hubert Hallford, a licensed physician, sought and was granted leave to intervene in Roe’s action. In his complaint he alleged that he had been arrested previously for violations of the Texas abortion statutes and that two such prosecutions were pending against him. He described conditions of patients who came to him seeking abortions, and he claimed that for many cases he, as a physician, was unable to determine whether they fell within or outside the exception recognized by Article 1196. He alleged that, as a consequence, the statutes were vague and uncertain, in violation of the Fourteenth Amendment, and that they violated his own and his patients’ rights to privacy in the doctor-patient relationship and his own right to practice medicine, rights he claimed were guaranteed by the First, Fourth, Fifth, Ninth, and Fourteenth Amendments.

John and Mary Doe, a married couple, filed a companion complaint to that of Roe. They also named the District Attorney as defendant, claimed like constitutional deprivations, and sought declaratory and injunctive relief. The Does alleged that they were a childless couple; that Mrs. Doe was suffering from a ‘neural-chemical’ disorder; that her physician had ‘advised her to avoid pregnancy until such time as her condition has materially improved’ (although a pregnancy at the present time would not present ‘a serious risk’ to her life); that, pursuant to medical advice, she had discontinued use of birth control pills; and that if she should become pregnant, she would want to terminate the pregnancy by an abortion performed by a competent, licensed physician under safe, clinical conditions. By an amendment to their complaint, the Does purported to sue ‘on behalf of themselves and all couples similarly situated.’

The two actions were consolidated and heard together by a duly convened three-judge district court. The suits thus presented the situations of the pregnant single woman, the childless couple, with the wife not pregnant, and the licensed practicing physician, all joining in the attack on the Texas criminal abortion statutes. Upon the filing of affidavits, motions were made for dismissal and for summary judgment. The court held that Roe and members of her class, and Dr. Hallford, had standing to sue and presented justiciable controversies, but that the Does had failed to allege facts sufficient to state a present controversy and did not have standing. It concluded that, with respect to the requests for a declaratory judgment, abstention was not warranted. On the merits, the District Court held that the ‘fundamental right of single women and married persons to choose where to have children is protected by the Ninth Amendment, through the Fourteenth Amendment,’ and that the Texas criminal abortion statutes were void on their face because they were both unconstitutionally vague and constituted an overbroad infringement of the plaintiffs’ Ninth Amendment rights. The court then held that abstention was warranted with respect to the requests for an injunction. It therefore dismissed the Does’ complaint, declared the abortion statutes void, and dismissed the application for injunctive relief.

The plaintiffs Roe and Doe and the intervenor Hallford, pursuant to 28 U.S.C. s 1253, have appealed to this Court from that part of the District Court’s judgment denying the injunction. The defendant District Attorney has purported to cross-appeal, pursuant to the same statute, from the court’s grant of declaratory relief to Roe and Hallford. Both sides also have taken protective appeals to the United States Court of Appeals for the Fifth Circuit. That court ordered the appeals held in abeyance pending



decision here. We postponed decision on jurisdiction to the hearing on the merits. 402 U.S. 941, 91 S.Ct. 1610, 29 L.Ed. 108 (1971).

#### IV

Despite the use of the pseudonym, no suggestion is made that Roe is a fictitious person. For purposes of her case, we accept as true, and as established, her existence; her pregnant state, as of the inception of her suit in March 1970 and as late as May 21 of that year when she filed an alias affidavit with the District Court; and her inability to obtain a legal abortion in Texas.

Viewing Roe's case as of the time of its filing and thereafter until as late as May, there can be little dispute that it then presented a case or controversy and that, wholly apart from the class aspects, she, as a pregnant single woman thwarted by the Texas criminal abortion laws, had standing to challenge those statutes (citations omitted). Indeed, we do not read the appellee's brief as really asserting anything to the contrary. The 'logical nexus between the status asserted and the claim sought to be adjudicated, 'and the necessary degree of contentiousness are both present.

The appellee notes, however, that the record does not disclose that Roe was pregnant at the time of the District Court hearing on May 22, 1970, or on the following June 17 when the court's opinion and judgment were filed. And he suggests that Roe's case must now be moot because she and all other members of her class are no longer subject to any 1970 pregnancy.

The usual rule in federal cases is that an actual controversy must exist at stages of appellate or certiorari review, and not simply at the date the action is initiated (citations omitted).

But when, as here, pregnancy is a significant fact in the litigation, the normal 266-day human gestation period is so short that the pregnancy will come to term before the usual appellate process is complete. If that termination makes a case moot, pregnancy litigation seldom will survive much beyond the trial stage, and appellate review will be effectively denied. Our law should not be that rigid. Pregnancy often comes more than once to the same woman, and in the general population, if man is to survive, it will always be with us. Pregnancy provides a classic justification for a conclusion of non-mootness. It truly could be 'capable of repetition, yet evading review' (citations omitted).

We, therefore, agree with the District Court that Jane Roe had standing to undertake this litigation, that she presented a justiciable controversy, and that the termination of her 1970 pregnancy has not rendered her case moot.

Dr. Hallford. The doctor's position is different. He entered Roe's litigation as a plaintiff-intervenor, alleging in his complaint that he:

'(I)n the past has been arrested for violating the Texas Abortion Laws and at the present time stands charged by indictment with violating said laws in the Criminal District Court of Dallas County, Texas to-wit: (1) The State of Texas vs. James H. Hallford, No. C-69-5307-IH, and (2) The State of Texas vs. James H. Hallford, No. C-69-2524-H. In both cases the defendant is charged with abortion . . .'

In his application for leave to intervene, the doctor made like representations as to the abortion charges pending in the state court. These representations were also repeated in the affidavit he executed and filed in support of his motion for summary judgment.

Dr. Hallford is, therefore, in the position of seeking, in a federal court, declaratory and injunctive relief with respect to the same statutes under which he stands charged in criminal prosecutions simultaneously pending in state court. Although he stated that he has been arrested in the past for violating the State's abortion laws, he makes no allegation of any substantial and immediate threat to any federally protected right that cannot be asserted in his defense against the state prosecutions. Neither is there any allegation of harassment or bad-faith prosecution. In order to escape the rule articulated in the cases cited in the next paragraph of this opinion that, absent harassment and bad faith, a defendant in a pending state criminal case cannot affirmatively challenge in federal court the statutes under which the State is prosecuting him, Dr. Hallford seeks to distinguish his status as a present state defendant from his status as a 'potential future defendant' and to assert only the latter for standing purposes here.

Dr. Hallford's complaint in intervention is to be dismissed. He is remitted to his defenses in the state criminal proceedings against him. We reverse the judgment of the District Court insofar as it granted Dr. Hallford relief and failed to dismiss his complaint in intervention.

In view of our ruling as to Roe's standing in her case, the issue of the Does' standing in their case has little significance. The claims they assert are essentially the same as those of Roe, and they attack the same statutes.

The Does therefore are not appropriate plaintiffs in this litigation. Their complaint was properly dismissed by the District Court, and we affirm that dismissal.

## V

The principal thrust of appellant's attack on the Texas statutes is that they improperly invade a right, said to be possessed by the pregnant woman, to choose to terminate her pregnancy. Appellant would discover this right in the concept of personal 'liberty' embodied in the Fourteenth Amendment's Due Process Clause; or in personal marital, familial, and sexual privacy said to be protected by the Bill of Rights or its penumbras or among those rights reserved to the people by the Ninth Amendment, *Griswold v. Connecticut*, 381 U.S., at 486, 85 S.Ct., at 1682 (Goldberg, J., concurring). Before addressing this claim, we feel it desirable briefly to survey, in several aspects, the history of abortion, for such insight as that history may afford us, and then to examine the state purposes and interests behind the criminal abortion laws.

## VI (Omitted)

## VII

Three reasons have been advanced to explain historically the enactment of criminal abortion laws in the 19th century and to justify their continued existence.

It has been argued occasionally that these laws were the product of a Victorian social concern to discourage illicit sexual conduct. Texas, however, does not advance this justification in the present case, and it appears that no court or commentator has taken the argument seriously. The appellants and amici contend, moreover, that this is not a proper state purpose at all and suggest that, if it were, the

Texas statutes are overbroad in protecting it since the law fails to distinguish between married and unwed mothers.

A second reason is concerned with abortion as a medical procedure. When most criminal abortion laws were first enacted, the procedure was a hazardous one for the woman. This was particularly true prior to the development of antiseptics. Antiseptic techniques, of course, were based on discoveries by Lister, Pasteur, and others first announced in 1867, but were not generally accepted and employed until about the turn of the century. Abortion mortality was high. Even after 1900, and perhaps until as late as the development of antibiotics in the 1940's, standard modern techniques such as dilation and curettage were not nearly so safe as they are today. Thus, it has been argued that a State's real concern in enacting a criminal abortion law was to protect the pregnant woman, that is, to restrain her from submitting to a procedure that placed her life in serious jeopardy.

Appellants and various amici refer to medical data indicating that abortion in early pregnancy, that is, prior to the end of the first trimester, although not without its risk, is now relatively safe. Mortality rates for women undergoing early abortions, where the procedure is legal, appear to be as low as or lower than the rates for normal childbirth. Consequently, any interest of the State in protecting the woman from an inherently hazardous procedure, except when it would be equally dangerous for her to forgo it, has largely disappeared. Of course, important state interests in the areas of health and medical standards do remain. The State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient. This interest obviously extends at least to the performing physician and his staff, to the facilities involved, to the availability of after-care, and to adequate provision for any complication or emergency that might arise. The prevalence of high mortality rates at illegal 'abortion mills' strengthens, rather than weakens, the State's interest in regulating the conditions under which abortions are performed. Moreover, the risk to the woman increases as her pregnancy continues. Thus, the State retains a definite interest in protecting the woman's own health and safety when an abortion is proposed at a late stage of pregnancy.

The third reason is the State's interest-some phrase it in terms of duty-in protecting prenatal life. Some of the argument for this justification rests on the theory that a new human life is present from the moment of conception. The State's interest and general obligation to protect life then extends, it is argued, to prenatal life. Only when the life of the pregnant mother herself is at stake, balanced against the life she carries within her, should the interest of the embryo or fetus not prevail. Logically, of course, a legitimate state interest in this area need not stand or fall on acceptance of the belief that life begins at conception or at some other point prior to life birth. In assessing the State's interest, recognition may be given to the less rigid claim that as long as at least potential life is involved, the State may assert interests beyond the protection of the pregnant woman alone.

Parties challenging state abortion laws have sharply disputed in some courts the contention that a purpose of these laws, when enacted, was to protect prenatal life. Pointing to the absence of legislative history to support the contention, they claim that most state laws were designed solely to protect the woman. Because medical advances have lessened this concern, at least with respect to abortion in early pregnancy, they argue that with respect to such abortions the laws can no longer be justified by any state interest. There is some scholarly support for this view of original purpose. The few state courts called upon to interpret their laws in the late 19th and early 20th centuries did focus on the State's interest in protecting the woman's health rather than in preserving the embryo and fetus. Proponents of this view point out that in many States, including Texas, by statute or judicial interpretation, the pregnant woman herself could not be prosecuted for self-abortion or for cooperating in an abortion

performed upon her by another. They claim that adoption of the ‘quickening’ distinction through received common law and state statutes tacitly recognizes the greater health hazards inherent in late abortion and impliedly repudiates the theory that life begins at conception.

It is with these interests, and the weight to be attached to them, that this case is concerned.

## VIII

The Constitution does not explicitly mention any right of privacy. In a line of decisions, however, going back perhaps as far as *Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251, 11 S.Ct. 1000, 1001, 35 L.Ed. 734 (1891), the Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution. In varying contexts, the Court or individual Justices have, indeed, found at least the roots of that right in the First Amendment, and in the Fourth and Fifth Amendments, (citations omitted). These decisions make it clear that only personal rights that can be deemed ‘fundamental’ or ‘implicit in the concept of ordered liberty,’ are included in this guarantee of personal privacy. They also make it clear that the right has some extension to activities relating to marriage, procreation, contraception, family relationships, and child rearing and education (citations omitted).

This right of privacy, whether it be founded in the Fourteenth Amendment’s concept of personal liberty and restrictions upon state action, as we feel it is, or, as the District Court determined, in the Ninth Amendment’s reservation of rights to the people, is broad enough to encompass a woman’s decision whether or not to terminate her pregnancy. The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved. All these are factors the woman and her responsible physician necessarily will consider in consultation.

On the basis of elements such as these, appellant and some amici argue that the woman’s right is absolute and that she is entitled to terminate her pregnancy at whatever time, in whatever way, and for whatever reason she alone chooses. With this we do not agree. Appellant’s arguments that Texas either has no valid interest at all in regulating the abortion decision, or no interest strong enough to support any limitation upon the woman’s sole determination, are unpersuasive. The Court’s decisions recognizing a right of privacy also acknowledge that some state regulation in areas protected by that right is appropriate. As noted above, a State may properly assert important interests in safeguarding health, in maintaining medical standards, and in protecting potential life. At some point in pregnancy, these respective interests become sufficiently compelling to sustain regulation of the factors that govern the abortion decision. The privacy right involved, therefore, cannot be said to be absolute. In fact, it is not clear to us that the claim asserted by some amici that one has an unlimited right to do with one’s body as one pleases bears a close relationship to the right of privacy previously articulated in the Court’s decisions. The Court has refused to recognize an unlimited right of this kind in the past.

We, therefore, conclude that the right of personal privacy includes the abortion decision, but that this right is not unqualified and must be considered against important state interests in regulation.

We note that those federal and state courts that have recently considered abortion law challenges have reached the same conclusion. A majority, in addition to the District Court in the present case, have held state laws unconstitutional, at least in part, because of vagueness or because of overbreadth and abridgment of rights (citations omitted).

Although the results are divided, most of these courts have agreed that the right of privacy, however based, is broad enough to cover the abortion decision; that the right, nonetheless, is not absolute and is subject to some limitations; and that at some point the state interests as to protection of health, medical standards, and prenatal life, become dominant. We agree with this approach.

Where certain ‘fundamental rights’ are involved, the Court has held that regulation limiting these rights may be justified only by a ‘compelling state interest,’ and that legislative enactments must be narrowly drawn to express only the legitimate state interests at stake (citations omitted).

In the recent abortion cases, cited above, courts have recognized these principles. Those striking down state laws have generally scrutinized the State’s interests in protecting health and potential life, and have concluded that neither interest justified broad limitations on the reasons for which a physician and his pregnant patient might decide that she should have an abortion in the early stages of pregnancy. Courts sustaining state laws have held that the State’s determinations to protect health or prenatal life are dominant and constitutionally justifiable.

## IX

The District Court held that the appellee failed to meet his burden of demonstrating that the Texas statute’s infringement upon Roe’s rights was necessary to support a compelling state interest, and that, although the appellee presented ‘several compelling justifications for state presence in the area of abortions,’ the statutes outstripped these justifications and swept ‘far beyond any areas of compelling state interest.’ 314 F.Supp., at 1222-1223. Appellant and appellee both contest that holding. Appellant, as has been indicated, claims an absolute right that bars any state imposition of criminal penalties in the area. Appellee argues that the State’s determination to recognize and protect prenatal life from and after conception constitutes a compelling state interest. As noted above, we do not agree fully with either formulation.

The appellee and certain amici argue that the fetus is a ‘person’ within the language and meaning of the Fourteenth Amendment. In support of this, they outline at length and in detail the well-known facts of fetal development. If this suggestion of personhood is established, the appellant’s case, of course, collapses, for the fetus’ right to life would then be guaranteed specifically by the Amendment. The appellant conceded as much on reargument. On the other hand, the appellee conceded on reargument that no case could be cited that holds that a fetus is a person within the meaning of the Fourteenth Amendment.

The Constitution does not define ‘person’ in so many words. Section 1 of the Fourteenth Amendment contains three references to ‘person.’ The first, in defining ‘citizens,’ speaks of ‘persons born or naturalized in the United States.’ The word also appears both in the Due Process Clause and in the Equal Protection Clause. ‘Person’ is used in other places in the Constitution: in the listing of qualifications for Representatives and Senators, Art. I, s 2, cl. 2, and s 3, cl. 3; in the Apportionment Clause, Art. I, s 2, cl. 3; in the Migration and Importation provision, Art. I, s 9, cl. 1; in the Emolument Clause, Art. I, s 9, cl. 8; in the Electors provisions, Art. II, s 1, cl. 2, and the superseded cl. 3; in the provision outlining qualifications for the office of President, Art. II, s 1, cl. 5; in the Extradition

provisions, Art. IV, s 2, cl. 2, and the superseded Fugitive Slave Clause 3; and in the Fifth, Twelfth, and Twenty-second Amendments, as well as in ss 2 and 3 of the Fourteenth Amendment. But in nearly all these instances, the use of the word is such that it has application only post-natally. None indicates, with any assurance, that it has any possible prenatal application.

All this, together with our observation, *supra*, that throughout the major portion of the 19th century prevailing legal abortion practices were far freer than they are today, persuades us that the word 'person,' as used in the Fourteenth Amendment, does not include the unborn. This is in accord with the results reached in those few cases where the issue has been squarely presented (citations omitted). Indeed, our decision in *United States v. Vuitch*, 402 U.S. 62, 91 S.Ct. 1294, 28 L.Ed.2d 601 (1971), inferentially is to the same effect, for we there would not have indulged in statutory interpretation favorable to abortion in specified circumstances if the necessary consequence was the termination of life entitled to Fourteenth Amendment protection.

This conclusion, however, does not of itself fully answer the contentions raised by Texas, and we pass on to other considerations.

The pregnant woman cannot be isolated in her privacy. She carries an embryo and, later, a fetus, if one accepts the medical definitions of the developing young in the human uterus. See *Dorland's Illustrated Medical Dictionary* 478-479, 547 (24th ed. 1965). The situation therefore is inherently different from marital intimacy, or bedroom possession of obscene material, or marriage, or procreation, or education, with which *Eisenstadt* and *Griswold*, *Stanley*, *Loving*, *Skinner* and *Pierce* and *Meyer* were respectively concerned. As we have intimated above, it is reasonable and appropriate for a State to decide that at some point in time another interest, that of health of the mother or that of potential human life, becomes significantly involved. The woman's privacy is no longer sole and any right of privacy she possesses must be measured accordingly.

Texas urges that, apart from the Fourteenth Amendment, life begins at conception and is present throughout pregnancy, and that, therefore, the State has a compelling interest in protecting that life from and after conception. We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer.

It should be sufficient to note briefly the wide divergence of thinking on this most sensitive and difficult question. There has always been strong support for the view that life does not begin until live birth. This was the belief of the Stoics. It appears to be the predominant, though not the unanimous, attitude of the Jewish faith. It may be taken to represent also the position of a large segment of the Protestant community, insofar as that can be ascertained; organized groups that have taken a formal position on the abortion issue have generally regarded abortion as a matter for the conscience of the individual and her family. As we have noted, the common law found greater significance in quickening. Physicians and their scientific colleagues have regarded that event with less interest and have tended to focus either upon conception, upon live birth, or upon the interim point at which the fetus becomes 'viable,' that is, potentially able to live outside the mother's womb, albeit with artificial aid. Viability is usually placed at about seven months (28 weeks) but may occur earlier, even at 24 weeks. The Aristotelian theory of 'mediate animation,' that held sway throughout the Middle Ages and the Renaissance in Europe, continued to be official Roman Catholic dogma until the 19th century, despite opposition to this 'ensoulment' theory from those in the Church who would recognize the existence of life from the moment of conception. The latter is now, of course, the official belief of the Catholic Church. As one

brief amicus discloses, this is a view strongly held by many non-Catholics as well, and by many physicians. Substantial problems for precise definition of this view are posed, however, by new embryological data that purport to indicate that conception is a ‘process’ over time, rather than an event, and by new medical techniques such as menstrual extraction, the ‘morning-after’ pill, implantation of embryos, artificial insemination, and even artificial wombs.

In areas other than criminal abortion, the law has been reluctant to endorse any theory that life, as we recognize it, begins before life birth or to accord legal rights to the unborn except in narrowly defined situations and except when the rights are contingent upon life birth. For example, the traditional rule of tort law denied recovery for prenatal injuries even though the child was born alive. That rule has been changed in almost every jurisdiction. In most States, recovery is said to be permitted only if the fetus was viable, or at least quick, when the injuries were sustained, though few courts have squarely so held. In a recent development, generally opposed by the commentators, some States permit the parents of a stillborn child to maintain an action for wrongful death because of prenatal injuries. Such an action, however, would appear to be one to vindicate the parents’ interest and is thus consistent with the view that the fetus, at most, represents only the potentiality of life. Similarly, unborn children have been recognized as acquiring rights or interests by way of inheritance or other devolution of property, and have been represented by guardians ad litem. Perfection of the interests involved, again, has generally been contingent upon live birth. In short, the unborn have never been recognized in the law as persons in the whole sense.

## X

In view of all this, we do not agree that, by adopting one theory of life, Texas may override the rights of the pregnant woman that are at stake. We repeat, however, that the State does have an important and legitimate interest in preserving and protecting the health of the pregnant woman, whether she be a resident of the State or a non-resident who seeks medical consultation and treatment there, and that it has still another important and legitimate interest in protecting the potentiality of human life. These interests are separate and distinct. Each grows in substantiality as the woman approaches term and, at a point during pregnancy, each becomes ‘compelling.’

With respect to the State’s important and legitimate interest in the health of the mother, the ‘compelling’ point, in the light of present medical knowledge, is at approximately the end of the first trimester. This is so because of the now-established medical fact, referred to above at 725, that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth. It follows that, from and after this point, a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. Examples of permissible state regulation in this area are requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; as to the licensing of the facility; and the like.

This means, on the other hand, that, for the period of pregnancy prior to this ‘compelling’ point, the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient’s pregnancy should be terminated. If that decision is reached, the judgment may be effectuated by an abortion free of interference by the State.

With respect to the State’s important and legitimate interest in potential life, the ‘compelling’ point is at viability. This is so because the fetus then presumably has the capability of meaningful life outside

the mother's womb. State regulation protective of fetal life after viability thus has both logical and biological justifications. If the State is interested in protecting fetal life after viability, it may go so far as to proscribe abortion during that period, except when it is necessary to preserve the life or health of the mother.

Measured against these standards, Art. 1196 of the Texas Penal Code, in restricting legal abortions to those 'procured or attempted by medical advice for the purpose of saving the life of the mother,' sweeps too broadly. The statute makes no distinction between abortions performed early in pregnancy and those performed later, and it limits to a single reason, 'saving' the mother's life, the legal justification for the procedure. The statute, therefore, cannot survive the constitutional attack made upon it here.

This conclusion makes it unnecessary for us to consider the additional challenge to the Texas statute asserted on grounds of vagueness. See *United States v. Vuitch*, 402 U.S., at 67-72, 91 S.Ct., at 1296-1299.

In *Doe v. Bolton*, 410 U.S. 179, 93 S.Ct. 739, 35 L.Ed.2d 201, procedural requirements contained in one of the modern abortion statutes are considered. That opinion and this one, of course, are to be read together.

This holding, we feel, is consistent with the relative weights of the respective interests involved, with the lessons and examples of medical and legal history, with the lenity of the common law, and with the demands of the profound problems of the present day. The decision leaves the State free to place increasing restrictions on abortion as the period of pregnancy lengthens, so long as those restrictions are tailored to the recognized state interests. The decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician. If an individual practitioner abuses the privilege of exercising proper medical judgment, the usual remedies, judicial and intra-professional, are available.

## XII

Our conclusion that Art. 1196 is unconstitutional means, of course, that the Texas abortion statutes, as a unit, must fall. The exception of Art. 1196 cannot be struck down separately, for then the State would be left with a statute proscribing all abortion procedures no matter how medically urgent the case.

Although the District Court granted appellant *Roe* declaratory relief, it stopped short of issuing an injunction against enforcement of the Texas statutes. The Court has recognized that different considerations enter into a federal court's decision as to declaratory relief, on the one hand, and injunctive relief, on the other (citations omitted). We are not dealing with a statute that, on its face, appears to abridge free expression, an area of particular concern under *Dombrowski* and refined in *Younger v. Harris*, 401 U.S., at 50, 91 S.Ct., at 753.

We find it unnecessary to decide whether the District Court erred in withholding injunctive relief, for we assume the Texas prosecutorial authorities will give full credence to this decision that the present criminal abortion statutes of that State are unconstitutional.



The judgment of the District Court as to intervenor Hallford is reversed, and Dr. Hallford's complaint in intervention is dismissed. In all other respects, the judgment of the District Court is affirmed. Costs are allowed to the appellee.

It is so ordered.

Affirmed in part and reversed in part.

***Planned Parenthood v. Casey*, 505 U.S. 833**

JUSTICE O'CONNOR, JUSTICE KENNEDY, and JUSTICE SOUTER announced the judgment of the Court and delivered the opinion of the Court with respect to Parts I, II, III, V–A, V–C, and VI, an opinion with respect to Part V–E, in which JUSTICE STEVENS joins, and an opinion with respect to Parts IV, V–B, and V–D.

I

Liberty finds no refuge in a jurisprudence of doubt. Yet 19 years after our holding that the Constitution protects a woman's right to terminate her pregnancy in its early stages, *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973), that definition of liberty is still questioned. Joining the respondents as *amicus curiae*, the United States, as it has done in five other cases in the last decade, again asks us to overrule *Roe*. See Brief for Respondents 104–117; Brief for United States as *Amicus Curiae* 8.

At issue in these cases are five provisions of the Pennsylvania Abortion Control Act of 1982, as amended in 1988 and 1989. 18 Pa. Cons.Stat. §§ 3203–3220 (1990). Relevant portions of the Act are set forth in the Appendix. *Infra*, at 2833. The Act requires that a woman seeking an abortion give her informed consent prior to the abortion procedure, and specifies that she be provided with certain information at least 24 hours before the abortion is performed. §3205. For a minor to obtain an abortion, the Act requires the informed consent of one of her parents, but provides for a judicial bypass option if the minor does not wish to or cannot obtain a parent's consent. § 3206. Another provision of the Act requires that, unless certain exceptions apply, a married woman seeking an abortion must sign a statement indicating that she has notified her husband of her intended abortion. § 3209. The Act exempts compliance with these three requirements in the event of a "medical emergency," which is defined in § 3203 of the Act. See §§ 3203, 3205(a), 3206 (a), 3209 (c). In addition to the above provisions regulating the performance of abortions, the Act imposes certain reporting requirements on facilities that provide abortion services. §§ 3207 (b), 3214(a), 3214 (f).

Before any of these provisions took effect, the petitioners, who are five abortion clinics and one physician representing himself as well as a class of physicians who provide abortion services, brought this suit seeking declaratory and injunctive relief. Each provision was challenged as unconstitutional on its face. The District Court entered a preliminary injunction against the enforcement of the regulations, and, after a 3–day bench trial, held all the provisions at issue here unconstitutional, entering a permanent injunction against Pennsylvania's enforcement of them. The Court of Appeals for the Third Circuit affirmed in part and reversed in part, upholding all of the regulations except for the husband notification requirement. We granted certiorari.

The Court of Appeals found it necessary to follow an elaborate course of reasoning even to identify the first premise to use to determine whether the statute enacted by Pennsylvania meets constitutional standards. See 947 F.2d, at 687-698. And at oral argument in this Court, the attorney for the parties challenging the statute took the position that none of the enactments can be upheld without overruling *Roe v. Wade*. Tr. of Oral Arg. 5–6. We disagree with that analysis; but we acknowledge that our decisions after *Roe* cast doubt upon the meaning and reach of its holding. Further, THE CHIEF JUSTICE admits that he would overrule the central holding of *Roe* and adopt the rational relationship test as the sole criterion of constitutionality. See post, at 2855, 2867. State and federal courts as well as legislatures throughout the Union must have guidance as they seek to address this subject in conformance with the Constitution. Given these premises, we find it imperative to review once more the principles that define the rights of the woman and the legitimate authority of the State respecting the termination of pregnancies by abortion procedures.

After considering the fundamental constitutional questions resolved by *Roe*, principles of institutional integrity, and the rule of *stare decisis*, we are led to conclude this: the essential holding of *Roe v. Wade* should be retained and once again reaffirmed.

It must be stated at the outset and with clarity that *Roe*’s essential holding, the holding we reaffirm, has three parts. First is a recognition of the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State. Before viability, the State’s interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman’s effective right to elect the procedure. Second is a confirmation of the State’s power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger the woman’s life or health. And third is the principle that the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child. These principles do not contradict one another; and we adhere to each.

## II

Constitutional protection of the woman’s decision to terminate her pregnancy derives from the Due Process Clause of the Fourteenth Amendment. It declares that no State shall “deprive any person of life, liberty, or property, without due process of law.” The controlling word in the cases before us is “liberty.” Although a literal reading of the Clause might suggest that it governs only the procedures by which a State may deprive persons of liberty, for at least 105 years, since *Mugler v. Kansas*, 123 U.S. 623, 660-661, 8 S.Ct. 273, 291, 31 L.Ed. 205 (1897), the Clause has been understood to contain a substantive component as well, one “barring certain government actions regardless of the fairness of the procedures used to implement them.” *Daniels v. Williams*, 474 U.S. 327, 331, 106 S.Ct. 662, 665, 88 L.Ed.2d 662 (1986). As Justice Brandeis (joined by Justice Holmes) observed, “[d]espite arguments to the contrary which had seemed to me persuasive, it is settled that the due process clause of the Fourteenth Amendment applies to matters of substantive law as well as to matters of procedure. Thus all fundamental rights comprised within the term liberty are protected by the Federal Constitution from invasion by the States “[T]he guaranties of due process, though having their roots in Magna Carta’s ‘*per legem terrae*’ and considered as procedural safeguards ‘against executive usurpation and tyranny,’ have in this country ‘become bulwarks also against arbitrary legislation.’” *Poe v. Ullman*, 367 U.S. 497, 541, 81 S.Ct. 1752, 1776, 6 L.Ed.2d 989 (1961) (Harlan, J., dissenting from dismissal on jurisdictional grounds) (quoting *Hurtado v. California*, 110 U.S. 516, 532, 4 S.Ct. 111, 119, 28 L.Ed. 232 (1884)).

The most familiar of the substantive liberties protected by the Fourteenth Amendment are those recognized by the Bill of Rights. We have held that the Due Process Clause of the Fourteenth Amendment incorporates most of the Bill of Rights against the States. See, e.g., *Duncan v. Louisiana* 391 U.S. 145, 147-148, 88 S.Ct. 1444, 1446, 20 L.Ed.2d 491 (1968). It is tempting, as a means of curbing the discretion of federal judges, to suppose that liberty encompasses no more than those rights already guaranteed to the individual against federal interference by the express provisions of the first eight Amendments to the Constitution. See *Adamson v. California*, 332 U.S. 46, 68-92, 67 S.Ct. 1572, 1693-1697, 91 L.Ed. 1903 (1947) (Black, J., dissenting). But of course this Court has never accepted that view.

It is also tempting, for the same reason, to suppose that the Due Process Clause protects only those practices, defined at the most specific level, that were protected against government interference by other rules of law when the Fourteenth Amendment was ratified. See *Michael H. v. Gerald D.*, 491 U.S. 110, 127-128, n. 6, 109 S.Ct. 2333, 2344-2345, n. 6, 105 L.Ed.2d 9189 (opinion of SCALIA, J.). But such a view would be inconsistent with our law. It is a promise of the Constitution that there is a realm of personal liberty which the government may not enter. We have vindicated this principle before. Marriage is mentioned nowhere in the Bill of Rights and interracial marriage was illegal in most States in the 19th century, but the Court was no doubt correct in finding it to be an aspect of liberty protected against state interference by the substantive component of the Due Process Clause in several cases (citations omitted).

Neither the Bill of Rights nor the specific practices of States at the time of the adoption of the Fourteenth Amendment marks the outer limits of the substantive sphere of liberty which the Fourteenth Amendment protects. See U.S. Const., Amdt. 9. As the second Justice Harlan recognized:

“[T]he full scope of the liberty guaranteed by the Due Process Clause cannot be found in or limited by the precise terms of the specific guarantees elsewhere provided in the Constitution. This ‘liberty’ is not a series of isolated points pricked out in terms of the taking of property; the freedom of speech, press, and religion; the right to keep and bear arms; the freedom from unreasonable searches and seizures; and so on. It is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints, and which also recognizes, what a reasonable and sensitive judgment must, that certain interests require particularly careful scrutiny of the state needs asserted to justify their abridgment.” *Poe v. Ullman*, supra, 367 U.S., at 543, 81 S.Ct., at 1777 (opinion dissenting from dismissal on jurisdictional grounds).

Justice Harlan wrote these words in addressing an issue the full Court did not reach in *Poe v. Ullman*, but the Court adopted his position four Terms later in *Griswold v. Connecticut*, supra. In *Griswold*, we held that the Constitution does not permit a State to forbid a married couple to use contraceptives. That same freedom was later guaranteed, under the Equal Protection Clause, for unmarried couples. See *Eisenstadt v. Baird*, 405 U.S. 438, 92 S.Ct. 1029, 31 L.Ed.2d 349 (1972). Constitutional protection was extended to the sale and distribution of contraceptives in *Carey v. Population Services International*, supra. It is settled now, as it was when the Court heard arguments in *Roe v. Wade*, that the Constitution places limits on a State’s right to interfere with a person’s most basic decisions about family and parenthood (citations omitted).

The inescapable fact is that adjudication of substantive due process claims may call upon the Court in interpreting the Constitution to exercise that same capacity which by tradition courts always have

exercised: reasoned judgment. Its boundaries are not susceptible of expression as a simple rule. That does not mean we are free to invalidate state policy choices with which we disagree; yet neither does it permit us to shrink from the duties of our office. As Justice Harlan observed:

“Due process has not been reduced to any formula; its content cannot be determined by reference to any code. The best that can be said is that through the course of this Court’s decisions it has represented the balance which our Nation, built upon postulates of respect for the liberty of the individual, has struck between that liberty and the demands of organized society. If the supplying of content to this Constitutional concept has of necessity been a rational process, it certainly has not been one where judges have felt free to roam where unguided speculation might take them. The balance of which I speak is the balance struck by this country, having regard to what history teaches are the traditions from which it developed as well as the traditions from which it broke. That tradition is a living thing. A decision of this Court which radically departs from it could not long survive, while a decision which builds on what has survived is likely to be sound. No formula could serve as a substitute, in this area, for judgment and restraint.” *Poe v. Ullman*, 367 U.S., at 542, 81 S.Ct., at 1776. (opinion dissenting from dismissal on jurisdictional grounds).

See also *Rochin v. California*, *supra*, 342 U.S., at 171-172, 72 S.Ct., at 209 (Frankfurter, J., writing for the Court) (“To believe that this judicial exercise of judgment could be avoided by freezing ‘due process of law’ at some fixed stage of time or thought is to suggest that the most important aspect of constitutional adjudication is a function for inanimate machines and not for judges”).

Men and women of good conscience can disagree, and we suppose some always shall disagree, about the profound moral and spiritual implications of terminating a pregnancy, even in its earliest stage. Some of us as individuals find abortion offensive to our most basic principles of morality, but that cannot control our decision. Our obligation is to define the liberty of all, not to mandate our own moral code. The underlying constitutional issue is whether the State can resolve these philosophic questions in such a definitive way that a woman lacks all choice in the matter, except perhaps in those rare circumstances in which the pregnancy is itself a danger to her own life or health, or is the result of rape or incest.

It is conventional constitutional doctrine that where reasonable people disagree the government can adopt one position or the other. See, e.g., *Ferguson v. Skrupa*, 372 U.S. 726, 83 S.Ct. 1028, 10 L.Ed.2d 93 (1963); *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483, 75 S.Ct. 461, 99 L.Ed. 563 (1955). That theorem, however, assumes a state of affairs in which the choice does not intrude upon a protected liberty. Thus, while some people might disagree about whether or not the flag should be saluted, or disagree about the proposition that it may not be defiled, we have ruled that a State may not compel or enforce one view or the other. See *West Virginia Bd. of Ed. v. Barnette*, 319 U.S. 624, 63 S.Ct. 1178, 87 L.Ed. 1628 (1943); *Texas v. Johnson*, 491 U.S. 397, 109 S.Ct. 2533, 105 L.Ed.2d 342 (1989).

Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education. *Carey v. Population Services International*, 431 U.S., at 685, 97 S.Ct., at 2016. Our cases recognize “the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.” *Eisenstadt v. Baird*, *supra*, 405 U.S., at 453, 92 S.Ct., at 1038 (emphasis in original). Our precedents “have respected the private realm of family life which the state cannot enter.” *Prince v. Massachusetts*, 321 U.S. 158, 166, 64 S.Ct. 438,

442, 88 L.Ed. 645 (1944). These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

These considerations begin our analysis of the woman's interest in terminating her pregnancy but cannot end it, for this reason: though the abortion decision may originate within the zone of conscience and belief, it is more than a philosophic exercise. Abortion is a unique act. It is an act fraught with consequences for others: for the woman who must live with the implications of her decision; for the persons who perform and assist in the procedure; for the spouse, family, and society which must confront the knowledge that these procedures exist, procedures some deem nothing short of an act of violence against innocent human life; and, depending on one's beliefs, for the life or potential life that is aborted. Though abortion is conduct, it does not follow that the State is entitled to proscribe it in all instances. That is because the liberty of the woman is at stake in a sense unique to the human condition and so unique to the law. The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. That these sacrifices have from the beginning of the human race been endured by woman with a pride that ennobles her in the eyes of others and gives to the infant a bond of love cannot alone be grounds for the State to insist she make the sacrifice. Her suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, however dominant that vision has been in the course of our history and our culture. The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society.

It should be recognized, moreover, that in some critical respects the abortion decision is of the same character as the decision to use contraception, to which *Griswold v. Connecticut*, *Eisenstadt v. Baird*, and *Carey v. Population Services International* afford constitutional protection. We have no doubt as to the correctness of those decisions. They support the reasoning in *Roe* relating to the woman's liberty because they involve personal decisions concerning not only the meaning of procreation but also human responsibility and respect for it. As with abortion, reasonable people will have differences of opinion about these matters. One view is based on such reverence for the wonder of creation that any pregnancy ought to be welcomed and carried to full term no matter how difficult it will be to provide for the child and ensure its well-being. Another is that the inability to provide for the nurture and care of the infant is a cruelty to the child and an anguish to the parent. These are intimate views with infinite variations, and their deep, personal character underlay our decisions in *Griswold*, *Eisenstadt*, and *Carey*. The same concerns are present when the woman confronts the reality that, perhaps despite her attempts to avoid it, she has become pregnant.

It was this dimension of personal liberty that *Roe* sought to protect, and its holding invoked the reasoning and the tradition of the precedents we have discussed, granting protection to substantive liberties of the person. *Roe* was, of course, an extension of those cases and, as the decision itself indicated, the separate States could act in some degree to further their own legitimate interests in protecting prenatal life. The extent to which the legislatures of the States might act to outweigh the interests of the woman in choosing to terminate her pregnancy was a subject of debate both in *Roe* itself and in decisions following it.

While we appreciate the weight of the arguments made on behalf of the State in the cases before us, arguments which in their ultimate formulation conclude that *Roe* should be overruled, the reservations

any of us may have in reaffirming the central holding of *Roe* are outweighed by the explication of individual liberty we have given combined with the force of *stare decisis*. We turn now to that doctrine.

### III

#### A

The obligation to follow precedent begins with necessity, and a contrary necessity marks its outer limit. With Cardozo, we recognize that no judicial system could do society's work if it eyed each issue afresh in every case that raised it. See B. Cardozo, *The Nature of the Judicial Process* 149 (1921). Indeed, the very concept of the rule of law underlying our own Constitution requires such continuity over time that a respect for precedent is, by definition, indispensable. See Powell, *Stare Decisis and Judicial Restraint*, 1991 *Journal of Supreme Court History* 13, 16. At the other extreme, a different necessity would make itself felt if a prior judicial ruling should come to be seen so clearly as error that its enforcement was for that very reason doomed.

Even when the decision to overrule a prior case is not, as in the rare, latter instance, virtually foreordained, it is common wisdom that the rule of *stare decisis* is not an "inexorable command," and certainly it is not such in every constitutional case (citations omitted). Rather, when this Court reexamines a prior holding, its judgment is customarily informed by a series of prudential and pragmatic considerations designed to test the consistency of overruling a prior decision with the ideal of the rule of law, and to gauge the respective costs of reaffirming and overruling a prior case. Thus, for example, we may ask whether the rule has proven to be intolerable simply in defying practical workability, *Swift & Co., v. Wickham*, 382 U.S. 111, 116, 86 S.Ct. 258, 261, 15 L.Ed.2d 194 (1965); whether the rule is subject to a kind of reliance that would lend a special hardship to the consequences of overruling and add inequity to the cost of repudiation, e.g., *United States v. Title Ins. & Trust Co.*, 265 U.S. 472, 486, 44 S.Ct. 621, 623, 68 L.Ed. 1110 (1924); whether related principles of law have so far developed as to have left the old rule no more than a remnant of abandoned doctrine, see *Patterson v. McLeone Credit Union*, 491 U.S. 164, 173-174, 109 S.Ct. 2363, 2370-2371, 105 L.Ed.2d 132 (1989); or whether facts have so changed, or come to be seen so differently, as to have robbed the old rule of significant application or justification, e.g., *Burnet*, *supra*, 285 U.S., at 412, 52 S.Ct., at 449 (Brandeis, J., dissenting).

So in this case we may enquire whether *Roe*'s central rule has been found unworkable; whether the rule's limitation on state power could be removed without serious inequity to those who have relied upon it or significant damage to the stability of the society governed by it; whether the law's growth in the intervening years has left *Roe*'s central rule a doctrinal anachronism discounted by society; and whether *Roe*'s premises of fact have so far changed in the ensuing two decades as to render its central holding somehow irrelevant or unjustifiable in dealing with the issue it addressed.

#### 1

Although *Roe* has engendered opposition, it has in no sense proven "unworkable," see *Garcia v. San Antonio Metropolitan Transit Authority*, 469 U.S. 528, 546, 105 S.Ct. 1005, 1015, 83 L.Ed.2d 1016 (1985), representing as it does a simple limitation beyond which a state law is unenforceable. While *Roe* has, of course, required judicial assessment of state laws affecting the exercise of the choice guaranteed against government infringement, and although the need for such review will remain as a consequence of today's decision, the required determinations fall within judicial competence.

#### 2

The inquiry into reliance counts the cost of a rule's repudiation as it would fall on those who have relied reasonably on the rule's continued application. Since the classic case for weighing reliance heavily in favor of following the earlier rule occurs in the commercial context, see *Payne v. Tennessee*, supra, 501 U.S., at 828, 111 S.Ct., at 2609-2610, where advance planning of great precision is most obviously a necessity, it is no cause for surprise that some would find no reliance worthy of consideration in support of *Roe*.

While neither respondents nor their *amici* in so many words deny that the abortion right invites some reliance prior to its actual exercise, one can readily imagine an argument stressing the dissimilarity of this case to one involving property or contract. Abortion is customarily chosen as an unplanned response to the consequence of unplanned activity or to the failure of conventional birth control, and except on the assumption that no intercourse would have occurred but for *Roe*'s holding, such behavior may appear to justify no reliance claim. Even if reliance could be claimed on that unrealistic assumption, the argument might run, any reliance interest would be *de minimis*. This argument would be premised on the hypothesis that reproductive planning could take virtually immediate account of any sudden restoration of state authority to ban abortions.

To eliminate the issue of reliance that easily, however, one would need to limit cognizable reliance to specific instances of sexual activity. But to do this would be simply to refuse to face the fact that for two decades of economic and social developments, people have organized intimate relationships and made choices that define their views of themselves and their places in society, in reliance on the availability of abortion in the event that contraception should fail. The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives. See, e.g., R. Petchesky, *Abortion and Woman's Choice* 109, 133, n. 7 (rev. ed. 1990). The Constitution serves human values, and while the effect of reliance on *Roe* cannot be exactly measured, neither can the certain cost of overruling *Roe* for people who have ordered their thinking and living around that case be dismissed.

3

No evolution of legal principle has left *Roe*'s doctrinal footings weaker than they were in 1973. No development of constitutional law since the case was decided has implicitly or explicitly left *Roe* behind as a mere survivor of obsolete constitutional thinking.

It will be recognized, of course, that *Roe* stands at an intersection of two lines of decisions, but in whichever doctrinal category one reads the case, the result for present purposes will be the same. The *Roe* Court itself placed its holding in the succession of cases most prominently exemplified by *Griswold v. Connecticut*, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965). See *Roe*, 410 U.S., at 152-153, 93 S.Ct., at 726. When it is so seen, *Roe* is clearly in no jeopardy, since subsequent constitutional developments have neither disturbed, nor do they threaten to diminish, the scope of recognized protection accorded to the liberty relating to intimate relationships, the family, and decisions about whether or not to beget or bear a child (citations omitted).

*Roe*, however, may be seen not only as an exemplar of *Griswold* liberty but as a rule (whether or not mistaken) of personal autonomy and bodily integrity, with doctrinal affinity to cases recognizing limits on governmental power to mandate medical treatment or to bar its rejection. If so, our cases since *Roe* accord with *Roe*'s view that a State's interest in the protection of life falls short of justifying any plenary override of individual liberty claims (citations omitted).

Finally, one could classify *Roe* as *sui generis*. If the case is so viewed, then there clearly has been no erosion of its central determination. The original holding resting on the concurrence of seven Members of the Court in 1973 was expressly affirmed by a majority of six in 1983.

Nor will courts building upon *Roe* be likely to hand down erroneous decisions as a consequence. Even on the assumption that the central holding of *Roe* was in error, that error would go only to the strength of the state interest in fetal protection, not to the recognition afforded by the Constitution to the woman's liberty. The latter aspect of the decision fits comfortably within the framework of the Court's prior decisions (citations omitted).

The soundness of this prong of the *Roe* analysis is apparent from a consideration of the alternative. If indeed the woman's interest in deciding whether to bear and beget a child had not been recognized as in *Roe*, the State might as readily restrict a woman's right to choose to carry a pregnancy to term as to terminate it, to further asserted state interests in population control, or eugenics, for example. Yet *Roe* has been sensibly relied upon to counter any such suggestions. In any event, because *Roe*'s scope is confined by the fact of its concern with post-conception potential life, a concern otherwise likely to be implicated only by some forms of contraception protected independently under *Griswold* and later cases, any error in *Roe* is unlikely to have serious ramifications in future cases.

4

We have seen how time has overtaken some of *Roe*'s factual assumptions: advances in maternal health care allow for abortions safe to the mother later in pregnancy than was true in 1973, and advances in neonatal care have advanced viability to a point somewhat earlier. But these facts go only to the scheme of time limits on the realization of competing interests, and the divergences from the factual premises of 1973 have no bearing on the validity of *Roe*'s central holding, that viability marks the earliest point at which the State's interest in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions. The soundness or unsoundness of that constitutional judgment in no sense turns on whether viability occurs at approximately 28 weeks, as was usual at the time of *Roe*, at 23 to 24 weeks, as it sometimes does today, or at some moment even slightly earlier in pregnancy, as it may if fetal respiratory capacity can somehow be enhanced in the future. Whenever it may occur, the attainment of viability may continue to serve as the critical fact, just as it has done since *Roe* was decided; which is to say that no change in *Roe*'s factual underpinning has left its central holding obsolete, and none supports an argument for overruling it.

5

The sum of the precedential enquiry to this point shows *Roe*'s underpinnings unweakened in any way affecting its central holding. While it has engendered disapproval, it has not been unworkable. An entire generation has come of age free to assume *Roe*'s concept of liberty in defining the capacity of women to act in society, and to make reproductive decisions; no erosion of principle going to liberty or personal autonomy has left *Roe*'s central holding a doctrinal remnant; *Roe* portends no developments at odds with other precedent for the analysis of personal liberty; and no changes of fact have rendered viability more or less appropriate as the point at which the balance of interests tips. Within the bounds of normal *stare decisis* analysis, then, and subject to the considerations on which it customarily turns, the stronger argument is for affirming *Roe*'s central holding, with whatever degree of personal reluctance any of us may have, not for overruling it.



The Court's duty in the present cases 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.

#### IV

From what we have said so far it follows that it is a constitutional liberty of the woman to have some freedom to terminate her pregnancy. We conclude that the basic decision in *Roe* was based on a constitutional analysis which we cannot now repudiate. The woman's liberty is not so unlimited, however, that from the outset the State cannot show its concern for the life of the unborn, and at a later point in fetal development the State's interest in life has sufficient force so that the right of the woman to terminate the pregnancy can be restricted.

That brings us, of course, to the point where much criticism has been directed at *Roe*, a criticism that always inheres when the Court draws a specific rule from what in the Constitution is but a general standard. We conclude, however, that the urgent claims of the woman to retain the ultimate control over her destiny and her body, claims implicit in the meaning of liberty, require us to perform that function. Liberty must not be extinguished for want of a line that is clear. And it falls to us to give some real substance to the woman's liberty to determine whether to carry her pregnancy to full term.

We conclude the line should be drawn at viability, so that before that time the woman has a right to choose to terminate her pregnancy. We adhere to this principle for two reasons. First, as we have said, is the doctrine of *stare decisis*. Any judicial act of line-drawing may seem somewhat arbitrary, but *Roe* was a reasoned statement, elaborated with great care. We have twice reaffirmed it in the face of great opposition. Although we must overrule those parts of *Thornburgh* and *Akron I* which, in our view, are inconsistent with *Roe*'s statement that the State has a legitimate interest in promoting the life or potential life of the unborn, see *infra*, at 2823–2824, the central premise of those cases represents an unbroken commitment by this Court to the essential holding of *Roe*. It is that premise which we reaffirm today.

The second reason is that the concept of viability, as we noted in *Roe*, 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. See *Roe v. Wade*, 410 US., at 163, 93 S.Ct., at 731. Consistent with other constitutional norms, legislatures may draw lines which appear arbitrary without the necessity of offering a justification. But courts may not. We must justify the lines we draw. And there is no line other than viability which is more workable. To be sure, as we have said, there may be some medical developments that affect the precise point of viability, see *supra*, at 2811, but this is an imprecision within tolerable limits given that the medical community and all those who must apply its discoveries will continue to explore the matter. The viability line also has, as a practical matter, an element of fairness. In some broad sense it might be said that a woman who fails to act before viability has consented to the State's intervention on behalf of the developing child.

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.

On the other side of the equation is the interest of the State in the protection of potential life. The *Roe* Court recognized the State's "important and legitimate interest in protecting the potentiality of human life." *Roe*, *supra*, at 162, 93 S.Ct., at 731. The weight to be given this state interest, not the strength of the woman's interest, was the difficult question faced in *Roe*. We do not need to say whether each of us, had we been Members of the Court when the valuation of the state interest came before it as an original matter, would have concluded, as the *Roe* Court did, that its weight is insufficient to justify a ban on abortions prior to viability even when it is subject to certain exceptions. The matter is not before us in the first instance, and coming as it does after nearly 20 years of litigation in *Roe*'s wake we are satisfied that the immediate question is not the soundness of *Roe*'s resolution of the issue, but the precedential force that must be accorded to its holding. And we have concluded that the essential holding of *Roe* should be reaffirmed.

Yet it must be remembered that *Roe v. Wade* speaks with clarity in establishing not only the woman's liberty but also the State's "important and legitimate interest in potential life." *Roe*, *supra*, at 163, 93 S.Ct., at 731. That portion of the decision in *Roe* has been given too little acknowledgment and implementation by the Court in its subsequent cases. Those cases decided that any regulation touching upon the abortion decision must survive strict scrutiny, to be sustained only if drawn in narrow terms to further a compelling state interest. See, e.g., *Akron I*, *supra*, 462 U.S., at 427, 103 S.Ct., at 2491. Not all of the cases decided under that formulation can be reconciled with the holding in *Roe* itself that the State has legitimate interests in the health of the woman and in protecting the potential life within her. In resolving this tension, we choose to rely upon *Roe*, as against the later cases.

*Roe* established a trimester framework to govern abortion regulations. Under this elaborate but rigid construct, almost no regulation at all is permitted during the first trimester of pregnancy; regulations designed to protect the woman's health, but not to further the State's interest in potential life, are permitted during the second trimester; and during the third trimester, when the fetus is viable, prohibitions are permitted provided the life or health of the mother is not at stake. *Roe*, *supra*, 410 U.S., at 163-166, 93 S.Ct., at 731-733. Most of our cases since *Roe* have involved the application of rules derived from the trimester framework. See, e.g., *Thornburgh v. American College of Obstetricians and Gynecologists*, *supra*; *Akron I*, *supra*.

The trimester framework no doubt was erected to ensure that the woman's right to choose not become so subordinate to the State's interest in promoting fetal life that her choice exists in theory but not in fact. We do not agree, however, that the trimester approach is necessary to accomplish this objective. A framework of this rigidity was unnecessary and in its later interpretation sometimes contradicted the State's permissible exercise of its powers.

Though the woman has a right to choose to terminate or continue her pregnancy before viability, it does not at all follow that the State is prohibited from taking steps to ensure that this choice is thoughtful and informed. Even in the earliest stages of pregnancy, the State may enact rules and regulations designed to encourage her to know that there are philosophic and social arguments of great weight that can be brought to bear in favor of continuing the pregnancy to full term and that there are procedures and institutions to allow adoption of unwanted children as well as a certain degree of state assistance if the mother chooses to raise the child herself. "[T]he Constitution does not forbid a State or city, pursuant to democratic processes, from expressing a preference for normal childbirth." *Webster v. Reproductive Health Services*, 492 U.S., at 511, 109 S.Ct., at 3053 (opinion of the Court)

(quoting). It follows that States are free to enact laws to provide a reasonable framework for a woman to make a decision that has such profound and lasting meaning. This, too, we find consistent with *Roe*'s central premises, and indeed the inevitable consequence of our holding that the State has an interest in protecting the life of the unborn.

We reject the trimester framework, which we do not consider to be part of the essential holding of *Roe*. Measures aimed at ensuring that a woman's choice contemplates the consequences for the fetus do not necessarily interfere with the right recognized in *Roe*, although those measures have been found to be inconsistent with the rigid trimester framework announced in that case. A logical reading of the central holding in *Roe* itself, and a necessary reconciliation of the liberty of the woman and the interest of the State in promoting prenatal life, require, in our view, that we abandon the trimester framework as a rigid prohibition on all previability regulation aimed at the protection of fetal life. The trimester framework suffers from these basic flaws: in its formulation it misconceives the nature of the pregnant woman's interest; and in practice it undervalues the State's interest in potential life, as recognized in *Roe*.

The fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it. Only where state regulation imposes an undue burden on a woman's ability to make this decision does the power of the State reach into the heart of the liberty protected by the Due Process Clause (citations omitted). For the most part, the Court's early abortion cases adhered to this view. *Maher v. Roe*, 432 U.S. 464, 473-474, 97 S.Ct. 2376, 2382, 53 L.Ed.2d 484 (1977), the Court explained: "Roe did not declare an unqualified 'constitutional right to an abortion,' as the District Court seemed to think. Rather, the right protects the woman from unduly burdensome interference with her freedom to decide whether to terminate her pregnancy." ("[T]he same test must be applied to state regulations that burden an individual's right to decide to prevent conception or terminate pregnancy by substantially limiting access to the means of effectuating that decision as is applied to state statutes that prohibit the decision entirely").

These considerations of the nature of the abortion right illustrate that it is an overstatement to describe it as a right to decide whether to have an abortion "without interference from the State." *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 61, 96 S.Ct. 2831, 2837, 49 L.Ed.2d 788 (1976) All abortion regulations interfere to some degree with a woman's ability to decide whether to terminate her pregnancy. It is, as a consequence, not surprising that despite the protestations contained in the original *Roe* opinion to the effect that the Court was not recognizing an absolute right, 410 U.S., at 154-155, 93 S.Ct., at 727, the Court's experience applying the trimester framework has led to the striking down of some abortion regulations which in no real sense deprived women of the ultimate decision. Those decisions went too far because the right recognized by *Roe* is a right "to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." *Eisenstadt v. Baird*, 405 U.S., at 453, 92 S.Ct., at 1038. Not all governmental intrusion is of necessity unwarranted; and that brings us to the other basic flaw in the trimester framework: even in *Roe*'s terms, in practice it undervalues the State's interest in the potential life within the woman.

*Roe v. Wade* was express in its recognition of the State's "important and legitimate interest[s] in preserving and protecting the health of the pregnant woman [and] in protecting the potentiality of human life." 410 U.S., at 162, 93 S.Ct., at 731. The trimester framework, however, does not fulfill *Roe*'s own promise that the State has an interest in protecting fetal life or potential life. *Roe* began the contradiction by using the trimester framework to forbid any regulation of abortion designed to

advance that interest before viability. *Id.*, at 162, 93 S.Ct., at 731. Before viability, *Roe* and subsequent cases treat all governmental attempts to influence a woman's decision on behalf of the potential life within her as unwarranted. This treatment is, in our judgment, incompatible with the recognition that there is a substantial state interest in potential life throughout pregnancy.

The very notion that the State has a substantial interest in potential life leads to the conclusion that not all regulations must be deemed unwarranted. Not all burdens on the right to decide whether to terminate a pregnancy will be undue. In our view, the undue burden standard is the appropriate means of reconciling the State's interest with the woman's constitutionally protected liberty. The concept of an undue burden has been utilized by the Court as well as individual Members of the Court, including two of us, in ways that could be considered inconsistent (citations omitted). Because we set forth a standard of general application to which we intend to adhere, it is important to clarify what is meant by an undue burden.

A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus. A statute with this purpose is invalid because the means chosen by the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it. And a statute which, while furthering the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends. Understood another way, we answer the question, left open in previous opinions discussing the undue burden formulation, whether a law designed to further the State's interest in fetal life which imposes an undue burden on the woman's decision before fetal viability could be constitutional. The answer is no.

Some guiding principles should emerge. What is at stake is the woman's right to make the ultimate decision, not a right to be insulated from all others in doing so. Regulations which do no more than create a structural mechanism by which the State, or the parent or guardian of a minor, may express profound respect for the life of the unborn are permitted, if they are not a substantial obstacle to the woman's exercise of the right to choose. See *infra*, at 2832 (addressing Pennsylvania's parental consent requirement). Unless it has that effect on her right of choice, a state measure designed to persuade her to choose childbirth over abortion will be upheld if reasonably related to that goal. Regulations designed to foster the health of a woman seeking an abortion are valid if they do not constitute an undue burden.

## V

The Court of Appeals applied what it believed to be the undue burden standard and upheld each of the provisions except for the husband notification requirement. We agree generally with this conclusion, but refine the undue burden analysis in accordance with the principles articulated above.

## B

We next consider the informed consent requirement.<sup>18</sup> Pa. Cons. Stat. s 3205 (1990). Except in a medical emergency, the statute requires that at least 24 hours before performing an abortion a physician inform the woman of the nature of the procedure, the health risks of the abortion and of childbirth, and the "probable gestational age of the unborn child." The physician or a qualified nonphysician must inform the woman of the availability of printed materials published by the State describing the fetus and providing information about medical assistance for childbirth, information about child support

from the father, and a list of agencies which provide adoption and other services as alternatives to abortion. An abortion may not be performed unless the woman certifies in writing that she has been informed of the availability of these printed materials and has been provided them if she chooses to view them.

Our prior decisions establish that as with any medical procedure, the State may require a woman to give her written informed consent to an abortion. See *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S., at 67, 96 S.Ct., at 2840. In this respect, the statute is unexceptional. Petitioners challenge the statute's definition of informed consent because it includes the provision of specific information by the doctor and the mandatory 24-hour waiting period. The conclusions reached by a majority of the Justices in the separate opinions filed today and the undue burden standard adopted in this opinion require us to overrule in part some of the Court's past decisions, decisions driven by the trimester framework's prohibition of all previability regulations designed to further the State's interest in fetal life.

We also see no reason why the State may not require doctors to inform a woman seeking an abortion of the availability of materials relating to the consequences to the fetus, even when those consequences have no direct relation to her health. An example illustrates the point. We would think it constitutional for the State to require that in order for there to be informed consent to a kidney transplant operation the recipient must be supplied with information about risks to the donor as well as risks to himself or herself. A requirement that the physician make available information similar to that mandated by the statute here was described in *Thornburgh* as "an outright attempt to wedge the Commonwealth's message discouraging abortion into the privacy of the informed-consent dialogue between the woman and her physician." We conclude, however, that informed choice need not be defined in such narrow terms that all considerations of the effect on the fetus are made irrelevant. As we have made clear, we depart from the holdings of *Akron I* and *Thornburgh* to the extent that we permit a State to further its legitimate goal of protecting the life of the unborn by enacting legislation aimed at ensuring a decision that is mature and informed, even when in so doing the State expresses a preference for childbirth over abortion. In short, requiring that the woman be informed of the availability of information relating to fetal development and the assistance available should she decide to carry the pregnancy to full term is a reasonable measure to ensure an informed choice, one which might cause the woman to choose childbirth over abortion. This requirement cannot be considered a substantial obstacle to obtaining an abortion, and, it follows, there is no undue burden.

Whatever constitutional status the doctor-patient relation may have as a general matter, in the present context it is derivative of the woman's position. The doctor-patient relation does not underlie or override the two more general rights under which the abortion right is justified: the right to make family decisions and the right to physical autonomy. On its own, the doctor-patient relation here is entitled to the same solicitude it receives in other contexts. Thus, a requirement that a doctor give a woman certain information as part of obtaining her consent to an abortion is, for constitutional purposes, no different from a requirement that a doctor give certain specific information about any medical procedure.

All that is left of petitioners' argument is an asserted First Amendment right of a physician not to provide information about the risks of abortion, and childbirth, in a manner mandated by the State. To be sure, the physician's First Amendment rights not to speak are implicated, see *Wooley v. Maynard*, 230 U.S. 705, 97 S.Ct. 1428, 51 L.Ed.2d 752 (1977), but only as part of the practice of medicine, subject to reasonable licensing and regulation by the State. We see no constitutional infirmity in the requirement that the physician provide the information mandated by the State here.

The Pennsylvania statute also requires us to reconsider the holding in Akron I that the State may not require that a physician, as opposed to a qualified assistant, provide information relevant to a woman's informed consent. Since there is no evidence on this record that requiring a doctor to give the information as provided by the statute would amount in practical terms to a substantial obstacle to a woman seeking an abortion, we conclude that it is not an undue burden. Our cases reflect the fact that the Constitution gives the States broad latitude to decide that particular functions may be performed only by licensed professionals, even if an objective assessment might suggest that those same tasks could be performed by others. See *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483, 75 S.Ct. 461, 99 L.Ed. 563 (1955). Thus, we uphold the provision as a reasonable means to ensure that the woman's consent is informed.

Our analysis of Pennsylvania's 24-hour waiting period between the provision of the information deemed necessary to informed consent and the performance of an abortion under the undue burden standard requires us to reconsider the premise behind the decision in Akron I invalidating a parallel requirement. In Akron I we said: "Nor are we convinced that the State's legitimate concern that the woman's decision be informed is reasonably served by requiring a 24-hour delay as a matter of course." We consider that conclusion to be wrong. The idea that important decisions will be more informed and deliberate if they follow some period of reflection does not strike us as unreasonable, particularly where the statute directs that important information become part of the background of the decision. The statute, as construed by the Court of Appeals, permits avoidance of the waiting period in the event of a medical emergency and the record evidence shows that in the vast majority of cases, a 24-hour delay does not create any appreciable health risk. In theory, at least, the waiting period is a reasonable measure to implement the State's interest in protecting the life of the unborn, a measure that does not amount to an undue burden.

Whether the mandatory 24-hour waiting period is nonetheless invalid because in practice it is a substantial obstacle to a woman's choice to terminate her pregnancy is a closer question. The findings of fact by the District Court indicate that because of the distances many women must travel to reach an abortion provider, the practical effect will often be a delay of much more than a day because the waiting period requires that a woman seeking an abortion make at least two visits to the doctor. The District Court also found that in many instances this will increase the exposure of women seeking abortions to "the harassment and hostility of anti-abortion protestors demonstrating outside a clinic." As a result, the District Court found that for those women who have the fewest financial resources, those who must travel long distances, and those who have difficulty explaining their whereabouts to husbands, employers, or others, the 24-hour waiting period will be "particularly burdensome."

These findings are troubling in some respects, but they do not demonstrate that the waiting period constitutes an undue burden. We do not doubt that, as the District Court held, the waiting period has the effect of "increasing the cost and risk of delay of abortions," but the District Court did not conclude that the increased costs and potential delays amount to substantial obstacles. Rather, applying the trimester framework's strict prohibition of all regulation designed to promote the State's interest in potential life before viability, the District Court concluded that the waiting period does not further the state "interest in maternal health" and "infringes the physician's discretion to exercise sound medical judgment." Yet, as we have stated, under the undue burden standard a State is permitted to enact persuasive measures which favor childbirth over abortion, even if those measures do not further a health interest. And while the waiting period does limit a physician's discretion, that is not, standing alone, a reason to invalidate it. In light of the construction given the statute's definition of medical emergency by the Court of Appeals, and the District Court's findings, we cannot say that the waiting period imposes a real health risk.

We also disagree with the District Court’s conclusion that the “particularly burdensome” effects of the waiting period on some women require its invalidation. A particular burden is not of necessity a substantial obstacle. Whether a burden falls on a particular group is a distinct inquiry from whether it is a substantial obstacle even as to the women in that group. And the District Court did not conclude that the waiting period is such an obstacle even for the women who are most burdened by it. Hence, on the record before us, and in the context of this facial challenge, we are not convinced that the 24-hour waiting period constitutes an undue burden.

We are left with the argument that the various aspects of the informed consent requirement are unconstitutional because they place barriers in the way of abortion on demand. Even the broadest reading of *Roe*, however, has not suggested that there is a constitutional right to abortion on demand. See, e.g., *Doe v. Bolton*, 410 U.S., at 189, 93 S.Ct., at 746. Rather, the right protected by *Roe* is a right to decide to terminate a pregnancy free of undue interference by the State. Because the informed consent requirement facilitates the wise exercise of that right, it cannot be classified as an interference with the right *Roe* protects. The informed consent requirement is not an undue burden on that right.

### C

Section 3209 of Pennsylvania’s abortion law provides, except in cases of medical emergency, that no physician shall perform an abortion on a married woman without receiving a signed statement from the woman that she has notified her spouse that she is about to undergo an abortion. The woman has the option of providing an alternative signed statement certifying that her husband is not the man who impregnated her; that her husband could not be located; that the pregnancy is the result of spousal sexual assault which she has reported; or that the woman believes that notifying her husband will cause him or someone else to inflict bodily injury upon her. A physician who performs an abortion on a married woman without receiving the appropriate signed statement will have his or her license revoked, and is liable to the husband for damages.

The District Court heard the testimony of numerous expert witnesses, and made detailed findings of fact regarding the effect of this statute.

These findings are supported by studies of domestic violence. The American Medical Association (AMA) has published a summary of the recent research in this field, which indicates that in an average 12-month period in this country, approximately two million women are the victims of severe assaults by their male partners. In a 1985 survey, women reported that nearly one of every eight husbands had assaulted their wives during the past year. The AMA views these figures as “marked underestimates,” because the nature of these incidents discourages women from reporting them, and because surveys typically exclude the very poor, those who do not speak English well, and women who are homeless or in institutions or hospitals when the survey is conducted. According to the AMA, “[r]esearchers on family violence agree that the true incidence of partner violence is probably *double* the above estimates; or four million severely assaulted women per year. Studies on prevalence suggest that from one-fifth to one-third of all women will be physically assaulted by a partner or ex-partner during their lifetime.” AMA Council on Scientific Affairs, *Violence Against Women* 7 (1991) (emphasis in original). Thus on an average day in the United States, nearly 11,000 women are severely assaulted by their male partners. Many of these incidents involve sexual assault. *Id.*, at 3–4; Shields & Hanneke, *Battered Wives’ Reactions to Marital Rape*, in *The Dark Side of Families: Current Family Violence Research* 131, 144 (D. Finkelhor, R. Gelles, G. Hataling, & M. Straus eds. 1983). In families where wifebeating takes place, moreover, child abuse is often present as well. *Violence Against Women*, *supra*, at 12.

Other studies fill in the rest of this troubling picture. Physical violence is only the most visible form of abuse. Psychological abuse, particularly forced social and economic isolation of women, is also common. L. Walker, *The Battered Woman Syndrome* 27–28 (1984). Many victims of domestic violence remain with their abusers, perhaps because they perceive no superior alternative. Herbert, Silver, & Ellard, *Coping with an Abusive Relationship: I. How and Why Do Women Stay?*, 53 *J. Marriage & the Family* 311 (1991). Many abused women who find temporary refuge in shelters return to their husbands, in large part because they have no other source of income. Aguirre, *Why Do They Return? Abused Wives in Shelters*, 30 *J.Nat.Assn. of Social Workers* 350, 352 (1985). Returning to one's abuser can be dangerous. Recent Federal Bureau of Investigation statistics disclose that 8.8 percent of all homicide victims in the United States are killed by their spouses. Mercy & Saltzman, *Fatal Violence Among Spouses in the United States, 1976–85*, 79 *Am.J.Public Health* 595 (1989). Thirty percent of female homicide victims are killed by their male partners. *Domestic Violence: Terrorism in the Home*, Hearing before the Subcommittee on Children, Family, Drugs and Alcoholism of the Senate Committee on Labor and Human Resources, 101st Cong., 2d Sess., 3 (1990).

The limited research that has been conducted with respect to notifying one's husband about an abortion, although involving samples too small to be representative, also supports the District Court's findings of fact. The vast majority of women notify their male partners of their decision to obtain an abortion. In many cases in which married women do not notify their husbands, the pregnancy is the result of an extramarital affair. Where the husband is the father, the primary reason women do not notify their husbands is that the husband and wife are experiencing marital difficulties, often accompanied by incidents of violence. Ryan & Plutzer, *When Married Women Have Abortions: Spousal Notification and Marital Interaction*, 51 *J. Marriage & the Family* 41, 44 (1989).

This information and the District Court's findings reinforce what common sense would suggest. In well-functioning marriages, spouses discuss important intimate decisions such as whether to bear a child. But there are millions of women in this country who are the victims of regular physical and psychological abuse at the hands of their husbands. Should these women become pregnant, they may have very good reasons for not wishing to inform their husbands of their decision to obtain an abortion. Many may have justifiable fears of physical abuse, but may be no less fearful of the consequences of reporting prior abuse to the Commonwealth of Pennsylvania. Many may have a reasonable fear that notifying their husbands will provoke further instances of child abuse; these women are not exempt from § 3209's notification requirement. Many may fear devastating forms of psychological abuse from their husbands, including verbal harassment, threats of future violence, the destruction of possessions, physical confinement to the home, the withdrawal of financial support, or the disclosure of the abortion to family and friends. These methods of psychological abuse may act as even more of a deterrent to notification than the possibility of physical violence, but women who are the victims of the abuse are not exempt from § 3209's notification requirement. And many women who are pregnant as a result of sexual assaults by their husbands will be unable to avail themselves of the exception for spousal sexual assault, § 3209(b)(3), because the exception requires that the woman have notified law enforcement authorities within 90 days of the assault, and her husband will be notified of her report once an investigation begins, § 3128(c). If anything in this field is certain, it is that victims of spousal sexual assault are extremely reluctant to report the abuse to the government; hence, a great many spousal rape victims will not be exempt from the notification requirement imposed by § 3209.

The spousal notification requirement is thus likely to prevent a significant number of women from obtaining an abortion. It does not merely make abortions a little more difficult or expensive to obtain; for many women, it will impose a substantial obstacle. We must not blind ourselves to the fact that the



significant number of women who fear for their safety and the safety of their children are likely to be deterred from procuring an abortion as surely as if the Commonwealth had outlawed abortion in all cases.

This conclusion is in no way inconsistent with our decisions upholding parental notification or consent requirements (citations omitted). Those enactments, and our judgment that they are constitutional, are based on the quite reasonable assumption that minors will benefit from consultation with their parents and that children will often not realize that their parents have their best interests at heart. We cannot adopt a parallel assumption about adult women.

We recognize that a husband has a “deep and proper concern and interest in his wife’s pregnancy and in the growth and development of the fetus she is carrying.” Danforth, *supra*, at 69, 96 S.Ct., at 2841. With regard to the children he has fathered and raised, the Court has recognized his “cognizable and substantial” interest in their custody (citations omitted). If these cases concerned a State’s ability to require the mother to notify the father before taking some action with respect to a living child raised by both, therefore, it would be reasonable to conclude as a general matter that the father’s interest in the welfare of the child and the mother’s interest are equal.

Before birth, however, the issue takes on a very different cast. It is an inescapable biological fact that state regulation with respect to the child a woman is carrying will have a far greater impact on the mother’s liberty than on the father’s. The effect of state regulation on a woman’s protected liberty is doubly deserving of scrutiny in such a case, as the State has touched not only upon the private sphere of the family but upon the very bodily integrity of the pregnant woman. The Court has held that “when the wife and the husband disagree on this decision, the view of only one of the two marriage partners can prevail. Inasmuch as it is the woman who physically bears the child and who is the more directly and immediately affected by the pregnancy, as between the two, the balance weighs in her favor.” Danforth, *supra*, 428 U.S., at 71, 96 S.Ct., at 2842. This conclusion rests upon the basic nature of marriage and the nature of our Constitution: “[T]he marital couple is not an independent entity with a mind and heart of its own, but an association of two individuals each with a separate intellectual and emotional makeup. If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.” *Eisenstadt v. Baird*, 405 U.S. at 453, 92 S.Ct., at 1038 (emphasis in original). The Constitution protects individuals, men and women alike, from unjustified state interference, even when that interference is enacted into law for the benefit of their spouses.

Section 3209 embodies a view of marriage consonant with the common-law status of married women but repugnant to our present understanding of marriage and of the nature of the rights secured by the Constitution. Women do not lose their constitutionally protected liberty when they marry. The Constitution protects all individuals, male or female, married or unmarried, from the abuse of governmental power, even where that power is employed for the supposed benefit of a member of the individual’s family. These considerations confirm our conclusion that § 3209 is invalid.

## D

We next consider the parental consent provision. Except in a medical emergency, an unemancipated young woman under 18 may not obtain an abortion unless she and one of her parents (or guardian) provides informed consent as defined above. If neither a parent nor a guardian provides consent, a

court may authorize the performance of an abortion upon a determination that the young woman is mature and capable of giving informed consent and has in fact given her informed consent, or that an abortion would be in her best interests.

We have been over most of this ground before. Our cases establish, and we reaffirm today, that a State may require a minor seeking an abortion to obtain the consent of a parent or guardian, provided that there is an adequate judicial bypass procedure (citations omitted). Under these precedents, in our view, the one-parent consent requirement and judicial bypass procedure are constitutional.

The only argument made by petitioners respecting this provision and to which our prior decisions do not speak is the contention that the parental consent requirement is invalid because it requires informed parental consent. For the most part, petitioners' argument is a reprise of their argument with respect to the informed consent requirement in general, and we reject it for the reasons given above. Indeed, some of the provisions regarding informed consent have particular force with respect to minors: the waiting period, for example, may provide the parent or parents of a pregnant young woman the opportunity to consult with her in private, and to discuss the consequences of her decision in the context of the values and moral or religious principles of their family. See *Hodgson*, supra, 497 U.S., at 448-449, 110 S.Ct., at 2944 (opinion of STEVENS, J.).

The judgment in No. 91-902 is affirmed. The judgment in No. 91-744 is affirmed in part and reversed in part, and the case is remanded for proceedings consistent with this opinion, including consideration of the question of severability.

*It is so ordered.*

### ***Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292**

JUSTICE BEYER delivered the opinion of the Court.

In *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 878, 112 S.Ct. 2791, L.Ed.2d 674 (1992), a plurality of the Court concluded that there “exists” an “undue burden” on a woman’s right to decide to have an abortion, and consequently a provision of law is constitutionally invalid, if the “*purpose or effect*” of the provision “*is to place a substantial obstacle* in the path of a woman seeking an abortion before the fetus attains viability.” (Emphasis added.) The plurality added that “[u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right.” *Ibid*.

We must here decide whether two provisions of Texas’ House Bill 2 violate the Federal Constitution as interpreted in *Casey*. The first provision, which we shall call the “*admitting-privileges requirement*,” says that

“[a] physician performing or inducing an abortion must, on the date the abortion is performed or induced, have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced.”

This provision amended Texas law that had previously required an abortion facility to maintain a written protocol “for managing medical emergencies and the transfer of patients requiring further emergency care to a hospital.” 38 Tex. Reg. 6546 (2013).

The second provision, which we shall call the “*surgical-center requirement*,” says that

“the minimum standards for an abortion facility must be equivalent to the minimum standards adopted under [the Texas Health and Safety Code section] for ambulatory surgical centers.”.

We conclude that neither of these provisions confers medical benefits sufficient to justify the burdens upon access that each imposes. Each places a substantial obstacle in the path of women seeking a previability abortion, each constitutes an undue burden on abortion access, *Casey*, supra, at 878, 112 S.Ct. 2791 (plurality opinion), and each violates the Federal Constitution. Amdt. 14, § 1.

## I

### A

In July 2013, the Texas Legislature enacted House Bill 2 (H.B. 2 or Act). In September (before the new law took effect), a group of Texas abortion providers filed an action in Federal District Court seeking facial invalidation of the law’s admitting-privileges provision. In late October, the District Court granted the injunction. But three days later, the Fifth Circuit vacated the injunction, thereby permitting the provision to take effect. *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 734 F.3d 406, 419 (2013).

The Fifth Circuit subsequently upheld the provision, and set forth its reasons in an opinion released late the following March. In that opinion, the Fifth Circuit pointed to evidence introduced in the District Court the previous October. It noted that Texas had offered evidence designed to show that the admitting-privileges requirement “will reduce the delay in treatment and decrease health risk for abortion patients with critical complications,” and that it would “‘screen out’ untrained or incompetent abortion providers.” *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 748 F.3d 583, 592 (2014) *Abbott*). The opinion also explained that the plaintiffs had not provided sufficient evidence “that abortion practitioners will likely be unable to comply with the privileges requirement.” *Id.*, at 598. The court said that all “of the major Texas cities, including Austin, Corpus Christi, Dallas, El Paso, Houston, and San Antonio,” would “continue to have multiple clinics where many physicians will have or obtain hospital admitting privileges.” *Ibid.* The *Abbott* plaintiffs did not file a petition for certiorari in this Court.

### B

On April 6, one week after the Fifth Circuit’s decision, petitioners, a group of abortion providers (many of whom were plaintiffs in the previous lawsuit), filed the present lawsuit in Federal District Court. They sought an injunction preventing enforcement of the admitting-privileges provision as applied to physicians at two abortion facilities, one operated by Whole Woman’s Health in McAllen and the other operated by Nova Health Systems in El Paso. They also sought an injunction prohibiting enforcement of the surgical-center provision anywhere in Texas. They claimed that the admitting-privileges provision and the surgical-center provision violated the Constitution’s Fourteenth Amendment, as interpreted in *Casey*.

The District Court subsequently received stipulations from the parties and depositions from the parties' experts. The court conducted a 4-day bench trial. It heard, among other testimony, the opinions from expert witnesses for both sides. On the basis of the stipulations, depositions, and testimony, that court reached the following conclusions:

1. Of Texas' population of more than 25 million people, "approximately 5.4 million" are "women" of "reproductive age," living within a geographical area of "nearly 280,000 square miles."
2. "In recent years, the number of abortions reported in Texas has stayed fairly consistent at approximately 15–16% of the reported pregnancy rate, for a total number of approximately 60,000–72,000 legal abortions performed annually."
3. Prior to the enactment of H.B. 2, there were more than 40 licensed abortion facilities in Texas, which "number dropped by almost half leading up to and in the wake of enforcement of the admitting-privileges requirement that went into effect in late-October 2013."
4. If the surgical-center provision were allowed to take effect, the number of abortion facilities, after September 1, 2014, would be reduced further, so that "only seven facilities and a potential eighth will exist in."
5. Abortion facilities "will remain only in Houston, Austin, San Antonio, and the Dallas/Fort Worth metropolitan region." 46 F.Supp.2d, at 681; App. 229–230. These include "one facility in Austin, two in Dallas, one in Fort Worth, two in Houston, and either one or two in San Antonio." 46 F.Supp.3d, at 680.
6. "Based on historical data pertaining to Texas's average number of abortions, and assuming perfectly equal distribution among the remaining seven or eight providers, this would result in each facility serving between 7,500 and 10,000 patients per year. Accounting for the seasonal variations in pregnancy rates and a slightly unequal distribution of patients at each clinic, it is foreseeable that over 1,200 women per month could be vying for counseling, appointments, and follow-up visits at some of these facilities."
7. The suggestion "that these seven or eight providers could meet the demand of the entire state stretches credulity."
8. "Between November 1, 2012 and May 1, 2014," that is, before and after enforcement of the admitting-privileges requirement, "the decrease in geographical distribution of abortion facilities" has meant that the number of women of reproductive age living more than 50 miles from a clinic has doubled (from 800,000 to over 1.6 million); those living more than 100 miles has increased by 150% (from 400,000 to 1 million); those living more than 150 miles has increased by more than 350% (from 86,000 to 400,000); and those living more than 200 miles has increased by about 2,800% (from 10,000 to 290,000). After September 2014, should the surgical-center requirement go into effect, the number of women of reproductive age living significant distances from an abortion provider will increase as follows: 2 million women of reproductive age will live more than 50 miles from an abortion provider; 1.3 million will live more than 100 miles from an abortion provider; 900,000 will live more than

150 miles from an abortion provider; and 750,000 more than 200 miles from an abortion provider.; App. 238–242.

9. The “two requirements erect a particularly high barrier for poor, rural, or disadvantaged women.”

10. “The great weight of evidence demonstrates that, before the act’s passage, abortion in Texas was extremely safe with particularly low rates of serious complications and virtually no deaths occurring on account of the procedure.”

11. “Abortion, as regulated by the State before the enactment of House Bill 2, has been shown to be much safer, in terms of minor and serious complications, than many common medical procedures not subject to such intense regulation and scrutiny.”

12. “Additionally, risks are not appreciably lowered for patients who undergo abortions at ambulatory surgical centers as compared to nonsurgical-center facilities.”

13. “[W]omen will not obtain better care or experience more frequent positive outcomes at an ambulatory surgical center as compared to a previously licensed facility.”

14. “[T]here are 433 licensed ambulatory surgical centers in Texas,” of which “336 are apparently either ‘grandfathered’ or enjo[y] the benefit of a waiver of some or all” of the surgical-center “requirements.”

15. The “cost of coming into compliance” with the surgical-center requirement “for existing clinics is significant,” “undisputedly approach[ing] 1 million dollars,” and “most likely exceed[ing] 1.5 million dollars,” with “[s]ome clinics” unable to “comply due to physical size limitations of their sites.” The “cost of acquiring land and constructing a new compliant clinic will likely exceed three million dollars.” *Ibid.*

On the basis of these and other related findings, the District Court determined that the surgical-center requirement “imposes an undue burden on the right of women throughout Texas to seek a previability abortion,” and that the “admitting-privileges requirement, in conjunction with the ambulatory-surgical-center requirement, imposes an undue burden on the right of women in the Rio Grande Valley, El Paso, and West Texas to seek a previability abortion.” The District Court concluded that the “two provisions” would cause “the closing of almost all abortion clinics in Texas that were operating legally in the fall of 2013,” and thereby create a constitutionally “impermissible obstacle as applied to all women seeking a previability abortion” by “restricting access to previously available legal facilities.” On August 29, 2014, the court enjoined the enforcement of the two provisions. *Ibid.*

## C

On October 2, 2014, at Texas’ request, the Court of Appeals stayed the District Court’s injunction. Within the next two weeks, this Court vacated the Court of Appeals’ stay (in substantial part) thereby leaving in effect the District Court’s injunction against enforcement of the surgical-center provision and its injunction against enforcement of the admitting-privileges requirement as applied to the McAllen and El Paso clinics. *Whole Woman’s Heath v. Lakey*, 574 U.S. \_\_\_, 135 S.Ct. 399, 190 L.Ed.2d 247 (2014). The Court of Appeals then heard Texas’ appeal.

On June 9, 2015, the Court of Appeals reversed the District Court on the merits. With minor exceptions, it found both provisions constitutional and allowed them to take effect. Because the Court of Appeals' decision rests upon alternative grounds and fact-related considerations, we set forth its basic reasoning in some detail. The Court of Appeals concluded:

- The District Court was wrong to hold the admitting-privileges requirement unconstitutional because (except for the clinics in McAllen and El Paso) the providers had not asked them to do so, and principles of res judicata barred relief.
- Because the providers could have brought their constitutional challenge to the surgical-center provision in their earlier lawsuit, principles of res judicata also barred that claim.
- In any event, a state law “regulating previability abortion is constitutional if: (1) it does not have the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus; and (2) it is reasonably related to (or designed to further) a legitimate state interest.” *Id.*, at 572.
- “[B]oth the admitting privileges requirement and” the surgical-center requirement “were rationally related to a legitimate state interest,” namely, “rais[ing] the standard and quality of care for women seeking abortions and protect[ing] the health and welfare of women seeking abortions.” *Id.*, at 584.
- “The “[p]laintiffs” failed “to proffer competent evidence contradicting the legislature’s statement of a legitimate purpose.” *Id.*, at 585.
- “[T]he district court erred by substituting its own judgment [as to the provisions’ effects] for that of the legislature, albeit in the name of the undue burden inquiry.” *Id.*, at 587.
- Holding the provisions unconstitutional on their face is improper because the plaintiffs had failed to show that either of the provisions “imposes an undue burden on a large fraction of women.” *Id.*, at 590.
- The District Court erred in finding that, if the surgical-center requirement takes effect, there will be too few abortion providers in Texas to meet the demand. That factual determination was based upon the finding of one of plaintiffs’ expert witnesses (Dr. Grossman) that abortion providers in Texas “will not be able to go from providing approximately 14,000 abortions annually, as they currently are, to providing the 60,000 to 70,000 abortions that are done each year in Texas once all” of the clinics failing to meet the surgical-center requirement “are forced to close.” *Id.*, at 589–590. But Dr. Grossman’s opinion is (in the Court of Appeals’ view) “ipse dixit;” the “record lacks any actual evidence regarding the current or future capacity of the eight clinics”; and there is no “evidence in the record that” the providers that currently meet the surgical-center requirement “are operating at full capacity or that they cannot increase capacity.” *Ibid.*

For these and related reasons, the Court of Appeals reversed the District Court’s holding that the admitting-privileges requirement is unconstitutional and its holding that the surgical-center requirement is unconstitutional. The Court of Appeals upheld in part the District Court’s more specific holding that the requirements are unconstitutional as applied to the McAllen facility and Dr. Lynn (a

doctor at that facility), but it reversed the District Court’s holding that the surgical-center requirement is unconstitutional as applied to the facility in El Paso. In respect to this last claim, the Court of Appeals said that women in El Paso wishing to have an abortion could use abortion providers in nearby New Mexico.

## II (Omitted)

## III

### *Undue Burden—Legal Standard*

We begin with the standard, as described in *Casey*. We recognize that the “State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient.” *Roe v. Wade*, 410 U.S. 113, 150, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973). But, we added, “a statute which, while furthering [a] valid state interest, has the effect of placing a substantial obstacle in the path of a woman’s choice cannot be considered a permissible means of serving its legitimate ends.” *Casey*, 505 U.S., at 877, 112 S.Ct. 2791 (plurality opinion). Moreover, “[u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right.” *Id.*, at 878, 112 S.Ct. 2791.

The Court of Appeals wrote that a state law is “constitutional if: (1) it does not have the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus; and (2) it is reasonably related to (or designed to further) a legitimate state interest.” The Court of Appeals went on to hold that “the district court erred by substituting its own judgment for that of the legislature” when it conducted its “undue burden inquiry,” in part because “medical uncertainty underlying a statute is for resolution by legislatures, not the courts” (citations omitted).

The Court of Appeals’ articulation of the relevant standard is incorrect. The first part of the Court of Appeals’ test may be read to imply that a district court should not consider the existence or nonexistence of medical benefits when considering whether a regulation of abortion constitutes an undue burden. The rule announced in *Casey*, however, requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer. See 505 U.S., at 887-898, 112 S.Ct. 2791 (opinion of the Court) (performing this balancing with respect to a spousal notification provision); *Id.*, at 899-901, 112 S.Ct. 2791 (joint opinion of O’Connor, Kennedy, and Souter, JJ.) (same balancing with respect to a parental notification provision). And the second part of the test is wrong to equate the judicial review applicable to the regulation of a constitutionally protected personal liberty with the less strict review applicable where, for example, economic legislation is at issue. See, e.g., *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483, 491, 75 S.Ct. 461, 99 L.Ed. 563 (1955). The Court of Appeals’ approach simply does not match the standard that this Court laid out in *Casey*, which asks courts to consider whether any burden imposed on abortion access is “undue.”

The statement that legislatures, and not courts, must resolve questions of medical uncertainty is also inconsistent with this Court’s case law. Instead, the Court, when determining the constitutionality of laws regulating abortion procedures, has placed considerable weight upon evidence and argument presented in judicial proceedings. In *Casey*, for example, we relied heavily on the District Court’s factual findings and the research-based submissions of *amici* in declaring a portion of the law at issue unconstitutional. 505 U.S., at 888-894, 112 S.Ct. 2791 (opinion of the Court) (discussing evidence related to the prevalence of spousal abuse in determining that a spousal notification provision erected

an undue burden to abortion access). And, in *Gonzales* the Court, while pointing out that we must review legislative “factfinding under a deferential standard,” added that we must not “place dispositive weight” on those “findings.” 550 U.S., at 165, 127 S.Ct. 1610. *Gonzales* went on to point out that the “Court retains an independent constitutional duty to review *factual findings where constitutional rights are at stake*.” *Ibid.* (emphasis added). Although there we upheld a statute regulating abortion, we did not do so solely on the basis of legislative findings explicitly set forth in the statute, noting that “evidence presented in the District Courts contradicts” some of the legislative findings. *Id.*, at 166, 127 S.Ct. 1610. In these circumstances, we said, “[u]ncritical deference to Congress’ factual findings is inappropriate.” *Ibid.*

Unlike in *Gonzales*, the relevant statute here does not set forth any legislative findings. Rather, one is left to infer that the legislature sought to further a constitutionally acceptable objective (namely, protecting women’s health). *Id.*, at 149-150, 127 S.Ct. 1610. For a district court to give significant weight to evidence in the judicial record in these circumstances is consistent with this Court’s case law. As we shall describe, the District Court did so here. It did not simply substitute its own judgment for that of the legislature. It considered the evidence in the record—including expert evidence, presented in stipulations, depositions, and testimony. It then weighed the asserted benefits against the burdens. We hold that, in so doing, the District Court applied the correct legal standard.

#### IV

##### *Undue Burden—Admitting—Privileges Requirement*

Turning to the lower courts’ evaluation of the evidence, we first consider the admitting-privileges requirement. Before the enactment of H.B. 2, doctors who provided abortions were required to “have admitting privileges *or* have a working arrangement with a physician(s) who has admitting privileges at a local hospital in order to ensure the necessary back up for medical complications.” The new law changed this requirement by requiring that a “physician performing or inducing an abortion must, on the date the abortion is performed or induced, have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced.” The District Court held that the legislative change imposed an “undue burden” on a woman’s right to have an abortion. We conclude that there is adequate legal and factual support for the District Court’s conclusion.

The purpose of the admitting-privileges requirement is to help ensure that women have easy access to a hospital should complications arise during an abortion procedure. Brief for Respondents 32–37. But the District Court found that it brought about no such health-related benefit. The court found that “[t]he great weight of evidence demonstrates that, before the act’s passage, abortion in Texas was extremely safe with particularly low rates of serious complications and virtually no deaths occurring on account of the procedure.” Thus, there was no significant health-related problem that the new law helped to cure.

The evidence upon which the court based this conclusion included, among other things:

- A collection of at least five peer-reviewed studies on abortion complications in the first trimester, showing that the highest rate of major complications—including those complications requiring hospital admission—was less than one-quarter of 1%. See App. 269–270.



- Figures in three peer-reviewed studies showing that the highest complication rate found for the much rarer second trimester abortion was less than one-half of 1% (0.45% or about 1 out of about 200). *Id.*, at 270.
- Expert testimony to the effect that complications rarely require hospital admission, much less immediate transfer to a hospital from an outpatient clinic. *Id.*, at 266–267 (citing a study of complications occurring within six weeks after 54,911 abortions that had been paid for by the fee-for-service California Medicaid Program finding that the incidence of complications was 2.1%, the incidence of complications requiring hospital admission was 0.23%, and that of the 54,911 abortion patients included in the study, only 15 required immediate transfer to the hospital on the day of the abortion).
- Expert testimony stating that “it is extremely unlikely that a patient will experience a serious complication at the clinic that requires emergent hospitalization” and “in the rare case in which [one does], the quality of care that the patient receives is not affected by whether the abortion provider has admitting privileges at the hospital.” *Id.*, at 381.
- Expert testimony stating that in respect to surgical abortion patients who do suffer complications requiring hospitalization, most of these complications occur in the days after the abortion, not on the spot. See *id.*, at 382; see also *id.*, at 267.
- Expert testimony stating that a delay before the onset of complications is also expected for medical abortions, as “abortifacient drugs take time to exert their effects, and thus the abortion itself almost always occurs after the patient has left the abortion facility.” *Id.*, at 278.
- Some experts added that, if a patient needs a hospital in the day or week following her abortion, she will likely seek medical attention at the hospital nearest her home. See, e.g., *id.*, at 153.
- We have found nothing in Texas’ record evidence that shows that, compared to prior law (which required a “working arrangement” with a doctor with admitting privileges), the new law advanced Texas’ legitimate interest in protecting women’s health.

We add that, when directly asked at oral argument whether Texas knew of a single instance in which the new requirement would have helped even one woman obtain better treatment, Texas admitted that there was no evidence in the record of such a case. See Tr. of Oral Arg. 47. This answer is consistent with the findings of the other Federal District Courts that have considered the health benefits of other States’ similar admitting-privileges laws (citations omitted).

At the same time, the record evidence indicates that the admitting-privileges requirement places a “substantial obstacle in the path of a woman’s choice.” *Casey*, 505 U.S., at 877, 112 S.Ct. 2791 (plurality opinion). The District Court found, as of the time the admitting-privileges requirement began to be enforced, the number of facilities providing abortions dropped in half, from about 40 to about 20. Eight abortion clinics closed in the months leading up to the requirement’s effective date. See App. 229–230; cf. Brief for Planned Parenthood Federation of America et al. as *Amici Curiae* 14 (noting that abortion facilities in Waco, San Angelo, and Midland no longer operate because Planned Parenthood is “unable to find local physicians in those communities with privileges who are willing to provide abortions due to the size of those communities and the hostility that abortion providers face”). Eleven more closed on the day the admitting-privileges requirement took effect. See App. 229–230; Tr. of Oral Arg. 58.

Other evidence helps to explain why the new requirement led to the closure of clinics. We read that other evidence in light of a brief filed in this Court by the Society of Hospital Medicine. That brief describes the undisputed general fact that “hospitals often condition admitting privileges on reaching a certain number of admissions per year.” Brief for Society of Hospital Medicine et al. as *Amici Curiae* 11. Returning to the District Court record, we note that, in direct testimony, the president of Nova Health Systems, implicitly relying on this general fact, pointed out that it would be difficult for doctors regularly performing abortions at the El Paso clinic to obtain admitting privileges at nearby hospitals because “[d]uring the past 10 years, over 17,000 abortion procedures were performed at the El Paso clinic [and n]ot a single one of those patients had to be transferred to a hospital for emergency treatment, much less admitted to the hospital.” App. 730. In a word, doctors would be unable to maintain admitting privileges or obtain those privileges for the future, because the fact that abortions are so safe meant that providers were unlikely to have any patients to admit.

Other *amicus* briefs filed here set forth without dispute other common prerequisites to obtaining admitting privileges that have nothing to do with ability to perform medical procedures. See Brief for Medical Staff Professionals as *Amici Curiae* 20–25 (listing, for example, requirements that an applicant has treated a high number of patients in the hospital setting in the past year, clinical data requirements, residency requirements, and other discretionary factors); see also Brief for American College of Obstetricians and Gynecologists et al. as *Amici Curiae* 16 (ACOG Brief) (“[S]ome academic hospitals will only allow medical staff membership for clinicians who also accept faculty appointments”). Again, returning to the District Court record, we note that Dr. Lynn of the McAllen clinic, a veteran obstetrics and gynecology doctor who estimates that he has delivered over 15,000 babies in his 38 years in practice was unable to get admitting privileges at any of the seven hospitals within 30 miles of his clinic. App. 390–394. He was refused admitting privileges at a nearby hospital for reasons, as the hospital wrote, “not based on clinical competence considerations.” *Id.*, at 393–394 (emphasis deleted). The admitting-privileges requirement does not serve any relevant credentialing function.

In our view, the record contains sufficient evidence that the admitting-privileges requirement led to the closure of half of Texas’ clinics, or thereabouts. Those closures meant fewer doctors, longer waiting times, and increased crowding. Record evidence also supports the finding that after the admitting-privileges provision went into effect, the “number of women of reproductive age living in a county more than 150 miles from a provider increased from approximately 86,000 to 400,000 and the number of women living in a county more than 200 miles from a provider from approximately 10,000 to 290,000.” We recognize that increased driving distances do not always constitute an “undue burden.” See *Casey*, 505 U.S., at 885–887, 112 S.Ct. 2791 (joint opinion of O’Connor, Kennedy, and Souter, JJ.). But here, those increases are but one additional burden, which, when taken together with others that the closings brought about, and when viewed in light of the virtual absence of any health benefit, lead us to conclude that the record adequately supports the District Court’s “undue burden” conclusion. Cf. *Id.*, at 895, 112 S.Ct. 2791 (opinion of the Court) (finding burden “undue” when requirement places “substantial obstacle to a woman’s choice” in “a large fraction of the cases in which” it “is relevant”).

The dissent’s only argument why these clinic closures, as well as the ones discussed in Part V, *infra*, may not have imposed an undue burden is this: Although “H.B. 2 caused the closure of *some* clinics,” *post*, at 2343 (emphasis added), other clinics may have closed for other reasons (so we should not “actually count” the burdens resulting from those closures against H.B. 2), *post*, at 2345 – 2347. But petitioners satisfied their burden to present evidence of causation by presenting direct testimony as well as plausible inferences to be drawn from the timing of the clinic closures. App. 182–183, 228–231. The District Court credited that evidence and concluded from it that H.B. 2 in fact led to the clinic

closures. The dissent’s speculation that perhaps other evidence, not presented at trial or credited by the District Court, might have shown that some clinics closed for unrelated reasons does not provide sufficient ground to disturb the District Court’s factual finding on that issue.

In the same breath, the dissent suggests that one benefit of H.B. 2’s requirements would be that they might “force unsafe facilities to shut down.” Post, at 2343. To support that assertion, the dissent points to the Kermit Gosnell scandal. Gosnell, a physician in Pennsylvania, was convicted of first-degree murder and manslaughter. He “staffed his facility with unlicensed and indifferent workers, and then let them practice medicine unsupervised” and had “[d]irty facilities; unsanitary instruments; an absence of functioning monitoring and resuscitation equipment; the use of cheap, but dangerous, drugs; illegal procedures; and inadequate emergency access for when things inevitably went wrong.” Report of Grand Jury in No. 0009901–2008 (1st Jud. Dist. Pa., Jan. 14, 2011), p. 24, online at <http://www.phila.gov/districtattorney/pdfs/grandjurywomensmedical.pdf> (as last visited June 27, 2016). Gosnell’s behavior was terribly wrong. But there is no reason to believe that an extra layer of regulation would have affected that behavior. Determined wrongdoers, already ignoring existing statutes and safety measures, are unlikely to be convinced to adopt safe practices by a new overlay of regulations. Regardless, Gosnell’s deplorable crimes could escape detection only because his facility went uninspected for more than 15 years. Id., at 20. Pre-existing Texas law already contained numerous detailed regulations covering abortion facilities, including a requirement that facilities be inspected at least annually. See *infra*, at 2314 (describing those regulations). The record contains nothing to suggest that H.B. 2 would be more effective than pre-existing Texas law at deterring wrongdoers like Gosnell from criminal behavior.

## V

### *Undue Burden—Surgical–Center Requirement*

The second challenged provision of Texas’ new law sets forth the surgical-center requirement. Prior to enactment of the new requirement, Texas law required abortion facilities to meet a host of health and safety requirements. Under those pre-existing laws, facilities were subject to annual reporting and recordkeeping requirements, see Tex. Admin. Code, tit. 25, §§ 139.4, 139.5, 139.55, 139.58; 139.4; a quality assurance program, see § 139.8; personnel policies and staffing requirements, see §§ 139.43, 139.46; physical and environmental requirements, see § 139.48; infection control standards, see § 139.49; disclosure requirements, see § 139.50; patient-rights standards, see § 139.51; and medical- and clinical-services standards, see § 139.53, including anesthesia standards, see § 139.59. These requirements are policed by random and announced inspections, at least annually, see §§ 139.23, 139.31; Tex. Health & Safety Code Ann. § 245.006(a) (West 2010), as well as administrative penalties, injunctions, civil penalties, and criminal penalties for certain violations, see Tex. Admin. Code, tit. 25, § 139.33; Tex. Health & Safety Code Ann. § 245.011 (criminal penalties for certain reporting violations).

H.B. 2 added the requirement that an “abortion facility” meet the “minimum standards or ambulatory surgical centers” under Texas law. (West Cum. Supp. 2015). The surgical-center regulations include, among other things, detailed specifications relating to the size of the nursing staff, building dimensions, and other building requirements. The nursing staff must comprise at least “an adequate number of [registered nurses] on duty to meet the following minimum staff requirements: director of the department (or designee), and supervisory and staff personnel for each service area to assure the immediate availability of [a registered nurse] for emergency care or for any patient when needed,” Tex. Admin. Code, tit. 25, § 135.15(a)(3) (2016), as well as “a second individual on duty on the premises

who is trained and currently certified in basic cardiac life support until all patients have been discharged from the facility” for facilities that provide moderate sedation, such as most abortion facilities, Tex. Admin. Code, tit. 25, § 135.15(b)(2)(A). Facilities must include a full surgical suite with an operating room that has “a clear floor area of at least 240 square feet” in which “[t]he minimum clear dimension between built-in cabinets, counters, and shelves shall be 14 feet.” § 135.52(d) (15) (A). There must be a preoperative patient holding room and a postoperative recovery suite. The former “shall be provided and arranged in a one-way traffic pattern so that patients entering from outside the surgical suite can change, gown, and move directly into the restricted corridor of the surgical suite,” § 135.52(d) (10) (A), and the latter “shall be arranged to provide a one-way traffic pattern from the restricted surgical corridor to the postoperative recovery suite, and then to the extended observation rooms or discharge,” § 135.52(d)(9)(A). Surgical centers must meet numerous other spatial requirements, see generally § 135.52, including specific corridor widths, § 135.52(e)(1)(B)(iii). Surgical centers must also have an advanced heating, ventilation, and air conditioning system, § 135.52(g)(5), and must satisfy particular piping system and plumbing requirements, § 135.52(h). Dozens of other sections list additional requirements that apply to surgical centers. See generally §§ 135.1–135.56.

There is considerable evidence in the record supporting the District Court’s findings indicating that the statutory provision requiring all abortion facilities to meet all surgical-center standards does not benefit patients and is not necessary. The District Court found that “risks are not appreciably lowered for patients who undergo abortions at ambulatory surgical centers as compared to nonsurgical-center facilities.” The court added that women “will not obtain better care or experience more frequent positive outcomes at an ambulatory surgical center as compared to a previously licensed facility.” *Ibid.* And these findings are well supported.

The record makes clear that the surgical-center requirement provides no benefit when complications arise in the context of an abortion produced through medication. That is because, in such a case, complications would almost always arise only after the patient has left the facility. See *supra*, at 2311 – 2312; App. 278. The record also contains evidence indicating that abortions taking place in an abortion facility are safe—indeed, safer than numerous procedures that take place outside hospitals and to which Texas does not apply its surgical-center requirements. See, *e.g.*, *id.*, at 223–224, 254, 275–279. The total number of deaths in Texas from abortions was five in the period from 2001 to 2012, or about one every two years (that is to say, one out of about 120,000 to 144,000 abortions). *Id.*, at 272. Nationwide, childbirth is 14 times more likely than abortion to result in death, *ibid.*, but Texas law allows a midwife to oversee childbirth in the patient’s own home. Colonoscopy, a procedure that typically takes place outside a hospital (or surgical center) setting, has a mortality rate 10 times higher than an abortion. *Id.*, at 276–277; see ACOG Brief 15 (the mortality rate for liposuction, another outpatient procedure, is 28 times higher than the mortality rate for abortion). Medical treatment after an incomplete miscarriage often involves a procedure identical to that involved in a nonmedical abortion, but it often takes place outside a hospital or surgical center. App. 254; see ACOG Brief 14 (same). And Texas partly or wholly grandfatheres (or waives in whole or in part the surgical-center requirement for) about two-thirds of the facilities to which the surgical-center standards apply. But it neither grandfatheres nor provides waivers for any of the facilities that perform abortions. See App. 184. These facts indicate that the surgical-center provision imposes “a requirement that simply is not based on differences” between abortion and other surgical procedures “that are reasonably related to” preserving women’s health, the asserted “purpos[e] of the Act in which it is found.” *Doe*, 410 U.S., at 194, 93 S.Ct. 739 (citations omitted).

Moreover, many surgical-center requirements are inappropriate as applied to surgical abortions. Requiring scrub facilities; maintaining a one-way traffic pattern through the facility; having ceiling,

wall, and floor finishes; separating soiled utility and sterilization rooms; and regulating air pressure, filtration, and humidity control can help reduce infection where doctors conduct procedures that penetrate the skin. App. 304. But abortions typically involve either the administration of medicines or procedures performed through the natural opening of the birth canal, which is itself not sterile. See *id.*, at 302–303. Nor do provisions designed to safeguard heavily sedated patients (unable to help themselves) during fire emergencies, see Tex. Admin. Code, tit. 25, § 135.41; App. 304, provide any help to abortion patients, as abortion facilities do not use general anesthesia or deep sedation, *id.*, at 304–305. Further, since the few instances in which serious complications do arise following an abortion almost always require hospitalization, not treatment at a surgical center, *id.*, at 255–256, surgical-center standards will not help in those instances either.

The upshot is that this record evidence, along with the absence of any evidence to the contrary, provides ample support for the District Court’s conclusion that “[m]any of the building standards mandated by the act and its implementing rules have such a tangential relationship to patient safety in the context of abortion as to be nearly arbitrary.” That conclusion, along with the supporting evidence, provides sufficient support for the more general conclusion that the surgical-center requirement “will not [provide] better care or more frequent positive outcomes.” *Ibid.* The record evidence thus supports the ultimate legal conclusion that the surgical-center requirement is not necessary.

At the same time, the record provides adequate evidentiary support for the District Court’s conclusion that the surgical-center requirement places a substantial obstacle in the path of women seeking an abortion. The parties stipulated that the requirement would further reduce the number of abortion facilities available to seven or eight facilities, located in Houston, Austin, San Antonio, and Dallas/Fort Worth. See App. 182–183. In the District Court’s view, the proposition that these “seven or eight providers could meet the demand of the entire State stretches credulity.” 46 F.Supp.3d, at 682. We take this statement as a finding that these few facilities could not “meet” that “demand.”

The Court of Appeals held that this finding was “clearly erroneous.” It wrote that the finding rested upon the “ipse dixit” of one expert, Dr. Grossman, and that there was no evidence that the current surgical centers (i.e., the seven or eight) are operating at full capacity or could not increase capacity. *Ibid.* Unlike the Court of Appeals, however, we hold that the record provides adequate support for the District Court’s finding.

For one thing, the record contains charts and oral testimony by Dr. Grossman, who said that, as a result of the surgical-center requirement, the number of abortions that the clinics would have to provide would rise from “14,000 abortions annually” to “60,000 to 70,000”—an increase by a factor of about five. The District Court credited Dr. Grossman as an expert witness. See 46 F.Supp.3d, at 678–679, n. 1 (finding “indicia of reliability” in Dr. Grossman’s conclusions). The Federal Rules of Evidence state that an expert may testify in the “form of an opinion” as long as that opinion rests upon “sufficient facts or data” and “reliable principles and methods.” Rule 702. In this case Dr. Grossman’s opinion rested upon his participation, along with other university researchers, in research that tracked “the number of open facilities providing abortion care in the state by requesting information from the Texas Department of State Health Services [t]hrough interviews with clinic staff[,] and review of publicly available information.” App. 227. The District Court acted within its legal authority in determining that Dr. Grossman’s testimony was admissible. See Fed. Rule Evid. 702; see also *Danbert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 589, 113 S.Ct. 2786, 125 L.Ed.2d 469 (1993) (“[U]nder the Rules the trial judge must ensure that any and all [expert] evidence admitted is not only relevant, but reliable”); 29 C. Wright & V. Gold, *Federal Practice and Procedure: Evidence* § 6266, p.

302 (2016) (“Rule 702 imposes impose[s] on the trial judge additional responsibility to determine whether that [expert] testimony is likely to promote accurate factfinding”).

For another thing, common sense suggests that, more often than not, a physical facility that satisfies a certain physical demand will not be able to meet five times that demand without expanding or otherwise incurring significant costs. Suppose that we know only that a certain grocery store serves 200 customers per week, that a certain apartment building provides apartments for 200 families, that a certain train station welcomes 200 trains per day. While it is conceivable that the store, the apartment building, or the train station could just as easily provide for 1,000 customers, families, or trains at no significant additional cost, crowding, or delay, most of us would find this possibility highly improbable. The dissent takes issue with this general, intuitive point by arguing that many places operate below capacity and that in any event, facilities could simply hire additional providers. See post, at 2347. We disagree that, according to common sense, medical facilities, well known for their wait times, operate below capacity as a general matter. And the fact that so many facilities were forced to close by the admitting-privileges requirement means that hiring more physicians would not be quite as simple as the dissent suggests. Courts are free to base their findings on commonsense inferences drawn from the evidence. And that is what the District Court did here.

The dissent now seeks to discredit Dr. Grossman by pointing out that a preliminary prediction he made in his testimony in *Abbott* about the effect of the admitting-privileges requirement on capacity was not borne out after that provision went into effect. See post, at 2346 – 2347, n. 22. If every expert who overestimated or underestimated any figure could not be credited, courts would struggle to find expert assistance. Moreover, making a hypothesis—and then attempting to verify that hypothesis with further studies, as Dr. Grossman did—is not irresponsible. It is an essential element of the scientific method. The District Court’s decision to credit Dr. Grossman’s testimony was sound, particularly given that Texas provided no credible experts to rebut it.

Texas suggests that the seven or eight remaining clinics could expand sufficiently to provide abortions for the 60,000 to 72,000 Texas women who sought them each year. Because petitioners had satisfied their burden, the obligation was on Texas, if it could, to present evidence rebutting that issue to the District Court. Texas admitted that it presented no such evidence. Tr. of Oral Arg. 46. Instead, Texas argued before this Court that one new clinic now serves 9,000 women annually. *Ibid.* In addition to being outside the record, that example is not representative. The clinic to which Texas referred apparently cost \$26 million to construct—a fact that even more clearly demonstrates that requiring seven or eight clinics to serve five times their usual number of patients does indeed represent an undue burden on abortion access. See *Planned Parenthood Debuts New Building: Its \$26 Million Center in Houston is Largest of Its Kind in U.S.*, *Houston Chronicle*, May 21, 2010, p. B1.

Attempting to provide the evidence that Texas did not, the dissent points to an exhibit submitted in *Abbott* showing that three Texas surgical centers, two in Dallas as well as the \$26-million facility in Houston, are each capable of serving an average of 7,000 patients per year. See post, at 2347 – 2349. That “average” is misleading. In addition to including the Houston clinic, which does not represent most facilities, it is underinclusive. It ignores the evidence as to the Whole Woman’s Health surgical-center facility in San Antonio, the capacity of which is described as “severely limited.” The exhibit does nothing to rebut the commonsense inference that the dramatic decline in the number of available facilities will cause a shortfall in capacity should H.B. 2 go into effect. And facilities that were still operating after the effective date of the admitting-privileges provision were not able to accommodate increased demand. See App. 238; Tr. of Oral Arg. 30–31; Brief for National Abortion Federation et al. as *Amici Curiae* 17–20 (citing clinics’ experiences since the admitting-privileges requirement went

into effect of 3–week wait times, staff burnout, and waiting rooms so full, patients had to sit on the floor or wait outside).

More fundamentally, in the face of no threat to women’s health, Texas seeks to force women to travel long distances to get abortions in crammed-to-capacity superfacilities. Patients seeking these services are less likely to get the kind of individualized attention, serious conversation, and emotional support that doctors at less taxed facilities may have offered. Healthcare facilities and medical professionals are not fungible commodities. Surgical centers attempting to accommodate sudden, vastly increased demand, may find that quality of care declines. Another commonsense inference that the District Court made is that these effects would be harmful to, not supportive of, women’s health.

Finally, the District Court found that the costs that a currently licensed abortion facility would have to incur to meet the surgical-center requirements were considerable, ranging from \$1 million per facility (for facilities with adequate space) to \$3 million per facility (where additional land must be purchased). This evidence supports the conclusion that more surgical centers will not soon fill the gap when licensed facilities are forced to close.

We agree with the District Court that the surgical-center requirement, like the admitting-privileges requirement, provides few, if any, health benefits for women, poses a substantial obstacle to women seeking abortions, and constitutes an “undue burden” on their constitutional right to do so.

## VI

We consider three additional arguments that Texas makes and deem none persuasive.

First, Texas argues that facial invalidation of both challenged provisions is precluded by H.B. 2’s severability clause. See Brief for Respondents 50–52. The severability clause says that “every provision, section, subsection, sentence, clause, phrase, or word in this Act, and every application of the provision in this Act, are severable from each other.” H.B. 2, § 10(b), App. to Pet. for Cert. 200a. It further provides that if “any application of any provision in this Act to any person, group of persons, or circumstances is found by a court to be invalid, the remaining applications of that provision to all other persons and circumstances shall be severed and may not be affected.” Ibid. That language, Texas argues, means that facial invalidation of parts of the statute is not an option; instead, it says, the severability clause mandates a more narrowly tailored judicial remedy. But the challenged provisions of H.B. 2 close most of the abortion facilities in Texas and place added stress on those facilities able to remain open. They vastly increase the obstacles confronting women seeking abortions in Texas without providing any benefit to women’s health capable of withstanding any meaningful scrutiny. The provisions are unconstitutional on their face: Including a severability provision in the law does not change that conclusion.

Severability clauses, it is true, do express the enacting legislature’s preference for a narrow judicial remedy. As a general matter, we attempt to honor that preference. But our cases have never required us to proceed application by conceivable application when confronted with a facially unconstitutional statutory provision. “We have held that a severability clause is an aid merely; not an inexorable command.” *Reno v. American Civil Liberties Union*, 521 844, 884-885, n. 49, 117 S.Ct. 2329, 138 L.Ed.2d 874 (1997) (internal quotation marks omitted). Indeed, if a severability clause could impose such a requirement on courts, legislatures would easily be able to insulate unconstitutional statutes from most facial review. See *ibid.* (“It would certainly be dangerous if the legislature could set a net large enough to catch all possible offenders, and leave it to the courts to step inside and say who could

be rightfully detained, and who should be set at large. This would, to some extent, substitute the judicial for the legislative department of the government” (internal quotation marks omitted)). A severability clause is not grounds for a court to “devise a judicial remedy that entail[s] quintessentially legislative work.”. *Ayotte v. Planned Parenthood of Northern New Eng.*, 546 U.S. 320, 329, 126 S.Ct. 961, 163 L.Ed.2d 812 (2006) Such an approach would inflict enormous costs on both courts and litigants, who would be required to proceed in this manner whenever a single application of a law might be valid. We reject Texas’ invitation to pave the way for legislatures to immunize their statutes from facial review.

Texas similarly argues that instead of finding the entire surgical-center provision unconstitutional, we should invalidate (as applied to abortion clinics) only those specific surgical-center regulations that unduly burden the provision of abortions, while leaving in place other surgical-center regulations (for example, the reader could pick any of the various examples provided by the dissent, see post, at 2352 – 2353). See Brief for Respondents 52–53. As we have explained, Texas’ attempt to broadly draft a requirement to sever “applications” does not require us to proceed in piecemeal fashion when we have found the statutory provisions at issue facially unconstitutional.

Nor is that approach to the regulations even required by H.B. 2 itself. The statute was meant to require abortion facilities to meet the integrated surgical-center standards—not some subset thereof. The severability clause refers to severing applications of words and phrases *in the Act*, such as the surgical-center requirement as a whole. See H.B. 2, § 4, App. to Pet. for Cert. 194a. It does not say that courts should go through the individual components of the different, surgical-center statute, let alone the individual *regulations* governing surgical centers to see whether those requirements are severable from each other as applied to abortion facilities. Facilities subject to some subset of those regulations do not qualify as surgical centers. And the risk of harm caused by inconsistent application of only a fraction of interconnected regulations counsels against doing so.

Second, Texas claims that the provisions at issue here do not impose a substantial obstacle because the women affected by those laws are not a “large fraction” of Texan women “of reproductive age,” which Texas reads *Casey* to have required. See Brief for Respondents 45, 48. But *Casey* used the language “large fraction” to refer to “a large fraction of cases in which [the provision at issue] is *relevant*,” a class narrower than “all women,” “pregnant women,” or even “the class of *women seeking abortions* identified by the State.” 505 U.S., at 894–895, 112 S.Ct. 2791 (opinion of the Court) (emphasis added). Here, as in *Casey*, the relevant denominator is “those [women] for whom [the provision] is an actual rather than an irrelevant restriction.” *Id.*, at 895, 112 S.Ct. 2791.

Third, Texas looks for support to *Simopoulos v. Virginia*, 462 U.S. 506, 103 S.Ct. 2532, 76 L.Ed.2d 755 (1983), a case in which this Court upheld a surgical-center requirement as applied to second-trimester abortions. This case, however, unlike *Simopoulos*, involves restrictions applicable to all abortions, not simply to those that take place during the second trimester. Most abortions in Texas occur in the first trimester, not the second. App. 236. More importantly, in *Casey* we discarded the trimester framework, and we now use “viability” as the relevant point at which a State may begin limiting women’s access to abortion for reasons unrelated to maternal health. 505 U.S., at 878, 112 S.Ct. 2791 (plurality opinion). Because the second trimester includes time that is both previability and postviability, *Simopoulos* cannot provide clear guidance. Further, the Court in *Simopoulos* found that the petitioner in that case, unlike petitioners here, had waived any argument that the regulation did not significantly help protect women’s health. 462 U.S., at 517, 103 S.Ct. 2532.

\* \* \*



For these reasons the judgment of the Court of Appeals is reversed, and the case is remanded for further proceedings consistent with this opinion.

*It is so ordered.*

### ***Notes, Questions, and Problems***

1. The primary principle adopted by the court in deciding *Roe v. Wade* is that the woman has the right to terminate her pregnancy before viability. The viability requirement was a recognition of the fact that the state's interest in protecting the fetus does not supersede the woman's right until the fetus is able to survive outside of the woman's body. To indicate what it meant by viability in *Roe v. Wade*, the court established a trimester framework. Under that framework, almost no regulation is allowed during the first trimester of the pregnancy; during the second trimester, regulations meant to protect the woman's health, but not to further the State's interest in the fetus, are permissible; and during the third trimester, once the fetus is deemed viable, the state can pass laws preventing abortions unless the life or the health of the mother is at stake.

2. Evaluate the three reasons the *Roe v. Wade* court discussed that have been put forth to justify making abortions illegal.

3. What were the provisions of the Pennsylvania statute that were challenged in *Casey*?

4. What are the three *Roe v. Wade* principles that were discussed by the *Casey* court?

5. In order to uphold the statute in *Casey*, the court had to overrule *Roe v. Wade*. What factors did the court consider when deciding whether or not to overrule *Roe*?

6. In *Casey*, the court defined *Roe*'s viability standard as "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." Critics have attacked the viability requirement because of advances in medical technology that makes the standard fluid. Why did the court in *Casey* decide to retain the viability requirement?

7. Why did the court in *Casey* reject the *Roe* trimester framework? What new test did the court establish?

8. Which of the following laws violate the *Casey* undue burden test?

- a. Before a physician can perform an abortion, the woman must wait 48 hours from the time she first meets the doctor.
- b. Before a physician can perform an abortion, the woman must get the written consent of the man who supplied the sperm used to produce the fetus.
- c. Before a physician can perform an abortion, the woman must agree to be sterilized after the procedure is completed.
- d. Before a physician can perform an abortion on a minor, the minor must get the written consent of her parents.
- e. Before a physician can perform an abortion, the woman must participate in 40 hours of spiritual counseling.

9. The United States Supreme Court upheld a federal law making partial-birth abortions illegal. *Gonzales v. Carhart*, 550 U.S. 124 (2007). The District Court concluded that the Act was unconstitutional because it lacked an exception allowing the procedure where necessary for the health of the mother. Should the Supreme Court have agreed with the District Court?

10. Most of the anti-abortion laws have been challenged by physicians. Thus, anti-abortion advocates are seeking to have the U.S. Supreme Court rule that physicians performing abortions lack standing to challenge laws that restrict abortions.

11. In May of 2019, the Alabama legislature passed the Alabama Human Life Protection Act that subjects a doctor who performs an abortion to as many as 99 years in prison. The law defines an unborn child as a human regardless of viability.

### ***Black Anti-Abortion Movement***

When people think of the anti-abortion movement, they usually think of it as a largely white undertaking. Nonetheless, the black anti-abortion movement has recently garnered public attention. African American women are 13% of the female population, but they account for 30% of abortions. Leaders of the black anti-abortion movement have used those numbers to accuse Planned Parenthood and other organizations of targeting African American women. The theory is that black women are encouraged to have abortions in an effort to decrease the number of additions to the black community. Some persons have gone so far as to accuse the leaders of the pro-choice movement of black genocide. They have bolstered that narrative by claiming that Margaret Sanger, the founder of birth control organizations that evolved into Planned Parenthood, was a key supporter of eugenics.

Leaders of the black anti-abortion movement like Star Parker have linked it to the “Black Lives Matter” movement. According to Parker, “We can talk all day about ‘black lives matter,’ but if we exclude abortion from the discussion we’ve excluded the fundamental of this discussion.” Therefore, people who have not thought about abortion as an issue that impacts the black community are changing their

positions. This could have an impact on the existence of Planned Parenthood. Planned Parenthood is under constant attack by politicians who want to see the organization defunded. Those politicians are now receiving support from members of the black anti-abortion movement who are criticizing Margaret Sanger, the person credited with being one of the founders of Planned Parenthood. For example, Dr. Ben Carson, former Republican presidential candidate and Secretary of the Housing and Urban Development Agency, made the following statements: “Maybe I’m not objective when it comes to Planned Parenthood, but I know who Margaret Sanger is, and I know that she believed in eugenics, and that she was not particularly enamored with black people, and one of the reasons that you can find most of their clinics in black neighborhoods is so that you can find a way to control that population.”

## CHAPTER SIX - THE RIGHT TO GIVE BIRTH WITHOUT GOVERNMENTAL INTERFERENCE

### 6.1 Maternal-Fetal Conflict

When a woman is pregnant, this may present a conflict for her physician. The physician may start to think of the woman and the fetus as her patient. That way of thinking is fine unless there is a conflict between what the woman wants and what the physician thinks is in the best interests of the fetus. Consider the following scenario. Abby Dennis was a patient of Dr. Stanley Yung. When Abby had been in labor for three hours, Dr. Yung recommended a C-section because he felt that the baby was in distress. Because she was a naturalist, Abby wanted to give birth naturally without medicine. Hence, she refused to consent to the C-section. When Abby's husband Steven arrived at the hospital, Dr. Yung had him sign the form consenting to the C-section. Over Abby's objections, Dr. Yung performed an emergency C-section and delivered a healthy baby. If Abby sued for lack of informed consent, what might be the outcome of the case? Is the fact that the fetus was viable and in distress relevant to the case?

There is a growing movement to have a fetus deemed to be a person even before it reaches viability. If that movement is successful, even more women will be held criminally responsible for the actions they take that might harm a fetus. Some people have gone so far as to claim that a frozen embryo should be classified as a person. When a freezer malfunctioned at a fertility clinic in Cleveland, more than 4000 eggs and embryos were destroyed. Rick and Wendy Penniman brought a wrongful death action against the fertility clinic claiming that life begins at conception, so their destroyed embryos were people.<sup>26</sup>

In 2014, Tennessee became the first state to enact a law specifically permitting prosecution of pregnant women who use drugs.<sup>27</sup>

#### ***Whitner v. South Carolina*, 492 S.E. 2d 777**

TOAL, JUSTICE.

This case concerns the scope of the child abuse and endangerment statute in the South Carolina Children's Code (the Code), S.C. Code Ann. §20-7-50 (1985). We hold the word "child" as used in that statute includes viable fetuses.

#### FACTS

On April 20, 1992, Cornelia Whitner (Whitner) pled guilty to criminal child neglect, S.C. Code Ann. §20-7-50 (1985), for causing her baby to be born with cocaine metabolites in its system by reason of

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<sup>26</sup> See Jeannie Suk Gersen, *How Fetal Personhood Emerged As the Next Stage of the Abortion Wars*, The New Yorker, at <https://www.newyorker.com/news/our-columnists/how-fetal-personhood-emerged-as-the-next-stage-of-the-abortion-wars> (June 5, 2019).

<sup>27</sup> Elizabeth Nolan Brown, *First Mom Arrested Under Tennessee's New Anti-Drug Law*, Reason, at <https://reason.com/2014/07/11/first-mom-arrested-for-tenn-drug-law/> (July 11, 2014).

Whitner's ingestion of crack cocaine during the third trimester of her pregnancy. The circuit court judge sentenced Whitner to eight years in prison. Whitner did not appeal her conviction.

Thereafter, Whitner filed a petition for Post-Conviction Relief (PCR), pleading the circuit court's lack of subject matter jurisdiction to accept her guilty plea as well as ineffective assistance of counsel. Her claim of ineffective assistance of counsel was based upon her lawyer's failure to advise her the statute under which she was being prosecuted might not apply to prenatal drug use. The petition was granted on both grounds. The State appeals.

## LAW/ANALYSIS

### *A. Subject Matter Jurisdiction*

The State first argues the PCR court erred in finding the sentencing circuit court lacked subject matter jurisdiction to accept Whitner's guilty plea. We agree.

Under South Carolina law, a circuit court lacks subject matter jurisdiction to accept a guilty plea to a nonexistent offense. See *Williams v. State*, 306 S.C. 89, 410 S.E.2d 563 (1991). For the sentencing court to have had subject matter jurisdiction to accept Whitner's plea, criminal child neglect under section 20-7-50 would have to include an expectant mother's use of crack cocaine after the fetus is viable. All other issues are ancillary to this jurisdictional issue.

S.C. Code Ann. §20-7-50 (1985) provides:

Any person having the legal custody of any *child* or helpless person, who shall, without lawful excuse, refuse or neglect to provide, as defined in § 20-7-490, the proper care and attention for such *child* or helpless person, so that the life, health or comfort of such *child* or helpless person is endangered or is likely to be endangered, shall be guilty of a misdemeanor and shall be punished within the discretion of the circuit court. (emphasis added).

The State contends this section encompasses maternal acts endangering or likely to endanger the life, comfort, or health of a *viable fetus*.

Under the Children's Code, "child" means a "person under the age of eighteen." S.C. Code Ann. §20-7-30(1) (1985). The question for this Court, therefore, is whether a viable fetus is a "person" for purposes of the Children's Code. South Carolina law has long recognized that viable fetuses are persons holding certain legal rights and privileges. In 1960, this Court decided *Hall v. Murphy*, 236 S.C. 257, 113 S.E.2d 790 (1960). That case concerned the application of South Carolina's wrongful death statute to an infant who died four hours after her birth as a result of injuries sustained prenatally during viability. The Appellants argued that a viable fetus was not a person within the purview of the wrongful death statute, because, *inter alia*, a fetus is thought to have no separate being apart from the mother. We found such a reason for exclusion from recovery "unsound, illogical and unjust," and concluded there was "no medical or other basis" for the "assumed identity" of mother and viable unborn child. *Id.* at 262, 113 S.E. 2d at 793. In light of that conclusion, this Court unanimously held: "We have no difficulty in concluding that a fetus having reached that period of prenatal maturity where it is capable of independent life apart from its mother *is a person.*" *Id.* at 263, 113 S.E. 2d at 793 (emphasis added).

Four years later in *Fowler v. Woodward*, 244 S.C. 608, 138 S.E.2d 42 (1964), we interpreted *Hall* as supporting a finding that a viable fetus injured while still in the womb need not be born alive for another to maintain an action for the wrongful death of the fetus.

Since a viable child is a *person before separation from the body of its mother* and since prenatal injuries tortiously inflicted on such a child are actionable, it is apparent that the complaint alleges such an ‘act, neglect or default’ by the defendant, to the injury of the child.

\* \* \* \* \*

Once the concept of the unborn, viable child as a person is accepted, we have no difficulty in holding that a cause of action for tortious injury to such a child arises immediately upon the infliction of the injury. *Id.* at 613, 138 S.E.2d at 44 (emphasis added). *Fowler* makes particularly clear that *Hall* rested on the concept of the viable fetus as a person vested with legal rights.

More recently, we held the word “person” as used in a *criminal* statute includes viable fetuses. *State v. Horne*, 282 S.C. 444, 319 S.E.2d 703 (1984), concerned South Carolina’s murder statute, S.C. Code Ann. § 16-3-10 (1976). (1985), The defendant in that case stabbed his wife, who was nine months’ pregnant, in the neck, arms, and abdomen. Although doctors performed an emergency cesarean section to deliver the child, the child died while still in the womb. The defendant was convicted of voluntary manslaughter and appealed his conviction on the ground South Carolina did not recognize the crime of feticide.

This Court disagreed. In a unanimous decision, we held it would be “grossly inconsistent to construe a viable fetus as a ‘person’ for the purposes of imposing civil liability while refusing to give it a similar classification in the criminal context.” *Id.* at 447, 319 S.E.2d at 704 (citing *Fowler v. Woodward*, *supra*). Accordingly, the Court recognized the crime of feticide with respect to viable fetuses.

Similarly, we do not see any rational basis for finding a viable fetus is not a “person” in the present context. Indeed, it would be absurd to recognize the viable fetus as a person for purposes of homicide laws and wrongful death statutes but not for purposes of statutes proscribing child abuse. Our holding in *Hall* that a viable fetus is a person rested primarily on the plain meaning of the word “person” in light of existing medical knowledge concerning fetal development. We do not believe that the plain and ordinary meaning of the word “person” has changed in any way that would now deny viable fetuses status as persons.

The policies enunciated in the Children’s Code also support our plain meaning reading of “person.” S.C. Code Ann. §20-7-20(C)(1985), which describes South Carolina’s policy concerning children, expressly states: “It shall be the policy of this State to concentrate on the *prevention of children’s problems* as the most important strategy which can be planned and implemented on behalf of children and their families.” (emphasis added). The abuse or neglect of a child at *any* time during childhood can exact a profound toll on the child herself as well as on society as a whole. However, the consequences of abuse or neglect which takes place after birth often pale in comparison to those resulting from abuse suffered by the viable fetus before birth. This policy of prevention supports a reading of the word “person” to include viable fetuses. Furthermore, the scope of the Children’s Code is quite broad. It applies “to *all* children who have need of services.” S.C. Code Ann. §20-7-20(B) (1985) (emphasis added). When coupled with the comprehensive remedial purposes of the Code, this language supports

the inference that the legislature intended to include viable fetuses within the scope of the Code's protection.

Whitner advances several arguments against an interpretation of "person" as used in the Children's Code to include viable fetuses. We shall address each of Whitner's major arguments in turn.

Whitner's first argument concerns the number of bills introduced in the South Carolina General Assembly in the past five years addressing substance abuse by pregnant women. Some of these bills would have criminalized substance abuse by pregnant women; others would have addressed the issue through mandatory reporting, treatment, or intervention by social service agencies. Whitner suggests that the introduction of several bills touching the specific issue at hand evinces a belief by legislators that prior legislation had not addressed the issue. Whitner argues the introduction of the bills proves that section 20-7-50 was not intended to encompass abuse or neglect of a viable fetus.

We disagree with Whitner's conclusion about the significance of the proposed legislation. Generally, the legislature's subsequent acts "cast no light on the intent of the legislature which enacted the statute being construed." *Home Health Servs., Inc. v. DHEC*, 298 S.C. 258, 262 n. 1, 379 S.E. 2d 734, 736 n. 1 (Ct. App. 1989) (citations omitted). Rather, this Court will look first to the *language* of the statute to discern legislative intent, because the language itself is the best guide to legislative intent. E.g., *State v. Blackmon*, 304 S.C. 270, 403 S.E. 2d 660 (1991). Here, we see no reason to look beyond the statutory language. See *Timmons v. South Carolina Tricentennial Comm'n*, *supra* (where statute's meaning can be determined from its language, no need to look beyond such language). Additionally, our existing case law strongly supports our conclusion about the meaning of the statute's language.

Whitner also argues an interpretation of the statute that includes viable fetuses would lead to absurd results obviously not intended by the legislature. Specifically, she claims if we interpret "child" to include viable fetuses, *every* action by a pregnant woman that endangers or is likely to endanger a fetus, whether otherwise legal or illegal, would constitute unlawful neglect under the statute. For example, a woman might be prosecuted under section 20-7-50 for smoking or drinking during pregnancy. Whitner asserts these "absurd" results could not have been intended by the legislature and, therefore, the statute should not be construed to include viable fetuses.

We disagree for a number of reasons. First, the same arguments against the statute can be made whether or not the child has been born. After the birth of a child, a parent can be prosecuted under section 20-7-50 for an action that is likely to endanger the child without regard to whether the action is illegal in itself. For example, a parent who drinks excessively could, under certain circumstances, be guilty of child neglect or endangerment even though the underlying act—consuming alcoholic beverages—is itself legal. Obviously, the legislature did not think it "absurd" to allow prosecution of parents for such otherwise legal acts when the acts actually or potentially endanger the "life, health or comfort" of the parents' born children. We see no reason such a result should be rendered absurd by the mere fact the child at issue is a viable fetus.

Moreover, we need not address this potential parade of horrors advanced by Whitner. In *this* case, which is the only case we are called upon to decide here, certain facts are clear. Whitner admits to having ingested crack cocaine during the third trimester of her pregnancy, which caused her child to be born with cocaine in its system. Although the precise effects of maternal crack use during pregnancy are somewhat unclear, it is well documented and within the realm of public knowledge that such use can cause serious harm to the viable unborn child. See, e.g., Joseph J. Volpe, M.D., *Effect of Cocaine Use on the Fetus*, 327 NEW ENG.J.MED. 399 (1992); Ira J. Chasnoff, M.D., et al., *Cocaine Use in*

*Pregnancy*, 313 NEW ENG.J.MED. 666 (1985). There can be no question here Whitner endangered the life, health, and comfort of her child. We need not decide any cases other than the one before us.

We are well aware of the many decisions from other states' courts throughout the country holding maternal conduct before the birth of the child does not give rise to criminal prosecution under state child abuse/endangerment or drug distribution statutes (citations omitted). Many of these cases were prosecuted under statutes forbidding delivery or distribution of illicit substances and depended on statutory construction of the terms "delivery" and "distribution." See, e.g., *Johnson v. State*, supra; *State v. Luster*, supra; *People v. Hardy*, supra. Obviously, such cases are inapplicable to the present situation. The cases concerning child endangerment statutes or construing the terms "child" and "person" are also distinguishable, because the states in which these cases were decided have entirely different bodies of case law from South Carolina. For example, in *Commonwealth v. Welch*, the Kentucky Supreme Court specifically noted Kentucky law has not construed the word "person" in the criminal homicide statute to include a fetus (viable or not). *Welch*, 864 S.W.2d at 281. In *Reyes v. Superior Court*, the California Court of Appeals noted California law did not recognize a fetus as a "human being" within the purview of the state murder and manslaughter statutes, and that it was thus improper to find the fetus was a "child" for purposes of the felonious child endangerment statute. *Reyes*, 75 Cal.App.3d at 217, 141 Cal.Rptr. 912.

Massachusetts, however, has a body of case law substantially similar to South Carolina's, yet a Massachusetts trial court has held that a mother pregnant with a viable fetus is not criminally liable for transmission of cocaine to the fetus. See *Commonwealth v. Pellegrini*, No. 87970, slip op. (Mass.Super.Ct. Oct. 15, 1990). Specifically, Massachusetts law allows wrongful death actions on behalf of viable fetuses injured *in utero* who are not subsequently born alive. *Mone v. Greyhound Lines, Inc.* 368 Mass. 354, 331 N.E. 2d 916 (1975). Similarly, Massachusetts law permits homicide prosecutions of third parties who kill viable fetuses. See *Commonwealth v. Cass*, 392 Mass. 799, 4667 N.E.2d 1324 (1984) (ruling a viable fetus is a person for purposes of vehicular homicide statute); *Commonwealth v. Lawrence*, 404 Mass. 378, 536 N.E.2d 571 (1989) (viable fetus is a person for purposes of common law crime of murder). Because of the similarity of the case law in Massachusetts to ours, the *Pellegrini* decision merits examination.

In *Pellegrini*, the Massachusetts Superior Court found that state's distribution statute does not apply to the distribution of an illegal substance to a viable fetus. The statute at issue forbade distribution of cocaine to persons under the age of eighteen. Rather than construing the word "distribution," however, the superior court found that a viable fetus is not a "person under the age of eighteen" within the meaning of the statute. *Pellegrini*, slip op. at 10. In so finding, the court had to distinguish *Lawrence* and *Cass*, supra, both of which held viable fetuses are "persons" for purposes of criminal laws in Massachusetts.

The Massachusetts trial court found *Lawrence* and *Cass* "accord legal rights to the unborn only where the mother's or parents' interest in the potentiality of life, not the state's interest, are sought to be vindicated." *Pellegrini*, slip op. at 11. In other words, a viable fetus should only be accorded the rights of a person for the sake of its mother or both its parents. Under this rationale, the viable fetus lacks rights of its own that deserve vindication. Whitner suggests we should interpret our decisions in *Hall*, *Fowler*, and *Horne* to accord rights to the viable fetus only when doing so protects the special parent-child relationship rather than any individual rights of the fetus or any State interest in potential life. We do not think *Hall*, *Fowler*, and *Horne* can be interpreted so narrowly.



If the Pellegrini decision accurately characterizes the rationale underlying Mone, Lawrence, and Cass, then the reasoning of those cases differs substantially from our reasoning in Hall, Fowler, and Horne, *supra*. First, Hall, Fowler, and Horne were decided primarily on the basis of the meaning of “person” as understood in the light of existing medical knowledge, rather than based on any policy of protecting the relationship between mother and child. As a homicide case, Horne also rested on the State’s—not the mother’s—interest in vindicating the life of the viable fetus. Moreover, the United States Supreme Court has repeatedly held that the states have a compelling interest in the life of a viable fetus (citations omitted). If, as Whitner suggests we should, we read Horne only as a vindication of the mother’s interest in the life of her unborn child, there would be no basis for prosecuting a mother who kills her viable fetus by stabbing it, by shooting it, or by other such means, yet a third party could be prosecuted for the very same acts. We decline to read Horne in a way that insulates the mother from all culpability for harm to her viable child. Because the rationale underlying our body of law—protection of the viable fetus—is radically different from that underlying the law of Massachusetts, we decline to follow the decision of the Massachusetts Superior Court in Pellegrini.

The dissent contends that our holding in this case is inconsistent with *Doe v. Clark*, 318 S.C. 274, 457 S.E.2d 336 (1995). Specifically, it suggests that *Doe v. Clark*, in which we construed another provision of the Children’s Code, stands for the proposition that the definition of “child” in S.C. Code Ann. §20-7-50 (1985) means a “child in being and not a fetus.” Contrary to the dissent’s characterization of that case, *Doe* turned on the specific language in the consent provisions of the Adoption Act, S.C. Code Ann. §§20-7-1690 (1985) and –1700 (Law.Co-op Supp.1994).

In *Doe*, Wylanda Clark, who was pregnant, signed a consent form allowing the Does to adopt the child upon its birth. After the child was born, Clark decided she wanted to keep the baby and attempted to argue that the consent she executed was void because it did not contain certain information required by statute. The trial judge held Clark’s consent was valid. Clark appealed.

On appeal, we reversed the trial court. However, the basis for our reversal was not that “child” as defined in the Children’s Code only includes born children, but that the adoption statutes contemplate that the natural mother’s consent to the adoption must be given after the birth of the child to be adopted. *Doe*, 318 S.C. at 276, 457 S.E.2d at 337. Specifically, section 20–7–1700(A)(3) requires the consent form to contain the race, sex, and *date of birth* of the adoptee, as well as any names by which the adoptee has been known. Clearly, the date of birth requirement could not be fulfilled until after the birth of the child. Furthermore, section 20-7-1690, which specifies who must consent to an adoption, provides that consent is required of “the mother of a child *born* when the mother was not married.” (emphasis added). Citing these sections as well as the Children’s Code’s definition of child, we concluded that a natural mother cannot consent to adoption until after the birth of her child. *Id.* We did *not* hold that the term “child” excludes viable fetuses, nor do we think our holding in *Doe* can be read so broadly.

Finally, the dissent implies that we have ignored the rule of lenity requiring us to resolve any ambiguities in a criminal statute in favor of the defendant. The dissent argues that “[a]t most, the majority only suggests that the term ‘child’ as used in section 20-7-50 is ambiguous,” and that the ambiguity “is created not by reference to our decisions under the Children’s Code or by reference to the statutory language and applicable rules of statutory construction, but by reliance on decisions in two different fields of the law, civil wrongful death and common law feticide.”

Plainly, the dissent misunderstands our opinion. First, we do not believe the statute is ambiguous and, therefore, the rule of lenity does not apply. Furthermore, our interpretation of the statute is based

primarily on the plain meaning of the word “person” as contained *in the statute*. We need not go beyond that language. However, because our prior decisions in *Murphy*, *Flowler*, and *Horne* support our reading of the statute, we have discussed the rationale underlying those holdings. We conclude that both statutory language and case law compel the conclusion we reach. We see no ambiguity.

### *C. Constitutional Issues*

#### 1. Fair Notice/Vagueness

Whitner argues that section 20-7-50 does not give her fair notice that her behavior is proscribed. We disagree.

The statute forbids any person having legal custody of a child from refusing or neglecting to provide proper care and attention to the child so that the life, health, or comfort of the child is endangered or is likely to be endangered. As we have found above, the *plain* meaning of “child” as used in this statute includes a viable fetus. Furthermore, it is common knowledge that use of cocaine during pregnancy can harm the viable unborn child. Given these facts, we do not see how Whitner can claim she lacked fair notice that her behavior constituted child endangerment as proscribed in section 20-7-50. Whitner had all the notice the Constitution requires.

#### 2. Right to Privacy

Whitner argues that prosecuting her for using crack cocaine after her fetus attains viability unconstitutionally burdens her right of privacy, or, more specifically, her right to carry her pregnancy to term. We disagree.

Whitner argues that section 20-7-50 burdens her right of privacy, a right long recognized by the United States Supreme Court (citations omitted). *See, e.g.,* She cites *Cleveland Board of Education v. LaFleur*, 414 U.S. 632, 94 S.Ct. 701, 39 L.Ed. 2d 52 (1974), as standing for the proposition that the Constitution protects women from measures penalizing them for choosing to carry their pregnancies to term.

In *LaFleur*, two junior high school teachers challenged their school systems’ maternity leave policies. The policies required “every pregnant school teacher to take maternity leave without pay, beginning [four or] five months before the expected birth of her child. *Id.* at 634, 94 S.Ct. at 794, 39 L.Ed. 2d at 57. “A teacher on maternity leave could not return to work until the beginning of the next regular school semester which follows the date when her child attains the age of three months.” *Id.* at 634-35, 94 S.Ct. at 794, 39 L.Ed. 2d at 57. The two teachers, both of whom had become pregnant and were required against their wills to comply with the school systems’ policies, argued that the policies were unconstitutional.

The United States Supreme Court agreed. It found that “[b]y acting to penalize the pregnant teacher for deciding to bear a child, overly restrictive maternity leave regulations can constitute a heavy burden on the exercise of these protected freedoms.” *Id.* at 640, 94 S.Ct. at 796, 39 L.Ed. 2d at 60. The Court then scrutinized<sup>7</sup> the policies to determine whether “the interests advanced in support of” the policy could “justify the particular procedures [the School Boards] ha[d] adopted.” *Id.* at 640, 94 S.Ct. at 796, 39 L.Ed. 2d at 60. Although it found that the purported justification for the policy—continuity of instruction—was a “significant and legitimate educational goal,” the Court concluded that the “absolute requirement [ ] of termination at the end of the fourth or fifth month of pregnancy” was not a rational means for achieving continuity of instruction and that such a requirement “may serve to

hinder attainment of the very continuity objectives that they are purportedly designed to promote.” *Id.* at 642-43, 94 S.Ct. at 797-98, 39 L.Ed. 2d at 61-62. Finding no rational relationship between the purpose of the maternity leave policy and the means crafted to achieve that end, the Court concluded the policy violated the Due Process Clause of the Fourteenth Amendment.

Whitner argues that the alleged violation here is far more egregious than that in *LaFleur*. She first suggests that imprisonment is a far greater burden on her exercise of her freedom to carry the fetus to term than was the unpaid maternity leave in *LaFleur*. Although she is, of course, correct that imprisonment is more severe than unpaid maternity leave, Whitner misapprehends the fundamentally different nature of her own interests and those of the government in this case as compared to those at issue in *LaFleur*.

First, the State’s interest in protecting the life and health of the viable fetus is not merely legitimate. It is compelling (citations omitted). The United States Supreme Court in *Casey* recognized that the State possesses a profound interest in the potential life of the fetus, not only after the fetus is viable, but throughout the expectant mother’s pregnancy. See *Casey*, 505 U.S. at 877, 112 S.Ct. 2821, 120 L.Ed.2d at 716 (plurality opinion).

Even more importantly, however, we do not think any fundamental right of Whitner’s—or any right at all, for that matter—is implicated under the present scenario. It strains belief for Whitner to argue that using crack cocaine during pregnancy is encompassed within the constitutionally recognized right of privacy. Use of crack cocaine is illegal, period. No one here argues that laws criminalizing the use of crack cocaine are themselves unconstitutional. If the State wishes to impose additional criminal penalties on pregnant women who engage in this already illegal conduct because of the effect the conduct has on the viable fetus, it may do so. We do not see how the fact of pregnancy elevates the use of crack cocaine to the lofty status of a fundamental right.

Moreover, as a practical matter, we do not see how our interpretation of section 20-7-50 imposes a burden on Whitner’s right to carry her child to term. In *LaFleur*, the Supreme Court found that the mandatory maternity leave policies burdened women’s rights to carry their pregnancies to term because the policies prevented pregnant teachers from exercising a freedom they would have enjoyed but for their pregnancies. In contrast, during her pregnancy after the fetus attained viability, Whitner enjoyed the same freedom to use cocaine that she enjoyed earlier in and predating her pregnancy—none whatsoever. Simply put, South Carolina’s child abuse and endangerment statute as applied to this case does not restrict Whitner’s freedom in any way that it was not already restricted. The State’s imposition of an additional penalty when a pregnant woman with a viable fetus engages in the already proscribed behavior does not burden a woman’s right to carry her pregnancy to term; rather, the additional penalty simply recognizes that a third party (the viable fetus or newborn child) is harmed by the behavior.

Section 20-7-50 does not burden Whitner’s right to carry her pregnancy to term or any other privacy right. Accordingly, we find no violation of the Due Process Clause of the Fourteenth Amendment.

## CONCLUSION

For the foregoing reasons, the decision of the PCR Court is REVERSED.

## 6.2 Forced Birth

### *In re A.C.*, 533 A.2d 1235

TERRY, ASSOCIATE JUDGE:

This case comes before the court for the second time. In *A.C.*, 533 A.2d 611 (D.C. 1987), a three-judge motions division denied a motion to stay an order of the trial court which had authorized a hospital to perform a caesarean section on a dying woman in an effort to save the life of her unborn child. The operation was performed, but both the mother and the child died. A few months later, the court ordered the case heard en banc and vacated the opinion of the motions division. In *re A.C.*, 539 A.2d 203 (D.C. 1988). Although the motions division recognized that, as a practical matter, it “decided the entire matter when [it] denied the stay,” 533 A.2d at 613, the en banc court has nevertheless heard the full case on the merits.

We are confronted here with two profoundly difficult and complex issues. First, we must determine who has the right to decide the course of medical treatment for a patient who, although near death, is pregnant with a viable fetus. Second, we must establish how that decision should be made if the patient cannot make it for herself—more specifically, how a court should proceed when faced with a pregnant patient, *in extremis*, who is apparently incapable of making an informed decision regarding medical care for herself and her fetus. We hold that in virtually all cases the question of what is to be done is to be decided by the patient—the pregnant woman—on behalf of herself and the fetus. If the patient is incompetent or otherwise unable to give an informed consent to a proposed course of medical treatment, then her decision must be ascertained through the procedure known as substituted judgment. Because the trial court did not follow that procedure, we vacate its order and remand the case for further proceedings.

### I

This case came before the trial court when George Washington University Hospital petitioned the emergency judge in chambers for declaratory relief as to how it should treat its patient, *A.C.*, who was close to death from cancer and was twenty-six and one-half weeks pregnant with a viable fetus. After a hearing lasting approximately three hours, which was held at the hospital (though not in *A.C.*’s room), the court ordered that a caesarean section be performed on *A.C.* to deliver the fetus. Counsel for *A.C.* immediately sought a stay in this court, which was unanimously denied by a hastily assembled division of three judges. In *re A.C.*, 533 A.2d 611 (D.C. 1987) The caesarean was performed, and a baby girl, *L.M.C.*, was delivered. Tragically, the child died within two and one-half hours, and the mother died two days later.

Counsel for *A.C.* now maintain that *A.C.* was competent and that she made an informed choice not to have the caesarean performed. Given this view of the facts, they argue that it was error for the trial court to weigh the state’s interest in preserving the potential life of a viable fetus against *A.C.*’s interest in having her decision respected. They argue further that, even if the substituted judgment procedure had been followed, the evidence would necessarily show that *A.C.* would not have wanted the caesarean section. Under either analysis, according to these arguments, the trial court erred in subordinating *A.C.*’s right to bodily integrity in favor of the state’s interest in potential life. Counsel for the hospital and for *L.M.C.* contend, on the other hand, that *A.C.* was incompetent to make her own medical decisions and that, under the substituted judgment procedure, the evidence clearly established

that A.C. would have consented to the caesarean. In the alternative, counsel for L.M.C. argues that even if L.M.C.'s interests and those of the state were in conflict with A.C.'s wishes, it was proper for the trial court to balance their interests and resolve the conflict in favor of surgical intervention.

We do not accept any of these arguments because the evidence, realistically viewed, does not support them.

## II

A.C. was first diagnosed as suffering from cancer at the age of thirteen. In the ensuing years she underwent major surgery several times, together with multiple radiation treatments and chemotherapy. A.C. married when she was twenty-seven, during a period of remission, and soon thereafter she became pregnant. She was excited about her pregnancy and very much wanted the child. Because of her medical history, she was referred in her fifteenth week of pregnancy to the high-risk pregnancy clinic at George Washington University Hospital.

On Tuesday, June 9, 1987, when A.C. was approximately twenty-five weeks pregnant, she went to the hospital for a scheduled check-up. Because she was experiencing pain in her back and shortness of breath, an x-ray was taken, revealing an apparently inoperable tumor which nearly filled her right lung. On Thursday, June 11, A.C. was admitted to the hospital as a patient. By Friday her condition had temporarily improved, and when asked if she really wanted to have her baby, she replied that she did.

Over the weekend A.C.'s condition worsened considerably. Accordingly, on Monday, June 15, members of the medical staff treating A.C. assembled, along with her family, in A.C.'s room. The doctors then informed her that her illness was terminal, and A.C. agreed to palliative treatment designed to extend her life until at least her twenty-eighth week of pregnancy. The "potential outcome [for] the fetus," according to the doctors, would be much better at twenty-eight weeks than at twenty-six weeks if it were necessary to "intervene." A.C. knew that the palliative treatment she had chosen presented some increased risk to the fetus, but she opted for this course both to prolong her life for at least another two weeks and to maintain her own comfort. When asked if she still wanted to have the baby, A.C. was somewhat equivocal, saying "something to the effect of 'I don't know, I think so.'" As the day moved toward evening, A.C.'s condition grew still worse, and at about 7:00 or 8:00 p.m. she consented to intubation to facilitate her breathing.

The next morning, June 16, the trial court convened a hearing at the hospital in response to the hospital's request for a declaratory judgment. The court appointed counsel for both A.C. and the fetus, and the District of Columbia was permitted to intervene for the fetus as *parens patriae*. The court heard testimony on the facts as we have summarized them, and further testimony that at twenty-six and a half weeks the fetus was viable, *i.e.*, capable of sustained life outside of the mother, given artificial aid. A neonatologist, Dr. Maureen Edwards, testified that the chances of survival for a twenty-six-week fetus delivered at the hospital might be as high as eighty percent, but that this particular fetus, because of the mother's medical history, had only a fifty to sixty percent chance of survival. Dr. Edwards estimated that the risk of substantial impairment for the fetus, if it were delivered promptly, would be less than twenty percent. However, she noted that the fetus' condition was worsening appreciably at a rapid rate, and another doctor-Dr. Alan Weingold, an obstetrician who was one of A.C.'s treating physicians-stated that any delay in delivering the child by caesarean section lessened its chances of survival.

Regarding A.C.'s ability to respond to questioning and her prognosis, Dr. Louis Hamner, another treating obstetrician, testified that A.C. would probably die within twenty-four hours "if absolutely nothing else is done. As far as her ability to interact, she has been heavily sedated in order to maintain her ventilatory function. She will open her eyes sometimes when you are in the room, but as far as her being able to carry on a meaningful-type conversation at this point, I don't think that is reasonable." When asked whether reducing her medication to "permit recovery of enough cognitive function on her part that we could get any sense from her as to what her preference would be as to therapy," Dr. Hamner replied, "I don't think so. I think her respiratory status has deteriorated to the point where she is [expending] an enormous amount of energy just to keep the heart going." Dr. Weingold, asked the same question, gave a similar answer: that A.C.'s few remaining hours of life "will be shortened by attempting to raise her level of consciousness because that is what is keeping her, in a sense, physiologically compliant with the respirator. If you remove that, then I think that will shorten her survival."

There was no evidence before the court showing that A.C. consented to, or even contemplated, a caesarean section before her twenty-eighth week of pregnancy. There was, in fact, considerable dispute as to whether she would have consented to an immediate caesarean delivery at the time the hearing was held. A.C.'s mother opposed surgical intervention, testifying that A.C. wanted "to live long enough to hold that baby" and that she expected to do so, "even though she knew she was terminal." Dr. Hamner testified that, given A.C.'s medical problems, he did not think she would have chosen to deliver a child with a substantial degree of impairment. Asked whether A.C. had been "confronted with the question of what to do if there were a choice that ultimately had to be made between her own life expectancy and that of her fetus," he replied that the question "was addressed [but] at a later gestational age. We had talked about the possibility at twenty-eight weeks, if she had to be intubated, if this was a terminal event, would we intervene, and the expression was yes, that we would, because we felt at twenty-eight weeks we had much more to offer as far as taking care of the child." Finally, Dr. Hamner stated that "the department as a whole" concluded that "we should abide by the wishes of the family." Dr. Lawrence Lessin, an oncologist and another of A.C.'s treating physicians, testified that in meetings with A.C. he had heard nothing to indicate that, if faced with the decision, she would have refused permission for a caesarean section. Dr. Weingold opposed the operation because he believed A.C. had not seriously considered that she might not survive the birth of her baby. Dr. Weingold made explicit what was implicit in Dr. Hamner's testimony: that "in dealing with her, a message that was sent to her was that the earliest we would feel comfortable in intervening, should there be indication as to either maternal or fetal grounds, would be twenty-eight weeks."

After hearing this testimony and the arguments of counsel, the trial court made oral findings of fact. It found, first, that A.C. would probably die, according to uncontroverted medical testimony, "within the next twenty-four to forty-eight hours"; second, that A.C. was "pregnant with a twenty-six and a half week viable fetus who, based upon uncontroverted medical testimony, has approximately a fifty to sixty percent chance to survive if a caesarean section is performed as soon as possible"; third, that because the fetus was viable, "the state has [an] important and legitimate interest in protecting the potentiality of human life"; and fourth, that there had been some testimony that the operation "may very well hasten the death of [A.C.]," but that there had also been testimony that delay would greatly increase the risk to the fetus and that "the prognosis is not great for the fetus to be delivered post-mortem." Most significantly, the court found:

The court is of the view that it does not clearly know what [A.C.'s] present views are with respect to the issue of whether or not the child should live or die. She's presently unconscious. As late as Friday of last week, she wanted the baby to live. As late as

yesterday, she did not know for sure.

Having made these findings of fact and conclusions of law, and expressly relying on *In re Madyun*, 114 Daily Wash.L.Rptr. 2233 (D.C.Super.Ct. July 26, 1986), the court ordered that a caesarean section be performed to deliver A.C.'s child.

The court's decision was then relayed to A.C., who had regained consciousness. When the hearing reconvened later in the day, Dr. Hamner told the court:

I explained to her essentially what was going on. I said it's been deemed we should intervene on behalf of the baby by caesarean section and it would give it the only possible chance of it living. Would you agree to this procedure? *She said yes.* I said, do you realize that you may not survive the surgical procedure? *She said yes.* And I repeated the two questions to her again [and] asked her did she understand. *She said yes.* [Emphasis added.]

When the court suggested moving the hearing to A.C.'s bedside, Dr. Hamner discouraged the court from doing so, but he and Dr. Weingold, together with A.C.'s mother and husband, went to A.C.'s room to confirm her consent to the procedure. What happened then was recounted to the court a few minutes later:

THE COURT: Will you bring us up to date? Did you have a conversation with [A.C.]?

DR. WEINGOLD: I did not. I observed the conversation between Dr. Hamner and [A.C.]. Dr. Hamner went into the room to attempt to verify his previous discussion with the patient, with the patient's husband at her right hand and her mother at her left hand. He, to my satisfaction, clearly communicated with [A.C.]. She understood.

THE COURT: You could hear what the parties were saying to one another?

DR. WEINGOLD: She does not make sound because of the tube in her windpipe. She nods and she mouths words. One can see what she's saying rather readily. She asked whether she would survive the operation. She asked [Dr.] Hamner if he would perform the operation. He told her he would only perform it if she authorized it but it would be done in any case. She understood that. She then seemed to pause for a few moments and then very clearly mouthed words several times, *I don't want it done. I don't want it done.* Quite clear to me.

Dr. Weingold later qualified his opinion as to A.C.'s ability to give an informed consent, stating that he thought the environment for an informed consent was non-existent because A.C. was in intensive care, flanked by a weeping husband and mother. Dr. Hamner stated that the sedation had "worn off enough for her to wake up to this state" and that "the level of drugs in her body is much different from several hours ago." Consequently, despite A.C.'s continued sedation, Dr. Weingold said that she was "quite reactive," and Dr. Hamner concurred.

After hearing this new evidence, the court found that it was "still not clear what her intent is" and again ordered that a caesarean section be performed. A. C.'s counsel sought a stay in this court, which was

denied. In re A.C., 533 A.2d 611, 613 (D.C. 1987). The operation took place, but the baby lived for only a few hours, and A.C. succumbed to cancer two days later.

### III

The reader may wonder why we are issuing an en banc opinion in this case despite its apparent mootness.<sup>6</sup> The case is moot only in the sense that the surgery which was ordered in this case has been performed, and no decision of ours can put the parties in the same position in which they found themselves before the trial court's order was issued. Otherwise the case is not moot, because collateral consequences will flow from any decision we make in this appeal.

The personal representative of A.C.'s estate has filed an action separate from this appeal against the hospital, based on the events leading to the trial court's order in this case. In these circumstances we adhere to our prior decisions refusing to dismiss an appeal as moot when resolution of the legal issues might affect a separate action, actual or prospective, between the parties. See *Kopff v. District of Columbia Alcoholic Beverage Control Board*, supra note 6, 381 A.2d at 1378 (citations omitted). Any right of action that A.C. may have had against the hospital as a result of the events that culminated in the trial court's order has probably survived her and may still be asserted by her estate (assuming that it is not otherwise subject to dismissal or barred for other reasons). See D.C. Code § 12-101 (1989) (survival statute).

Even if this case were truly moot and had no collateral consequences, we would nevertheless elect to hear it because what occurred here is "capable of repetition, yet evading review" (citations omitted). The challenged action here is not just the trial court's order but the hospital's handling of the medical emergency, which necessarily was too short to be fully litigated, given A.C.'s rapidly declining condition. Additionally, this is a suit for a declaratory judgment, in which the plaintiff is not A.C. but the hospital. Because the hospital operates a high-risk pregnancy clinic, it will in all likelihood again face a situation in which a pregnant but dying patient is either incapable of consenting to treatment or affirmatively refusing treatment. Indeed, any hospital in the District of Columbia may find itself in the same situation, even one without a specialized facility for such patients. There is thus a reasonable expectation that the challenged action in this case—i.e., the hospital's decision to seek judicial authorization for a medical procedure affecting a pregnant patient *in extremis*—may occur again. See *Honig v. Doe*, 484 U.S. 305, 108 S.Ct. 592, 601-602 & n. 6, 98 L.E.2d 686 (1988). Accordingly, we conclude that we should entertain this appeal in the exercise of our discretion, even assuming that it is partially or wholly moot.

### IV

Although we decide this case on the merits of the legal issues, it is important to remember that factual disputes dominate this controversy and determine how the legal issues are framed. It is, of course, beyond dispute that the trial court's findings of fact are binding on this court unless clearly erroneous. D.C. Code § 17-305(a) (1989); See e.g., *Bell v. Jones*, 523 A.2d 982, 992 (D.C.1986). Sitting as an appellate court, we cannot engage in fact-finding. See *Harmatz v. Zenith Radio Corp.*, 265 A.2d 291, 292 (D.C.1970). With these preliminary observations, we proceed to address the issues as we understand them.



### *A. Informed Consent and Bodily Integrity*

A number of learned articles have been written about the propriety or impropriety of court-ordered caesarean sections. (citations omitted) Commentators have also considered how medical decisions for incompetent persons which may involve some detriment or harm to them should be made. (citations omitted) These and other articles demonstrate the complexity of medical intervention cases, which become more complex with the steady advance of medical technology. From a recent national survey, it appears that over the five years preceding the survey there were thirty-six attempts to override maternal refusals of proposed medical treatment, and that in fifteen instances where court orders were sought to authorize caesarean interventions, thirteen such orders were granted. *Obstetrical Interventions, supra*, 316 NEW ENG. J. MED. at 1192-1193. Compare Goldberg, Medical Choices During Pregnancy: Whose Decision Is it Anyway? 41 Rutgers L.Rev. 591, 609 (1989) (finding twelve such cases). Nevertheless, there is only one published decision from an appellate court that deals with the question of when, or even whether, a court may order a caesarean section: *Jefferson v. Griffin Spalding County Hospital Authority*, 247 Ga. 86, 274 S.E.2d 457 (1981).

*Jefferson* is of limited relevance, if any at all, to the present case. In *Jefferson* there was a competent refusal by the mother to undergo the proposed surgery, but the evidence showed that performance of the caesarean was in the medical interests of both the mother and the fetus. In the instant case, by contrast, the evidence is unclear as to whether A.C. was competent when she mouthed her apparent refusal of the caesarean (“I don’t want it done”), and it was generally assumed that while the surgery would most likely be highly beneficial to the fetus, it would be dangerous for the mother. Thus there was no clear maternal-fetal conflict in this case arising from a competent decision by the mother to forego a procedure for the benefit of the fetus. The procedure may well have been against A.C.’s medical interest, but if she was competent and given the choice, she may well have consented to an operation of significant risk to herself in order to maximize her fetus’ chance for survival. From the evidence, however, we simply cannot tell whether she would have consented or not.

Thus our analysis of this case begins with the tenet common to all medical treatment cases: that any person has the right to make an informed choice, if competent to do so, to accept or forego medical treatment. The doctrine of informed consent, based on this principle and rooted in the concept of bodily integrity, is ingrained in our common law (citations omitted). Under the doctrine of informed consent, a physician must inform the patient, “at a minimum,” of “the nature of the proposed treatment, any alternative treatment procedures, and the nature and degree of risks and benefits inherent in undergoing and in abstaining from the proposed treatment.” *Crain v. Allison, supra*, 443 A.2d at 562 (footnote omitted). To protect the right of every person to bodily integrity, courts uniformly hold that a surgeon who performs an operation without the patient’s consent may be guilty of a battery, *Canterbury v. Spence, supra*, 150 U.S.App.D.C. at 274, 464 F.2d at 783, or that if the surgeon obtains an insufficiently informed consent, he or she may be liable for negligence. *Crain v. Allison, supra*, 443 A.2d at 561-562. Furthermore, the right to informed consent “also encompasses a right to informed refusal.” *In re Conroy*, 98 N.J. 321, 336, 486 A.2d 1209, 1222 (1985) (citation omitted).

In the same vein, courts do not compel one person to permit a significant intrusion upon his or her bodily integrity for the benefit of another person’s health. See, e.g., *Bonner v. Moran*, 75 U.S.App.D.C. 156, 157, 126 F.2d 121, 122 (1941) (parental consent required for skin graft from fifteen-year-old for benefit of cousin who had been severely burned); *McFall v. Shimp*, 10 Pa.D. & C.3d 90 (Allegheny County Ct. 1978). In *McFall* the court refused to order Shimp to donate bone marrow which was necessary to save the life of his cousin, *McFall*:

The common law has consistently held to a rule which provides that one human being is under no legal compulsion to give aid or to take action to save another human being or to rescue. For our law to *compel* defendant to submit to an intrusion of his body would change every concept and principle upon which our society is founded. To do so would defeat the sanctity of the individual, and would impose a rule which would know no limits, and one could not imagine where the line would be drawn.

Id. at 91 (emphasis in original). Even though Shimp's refusal would mean death for McFall, the court would not order Shimp to allow his body to be invaded. It has been suggested that fetal cases are different because a woman who "has chosen to lend her body to bring [a] child into the world" has an enhanced duty to assure the welfare of the fetus, sufficient even to require her to undergo caesarean surgery. Robertson, *Procreative Liberty*, supra, 69 Va.L.Rev. at 456. Surely, however, a fetus cannot have rights in this respect superior to those of a person who has already been born.

Courts have generally held that a patient is competent to make his or her own medical choices when that patient is capable of "the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each." *Canterbury v. Spence*, supra, 150 U.S.App.D.C. at 271, 464 F.2d at 780. Thus competency in a case such as this turns on the patient's ability to function as a decision-maker, acting in accordance with her preferences and values. *United States v. Charters*, 829 F.2d 479, 495-497 & nn. 23-26 (4<sup>th</sup> Cir. 1987) (competency to make treatment decisions depends on whether the patient is able to make a rational choice based on reason); *In re Farrell* 108 N.J. 335, 354 & n. 7, 529 A.2d 404, 413 & n. 7 (1987) ("A competent patient has a clear understanding of the nature of his or her illness and prognosis, and of the risks and benefits of the proposed treatment, and has the capacity to reason and make judgments about that information" (citations omitted)).

This court has recognized as well that, above and beyond common law protections, the right to accept or forego medical treatment is of constitutional magnitude. See *In re Bryant*, 542 A.2d 1216, 1218 (D.C.1988); *In re Boyd*, 403 A.2d 744, 748 (D.C.1979); *In re Osborne*, 294 A.2d 372 (D.C.1972). Other courts also have found a basis in the Constitution for refusing medical treatment. *e.g.*, *United States v. Charters*, supra, 829 F.2d at 491 & nn. 18-19 ("[t]he right to be free of unwanted physical invasions" is constitutionally protected); *Bee v. Greaves*, 744 F.2d 1387, 1392-1393 (10<sup>th</sup> Cir. 1984) (same), *cert. denied*, 469 U.S. 1214, 105 S.Ct. 1187, 84 L.Ed.2d 334 (1985); *Tune v. Walter Reed Army Medical Hospital*, 602 F.Supp. 1452, 1456 (D.D.1985) (competent patient has right to order removal of life-sustaining medical systems); *Ramsussen ex rel. Mitchell v. Fleming*, 154 Ariz. 207, 215, 741 P.2d 674, 681-682 (1987) (constitutional right of privacy encompasses the right to refuse life-sustaining care); see also *John F. Kennedy Memorial Hospital, Inc. v. Bludworth*, 452 So.2d 921, 923-926 (Fla. 1984) (incompetent persons have the right to discontinue life-sustaining care); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 739, 370 N.E.2d 417, 426 (1977) (incompetent person may decline medical treatment for incurable illness); *In re Conroy*, supra, 98 N.J. at 336-37, 486 A.2d at 1222-1223, 1229 (competent persons have constitutional right to refuse medical treatment, and persons who become incompetent retain that right).

Decisions of the Supreme Court, while not explicitly recognizing a right to bodily integrity, seem to assume that individuals have the right, depending on the circumstances, to accept or refuse medical treatment or other bodily invasion. See, *e.g.*, *Winston v. Lee*, 470 U.S. 753, 105 S.Ct. 1611, 84 L.Ed. 2d 662 (1985); *Schmeber v. California*, 384 U.S. 757, 86 S.Ct. 1826, 16 L.Ed.2d 908 (1966); *Rochin v. California*, supra note 8; *cf.* *Union Pacific Ry. V. Botsford*, 141 U.S. 250, 251, 11 S.Ct. 1000, 35 L.Ed. 734 (1891) ("No right is held more sacred, or is more carefully guarded, by the common law,

than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law” (emphasis added)). In *Winston v. Lee*, *supra*, a robbery suspect challenged the state’s right to compel him to submit to surgery for the removal of a bullet which was lodged in a muscle in his chest. The Court noted that the proposed surgery, which would require a general anesthetic, “would be an ‘extensive’ intrusion on respondent’s personal privacy and bodily integrity” and a “virtually total divestment of respondent’s ordinary control over surgical probing beneath his skin,” 470 U.S. at 764-765, 105 S.Ct. at 1619 (citation omitted), and held that, without the patient-suspect’s consent, the surgery was constitutionally impermissible. Nevertheless, even in recognizing a right to refuse medical treatment or state-imposed surgery, neither *Winston* nor any other Supreme Court decision holds that this right of refusal is absolute. Rather, in discussing the constitutional “reasonableness of surgical intrusions beneath the skin,” the Court said in *Winston* that the Fourth Amendment “neither forbids nor permits all such intrusions.” *Id.* at 760, 105 S.Ct. at 1616 (citing *Schmerber v. California*, *supra*); see also *Jacobson v. Massachusetts*, 197 U.S. 11, 25 S.Ct. 358, 49 L.Ed. 643 (1905) (upholding compulsory smallpox vaccinations over religious objections).

This court and others, while recognizing the right to accept or reject medical treatment, have consistently held that the right is not absolute (citations omitted). In some cases, especially those involving life-or-death situations or incompetent patients, the courts have recognized four countervailing interests that may involve the state as *parens patriae*: preserving life, preventing suicide, maintaining the ethical integrity of the medical profession, and protecting third parties (citations omitted). In *re Farrell*, *supra*, 108 N.J. at 350, 529 A.2d at 410-411. Neither the prevention of suicide nor the integrity of the medical profession has any bearing on this case. Further, the state’s interest in preserving life must be truly compelling to justify overriding a competent person’s right to refuse medical treatment. In *re Osborne*, *supra*, 294 A.2d at 374-375; *Tune v. Walter Reed Army Medical Hospital*, *supra*, 602 F.Supp. at 1455-1456. This is equally true for incompetent patients, who have just as much right as competent patients to have their decisions made while competent respected, even in a substituted judgment framework (citations omitted).

In those rare cases in which a patient’s right to decide her own course of treatment has been judicially overridden, courts have usually acted to vindicate the state’s interest in protecting third parties, even if in fetal state. See *Jefferson v. Griffin Spalding County Hospital Authority*, *supra* (ordering that caesarean section be performed on a woman in her thirty-ninth week of pregnancy to save both the mother and the fetus); *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*, 42 N.J. 421, 201 A.2d 537 (ordering blood transfusions over the objection of a Jehovah’s Witness, in her thirty-second week of pregnancy, to save her life and that of the fetus), cert. denied, 377 U.S. 985, 84 S.Ct. 1894, 12 L.Ed.2d 1032 (1964); *In re Jamaica Hospital*, 128 Misc.2d 1006, 491 N.Y.S.2d 898 (Sup.Ct. 1985) (ordering the transfusion of blood to a Jehovah’s Witness eighteen weeks pregnant, who objected on religious grounds, and finding that the state’s interest in the not-yet-viable fetus outweighed the patient’s interests); *Crouse Irving Memorial Hospital, Inc. v. Paddock*, 127 Misc.2d 101, 485 N.Y.S.2d 443 (Sup.Ct. 1985) (ordering transfusions as necessary over religious objections to save the mother and a fetus that was to be prematurely delivered); cf. *In re President & Directors of Georgetown College, Inc.*, *supra*, 118 U.S.App.D.C. at 88, 331 F.2d at 1008 (ordering a transfusion, *inter alia*, because of a mother’s parental duty to her living minor children). But see *Taft v. Taft*, 388 Mass. 331, 446 N.E.2d 395 (1983) (vacating an order which required a woman in her fourth month of pregnancy to undergo a “purse-string” operation, on the ground that there were no compelling circumstances to justify overriding her religious objections and her constitutional right of privacy).

What we distill from the cases discussed in this section is that every person has the right, under the common law and the Constitution, to accept or refuse medical treatment. This right of bodily integrity belongs equally to persons who are competent and persons who are not. Further, it matters not what the quality of a patient's life may be; the right of bodily integrity is not extinguished simply because someone is ill, or even at death's door. To protect that right against intrusion by others—family members, doctors, hospitals, or anyone else, however well-intentioned—we hold that a court must determine the patient's wishes by any means available, and must abide by those wishes unless there are truly extraordinary or compelling reasons to override them. In *re Osborne*, *supra*. When the patient is incompetent, or when the court is unable to determine competency, the substituted judgment procedure must be followed.

From the record before us, we simply cannot tell whether A.C. was ever competent, after being sedated, to make an informed decision one way or the other regarding the proposed caesarean section. The trial court never made any finding about A.C.'s competency to decide. Undoubtedly, during most of the proceedings below, A.C. was incompetent to make a treatment decision; that is, she was unable to give an informed consent based on her assessment of the risks and benefits of the contemplated surgery. The court knew from the evidence that A.C. was sedated and unconscious, and thus it could reasonably have found her incompetent to render an informed consent; however, it made no such finding. On the other hand, there was no clear evidence that A.C. was competent to render an informed consent after the trial court's initial order was communicated to her.

We think it is incumbent on any trial judge in a case like this, unless it is impossible to do so, to ascertain whether a patient is competent to make her own medical decisions. Whenever possible, the judge should personally attempt to speak with the patient and ascertain her wishes directly, rather than relying exclusively on hearsay evidence, even from doctors. See *In re Osborne*, *supra*, 294 A.2d at 374; *In re President & Directors of Georgetown College, Inc.*, *supra*, 118 U.S.App.D.C. at 87, 331 F.2d at 1007. It is improper to presume that a patient is incompetent. *United States v. Charters*, *supra*, 829 F.2d at 495. We have no reason to believe that, if competent, A.C. would or would not have refused consent to a caesarean. We hold, however, that without a competent refusal from A.C. to go forward with the surgery, and without a finding through substituted judgment that A.C. would not have consented to the surgery, it was error for the trial court to proceed to a balancing analysis, weighing the rights of A.C. against the interests of the state.

There are two additional arguments against overriding A.C.'s objections to caesarean surgery. First, as the American Public Health Association cogently states in its *amicus curiae* brief:

Rather than protecting the health of women and children, court-ordered caesareans erode the element of trust that permits a pregnant woman to communicate to her physician—without fear of reprisal—all information relevant to her proper diagnosis and treatment. An even more serious consequence of court-ordered intervention is that it drives women at high risk of complications during pregnancy and childbirth out of the health care system to avoid coerced treatment.

Second, and even more compellingly, any judicial proceeding in a case such as this will ordinarily take place—like the one before us here—under time constraints so pressing that it is difficult or impossible for the mother to communicate adequately with counsel, or for counsel to organize an effective factual and legal presentation in defense of her liberty and privacy interests and bodily integrity. Any intrusion implicating such basic values ought not to be lightly undertaken when the mother not only is precluded from conducting pre-trial discovery (to which she would be entitled as a matter of course in any

controversy over even a modest amount of money) but also is in no position to prepare meaningfully for trial.

In this case A.C.'s court-appointed attorney was unable even to meet with his client before the hearing. By the time the case was heard, A.C.'s condition did not allow her to be present, nor was it reasonably possible for the judge to hear from her directly. The factual record, moreover, was significantly flawed because A.C.'s medical records were not before the court and because Dr. Jeffrey Moscow, the physician who had been treating A.C. for many years, was not even contacted and hence did not testify. Finally, the time for legal preparation was so minimal that neither the court nor counsel mentioned the doctrine of substituted judgment, which-with benefit of briefs, oral arguments, and above all, time-we now deem critical to the outcome of this case. We cannot be at all certain that the trial judge would have reached the same decision if the testimony of Dr. Moscow and the abundant legal scholarship filed in this court had been meaningfully available to him, and if there had been enough time for him to consider and reflect on these matters as a judge optimally should do.

## V

Ordinarily, when the factual record in a case is insufficient to support the trial court's decision, we remand for additional findings. In this case, however, a remand for supplemental findings would be inappropriate and futile because the caesarean has been performed and cannot be undone. The record is unclear as to whether A.C. was ever competent, after being sedated, to make her own decision, and the likelihood of marshaling further evidence now on this question is doubtful at best.

Accordingly, we vacate the order of the trial court and remand the case for such further proceedings as may be appropriate. We note, in doing so, that the trial court's order allowing the hospital to perform the caesarean section was presumptively valid from the date it was entered until today. What the legal effect of that order may have been during its lifetime is a matter on which we express no opinion here.

Vacated and remanded.

## ***Bioethics Consultation***

Senator Alberto Reyes has introduced a bill containing the following provisions: (1) advanced directives and living wills are unenforceable if the patient is pregnant, regardless of the stage of the pregnancy; (2) healthcare providers must continue treatment of incompetent pregnant women regardless of if the fetus is known to be viable even if that runs counter with the express wishes of the patient, the patient's next-of-kin, or the designated surrogate decision-maker; (3) healthcare providers must have someone other than the pregnant woman sign an informed consent form on behalf of the child. Senator Reyes would like to know if these provisions are unconstitutional. Please advise. As a part of your advice, please let him know if he can achieve his goals by modifying the law in ways that will not run afoul of the Constitution.

Section (1) is permissible in a growing number of states.<sup>28</sup>

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<sup>28</sup> See Linda Carroll, *In many states, pregnancy invalidates a woman's DNR*, Reuters, at <https://www.reuters.com/article/us-health-pregnancy-advance-directives/in-many-states-pregnancy-invalidates-a-womans-dnr-idUSKCN1RZ1P4> (April 23, 2019).

Section (2) is becoming more common.<sup>29</sup>

Section (3) is not yet allowed. However, in light of the personhood movement, it is only a matter of time before it is.

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<sup>29</sup> See Avianne Tan, *Baby Delivered by Brain-Dead Mother on Life Support for 54 Days Leaves Hospital*, abcnews, at <https://abcnews.go.com/Health/baby-delivered-brain-dead-mother-life-support-54/story?id=31676251> (June 10, 2015); Manny Fernandez, *Texas Woman is Taken Off Life Support After Order*, The New York Times, at <https://www.nytimes.com/2014/01/27/us/texas-hospital-to-end-life-support-for-pregnant-brain-dead-woman.html> (Jan. 26, 2014).

## **PART III - DYING AND DEATH**

As the information in Part II indicates, Congress and state legislatures have enacted countless laws seeking to regulate reproductive choices. Those entities have been equally obsessed with regulating death. Legislators have enacted laws making it a crime for a person to commit suicide or to help another person commit suicide. A person who has not even been convicted of a crime may be deprived of his or her freedom and placed in a mental facility if that person is deemed to be suicidal. The chapters in this portion of the book focus upon the ethical and legal issues that surround the process of dying and death. The first chapter deals with the patient's right to refuse and to request the withdrawal of life-sustaining treatment. This right may be exercised on the patient's behalf by a third party. The second chapter deals with the legal issues that arise in situations when treatment is deemed to be medically futile. In those circumstances, the patient may want to continue treatment even after the healthcare providers have given up hope. The final chapter deals with the most controversial legal issue of the last few decades—whether a person should have the legal right to die with the assistance of a physician.

## CHAPTER SEVEN - THE RIGHT TO REFUSAL OF LIFE-SUSTAINING MEDICAL TREATMENT

A competent patient has the legal right to refuse life-sustaining medical treatment even if that refusal results in death. Courts have concluded that the right to refuse life-sustaining medical treatment stems from the following three sources: (1) the right to privacy; (2) the right to liberty; and (3) the right to give informed consent. To have the opportunity to exercise the right to refuse life-sustaining medical treatment, the person must be deemed to be legally competent. A finding of legal competence is not the same thing as a determination that the person is mentally sound.

### 7.1 Determining Competency

When deciding if a patient is legally competent, courts typically consider the following factors: (1) whether the patient expresses a preference for or against treatment; (2) whether the patient's decision is a reasonable one; (3) whether the patient's decision is based on rational reasons; and (4) whether the patient has the ability to understand or has demonstrated an understanding.

#### *Problems and Questions*

1. In which of the following situations, might the patient be deemed to be incompetent?
  - a. Dr. Ellis informed Brenda, an 87-year-old professional body builder, that she needed to have surgery to remove a small tumor from her gallbladder. Brenda refused to have the surgery because she was worried that the surgery might leave a scar on her stomach.
  - b. Ex-professional pilot Colbert went on a hunger strike because he wanted to protest the fact that Congress was financially bailing out the airlines. His doctors informed Colbert that if he did not agree to be put on a tube to get nutrition and hydration, he would die. Colbert refused the life-sustaining treatment because he wanted to finish what he had started.
  - c. After her husband was found dead at the bottom of the basement stairs, Wanda accused Taylor, her son, of pushing his father down the stairs. The police cleared Taylor of the murder because he proved that he was out of the country when his father died. The medical examiner also concluded that Wanda's husband accidentally fell down the stairs. Wanda stopped taking her insulin because she was afraid that Taylor had put poison in it. Doctors informed Wanda that she would die without the insulin. Wanda said that she would not take the insulin until the police arrested Taylor for his father's murder.
2. Why were the outcomes of the *Lane* and the *Northern* cases different? Do you agree with the results of the cases?



***Lane v. Candura*, 376 N.E. 2d 1232**

BY THE COURT.

This case concerns a 77-year old widow, Mrs. Rosaria Candura, of Arlington, who is presently a patient at the Symmes Hospital in Arlington suffering from gangrene in the right foot and lower leg. Her attending physicians recommended in April that the leg be amputated without delay. After some vacillation, she refused to consent to the operation, and she persists in that refusal. Her daughter, Grace R. Lane of Medford, filed a petition in the Probate Court for Middlesex County seeking appointment of herself as temporary guardian with authority to consent to the operation on behalf of her mother. An order and a judgment were entered in the Probate Court to that effect, from which the guardian ad litem appointed to represent Mrs. Candura has appealed.

We hold that Mrs. Candura has the right under the law to refuse to submit either to medical treatment or a surgical operation, that on the evidence and findings in this case the decision is one that she may determine for herself, and that therefore her leg may not be amputated unless she consents to that course of action.

The right of a person in most circumstances to decline treatment is clearly recognized in the important recent case of *Superintendent of Belchertown State Sch. v. Saikewicz*, — Mass. — - —, 370 N.E.2d 417 (1977). “The constitutional right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice.” *Id.*, at —, 370 N.E.2d at 426. Although the *Saikewicz* case also recognizes certain countervailing interests of the State which may in some cases outweigh the right of a competent individual to refuse lifesaving or life prolonging treatment, the case before us does not involve factors which would bring it within those lines of cases and thus warrant a court’s overriding the will of a competent person.

The principal question arising on the record before us, therefore, is whether Mrs. Candura has the legally requisite competence of mind and will to make the choice for herself. We look first to the findings of fact made by the judge who heard the testimony, including that of Mrs. Candura herself. His decision does not include a clear-cut finding that Mrs. Candura lacks the requisite legal competence. The nearest approach to such a finding is contained in the following passage from his decision:

“It is fair to conclude without necessarily finding that the ward is mentally ill for all purposes that she is incapable of making a rational and competent choice to undergo or reject the proposed surgery to her right leg. To this extent, at least, her behavior is irrational. She has closed her mind to the entire issue to the extent that the Court cannot conclude that her decision to reject further treatment is rational and informed. In the absence of substantial evidence that the ward has come to her current position as a result of a rational process after careful consideration of the medical alternatives, the Court finds that her confused mental condition resulting from her underlying senility and depression warrants the exercise of the jurisdiction of this Court and the application of a substitute choice for the ward as enunciated in the (*Saikewicz* ) case.”

In context, the quoted passage means only that, given some indications of a degree of senility and confusion on some subjects, the judge was not satisfied that Mrs. Candura arrived at her decision in a rational manner, i. e., “after careful consideration of the medical alternatives.” We do not think that the passage can be construed as a finding of legal incompetence, and we do not think that the evidence in the case would have warranted such a finding.

The facts found by the judge or established by uncontradicted evidence are as follows. Mrs. Candura was born in Italy, emigrated to the United States in 1918, was married, and had a daughter and three sons. She lost her husband in 1976 and has been depressed and unhappy since that time. Her relationship with her children is marked by a considerable degree of conflict. She lived in her own home until her hospitalization in November, 1977. In 1974 she had an infection in a toe on her right foot which became gangrenous. It was discovered at that time that she was diabetic. The toe was amputated. In 1977 she bruised her right leg while getting into a bus. The bruise developed into gangrene which resulted in an operation in November, 1977, in which a portion of her right foot was amputated. At that time an arterial bypass was done to decrease the likelihood that gangrene would recur. She went from the hospital to a rehabilitation center, where she remained until April. She then returned to the hospital and was found to have gangrene in the remainder of the foot. She originally agreed to amputation of the leg, but she withdrew her consent on the morning scheduled for the operation. She was discharged on April 21 and went to her daughter’s home but returned to the Symmes Hospital after a few days. Around May 9, responding to the persuasion of a doctor who has known Mrs. Candura for many years, she consented to the operation, but soon thereafter she reiterated her refusal.

She has discussed with some persons the reasons for her decision: that she has been unhappy since the death of her husband; that she does not wish to be a burden to her children; that she does not believe that the operation will cure her; that she does not wish to live as an invalid or in a nursing home; and that she does not fear death but welcomes it. She is discouraged by the failure of the earlier operations to arrest the advance of the gangrene. She tends to be stubborn and somewhat irascible. In her own testimony before the judge she expressed a desire to get well but indicated that she was resigned to death and was adamantly against the operation. Her testimony (corroborated by that of several of the witnesses) showed that she is lucid on some matters and confused on others. Her train of thought sometimes wanders. Her conception of time is distorted. She is hostile to certain doctors. She is on occasion defensive and sometimes combative in her responses to questioning. But she has exhibited a high degree of awareness and acuity. When responding to questions concerning the proposed operation. She has made it clear that she does not wish to have the operation even though that decision will in all likelihood lead shortly to her death. We find no indication in any of the testimony that that is not a choice with full appreciation of the consequences. The most that is shown is that the decision involves strong, emotional factors, that she does not choose to discuss the decision with certain persons, and that occasionally her resolve against giving consent weakens.

We start with the proposition that, in a proceeding for the appointment of a guardian under G.L.c. 201s 6A or s14 (permanent and temporary guardianships, respectively), the burden is on the petitioner to prove that the proposed ward is incompetent. *Willett v. Willett*, 333 Mass. 323, 324, 130 N.E.2d 582 (1955). A person is presumed to be competent unless shown by the evidence not to be competent. *Howe v. Howe*, 99 Mass. 88, 98-99 (1968). See *Wright v. Wright*, 139 Mass. 177, 182, 29 N.E. 380 (1885). Such evidence is lacking in this case. We recognize that Dr. Kelley, one of two psychiatrists who testified, did state that in his opinion Mrs. Candura was incompetent to make a rational choice whether to consent to the operation. His opinion appears to have been based upon (1) his inference from her unwillingness to discuss the problem with him that she was unable to face up to the problem

or to understand that her refusal constituted a choice; (2) his characterization of “an unwilling(ness), for whatever reason, to consent to life saving treatment as suicidal;” and (3) a possibility, not established by evidence as a reasonable probability, that her mind might be impaired by toxicity caused by the gangrenous condition. His testimony, read closely, and in the context of the questions put to him, indicates that his opinion is not one of incompetency in the legal sense, but rather that her ability to make a rational choice (by which he means the medically rational choice) is impaired by the confusion existing in her mind by virtue of her consideration of irrational and emotional factors.

A careful analysis of the evidence in this case, including the superficially conflicting psychiatric testimony, indicates that there is no real conflict as to the underlying facts. Certainly, the evidence presents no issue of credibility. The principal question is whether the facts established by the evidence justify a conclusion of legal incompetence. The panel are unanimous in the opinion that they do not.

The decision of the judge, as well as the opinion of Dr. Kelley, predicates the necessity for the appointment of a guardian chiefly on the irrationality (in medical terms) of Mrs. Candura’s decision to reject the amputation. Until she changed her original decision and withdrew her consent to the amputation, her competence was not questioned. But the irrationality of her decision does not justify a conclusion that Mrs. Candura is incompetent in the legal sense. The law protects her right to make her own decision to accept or reject treatment, whether that decision is wise or unwise. Similarly, the fact that she has vacillated in her resolve not to submit to the operation does not justify a conclusion that her capacity to make the decision is impaired to the point of legal incompetence. Indeed, her reaction may be readily understandable in the light of her prior surgical experience and the prospect of living the remainder of her life nonambulatory. Senile symptoms, in the abstract, may, of course, justify a finding of incompetence, but the inquiry must be more particular. What is lacking in this case is evidence that Mrs. Candura’s areas of forgetfulness and confusion cause, or relate in any way to, impairment of her ability to understand that in rejecting the amputation she is, in effect, choosing death over life.

This is not a case, therefore, like *In the Matter of Northern*, Tenn.App. (1978), in which the ward elected both to live and to reject an amputation operation, not appreciating that she must choose. Rather, this case is like *In the Matter of Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785 (Morris County Ct. 1978), in which an elderly person, although subject (like Mrs. Candura) to fluctuations in mental lucidity and to occasional losses of his train of thought, was held to be competent to reject a proposed operation to amputate gangrenous legs because he was capable of appreciating the nature and consequences of his decision. Contrast *Matter of Schiller*, 148 N.J. Super. 168, 372 A.2d 360 (1977), and *Application of L.I. Jewish-Hillside Medical Center*, 73 Misc.2d 395, 342 N.Y.S.2d 356 (1973), both amputation cases in which the patient was held to be incompetent.

Mrs. Candura’s decision may be regarded by most as unfortunate, but on the record in this case it is not the uninformed decision of a person incapable of appreciating the nature and consequences of her act. We cannot anticipate whether she will reconsider and will consent to the operation, but we are all of the opinion that the operation may not be forced on her against her will.

The order appointing a temporary guardian and the judgment authorizing the temporary guardian to consent to the operation are reversed, and a new judgment is to enter dismissing the petition.

So ordered.

***Dept. of H.S. v. Northern, 563 S.W.2d. 197***

TODD, JUDGE.

Opinion

This is a proceeding under Chapter 23, Title 14, T.C.A. entitled “Protective Services for Elderly Persons.”

Section 14-2301 declares:

“14-2301. Legislative intent and purpose. It shall be the responsibility of the state of Tennessee to develop and to encourage the provision of protective services for elderly persons residing in the state in need of such services. (Acts 1974 (Adj.S.), ch. 730, s 1.)”

On January 24, 1978, the Tennessee Department of Human Services filed this suit alleging that Mary C. Northern was 72 years old, with no available help from relatives; that Miss Northern resided alone under unsatisfactory conditions as a result of which she had been admitted to and was a patient in Nashville General Hospital; that the patient suffered from gangrene of both feet which required the removal of her feet to save her life; that the patient lacked the capacity to appreciate her condition or to consent to necessary surgery.

Attached to the complaint are identical letters from Drs. Amos D. Tackett and R. Benton Adkins which read as follows:

“Mrs. Mary Northern is a patient under our care at Nashville General Hospital. She has gangrene of both feet probably secondary to frost bite and then thermal burning of the feet. She has developed infection along with the gangrene of her feet. This is placing her life in danger. Mrs. Northern does not understand the severity or consequences of her disease process and does not appear to understand that failure to amputate the feet at this time would probably result in her death. It is our recommendation as the physicians in charge of her case, that she undergo amputation of both feet as soon as possible.”

On January 24, 1978, the Chancellor appointed a guardian ad litem to defend the cause and to receive service of process pursuant to Rule 4.04(2) T.R.C.P.

On January 25, 1978, the guardian ad litem answered as follows:

“The Respondent, by and through her guardian ad litem, states as follows:

1. She is 72 years of age and a resident of Davidson County, Tennessee.
2. She is presently in the intensive care unit of General Hospital, Nashville, Tennessee, because of gangrenous condition in her two feet.

3. She feels very strongly that her present physical condition is improving, and that she will recover without the necessity of surgery.
4. She is in possession of a good memory and recall, responds accurately to questions asked her, is coherent and intelligent in her conversation and is of sound mind.
5. She is aware that the Tennessee Department of Human Services has filed this complaint, knows the nature of the complaint, and does not wish for her feet to be amputated.
6. There is no psychiatric report of her mental capacity, and there is nothing in the hospital or court record to support the statement that she lacks the capacity to realize the need for protective services.
7. The Court should not grant the relief sought by the Department of Human Services until a psychiatric report of the Respondent's present mental state has been made a part of this record, and the Court finds that the Respondent lacks the mental capacity to consent to medical treatment.
8. The Court is without jurisdiction to grant the relief to award physical custody of the respondent to the Department of Human Services absent a finding that the Respondent is guilty of a crime, or absent a finding that the Respondent lacks sufficient mental capacity in accordance with T.C.A. 33-501 et seq., (Mentally Retarded Person), and/or T.C.A. 33-601 et seq., (Mentally Ill Person).
9. The relief sought by the Department of Human Services should be denied.
10. In the event that the court deems it proper to grant the relief sought, the appointment should be limited to allow the Department of Human Services only to consent to the operation and necessary medical care.
11. Although over fourteen years of age and mentally competent, the Respondent is not physically capable of signing this Answer, and the guardian ad litem signs on her behalf. "

On January 25, 1978, the Chancellor entered an order containing the following:

"This cause came on to be heard on the 25th day of January 1978, before the Honorable C. Allen High, Chancellor of Part II of the Chancery Court of Davidson County, Tennessee, upon the complaint filed by the Department of Human Services, the order of the Court appointing a guardian ad litem for Mary C. Northern, and upon the entire record, from all of which the Court is of the opinion that given the circumstances under which Mary C. Northern was found, the testimony of Charles Burch and Marie Hinkle, the statements of two physicians, the age of Mrs. Northern, the lack of relatives willing to act in her best interest, and her present physical condition, the Court is of the opinion that Mary C. Northern is indigent and is imminent (sic) danger of death if she does not receive the protective services of the Department of Human Services and she lacks the capacity to consent to said protective services, therefore the Court finds that the Department of Human Services should be designated responsible for the personal welfare of Mary C. Northern."

It is therefore, ordered, adjudged and decreed by the Court that:

1. Mary C. Northern is in imminent danger of death if she does not receive protective services and lacks the capacity to consent to protective services;

2. That the State of Tennessee, Department of Human Services, be and the same is hereby designated responsible for the personal welfare of the Respondent and for consenting to protective services in her behalf including taking the Respondent into physical custody and custody and consenting to any necessary medical treatment. “

On the same date, January 25, 1978, at 4:00 P.M., the Chancellor entered a further order staying the effectiveness of the preceding order until further order of Court.

On January 26, 1978, there was filed in this cause a letter from Dr. John J. Griffin, reporting that he found the patient to be generally lucid and sane, but concluding:

“Nonetheless, I believe that she is functioning on a psychotic level with respect to ideas concerning her gangrenous feet. She tends to believe that her feet are black because of soot or dirt. She does not believe her physicians about the serious infection. There is an adamant belief that her feet will heal without surgery, and she refused to even consider the possibility that amputation is necessary to save her life. There is no desire to die, yet her judgment concerning recovery is markedly impaired. If she appreciated the seriousness of her condition, heard her physicians’ opinions, and concluded against an operation, then I would believe she understood and could decide for herself. But my impression is that she does not appreciate the dangers to her life. I conclude that she is incompetent to decide this issue. A corollary to this denial is seen in her unwillingness to consider any future plans. Here again I believe she was utilizing a psychotic mechanism of denial.

“This is a schizoid woman who has been urged by everyone to have surgery. Having been self-sufficient previously (albeit a marginal adjustment), she is continuing to decide alone. The risks with surgery are great and her lifestyle has been permanently disrupted. If she has surgery, there is a tremendous danger for physical and psychological complications. The chances for a post-operative psychosis are immense, yet the surgeons believe an operation is necessary to save her life. I would advise delaying surgery (if feasible) for a few days in order to attempt some work for strengthening her psychologically. Even if she does not consent to the operation after that time, however, I believe she is incompetent to make the decision.”

On January 26, 1978, the Chancellor entered a further order vacating the stay of the first order and reinstating the previous (first) order, and providing further:

“The court requested that the guardian ad litem contact the head surgeon and delay surgery as recommended by Dr. Griffin.

“It is further ordered that the oral motion of the guardian ad litem to modify the original order be granted and reserved for later hearing.

“It is further ordered that the Department of Human Services compensate Dr. Griffin for his services rendered in this cause within a reasonable period of time.”

On January 27, 1978, the guardian ad litem moved for a new trial and stay of previous orders on grounds of unconstitutionality of Title 14, Chapter 23, T.C.A. and a number of other grounds.

On January 27, 1978, the Chancellor entered a decree overruling the motion for new trial and stay and reciting:

“The Chancellor announced at the final hearing on the merits that he found the respondent incompetent and that he was acting not only pursuant to the jurisdiction granted by T.C.A. s 14 T.C.A. s 14-2306 but also pursuant to Chancery jurisdiction of incompetent persons.

“From the orders of the Court in granting custody of the respondent to the State of Tennessee, in dissolving the temporary restraining order, and overruling her motion for new trial and for stay pending appeal, the respondent respectfully excepted and prayed an appeal to the Court of Appeals of Tennessee, which appeal is granted, provided that the appeal shall not act as a stay of the prior order of the Court.”

On January 27, 1978, the guardian ad litem presented to a member of this Court a petition for supersedeas which was not accompanied by a certified record as required by the Rules of this Court. The application for supersedeas was recessed until January 28, 1978, at 9 a.m.

On January 28, 1978, a certified transcript was filed, and two members of this Court heard argument on behalf of the parties and on behalf of a proposed amicus curiae, after which it was announced that this Court would act under s 27-327 T.C.A. to investigate the facts.

On the same date two members of this Court heard testimony of the three doctors previously mentioned and visited the patient in the intensive care unit of the hospital. Said testimony and the conversation with the patient were preserved by bill of exceptions filed with the Clerk of this Court.

On the same date, January 28, 1978, this Court entered an order reciting the following:

“From all of the above the Court Finds:

1. That the respondent is not now in ‘imminent danger of death’ in the extreme sense of the words, but that her present condition is such that ‘imminent danger of death’ may reasonably be expected during her continued hospitalization.
2. That both feet of respondent are severely necrotic and affected by wet gangrene, an infection which probably will result in death unless properly treated by amputation of the feet.
3. That the probability of respondent’s survival without amputation is from 5% to 10%; and the probability of survival after amputation is about 50%, with possible severe psychotic results.
4. That, with or without amputation, the prognosis of respondent’s condition is poor.
5. That respondent is an intelligent, lucid, communicative and articulate individual who does not accept the fact of the serious condition of her feet and is unwilling to discuss the seriousness of such condition or its fatal potentiality.
6. That, because of her inability or unwillingness to recognize the actual condition of her feet which is clearly observable by her, she is incompetent to make a rational decision as to the amputation of her feet.
7. That respondent has no wish to die, but is unable or unwilling to recognize an obvious condition which will probably result in her death if untreated.

“This Court is therefore of the opinion that a responsible individual should be named with authority to consent to amputation of respondent’s feet when urgently recommended in writing by respondent’s physicians because of the development of (symptoms) indicating an emergency and severe imminence of death.

“It is therefore ordered that the order of the Chancellor is modified to delete therefrom the words, ‘and consenting to any necessary medical treatment’ and to add thereto the following provision:

“The Hon. Horace Bass, Commissioner of the Department of Human Services of the State of Tennessee, or his successor in said office is hereby designated and authorized to act for and on behalf of respondent in consenting to the amputation of respondent’s feet at any time that Drs. Amos D. Tackett and R. Benton Adkins join in signing a written certificate that respondent’s condition has developed to such a critical stage as to demand immediate amputation to save her life.

“To the extent indicated, the writ of supersedeas is granted and the order of the Chancellor is so modified. In all other respects, the petition for writ of supersedeas is denied.”

The first assignment of error asserts that Title 14, Chapter 23, T.C.A. is unconstitutional.

Even if the original enactment of the statute were invalid because of insufficient caption, this was cured by subsequent re-enactment when incorporated into the Code. *Doughty v. Hammond*, 207 Tenn. 545, 555, 341 S.W.2d 713 (1960).

Appellant challenges the constitutionality of the provision of the statute authorizing ex parte preliminary orders without hearing. No action of the Chancellor taken without a hearing has been implemented, and all actions by this Court have occurred after full hearing. Therefore, it would seem unnecessary for this Court to rule upon the validity of such provision in this case. However, in the view of this Court, the statute properly and constitutionally recognizes and utilizes the inherent power of a court of equity to act in a preliminary, ex parte, manner to preserve the status quo and integrity of the subject matter of the suit. That is, in emergency cases, where there is inadequate time to give notice and hold a hearing, a Chancellor may, by preliminary order, take necessary measures to preserve and protect the subject matter of the suit until notice can be given and a hearing held. This power is to be exercised with caution and restraint, and is not to be utilized to the injury of the parties or to create new or irreversible conditions. Said equity power of preliminary action may be properly exercised under s 14s 14-2306(a) in authorizing and providing for the elderly person such protection and services the lack of which has produced the imminence of death. Such protection and services were afforded the patient prior to this suit without an order of court.

Affirmative steps producing an injury or irreversible condition (such as amputation) would not lie within the inherent powers of equity for preliminary relief, hence would not be authorized under s 14s 14-s-2306(a) without due notice and hearing.

The disposition of this appeal by this Court is considered to be in conformity with the foregoing principles. The application of the statute only to persons over 60 years of age is not per se an unconstitutional discrimination. *Massachusetts Board of Retirement v. Murgia*, 427 U.S. 307, 96 S.Ct. 2562, 49 L.Ed.2d 520 (1976).

This controversy arises from the fact that Miss Northern’s attending physicians have determined that all of the soft tissue of her feet has been killed by frostbite, that said dead tissue has become infected



with gangrene and that the feet must be removed to prevent loss of life from spreading of gangrene and its effects to the entire body. Miss Northern has refused to consent to the surgery.

The physicians have determined, and the Chancellor and this Court have found, that Miss Northern's life is critically endangered; that she is mentally incapable of comprehending the facts which constitute that danger; and that she is, to that extent, incompetent, thereby justifying State action to preserve her life.

As will be observed from the bill of exceptions, a member of this Court asked Miss Northern if she would prefer to die rather than lose her feet, and her answer was "possibly." This is the most definitive expression of her desires in this record.

The patient has not expressed a desire to die. She evidences a strong desire to live and an equally strong desire to keep her dead feet. She refuses to make a choice.

If the patient would assume and exercise her rightful control over her own destiny by stating that she prefers death to the loss of her feet, her wish would be respected. The doctors so testified; this Court so informed her; and this Court here and now reiterates its commitment to this principle.

For the reasons just stated, this is not a "right to die" case.

Even though the patient and her guardian ad litem may not have received the 48 hours' notice prior to the hearing before the Chancellor, they obtained a re-hearing before this Court which satisfies the requirement of the statute. That is, at the time of the hearing before this Court on January 28, 1978, more than 48 hours had elapsed from the original appointment of the guardian ad litem and her visit with the patient.

Any alleged insufficiency of evidence has been adequately supplied by the hearing before this Court on January 28, 1978. Any alleged insufficiency in interrogation of the patient by the psychiatrist was supplied by the testimony of the psychiatrist before this Court on January 28, 1978 and the interview of the patient conducted by judges of this Court and preserved as part of the record of proceedings on January 28, 1978.

This Court is satisfied from the testimony and from its own examination of the patient, both orally and visually, that the evidence is adequate in the challenged respects.

The statute authorizes the designation of "an individual or organization to be responsible for the personal welfare of the elderly person and for consenting to protective services." This Court does recognize the problems incident to designation of a governmental department or other agency rather than an individual to administer or execute the order of court in respect to certain matters. In respect to other matters such problems would not appear.

An organization might properly be designated to provide or make available the necessities of the elderly person. However, where the fiduciary function involves decision making on behalf of or control of the elderly person, it would be more appropriate to designate a particular individual to assure direct and specific responsibility and accountability.

In the present case, the Chancellor was not called upon to act until the imminence of death was moderately severe. By the time of the hearing before this Court, the imminence of death had lessened

somewhat but remained real and appreciable. Accordingly, this Court, recognizing a present real and appreciable imminence of death, made provision for drastic emergency measures to be taken only in event of severe and urgent imminence of death.

Appellant also complains of vagueness of the meaning of “capacity to consent.” Capacity means mental ability to make a rational decision, which includes the ability to perceive, appreciate all relevant facts and to reach a rational judgment upon such facts.

Capacity is not necessarily synonymous with sanity. A blind person may be perfectly capable of observing the shape of small articles by handling them, but not capable of observing the shape of a cloud in the sky.

A person may have “capacity” as to some matters and may lack “capacity” as to others.

In the present case, this Court has found the patient to be lucid and apparently of sound mind generally. However, on the subjects of death and amputation of her feet, her comprehension is blocked, blinded or dimmed to the extent that she is incapable of recognizing facts which would be obvious to a person of normal perception.

For example, in the presence of this Court, the patient looked at her feet and refused to recognize the obvious fact that the flesh was dead, black, shriveled, rotting and stinking.

The record also discloses that the patient refuses to consider the eventuality of death which is or ought to be obvious in the face of such dire bodily deterioration.

As described by the doctors and observed by this Court, the patient wants to live and keep her dead feet, too, and refuses to consider the impossibility of such a desire. In order to avoid the unpleasant experience of facing death and/or loss of feet, her mind or emotions have resorted to the device of denying the unpleasant reality so that, to the patient, the unpleasant reality does not exist. This is the “delusion” which renders the patient incapable of making a rational decision as to whether to undergo surgery to save her life or to forego surgery and forfeit her life.

The physicians speak of probabilities of death without amputation as 90 to 95% And the probability of death with surgery as 50-50 (1 in 2). Such probabilities are not facts, but the existence and expression of such opinions are facts which the patient is unwilling or unable to recognize or discuss.

If, as repeatedly stated, this patient could and would give evidence of a comprehension of the facts of her condition and could and would express her unequivocal desire in the face of such comprehended facts, then her decision, however unreasonable to others, would be accepted and honored by the Courts and by her doctors. The difficulty is that she cannot or will not comprehend the facts.

This Court is painfully and acutely aware of the possible tragic results of amputation. According to the doctors, the patient has only a 50% Chance of surviving the surgery; and, if she survives, she will never be able to walk and may suffer severe mental and emotional problems.

On the other hand, the doctors testified, and this Court finds, that the patient’s chances of survival without amputation are from 5% To 10% A rather remote and fragile chance. Moreover, as testified by the doctors and found by this Court, even if the patient should survive without amputation, she will never walk because the dead flesh will fall off the bones of her feet leaving only bare bones.

Appellant's argument ignores the fact that this proceeding was begun after the patient was removed to a hospital, after she had been under treatment for seven days and only because of her refusal to agree to surgery.

No action has been taken in regard to the patient by virtue of any order entered in this case and no action is contemplated except amputation if and when such becomes imperatively necessary to save her life.

This is not a case of wrongful custody or detention, but a case limited to the issue of competency to consent to surgery and the furnishing of competent consent.

Appellant's brief presents several serious issues which this Court answers as follows:

1. Does the State have the constitutional power to act for incompetents? Answer: It has.
2. Does the power of the State over incompetents extend to partial incompetents? Answer: To the extent of the partial incompetency, Yes.
3. Is the patient incompetent? Answer, Yes, partially, to the extent indicated.
4. Is the patient in imminent danger of death? Answer, Yes, sufficient to invoke T.C.A. 14-2306a.
5. Is an order authorizing amputation justified? Answer, Yes, within the limitations and guidelines of the order entered by this Court on January 28, 1978.
6. Has the patient been accorded due process? Answer: The procedure before the Chancellor and this Court, taken together, satisfies due process.
7. Is Title 14, Chapter 23, T.C.A. constitutional? Answer, Yes.

By order of the Presiding Judge of this Court, a brief has been filed by the Society for the Right to Die, Inc. The discussion therein is largely irrelevant in the light of the finding of fact that the patient is incompetent on the subject of feet, amputation and death.

The order of the Chancellor entered on January 25, 1978, and previously quoted is modified to read as follows:

"The Court is of the opinion that Mary C. Northern is in imminent danger of death if she does not receive certain protective services and she lacks the capacity to consent to said protective services."

"It is, therefore, ordered, adjudged and decreed that

"1. Mary C. Northern is in imminent danger of death if she does not receive surgical amputation of her lower extremities and she lacks the capacity to consent or refuse consent for such surgery.

"2. That Honorable Horace Bass, Commissioner of Human Services of the State of Tennessee or his successor in office is hereby designated and authorized to act for and on behalf of said Mary C. Northern in consenting to surgical amputation of her lower extremities and of exercising such custodial supervision as is necessarily incident thereto at any time that Drs. Amos D. Tackett and R. Benton Adkins join in signing a written certificate that Mary C. Northern's condition has developed to such a critical stage as to demand immediate amputation to save her life. The previous order of this Court is likewise so modified.

As modified, the order of the Chancellor is affirmed. The cause is remanded for further appropriate proceedings including fixing of such additional guardian ad litem fee as may be appropriate.

Modified, Affirmed and Remanded.

\*On May 1, 1978, Mary Northern died in a Nashville hospital as the result of a clot from the gangrenous tissue migrating through the bloodstream to a vital organ. Because of complications rendering surgery more dangerous, the proposed surgery was never performed.

## 7.2 Right of the Competent Patient

### *Conroy*, 486 A.2d 1209 (Part I)

SCHREIBER, J.

At issue here are the circumstances under which life-sustaining treatment may be withheld or withdrawn from incompetent, institutionalized, elderly patients with severe and permanent mental and physical impairments and a limited life expectancy.

Plaintiff, Thomas C. Whittemore, nephew and guardian of Claire Conroy, an incompetent, sought permission to remove a nasogastric feeding tube, the primary conduit for nutrients, from his ward, an eighty-four-year-old bedridden woman with serious and irreversible physical and mental impairments who resided in a nursing home. John J. Delaney, Jr., Conroy's guardian *ad litem*, opposed the guardian's petition. The trial court granted the guardian permission to remove the tube, and the Appellate Division reversed.

I

In 1979 Claire Conroy, who was suffering from an organic brain syndrome that manifested itself in her exhibiting periodic confusion, was adjudicated an incompetent, and plaintiff, her nephew, was appointed her guardian. The guardian had Ms. Conroy placed in the Parkview Nursing Home, a small nursing facility with thirty beds. There she came under the care of Dr. Kazemi, a family practitioner, and Catherine Rittel, a registered nurse, who was the nursing home administrator. Upon her admission, Ms. Conroy, although confused, could converse and follow directions, was ambulatory, and was in relatively good physical condition. Thereafter, she became increasingly confused, disoriented, and physically dependent.

Ms. Conroy was hospitalized on two occasions at Clara Maas Hospital, once between July 23, 1979 and August 8, 1979, for dehydration and a urinary tract infection, and later between July 21, 1982 and November 17, 1982, for an elevated temperature and dehydration. During the latter hospitalization the diagnostic evaluation showed that Ms. Conroy had necrotic gangrenous ulcers on her left foot. Two orthopedic surgeons recommended that to save her life, her leg should be amputated. However, her nephew refused to consent to the surgery because he was confident that she would not have wanted it. Contrary to the doctors' prognosis, Ms. Conroy did not die from the gangrene.

During this second hospitalization, Dr. Kazemi observed that Ms. Conroy was not eating adequately, and therefore, on July 23, he inserted a nasogastric tube that extended from her nose through her esophagus to her stomach. Medicines and food were then given to her through this tube. On October 18, the tube was removed, and Ms. Conroy was fed by hand through her mouth for two weeks. However, she was unable to eat a sufficient amount in this manner, and the tube was reinserted on November 3.

When Ms. Conroy was discharged from the hospital to the nursing home on November 17, 1982, the tube was left in place. It continued to be used for the same purposes thereafter. A second attempt to feed Ms. Conroy through her mouth about January, 1983 failed because Ms. Conroy was incapable of swallowing sufficient amounts of nutrients and water. According to the testimony of Dr. Kazemi, Ms. Conroy had such difficulty swallowing that even a person with great time and patience could probably not have coaxed her into absorbing enough fluids and solid food by mouth to sustain herself.

At the time of trial, Ms. Conroy was no longer ambulatory and was confined to bed, unable to move from a semi-fetal position. She suffered from arteriosclerotic heart disease, hypertension, and diabetes mellitus; her left leg was gangrenous to her knee; she had several necrotic decubitus ulcers (bed sores) on her left foot, leg, and hip; an eye problem required irrigation; she had a urinary catheter in place and could not control her bowels; she could not speak; and her ability to swallow was very limited. On the other hand, she interacted with her environment in some limited ways: she could move her head, neck, hands, and arms to a minor extent; she was able to scratch herself, and had pulled at her bandages, tube, and catheter; she moaned occasionally when moved or fed through the tube, or when her bandages were changed; her eyes sometimes followed individuals in the room; her facial expressions were different when she was awake from when she was asleep; and she smiled on occasion when her hair was combed, or when she received a comforting rub.

Dr. Kazemi and Dr. Davidoff, a specialist in internal medicine who observed Ms. Conroy before testifying as an expert on behalf of the guardian, testified that Ms. Conroy was not brain dead, comatose, or in a chronic vegetative state. They stated, however, that her intellectual capacity was very limited, and that her mental condition probably would never improve. Dr. Davidoff characterized her as awake, but said that she was severely demented, was unable to respond to verbal stimuli, and, as far as he could tell, had no higher functioning or consciousness. Dr. Kazemi, in contrast, said that although she was confused and unaware, “she responds somehow.”

The medical testimony was inconclusive as to whether, or to what extent, Ms. Conroy was capable of experiencing pain. Dr. Kazemi thought that Ms. Conroy might have experienced some degree of pain from her severely contracted limbs, or that the contractures were a reaction to pain, but that she did not necessarily suffer pain from the sores on her legs. According to Dr. Davidoff, it was unclear whether Ms. Conroy’s feeding tube caused her pain, and it was “an open question whether she [felt] pain” at all; however, it was possible that she was experiencing a great deal of pain. Dr. Davidoff further testified that she responded to noxious or painful stimuli by moaning. The trial court determined that the testimony of a neurologist who had examined Ms. Conroy would not be necessary, since it believed that it had sufficient evidence about her medical condition on which to base a decision.

Both doctors testified that if the nasogastric tube were removed, Ms. Conroy would die of dehydration in about a week. Dr. Davidoff believed that the resulting thirst could be painful but that Ms. Conroy would become unconscious long before she died. Dr. Kazemi concurred that such a death would be painful.

Dr. Kazemi stated that he did not think it would be acceptable medical practice to remove the tube and that he was in favor of keeping it in place. As he put it, “she’s a human being and I guess she has a right to live if it’s possible.” Ms. Rittel, the nurse, also thought the tube should not be removed since in her view it was not an extraordinary treatment. The nursing home had taken no position on the subject.

Dr. Davidoff said that if he had been the treating physician and the case had not come to court, he would have removed the tube with the family’s consent. In his opinion, although Ms. Conroy seemed to be receiving excellent care, she did not have long to live, perhaps a few months. In those circumstances, he considered nasogastric feeding an extraordinary, or optional, medical treatment, because it went “beyond the necessities of life.” He analogized the nasogastric tube to a respirator that supplies oxygen and said that since Ms. Conroy was “hopelessly ill with no possibility of returning to any sort of cognitive function, in the face of possibly [*sic*] suffering taking place at the moment,” he could recommend that the feeding tube be removed.

Ms. Conroy had lived a rather cloistered life. She had been employed by a cosmetics company from her teens until her retirement at age 62 or 63. She had lived in the same home from her childhood until she was placed in the nursing home, had never married, and had very few friends. She had been very close to her three sisters, all of whom had died.

Ms. Conroy’s only surviving blood relative was her nephew, the guardian, Thomas Whittemore. He had known her for over fifty years, had visited her approximately once a week for four or five years prior to her commitment to the nursing home, and had continued to visit her regularly at the nursing home for some time. The record contained additional evidence about the nephew’s and aunt’s financial situations and the history of their relationship. Based on the details of that record, there was no question that the nephew had good intentions and had no real conflict of interest due to possible inheritance when he sought permission to remove the tube.

Mr. Whittemore testified that Ms. Conroy feared and avoided doctors and that, to the best of his knowledge, she had never visited a doctor until she became incompetent in 1979. He said that on the couple of occasions that Ms. Conroy had pneumonia, “[y]ou couldn’t bring a doctor in,” and his wife, a registered nurse, would “try to get her through whatever she had.” He added that once, when his wife took Ms. Conroy to the hospital emergency room, “as foggy as she was she snapped out of it, she would not sign herself in and she would have signed herself out immediately.” According to the nephew, “[a]ll [Ms. Conroy and her sisters] wanted was to \*have their bills paid and die in their own house.” He also stated that he had refused to consent to the amputation of her gangrenous leg in 1982 and that he now sought removal of the nasogastric tube because, in his opinion, she would have refused the amputation and “would not have allowed [the nasogastric tube] to be inserted in the first place.”

Ms. Conroy was a Roman Catholic. The Rev. Joseph Kukura, a Roman Catholic priest and an associate professor of Christian Ethics at the Immaculate Conception Seminary in Mahwah, New Jersey, testified that acceptable church teaching could be found in a document entitled “Declaration of Euthanasia” published by the Vatican Congregation for the Doctrine of the Faith, dated June 26, 1980. The test that this document espoused required a weighing of the burdens and the benefits to the patient of remaining alive with the aid of extraordinary life-sustaining medical treatment. Father Kukura said that life-sustaining procedures could be withdrawn if they were extraordinary, which he defined to embrace “all procedures, operations or other interventions which are excessively expensive, burdensome or inconvenient or which offer no hope of benefit to a patient.” Here, he said, the hope of recovery and of returning to cognitive life, even with the nasogastric feeding, was not a reasonable possibility. The

means of care were not adding to the value of her life, which was outweighed by the burdens of that life. He therefore considered the use of the nasogastric tube extraordinary. It was his judgment that removal of the tube would be ethical and moral, even though the ensuing period until her death would be painful.

The trial court decided to permit removal of the tube. 188 N.J. Super, 523, 457 A.2d 1232 (Ch Div. 1983). It reasoned that the focus of inquiry should be whether life has become impossibly and permanently burdensome to the patient. If so, the court held, prolonging life becomes pointless and perhaps cruel. It determined that removal of the tube would lead to death by starvation and dehydration within a few days, and that the death might be painful. Nevertheless, it found that Ms. Conroy's intellectual functioning had been permanently reduced to a very primitive level, that her life had become impossibly and permanently burdensome, and that removal of the feeding tube should therefore be permitted.

The guardian *ad litem* appealed. While the appeal was pending, Ms. Conroy died with the nasogastric tube intact. Nevertheless, the Appellate Division decided to resolve the meritorious issues, finding that they were of significant public importance and that this type of case was capable of repetition but would evade review because the patients involved frequently die during litigation. 190 N.J. Super. 453, 459-60, 464 A.2d 303 (1983).

The Appellate Division viewed the ultimate question to be whether Claire Conroy's right of privacy outweighed the State's interest in preserving life. 190 N.J. Super. at 460, 464 A.2d 303. It held that the right to terminate life-sustaining treatment based on a guardian's judgment was limited to incurable and terminally ill patients who are brain dead, irreversibly comatose, or vegetative, and who would gain no medical benefit from continued treatment. 190 N.J. Super. at 466, 464 A.2d 303. As an alternative ground for its decision, it held that a guardian's decision may never be used to withhold nourishment, as opposed to the treatment or attempted curing of a disease, from an incompetent patient who is not comatose, brain dead, or vegetative, and whose death is not irreversibly imminent. 190 N.J. Super. at 456-70, 464 A.2d 303. Depriving a patient of a basic necessity of life, such as food, under those circumstances, the court stated, would hasten death rather than simply allow the illness to take its natural course. 190 N.J. Super. at 473, 464 A.2d 303. The court concluded that withdrawal of Ms. Conroy's nasogastric tube would be tantamount to killing her—not simply letting her die—and that such active euthanasia was ethically impermissible. *Id.*, 190 N.J. Super. at 475, 464 A.2d 303. The Appellate Division therefore reversed the trial court's judgment.

We granted the guardian's petition for certification, 95 N.J. 195, 470 A.2d 418 (1983), despite Ms. Conroy's death, since we agree with the Appellate Division that the matter is of substantial importance and is capable of repetition but evades review. We permitted the participation as *amici curiae* of New Jersey Hospital Association; former Commissioners and professional staff members of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research; National Citizens' Coalition for Nursing Home Reform; John R. Connery, S.J., William E. May, William Smith, Benedict Ashley, O.P., the Student Ad Hoc Committee Against the War in Vietnam, and the New Jersey Concerned Taxpayers; The American Geriatrics Society; New Jersey Catholic Conference; New Jersey Right to Life Committee, Inc.; and Concern for Dying.

## II

This case requires us 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 issues: what substantive guidelines are appropriate for making these treatment decisions for incompetent patients, and what procedures should be followed in making them.

A tragic situation like that of Claire Conroy raises profoundly disturbing questions that do not lend themselves to easy answers or ideal solutions. As scientific advances make it possible for us to live longer than ever before, even when most of our physical and mental capacities have been irrevocably lost, patients and their families are increasingly asserting a right to die a natural death without undue dependence on medical technology or unnecessarily protracted agony—in short, a right to “die with dignity.” On the other hand, all persons have a fundamental right to expect that their lives will not be foreshortened against their will. The President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, an interdisciplinary group of ethicists, lawyers, doctors, theologians, and others established by Congress in 1978 to propose guidelines for resolving these and similar issues, stated the problem this way: “Once someone realizes that the time and manner of death are substantially under the control of medical science, he or she wants to be protected against decisions that make death too easy and quick as well as from those that make it too agonizing and prolonged.” *President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment* 23 (1983) [hereinafter cited as *President’s Commission Report* ].

Deciding on a course of treatment for an incompetent patient without impinging on either of these two interests is a difficult task. To err either way—to keep a person alive under circumstances under which he would rather have been allowed to die, or to allow that person to die when he would have chosen to cling to life—would be deeply unfortunate.

We thus approach this case with caution, conscious that life-and-death decisions like these are an awesome responsibility that can be undertaken only with a profound sense of humility and reserve. The case of Claire Conroy raises moral, social, technological, philosophical, and legal questions involving the interplay of many disciplines. No one person or profession has all the answers.

Perhaps it would be best if the Legislature formulated clear standards for resolving requests to terminate life-sustaining treatment for incompetent patients. As an elected body, the Legislature is better able than any other single institution to reflect the social values at stake. In addition, it has the resources and ability to synthesize vast quantities of data and opinions from a variety of fields and to formulate general guidelines that may be applicable to a broad range of situations.

We have had the benefit of some legislation in this state concerning the rights of the institutionalized elderly. See N.J.S.A. 30:13-1 to -11 and N.J.S.A. 52:27G-1 to -16. The former statute prescribes certain responsibilities of nursing homes and rights of residents. The latter statute, discussed in detail *infra* at pages — — — (slip op. at 64–68), is directed to the protection of the civil and human rights of the elderly confined to long-term care facilities and similar institutions. However, neither statute provides specific guidelines concerning termination of life-sustaining treatment.

Meanwhile, in the absence of specific legislation on the termination of life-sustaining treatment, we may not properly avoid the issue that we have been asked to resolve merely because it is troubling or difficult. Every day, and with limited legal guidance, families and doctors are making decisions for patients like Claire Conroy. See Howell, “Caretakers’ Views on Responsibilities for the Care of the



Demented Elderly,” 32(9) *J. Am. Geriatrics Soc’y* 657, 658–59 (1984), and Hilfiker, “Sounding Board: Allowing the Debilitated to Die,” 308 *New Eng. J. Med.* 716 (1983) (describing wide variety of contexts in which health care professionals may be forced to make such subjective decisions for patients and their families). The courts, as guardians of our personal rights, have a special responsibility to place appropriate constraints on such private decision-making and to create guideposts that will help protect people’s interests in determining the course of their own lives. See *Satz v. Perlmutter*, supra, 379 So.2d at 360-61. As we wrote in *In re Quinlan*, 70 N.J. 10, 44 355 A.2d 647, cert. denied sub nom. *Garger v. New Jersey*, 429 U.S. 922, 97 S.Ct. 319, 50 L.Ed.2d 289 (1976): “[T]he law, equity and justice must not themselves quail and be helpless in the face of modern technological marvels presenting questions hitherto unthought of.”

### III

The starting point in analyzing whether life-sustaining treatment may be withheld or withdrawn from an incompetent patient is to determine what rights a competent patient has to accept or reject medical care. It is therefore necessary at the outset of this discussion to identify the nature and extent of a patient’s rights that are implicated by such decisions.

The right of a person to control his own body is a basic societal concept, long recognized in the common law:

No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law. As well said by *Judge Cooley*, “The right to one’s person may be said to be a right of complete immunity: to be let alone.” *Cooley on Torts*, 29. *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251, 11 S.Ct. 1000, 1001, 35 L.Ed. &34, 737 (1891 (refusing to compel personal injury plaintiff to undergo pretrial medical examination).]

Accord *Perna v. Pirozzi*, 92 N.J. 446, 459-65, 457 A.2d 431 (1983). Judge Cardozo succinctly captured the essence of this theory as follows: “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.” *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914).

The doctrine of informed consent is a primary means developed in the law to protect this personal interest in the integrity of one’s body. “Under this doctrine, no medical procedure may be performed without a patient’s consent, obtained after explanation of the nature of the treatment, substantial risks, and alternative therapies.” Cantor, “A Patient’s Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life,” 26 *Rutgers L.Rev.* 228, 237 (1973) (footnote omitted); see also *Perna v. Pirozzi*, supra, 92 N.J. at 461, 457 A.2d 431 (“Absent an emergency, patients have the right to determine not only whether surgery is to be performed on them, but who shall perform it.”)

The doctrine of informed consent presupposes that the patient has the information necessary to evaluate the risks and benefits of all the available options and is competent to do so. *Cf.* Wanzer, Adelstein, Cranford, Federman, Hook, Moertel, Safar, Stone, Taussig & Van Eys, “The Physician’s Responsibility Toward Hopelessly Ill Patients,” 310 *New Eng. J. Med.* 955, 957 (1984) (“There are three basic prerequisites for informed consent: the patient must have the capacity to reason and make judgments, the decision must be made voluntarily and without coercion, and the patient must have a

clear understanding of the risks and benefits of the proposed treatment alternatives or nontreatment, along with a full understanding of the nature of the disease and the prognosis.”). In general, it is the doctor’s role to provide the necessary medical facts and the patient’s role to make the subjective treatment decision based on his understanding of those facts. Cf. Hilfiker, *supra*, 308 *New Eng. J. Med.* at 718 (acknowledging that “our ability [as doctors] to phrase options, stress information, and present our own advice gives us tremendous power”).

The patient’s ability to control his bodily integrity through informed consent is significant only when one recognizes that this right also encompasses a right to informed refusal. Note, “Informed Consent and the Dying Patient,” 83 *Yale L.J.* 1632, 1648 (1974). Thus, a competent adult person generally has the right to decline to have any medical treatment initiated or continued. See *Superintendent of Belchertown State School v. Saikewicz*, 372 Mass. 728, 738, 370 N.E.2d 417, 424 (1977); *In re Quackenbush*, 156 N.J. Super. 282, 290, 383 A.2d 785 (Cty.Ct.1978); *of Bennan v. Parsonnet*, 83 N.J.L. 20, 22-23, 83 A.948 (Sup. Ct. 1912) (acknowledging common-law rule that patient is “the final arbiter as to whether he shall take his chances with the operation or take his chances of living without it,” but holding that surgeon had implied consent while patient was unconscious to perform necessary surgical operation).

The right to make certain decisions concerning one’s body is also protected by the federal constitutional right of privacy. The Supreme Court first articulated the right of privacy in *Griswold v. Connecticut*, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965), which held that married couples have a constitutional right to use contraceptives. The Court in *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973), further extended its recognition of the privacy right to protect a woman’s decision to abort a pregnancy although the woman’s right to choose abortion directly conflicted with the state’s legitimate and important interest in preserving the potentiality of fetal life. Finally, in *Quinlan*, *supra*, 70 N.J. at 40, 355 A.2d 647, we indicated that the right of privacy enunciated by the Supreme Court “is broad enough to encompass a patient’s decision to decline medical treatment under certain circumstances,” even if that decision might lead to the patient’s death. Accord *Saikewicz*, *supra*, 373 Mass. at 738, 370 N.E.2d at 424, *Quackenbush*, *supra*, 156 N.J. Super. at 289-90, 383 A.2d 785. While this right of privacy might apply in a case such as this, we need not decide that issue since the right to decline medical treatment is, in any event, embraced within the common-law right to self-determination (citations omitted).

Whether based on common-law doctrines or on constitutional theory, the right to decline life-sustaining medical treatment is not absolute. In some cases, it may yield to countervailing societal interests in sustaining the person’s life. Courts and commentators have commonly identified four state interests that may limit a person’s right to refuse medical treatment: preserving life, preventing suicide, safeguarding the integrity of the medical profession, and protecting innocent third parties (citations omitted).

The state’s interest in preserving life is commonly considered the most significant of the four state interests (citations omitted). It may be seen as embracing two separate but related concerns: an interest in preserving the life of the particular patient, and an interest in preserving the sanctity of all life. Cantor, “Quinlan, Privacy, and the Handling of Incompetent Dying Patients,” see Annas, “In re Quinlan: Legal Comfort for Doctors,” *Hastings Center Rep.*, June 1976, at 29.

While both of these state interests in life are certainly strong, in themselves they will usually not foreclose a competent person from declining life-sustaining medical treatment for himself. This is because the life that the state is seeking to protect in such a situation is the life of the same person who

has competently decided to forego the medical intervention; it is not some other actual or potential life that cannot adequately protect itself.

In cases that do not involve the protection of the actual or potential life of someone other than the decision maker, the state's indirect and abstract interest in preserving the life of the competent patient generally gives way to the patient's much stronger personal interest in directing the course of his own life. See, e.g., *Quackenbus*, supra, 156 N.J. Super. at 290, 383 A.2d 785; *Cantor*, supra, 30 Rutgers L.Rev. at 249–50. Indeed, insofar as the “sanctity of individual free choice and self-determination [are] fundamental constituents of life,” the value of life may be lessened rather than increased “by the failure to allow a competent human being the right of choice.” *Saikewicz*, supra, 373 Mass. At 742, 370 N.E.2d at 426; see also *Cantor*, supra, 30 Rutgers L.Rev. at 250 (“Government tolerance of the choice to resist treatment reflects concern for individual self-determination, bodily integrity, and avoidance of suffering, rather than a deprecation of life's value.”).

It may be contended that in conjunction with its general interest in preserving life, this state has a particular legislative policy of preventing suicide. See *N.J.S.A.* 30:4-26.3a (subjecting any person who attempts suicide to temporary hospitalization when the person's behavior suggests the existence of mental illness and constitutes a peril to life, person, or property); see also *N.J.S.A.* 2C:11-6 (“A person who purposely aids another to commit suicide is guilty of a crime of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a crime of the fourth degree.”). This state interest in protecting people from direct and purposeful self-destruction is motivated by, if not encompassed within, the state's more basic interest in preserving life. Thus, it is questionable whether it is a distinct state interest worthy of independent consideration.

In any event, declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury (citations omitted).

Recognizing the right of a terminally ill person to reject medical treatment respects that person's intent, not to die, but to suspend medical intervention at a point consonant with the “individual's view respecting a personally preferred manner of concluding life.” Note, “The Tragic Choice: Termination of Care for Patients in a Permanent Vegetative State,” 51 N.Y.U.L.Rev. 285, 310 (1976). The difference is between self-infliction or self-destruction and self-determination. See *Byrn*, “Compulsory Lifesaving Treatment for the Competent Adult,” 44 Fordham L.Rev. 1, 16–23 (1975). To the extent that our decision in *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 581–82, 279 A.2d 670 (1971), implies the contrary, we now overrule it.

The third state interest that is frequently asserted as a limitation on a competent patient's right to refuse medical treatment is the interest in safeguarding the integrity of the medical profession. This interest, like the interest in preventing suicide, is not particularly threatened by permitting competent patients to refuse life-sustaining medical treatment. Medical ethics do not require medical intervention in disease at all costs. As long ago as 1624, Francis Bacon wrote, “I esteem it the office of a physician not only to restore health, but to mitigate pain and dolours; and not only when such mitigation may conduce to recovery, but when it may serve to make a fair and easy passage.” F. Bacon, *New Atlantis*, quoted in *Mannes*, “Euthanasia vs. The Right to Life,” 27 Baylor L.Rev. 68, 69 (1975). More recently, we wrote in *Quinlan*, supra, 70 N.J. at 47, 355 A.2d 647, that modern-day “physicians distinguish between curing the ill and comforting and easing the dying; that they refuse to treat the curable as if they were dying or ought to die, and that they have sometimes refused to treat the hopeless and dying

as if they were curable.” Indeed, recent surveys have suggested that a majority of practicing doctors now approve of passive euthanasia and believe that it is being practiced by members of the profession (citations omitted).

Moreover, even if doctors were exhorted to attempt to cure or sustain their patients under all circumstances, that moral and professional imperative, at least in cases of patients who were clearly competent, presumably would not require doctors to go beyond advising the patient of the risks of foregoing treatment and urging the patient to accept the medical intervention (citations omitted). If the patient rejected the doctor’s advice, the onus of that decision would rest on the patient, not the doctor. Indeed, if the patient’s right to informed consent is to have any meaning at all, it must be accorded respect even when it conflicts with the advice of the doctor or the values of the medical profession as a whole.

The fourth asserted state interest in overriding a patient’s decision about his medical treatment is the interest in protecting innocent third parties who may be harmed by the patient’s treatment decision. When the patient’s exercise of his free choice could adversely and directly affect the health, safety, or security of others, the patient’s right of self-determination must frequently give way. Thus, for example, courts have required competent adults to undergo medical procedures against their will if necessary to protect the public health, *Jacobson v. Massachusetts*, 197 U.S. 11, 25 S.Ct. 358, 49 L.Ed. 643 (1905) (recognizing enforceability of compulsory smallpox vaccination law); to prevent a serious risk to prison security, *Myers*, *supra*, 379 Mass. at 263, 265, 399 N.E.2d at 457, 458 (compelling prisoner with kidney disease to submit to dialysis over his protest rather than acquiescing in his demand to be transferred to a lower-security prison); accord *Caulk*, *supra*, 48- A.2d at 96; or to prevent the emotional and financial abandonment of the patient’s minor children, *Application of President & Directors of Georgetown College, Inc.*, 331 F.2d 1000, 1008 (D.C.Cir.), cert. denied, 377 U.S. 978, 84 S.Ct. 1883, 12 L.Ed.2d 746 (1964) (ordering mother of seven-month-old infant to submit to blood transfusion over her religious objections because of the mother’s “responsibility to the community to care for her infant”); *Holmes v. Silver Cross Hosp.*, 340 F.Supp. 125, 130 (N.D. Ill. 1972) (indicating that patient’s status as father of minor child might justify authorizing blood transfusion to save his life despite his religious objections).

On balance, the right to self-determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death. Most of the cases that have held otherwise, unless they involved the interest in protecting innocent third parties, have concerned the patient’s competency to make a rational and considered choice of treatment. *See* Annot., 93 A.L.R.3d 67, at 80-85 (1979) (“Patient’s Right to Refuse Treatment Allegedly Necessary to Sustain Life”).

In view of the case law, we have no doubt that Ms. Conroy, if competent to make the decision and if resolute in her determination, could have chosen to have her nasogastric tube withdrawn. Her interest in freedom from nonconsensual invasion of her bodily integrity would outweigh any state interest in preserving life or in safeguarding the integrity of the medical profession. In addition, rejecting her artificial means of feeding would not constitute attempted suicide, as the decision would probably be based on a wish to be free of medical intervention rather than a specific intent to die, and her death would result, if at all, from her underlying medical condition, which included her inability to swallow. Finally, removal of her feeding tube would not create a public health or safety hazard, nor would her death leave any minor dependents without care or support.

It should be noted that if she were competent, Ms. Conroy's right to self-determination would not be affected by her medical condition or prognosis. Our Legislature has recognized that an institutionalized, elderly person, whatever his physical and mental limitations and life expectancy, has the same right to receive medical treatment as a competent young person whose physical functioning is basically intact. *See N.J.S.A. 52:27G-1* (declaring "that it is the public policy of this State to secure for elderly patients, residents and clients of health care facilities serving their specialized needs and problems, *the same civil and human rights guaranteed to all citizens*") (emphasis added). Moreover, a young, generally healthy person, if competent, has the same right to decline life-saving medical treatment as a competent elderly person who is terminally ill. Of course, a patient's decision to accept or reject medical treatment may be influenced by his medical condition, treatment, and prognosis; nevertheless, a competent person's common-law and constitutional rights do not depend on the quality or value of his life.

### **7.3 Right of the Incompetent Patient**

#### ***Conroy*, 486 A.2d 1209 (Part II)**

#### **IV**

More difficult questions arise in the context of patients who, like Claire Conroy, are incompetent to make particular treatment decisions for themselves. Such patients are unable to exercise directly their own right to accept or refuse medical treatment. In attempting to exercise that right on their behalf, substitute decision-makers must seek to respect simultaneously both aspects of the patient's right to self-determination—the right to live, and the right, in some cases, to die of natural causes without medical intervention.

#### **A.**

Discussion of the appropriateness of withholding or withdrawing life-sustaining treatment from an incompetent person must commence with an analysis of *In re Quinlan*, supra, 70 N.J. 10, 355 A.2d 647. In that case the father of Karen Ann Quinlan, a twenty-two-year-old woman, sought to be appointed her guardian and to be authorized to disconnect a respirator that was believed to be sustaining her life. Ms. Quinlan had been totally unconscious, unaware of anyone or anything around her, since one night in 1975, when she had sustained sudden and severe neurological damage of uncertain etiology. The consensus of the medical experts was that she was in a comatose or vegetative state and that her coma could appropriately be characterized as chronic and persistent, since no form of medical treatment could cure or improve it.

Although Ms. Quinlan's cognitive abilities had been irreversibly lost, only the more highly developed part of her brain had been destroyed, and she was therefore not "brain dead" under any of the criteria established by the Ad Hoc Committee of the Harvard Medical School. Her brain stem, which controlled her body temperature, breathing, heart rate, chewing, swallowing, sleeping, waking, and similar physiological functions, was still biologically alive. Ms. Quinlan was therefore able to exist at a primitive reflex level, and to exhibit such reactions as blinking her eyes and reacting to light, sound, and noxious (painful) stimuli. She also grimaced, made stereotyped cries and sounds, and had chewing motions. The quality of her "feeling impulses" was not known.

Because her neurological condition had affected her respiratory function, Ms. Quinlan had been placed on a respirator, a machine that delivered a given volume of air at a certain rate and that periodically provided a relatively large volume of air designed to purge her lungs. She was nourished by feeding through a nasogastric tube. The unanimous opinion of all the doctors was that Ms. Quinlan would die if the respirator were removed.

This Court approved the father's designation as guardian and authorized removal of the respirator on the condition that the rest of the family and the attending physicians concurred with his decision and that those physicians and an "Ethics Committee" (or, more accurately, a prognosis committee) in the hospital agreed "that there [was] no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state." *Id.*, 70 N.J. at 55, 355 A.2d 647. It reasoned that Ms. Quinlan, if competent, would have had a fundamental right to decline such treatment.

Though couched in constitutional terms of the right of privacy, *Id.*, 70 N.J. at 39-40, 355 A.2d 647, the underlying concept was an individual's right to behave and act as he deems fit, provided that such behavior and activity do not conflict with the precepts of society.

Since Ms. Quinlan could not express her intent, the Court held that her father as guardian would be permitted to express her intent on her behalf upon a showing sufficient to demonstrate her wishes, provided that the decision that she would have made was also objectively reasonable.

## B.

The *Quinlan* decision dealt with a special category of patients: those in a chronic, persistent vegetative or comatose state. In a footnote, the opinion left open the question whether the principles it enunciated might be applicable to incompetent patients in "other types of terminal medical situations, not necessarily involving the hopeless loss of cognitive or sapient life." *Id.*, 70 N.J. at 54 n. 10, 355 A.2d 647. We now are faced with one such situation: that of elderly, formerly competent nursing-home residents who, unlike Karen Quinlan, are awake and conscious and can interact with their environment to a limited extent, but whose mental and physical functioning is severely and permanently impaired and whose life expectancy, even with the treatment, is relatively short. The capacities of such people, while significantly diminished, are not as limited as those of irreversibly comatose persons, and their deaths, while no longer distant, may not be imminent. Large numbers of aged, chronically ill, institutionalized persons fall within this general category.

Such people (like newborns, mentally retarded persons, permanently comatose individuals, and members of other groups with which this case does not deal) are unable to speak for themselves on life-and-death issues concerning their medical care. This does not mean, however, that they lack a right to self-determination. The right of an adult who, like Claire Conroy, was once competent, to determine the course of her medical treatment remains intact even when she is no longer able to assert that right or to appreciate its effectuation. *John F. Kennedy Memorial Hosp., Inc. v. Bludworth*, 452 So.2d 921, 924 (Fla. 1984).

Any other view would permit obliteration of an incompetent's panoply of rights merely because the patient could no longer sense the violation of those rights. [*Id.* at 252.]

Since the condition of an incompetent patient makes it impossible to ascertain definitively his present desires, a third party acting on the patient's behalf often cannot say with confidence that his treatment decision for the patient will further rather than frustrate the patient's right to control his own body. *Cf.*

Smith, “In re Quinlan: the Basis for Terminating Life Support Under the Right of Privacy,” 12 *Tulsa L.J.* 150, 161 (1976) (arguing that permitting a guardian to make personal medical decisions for an incompetent patient actually interferes with the patient’s right of privacy). Nevertheless, 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. Ideally, both aspects of the patient’s right to bodily integrity—the right to consent to medical intervention and the right to refuse it—should be respected.

In light of these rights and concerns, we hold that life-sustaining treatment may be withheld or withdrawn from an incompetent patient when it is clear that the particular patient would have refused the treatment under the circumstances involved. The standard we are enunciating is a subjective one, consistent with the notion that the right that we are seeking to effectuate is a very personal right to control one’s own life. The question is not what a reasonable or average person would have chosen to do under the circumstances but what the particular patient would have done if able to choose for himself.

The patient may have expressed, in one or more ways, an intent not to have life-sustaining medical intervention. Such an intent might be embodied in a written document, or “living will,” stating the person’s desire not to have certain types of life-sustaining treatment administered under certain circumstances. It might also be evidenced in an oral directive that the patient gave to a family member, friend, or health care provider. It might consist of a durable power of attorney or appointment of a proxy authorizing a particular person to make the decisions on the patient’s behalf if he is no longer capable of making them for himself. See N.J.S.A. 46:2B-8. It might also be deduced from a person’s religious beliefs and the tenets of that religion, *Id.* at 378, 420 N.E.2d at 72, 438 N.Y.S.2d at 274, or from the patient’s consistent pattern of conduct with respect to prior decisions about his own medical care. Of course, dealing with the matter in advance in some sort of thoughtful and explicit way is best for all concerned.

Any of the above types of evidence, and any other information bearing on the person’s intent, may be appropriate aids in determining what course of treatment the patient would have wished to pursue. In this respect, we now believe that we were in error in *Quinlan*, supra, 70 N. J. at 21, 41, 355 A.2d 647, to disregard evidence of statements that Ms. Quinlan made to friends concerning artificial prolongation of the lives of others who were terminally ill. See criticism of this portion of *Quinlan* opinion in Collester, supra, 30 Rutgers L.Rev. at 318; Smith, supra, 12 *Tulsa L.J.* at 163; and D. Meyers, supra, at 282 n. 65. Such evidence is certainly relevant to shed light on whether the patient would have consented to the treatment if competent to make the decision.

Although all evidence tending to demonstrate a person’s intent with respect to medical treatment should properly be considered by surrogate decision-makers, or by a court in the event of any judicial proceedings, the probative value of such evidence may vary depending on the remoteness, consistency, and thoughtfulness of the prior statements or actions and the maturity of the person at the time of the statements or acts. Colyer, supra, 99 Wash.2d at 131, 660 P.2d at 748. Thus, for example, an offhand remark about not wanting to live under certain circumstances made by a person when young and in the peak of health would not in itself constitute clear proof twenty years later that he would want life-sustaining treatment withheld under those circumstances. In contrast, a carefully considered position, especially if written, that a person had maintained over a number of years or that he had acted upon in comparable circumstances might be clear evidence of his intent.

Another factor that would affect the probative value of a person's prior statements of intent would be their specificity. Of course, no one can predict with accuracy the precise circumstances with which he ultimately might be faced. Nevertheless, any details about the level of impaired functioning and the forms of medical treatment that one would find tolerable should be incorporated into advance directives to enhance their later usefulness as evidence.

Medical evidence bearing on the patient's condition, treatment, and prognosis, like evidence of the patient's wishes, is an essential prerequisite to decision-making under the subjective test. The medical evidence must establish that the patient fits within the Claire Conroy pattern: an elderly, incompetent nursing-home resident with severe and permanent mental and physical impairments and a life expectancy of approximately one year or less. In addition, since the goal is to effectuate the patient's right of informed consent, the surrogate decision-maker must have at least as much medical information upon which to base his decision about what the patient would have chosen as one would expect a competent patient to have before consenting to or rejecting treatment. Such information might include evidence about the patient's present level of physical, sensory, emotional, and cognitive functioning; the degree of physical pain resulting from the medical condition, treatment, and termination of treatment, respectively; the degree of humiliation, dependence, and loss of dignity probably resulting from the condition and treatment; the life expectancy and prognosis for recovery with and without treatment; the various treatment options; and the risks, side effects, and benefits of each of those options. Particular care should be taken not to base a decision on a premature diagnosis or prognosis. See *Colyer, supra*, 99 Wash.2d at 143-45, 660 P.2d at 754-55 (Dore, J., dissenting).

We recognize that for some incompetent patients it might be impossible to be clearly satisfied as to the patient's intent either to accept or reject the life-sustaining treatment. Many people may have spoken of their desires in general or casual terms,<sup>7</sup> or, indeed, never considered or resolved the issue at all. In such cases, a surrogate decision-maker cannot presume that treatment decisions made by a third party on the patient's behalf will further the patient's right to self-determination, since effectuating another person's right to self-determination presupposes that the substitute decision-maker knows what the person would have wanted. Thus, in the absence of adequate proof of the patient's wishes, it is naive to pretend that the right to self-determination serves as the basis for substituted decision-making. See *Storar, supra*, 52 N.Y.2d at 378-380, 420 N.E.2d at 72-73, 438 N.Y.S.2d at 274-75; Veatch, "An Ethical Framework for Terminal Care Decisions: A New Classification of Patients," 32(9) J.Am. Geriatrics Soc'y 665, 666 (1984).

We hesitate, however, to foreclose the possibility of humane actions, which may involve termination of life-sustaining treatment, for persons who never clearly expressed their desires about life-sustaining treatment but who are now suffering a prolonged and painful death. An incompetent, like a minor child, is a ward of the state, and the state's *parens patriae* power supports the authority of its courts to allow decisions to be made for an incompetent that serve the incompetent's best interests, even if the person's wishes cannot be clearly established. This authority permits the state to authorize guardians to withhold or withdraw life-sustaining treatment from an incompetent patient if it is manifest that such action would further the patient's best interests in a narrow sense of the phrase, even though the subjective test that we articulated above may not be satisfied. We therefore hold that life-sustaining treatment may also be withheld or withdrawn from a patient in Claire Conroy's situation if either of two "best interests" tests—a limited-objective or a pure-objective test—is satisfied.

Under the limited-objective test, life-sustaining treatment may be withheld or withdrawn from a patient in Claire Conroy's situation when there is some trustworthy evidence that the patient would have refused the treatment, and the decision-maker is satisfied that it is clear that the burdens of the patient's



continued life with the treatment outweigh the benefits of that life for him. By this we mean that the patient is suffering, and will continue to suffer throughout the expected duration of his life, unavoidable pain, and that the net burdens of his prolonged life (the pain and suffering of his life with the treatment less the amount and duration of pain that the patient would likely experience if the treatment were withdrawn) markedly outweigh any physical pleasure, emotional enjoyment, or intellectual satisfaction that the patient may still be able to derive from life. This limited-objective standard permits the termination of treatment for a patient who had not unequivocally expressed his desires before becoming incompetent, when it is clear that the treatment in question would merely prolong the patient's suffering.

Medical evidence will be essential to establish that the burdens of the treatment to the patient in terms of pain and suffering outweigh the benefits that the patient is experiencing. The medical evidence should make it clear that the treatment would merely prolong the patient's suffering and not provide him with any net benefit. Information is particularly important with respect to the degree, expected duration, and constancy of pain with and without treatment, and the possibility that the pain could be reduced by drugs or other means short of terminating the life-sustaining treatment. The same types of medical evidence that are relevant to the subjective analysis, such as the patient's life expectancy, prognosis, level of functioning, degree of humiliation and dependency, and treatment options, should also be considered.

This limited-objective test also requires some trustworthy evidence that the patient would have wanted the treatment terminated. This evidence could take any one or more of the various forms appropriate to prove the patient's intent under the subjective test. Evidence that, taken as a whole, would be too vague, casual, or remote to constitute the clear proof of the patient's subjective intent that is necessary to satisfy the subjective test—for example, informally expressed reactions to other people's medical conditions and treatment—might be sufficient to satisfy this prong of the limited-objective test.

In the absence of trustworthy evidence, or indeed any evidence at all, that the patient would have declined the treatment, life-sustaining treatment may still be withheld or withdrawn from a formerly competent person like Claire Conroy if a third, pure-objective test is satisfied. Under that test, as under the limited-objective test, the net burdens of the patient's life with the treatment should clearly and markedly outweigh the benefits that the patient derives from life. Further, the recurring, unavoidable and severe pain of the patient's life with the treatment should be such that the effect of administering life-sustaining treatment would be inhumane. Subjective evidence that the patient would not have wanted the treatment is not necessary under this pure-objective standard. Nevertheless, even in the context of severe pain, life-sustaining treatment should not be withdrawn from an incompetent patient who had previously expressed a wish to be kept alive in spite of any pain that he might experience.

Although we are condoning a restricted evaluation of the nature of a patient's life in terms of pain, suffering, and possible enjoyment under the limited-objective and pure-objective tests, we expressly decline to authorize decision-making based on assessments of the personal worth or social utility of another's life, or the value of that life to others. We do not believe that it would be appropriate for a court to designate a person with the authority to determine that someone else's life is not worth living simply because, to that person, the patient's "quality of life" or value to society seems negligible. The mere fact that a patient's functioning is limited or his prognosis dim does not mean that he is not enjoying what remains of his life or that it is in his best interests to die. But cf. *In re Dinnerstein*, 6 Mass.App.Ct. 466, 473, 380 N.E.2d 134, 138 (1978) (indicating, in reference to possible resuscitation of half-paralyzed, elderly victim of Alzheimer's disease, that prolongation of life is not required if there is no hope of return to a "normal, integrated, functioning, cognitive existence"); see also

President's Commission Report, *supra*, at 135 (endorsing termination of treatment whenever surrogate decision-maker in his discretion believes it is in the patient's best interests, defined broadly to "take into account such factors as the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of life sustained"). More wide-ranging powers to make decisions about other people's lives, in our view, would create an intolerable risk for socially isolated and defenseless people suffering from physical or mental handicaps.

We are aware that it will frequently be difficult to conclude that the evidence is sufficient to justify termination of treatment under either of the "best interests" tests that we have described. Often, it is unclear whether and to what extent a patient such as Claire Conroy is capable of, or is in fact, experiencing pain. Similarly, medical experts are often unable to determine with any degree of certainty the extent of a nonverbal person's intellectual functioning or the depth of his emotional life. When the evidence is insufficient to satisfy either the limited-objective or pure-objective standard, however, we cannot justify the termination of life-sustaining treatment as clearly furthering the best interests of a patient like Ms. Conroy.

The surrogate decision-maker should exercise extreme caution in determining the patient's intent and in evaluating medical evidence of the patient's pain and possible enjoyment, and should not approve withholding or withdrawing life-sustaining treatment unless he is manifestly satisfied that one of the three tests that we have outlined has been met. Cf. *In re Grady*, 85 N.J. 235, 266, 426 A.2d 467 (1981) (requiring that evidence be clear and convincing before a court would approve sterilization of an incompetent, mentally retarded adult). When evidence of a person's wishes or physical or mental condition is equivocal, it is best to err, if at all, in favor of preserving life. See *Osborne, supra*, 294 A.2d at 374 (stating in dictum that when a patient is "suffering impairment of capacity for choice, it may be better to give weight to the known instinct for survival"); Dyck, "Ethical Aspects of Care for the Dying Incompetent," 32(9) *J.Am. Geriatrics Soc'y* 661, 663 (1984) ("[S]ituations in which [decision-makers] are uncertain about what is best should be resolved in favor of extending life where possible."). Or, as one writer has said as a justification for requiring a high degree of safety and certainty of diagnosis in the determination of brain death: "[I]f there is a lot to lose by being wrong, it is generally better to stick to the safer, known way in the absence of the highest probability for proceeding otherwise." D. Walton, *Ethics of Withdrawal of Life-Support Systems: Case Studies on Decision Making in Intensive Care* 82 (1983).

### C.

We emphasize that in making decisions whether to administer life-sustaining treatment to patients such as Claire Conroy, the primary focus should be the patient's desires and experience of pain and enjoyment—not the type of treatment involved. Thus, we reject the distinction that some have made between actively hastening death by terminating treatment and passively allowing a person to die of a disease as one of limited use in a legal analysis of such a decision-making situation.

The distinction is particularly nebulous, however, in the context of decisions whether to withhold or withdraw life-sustaining treatment. In a case like that of Claire Conroy, for example, would a physician who discontinued nasogastric feeding be actively causing her death by removing her primary source of nutrients; or would he merely be omitting to continue the artificial form of treatment, thus passively allowing her medical condition, which includes her inability to swallow, to take its natural course? See *President's Commission Report, supra*, at 65–66. The ambiguity inherent in this distinction is further heightened when one performs an act within an over-all plan of non-intervention, such as when a doctor writes an order not to resuscitate a patient. *Id.* at 67.

For a similar reason, we also reject any distinction between withholding and withdrawing life-sustaining treatment. Some commentators have suggested that discontinuing life-sustaining treatment once it has been commenced is morally more problematic than merely failing to begin the treatment. See Clouser, “Allowing or Causing: Another Look,” 87 *Annals Internal Med.* 622, 624 (1977) (“To stop [therapy] seems different in principle from refusing to initiate a therapy in response to a new crisis.”). Discontinuing life-sustaining treatment, to some, is an “active” taking of life, as opposed to the more “passive” act of omitting the treatment in the first instance. In the words of one writer, “[T]he difference between taking away that which one has come to count on as normal support for life and not instituting therapy when a new crisis begins fits nicely a basic moral distinction throughout life—we are not morally obligated to help another person, but we are morally obligated not to interfere with his life-sustaining routines.” *Id.*

This distinction is more psychologically compelling than logically sound. As mentioned above, the line between active and passive conduct in the context of medical decisions is far too nebulous to constitute a principled basis for decision-making. Whether necessary treatment is withheld at the outset or withdrawn later on, the consequence—the patient’s death—is the same. Moreover, from a policy standpoint, it might well be unwise to forbid persons from discontinuing a treatment under circumstances in which the treatment could permissibly be withheld. Such a rule could discourage families and doctors from even attempting certain types of care and could thereby force them into hasty and premature decisions to allow a patient to die. See Lynn & Childress, “Must Patients Always Be Given Food and Water?,” 13 *Hastings Center Rep.* 17, 19–20 (1983).

We also find unpersuasive the distinction relied upon by some courts, commentators, and theologians between “ordinary” treatment, which they would always require, and “extraordinary” treatment, which they deem optional (citations omitted). The terms “ordinary” and “extraordinary” have assumed too many conflicting meanings to remain useful. To draw a line on this basis for determining whether treatment should be given leads to a semantical milieu that does not advance the analysis. See President’s Commission Report, *supra*, at 87.

The distinction between ordinary and extraordinary treatment is frequently phrased as one between common and unusual, or simple and complex, treatment, President’s Commission Report, *supra*, at 84; “extraordinary” treatment also has been equated with elaborate, artificial, heroic, aggressive, expensive, or highly involved or invasive forms of medical intervention, *id.* at 84; *D. Walton*, *supra*, at 222–23. Depending on the definitions applied, a particular treatment for a given patient may be considered both ordinary and extraordinary. President’s Commission Report, *supra*, at 84. Further, since the common/unusual and simple/complex distinctions among medical treatments “exist on continuums with no precise dividing line,” *ibid.*, and the continuum is constantly shifting due to progress in medical care, disagreement will often exist about whether a particular treatment is ordinary or extraordinary. In addition, the competent patient generally could refuse even ordinary treatment; therefore, an incompetent patient theoretically should also be able to make such a choice when the surrogate decision-making is effectuating the patient’s subjective intent. In such cases, the ordinary/extraordinary distinction is irrelevant except insofar as the particular patient would have made the distinction.

The ordinary/extraordinary distinction has also been discussed in terms of the benefits and burdens of treatment for the patient. If the benefits of the treatment outweigh the burdens it imposes on the patient, it is characterized as ordinary and therefore ethically required; if not, it is characterized as extraordinary and therefore optional. See President’s Commission Report, *supra*, at 84–85 & n. 122; “Declaration on

Euthanasia,” *supra*. This formulation is extremely fact-sensitive and would lead to different classifications of the same treatment in different situations. Thus, for example, we stated in *Quinlan*, *supra*, 70 N.J. at 48, 355 A.2d 647: “[T]he use of the same respirator or like support could be considered ‘ordinary’ in the context of the possibly curable patient but ‘extraordinary’ in the context of the forced sustaining by cardio-respiratory processes of an irreversibly doomed patient.” Moreover, while the analysis may be useful in weighing the implications of the specific treatment for the patient, essentially it merely restates the question: whether the burdens of a treatment so clearly outweigh its benefits to the patient that continued treatment would be inhumane. As the President’s Commission noted: “The claim, then, that the treatment is extraordinary is more of an expression of the conclusion than a justification for it.” President’s Commission Report, *supra*, at 88.

Some commentators, as indeed did the Appellate Division here, 190 N.J. Super. at 473, 464 A.2d 303, have made yet a fourth distinction, between the termination of artificial feedings and the termination of other forms of life-sustaining medical treatment. See, e.g., E. Healy, *Medical Ethics* 66 (1956); J. Piccione, *Last Rights: Treatment and Care Issues in Medical Ethics* 23, 38 (1984).

Certainly, feeding has an emotional significance. As infants we could breathe without assistance, but we were dependent on others for our lifeline of nourishment. Even more, feeding is an expression of nurturing and caring, certainly for infants and children, and in many cases for adults as well.

Once one enters the realm of complex, high-technology medical care, it is hard to shed the “emotional symbolism” of food. See Barber, *supra*, 147 Cal.App.3d at 1016, 195 Cal.Rptr. at 490. However, artificial feedings such as nasogastric tubes, gastrostomies, and intravenous infusions are significantly different from bottle-feeding or spoon-feeding—they are medical procedures with inherent risks and possible side effects, instituted by skilled health-care providers to compensate for impaired physical functioning. Analytically, artificial feeding by means of a nasogastric tube or intravenous infusion can be seen as equivalent to artificial breathing by means of a respirator. Both prolong life through mechanical means when the body is no longer able to perform a vital bodily function on its own. *Ibid*.

Furthermore, while nasogastric feeding and other medical procedures to ensure nutrition and hydration are usually well tolerated, they are not free from risks or burdens; they have complications that are sometimes serious and distressing to the patient (citations omitted). Nasogastric tubes may lead to pneumonia, cause irritation and discomfort, and require arm restraints for an incompetent patient. Lo & Dornbrand, *supra*, 311 New Eng.J.Med. at 403; Lynn & Childress, *supra*, 13 *Hastings Center Rep.* at 17–18. The volume of fluid needed to carry nutrients itself is sometimes harmful. Zerwekh, *supra*, 13 *Nursing* 83 at 51.

Finally, dehydration may well not be distressing or painful to a dying patient. For patients who are unable to sense hunger and thirst, withholding of feeding devices such as nasogastric tubes may not result in more pain than the termination of any other medical treatment. See Lynn & Childress, *supra*, 13 *Hastings Center Rep.* at 19, 20; Paris & Fletcher, *supra*, 11 *Law, Med. & Health Care* at 211. Indeed, it has been observed that patients near death who are not receiving nourishment may be more comfortable than patients in comparable conditions who are being fed and hydrated artificially. See Zerwekh, *supra*, 13 *Nursing* 83 at 51; Lynn & Childress, *supra*, 13 *Hastings Center Rep.* at 19. Thus, it cannot be assumed that it will always be beneficial for an incompetent patient to receive artificial feeding or harmful for him not to receive it. See Wanzer, Adelstein, Cranford, Federman, Hook, Moertel, Safar, Stone, Taussig & Van Eys, *supra*, 310 New Eng.J.Med. at 959 (“If [a severely and irreversibly demented] patient rejects food and water by mouth, it is ethically permissible to withhold

nutrition and hydration artificially administered by vein or gastric tube. Spoon feeding should be continued if needed for comfort.”).

Under the analysis articulated above, withdrawal or withholding of artificial feeding, like any other medical treatment, would be permissible if there is sufficient proof to satisfy the subjective, limited-objective, or pure-objective test. A competent patient has the right to decline any medical treatment, including artificial feeding, and should retain that right when and if he becomes incompetent. In addition, in the case of an incompetent patient who has given little or no trustworthy indication of an intent to decline treatment and for whom it becomes necessary to engage in balancing under the limited-objective or pure-objective test, the pain and invasiveness of an artificial feeding device, and the pain of withdrawing that device, should be treated just like the results of administering or withholding any other medical treatment.

## V

### A.

The decision-making procedure for comatose, vegetative patients suggested in Quinlan, namely, the concurrence of the guardian, family, attending physician, and hospital prognosis committee, is not entirely appropriate for patients such as Claire Conroy, who are confined to nursing homes. There are significant differences in the patients, the health-care providers, and the institutional structures of nursing homes and hospitals.

First, residents of nursing homes are a particularly vulnerable population. Nursing home residents are often quite elderly, with an average age of eighty-two nation-wide. Subcomm. on Long-Term Care of the Special Comm. on Aging, United States Senate Nursing Home Care in the United States: Failure in Public Policy, Introductory Report, S.Rep. No. 1420, 93d Cong., 2d Sess. 16 (1974) [hereinafter cited as Senate Report on Aging]. Most suffer from chronic or crippling disabilities and mental impairments, and need assistance in activities of daily living. *Id.* at 17. The vast majority of patients who enter a nursing home will eventually die there, *id.* at 16–17, and their illnesses and deaths will be viewed as consistent with their advanced age and general infirmity.

Second, nursing-home residents are often without any surviving family. More than half have no surviving parents, siblings, or children. Their social isolation is severe. Many never have visits from anyone and few ever spend nights away except for medical reasons. *Id.* at 16, 18. Thus, the involvement of caring family members that was an integral part of the decision-making process in Quinlan may not be a realistic possibility for many nursing-home residents.

Third, physicians play a much more limited role in nursing homes than in hospitals. The Subcommittee on Long-Term Care of the Senate Special Committee on Aging states that physicians visit their patients in nursing homes infrequently, and then for only brief periods of time. Senate Report on Aging, *supra*, Supporting Paper No. 3, Doctors in Nursing Homes: The Shunned Responsibility 323–24 (1975). According to the Subcommittee, physicians avoid nursing homes because of the general shortage of physicians, the low priority for elderly citizens in medical education, the red tape and low reimbursement associated with Medicare and Medicaid, the shortage of trained “backup” personnel in nursing homes, the emphasis on acute care in American medicine, the depressing environment in many nursing homes, and the disincentives of time and travel. *Id.* at 325–31. The “missing physician” is the general rule in nursing homes. B. Vladeck, *Unloving Care: The Nursing Home Tragedy* 17 (1980). The Conroy case is an example. Ms. Conroy’s attending physician visited Ms. Conroy only about once

a month. Moreover, physicians caring for nursing home residents generally are not chosen by the residents and are not familiar with their personalities and preferences. Besdine, "Decisions to Withhold Treatment from Nursing Home Residents," 31 J.Am. Geriatrics Soc'y 602, 603 (1983).

Fourth, nursing homes as institutions suffer from peculiar industry-wide problems to which hospitals are less prone. Ideally, "[c]are for older persons in need of long-term attention should be one of the most tender and effective services a society can offer to its people." Senate Report on Aging, *supra*, at iv.

Despite those worthwhile ideals, however, the Senate Subcommittee has referred to long-term care for older people as perhaps "the most troubled, and troublesome, component of our entire health care system." *Ibid*.

Few nursing homes, in any event, have "ethics" or "prognosis" committees to review the attending doctor's assessment of a patient's prognosis.

Finally, nursing homes generally are not faced with the need to make decisions about a patient's medical care with the same speed that is necessary in hospitals. Hospitals are called upon for urgent care, and treatment decisions in that context must be made quickly. Nursing homes, in contrast, care for individuals whose lives are slowly declining and for whom treatment issues arise more gradually and are foreseeable longer in advance.

## B.

Despite the universality of the aging process, our society has generally been reluctant to confront the consequences of human aging. New Jersey Governor's Conference on Aging, Report and Recommendations Toward an Aging Policy Today, Tomorrow, Together 45 (1981) [hereinafter cited as Report and Recommendations]. New Jersey, however, has been at the forefront of efforts to deal constructively with its elderly citizens and their families. In 1957, it became the first state in the nation to establish an office, the New Jersey Division on Aging, devoted solely to the needs of the elderly. Governor's Conference on Aging, Today, Tomorrow, Together 3 (1981) [hereinafter cited as Today, Tomorrow, Together]. Since then, it has continued its efforts to meet the needs of this group. See Report and Recommendations; Today, Tomorrow, Together.

In 1976, the Legislature attempted to ameliorate the harsh conditions of the elderly in nursing homes by enacting an "Act concerning the responsibilities of nursing homes and the rights of nursing home residents," N.J.S.A. 30:13-1 to -11, which imposed certain minimal requirements on providers of nursing-home care. The Act charges nursing homes with numerous responsibilities, such as ensuring that admission is limited to only that number of residents for which "it can safely and adequately provide nursing care" and that physical restraints and drugs are not used for purposes of punishment or for the convenience of nursing-home personnel. *N.J.S.A.* 30:13-3c, -3e, and -3f. The Act also delineates certain rights of residents, among them a right of privacy, a right to "considerate and respectful care that recognizes the dignity and individuality of the resident," and a right "[n]ot [to] be deprived of any constitutional, civil or legal right solely by reason of admission to a nursing home." *N.J.S.A.* 30:13-5f, -5j, and -5m.

More recently, the Legislature determined that an additional program was required to safeguard the rights of the institutionalized elderly. It recognized that elderly residents of long-term and chronic-care facilities, including nursing homes, constituted a unique population whose members' rights may be

difficult to secure, “since such persons may be afflicted with physical and mental infirmities, deprived of the comfort and counsel of family and friends, and forced to exist with minimum economic resources, all of which may preclude them from defending and acting in their own best interests.” N.J.S.A. 52:27G-1. Accordingly, the Legislature proclaimed that

In 1983, the statute was amended to address even more specific problems of the institutionalized elderly. The amendment charges the Office of the Ombudsman for the Institutionalized Elderly with the responsibility to guard against “abuse” of such elderly patients. “Abuse” is defined as

the willful infliction of physical pain, injury or mental anguish, unreasonable confinement; or, the willful deprivation of services which are necessary to maintain a person’s physical and mental health. However, no person shall be deemed to be abused for the sole reason he is being furnished nonmedical remedial treatment by spiritual means through prayer alone in accordance with a recognized religious method of healing in lieu of medical treatment. [N.J.S.A. 52:27G–2a (emphasis added).]

The new provisions regarding abuse of the elderly create a vehicle for safeguarding the rights of elderly, institutionalized, incompetent patients both to receive medical treatment and to refuse life-sustaining medical treatment under certain circumstances. Upon receipt of notice of possible abuse of an elderly, institutionalized person, the ombudsman must conduct a prompt and thorough investigation that includes a visit to the elderly person and consultation with others who have knowledge of the particular case. N.J.S.A. 52:27G-7.2. Under its investigatory authority, the ombudsman may also make whatever inquiries he finds necessary, hold public or private hearings, subpoena witnesses, and compel the production of records and other evidence. N.J.S.A. 52:27G-8. Furthermore, the ombudsman has the power to hire consultants and experts as he deems necessary. *N.J.S.A. 52:27G–5b*. Within twenty-four hours after first hearing of the possible abuse, the ombudsman must notify the Commissioner of Human Services and any other governmental agency that regulates or operates the facility. *N.J.S.A. 52:27G–7.2a*. At the completion of the investigation, the Commissioner must be given a written report of the findings and recommendations. *N.J.S.A. 52:27G–7.2b*. Finally, “[i]f a determination is made that an elderly person may have been criminally abused or exploited, the ombudsman shall refer such findings, in writing, to the county prosecutor.” *N.J.S.A. 52:27g–7.2d*.

Our decision allowing life-sustaining medical treatment to be withheld or withdrawn under certain circumstances from institutionalized, elderly patients does not conflict with N.J.S.A. 52:27G-1 to –16. With regard to health care services, the statute defines “abuse” as “the willful deprivation of services which are necessary to maintain a person’s physical and mental health.” *N.J.S.A. 52:27G–2a*. As commonly used, “deprivation” means taking something from a person or preventing him from getting it. If, after a fully informed consent, a competent elderly person decided to forego medical treatment, health care providers acting in accordance with those wishes would not be “willfully depriving” the person of medical services. Complying with the previously expressed wishes of a now-incompetent patient pursuant to a subjective standard of decision-making would similarly be effectuating that person’s right to self-determination. On the other hand, if an institutionalized, elderly person had not clearly expressed his wishes before becoming incompetent but the burdens of the patient’s continued existence with the treatment so clearly outweighed its benefits that the limited-objective or pure-objective test had been satisfied, administering the treatment would only prolong the patient’s suffering, and terminating the treatment would therefore be in the patient’s best interests. In that situation, withholding or withdrawing treatment can be seen not as an intentional, wrongful act to harm the patient, but as conduct motivated by a concern for the patient’s pain. Accordingly, such a termination may not fairly be characterized as a “willful deprivation of services.”

Because of the special vulnerability of mentally and physically impaired, elderly persons in nursing homes and the potential for abuse with unsupervised institutional decision-making in such homes, life-sustaining treatment should not be withdrawn or withheld from a nursing-home resident like Claire Conroy in the absence of a guardian's decision, made in accordance with the procedure outlined below, that the elements of the subjective, limited-objective, or pure-objective test have been satisfied. A necessary prerequisite to surrogate decision-making is a judicial determination that the patient is incompetent to make the decision for himself and designation of a guardian for the incompetent patient if he does not already have one.

Substitute decision-making by a guardian is not permissible unless the patient has been proven incompetent to make the particular medical treatment decision at issue. *See* Veatch, "An Ethical Framework for Terminal Care Decisions: A New Classification of Patients," 32(9) J. Am. Geriatrics Soc'y 665, 668 (1984) ("[O]ne cannot simply presume that a patient is incompetent. There must be some sort of due process, and if the patient has not been adjudicated to be incompetent, he must be treated as competent."). A patient may be incompetent because he lacks the ability to understand the information conveyed, to evaluate the options, or to communicate a decision. Medical evidence bearing on these capabilities should be furnished to a court by at least two doctors with expertise in relevant fields who have personally examined the patient. *See* R. 4:83-2(b). The proof must be clear and convincing that the patient does not have and will not regain the capability of making the decision for himself.

Determining whether the patient is competent to make the medical decision at issue is necessary even if the patient previously had been adjudicated an incompetent and had a general guardian appointed pursuant to N.J.S.A. 3B:12-25. Here, for example, the plaintiff, Mr. Whittemore, had been appointed Ms. Conroy's guardian in 1979, when she entered the nursing home, at which time she was still lucid sporadically and could speak. That designation was made pursuant to Rule 4:83, which requires medical proof that "the alleged incompetent is unfit and unable to govern himself and to manage his affairs." R. 4:83-2(b); *see also* N.J.S.A. 3B:12-25. (providing that the Superior Court may determine "mental incompetency" and "appoint a guardian" for the incompetent's person and estate). Such a general appointment does not necessarily mean that the incompetent cannot make an informed judgment regarding a particular medical treatment. *See* Grady, *supra*, 85 N.J. at 265, 426 A.2d 467.

If the patient already has a general guardian, the court should determine whether that guardian is a suitable person to represent the patient with respect to the medical decision in question. Such a determination necessitates an inquiry into the guardian's knowledge of the patient and motivations or possible conflicts of interest. If the patient, although incompetent to make the treatment decision for himself, does not yet have a guardian, a suitable person should be appointed as guardian for him.

We hold that to determine whether withholding or withdrawing life-sustaining treatment from an elderly nursing-home resident who is incompetent to make the decision for himself is justified under any of the three tests articulated above, the following procedure is required. A person who believes that withholding or withdrawing life-sustaining treatment would effectuate an incompetent patient's wishes or would be in his "best interests" should notify the Office of the Ombudsman of the contemplated action. Such notification may be undertaken by the patient's guardian, or by another interested party, such as a close family member, an attending physician, or the nursing home in which the patient resides. Any person who believes the contrary, that is, who has reasonable cause to suspect that withholding or withdrawing the life-sustaining treatment would be an abuse of that patient, should also report such information to the ombudsman.



We believe the ombudsman should be involved in the process at this stage. The ombudsman should treat every notification that life-sustaining treatment will be withheld or withdrawn from an institutionalized, elderly patient as a possible “abuse.” Under N.J.S.A. 52:27G–7.2a, the ombudsman would then be required to investigate the situation and to report it within twenty-four hours to the Commissioner of Human Services and to any other government agency that regulates or operates the facility.

Evidence concerning the patient’s condition should be furnished by the attending physician and nurses. Two other physicians, unaffiliated with the nursing home and with the attending physician, should then be appointed to confirm the patient’s medical condition and prognosis. We recommend that the ombudsman exercise his discretionary authority under N.J.S.A. 52:27G–5b to appoint the physicians. In the event that the ombudsman chooses not to exercise his authority in this regard, application may be made to the assignment judge of the appropriate vicinage for designation of the two physicians. Depending upon the circumstances of a particular case, the physicians may be compensated by the patient’s estate, the guardian, the family, or the nursing home. If the funds from these sources are insufficient, the guardian may seek reimbursement from the ombudsman or possibly from Medicare.

Provided that the two physicians supply the necessary medical foundation, the guardian, with the concurrence of the attending physician, may withhold or withdraw life-sustaining medical treatment if he believes in good faith, based on the medical evidence and any evidence of the patient’s wishes, that it is clear that the subjective, limited-objective, or pure-objective test is satisfied. In addition, the ombudsman must concur in that decision. This role would be consonant with his legislative responsibilities. Finally, if the limited-objective or pure-objective test is being used, the family—that is, the patient’s spouse, parents, and children, or, in their absence, the patient’s next of kin, if any—must also concur in the decision to withhold or withdraw life-sustaining treatment.

In the absence of bad faith, no participant in the decision-making process shall be civilly or criminally liable for actions taken in accordance with the procedures set forth in this opinion. Cf. *Quinlan*, supra *Quinlan*, supra, 70 N.J. at 54, 355 A.2d 647 (providing for complete civil and criminal immunity for guardians, physicians, hospitals, and others, who, after complying with the procedures articulated in *Quinlan*, participate in a decision to withhold life support treatment). However, the decision-making procedure that we have outlined does not necessarily immunize its participants entirely from judicial oversight. As previously noted, the ombudsman can refer cases of questionable criminal abuse to the county prosecutor. N.J.S.A. 52:27G–7.2d.

## VI

As noted above, supra at —, the guardian will resolve the issues in these matters and make the ultimate decision with such concurrences as we have required. Ordinarily, court involvement will be limited to the determination of incompetency, and the appointment of a guardian unless a personal guardian has been previously appointed, who will determine whether the standards we have prescribed have been satisfied. The record in this case did not satisfy those standards. The evidence that Claire Conroy would have refused the treatment, although sufficient to meet the lower showing of intent required under the limited-objective test, was certainly not the “clear” showing of intent contemplated under the subjective test. More information should, if possible, have been obtained by the guardian with respect to Ms. Conroy’s intent. What were her ethical, moral, and religious beliefs? She did try to refuse initial hospitalization, and indeed had “scorned medicine.” 188 N.J. Super. at 525, 457 A.2d 1232. However, she allowed her nephew’s wife, a registered nurse, to care for her during several

illnesses. It was not clear whether Ms. Conroy permitted the niece to administer any drugs or other forms of medical treatment to her during these illnesses. Although it may often prove difficult, and at times impossible, to ascertain a person's wishes, the Conroy case illustrates the sources to which the guardian might turn. For example, in more than eight decades of life in the same house, it is possible that she revealed to persons other than her nephew her feelings regarding medical treatments, other values, and her goals in life. Some promising avenues for such an inquiry about her personal values included her response to the illnesses, and deaths of her sisters and others, and her statements with respect to not wanting to be in a nursing home.

Moreover, there was insufficient information concerning the benefits and burdens of Ms. Conroy's life to satisfy either the limited-objective or pure-objective test. Although the treating doctor and the guardian's expert testified as to Claire Conroy's condition, neither testified conclusively as to whether she was in pain or was capable of experiencing pain or thirst. There was medical agreement that removal of the tube would have caused pain during the period of approximately one week that would have elapsed before her death, or at least until she were to lapse into a coma. On the other hand, there was little, if any, evidence of the discomfort, suffering, and pain she would endure if she continued to be fed and medicated through the tube during her remaining life—contemplated to be up to one year. Apparently her feedings sometimes occasioned moaning, but it remains unclear whether these were reflex responses or expressions of discomfort. Moreover, although she tried to remove the tube, it is not clear that this was intentional, and there was little evidence that she was in distress. Her treating physician also offered contradictory views as to whether the contractures of her legs caused pain or whether, indeed, they might be the result of pain, without offering any evidence on that issue. The trial court rejected as superfluous the offer to present as an expert witness a neurologist, who might have been able to explain what Ms. Conroy's reactions to the environment indicated about her perception of pain.

The evidence was also unclear with respect to Ms. Conroy's capacity to feel pleasure, another issue as to which the information supplied by a neurologist might have been helpful. What was known of her awareness of the world? Although Ms. Conroy had some ability to smile and scratch, the relationship of these activities to external stimuli apparently was quite variable.

The trial transcript reveals no exploration of the discomfort and risks that attend nasogastric feedings. A casual mention by the nurse/administrator of the need to restrain the patient to prevent the removal of the tube was not followed by an assessment of the detrimental impact, if any, of those restraints. Alternative modalities, including gastrostomies, intravenous feeding, subcutaneous or intramuscular hydration, or some combination, were not investigated. Neither of the expert witnesses presented empirical evidence regarding the treatment options for such a patient.

It can be seen that the evidence at trial was inadequate to satisfy the subjective, the limited-objective, or the pure-objective standard that we have set forth. Were Claire Conroy still alive, the guardian would have been required to explore these issues prior to reaching any decision. Guardians—and courts, if they are involved—should act cautiously and deliberately in deciding these cases. The consequences are most serious—life or death.

We have not attempted to set forth guidelines for decision-making with respect to life-sustaining treatment in a variety of other situations that are not currently before us. Innumerable variations are possible. However, each case—such as that of the severely deformed newborn, of the never-competent adult suffering from a painful and debilitating illness, and of the mentally alert quadriplegic who has given up on life—poses its own unique difficulties. We do not deem it advisable to attempt to resolve

all such human dilemmas in the context of this case. It is preferable, in our view, to move slowly and to gain experience in this highly sensitive field. As we noted previously, the Legislature is better equipped than we to develop and frame a comprehensive plan for resolving these problems.

The judgment of the Appellate Division is reversed. In light of Ms. Conroy's death, we do not remand the matter for further proceedings.

### ***Notes, Questions, and Problems***

1. Why did the *Conroy* court state that refusing life-sustaining medical treatment is different from committing suicide? If a person with end-stage renal disease refuses to take dialysis, is that not the same thing as committing suicide?

2. Carrie had never heard a conspiracy theory she did not believe. Thus, when people in her Facebook group said that the COVID-19 virus was a government plot designed to experiment on members of the public, she believed it. Consequently, Carrie refused to take the COVID-19 vaccine. The small city of Groves where Carrie lives had about three times the national average of COVID-19 cases. To get a handle on things, the City Council enacted a law making it mandatory for everyone to take the COVID-19 vaccine unless they have a medical or religious reason not to do so. Carrie wants to know if the "man" can force her to be vaccinated. Please advise.

3. Maggie died in childbirth, leaving her husband, Gary to care for the newborn. When the baby was six months old, Gary was diagnosed with prostate cancer. Gary refused to have chemo because that treatment was against his religion. The hospital plans to go to court to force Gary to receive the treatment. What is the likely outcome of the case?

4. In *Conroy*, the court rejects the "ordinary" treatment versus "extraordinary" treatment distinction. Does the distinction make sense?

5. Is there a difference between the termination of artificial feeding and the termination of other forms of life-sustaining medical treatment? What does the court in *Conroy* say about the difference?

6. What are the special rules that the *Conroy* court sets forth for persons residing in nursing homes? Do these rules make sense? Are nursing home patients more vulnerable than other types of patients?

7. What are the four state interests that may restrict a person's right to refuse medical treatment?

***Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261**

CHIEF JUSTICE REHNQUIST delivered the opinion of the Court.

Petitioner Nancy Beth Cruzan was rendered incompetent as a result of severe injuries sustained during an automobile accident. Copetitioners Lester and Joyce Cruzan, Nancy's parents and coguardians, sought a court order directing the withdrawal of their daughter's artificial feeding and hydration equipment after it became apparent that she had virtually no chance of recovering her cognitive faculties. The Supreme Court of Missouri held that because there was no clear and convincing evidence of Nancy's desire to have life-sustaining treatment withdrawn under such circumstances, her parents lacked authority to effectuate such a request. We granted certiorari, 492 U.S. 917, 109 S.Ct. 3240, 106 L.Ed.2d 587 (1989), and now affirm.

On the night of January 11, 1983, Nancy Cruzan lost control of her car as she traveled down Elm Road in Jasper County, Missouri. The vehicle overturned, and Cruzan was discovered lying face down in a ditch without detectable respiratory or cardiac function. Paramedics were able to restore her breathing and heartbeat at the accident site, and she was transported to a hospital in an unconscious state. An attending neurosurgeon diagnosed her as having sustained probable cerebral contusions compounded by significant anoxia (lack of oxygen). The Missouri trial court in this case found that permanent brain damage generally results after 6 minutes in an anoxic state; it was estimated that Cruzan was deprived of oxygen from 12 to 14 minutes. She remained in a coma for approximately three weeks and then progressed to an unconscious state in which she was able to orally ingest some nutrition. In order to ease feeding and further the recovery, surgeons implanted a gastrostomy feeding and hydration tube in Cruzan with the consent of her then husband. Subsequent rehabilitative efforts proved unavailing. She now lies in a Missouri state hospital in what is commonly referred to as a persistent vegetative state: generally, a condition in which a person exhibits motor reflexes but evinces no indications of significant cognitive function. The State of Missouri is bearing the cost of her care.

After it had become apparent that Nancy Cruzan had virtually no chance of regaining her mental faculties, her parents asked hospital employees to terminate the artificial nutrition and hydration procedures. All agree that such a removal would cause her death. The employees refused to honor the request without court approval. The parents then sought and received authorization from the state trial court for termination. The court found that a person in Nancy's condition had a fundamental right under the State and Federal Constitutions to refuse or direct the withdrawal of "death prolonging procedures." App. to Pet. for Cert. A99. The court also found that Nancy's "expressed thoughts at age twenty-five in somewhat serious conversation with a housemate friend that if sick or injured she would not wish to continue her life unless she could live at least halfway normally suggests that given her present condition she would not wish to continue on with her nutrition and hydration." *Id.*, at A97-A98.

The Supreme Court of Missouri reversed by a divided vote. The court recognized a right to refuse treatment embodied in the common-law doctrine of informed consent, but expressed skepticism about the application of that doctrine in the circumstances of this case. *Cruzan v. Harmon*, 760 S.W.2d 408, 416-417 (1988) (en banc). The court also declined to read a broad right of privacy into the State Constitution which would "support the right of a person to refuse medical treatment in every circumstance," and expressed doubt as to whether such a right existed under the United States Constitution. *Id.*, at 417-418. It then decided that the Missouri Living Will statute, Mo.Rev.Stat. 459.010 et. seq. (1986), embodied a state policy strongly favoring the preservation of life. 760 S.W.2d at 419-420. The court found that Cruzan's statements to her roommate regarding her desire to live or

die under certain conditions were “unreliable for the purpose of determining her intent,” *id.*, at 424, “and thus insufficient to support the co-guardians [’] claim to exercise substituted judgment on Nancy’s behalf.” *id.*, at 426. It rejected the argument that Cruzan’s parents were entitled to order the termination of her medical treatment, concluding that “no person can assume that choice for an incompetent in the absence of the formalities required under Missouri’s Living Will statutes or the clear and convincing, inherently reliable evidence absent here.” *id.*, at 425. The court also expressed its view that “[b]road policy questions bearing on life and death are more properly addressed by representative assemblies” than judicial bodies. *id.*, at 426.

We granted certiorari to consider the question whether Cruzan has a right under the United States Constitution which would require the hospital to withdraw life-sustaining treatment from her under these circumstances.

At common law, even the touching of one person by another without consent and without legal justification was a battery. See W. Keeton, D. Dobbs, R. Keeton, & D. Owen, *Prosser and Keeton on Law of Torts* § 9, pp. 39-42 (5th ed. 1984). Before the turn of the century, this Court observed that “[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.” *Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251, 11 S.Ct. 1000, 1001, 35 L.Ed. 734 (1891). This notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment. The informed consent doctrine has become firmly entrenched in American tort law. See Keeton, Dobbs, Keeton, & Owen, *supra*, § 32, pp. 189-192; F. Rozovsky, *Consent to Treatment, A Practical Guide* 1-98 (2d ed. 1990).

The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment. Until about 15 years ago and the seminal decision in *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied sub nom. *Garger v. New Jersey*, 429 U.S. 922, 97 S.Ct. 319, 50 L.Ed.2d 289 (1976), the number of right-to-refuse-treatment decisions was relatively few. Most of the earlier cases involved patients who refused medical treatment forbidden by their religious beliefs, thus implicating First Amendment rights as well as common-law rights of self-determination. More recently, however, with the advance of medical technology capable of sustaining life well past the point where natural forces would have brought certain death in earlier times, cases involving the right to refuse life-sustaining treatment have burgeoned. See 760 S.W.2d at 412, n. 4 (collecting 54 reported decisions from 1976 through 1988).

After *Quinlan*, however, most courts have based a right to refuse treatment either solely on the common-law right to informed consent or on both the common-law right and a constitutional privacy right. See L. Tribe, *American Constitutional Law* § 15-11, p. 1365 (2d ed. 1988). In *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977) the Supreme Judicial Court of Massachusetts relied on both the right of privacy and the right of informed consent to permit the withholding of chemotherapy from a profoundly retarded 67-year-old man suffering from leukemia. *Id.*, at 737-738, 370 N.E.2d, at 424. Reasoning that an incompetent person retains the same rights as a competent individual “because the value of human dignity extends to both,” the court adopted a “substituted judgment” standard whereby courts were to determine what an incompetent individual’s decision would have been under the circumstances. *Id.*, at 745, 752-753, 757-758, 370 N.E.2d, at 427, 431, 434. Distilling certain state interests from prior case law—the preservation of life, the protection of the interests of innocent third parties, the prevention of suicide, and the maintenance of the ethical integrity of the medical profession—the court recognized the first interest as paramount

and noted it was greatest when an affliction was curable, “as opposed to the State interest where, as here, the issue is not whether, but when, for how long, and at what cost to the individual [a] life may be briefly extended.” *Id.*, at 742, 370 N.E.2d, at 426.

In *In re Storar*, 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64, cert. denied, 454 U.S. 858, 102 S.Ct. 309, 70 L.Ed.2d 153 (1981), the New York Court of Appeals declined to base a right to refuse treatment on a constitutional privacy right. Instead, it found such a right “adequately supported” by the informed consent doctrine. *Id.*, at 376-377, 438 N.Y.S.2d, at 272, 420 N.E.2d, at 70. In *In re Eichner* (decided with *In re Storar*, *supra*), an 83-year-old man who had suffered brain damage from anoxia entered a vegetative state and was thus incompetent to consent to the removal of his respirator. The court, however, found it unnecessary to reach the question whether his rights could be exercised by others since it found the evidence clear and convincing from statements made by the patient when competent that he “did not want to be maintained in a vegetative coma by use of a respirator.” *Id.*, at 380, 438 N.Y.S.2d, at 274, 420 N.E.2d, at 72. In the companion *Storar* case, a 52-year-old man suffering from bladder cancer had been profoundly retarded during most of his life. Implicitly rejecting the approach taken in *Saikewicz*, *supra*, the court reasoned that due to such life-long incompetency, “it is unrealistic to attempt to determine whether he would want to continue potentially life prolonging treatment if he were competent.” 52 N.Y.2d, at 380, 438 N.Y.S.2d, at 275, 420 N.E.2d, at 72. As the evidence showed that the patient’s required blood transfusions did not involve excessive pain and without them his mental and physical abilities would deteriorate, the court concluded that it should not “allow an incompetent patient to bleed to death because someone, even someone as close as a parent or sibling, feels that this is best for one with an incurable disease.” *Id.*, at 382, 438 N.Y.S.2d, at 275, 420 N.E.2d at 73.

Many of the later cases build on the principles established in *Quinlan*, *Saikewicz*, *Storar/Eichner*. For instance, in *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985), the same court that decided *Quinlan* considered whether a nasogastric feeding tube could be removed from an 84-year-old incompetent nursing-home resident suffering irreversible mental and physical ailments. While recognizing that a federal right of privacy might apply in the case, the court, contrary to its approach in *Quinlan*, decided to base its decision on the common-law right to self-determination and informed consent. 98 N.J., at 348, 486 A.2d, at 1223. “On balance, the right to self-determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death. Most of the cases that have held otherwise, unless they involved the interest in protecting innocent third parties, have concerned the patient’s competency to make a rational and considered choice.” *Id.*, at 353-354, 486 A.2d, at 1225.

Reasoning that the right of self-determination should not be lost merely because an individual is unable to sense a violation of it, the court held that incompetent individuals retain a right to refuse treatment. It also held that such a right could be exercised by a surrogate decisionmaker using a “subjective” standard when there was clear evidence that the incompetent person would have exercised it. Where such evidence was lacking, the court held that an individual’s right could still be invoked in certain circumstances under objective “best interest” standards. *Id.*, at 361-368, 486 A.2d, at 1229-1233. Thus, if some trustworthy evidence existed that the individual would have wanted to terminate treatment, but not enough to clearly establish a person’s wishes for purposes of the subjective standard, and the burden of a prolonged life from the experience of pain and suffering markedly outweighed its satisfactions, treatment could be terminated under a “limited-objective” standard. Where no trustworthy evidence existed, and a person’s suffering would make the administration of life-sustaining treatment inhumane, a “pure-objective” standard could be used to terminate treatment. If none of these conditions obtained, the court held it was best to err in favor of preserving life. *Id.*, at 364-368, 486 A.2d, at 1231-1233.

The court also rejected certain categorical distinctions that had been drawn in prior refusal-of-treatment cases as lacking substance for decision purposes: the distinction between actively hastening death by terminating treatment and passively allowing a person to die of a disease; between treating individuals as an initial matter versus withdrawing treatment afterwards; between ordinary versus extraordinary treatment; and between treatment by artificial feeding versus other forms of life-sustaining medical procedures. *Id.*, at 369-374, 486 A.2d, at 1233-1237. As to the last item, the court acknowledged the “emotional significance” of food, but noted that feeding by implanted tubes is a “medical procedur[e] with inherent risks and possible side effects, instituted by skilled health-care providers to compensate for impaired physical functioning” which analytically was equivalent to artificial breathing using a respirator. *Id.*, at 373, 486 A.2d, at 1236.

In contrast to *Conroy*, the Court of Appeals of New York recently refused to accept less than the clearly expressed wishes of a patient before permitting the exercise of her right to refuse treatment by a surrogate decisionmaker. In *re Westchester County Medical Center on behalf of O’Connor*, 72 N.Y.2d 517, 534 N.Y.S.2d 886, 531 N.E.2d 607 (1988) (O’Connor). There, the court, over the objection of the patient’s family members, granted an order to insert a feeding tube into a 77-year-old woman rendered incompetent as a result of several strokes. While continuing to recognize a common-law right to refuse treatment, the court rejected the substituted judgment approach for asserting it “because it is inconsistent with our fundamental commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another. Consequently, we adhere to the view that, despite its pitfalls and inevitable uncertainties, the inquiry must always be narrowed to the patient’s expressed intent, with every effort made to minimize the opportunity for error.” *Id.*, at 530, 534 N.Y.S.2d, at 892, 531 N.E.2d, at 613 (citation omitted). The court held that the record lacked the requisite clear and convincing evidence of the patient’s expressed intent to withhold life-sustaining treatment. *Id.*, at 531-534, 534 N.Y.S.2d, at 892-894, 531 N.E.2d, at 613-615.

Other courts have found state statutory law relevant to the resolution of these issues. In *Conservatorship of Drabick*, 200 Cal.App.3d 185, 245 Cal.Rptr. 840, cert. denied, 488 U.S. 958, 109 S.Ct. 399, 102 L.Ed.2d 387 (1988), the California Court of Appeal authorized the removal of a nasogastric feeding tube from a 44-year-old man who was in a persistent vegetative state as a result of an auto accident. Noting that the right to refuse treatment was grounded in both the common law and a constitutional right of privacy, the court held that a state probate statute authorized the patient’s conservator to order the withdrawal of life-sustaining treatment when such a decision was made in good faith based on medical advice and the conservatee’s best interests. While acknowledging that “to claim that [a patient’s] ‘right to choose’ survives incompetence is a legal fiction at best,” the court reasoned that the respect society accords to persons as individuals is not lost upon incompetence and is best preserved by allowing others “to make a decision that reflects [a patient’s] interests more closely than would a purely technological decision to do whatever is possible.” *Id.*, 200 Cal.App.3d, at 208, 245 *Id.*, 200 Cal.App.3d, at 208, 245 Cal. Rptr., at 854-855. See also *In re Conservatorship of Torres*, 357 N.W.2d 332 (Minn. 1984) (Minnesota court had constitutional and statutory authority to authorize a conservator to order the removal of an incompetent individual’s respirator since in patient’s best interests).

In *In re Estate of Longeway*, 133 Ill.2d 33, 139 Ill.Dec. 780, 549 N.E.2d 292 (1989), the Supreme Court of Illinois considered whether a 76-year-old woman rendered incompetent from a series of strokes had a right to the discontinuance of artificial nutrition and hydration. Noting that the boundaries of a federal right of privacy were uncertain, the court found a right to refuse treatment in the doctrine of informed consent. *Id.*, at 43-45, 139 Ill.Dec. at 784-785, 549 N.E.2d, at 296-297. The court further held that the State Probate Act impliedly authorized a guardian to exercise a ward’s right to refuse

artificial sustenance in the event that the ward was terminally ill and irreversibly comatose. *Id.*, at 45-47, 139 Ill.Dec., at 786, 549 N.E.2d, at 298. Declining to adopt a best interests standard for deciding when it would be appropriate to exercise a ward's right because it "lets another make a determination of a patient's quality of life," the court opted instead for a substituted judgment standard. *Id.*, at 49, *Id.*, at 49, 139 Ill.Dec., at 787, 549 N.E.2d, at 299. Finding the "expressed intent" standard utilized in *O'Connor*, *supra* too rigid, the court noted that other clear and convincing evidence of the patient's intent could be considered. 133 Ill.2d, at 50-51, 139 Ill.Dec., at 787, 549 N.E.2d, at 300. The court also adopted the "consensus opinion [that] treats artificial nutrition and hydration as medical treatment." *Id.*, at 42, 139 Ill.Dec., at 784, 549 N.E.2d, at 296. Cf. *McConnell v. Beverly Enterprises-Connecticut, Inc.*, 209 Conn. 692, 705, 553 A.2d 596, 603 (1989)(right to withdraw artificial nutrition and hydration found in the Connecticut Removal of Life Support Systems Act, which "provid[es] functional guidelines for the exercise of the common law and constitutional rights of self-determination"; attending physician authorized to remove treatment after finding that patient is in a terminal condition, obtaining consent of family, and considering expressed wishes of patient).

As these cases demonstrate, the common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment. Beyond that, these cases demonstrate both similarity and diversity in their approaches to decision of what all agree is a perplexing question with unusually strong moral and ethical overtones. State courts have available to them for decision a number of sources-state constitutions, statutes, and common law-which are not available to us. In this Court, the question is simply and starkly whether the United States Constitution prohibits Missouri from choosing the rule of decision which it did. This is the first case in which we have been squarely presented with the issue whether the United States Constitution grants what is in common parlance referred to as a "right to die." We follow the judicious counsel of our decision in *Twin City Bank v. Nebeker*, 167 U.S. 196, 202, 17 S.Ct. 766, 769, 42 L.Ed. 134 (1897), where we said that in deciding "a question of such magnitude and importance it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject."

The Fourteenth Amendment provides that no State shall "deprive any person of life, liberty, or property, without due process of law." The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions. In *Jacobson v. Massachusetts*, 197 U.S. 11, 24-30, 25 S.Ct. 358, 360-361, 49 L.Ed. 643 (1905), for instance, the Court balanced an individual's liberty interest in declining an unwanted smallpox vaccine against the State's interest in preventing disease. Decisions prior to the incorporation of the Fourth Amendment into the Fourteenth Amendment analyzed searches and seizures involving the body under the Due Process Clause and were thought to implicate substantial liberty interests. See, e.g., *Breithaupt v. Abram*, 352 U.S. 432, 439, 77 S.Ct. 408, 412, 1 L.Ed.2d 448 (1957) ("As against the right of an individual that his person be held inviolable must be set the interests of society.").

Just this Term, in the course of holding that a State's procedures for administering antipsychotic medication to prisoners were sufficient to satisfy due process concerns, we recognized that prisoners possess "a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment." *Washington v. Harper*, 494 U.S. 210, 221-222, 110 S.Ct. 1028, 1036, 108 L.Ed.2d 178 (1990); see also *Id.*, at 229, 110 S.Ct., at 1041 ("The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty"). Still other cases support the recognition of a general liberty interest in refusing medical treatment. *Vitek v. Jones*, 445 U.S. 480, 494, 100 S.Ct. 1254, 1264, 63 L.Ed.2d 552 (1980) (transfer to mental hospital coupled with mandatory behavior modification treatment implicated liberty interests); *Parham v. J.R.*, 442 U.S. 584, 600, 99 S.Ct. 2493, 2503, 61



L.Ed.2d 101 (1979) (“[A] child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment”).

But determining that a person has a “liberty interest” under the Due Process Clause does not end the inquiry; “whether respondent’s constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests.” *Youngberg v. Romeo*, 457 U.S. 307, 321, 102 S.Ct. 2452, 2461, 73 L.Ed.2d 28 (1982). See also *Mills v. Rogers*, 457 U.S. 291, 299, 102 S.Ct. 2442, 2448, 73 L.Ed.2d 16 (1982).

Petitioners insist that under the general holdings of our cases, the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life, would implicate a competent person’s liberty interest. Although we think the logic of the cases discussed above would embrace such a liberty interest, the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.

Petitioners go on to assert that an incompetent person should possess the same right in this respect as is possessed by a competent person. They rely primarily on our decisions in *Parham v. J.R.*, *supra*, and *Youngberg v. Romeo*, *supra*, 102 S.Ct. 2452, 73 L.Ed.2d 28 (1982). In *Parham*, we held that a mentally disturbed minor child had a liberty interest in “not being confined unnecessarily for medical treatment,” 442 U.S., at 600, 99 S.Ct., at 2503, but we certainly did not intimate that such a minor child, after commitment, would have a liberty interest in refusing treatment. In *Youngberg*, we held that a seriously retarded adult had a liberty interest in safety and freedom from bodily restraint, 457 U.S., at 320, 102 S.Ct., at 2460. *Youngberg*, however, did not deal with decisions to administer or withhold medical treatment.

The difficulty with petitioners’ claim is that in a sense it begs the question: An incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right. Such a “right” must be exercised for her, if at all, by some sort of surrogate. Here, Missouri has in effect recognized that under certain circumstances a surrogate may act for the patient in electing to have hydration and nutrition withdrawn in such a way as to cause death, but it has established a procedural safeguard to assure that the action of the surrogate conforms as best it may to the wishes expressed by the patient while competent. Missouri requires that evidence of the incompetent’s wishes as to the withdrawal of treatment be proved by clear and convincing evidence. The question, then, is whether the United States Constitution forbids the establishment of this procedural requirement by the State. We hold that it does not.

Whether or not Missouri’s clear and convincing evidence requirement comports with the United States Constitution depends in part on what interests the State may properly seek to protect in this situation. Missouri relies on its interest in the protection and preservation of human life, and there can be no gainsaying this interest. As a general matter, the States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide. We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death.

But in the context presented here, a State has more particular interests at stake. 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 an 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.” *In re Jobes*, 108 N.J. 394, 419, 529 A.2d 434, 447 (1987). 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 factfinding that the adversary process brings with it. See *Ohio v. Akron Center for Reproductive Health*, 497 U.S. 502, 515-516, 110 S.Ct. 2972, 2981-2982, 111 L.Ed.2d 405 (1990). 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. “The function of a standard of proof, as that concept is embodied in the Due Process Clause and in the realm of fact finding, is to ‘instruct the factfinder concerning the degree of confidence our society thinks he should have in the correctness of factual conclusions for a particular type of adjudication.’” (citations omitted). “This Court has mandated an intermediate standard of proof-‘clear and convincing evidence’-when the individual interests at stake in a state proceeding are both ‘particularly important’ and ‘more substantial than mere loss of money.’” *Santosky v. Kramer*, 455 U.S. 745, 756, 102 S.Ct. 1388, 1397, 71 L.Ed.2d 599 (1982) (quoting *Addington*, *supra*, at 424, 99 S.Ct., at 1808). Thus, such a standard has been required in deportation proceedings, *Woody v. INS*, 385 U.S. 276, 87 S.Ct. 483, 17 L.Ed.2d 362 (1966), in denaturalization proceedings, *Schneiderman v. United States*, 320 U.S. 118, 63 S.Ct. 1333, 87 L.Ed. 1796 (1943), in civil commitment proceedings, *Addington*, *supra*, and in proceedings for the termination of parental rights, *Santosky*, *supra*. Further, this level of proof, “or an even higher one, has traditionally been imposed in cases involving allegations of civil fraud, and in a variety of other kinds of civil cases involving such issues as lost wills, oral contracts to make bequests, and the like.” *Woodby*, *supra*, 385 U.S., at 285, n. 18, 87 S.Ct., at 488, n. 18.

We think it self-evident that the interests at stake in the instant proceedings are more substantial, both on an individual and societal level, than those involved in a run-of-the-mine civil dispute. But not only does the standard of proof reflect the importance of a particular adjudication, it also serves as “a societal judgment about how the risk of error should be distributed between the litigants.” *Santosky*, *supra*, 455 U.S. at 755, 102 S.Ct., at 1395; *Addington*, *supra*, 441 U.S., at 423, 99 S.Ct., at 1807-1808. The more stringent the burden of proof a party must bear, the more that party bears the risk of an erroneous decision. We believe that Missouri may permissibly place an increased risk of an erroneous decision on those seeking to terminate an incompetent individual’s life-sustaining treatment. An erroneous decision not to terminate results in a maintenance of the status quo; the possibility of subsequent developments such as advancements in medical science, the discovery of new evidence regarding the patient’s intent, changes in the law, or simply the unexpected death of the patient despite the administration of life-sustaining treatment at least create the potential that a wrong decision will eventually be corrected or its impact mitigated. An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible of correction. In *Santosky*, one of the factors which led the Court to require proof by clear and convincing evidence in a proceeding to terminate parental rights was that a decision in such a case was final and irrevocable. *Santosky*, *supra*, 445 U.S., at 759, 102 S.Ct., at

1397-1398. The same must surely be said of the decision to discontinue hydration and nutrition of a patient such as Nancy Cruzan, which all agree will result in her death.

It is also worth noting that most, if not all, States simply forbid oral testimony entirely in determining the wishes of parties in transactions which, while important, simply do not have the consequences that a decision to terminate a person's life does. At common law and by statute in most States, the parole evidence rule prevents the variations of the terms of a written contract by oral testimony. The statute of frauds makes unenforceable oral contracts to leave property by will, and statutes regulating the making of wills universally require that those instruments be in writing. See 2 A. Corbin, *Contracts* § 398, pp. 360-361 (1950); 2 W. Page, *Law of Wills* §§ 19.3-19.5, pp. 61-71 (1960). There is no doubt that statutes requiring wills to be in writing, and statutes of frauds which require that a contract to make a will be in writing, on occasion frustrate the effectuation of the intent of a particular decedent, just as Missouri's requirement of proof in this case may have frustrated the effectuation of the not-fully-expressed desires of Nancy Cruzan. But the Constitution does not require general rules to work faultlessly; no general rule can.

In sum, we conclude that a State may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state. We note that many courts which have adopted some sort of substituted judgment procedure in situations like this, whether they limit consideration of evidence to the prior expressed wishes of the incompetent individual, or whether they allow more general proof of what the individual's decision would have been, require a clear and convincing standard of proof for such evidence (citations omitted).

The Supreme Court of Missouri held that in this case the testimony adduced at trial did not amount to clear and convincing proof of the patient's desire to have hydration and nutrition withdrawn. In so doing, it reversed a decision of the Missouri trial court which had found that the evidence "suggest [ed]" Nancy Cruzan would not have desired to continue such measures, App. to Pet. for Cert. A98, but which had not adopted the standard of "clear and convincing evidence" enunciated by the Supreme Court. The testimony adduced at trial consisted primarily of Nancy Cruzan's statements made to a housemate about a year before her accident that she would not want to live should she face life as a "vegetable," and other observations to the same effect. The observations did not deal in terms with withdrawal of medical treatment or of hydration and nutrition. We cannot say that the Supreme Court of Missouri committed constitutional error in reaching the conclusion that it did.

Petitioners alternatively contend that Missouri must accept the "substituted judgment" of close family members even in the absence of substantial proof that their views reflect the views of the patient.

No doubt is engendered by anything in this record but that Nancy Cruzan's mother and father are loving and caring parents. If the State were required by the United States Constitution to repose a right of "substituted judgment" with anyone, the Cruzans would surely qualify. But we do not think the Due Process Clause requires the State to repose judgment on these matters with anyone but the patient herself. Close family members may have a strong feeling—a feeling not at all ignoble or unworthy, but not entirely disinterested, either—that they do not wish to witness the continuation of the life of a loved one which they regard as hopeless, meaningless, and even degrading. But there is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been had she been confronted with the prospect of her situation while competent. All of the reasons previously discussed for allowing Missouri to require clear and convincing evidence of the

patient's wishes lead us to conclude that the State may choose to defer only to those wishes, rather than confide the decision to close family members.

The judgment of the Supreme Court of Missouri is

Affirmed.

***In re Jobes*, 529 A.2d 434 (1987)**

GARIBALD, J.

Today, in *In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987), we set forth the guidelines and procedures under which life-sustaining medical treatment could be withdrawn from an elderly nursing home patient in a persistent vegetative state who, prior to her incompetency, had clearly expressed her desire not to be sustained in that condition. This appeal requires us to develop the guidelines and procedures under which life-sustaining medical treatment may be withdrawn from a non-elderly nursing home patient in a persistent vegetative state who, prior to her incompetency, failed to express adequately her attitude toward such treatment. Specifically, we must determine who decides for the incompetent patient, the standard that the surrogate decisionmaker must use, and who must be consulted and concur in the decision.

Embarking on this task, we are mindful that the patient's right to self-determination is the guiding principle in determining whether to continue or withdraw life-sustaining medical treatment; that therefore the goal of a surrogate decision-maker for an incompetent patient must be to determine and effectuate what that patient, if competent, would want; and that the court does not decide whether to withdraw life-supporting treatment. Rather, our role is to establish for those who make that decision criteria that respect the right to self-determination and yet protect incompetent patients.

I

Since July 1980, Nancy Jobes has been a resident patient at the Lincoln Park Nursing Home (hereinafter nursing home). In May 1985 her husband John and her parents requested that the nursing home withdraw the jejunostomy tube (hereinafter j-tube), which provides her with nutrition and hydration. The nursing home refused on moral grounds.

Thereafter Mr. Jobes asked the Chancery Division to "authorize and order" the withdrawal of the j-tube.<sup>1</sup> He contended that his wife was in a persistent vegetative state, and that therefore he and her family had concluded that she would choose to terminate artificial feeding and that it was in her best interests to do so.

The trial court appointed Richard Kahn, Esq., as guardian *ad litem* for Mrs. Jobes. After reviewing the medical evidence and interviewing her family, close friends and clergyman, Mr. Kahn filed a report in favor of Mr. Jobes' decision. The nursing home then moved for the appointment of a "life advocate." The trial court denied that motion. *In re Jobes*, 210 N.J. Super. 543, 510 A.2d 133 (Ch. Div. 1986). The nursing home unsuccessfully appealed that decision.

The Public Advocate intervened, with the consent of Mr. Jobes and Mr. Kahn, as a party in opposition to them.

Prior to trial, the judge visited Mrs. Jobes at the nursing home and filed an observation report. After a seven-day trial, the court found that Mr. Jobes had proved by clear and convincing evidence that his wife is in a persistent vegetative state with no prospect of improvement, and that, if competent, she would not want to be sustained by the j-tube under her present circumstances. The court therefore authorized Mr. Jobes to implement removal of the j-tube under the supervision of a licensed physician. However, the court held that the nursing home was entitled to refuse to participate in the withdrawal of the j-tube and could keep Mrs. Jobes connected to it until she was transferred out of that facility. Judgment was entered on April 28, 1986, but relief was stayed pending final determination of this appeal. Both Mr. Jobes and the nursing home petitioned this court for direct certification, which we granted. 105 N.J. 532, 523 A.2d 173 (1986).

## II

Nancy Ellen Jobes is thirty-one years old. She is the daughter of Robert and Eleanor Laird, both of whom are living. She has three living siblings. She married John H. Jobes, III, on July 31, 1976. Prior to March of 1980, Mrs. Jobes had no significant mental or physical handicap. She was employed as a certified laboratory technologist, and was four and one-half months pregnant with her first child.

On March 11, 1980, Mrs. Jobes was admitted to Riverside Hospital for treatment of injuries sustained in an automobile accident. Doctors soon determined that her fetus had been killed. During the course of an operation to remove the dead fetus, she sustained a severe loss of oxygen and blood flow to her brain. She suffered massive and irreversible damage to the part of her brain that controls thought and movement. She has never regained consciousness.

On July 28, 1980, Mrs. Jobes was transferred to the nursing home. Her condition has not changed since she was admitted. She is unable to speak or make any kind of noise. A towel is kept under her chin to catch the secretions that drip from her mouth. She has a tracheostomy, which is covered with a plastic shield to which a flexible tube is attached. An air compressor must humidify the air moving into her throat through this tube to prevent it from becoming clogged with mucous.

She is incontinent and requires a catheter to continuously irrigate her bladder. She receives routine enemas for bowel evacuation. She has chronic urinary tract infections. She is given antibiotics when necessary, as well as medication intended to prevent seizures.

Her muscles have atrophied and her limbs are rigidly contracted. Her extremities cannot be moved. Her closely clenched fingers are padded to prevent the skin between them from deteriorating.

She cannot swallow. Originally she was fed and hydrated intravenously, then through a nasogastric tube, then a gastrostomy tube. In June 1985, complications with the gastrostomy tube necessitated an even more direct approach. Since then, Mrs. Jobes has been fed through a j-tube inserted—through a hole cut into her abdominal cavity—into the jejunum of her small intestine. Water and a synthetic, pre-digested formula of various amino acids are pumped through the j-tube continuously. She has been removed to Morristown Memorial Hospital at least three times because of complications with the j-tube.

After Mr. Jobes instituted this suit, Mrs. Jobes was admitted to Cornell Medical Center-New York Hospital (Cornell) for four days of observation and testing. All of the resulting medical evidence supports Mr. Jobes' characterization of her condition. Dr. Fred Plum, Professor and Chairman of the Department of Neurology at Cornell, examined Mrs. Jobes every day while she was there. As a witness for Mr. Jobes, he testified that she is in a persistent, i.e., irreversible, vegetative state. Dr. Plum is a world renowned expert on the "persistent vegetative state." He originally created that term, and is the author of several treatises and numerous articles explaining it.

Dr. David E. Levy, an associate professor of neurology at Cornell and an associate of Dr. Plum, was retained as an expert by both the Public Advocate and the guardian *ad litem*, but testified only for the guardian *ad litem*. Dr. Levy is the author of numerous publications on brain damage resulting from a reduction in blood flow and oxygen, and the persistent vegetative state. He has studied over six hundred comatose patients.

Dr. Levy observed and tested Mrs. Jobes far more extensively than any of the other neurological experts. He observed her first at the nursing home and then every day that she was at Cornell. He spent several hours with her during each of the days that a positron-emission tomograph scan and a nuclear magnetic resonance scan were conducted. On the basis of his clinical observations, Dr. Levy concluded that Mrs. Jobes is in a persistent vegetative state without any chance of recovery.

All the laboratory tests performed on Mrs. Jobes at Cornell were consistent with that diagnosis. A CAT scan and the nuclear magnetic resonance scan both indicated atrophy of the cerebral brain tissue. The positron emission tomograph scan indicated that blood flow and metabolism in Mrs. Jobes' cerebral cortex are only thirty to forty percent of that of a normal cognitive brain. This level of brain activity is found in persons under very deep anesthesia and those who have suffered a massive loss in brain function.

Several other doctors examined Mrs. Jobes at the Nursing Home, and testified about their observations. Dr. Henry Liss, a neurosurgeon and Professor of Neurological Surgery at the College of Physicians and Surgeons of Columbia University, and an associate professor of surgery at Rutgers Medical School, and Dr. Daniel Carlin, a neurologist and an associate professor of neurology at Rutgers Medical School, testified for Mr. Jobes. Each reviewed Mrs. Jobes' medical reports, and examined her in June and again in the Autumn of 1985. Each of them concluded that she is in a persistent vegetative state with no chance of recovery.

Dr. Allan H. Ropper, an associate professor of medicine at Harvard Medical School and Director of the Neurosurgery-Neurology Intensive Care Unit at Massachusetts General Hospital, and Dr. Maurice Victor, Professor of Neurosurgery at Case Western Reserve University School of Medicine, testified for the nursing home. Neither performed any laboratory tests. Dr. Victor examined Mrs. Jobes once at the nursing home for about one and one-half hours. He testified that although Mrs. Jobes had suffered severe and irreversible cerebral damage, he did not believe that she is in a vegetative state. Dr. Victor had no written record of Mrs. Jobes' responses during his examination of her. He based his opinion on his recollection of her reactions to stimuli. He recalled that on four or five occasions he had said, "Nancy, pick up your head" and that, with only one exception, after one or two seconds, she obeyed. He testified that she had responded to commands to wiggle her toes on eight out of twelve occasions; to move her leg once; to stick out her tongue in response to four or five requests. These responses indicated to Dr. Victor that Mrs. Jobes could hear and understand him and that her brain could connect the cerebral cortex, where hearing and understanding take place, to the muscles that she moved.

Dr. Victor testified that he interpreted Mrs. Jobes' reaction to ammonia under her nose—a “violent grimace” and a retraction of her head—as not purely reflexive. He admitted that this was a “pure interpretation” and that he was less sure about this than he was about her responses to commands.

Dr. Victor testified that he had observed emotions in Mrs. Jobes' facial gestures. He characterized them as ‘anticipatory’ when he entered her room; “intent” when she received commands; “satisfied” when she was congratulated on having responded.

Dr. Ropper, like Dr. Victor, examined Mrs. Jobes at the nursing home for approximately ninety minutes. He observed that she had a wide range of random or spontaneous movements:

Approximately every thirty seconds to a minute she would lift her right shoulder up off the recliner. She would lift her head from the left armrest off the armrest to sort of a neutral position and move it to the right, taking about three to four seconds to do that, and that she did spontaneously every three to five minutes.

She would move her foot downward and her toes slowly about every ten to forty seconds. She would lift her leg, right leg stiffly off the chair about a half inch to an inch every five to ten minutes.

Like Dr. Victor, Dr. Ropper testified that he had elicited command-responses from Mrs. Jobes.

As a result of his observations, Dr. Ropper concluded that Mrs. Jobes fell “slightly outside of [his] operational definition of the persistent vegetative state.” Dr. Ropper defines that state as one in which the patient “is in or has sleep/wake cycles, is totally incapable of responding and is totally unaware of environment or self.” His definition is subtly but significantly different from that which was offered by Dr. Plum, and accepted by this court in *Quinlan*, supra, 70 N.J. at 25, 355 A.2d 647. Primitive reflex responses to external stimuli would exclude a patient from the persistent vegetative state under Dr. Ropper's definition but not under Dr. Plum's.

All of the medical experts retained by the plaintiff, the guardian, and the Public Advocate were unsuccessful in eliciting volitional responses from Mrs. Jobes. They observed the kind of movements reported by Drs. Victor and Ropper, but concluded that they were startle reflexes and random movements rather than evidence of any cognitive awareness.

Some of the nurses and nurses' aides who work at the nursing home testified that they had observed examples of what they interpreted as cognitive awareness on the part of Mrs. Jobes. They claimed that she moved her head to aid them in washing her hair; smiled at appropriate times; followed people with her eyes; and relaxed when spoken to or touched in a soothing manner.

In addition, several nurses and aides testified that they saw tears in Mrs. Jobes' eyes when her family visited. Nurses pointed out the phenomenon they described as “tears” to Dr. Carlin when he examined her at the nursing home. He characterized it as an unemotional collection of secretions in the corner of Mrs. Jobes' eyes. Dr. Liss also observed these secretions. He explained that they are merely accumulations of liquid that keep the conjunctiva moist and that they are created by rapid, reflexive eye-blinking, rather than emotions.

Other nurses and nurses' aides testified that they had not observed any cognitive awareness in Mrs. Jobes, and that she gave no response to their verbal commands.

### III

In the two other cases that we have decided today, *In re Farrell*, 108 N.J. 335, 529 A.2d 404 (1987) and *In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987), well as *Quinlan and Conroy*, there was no disagreement among the medical experts about the patient's medical condition or prognosis. Moreover, we have not found a dispute among medical experts over a patient's condition in any other case concerning the withdrawal of life-sustaining treatment. In this case all the medical experts agree that Mrs. Jobes is severely brain damaged. But while the experts for Mr. Jobes, the guardian *ad litem*, and the Public Advocate contend that she is in a persistent vegetative state, the two nursing home experts contend that she falls slightly outside of their definition of the persistent vegetative state.

Evidence may be uncontroverted, and yet not be "clear and convincing." (citations omitted). Conversely, evidence may be "clear and convincing" despite the fact that it has been contradicted. In this case, the reports and testimony of the Nursing Home's experts are inconsistent with the trial court's conclusion that Mrs. Jobes is in a persistent vegetative state. Nevertheless, we believe that conclusion was supported by clear and convincing evidence.

Doctors Plum and Levy, each of whom concluded that Mrs. Jobes is in a persistent vegetative state, have devoted their medical careers to the diagnosis, treatment, and prognosis of patients in the persistent vegetative state. Doctors Victor and Ropper, who testified that Mrs. Jobes has some cognitive ability, are unquestionably accomplished neurologists, but their experience and training in this particular area is comparatively limited. Moreover, Doctors Victor and Ropper each based his opinion of Mrs. Jobes' condition on a single, ninety-minute observation. In contrast, Doctors Plum, Levy, Carlin and Liss—all of whom agree that Mrs. Jobes is in a persistent vegetative state—each spent more time with her. Doctors Plum and Levy in particular based their opinions on extensive clinical and laboratory examinations and observations.

We take special note of the testimony of Dr. Levy because, in addition to his having spent the most amount of time with Mrs. Jobes, he was retained by the two most disinterested participants in this case, the Public Advocate and the Guardian *ad litem*. We cannot ignore the possibility that experts retained in order to litigate an extremely emotional issue like the withdrawal of a life-sustaining feeding tube might be partisan.

Accordingly, we conclude that the neurological experts who testified for Mr. Jobes, the guardian *ad litem* and the Public Advocate offered sufficiently clear and convincing evidence to support the trial court's finding that Mrs. Jobes is in an irreversible vegetative state. The trial court heard the testimony, observed the witnesses, and even visited Mrs. Jobes at the nursing home. It was uniquely equipped to decide which experts were more credible. We have always given great deference to trial court evaluations of conflicting medical evidence. See generally *Baxter v. Fairmont Food Co.*, 74 N.J. 588, 597-98, 379 A.2d 225 (1977) (Hughes, C.J.) (explaining the "very considerable respect" accorded to trial court evaluations of medical evidence). While we recognize the gravity of the responsibility to evaluate medical evidence in withdrawal-of-treatment cases, we believe that our traditional confidence in the factual determinations made by our trial courts is as appropriate in this as in other contexts.

### IV

Mrs. Jobes' closest friends, her cousin, her clergyman, and her husband offered testimony that was intended to prove that if she were competent, Mrs. Jobes would refuse to be sustained by the j-tube. Deborah Holdsworth, a registered nurse and life-long friend of Mrs. Jobes, recalled a conversation in



1971 in which Mrs. Jobes stated that if she were ever crippled like the children with multiple sclerosis and muscular dystrophy that Ms. Holdsworth cared for, she would not want to live. Ms. Holdsworth also recalled telling Mrs. Jobes on numerous occasions that she, Holdsworth, would not want to live like Karen Quinlan did after the removal of her respirator. She recalled that Mrs. Jobes had not disagreed with her, but could not recall Mrs. Jobes' position any more clearly than that. Finally, Holdsworth recalled that in late 1979 Mrs. Jobes specifically stated that she would not want to be kept alive on a respirator like a patient suffering from amyotrophic lateral sclerosis whom Ms. Holdsworth had described to her.

Another friend of Mrs. Jobes' since childhood, Donna DeChristofaro, testified that in Autumn 1979 Mrs. Jobes had told her that "it was a shame that [Karen Quinlan] hadn't died when they removed the respirator; that that wasn't living, it was existing; that she had wished that God had taken her then."

Mrs. Jobes' first cousin, Dr. Cleve Laird, recalled a discussion he had with her in the summer of 1975 about a victim of an automobile accident who was being kept alive by a cardiac stimulator:

She said that she wouldn't want those measures taken in her case and that she certainly wouldn't want to live that way.

I said, well, they wouldn't do that to me because I carried and still carry a form of identification that says that I do not wish to have any heroic measures taken in case of massive injury.

Subsequent to that she became interested in where I had gotten that and I told her that it was pretty common both at Baylor where I had taught prior to going up to Massachusetts and also at Harvard. I said that I would send her a card. My wife was there and I turned around to her and told her why didn't she send one. Then we moved on into discussion of other technical things.

Dr. Laird testified that his wife had sent the card to Mrs. Jobes, and that Mrs. Jobes thanked them for it in a note she sent them at Christmas. The card has not been found.

John Jobes testified that if his wife were competent, she would "definitely" choose to terminate the artificial feeding that sustains her in her present condition. He generally recalled her having stated that she would not want to be kept alive under Karen Quinlan's circumstances. She did this frequently when the Quinlan case was in the news, mostly during 1976-77.

The Reverend George A. Vorsheim, minister of the Morris Plains Presbyterian Church, testified that he had married the Jobes, and that he was familiar with them and with Mrs. Jobes' parents. They are all members of the Presbyterian Church (U.S.A.). The Reverend Mr. Vorsheim testified that Mrs. Jobes was raised in the Presbyterian Faith, and that in the Presbyterian Faith there is no religious requirement to perpetuate life by artificial means nor is there any doctrine prohibiting life-sustaining medical treatment. The Presbyterian Church leaves decisions like the one at issue here to the individual conscience. See generally Advisory Council of the Presbyterian Church (U.S.A.) on Church and Society, *An Essay on the Problems Related to the Prolongation of Life by Technological Methods* (1974) (adopted by the 186th General Assembly of the United Presbyterian Church (U.S.A.)); Advisory Council of the Presbyterian Church (U.S.A.) on Church and Society, *The Covenant of Life and the Caring Community and Covenant* (1983) (adopted by the 195th General Assembly of the United Presbyterian Church (U.S.A.)).

## V

In *Conroy* and *Peter*, we have described the type of evidence that can establish a person's medical preferences under the "subjective test." See *Peter*, supra, 108 N.J. at 377-379, 529 A.2d at 425-26; *Conroy*, supra, 98 N.J. at 361-63, 486 A.2d 1209. We have explained that the probative value of prior statements offered to prove a patient's inclination for or against medical treatment depends on their specificity, see *Conroy*, supra, 98 N.J. at 363, 486 A.2d 1209, their "remoteness, consistency and thoughtfulness [,] and the maturity of the person at the time of the statements." Id. at 362, 486 A.2d 1209. All of the statements about life-support that were attributed to Mrs. Jobes were remote, general, spontaneous, and made in casual circumstances. Indeed, they closely track the examples of evidence that we have explicitly characterized as unreliable. See Id. at 362-63, 486 A.2d 1209 (negating probative value of "an off-hand remark about not wanting to live under certain circumstances made by a person when young and in the peak of health"); Id. at 366, 486 A.2d 1209 (noting that "informally expressed reactions to other people's medical condition and treatment" do not constitute clear proof of a patient's intent).

Other than her prior statements, the only evidence of Mrs. Jobes' intent that the trial court relied on was her membership in the Presbyterian Church. There is no specific evidence of her personal belief in the tenets of that Church; nevertheless, we have consistently recognized that "a person's religious affiliation and the tenets of that religion may furnish evidence of his or her intent with regard to medical decisions." *Conroy*, supra, 98 N.J. at 362, 486 A.2d 1209; see *Quinlan*, supra, 70 N.J. at 30-31, 355 A.2d 647. In this case, however, Mrs. Jobes' minister testified that her religion neither requires nor forbids medical treatment like that at issue here. Therefore, Mrs. Jobes' religious affiliation does not offer much guidance in determining what her preference would be in this situation.

Thus, we conclude that although there is some "trustworthy" evidence that Mrs. Jobes, if competent, would want the j-tube withdrawn, it is not sufficiently "clear and convincing" to satisfy the subjective test. Therefore, we must determine the guidelines and procedures under which life-sustaining medical treatment may be withdrawn from a patient like Mrs. Jobes when there is no clear and convincing proof of her attitude toward such treatment.

## VI

Because of the unique problems involved in decisionmaking for any patient in the persistent vegetative state, we necessarily distinguish their cases from cases involving other patients. Accordingly, in *Peter* we held that neither the life-expectancy test nor the balancing tests set forth in *Conroy* are appropriate in the case of a persistently vegetative patient. See *Peter*, supra, 108 N.J. at 374-376, 529 A.2d at 423-425. Those holdings are equally relevant in this case. In any case involving a patient in the persistent vegetative state, "we look instead primarily to *Quinlan* for guidance." Id. at 376, 529 A.2d at 425.

Karen *Quinlan* was twenty-two years old and hospitalized in an irreversible vegetative state when her father sought authorization to withdraw the respirator that was thought to be sustaining her.<sup>9</sup> We began our analysis of his request by recognizing that "if Karen were herself miraculously lucid for an interval (not altering the existing prognosis of the condition to which she would soon return) and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death." *Quinlan*, supra, 70 N.J. at 39, 355 A.2d 647. We realized that the state had potential interests in prolonging any individual's life. We explained, however, that those interests weaken and the individual's right to privacy becomes stronger "as the

degree of bodily invasion [effected by the medical treatment at issue] increases and the prognosis [for recovery to a cognitive, sapient state] dims.” 70 N.J. at 41, 355 A.2d 647. We concluded that Karen Quinlan’s right to choose whether to consent to or refuse life-support outweighed any relevant state interests. Our confidence in that conclusion has not been undermined by our subsequent articulation of the four specific state interests which are generally relevant in cases of this type. See Farrell, *supra*, 108 N.J. at 349-354, 529 A.2d at 411-413; Conroy, *supra*, 98 N.J. at 348-49, 486 A.2d 1209. “find it difficult to conceive of a case in which the State could have an interest strong enough to subordinate a patient’s right to choose not to be sustained in a persistent vegetative state.” Peter, *supra*, 108 N.J. at 380, 529 A.2d at 427.

In light of Karen Quinlan’s inability to assert her right to decline continued artificial respiration, we determined that “[t]he only practical way to prevent destruction of the right [was] to permit the guardian and family of Karen to render their best judgment, subject to the qualifications [t]hereinafter stated, as to whether she would exercise it in [her] circumstances.” The term “substituted judgment” is commonly used to describe our approach in *Quinlan*. See *President’s Commission Report, supra*, at 136; N. Cantor, *Legal Frontiers of Death and Dying* 79 (1987). This approach is intended to ensure that the surrogate decisionmaker effectuates as much as possible the decision that the incompetent patient would make if he or she were competent. Under the substituted judgment doctrine, where an incompetent’s wishes are not clearly expressed, a surrogate decisionmaker considers the patient’s personal value system for guidance. The surrogate considers the patient’s prior statements about and reactions to medical issues, and all the facets of the patient’s personality that the surrogate is familiar with—with, of course, particular reference to his or her relevant philosophical, theological, and ethical values—in order to extrapolate what course of medical treatment the patient would choose. See *In re Roe*, 383 Mass. 415, 442, 421 N.E.2d 40, 56-59 (1981).

In *Quinlan* we held that the patient’s family members were the proper parties to make a substituted medical judgment on her behalf. See *Quinlan, supra*, 70 N.J. at 41, 355 A.2d 647. We make the same determination today. Almost invariably the patient’s family has an intimate understanding of the patient’s medical attitudes and general world view and therefore is in the best position to know the motives and considerations that would control the patient’s medical decisions.

Family members are best qualified to make substituted judgments for incompetent patients not only because of their peculiar grasp of the patient’s approach to life, but also because of their special bonds with him or her. Our common human experience informs us that family members are generally most concerned with the welfare of a patient. It is they who provide for the patient’s comfort, care, and best interests, see *Id.* at 35, 355 A.2d 647; see Farrell *supra*, 108 N.J. at 355, 529 A.2d at 414, and they who treat the patient as a person, rather than a symbol of a cause. Where strong and emotional opinions and proponents exist on an issue involving the treatment of an incompetent, extreme care must be exercised in determining who will act as his or her surrogate decisionmaker. We believe that a family member is generally the best choice.

Other courts have agreed that the family’s substituted judgment is the best guide in cases where the patient’s intention to accept or refuse life-sustaining treatment has not been clearly established (citations omitted).

Medical authorities also have recognized that family members are the appropriate surrogate decisionmakers for incompetent patients.

Our review of these cases and medical authorities confirms our conclusion that we should continue to defer, as we did in *Quinlan*, to family members' substituted judgments about medical treatment for irreversibly vegetative patients who did not clearly express their medical preferences while they were competent. Those decisions are best made by the family because the family is best able to decide what the patient would want.

Normally those family members close enough to make a substituted judgment would be a spouse, parents, adult children, or siblings. Generally, in the absence of such a close degree of kinship, we would not countenance health care professionals deferring to the relatives of a patient, and a guardian would have to be appointed. However, if the attending health care professionals determine that another relative, e.g., a cousin, aunt, uncle, niece, or nephew, functions in the role of the patient's nuclear family, then that relative can and should be treated as a close and caring family member. See *In re Farrell*, supra, 108 N.J. at 355, 529 A.2d at 414 (noting the conspicuous presence of family members vis-a-vis health care professionals).

There will, of course, be some unfortunate situations in which family members will not act to protect a patient. We anticipate that such cases will be exceptional. Whenever a health-care professional becomes uncertain about whether family members are properly protecting a patient's interests, termination of life-sustaining treatment should not occur without the appointment of a guardian.

We realize that there may be rare situations where a health-care professional's assessment of a family situation proves to be wrong. In such a case, if the professional has made a good faith determination in this regard, he or she will not be subject to any criminal or civil liability.

Mrs. Jobes is blessed with warm, close, and loving family members. It is entirely proper to assume that they are best qualified to determine the medical decisions she would make. Moreover, there is some trustworthy evidence that supports their judgment of Mrs. Jobes' personal inclinations. Therefore, we will not presume to disturb their decision.

Thus, we hold that the right of a patient in an irreversibly vegetative state to determine whether to refuse life-sustaining medical treatment may be exercised by the patient's family or close friend. If there are close and caring family members who are willing to make this decision there is no need to have a guardian appointed. We require merely that the responsible relatives comply with the medical confirmation procedures that we henceforth establish. See *infra* at 447–448. If there are no close family members, and the patient has not left clear and convincing evidence that he or she intended another relative or a nonrelative friend to make surrogate medical decisions in the case of his or her incompetency, see, e.g., *Peter*, supra, 108 N.J. at 370, 529 A.2d at 422 (where patient gave her friend durable power of attorney to make medical decisions), then a guardian must be appointed and comply with the following procedural requirements. Cf. *Id.* at 384, 529 A.2d at 429.

## VII

In *Quinlan*, we realized that in the absence of legislation, the responsibility of establishing procedural guidelines for the effectuation of decisions to withdraw life-support is incumbent upon the court. Therefore, we held that when the guardian, the family, and the attending physician concur that life support should be withdrawn from a hospital patient in a persistent vegetative state, they must secure the confirmation of a hospital prognosis committee that there is no reasonable possibility that the patient might recover to a cognitive sapient state. See *Quinlan*, supra, 70 N.J. at 50, 355 A.2d 647. Once such a confirmation is secured, the life-supporting treatment may be withdrawn. *Id.* *Quinlan*

specifically rejected any provision for judicial review of this procedure as unnecessary and “impossibly cumbersome.” See *Id.*

*Amicus* New Jersey Hospital Association has informed us that since *Quinlan* was decided, approximately eighty-five percent of New Jersey’s acute-care hospitals have established prognosis committees that check the attending physician’s prognosis when withdrawal of life support from a vegetative patient is under consideration. Thus it appears that the *Quinlan* procedure is functioning in the setting for which it was intended.

Mrs. Jobes, of course, is in a nursing home rather than a hospital. We believe, however, that the processes of surrogate decisionmaking should be substantially the same regardless of where the patient is located. Otherwise, the patient’s right to determine his or her medical treatment could be frustrated by an irrelevant factor. Nevertheless, we recognize there are safeguards in a hospital that are usually not present in a nursing home, i.e., the hospital patient normally has his or her own attending physician and, as noted above, many hospitals have prognosis committees. The lack of these safeguards was among the reasons that we developed the Ombudsman procedures that protect elderly nursing home patients. See *Conroy*, *supra*, 98 N.J. at 375-76, 486 A.2d 1209; *Peter*, *supra*, 108 N.J. at 383, 529 A.2d at 428.

Because Mrs. Jobes is not elderly, the Ombudsman does not have jurisdiction over her case. See N.J.S.A. 52:27G-1, 2(i) (Ombudsman has jurisdiction only in cases where the patient is at least sixty years old). Fortunately, Mrs. Jobes is not in the vulnerable predicament that so many elderly nursing home patients are in because she has a caring and responsible family. For non-elderly non-hospitalized patients in a persistent vegetative state who, like Mrs. Jobes, have a caring family or close friend, or a court-appointed guardian in attendance, we hold that the surrogate decisionmaker who declines life-sustaining medical treatment must secure statements from at least two independent physicians knowledgeable in neurology that the patient is in a persistent vegetative state and that there is no reasonable possibility that the patient will ever recover to a cognitive, sapient state. If the patient has an attending physician, then that physician likewise must submit such a statement. These independent neurological confirmations will substitute for the concurrence of the prognosis committee for patients who are not in a hospital setting and thereby prevent inappropriate withdrawal of treatment. In a proper case, however, they should not be difficult to obtain, and this requirement should not subject the patient to undesired treatment.

The “substituted judgment” approach to decisionmaking for patients in the persistent vegetative state is our ideal. We realize that in some cases it may be unworkable, *e.g.*, when the patient has always been incompetent, see President’s Commission Report, *supra*, at 132–33 (“The substituted judgment standard can be used only if a patient was once capable of developing views relevant to the matter at hand.”), or when the patient has no family or close friends in a position to know his or her subjective personality. See *Conroy*, *supra*, 98 N.J. at 375, 486 A.2d 1209 (noting the social isolation of many nursing home patients). We need not and therefore do not decide those cases today.

## VIII

The trial court held that the nursing home could refuse to participate in the withdrawal of the j-tube by keeping Mrs. Jobes connected to it until she is transferred out of that facility. Under the circumstances of this case, we disagree, and we reverse that portion of the trial court’s order.

Mrs. Jobes' family had no reason to believe that they were surrendering the right to choose among medical alternatives when they placed her in the nursing home. See N.J.S.A. 30:13-5(m) (nursing home residents may not be deprived of constitutional, civil, or legal rights solely by reason of their admission to a nursing home). The nursing home apparently did not inform Mrs. Jobes' family about its policy toward artificial feeding until May of 1985 when they requested that the j-tube be withdrawn. In fact, there is no indication that this policy has ever been formalized. Under these circumstances Mrs. Jobes and her family were entitled to rely on the nursing home's willingness to defer to their choice among courses of medical treatment. See *In re Requena*, 213 N.J. Super. 443, 517 A.2d 869 (App.Div.), *aff'd* 214 N.J. Super. 475, 517 A.2d 886 (Ch.Div.1986) (subverting a hospital's policy not to participate in the withholding or withdrawal of artificial feeding where long-term patient had no notice of it prior to her decision to forego such treatment).

We do not decide the case in which a nursing home gave notice of its policy not to participate in the withdrawal or withholding of artificial feeding at the time of a patient's admission. Thus, we do not hold that such a policy is never enforceable. But we are confident in this case that it would be wrong to allow the nursing home to discharge Mrs. Jobes. The evidence indicates that at this point it would be extremely difficult, perhaps impossible, to find another facility that would accept Mrs. Jobes as a patient. Therefore, to allow the nursing home to discharge Mrs. Jobes if her family does not consent to continued artificial feeding would essentially frustrate Mrs. Jobes' right of self-determination. See *generally* Annas, "Transferring the Ethical Hot Potato," 17 *Hastings Center Report* 20-21 (Feb.1987) (explaining how patients' rights are threatened by legal decisions that allow medical institutions to discharge "patients who do not accept everything they offer").

Throughout the six years that Mrs. Jobes has been at the nursing home she has received extraordinary attention and tender care. We are confident that this excellent treatment will continue. "A decision to forego life-sustaining treatment is not a ground to withdraw all care—nor should care givers treat it in this way." President's Commission Report, *supra*, at 90. Health care professionals must provide for the comfort and dignity of "people who choose to forego life-sustaining therapy or for whom no such therapies are available." *Id.* at 4. Their specific obligations depend, of course, on the condition and treatment preferences of the individuals they attend. Certainly, however, "hygienic measures and dignified care for the body" are necessary in every case. *Id.* at 189; see also Farrell, *supra*, 108 N.J. at 364-365, 529 A.2d at 419 (O'Hern, J., concurring). Thus, we recognize that our decision will be burdensome for some of the nursing home personnel. Nevertheless, in view of the immense hardship that would fall on Mrs. Jobes and her family if she were forced out of the nursing home, we are compelled to impose on it for her continued care.

## IX

In summary, we state again that the fateful decision to withdraw life-supporting treatment is extremely personal. Accordingly, a competent patient's right to make that decision generally will outweigh any countervailing state interests. See Farrell, *supra*, 108 N.J. at 354, 529 A.2d at 414. An incompetent patient does not lose his or her right to refuse life-sustaining treatment. Where such a patient has clearly expressed her intentions about medical treatment, they will be respected. Peter, *supra*, 108 N.J. at 378, 529 A.2d at 425.

Where an irreversibly vegetative patient like Mrs. Jobes has not clearly expressed her intentions with respect to medical treatment, the Quinlan "substituted judgment" approach best accomplishes the goal of having the patient make her own decision. In most cases in which the "substituted judgment" doctrine is applied, the surrogate decisionmaker will be a family member or close friend of the patient.

Generally, it is the patient's family or other loved ones who support and care for the patient, and who best understand the patient's personal values and beliefs. Hence they will be best able to make a substituted medical judgment for the patient.

The location of the patient should occasion minimal interference with the patient's right, expressed either directly or through a surrogate decisionmaker, to determine his or her treatment. Particularly at the present time—when terminal and vegetative patients are not permitted to remain in hospitals—we prefer not to impose extra restrictions on the withdrawal of treatment because the patient is at home or in a nursing home. Nevertheless, we recognize that generally, because of the presence of attending physicians and prognosis committees, hospitals afford greater protection against the premature termination or undue prolongation of life-support measures. We believe that the procedures of independent medical verification that we establish today adequately protect patients, without unduly burdening their rights to self-determination and privacy.

If a disagreement arises among the patient, family, guardian, or doctors, or if there is evidence of improper motives or malpractice, judicial intervention will be required. We expect, however, that disagreements will be rare and that intervention seldom will be necessary. We emphasize that even in those few cases in which the courts may have to intervene, they will not be making the ultimate decision whether to terminate medical treatment. Rather, they will be acting to insure that all the guidelines and procedures that we have set forth are properly followed.

Courts are not the proper place to resolve the agonizing personal problems that underlie these cases. Our legal system cannot replace the more intimate struggle that must be borne by the patient, those caring for the patient, and those who care about the patient.

Ideally, each person should set forth his or her intentions with respect to life-supporting treatment. This insures that the patient's own resolution of this extraordinarily personal issue will be honored. Failure to express one's intentions imposes an awesome and painful responsibility on the surrogate decisionmaker.

As we have previously explained, the Legislature is better equipped than the judiciary to frame comprehensive guidelines and procedures for the withdrawal of life-sustaining treatment. Accordingly, we urge it to pass legislation in this area.

As modified, we affirm the judgment of the trial court.

### ***Bioethics Consultations***

1. Mattie Green is an 85-year-old former professional dancer with severe dementia who now resides in a locked dementia unit at Greenrose Nursing Home. Except for dementia, her only medical problems are kidney disease, controlled with dialysis, and a heart arrhythmia controlled with a pacemaker implanted several years ago. Mattie can eat and drink without significant problems. She can still dance.

Because of her dementia, Mattie no longer recognizes her family or the nursing home staff. Multiple trials of antipsychotic drugs and sedatives have failed to control her hallucinations and aggressive behavior or caused serious adverse effects (i.e., gait instability, falls, swallowing problems, and fecal incontinence). When she is not taking the medications, she is physically and verbally abusive.

Mattie is a widower. Her only child is twenty-seven-year-old Marcie. Marcie has asked that Mattie's pacemaker be turned off and her dialysis discontinued. Marcie says that her mother has always been a very proud woman and hates violence of all kinds. She says that her mother would be horrified to see herself in such a state, and she is confident that her mother would not have wanted to live in her current state. Mattie does not have an advance directive.

According to Steve, Mattie's friend of forty years, Mattie frequently told him that her greatest desire was to die peacefully in her sleep.

Carlos, Mattie's pastor, stated that Mattie believes that suicide is a sin. According to Carlos, Mattie embraced the church's teachings that a person should not be kept alive by artificial means because God is the giver and the taker of life.

Wendy, Mattie's sister, often told the following story. When Mattie was sixteen years old, she was involved in a car accident with two of her friends, Amanda and Jennifer. Jennifer was killed instantly. Amanda was severely injured and remained in a coma for several months. Amanda recovered, but was paralyzed. Mattie suffered only minor injuries. Afterward, Mattie told Wendy that she felt that Jennifer was better off than Amanda.

Greenrose does not have a stated policy on how to handle Marcie's request. In the past, Greenrose has honored requests from family members to discontinue medication for patients with pneumonia. However, those patients have usually been non-ambulatory. Janice Clark, the administrator of Greenrose, has contacted your law firm seeking advice on how to proceed. Please advise.

2. In 2010, Clayton Monroe raped Abigail Dillon and beat her husband Willie Dillion to death. As a result, Clayton was convicted and sentenced to die by lethal injection. After exhausting all his appeals, in 2015, Clayton went on a hunger strike to protest the death penalty. He stopped eating solid food and ingested liquids in scant amounts insufficient to sustain his health. The medical staff at the prison monitored Clayton's health. Eventually, he was placed in the prison infirmary for close observation. The medical staff advised Clayton that his refusal to eat was causing potentially irreversible damage to his internal organs that could lead to death. In response, Clayton stated, "I saw God and He told me that all killing is wrong. This hunger strike is my service to God." Consequently, Clayton refused to alter his behavior. After a month, Clayton had lost 15 percent of his body weight. The warden would like to get a court order giving the prison permission to insert a nasogastric tube and to take other reasonable steps to provide hydration and nutrition to Clayton. The warden has contacted you asking if he will be successful in court. He also wants to know if there are things he can do to force Clayton to eat without obtaining a court order. Please advise.

3. Juanita and Mateo Garcia were married in 1986 and had two children. In June of 2020, Mateo sustained debilitating injuries in a boating accident, including a closed head injury that affected the bilateral hemisphere of his brain. The injuries substantially impaired his physical and cognitive abilities, left him unable to walk or talk, and rendered him dependent on a colostomy for defecation and a gastrostomy tube for nutrition. Juanita was appointed Mateo's legal guardian and conservator. Mateo resided at different nursing homes for the first few months after the accident. Then, he was transferred to a neurological center.



In December of 2020, while Mateo was being treated at City Hospital for an obstructed bowel, Juanita filed a petition asking for authorization to have the hospital withdraw Mateo's nutritional support. Isabella and Miranda, Mateo's mother and sister, respectively, opposed the petition and filed a petition to have Juanita removed as Mateo's guardian and conservator.

Juanita stated that Mateo was a private, but active person, prior to the accident. She claimed that he was always bothered by, and intolerant of, people who were disabled or dependent on others and often stated that he would rather die than be dependent on people and machines. Thus, Juanita argued that Mateo would not want to be kept alive in his present condition. Two of Mateo's former co-workers testified that he had remarked to them before the accident that he would not want to continue living in a vegetative state. The remark was made to one of the co-workers during a casual conversation around the lunch table and to the other while discussing someone else who had been hospitalized with COVID-19. Both co-workers testified that Mateo's present condition is not the type of condition to which Mateo was referring in the conversation he had with them prior to the accident. Miranda admitted that Mateo told her that he would not want to be kept alive by respirator if he were in a coma.

Conflicting testimony was presented regarding Mateo's current level of physical, sensory, emotional, and cognitive functioning. Dr. Fred White, who is the head of the Department of Psychiatry at City State University and the chairman of the Bioethics Committee at Children's Hospital, testified that Mateo has no voluntary control over any of his limbs, or any ability to function on a voluntary level, and therefore, lacks any meaningful interaction with his environment. Nonetheless, Dr. Maggie Kahn, who is the director of the Brain Injury Rehabilitation Program at the McKnight Rehabilitation Center, testified that Mateo demonstrated the ability to carry out some voluntary motor commands on his right side, including the ability to pinch and grasp, as well as the ability to recognize faces, respond emotionally, and communicate with others with head nods. According to Dr. Kahn, Mateo seemed content with his environment and indicated "no" with a head nod when asked whether he has been in any pain or discomfort, and also when asked if there were ever any times when he felt that he did not want to go on living. What are the relevant ethical and legal issues?

## CHAPTER EIGHT - THE RIGHT TO DEMAND MEDICAL TREATMENT (MEDICAL FUTILITY)

The previous chapter dealt with cases involving patients who did not want medical treatment to be continued. This chapter deals with the opposite situations where the physicians want to eliminate medical treatment and the patients want the physicians to do as much as possible to render medical care. Conflicts occur when the physicians give up hope and the patients and/or their relatives do not. The cases are especially troubling when children and/or persons with disabilities are involved.

Medical futility exists when medical interventions are not likely to produce any significant benefit to the patient. The theory of medical futility may be quantitative or qualitative. Quantitative medical futility refers to a situation where the likelihood that an intervention will benefit the patient is very poor. Qualitative medical futility describes a situation in which the quality of benefit an intervention will produce is really slim. There are many reasons for adopting a medical futility approach to medical treatment. One reason is to reduce the [costs](#)<sup>30</sup> associated with the dying process. Almost 25% of Medicare spending goes to pay to care for people in the last year of their lives. One of the lessons that we learned from the global pandemic in 2020 was that our health care resources are finite. Therefore, healthcare providers are forced to make difficult decisions. For example, they must decide whether to expend resources to prolong dying or to use those resources to provide care that will save lives. In some cases, a medical futility declaration will prevent the doctors from giving false hope to patients and their families. Moreover, continuing medical treatment after the situation is deemed hopeless may increase the patient's pain and discomfort needlessly.

Some states have adopted statutes permitting doctors to stop treatment without the consent of the patient or the family member if the physician can show that the treatment is medically inappropriate. However, federal legislation, such as the Americans with Disabilities Act (ADA) and Emergency Medical Treatment and Active Labor Act (EMTALA), that preempts state law, does not recognize a healthcare provider's right to withdraw life-sustaining care deemed medically inappropriate. Restrictions on a healthcare provider's ability to limit or cease medical treatment are necessary to ensure that people of color, people with disabilities, immigrants, and other marginalized groups have faith in the healthcare system.

### ***Causey v. St. Francis Medical Center*, 719 So.2d 1072 (La.App. 2 Cir. 1998)**

BROWNE, JUDGE.

The facts of this end of life drama are not materially disputed. Believing it medically and ethically inappropriate, a physician and hospital withdrew life-sustaining care to a 31-year-old, quadriplegic, end-stage renal failure, comatose patient over the strongly expressed objections of the patient's family. As filed, this action was premised as an intentional battery-based tort. The trial court, however, found that defendants "acted in accordance with professional opinions and professional judgment" and thus this action was covered by the medical malpractice act which required that it first be presented to a medical review panel. Accordingly, the trial court dismissed the action as premature.

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<sup>30</sup> *The Cost of Dying: End-of-Life Care*, CBS, at <https://www.youtube.com/watch?v=F6xPBmkrm0g> (Aug. 12, 2010).

## Facts

Having suffered cardiorespiratory arrest, Sonya Causey was transferred to St. Francis Medical Center (SFMC) from a nursing home. She was comatose, quadriplegic and in end-stage renal failure. Her treating physician, Dr. Herschel R. Harter, believed that continuing dialysis would have no benefit. Although Dr. Harter agreed that with dialysis and a ventilator Mrs. Causey could live for another two years, he believed that she would have only a slight (1% to 5%) chance of regaining consciousness. Because Mrs. Causey's family demanded aggressive life-sustaining care, Dr. Harter sought unsuccessfully to transfer her to another medical facility willing to provide this care. Dr. Harter enlisted support from SFMC's Morals and Ethics Board. The Board agreed with Dr. Harter's opinion to discontinue dialysis, life-support procedures, and to enter a "no-code" status (do not resuscitate). Mrs. Causey was taken off a feeding tube and other similar devices. The day the ventilator was removed, Mrs. Causey died of respiratory and cardiac failure.

Plaintiffs, the husband, father and mother of Sonya Causey, brought this petition for damages against SFMC and Dr. Harter. Defendants filed an exception of prematurity asserting that this action was covered under Louisiana's Medical Malpractice Act, La. R.S. 40:1299.41 et seq., which requires that malpractice claims be first submitted to a medical review panel before any action can be filed. La. R.S. 40:1299.47. Plaintiffs claim that to discontinue dialysis, remove life-support systems and enter a "no code" order was treatment without consent and an intentional tort not covered by the malpractice act. Finding that defendants made a medical decision, the trial court sustained the exception and dismissed the lawsuit as premature. Plaintiffs have appealed.

## Discussion

Patient participation in medical decision-making is now well-established. Recognizing individual autonomy and the right to self-determination, our state legislature enacted a statute granting a competent, terminally ill person the right to *refuse* medical treatment. La. R.S. 40:1299.58.1, et seq. In the Karen Quinlan case the court rejected a physician's adamant stand that he had a moral duty to treat to the last gasp. In that case, the father, not the physician, was given the power to decide whether his comatose daughter's life-prolonging care was beneficial (citations omitted). The legal basis for individual autonomy is the requirement of informed consent. Implicitly, the decision to refuse care is based on the patient's personal values. If a patient is incompetent, then the responsibility or authority to make decisions falls to the next of kin. La. R.S. 40:1299.58.5. The court as the protector of incompetents, however, can override an intolerable choice by a surrogate decision-maker. In re P.V.W., 424 So.2d 1015 (La. 1972).

Now the roles are reversed. Patients or, if incompetent, their surrogate decision-makers, are demanding life-sustaining treatment regardless of its perceived futility, while physicians are objecting to being compelled to prolong life with procedures they consider futile. The right or autonomy of the patient to refuse treatment is simply a severing of the relationship with the physician. In this case, however, the patient (through her surrogate) is not severing a relationship, but demanding treatment the physician believes is "inappropriate."

The problem is not with care that the physician believes is harmful or literally has no effect. For example, radiation treatment for Mrs. Causey's condition would not have been appropriate. This is arguably based on medical science. Rather, the problem is with care that has an effect on the dying process, but which the physician believes has no benefit. Such life-prolonging care is grounded in beliefs and values about which people disagree. Strictly speaking, if a physician can keep the patient

alive, such care is not medically or physiologically "futile;" however, it may be "futile" on philosophical, religious or practical grounds.

Placement of statistical cut-off points for futile treatment involves subjective value judgments. The difference in opinion as to whether a 2% or 9% probability of success is the critical point for determining futility can be explained in terms of personal values, not in terms of medical science. When the medical professional and the patient, through a surrogate, disagree on the worth of pursuing life, this is a conflict over values, i.e., whether extra days obtained through medical intervention are worth the burden and costs.

SFMC had in place a Futile Care Policy which allowed for the discontinuance of medical care over and above that necessary for comfort and support if the probability of improving the patient's condition was slight and would serve only to prolong life in that condition. The inclusion of non-medical persons on the Morals and Ethics Board signals that this is not strictly a physiological or medical futility policy, but a policy asserting values and beliefs on the worth of sustaining life, even in a vegetative condition.

Futility is a subjective and nebulous concept which, except in the strictest physiological sense, incorporates value judgments. Obviously, in this case, subjective personal values of the benefit of prolonging life with only a slight possibility of improvement dictated SFMC's and Dr. Harter's decision.

To focus on a definition of "futility" is confusing and generates polemical discussions. We turn instead to an approach emphasizing the standard of medical care.

Physicians are professionals and occupy a special place in our community. They are licensed by society to perform this special role. No one else is permitted to use life-prolonging technology, which is considered by many as "fundamental" health care. The physician has an obligation to present all medically acceptable treatment options for the patient or her surrogate to consider and either choose or reject; however, this does not compel a physician to provide interventions that in his view would be harmful, without effect or "medically inappropriate." *Lugenbuhl v. Dowling*, 96-1575 (La.10/10/97), 701 So. 2d 447. In recognizing a terminal patient's right to refuse care, La. R.S. 40:1299.58.1(A)(4) states that the statute is not to be construed "to require the application of *medically inappropriate* treatment or life-sustaining procedures to any patient or to interfere with *medical judgment* with respect to the application of medical treatment or life-sustaining procedures." (Emphasis added). Unfortunately, "medically inappropriate" and "medical judgment" are not defined.

A physician's obligation to obtain informed consent is both an ethical requirement and a legal standard of care derived from principles of individual integrity and self-determination. *Cruzan*, supra. Informed consent implicates the disclosure and explanation of all material information of the nature, purpose, expected benefit and foreseeable risks of any treatment. La. 40:1299.40. In the present case, Dr. Harter fully explained to Mrs. Causey's family the situation. The family rejected the proposed withdrawal of treatment. Despite the lack of any consent, defendants proceeded to withdraw what they considered to be "medically inappropriate" treatment.

In *Lugenbuhl*, supra, the court rejected intentional battery-based liability "in lack of informed consent cases (*which include no consent cases*) in favor of liability based on breach of the doctor's duty (negligence) to provide the patient with material information concerning the medical

procedure." (Emphasis added). The court rejected its prior decision in *Roberson v. Provident House*, 576 So.2d 992 (La.1991), which held that performing a medical procedure without obtaining any kind of consent, as opposed to inadequate disclosure, was a battery. In a footnote, the Lugenbuhl court stated that "one can hardly argue that it is not below the appropriate standard of care for a doctor or nurse to perform a medical procedure without obtaining any kind of consent." Lugenbuhl, *supra*, fn. 5, p. 452.

Standards of medical malpractice require a physician to act with the degree of skill and care ordinarily possessed by those in that same medical specialty acting under the same or similar circumstances. Departure from this prevailing standard of care, coupled with harm, may result in professional malpractice liability. La. R.S. 40:1299.41. A finding that treatment is "medically inappropriate" by a consensus of physicians practicing in that specialty translates into a standard of care. Thus, in this case, whether Dr. Harter and SFMC met the standard of care concerning the withdrawal of dialysis, life-support procedures and the entering of a "no code" status must be determined. If the withdrawal of or the refusal to provide care is considered a "medical procedure," then it may be that the circumstances of this case present an exception to the supreme court's statement in Lugenbuhl that "one can hardly argue that it is not below the appropriate standard of care for a doctor or nurse to perform a medical procedure without obtaining any kind of consent."<sup>[3]</sup> In any event, the Medical Malpractice Act is applicable and the matter should first be submitted to a medical review panel.

We further find no merit to plaintiffs' claim that the Morals and Ethics Board is not a "health care provider" as defined by the La. Medical Malpractice Act. Plaintiffs have sued SFMC and do not dispute that SFMC is a qualified health care provider. The Board is part of SFMC and the fact that there are non-medical persons on it is of no greater consequence than that there are other non-medical employees of the hospital.

### Conclusion

For the reasons expressed above, the judgment of the trial court dismissing plaintiffs' action as premature is Affirmed. Costs are assessed to plaintiffs-appellants.

### ***In re Baby K*, 16 F.3d 590 (4<sup>th</sup> Cir. 1994)**

WILKINS, CIRCUIT JUDGE:

The Hospital instituted this action against Ms. H, Mr. K, and Baby K, seeking a declaratory judgment that it is not required under the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C.A. s 1395dd (West 1992), to provide treatment other than warmth, nutrition, and hydration to Baby K, an anencephalic infant. Because we agree with the district court, 832 F.Supp. 1022, that EMTALA gives rise to a duty on the part of the Hospital to provide respiratory support to Baby K when she is presented at the Hospital in respiratory distress and treatment is requested for her, we affirm.

### I.

Baby K was born at the Hospital in October of 1992 with anencephaly, a congenital malformation in which a major portion of the brain, skull, and scalp are missing. While the presence of a brain stem does support her autonomic functions and reflex actions, because Baby K lacks a cerebrum, she is permanently unconscious. Thus, she has no cognitive abilities or awareness. She cannot see, hear, or otherwise interact with her environment.

When Baby K had difficulty breathing on her own at birth, Hospital physicians placed her on a mechanical ventilator. This respiratory support allowed the doctors to confirm the diagnosis and gave Ms. H, the mother, an opportunity to fully understand the diagnosis and prognosis of Baby K's condition. The physicians explained to Ms. H that most anencephalic infants die within a few days of birth due to breathing difficulties and other complications. Because aggressive treatment would serve no therapeutic or palliative purpose, they recommended that Baby K only be provided with supportive care in the form of nutrition, hydration, and warmth. Physicians at the Hospital also discussed with Ms. H the possibility of a "Do Not Resuscitate Order" that would provide for the withholding of lifesaving measures in the future.

The treating physicians and Ms. H failed to reach an agreement as to the appropriate care. Ms. H insisted that Baby K be provided with mechanical breathing assistance whenever the infant developed difficulty breathing on her own, while the physicians maintained that such care was inappropriate. As a result of this impasse, the Hospital sought to transfer Baby K to another hospital. This attempt failed when all of the hospitals in the area with pediatric intensive care units declined to accept the infant. In November of 1992, when Baby K no longer needed the services of an acute-care hospital, she was transferred to a nearby nursing home.

Since being transferred to the nursing home, Baby K has been readmitted to the Hospital three times due to breathing difficulties. Each time she has been provided with breathing assistance and, after stabilization, has been discharged to the nursing home. Following Baby K's second admission, the Hospital filed this action to resolve the issue of whether it is obligated to provide emergency medical treatment to Baby K that it deems medically and ethically inappropriate. Baby K's guardian *ad litem* and her father, Mr. K, joined in the Hospital's request for a declaration that the Hospital is not required to provide respiratory support or other aggressive treatments. Ms. H contested the Hospital's request for declaratory relief. After the district court issued its findings of fact and conclusions of law denying the requested relief, the Hospital, Mr. K, and Baby K's guardian *ad litem* (collectively referred to as the "Hospital") noticed this appeal.

## II.

Congress enacted EMTALA in response to its "concern that hospitals were 'dumping' patients [who were] unable to pay, by either refusing to provide emergency medical treatment or transferring patients before their emergency conditions were stabilized." *Brooks v. Maryland Gen. Hosp. Inc.*, 996 F.2d 708, 710 (4<sup>th</sup> Cir. 1993). Through EMTALA, Congress sought "to provide an 'adequate first response to a medical crisis' for all patients," *Baber v. Hospital Corp. of America*, 977 F.2d 872, 880 (4<sup>th</sup> Cir. 1992) (quoting 131 Cong.Rec. S13904 (daily ed. Oct. 23, 1985) (statement of Sen. Dole)); see also *Brooker v. Desert Hosp. Corp.*, 947 F.2d 412, 415 (9<sup>th</sup> Cir. 1991) (holding that EMTALA applies "to any and all patients").

First, those hospitals with an emergency medical department must provide an appropriate medical screening to determine whether an emergency medical condition exists for any individual who comes to the emergency medical department requesting treatment. 42 U.S.C.A. s 1395dd(a). A hospital fulfills

this duty if it utilizes identical screening procedures for all patients complaining of the same condition or exhibiting the same symptoms. See *Baber*, 977 F.2d at 879 n. 6. An additional duty arises if an emergency medical condition is discovered during the screening process. See 42 U.S.C.A. s 1395dd(b). EMTALA defines an “emergency medical condition” as including: 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 in serious jeopardy,
- (ii) serious impairment to bodily functions, or
- (iii) serious dysfunction of any bodily organ or part.

42 U.S.C.A. s 1395dd(e)(1)(A). When an individual is diagnosed as presenting an emergency medical condition: the hospital must provide either-

- (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition,  
or
- (B) for the transfer of the individual to another medical facility in accordance with subsection (c) of this section.

42 U.S.C.A. s 1395dd(b)(1). The treatment required “to stabilize” an individual is that treatment “necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.” 42 U.S.C.A. s 1395dd(e)(3)(A). Therefore, once an individual has been diagnosed as presenting an emergency medical condition, the hospital must provide that treatment necessary to prevent the material deterioration of the individual’s condition or provide for an appropriate transfer to another facility.

In the application of these provisions to Baby K, the Hospital concedes that when Baby K is presented in respiratory distress a failure to provide “immediate medical attention” would reasonably be expected to cause serious impairment of her bodily functions. See 42 U.S.C.A. s 1395dd(e)(1)(A). Thus, her breathing difficulty qualifies as an emergency medical condition, and the diagnosis of this emergency medical condition triggers the duty of the hospital to provide Baby K with stabilizing treatment or to transfer her in accordance with the provisions of EMTALA. Since transfer is not an option available to the Hospital at this juncture, the Hospital must stabilize Baby K’s condition.

The Hospital acknowledged in its complaint that aggressive treatment, including mechanical ventilation, is necessary to “assure within a reasonable medical probability, that no material deterioration of Baby K’s condition is likely to occur.” Thus, stabilization of her condition requires the Hospital to provide respiratory support through the use of a respirator or other means necessary to ensure adequate ventilation. In sum, a straightforward application of the statute obligates the Hospital to provide respiratory support to Baby K when she arrives at the department of the Hospital in respiratory distress and treatment is requested on her behalf.

### III.

In an effort to avoid the result that follows from the plain language of EMTALA, the Hospital offers four arguments. The Hospital claims: (1) that this court has previously interpreted EMTALA as only requiring uniform treatment of all patients exhibiting the same condition; (2) that in prohibiting disparate emergency medical treatment Congress did not intend to require physicians to provide treatment outside the prevailing standard of medical care; (3) that an interpretation of EMTALA that requires a hospital or physician to provide respiratory support to an anencephalic infant fails to recognize a physician's ability, under Virginia law, to refuse to provide medical treatment that the physician considers medically or ethically inappropriate; and (4) that EMTALA only applies to patients who are transferred from a hospital in an unstable condition. We find these arguments unavailing.

A.

Relying on the decisions of this court in *Baber v. Hospital Corp. of America*, 977 F.2d 872 (4<sup>th</sup> Cir. 1992), and *Brooks v. Maryland Gen. Hosp. Inc.*, 996 F.2d 708 (4<sup>th</sup> Cir.1993), the Hospital contends that it is only required to provide Baby K with the same treatment that it would provide other anencephalic infants-supportive care in the form of warmth, nutrition, and hydration. The Hospital quotes language from *Baber* and *Brooks* as supporting the proposition that EMTALA only requires participating hospitals to provide uniform treatment to all patients exhibiting the same emergency medical condition. Advancing the proposition that anencephaly, as opposed to respiratory distress, is the emergency medical condition at issue, the Hospital concludes that it is only required to provide uniform treatment to all anencephalic infants. We disagree.

In *Baber* and *Brooks*, this court addressed the “appropriate medical screening” requirement of EMTALA. In the absence of a statutory definition for this term, we concluded that it should be defined as requiring participating hospitals to apply uniform screening procedures to all individuals coming to the emergency room of the hospital requesting treatment. *Baber*, 977 F.2d at 880, *Brooks* 996 F.2d 710-11. These cases dealt with screening procedures; neither addressed a hospital's duty to provide stabilizing treatment for an emergency medical condition.

With this issue now before us, we conclude that the duty of the Hospital to provide stabilizing treatment for an emergency medical condition is not coextensive with the duty of the Hospital to provide an “appropriate medical screening.” Congress has statutorily defined the duty of a hospital to provide stabilizing treatment as requiring that treatment necessary to prevent the material deterioration of a patient's condition. 42 U.S.C.A. s 1395dd(e)(3)(A). If, as the Hospital suggests, it were only required to provide uniform treatment, it could provide any level of treatment to Baby K, including a level of treatment that would allow her condition to materially deteriorate, so long as the care she was provided was consistent with the care provided to other individuals. See *Baber*, 977 F.2d at 879, n. 7 (“[H]ospitals could theoretically avoid liability by providing very cursory and substandard screenings to all patients.”). The definition of stabilizing treatment advocated by the Hospital directly conflicts with the plain language of EMTALA.

As we have previously stated, “it is not our role to rewrite legislation passed by Congress. When a statute is clear and unambiguous, we must apply its terms as written.” *Baber*, 977 F.2d at 878. The terms of EMTALA as written do not allow the Hospital to fulfill its duty to provide stabilizing treatment by simply dispensing uniform treatment. Rather, the Hospital must provide that treatment necessary to prevent the material deterioration of each patient's emergency medical condition. In the case of Baby K, the treatment necessary to prevent the material deterioration of her condition when she is in respiratory distress includes respiratory support.



Even if this court were to interpret EMTALA as requiring hospitals to provide uniform treatment for emergency medical conditions, we could not find that the Hospital is only required to provide Baby K with warmth, nutrition, and hydration. As the Hospital acknowledged during oral argument, Baby K resides at the nursing home for months at a time without requiring emergency medical attention. Only when she has experienced episodes of bradypnea or apnea has Baby K required respiratory support to prevent serious impairment of her bodily functions. It is bradypnea or apnea, not anencephaly, that is the emergency medical condition that brings Baby K to the Hospital for treatment. Uniform treatment of emergency medical conditions would require the Hospital to provide Baby K with the same treatment that the Hospital provides all other patients experiencing bradypnea or apnea. The Hospital does not allege that it would refuse to provide respiratory support to infants experiencing bradypnea or apnea who do not have anencephaly. Indeed, a refusal to provide such treatment would likely be considered as providing no emergency medical treatment. See *Baber*, 977 F.2d at 879, n. 7 (stating that the provision of cursory medical screenings might be considered a failure to screen).

### B.

The second argument of the Hospital is that, in redressing the problem of disparate emergency medical treatment, Congress did not intend to require physicians to provide medical treatment outside the prevailing standard of medical care. The Hospital asserts that, because of their extremely limited life expectancy and because any treatment of their condition is futile, the prevailing standard of medical care for infants with anencephaly is to provide only warmth, nutrition, and hydration. Thus, it maintains that a requirement to provide respiratory assistance would exceed the prevailing standard of medical care. However, the plain language of EMTALA requires stabilizing treatment for any individual who comes to a participating hospital, is diagnosed as having an emergency medical condition, and cannot be transferred. 42 U.S.C.A. s 1395dd (b). “[I]n the absence of ‘a clearly expressed legislative intent to the contrary,’” unambiguous statutory language is ordinarily conclusive. *United States v. Blackwell*, 946 F.2d 1049, 1052 (4<sup>th</sup> Cir.1991) (quoting *Russell v. United States*, 464 U.S. 16, 20 104 S.Ct. 296, 299, 78 L.Ed.2d 17 (1983)). The Hospital has been unable to identify, nor has our research revealed, any statutory language or legislative history evincing a Congressional intent to create an exception to the duty to provide stabilizing treatment when the required treatment would exceed the prevailing standard of medical care. We recognize the dilemma facing physicians who are requested to provide treatment they consider morally and ethically inappropriate, but we cannot ignore the plain language of the statute because “to do so would ‘transcend our judicial function.’” *Baber*, 977 F.2d at 884 (quoting *Iselin v. United States*, 270 U.S. 245, 250-51, 46 S.Ct. 248, 250, 70 L.Ed. 566 (1926)). The appropriate branch to redress the policy concerns of the Hospital is Congress.

### C.

The Hospital further argues that EMTALA cannot be construed to require it to provide respiratory support to anencephalics when its physicians deem such care inappropriate, because Virginia law permits physicians to refuse to provide such care. Section 54.1-2990 of the Health Care Decisions Act (HCDA) of Virginia provides that “[n]othing in this article shall be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be medically or ethically inappropriate.” Va.Code Ann. S 54-1-2990 (Michie Supp.1993). The Hospital maintains that EMTALA only obligates a hospital to provide stabilizing treatment “within the staff and facilities available at the hospital,” 42 U.S.C.A. s 1395dd(b)(1)(A). It reasons that because its physicians object to providing respiratory support to anencephalics, it has no physicians available to provide respiratory treatment for Baby K and, therefore, is not required by EMTALA to provide such treatment. We disagree.

The duty to provide stabilizing treatment set forth in EMTALA applies not only to participating hospitals but also to treating physicians in participating hospitals. 42 U.S.C.A. s 1395dd(d)(1)(B). EMTALA does not provide an exception for stabilizing treatment physicians may deem medically or ethically inappropriate. Consequently, to the extent s54.1-2990 exempts physicians from providing care they consider medically or ethically inappropriate, it directly conflicts with the provisions of EMTALA that require stabilizing treatment to be provided.

It is well settled that state action must give way to federal legislation where a valid “act of Congress, fairly interpreted, is in actual conflict with the law of the state,” *Savage v. Jones*, 225 U.S. 501, 533, 32 S.Ct. 715, 726, 56 L.Ed. 1182 (1912), and EMTALA provides that state and local laws that directly conflict with the requirements of EMTALA are preempted. 42 U.S.C.A. s 1395dd(f). The Hospital does not allege that EMTALA is an invalid act of Congress. Therefore, to the extent that s 54.1-2990 applies to medical treatment decisions on behalf of infants and to the extent that 54.1-2990 exempts treating physicians in participating hospitals from providing care they consider medically or ethically inappropriate, it is preempted-it does not allow the physicians treating Baby K to refuse to provide her with respiratory support.

#### D.

The final contention advanced by the Hospital is that EMTALA only applies to patients who are transferred from a hospital in an unstable condition. The Hospital grounds this argument on the definition of stabilizing treatment as that treatment “necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the *transfer* of the individual from a facility.” 42 U.S.C.A. s 1395dd(e)(3)(A) (emphasis added). According to the Hospital, the use of the word “transfer” limits the duty of hospitals and physicians to provide stabilizing treatment to situations in which the patient is to be subsequently transferred to another facility. The end result of this reasoning would allow hospitals and physicians to avoid providing stabilizing treatment by simply refusing to transfer the patient or, as in the case of Baby K, elect not to provide stabilizing treatment because other hospitals will not accept a transfer.

As previously stated, s 1395dd(b) requires a hospital to provide stabilizing treatment to any individual who comes to a participating hospital, is diagnosed as presenting an emergency medical condition, and cannot be transferred in accordance with the provisions of subsection (c). The use of the word “transfer” to describe the duty of a hospital to provide stabilizing treatment evinces a Congressional intent to require stabilization prior to discharge or that treatment necessary to prevent material deterioration of the patient’s condition during transfer. It was not intended to allow hospitals and physicians to avoid liability under EMTALA by accepting and screening a patient and then refusing to treat the patient because the patient cannot or will not be transferred. See, e.g., *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131, 1134 (6<sup>th</sup> Cir. 1990) (“Once a patient is found to suffer from an emergency medical condition, the hospital must give the patient treatment to stabilize that condition unless the patient can be transferred without danger of the patient’s condition deteriorating.”); *Burditt v. U.S. Dept. of Health & Human Services*, 934 F.2d 1362, 1368 (5<sup>th</sup> Cir. 1991) (“Patients diagnosed with an ‘emergency medical condition’ must either be treated or be transferred.”). The argument of the Hospital to the contrary is without merit.

#### IV.

It is beyond the limits of our judicial function to address the moral or ethical propriety of providing emergency stabilizing medical treatment to anencephalic infants. We are bound to interpret federal statutes in accordance with their plain language and any expressed congressional intent. Congress rejected a case-by-case approach to determining what emergency medical treatment hospitals and physicians must provide and to whom they must provide it; instead, it required hospitals and physicians to provide stabilizing care to any individual presenting an emergency medical condition. EMTALA does not carve out an exception for anencephalic infants in respiratory distress any more than it carves out an exception for comatose patients, those with lung cancer, or those with muscular dystrophy—all of whom may repeatedly seek emergency stabilizing treatment for respiratory distress and also possess an underlying medical condition that severely affects their quality of life and ultimately may result in their death. Because EMTALA does not provide for such an exception, the judgment of the district court is affirmed.

Affirmed.

### ***Notes, Questions, and Problems***

1. The person involved in the *Causey* case was Sonya Causey. In the fall of 1995, Sonya Causey, a former employee of SFMC, suffered complications during childbirth which left her essentially "quadriplegic." She was transferred to the Oak Wood Nursing Home in Mer Rouge, Louisiana. Thereafter, she received dialysis three times a week at SFMC. A permanent tracheal tube was put in place to assist her in breathing. At the time of this incident, she had end-stage renal disease, diabetes mellitus, hypertension, and quadriplegia. On October 17, 1996, while at the nursing home, Mrs. Causey developed respiratory distress and was taken by ambulance to Morehouse General Hospital. She experienced cardiorespiratory arrest and was transferred to SFMC in a comatose condition. She remained at SFMC until her death on November 22, 1996. At that time, she was diagnosed with stage IV coma, secondary to at least three or four cardiopulmonary arrests.

2. The court in *In re Baby K* found that to the extent that state law exempted physicians from providing care they considered medically inappropriate, it conflicted with EMTALA provisions requiring continuous stabilizing treatment for emergency patients and was thus preempted by EMTALA. *See*, however, distinguishing opinion of *Bryan v. Rectors and Visitors of University of Virginia*, 95 F.3d 349 (4th Cir.1996).

In *Bryan*, *supra*, the Fourth Circuit backed off the sweeping statement made in the *Baby K* case that EMTALA imposed upon the hospital an obligation not only to admit a patient for treatment of an emergency condition, which was done, but thereafter to continuously stabilize her condition, no matter how long required. Instead, the court in *Bryan* stated that EMTALA was a limited "anti-dumping" statute, not a federal malpractice law. "Its core purpose is to get patients into the system who might otherwise go untreated and be left without a remedy because traditional medical malpractice law affords no claim for failure to treat." *Id.* at 351. The court recognized that EMTALA imposed a duty on hospitals to provide emergency care and created a new cause of action "generally unavailable under state tort law, for what amounts to a failure to treat." *Id.* However, EMTALA was found to regulate the hospital's care of the patient only in the immediate aftermath of the act of admitting her for

emergency treatment and while it considered whether it would undertake longer-term full treatment. Supra at 352. In this respect, *In re Baby K* was not followed.

3. Alberto has end-stage renal disease. Dr. Sawie, Alberto's doctor, has placed Alberto on the kidney transplant list and prescribed dialysis. Alberto read in a magazine that, in some countries, they are experimenting with ape-to-human kidney transplants. Because of his personal beliefs, Dr. Sawie does not think that transplants should be done using animal organs because the animals are not capable of giving informed consent. He tells Alberto that there is nothing else he can do for him. Alberto would like to force the doctor to help him get a kidney from an ape. What are Alberto's legal options?

4. Texas is a state that has a detailed medical futility law.<sup>31</sup>

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<sup>31</sup> Joey Berlin, *Medical Futility Law Sustained*, Texas Medicine, at <https://www.texmed.org/Template.aspx?id=50660> (June 2019).

## CHAPTER NINE - THE RIGHT TO DEMAND DEATH - PHYSICIAN-ASSISTED SUICIDE

The physician-assisted suicide battle has been and continues to be fought in the legal court and in the court of public opinion. After the United States Supreme Court held that a person does not have a fundamental right to determine the time and manner of his or her death, the proponents of physician-assisted suicide used the media to take the fight to the people. Persons on both sides of the debate have spent a lot of time and resources lobbying lawmakers. They have also expended a great deal of money waging media campaigns to garner public support for their respective positions. Both sides have used terminology in an attempt to control the manner in which the public perceives the process that permits a licensed physician to write a prescription for a lethal dose of medication so a terminally ill patient can end his or her life. Opponents of the procedure often refer to it as physician-assisted suicide with emphasis on the word “suicide.” They hope to conjure up the image of physicians helping patients to commit suicide. The word “suicide” has a negative connotation for many people. Historically, committing suicide was a criminal offense.<sup>32</sup> The punishment was the denial of a proper burial for the deceased and the inability of the decedent’s family to inherit his or her property. Moreover, persons who committed suicide were denied the right to be buried in consecrated ground. Though religions have lessened their condemnation of persons who commit suicide, the stigma still exists.<sup>33</sup> The majority of states no longer classify suicide or attempted suicide as a crime; however, some American jurisdictions and some countries impose criminal liability on a person who aides or abets a suicide. Suicide clauses imposing restrictions are included in some life insurance policies.

Proponents of the practice argue that it should be called physician-aided dying. Their objective is to get the public to see the physician as a comforter who is helping the patient to die with dignity. They contend that suicide is not involved because the patient is already dying; the physician’s action merely hastens the dying process so the patient can avoid unnecessary suffering. In this book, I use physician-assisted suicide because it is the term that has typically been used to refer to the practice. The main opponents of the legalization of physician-assisted suicide are religious organizations like the Roman Catholic Church and physician groups like the American Medical Association (AMA). The Disability Rights Education & Defense Fund and other advocates for persons with disabilities also oppose the legalization of physician-assisted suicide. According to Catholic Doctrine, suicide is a mortal sin, so the Church strongly opposes any attempt to legalize the practice. In fact, Pope Francis denounced the “right to die” movement, stating that it is a “false sense of compassion” to deem euthanasia as an act of dignity because it is a sin against God and creation.<sup>34</sup> The Church of England actively opposed the assisted suicide bill introduced in Parliament. Prior to the vote on the bill, the Church updated its website to state the following: “The value of individuals’ lives, protection of the vulnerable and respect for the integrity of the doctor-patient relationship are central to the Church of England’s concerns about any proposal to change the law.”<sup>35</sup>

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<sup>32</sup> Adam Lamparello, *Suicide: A Legal, Constitutional, and Human Right*, 18 Tex. Wesleyan L. Rev. 797, 814 (Summer 2012).

<sup>33</sup> See Beth Daley, *Why religions of the world condemn suicide*, The Conversation, at <https://theconversation.com/why-religions-of-the-world-condemn-suicide-98067> (June 12, 2018).

<sup>34</sup> Katharine Lackey, *Where Pope Francis stands on 10 major issues*, USA Today, at <https://www.usatoday.com/story/news/world/2015/09/01/pope-francis-social-issues-abortion-gay-rights-climate-change/71520372/> (Sept. 1, 2015).

<sup>35</sup> Peter Saunders, *Why Lord Carey is so desperately wrong about legalizing assisted suicide*, The Pulse, LifeSiteNews.com, at <https://www.lifesitenews.com/pulse/why-lord-carey-is-so-desperately-wrong-about-legalizing-assisted-suicide> (July 14, 2014).

The AMA issued an opinion stating its opposition to physician-assisted suicide. The AMA explained its position by stating, “Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.”<sup>36</sup> The two non-profit organizations going around the country advocating for the legalization of physician-assisted suicide are Compassion and Choices and the Death with Dignity National Center. According to its website, Compassion and Choices “helps people plan for and achieve a good death.” The Death with Dignity National Center claims that its mission is “to promote Death with Dignity laws based on the model Oregon Death with Dignity Act, both to provide an option for dying individuals and to stimulate nationwide improvements in end-of life care.” Even in the states where physician-assisted suicide is permitted, the availability of the procedure is limited. American legislatures are often influenced by public opinion when making laws that impact personal decision-making. The reluctance on the part of the courts and legislatures to conclude that persons have a fundamental right to assisted suicide may stem from the fact that assisted suicide has not been widely embraced by the American people. However, the tide may be turning. The Catholic Church, a key opponent of physician-assisted suicide, appears to be losing its ability to influence the way personal issues like abortion and same-sex marriages are viewed. When the public sees these issues as personal choices instead of moral concerns, opinions are more likely to shift towards respecting the rights of people to make their own decisions with regard to these matters.

In 2004, the Hemlock Society, one of the main proponents of physician-assisted suicide, merged with an organization called Compassion in Dying. After the merger, the name of the organization was changed to Compassion and Choices. The original members of that non-profit organization emphasized the right to die. In fact, Derek Humphry, a British journalist and founder of the Hemlock Society, wrote a book detailing how he helped his first wife, who was suffering from bone cancer, to end her life. The current members have attempted to change the tone of the conversation by stressing that their mission is for patients to have the choice to decide how and when they die. In addition, media coverage of the topic may have impacted the manner in which members of the public feel about the “right to die” movement.

In the beginning, the face of the movement was Dr. Jacob “Jack” Kevorkian, a self-proclaimed euthanasia activist who invented a “suicide machine.” After several arrests for assisting in suicides, Kevorkian was convicted of second-degree murder for administering a lethal dose of drugs to a patient suffering from Lou Gehrig’s disease. During Kevorkian’s trial, the media reported that he had been nicknamed “Doctor Death” and speculated that he was a little too aggressive when it came to assisting in suicides. Consequently, persons who opposed physician-assisted suicide were able to convince members of the public that the legalization of the procedure would lead to doctors coercing patients, especially the elderly and disabled, to end their lives. Kevorkian died on June 3, 2011, so any damage his actions may have done to the “right to die” movement has faded. Persons advocating for the legalization of physician-assisted suicide now have a new “poster person” in the form of Brittany Maynard. When she was newly married, twenty-nine-year-old Maynard was diagnosed with aggressive cancer. After a few unsuccessful treatments, Maynard’s doctors told her that her brain tumor was inoperable and that she had only six months to live. Maynard and her family decided that physician-assisted suicide was the best option for her. Since Maynard lived in California, a state that had not legalized physician-assisted suicide, she and her family relocated to Oregon where she could legally end her life. Maynard received support from Compassion and Choices. Prior to her death, Maynard gave numerous interviews arguing that every terminally ill patient should have the right to choose

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<sup>36</sup>American Medical Association (AMA), *Physician-Assisted Suicide*, Ethics Opinion 5.7, at <https://www.ama-assn.org/delivering-care/ethics/physician-assisted-suicide> (last visited April 7, 2021).

when and how they die. Maynard's experience was instrumental in getting California to legalize physician-assisted suicide and in placing the "right to die" issue on legislative agendas throughout the United States.

The majority of states in the United States have not taken steps to legalize physician-assisted suicide. The process is probably illegal in those jurisdictions because of the existence of blanket manslaughter statutes. Five states have explicitly criminalized the process by statute. Terminally ill patients in Hawaii live in a state of limbo because, even though physician-assisted suicide has not been legalized in that state, there is not a criminal prohibition against the process. Currently, only nine American states and the District of Columbia have laws that permit physicians to prescribe lethal doses of medication for terminally ill patients who want to end their lives.<sup>37</sup> A Montana court made lethal doses of medication available to terminally-ill patients in that state by preventing the conviction of doctors who write the prescriptions. Thus, physician-assisted suicide is judicially recognized as a valid statutory defense to homicide in Montana.

### *Notes and Questions*

1. **Suicide Tourism:** Like Brittany Maynard, many persons in the United States who want to avail themselves of physician-assisted suicide are forced to relocate to one of the few states where the practice is legal. This relocation is called suicide tourism. Physician-assisted suicide has been legal in several European countries for decades. In 2012, I spent two months in Switzerland doing research on their laws and practices. Consequently, in the early 1980s, Americans went to countries like Switzerland in search of assistance with dying. The provisions of the assisted suicide laws in Europe are more liberal than those in the United States. For example, the requirement that the person be terminally ill is absent from most of those statutes. Consequently, people still travel to Europe seeking assistance with dying. The solution is for the federal government to pass a law legalizing physician-assisted suicide. What provisions should such a law include?

2. Most of the physician-assisted suicide statutes require the patient to be terminally ill to be eligible to receive assistance to die. To be classified as terminally ill, the person must have less than 6 months to live. Does it make sense that a person predicted to live 8 months cannot receive assistance? Should terminal illness include conditions like severe dementia or Alzheimer's disease?

3. Opponents of physician-assisted suicide express concern for the elderly, persons with disabilities, and persons of color. What safeguards can be added to the statutes to protect members of these vulnerable populations?

4. The next two cases involve challenges to law banning physician-assisted suicide. The first one challenges the constitutionality of the law based on the Due Process Clause. The second one relies on the Equal Protection Clause to support the argument that the law is invalid.

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<sup>37</sup> Those states are California, Colorado, Hawaii, Maine, New Jersey, New Mexico, Oregon, Vermont, and Washington.

## 9.1 Washington v. Gluckberg, 521 U.S. 702 (Due Process Clause)

CHIEF JUSTICE REHNQUIST delivered the opinion of the Court.

The question presented in this case is whether Washington's prohibition against "caus[ing]" or "aid[ing]" a suicide offends the Fourteenth Amendment to the United States Constitution. We hold that it does not.

It has always been a crime to assist a suicide in the State of Washington. In 1854, Washington's first Territorial Legislature outlawed "assisting another in the commission of self-murder." Today, Washington law provides: "A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide." Wash. Rev. Code s 9A.36.060(1) (1994). "Promoting a suicide attempt" is a felony, punishable by up to five years' imprisonment and up to a \$10,000 fine. ss 9A.36.060(2) and s 9A.20.012 (1)(c). At the same time, Washington's Natural Death Act, enacted in 1979, states that the "withholding or withdrawal of life-sustaining treatment" at a patient's direction "shall not, for any purpose, constitute a suicide." Wash. Rev. Code s 70.122.070(1).

Petitioners in this case are the State of Washington and its Attorney General. Respondents Harold Glucksberg, M. D., Abigail Halperin, M. D., Thomas A. Preston, M. D., and Peter Shalit, M. D., are physicians who practice in Washington. These doctors occasionally treat terminally ill, suffering patients, and declare that they would assist these patients in ending their lives if not for Washington's assisted-suicide ban. In January 1994, respondents, along with three gravely ill, pseudonymous plaintiffs who have since died and Compassion in Dying, a nonprofit organization that counsels people considering physician-assisted suicide, sued in the United States District Court, seeking a declaration that Wash. Rev. Code s 9A.36.060(1) (1994) is, on its face, unconstitutional.

The plaintiffs asserted "the existence of a liberty interest protected by the Fourteenth Amendment which extends to a personal choice by a mentally competent, terminally ill adult to commit physician-assisted suicide." *Ibid.* Relying primarily on *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 112 S.Ct. 2791, 120 L.Ed.2d 674 (1992), and *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 110 S.Ct. 2841, 111 L.Ed.2d 224 (1990) the District Court agreed, 850 F.Supp., at 1459-1462, and concluded that Washington's assisted-suicide ban is unconstitutional because it "places an undue burden on the exercise of [that] constitutionally protected liberty interest." *Id.*, at 1465. The District Court also decided that the Washington statute violated the Equal Protection Clause's requirement that "all persons similarly situated be treated alike." *Id.*, at 1466 (quoting *Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 439, 105 S.Ct. 3249, 3253-3254, 87 L.Ed.2d 313 (1985)).

A panel of the Court of Appeals for the Ninth Circuit reversed, emphasizing that "[i]n the two hundred and five years of our existence no constitutional right to aid in killing oneself has ever been asserted and upheld by a court of final jurisdiction." *Compassion in Dying v. Washington*, 49 F.3d 586, 591 (1995). The Ninth Circuit reheard the case en banc, reversed the panel's decision, and affirmed the District Court. *Compassion in Dying v. Washington*, 79 F.3d 790, 798 (1996). Like the District Court, the en banc Court of Appeals emphasized our *Casey* and *Cruzan* decisions. 79 F.3d, at 813-816. The court also discussed what it described as "historical" and "current societal attitudes" toward suicide and assisted suicide, *Id.*, at 806-812, and concluded that "the Constitution encompasses a due process liberty interest in controlling the time and manner of one's death—that there is, in short, a constitutionally-recognized 'right to die.'" *Id.* at 816. After "[w]eighing and then balancing" this interest against Washington's various interests, the court held that the State's assisted-suicide ban was



unconstitutional “as applied to terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians.” *Id.*, at 836, 837. The court did not reach the District Court’s equal protection holding. *Id.*, at 838. We granted certiorari, 518 U.S. 1057, 117 S.Ct. 37, 135 L.Ed.2d 1128 (1996), and now reverse.

## I

We begin, as we do in all due process cases, by examining our Nation’s history, legal traditions, and practices. See, e.g., *Casey*, supra, at 849-850, 112 S.Ct., at 2805-2806; *Cruzan*, supra, at 269-279, 110 S.Ct., at 2846-2842; *Moore v. East Cleveland*, 431 U.S. 494, 503, 97 S.Ct. 1932, 1937-1938, 52 L.Ed.2d 531 (1977) (plurality opinion) (noting importance of “careful ‘respect for the teachings of history’”). In almost every State—indeed, in almost every western democracy—it is a crime to assist a suicide. The States’ assisted-suicide bans are not innovations. Rather, they are longstanding expressions of the States’ commitment to the protection and preservation of all human life. *Cruzan*, supra, at 280, 110 S.Ct., at 2852 (“[T]he States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide”); see *Stanford v. Kentucky*, 492 U.S. 361, 373, 109 S.Ct. 2969, 2977, 106 L.Ed.2d 306 (1989) (“[T]he primary and most reliable indication of [a national] consensus is the pattern of enacted laws”). Indeed, opposition to and condemnation of suicide—and, therefore, of assisting suicide—are consistent and enduring themes of our philosophical, legal, and cultural heritages. See generally Marzen 17–56; New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* 77–82 (May 1994) (hereinafter New York Task Force).

More specifically, for over 700 years, the Anglo–American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide. *Cruzan*, 497 U.S., at 294-295, 110 S.Ct., at 2859-2860 (SCALIA, J., concurring). In the 13th century, Henry de Bracton, one of the first legal-treatise writers, observed that “[j]ust as a man may commit felony by slaying another so may he do so by slaying himself.” 2 Bracton on Laws and Customs of England 423 (f.150) (G. Woodbine ed., S. Thorne transl., 1968). The real and personal property of one who killed himself to avoid conviction and punishment for a crime were forfeit to the King; however, thought Bracton, “if a man slays himself in weariness of life or because he is unwilling to endure further bodily pain [only] his movable goods [were] confiscated.” *Id.*, at 423–424 (f.150). Thus, “[t]he principle that suicide of a sane person, for whatever reason, was a punishable felony was introduced into English common law.” Centuries later, Sir William Blackstone, whose *Commentaries on the Laws of England* not only provided a definitive summary of the common law but was also a primary legal authority for 18th- and 19th-century American lawyers, referred to suicide as “self-murder” and “the pretended heroism, but real cowardice, of the Stoic philosophers, who destroyed themselves to avoid those ills which they had not the fortitude to endure.” 4 W. Blackstone, *Commentaries* 189. Blackstone emphasized that “the law has ranked [suicide] among the highest crimes,” *ibid.*, although, anticipating later developments, he conceded that the harsh and shameful punishments imposed for suicide “borde[r] a little upon severity.” *Id.*, at 190.

For the most part, the early American Colonies adopted the common-law approach. For example, the legislators of the Providence Plantations, which would later become Rhode Island, declared, in 1647, that “[s]elf-murder is by all agreed to be the most unnatural, and it is by this present Assembly declared, to be that, wherein he that doth it, kills himself out of a premeditated hatred against his own life or other humor: his goods and chattels are the king’s custom, but not his debts nor lands; but in case he be an infant, a lunatic, mad or distracted man, he forfeits nothing.” *The Earliest Acts and Laws of the Colony of Rhode Island and Providence Plantations 1647–1719*, p. 19 (J. Cushing ed.1977). Virginia

also required ignominious burial for suicides, and their estates were forfeit to the Crown. A. Scott, *Criminal Law in Colonial Virginia* 108, and n. 93, 198, and n. 15 (1930).

Over time, however, the American Colonies abolished these harsh common-law penalties. William Penn abandoned the criminal-forfeiture sanction in Pennsylvania in 1701, and the other Colonies (and later, the other States) eventually followed this example. However, the movement away from the common law's harsh sanctions did not represent an acceptance of suicide; rather this change reflected the growing consensus that it was unfair to punish the suicide's family for his wrongdoing. Cruzan, *supra*, at 294, 110 S.Ct., at 2859 (SCALIA, J., concurring). Nonetheless, although States moved away from Blackstone's treatment of suicide, courts continued to condemn it as a grave public wrong. See, e.g. *Bigelow v. Bershire Life Ins. Co.*, 93 U.S. 284, 286, 23 L.Ed. 918 (1876) (suicide is "an act of criminal self-destruction"); *Von Holden v. Chapman*, 87 A.D.2d 66, 70-71, 450 N.Y.S.2d 623, 626-627 (1982); *Blackwood v. Jones*, 111 Fla. 528, 532, 149 So. 600, 601 (1933) ("No sophistry is tolerated which seek[s] to justify self-destruction as commendable or even a matter of personal right").

That suicide remained a grievous, though nonfelonious, wrong is confirmed by the fact that colonial and early state legislatures and courts did not retreat from prohibiting assisting suicide. Swift, in his early 19th-century treatise on the laws of Connecticut, stated that "[i]f one counsels another to commit suicide, and the other by reason of the advice kills himself, the advisor is guilty of murder as principal." 2 Z. Swift, *A Digest of the Laws of the State of Connecticut* 270 (1823). This was the well-established common-law view, see *In re Joseph G.*, 34 Cal.3d 429, 434-435, 194 Cal.Rptr. 163, 166, 667 P.2d 1176, 1179 (1983); *Commonwealth v. Mink*, 123 Mass. 422, 428 (1877) (" 'Now if the murder of one's self is felony, the accessory is equally guilty as if he had aided and abetted in the murder' ") (quoting Chief Justice Parker's charge to the jury in *Commonwealth v. Bowen*, 13 Mass. 356 (1816)), as was the similar principle that the consent of a homicide victim is "wholly immaterial to the guilt of the person who cause[d] [his death]," 3 J. Stephen, *A History of the Criminal Law of England* 16 (1883); see 1 F. Wharton, *Criminal Law* §§ 451-452 (9th ed. 1885); *Martin v. Commonwealth*, 184 Va. 1009, 1018-1019, 37 S.E.2d 43, 47 (1946) (" 'The right to life and to personal security is not only sacred in the estimation of the common law, but it is inalienable' "). And the prohibitions against assisting suicide never contained exceptions for those who were near death. Rather, "[t]he life of those to whom life ha[d] become a burden—of those who [were] hopelessly diseased or fatally wounded—nay, even the lives of criminals condemned to death, [were] under the protection of the law, equally as the lives of those who [were] in the full tide of life's enjoyment, and anxious to continue to live." *Blackburn v. State*, 23 Ohio St. 146, 163 (1872) see *Bowen*, *supra*, at 360 (prisoner who persuaded another to commit suicide could be tried for murder, even though victim was scheduled shortly to be executed).

The earliest American statute explicitly to outlaw assisting suicide was enacted in New York in 1828, Act of Dec. 10, 1828, ch. 20, § 4, 1828 N.Y. Laws 19 (codified at 2 N.Y.Rev.Stat. pt. 4, ch. 1, Tit. 2, Art. 1, § 7, p. 661 (1829)), and many of the new States and Territories followed New York's example. Marzen 73-74. Between 1857 and 1865, a New York commission led by Dudley Field drafted a criminal code that prohibited "aiding" a suicide and, specifically, "furnish[ing] another person with any deadly weapon or poisonous drug, knowing that such person intends to use such weapon or drug in taking his own life." *Id.*, at 76-77. By the time the Fourteenth Amendment was ratified, it was a crime in most States to assist a suicide. See *Cruzan*, 497 U.S. at 294-295, 110 S.Ct. at 2859-2860 (SCALIA, J., concurring). The Field Penal Code was adopted in the Dakota Territory in 1877 and in New York in 1881, and its language served as a model for several other western States' statutes in the late 19th and early 20th centuries. Marzen 76-77, 205-206, 212-213. California, for example, codified its assisted-suicide prohibition in 1874, using language similar to the Field Code's. In this

century, the Model Penal Code also prohibited “aiding” suicide, prompting many States to enact or revise their assisted-suicide bans. The code’s drafters observed that “the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request, of the suicide victim.” American Law Institute, Model Penal Code s 210.5, Comment 5, p. 100 (Official Draft and Revised Comments 1980).

Though deeply rooted, the States’ assisted-suicide bans have in recent years been reexamined and, generally, reaffirmed. Because of advances in medicine and technology, Americans today are increasingly likely to die in institutions, from chronic illnesses. President’s Comm’n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment* 16–18 (1983). Public concern and democratic action are therefore sharply focused on how best to protect dignity and independence at the end of life, with the result that there have been many significant changes in state laws and in the attitudes these laws reflect. Many States, for example, now permit “living wills,” surrogate health-care decisionmaking, and the withdrawal or refusal of life-sustaining medical treatment (citations omitted). At the same time, however, voters and legislators continue for the most part to reaffirm their States’ prohibitions on assisting suicide.

The Washington statute at issue in this case, Wash. Rev. Code s 9A.36.060 (1994), was enacted in 1975 as part of a revision of that State’s criminal code. Four years later, Washington passed its Natural Death Act, which specifically stated that the “withholding or withdrawal of life-sustaining treatment shall not, for any purpose, constitute a suicide” and that “[n]othing in this chapter shall be construed to condone, authorize, or approve mercy killing.” Natural Death Act, 1979 Wash. Laws, ch. 112, § 8(1), p. 11 (codified at Wash. Rev. Code ss 70.122.070(1), 70.122.100 (1994)). In 1991, Washington voters rejected a ballot initiative which, had it passed, would have permitted a form of physician-assisted suicide. Washington then added a provision to the Natural Death Act expressly excluding physician-assisted suicide. 1992 Wash. Laws, ch. 98, § 10; Wash. Rev. Code s 70.122.100 (1994).

California voters rejected an assisted-suicide initiative similar to Washington’s in 1993. On the other hand, in 1994, voters in Oregon enacted, also through ballot initiative, that State’s “Death With Dignity Act,” which legalized physician-assisted suicide for competent, terminally ill adults. Since the Oregon vote, many proposals to legalize assisted-suicide have been and continue to be introduced in the States’ legislatures, but none has been enacted. And just last year, Iowa and Rhode Island joined the overwhelming majority of States explicitly prohibiting assisted suicide. See Iowa Code Ann. Ss 707A.2, 707A.3 (Supp.1997); R.I. Gen. Laws ss 11-60-1, 11-60-3 (Supp.1996). Also, on April 30, 1997, President Clinton signed the Federal Assisted Suicide Funding Restriction Act of 1997, which prohibits the use of federal funds in support of physician-assisted suicide. Pub.L. 105-12, 111 Stat. 23 (codified at 42 U.S.C. s 14401 et. seq.)

Thus, the States are currently engaged in serious, thoughtful examinations of physician-assisted suicide and other similar issues. For example, New York State’s Task Force on Life and the Law—an ongoing, blue-ribbon commission composed of doctors, ethicists, lawyers, religious leaders, and interested laymen—was convened in 1984 and commissioned with “a broad mandate to recommend public policy on issues raised by medical advances.” New York Task Force vii. Over the past decade, the Task Force has recommended laws relating to end-of-life decisions, surrogate pregnancy, and organ donation. *Id.*, at 118–119. After studying physician-assisted suicide, however, the Task Force unanimously concluded that “[l]egalizing assisted suicide and euthanasia would pose profound risks to many individuals who are ill and vulnerable. [T]he potential dangers of this dramatic change in public policy would outweigh any benefit that might be achieved.” *Id.*, at 120.

Attitudes toward suicide itself have changed since Bracton, but our laws have consistently condemned, and continue to prohibit, assisting suicide. Despite changes in medical technology and notwithstanding an increased emphasis on the importance of end-of-life decisionmaking, we have not retreated from this prohibition. Against this backdrop of history, tradition, and practice, we now turn to respondents' constitutional claim.

## II

The Due Process Clause guarantees more than fair process, and the “liberty” it protects includes more than the absence of physical restraint. *Collins v. Harker Heights*, 503 U.S. 115, 125, 112 S.Ct. 1061, 1068-1069, 117 L.Ed.2d 261 (1992) (Due Process Clause “protects individual liberty against ‘certain government actions regardless of the fairness of the procedures used to implement them’”) (quoting *Daniels v. Williams*, 474 U.S. 327, 331, 106 S.Ct. 662, 665, 88 L.Ed.2d 662 (1986)). The Clause also provides heightened protection against government interference with certain fundamental rights and liberty interests. *Reno v. Flores*, 507 U.S. 292, 301-302, 113 S.Ct. 1439, 1446-1447, 123 L.Ed.2d 1 (1993); *Casey*, 505 U.S., at 851, 112 S.Ct., at 2806-2807. In a long line of cases, we have held that, in addition to the specific freedoms protected by the Bill of Rights, the “liberty” specially protected by the Due Process Clause includes the rights to marry, *Loving v. Virginia*, 388 U.S. 1, 87 S.Ct. 1817, 18 L.Ed.2d 1010 (1967); to have children, *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535, 62 S.Ct. 1110, 86 L.Ed. 1655 (1942); to direct the education and upbringing of one's children, *Meyer v. Nebraska*, 262 U.S. 390, 43 S.Ct. 625, 67 L.Ed. 1042 (1923); *Pierce v. Society of Sisters*, 268 U.S. 510, 45 S.Ct. 571, 69 L.Ed. 1070 (1925); to marital privacy, *Griswold v. Connecticut*, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965); to use contraception, *Ibid.*; *Eisenstadt v. Baird*, 405 U.S. 438, 92 S.Ct. 1029, 31 L.Ed.2d 349 (1972); to bodily integrity, *Rochin v. California*, 342 U.S. 165, 72 S.Ct. 205, 96 L.Ed. 183 (1952), and to abortion, *Casey*, *supra*. We have also assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment. *Cruzan*, 497 U.S., at 278-279, 110 S.Ct. at 2851-2852.

But we “ha[ve] always been reluctant to expand the concept of substantive due process because guideposts for responsible decisionmaking in this uncharted area are scarce and open-ended.” *Collins*, 503 U.S., at 125, 112 S.Ct., at 1068. By extending constitutional protection to an asserted right or liberty interest, we, to a great extent, place the matter outside the arena of public debate and legislative action. We must therefore “exercise the utmost care whenever we are asked to break new ground in this field,” *ibid.*, lest the liberty protected by the Due Process Clause be subtly transformed into the policy preferences of the Members of this Court, *Moore*, 431 U.S., at 502, 97 S.Ct., at 1937 (plurality opinion).

Our established method of substantive-due-process analysis has two primary features: First, we have regularly observed that the Due Process Clause specially protects those fundamental rights and liberties which are, objectively, “deeply rooted in this Nation's history and tradition,” *Id.*, at 503, 97 S.Ct., at 1938 (plurality opinion); *Snyder v. Massachusetts*, 291 U.S. 97, 105, 54 S.Ct. 330, 332, 78 L.Ed. 674 (1934) (“so rooted in the traditions and conscience of our people as to be ranked as fundamental”), and “implicit in the concept of ordered liberty,” such that “neither liberty nor justice would exist if they were sacrificed,” *Palko v. Connecticut*, 302 U.S. 319, 325, 326, 58 S.Ct. 149, 152, 82 L.Ed. 288 (1937). Second, we have required in substantive-due-process cases a “careful description” of the asserted fundamental liberty interest. *Flores*, *supra*, at 302, 113 S.Ct., at 1447; *Collins*, *supra*, at 125, 112 S.Ct., at 1068; *Cruzan*, *supra*, at 277-278, 110 S.Ct., at 2850-2851. Our Nation's history, legal traditions, and practices thus provide the crucial “guideposts for responsible decisionmaking,” *Collins*, *supra*, at 125,

112 S.Ct., at 1068, that direct and restrain our exposition of the Due Process Clause. As we stated recently in *Flores*, the Fourteenth Amendment “forbids the government to infringe ‘fundamental’ liberty interests at all, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest.” 507 U.S., at 302, 113 S.Ct., at 1447.

Justice Souter, relying on Justice Harlan’s dissenting opinion in *Poe v. Ullman*, would largely abandon this restrained methodology, and instead ask “whether [Washington’s] statute sets up one of those ‘arbitrary impositions’ or ‘purposeless restraints’ at odds with the Due Process Clause of the Fourteenth Amendment,” post, at 2275 (quoting *Poe*, 367 U.S. 497, 543, 81 S.Ct. 1752, 1776-1777, 6 L.Ed.2d 989 (1961) (Harlan, J., dissenting)). In our view, however, the development of this Court’s substantive-due-process jurisprudence, described briefly supra, at 2267, has been a process whereby the outlines of the “liberty” specially protected by the Fourteenth Amendment—never fully clarified, to be sure, and perhaps not capable of being fully clarified—have at least been carefully refined by concrete examples involving fundamental rights found to be deeply rooted in our legal tradition. This approach tends to rein in the subjective elements that are necessarily present in due-process judicial review. In addition, by establishing a threshold requirement—that a challenged state action implicate a fundamental right—before requiring more than a reasonable relation to a legitimate state interest to justify the action, it avoids the need for complex balancing of competing interests in every case.

Turning to the claim at issue here, the Court of Appeals stated that “[p]roperly analyzed, the first issue to be resolved is whether there is a liberty interest in determining the time and manner of one’s death,” 79 F.3d, at 801, or, in other words, “[i]s there a right to die?,” Id., at 799. Similarly, respondents assert a “liberty to choose how to die” and a right to “control of one’s final days,” Brief for Respondents 7, and describe the asserted liberty as “the right to choose a humane, dignified death,” Id., at 15, and “the liberty to shape death,” Id., at 18. As noted above, we have a tradition of carefully formulating the interest at stake in substantive-due-process cases. For example, although *Cruzan* is often described as a “right to die” case, see 79 F.3d, at 799; 521 U.S., at 745, 117 S.Ct., at 2307 (STEVENS, J., concurring in judgments) (*Cruzan* recognized “the more specific interest in making decisions about how to confront an imminent death”), we were, in fact, more precise: We assumed that the Constitution granted competent persons a “constitutionally protected right to refuse lifesaving hydration and nutrition.” *Cruzan*, 497 U.S., at 279, 110 S.Ct., at 2843; Id., at 287, 110 S.Ct., at 2856 (O’CONNOR, J., concurring) (“[A] liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions”). The Washington statute at issue in this case prohibits “aid[ing] another person to attempt suicide,” Wash. Rev. Code s 9A.36.060 (1) (1994), and, thus, the question before us is whether the “liberty” specially protected by the Due Process Clause includes a right to commit suicide which itself includes a right to assistance in doing so.

We now inquire whether this asserted right has any place in our Nation’s traditions. Here, as discussed supra, at 2262–2267, we are confronted with a consistent and almost universal tradition that has long rejected the asserted right, and continues explicitly to reject it today, even for terminally ill, mentally competent adults. To hold for respondents, we would have to reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every State (citations omitted).

Respondents contend, however, that the liberty interest they assert is consistent with this Court’s substantive-due-process line of cases, if not with this Nation’s history and practice. Pointing to *Casey* and *Cruzan*, respondents read our jurisprudence in this area as reflecting a general tradition of “self-sovereignty,” Brief for Respondents 12, and as teaching that the “liberty” protected by the Due Process Clause includes “basic and intimate exercises of personal autonomy,” Id., at 10; see *Casey*, 505 U.S., at 847, 112 S.Ct., at 2804-2805 (“It is a promise of the Constitution that there is a realm of personal

liberty which the government may not enter”). According to respondents, our liberty jurisprudence, and the broad, individualistic principles it reflects, protects the “liberty of competent, terminally ill adults to make end-of-life decisions free of undue government interference.” Brief for Respondents 10. The question presented in this case, however, is whether the protections of the Due Process Clause include a right to commit suicide with another’s assistance. With this “careful description” of respondents’ claim in mind, we turn to *Casey* and *Cruzan*.

In *Cruzan*, we considered whether Nancy Beth *Cruzan*, who had been severely injured in an automobile accident and was in a persisted vegetative state, “ha[d] a right under the United States Constitution which would require the hospital to withdraw life-sustaining treatment” at her parents’ request. 497 U.S., at 269, 110 S.Ct., at 2846-2847. We began with the observation that “[a]t common law, even the touching of one person by another without consent and without legal justification was a battery.” *Ibid*. We then discussed the related rule that “informed consent is generally required for medical treatment.” *Ibid*. After reviewing a long line of relevant state cases, we concluded that “the common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment.” *Id.*, at 277, 110 S.Ct., at 2851. Next, we reviewed our own cases on the subject, and stated that “[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.” *Id.*, at 278, 110 S.Ct., at 2851. Therefore, “for purposes of [that] case, we assume[d] that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.” *Id.*, at 279, 110 S.Ct., at 2852; see *Id.*, at 287, 110 S.Ct., at 2856 (O’CONNOR, J., concurring). We concluded that, notwithstanding this right, the Constitution permitted Missouri to require clear and convincing evidence of an incompetent patient’s wishes concerning the withdrawal of life-sustaining treatment. *Id.*, at 280-281, 110 S.Ct., at 2852-2853.

Respondents contend that in *Cruzan* we “acknowledged that competent, dying persons have the right to direct the removal of life-sustaining medical treatment and thus hasten death,” Brief for Respondents 23, and that “the constitutional principle behind recognizing the patient’s liberty to direct the withdrawal of artificial life support applies at least as strongly to the choice to hasten impending death by consuming lethal medication,” *id.*, at 26. Similarly, the Court of Appeals concluded that “*Cruzan*, by recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water, necessarily recognize[d] a liberty interest in hastening one’s own death.” 79 F.3d, at 816.

The right assumed in *Cruzan*, however, was not simply deduced from abstract concepts of personal autonomy. Given the common-law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment, our assumption was entirely consistent with this Nation’s history and constitutional traditions. The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct. See *Vacco v. Quill*, 521 U.S., at 800-808, 117 S.Ct., at 2298-2302. In *Cruzan* itself, we recognized that most States outlawed assisted suicide—and even more do today—and we certainly gave no intimation that the right to refuse unwanted medical treatment could be some-how transmuted into a right to assistance in committing suicide. 497 U.S., at 280, 110 S.Ct., at 2852.

Respondents also rely on *Casey*. There, the Court’s opinion concluded that “the essential holding of [*Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973),] should be retained and once again reaffirmed.” 505 U.S., at 846, 112 S.Ct., at 2804. We held, first, that a woman has a right, before her fetus is viable, to an abortion “without undue interference from the State”; second, that States may

restrict post viability abortions, so long as exceptions are made to protect a woman's life and health; and third, that the State has legitimate interests throughout a pregnancy in protecting the health of the woman and the life of the unborn child. *Ibid.* In reaching this conclusion, the opinion discussed in some detail this Court's substantive-due-process tradition of interpreting the Due Process Clause to protect certain fundamental rights and "personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education," and noted that many of those rights and liberties "involv[e] the most intimate and personal choices a person may make in a lifetime." *Id.*, at 851, 112 S.Ct., at 2807.

The Court of Appeals, like the District Court, found *Casey* "highly instructive" and "almost prescriptive" for determining "what liberty interest may inhere in a terminally ill person's choice to commit suicide":

"Like the decision of whether or not to have an abortion, the decision how and when to die is one of 'the most intimate and personal choices a person may make in a lifetime,' a choice 'central to personal dignity and autonomy.'" 79 F.3d, at 813-814.

Similarly, respondents emphasize the statement in *Casey* that:

"At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." *Casey*, 505 U.S., at 851, 112 S.Ct., at 2807.

Brief for Respondents 12. By choosing this language, the Court's opinion in *Casey* described, in a general way and in light of our prior cases, those personal activities and decisions that this Court has identified as so deeply rooted in our history and traditions, or so fundamental to our concept of constitutionally ordered liberty, that they are protected by the Fourteenth Amendment. The opinion moved from the recognition that liberty necessarily includes freedom of conscience and belief about ultimate considerations to the observation that "though the abortion decision may originate within the zone of conscience and belief, it is more than a philosophic exercise." *Casey*, 505 U.S., at 852, 112 S.Ct., at 2807 (emphasis added). That many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected, *San Antonio Independent School Dist. V. Rodriguez*, 411 U.S. 1, 33-35, 93 S.Ct. 1278, 1296-1298, 36 L.Ed.2d 16 (1973), and *Casey* did not suggest otherwise.

The history of the law's treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it. That being the case, our decisions lead us to conclude that the asserted "right" to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause. The Constitution also requires, however, that Washington's assisted-suicide ban be rationally related to legitimate government interests (citations omitted). Washington's assisted-suicide ban implicates a number of state interests. See 49 F.3d, at 592-593; Brief for State of California et al. as Amici Curiae 26-29; Brief for United States as Amicus Curiae 16-27.

First, Washington has an "unqualified interest in the preservation of human life." *Cruzan*, 497 U.S., at 282, 110 S.Ct. at 2853. The State's prohibition on assisted suicide, like all homicide laws, both reflects and advances its commitment to this interest. See *Id.* at 282, 110 S.Ct. at 2852; Model Penal Code

s210.5, Comment 5, at 100 (“[T]he interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another”). This interest is symbolic and aspirational as well as practical:

“While suicide is no longer prohibited or penalized, the ban against assisted suicide and euthanasia shores up the notion of limits in human relationships. It reflects the gravity with which we view the decision to take one’s own life or the life of another, and our reluctance to encourage or promote these decisions.” New York Task Force 131–132.

Respondents admit that “[t]he State has a real interest in preserving the lives of those who can still contribute to society and have the potential to enjoy life.” Brief for Respondents 35, n. 23. The Court of Appeals also recognized Washington’s interest in protecting life, but held that the “weight” of this interest depends on the “medical condition and the wishes of the person whose life is at stake.” 79 F.3d, at 817. Washington, however, has rejected this sliding-scale approach and, through its assisted-suicide ban, insists that all persons’ lives, from beginning to end, regardless of physical or mental condition, are under the full protection of the law. See *United States v. Rutherford*, 442 U.S. 544, 558, 99 S.Ct. 2470, 2478–2479, 61 L.Ed.2d 68 (1979) (“Congress could reasonably have determined to protect the terminally ill, no less than other patients, from the vast range of self-styled panaceas that inventive minds can devise”). As we have previously affirmed, the States “may properly decline to make judgments about the ‘quality’ of life that a particular individual may enjoy,” *Cruzan*, *supra*, at 282, 110 S.Ct. at 2853. This remains true, as *Cruzan* makes clear, even for those who are near death.

Relatedly, all admit that suicide is a serious public-health problem, especially among persons in otherwise vulnerable groups. See Washington State Dept. of Health, *Annual Summary of Vital Statistics* 1991, pp. 29–30 (Oct.1992) (suicide is a leading cause of death in Washington of those between the ages of 14 and 54); New York Task Force 10, 23–33 (suicide rate in the general population is about one percent, and suicide is especially prevalent among the young and the elderly). The State has an interest in preventing suicide, and in studying, identifying, and treating its causes. See 79 F.3d, at 820; *Id.*, at 854 (Beezer, J., dissenting) (“The state recognizes suicide as a manifestation of medical and psychological anguish”); Marzen 107–146.

Those who attempt suicide—terminally ill or not—often suffer from depression or other mental disorders. See New York Task Force 13–22, 126–128 (more than 95% of those who commit suicide had a major psychiatric illness at the time of death; among the terminally ill, uncontrolled pain is a “risk factor” because it contributes to depression); *Physician-Assisted Suicide and Euthanasia in the Netherlands: A Report of Chairman Charles T. Canady to the Subcommittee on the Constitution of the House Committee on the Judiciary*, 104th Cong., 2d Sess., 10–11 (Comm. Print 1996); cf. Back, Wallace, Starks, & Pearlman, *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919, 924 (1996) (“[I]ntolerable physical symptoms are not the reason most patients request physician-assisted suicide or euthanasia”). Research indicates, however, that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated. H. Hendin, *Seduced by Death: Doctors, Patients and the Dutch Cure* 24–25 (1997) (suicidal, terminally ill patients “usually respond well to treatment for depressive illness and pain medication and are then grateful to be alive”); New York Task Force 177–178. The New York Task Force, however, expressed its concern that, because depression is difficult to diagnose, physicians and medical professionals often fail to respond adequately to seriously ill patients’ needs. *Id.*, at 175. Thus, legal physician-assisted suicide could make it more difficult for the State to protect depressed or mentally ill persons, or those who are suffering from untreated pain, from suicidal impulses.



The State also has an interest in protecting the integrity and ethics of the medical profession. In contrast to the Court of Appeals' conclusion that "the integrity of the medical profession would [not] be threatened in any way by [physician-assisted suicide]," 79 F.3d, at 827, the American Medical Association, like many other medical and physicians' groups, has concluded that "[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer." American Medical Association, Code of Ethics § 2.211 (1994); see Council on Ethical and Judicial Affairs, Decisions Near the End of Life, 267 JAMA 2229, 2233 (1992) ("[T]he societal risks of involving physicians in medical interventions to cause patients' deaths is too great"); New York Task Force 103–109 (discussing physicians' views). And physician-assisted suicide could, it is argued, undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming. Assisted Suicide in the United States, Hearing Before the Subcommittee on the Constitution of the House Committee on the Judiciary, 104th Cong., 2d Sess., 355–356 (1996) (testimony of Dr. Leon R. Kass) ("The patient's trust in the doctor's whole-hearted devotion to his best interests will be hard to sustain").

Next, the State has an interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and mistakes. The Court of Appeals dismissed the State's concern that disadvantaged persons might be pressured into physician-assisted suicide as "ludicrous on its face." 79 F.3d, at 825. We have recognized, however, the real risk of subtle coercion and undue influence in end-of-life situations. *Cruzan*, 497 U.S., at 281, 110 S.Ct., at 2852. Similarly, the New York Task Force warned that "[l]egalizing physician-assisted suicide would pose profound risks to many individuals who are ill and vulnerable. The risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group." New York Task Force 120; see *Compassion in Dying*, 49 F.3d, at 593 ("An insidious bias against the handicapped—again coupled with a cost-saving mentality—makes them especially in need of Washington's statutory protection"). If physician-assisted suicide were permitted, many might resort to it to spare their families the substantial financial burden of end-of-life health-care costs.

The State's interest here goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and "societal indifference." 49 F.3d, at 592. The State's assisted-suicide ban reflects and reinforces its policy that the lives of terminally ill, disabled, and elderly people must be no less valued than the lives of the young and healthy, and that a seriously disabled person's suicidal impulses should be interpreted and treated the same way as anyone else's. See New York Task Force 101–102; *Physician-Assisted Suicide and Euthanasia in the Netherlands: A Report of Chairman Charles T. Canady*, *supra*, at 9, 20 (discussing prejudice toward the disabled and the negative messages euthanasia and assisted suicide send to handicapped patients).

Finally, the State may fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia. The Court of Appeals struck down Washington's assisted-suicide ban only "as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors." 79 F.3d, at 838. Washington insists, however, that the impact of the court's decision will not and cannot be so limited. Brief for Petitioners 44–47. If suicide is protected as a matter of constitutional right, it is argued, "every man and woman in the United States must enjoy it." *Compassion in Dying*, 49 F.3d, at 591; *Kevorkian*, 447 Mich., at 470, n. 41, 527 N.W.2d, at 727–728, n. 41. The Court of Appeals' decision, and its expansive reasoning, provide ample support for the State's concerns. The court noted, for example, that the "decision of a duly appointed

surrogate decision maker is for all legal purposes the decision of the patient himself,” 79 F.3d, at 832, n. 120; that “in some instances, the patient may be unable to self-administer the drugs and administration by the physician may be the only way the patient may be able to receive them,” *Id.*, at 831 and that not only physicians, but also family members and loved ones, will inevitably participate in assisting suicide, *Id.*, at 839, n. 140. Thus, it turns out that what is couched as a limited right to “physician-assisted suicide” is likely, in effect, a much broader license, which could prove extremely difficult to police and contain. Washington’s ban on assisting suicide prevents such erosion.

This concern is further supported by evidence about the practice of euthanasia in the Netherlands. The Dutch government’s own study revealed that in 1990, there were 2,300 cases of voluntary euthanasia (defined as “the deliberate termination of another’s life at his request”), 400 cases of assisted suicide, and more than 1,000 cases of euthanasia without an explicit request. In addition to these latter 1,000 cases, the study found an additional 4,941 cases where physicians administered lethal morphine overdoses without the patients’ explicit consent. *Physician-Assisted Suicide and Euthanasia in the Netherlands: A Report of Chairman Charles T. Canady*, *supra*, at 12–13 (citing Dutch study). This study suggests that, despite the existence of various reporting procedures, euthanasia in the Netherlands has not been limited to competent, terminally ill adults who are enduring physical suffering, and that regulation of the practice may not have prevented abuses in cases involving vulnerable persons, including severely disabled neonates and elderly persons suffering from dementia. *Id.*, at 16–21; see generally C. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands* (1991); H. Hendin, *Seduced By Death: Doctors, Patients, and the Dutch Cure* (1997). The New York Task Force, citing the Dutch experience, observed that “assisted suicide and euthanasia are closely linked,” New York Task Force 145, and concluded that the “risk of abuse is neither speculative nor distant,” *id.*, at 134. Washington, like most other States, reasonably ensures against this risk by banning, rather than regulating, assisting suicide. See *United States v. 12 200-ft. Reels of Super 8MM. Film*, 413 U.S. 123, 127, 93 S.Ct. 2665, 2668, 37 L.Ed. 500 (1973) (“Each step, when taken, appear[s] a reasonable step in relation to that which preceded it, although the aggregate or end result is one that would never have been seriously considered in the first instance”).

We need not weigh exactly the relative strengths of these various interests. They are unquestionably important and legitimate, and Washington’s ban on assisted suicide is at least reasonably related to their promotion and protection. We therefore hold that Wash. Rev. Code s 9A.36.060 (1) (1994) does not violate the Fourteenth Amendment, either on its face or “as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors.” 79 F.3d, at 838.

Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society. The decision of the en banc Court of Appeals is reversed, and the case is remanded for further proceedings consistent with this opinion.

It is so ordered.

## 9.2 *Vaco v. Quill*, 521 U.S. 793 (Equal Protection)

CHIEF JUSTICE REHNQUIST delivered the opinion of the Court.

In New York, as in most States, it is a crime to aid another to commit or attempt suicide, but patients may refuse even lifesaving medical treatment. The question presented by this case is whether New York's prohibition on assisting suicide therefore violates the Equal Protection Clause of the Fourteenth Amendment. We hold that it does not.

Petitioners are various New York public officials. Respondents Timothy E. Quill, Samuel C. Klagsbrun, and Howard A. Grossman are physicians who practice in New York. They assert that although it would be "consistent with the standards of [their] medical practice[s]" to prescribe lethal medication for "mentally competent, terminally ill patients" who are suffering great pain and desire a doctor's help in taking their own lives, they are deterred from doing so by New York's ban on assisting suicide. App. 25–26. Respondents, and three gravely ill patients who have since died, sued the State's Attorney General in the United States District Court. They urged that because New York permits a competent person to refuse life-sustaining medical treatment, and because the refusal of such treatment is "essentially the same thing" as physician-assisted suicide, New York's assisted-suicide ban violates the Equal Protection Clause. *Quill v. Koppell*, 870 F.Supp. 78, 84–85 (S.D.N.Y. 1994).

The District Court disagreed: "[I]t is hardly unreasonable or irrational for the State to recognize a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing device." *Id.*, at 84. The court noted New York's "obvious legitimate interests in preserving life, and in protecting vulnerable persons," and concluded that "[u]nder the United States Constitution and the federal system it establishes, the resolution of this issue is left to the normal democratic processes within the State." *Id.*, at 84–85.

The Court of Appeals for the Second Circuit reversed. 80 F.3d 716 (1996). The court determined that, despite the assisted-suicide ban's apparent general applicability, "New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths," because "those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs." *Id.*, at 727, 729. In the court's view, "[t]he ending of life by [the withdrawal of life-support systems] is nothing more nor less than assisted suicide." *Id.*, at 729. (emphasis added). The Court of Appeals then examined whether this supposed unequal treatment was rationally related to any legitimate state interests and concluded that "to the extent that [New York's statutes] prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally-ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest." *Id.*, at 731. We granted certiorari, 518 U.S. 1055, 117 S.Ct. 36, 135 L.Ed.2d 1127 (1996), and now reverse.

The Equal Protection Clause commands that no State shall "deny to any person within its jurisdiction the equal protection of the laws." This provision creates no substantive rights. *San Antonio Independent School Dist. V. Rodriguez*, 411 U.S. 1, 33, 93 S.Ct. 1278, 129601297, 36 L.Ed.2d 16 (1973); *Id.* at 59, 93 S.Ct. 1310 (Stewart, J., concurring). Instead, it embodies a general rule that States must treat like cases alike but may treat unlike cases accordingly. *Plyer v. Doe*, 457 U.S. 202, 216, 102 S.Ct. 2382, 2394, 72 L.Ed.2d 786 (1982) ("[T]he Constitution does not require things which are

different in fact or opinion to be treated in law as though they were the same”) (quoting *Tigner v. Texas*, 310 U.S. 141, 147, 60 S.Ct. 879, 882, 84 L.Ed. 1124 (1940)). If a legislative classification or distinction “neither burdens a fundamental right nor targets a suspect class, we will uphold [it] so long as it bears a rational relation to some legitimate end.” *Romer v. Evans*, 517 U.S. 620, 631, 116 S.Ct. 1620, 1627, 134 L.Ed.2d 855 (1996).

New York’s statutes outlawing assisting suicide affect and address matters of profound significance to all New Yorkers alike. They neither infringe fundamental rights nor involve suspect classifications. *Washington v. Glucksberg*, at 719-728, 117 S.Ct., at 2267-2271; see 80 F.3d, at 726; *San Antonio School Dist.*, 411 U.S., at 28, 93 S.Ct., at 1294 (“The system of alleged discrimination and the class it defines have none of the traditional indicia of suspectness”); *Id.*, at 33-35, 93 S.Ct., at 1296-1298 (courts must look to the Constitution, not the “importance” of the asserted right, when deciding whether an asserted right is “fundamental”). These laws are therefore entitled to a “strong presumption of validity.” *Heller v. Doe*, 509 U.S. 312, 319, 113 S.Ct. 2637, 2642, 125 L.Ed.2d 257 (1993).

On their faces, neither New York’s ban on assisting suicide nor its statutes permitting patients to refuse medical treatment treat anyone differently from anyone else or draw any distinctions between persons. Everyone, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; no one is permitted to assist a suicide. Generally speaking, laws that apply evenhandedly to all “unquestionably comply” with the Equal Protection Clause. *New York City Transit Authority v. Beazer*, 440 U.S. 568, 587, 99 S.Ct. 1355, 1366-1367, 59 L.Ed.2d 587 (1979); see *Personnel Administrator of Mass. v. Feeney*, 442 U.S. 256, 271-273, 99 S.Ct. 2282, 2292-2293, 60 L.Ed.2d 870 (1979) (“[M]any [laws] affect certain groups unevenly, even though the law itself treats them no differently from all other members of the class described by the law”).

The Court of Appeals, however, concluded that some terminally ill people—those who are on life-support systems—are treated differently from those who are not, in that the former may “hasten death” by ending treatment, but the latter may not “hasten death” through physician-assisted suicide. 80 F.3d, at 729. This conclusion depends on the submission that ending or refusing lifesaving medical treatment “is nothing more nor less than assisted suicide.” *Ibid.* Unlike the Court of Appeals, we think the distinction between assisting suicide and withdrawing life-sustaining treatment, a distinction widely recognized and endorsed in the medical profession<sup>6</sup> and in our legal traditions, is both important and logical; it is certainly rational. See *Feeney*, *supra*, at 272, 99 S.Ct., at 2292 (“When the basic classification is rationally based, uneven effects upon particular groups within a class are ordinarily of no constitutional concern”).

The distinction comports with fundamental legal principles of causation and intent. First, when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication. See, e.g., *People v. Kevorkian*, 447 Mich. 436, 470-472, 527 N.W.2d 714, 728 (1994), cert. denied, 514 U.S. 1083, 115 S.Ct. 1795, 131 L.Ed.2d 723 (1995); *Matter of Conroy*, 98 N.J. 321, 355, 486 A.2d 1209, 1226 (1985) (when feeding tube is removed, death “result[s] from [the patient’s] underlying medical condition”); *In re Colyer*, 99 Wash.2d 114, 123, 660 P.2d 738, 743 (1983) (“[D]eath which occurs after the removal of life sustaining systems is from natural causes”); *American Medical Association, Council on Ethical and Judicial Affairs, Physician-Assisted Suicide*, 10 *Issues in Law & Medicine* 91, 93 (1994) (“When a life-sustaining treatment is declined, the patient dies primarily because of an underlying disease”).

Furthermore, a physician who withdraws, or honors a patient's refusal to begin, life-sustaining medical treatment purposefully intends, or may so intend, only to respect his patient's wishes and "to cease doing useless and futile or degrading things to the patient when [the patient] no longer stands to benefit from them." Assisted Suicide in the United States, Hearing before the Subcommittee on the Constitution of the House Committee on the Judiciary, 104th Cong., 2d Sess., 368 (1996) (testimony of Dr. Leon R. Kass). The same is true when a doctor provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain. A doctor who assists a suicide, however, "must, necessarily and indubitably, intend primarily that the patient be made dead." *Id.*, at 367. Similarly, a patient who commits suicide with a doctor's aid necessarily has the specific intent to end his or her own life, while a patient who refuses or discontinues treatment might not (citations omitted).

The law has long used actors' intent or purpose to distinguish between two acts that may have the same result. See, e.g., *United States v. Bailey*, 444 U.S. 394, 403-406, 100 S.Ct. 624, 631-633, 62 L.Ed.2d 575 (1980) ("[T]he common law of homicide often distinguishes between a person who knows that another person will be killed as the result of his conduct and a person who acts with the specific purpose of taking another's life"); *Morissette v. United States*, 342 U.S. 246, 250, 72 S.Ct. 240, 243, 96 L.Ed. 288 (1952) (distinctions based on intent are "universal and persistent in mature systems of law"); *M. Hale*, 1 *Pleas of the Crown* 412 (1847) ("If A. with an intent to prevent a gangrene beginning in his hand doth without any advice cut off his hand, by which he dies, he is not thereby *felo de se* for tho it was a voluntary act, yet it was not with an intent to kill himself"). Put differently, the law distinguishes actions taken "because of" a given end from actions taken "in spite of" their unintended but foreseen consequences. *Feeney*, 442 U.S., at 279, 99 S.Ct., at 2296; *Compassion in Dying v. Washington*, 79 #d 790, 858 (C.A.9 1996) (Kleinfeld, J., dissenting) ("When General Eisenhower ordered American soldiers onto the beaches of Normandy, he knew that he was sending many American soldiers to certain death. His purpose, though, was to liberate Europe from the Nazis").

Given these general principles, it is not surprising that many courts, including New York courts, have carefully distinguished refusing life-sustaining treatment from suicide. In fact, the first state-court decision explicitly to authorize withdrawing lifesaving treatment noted the "real distinction between the self-infliction of deadly harm and a self-determination against artificial life support." *In re Quinlan*, 70 N.J. 10, 43 52, and n. 9, 355 A.2d 647, 665, 670, and n. 9, cert. denied sub nom. *Garger v. New Jersey*, 429 U.S. 922, 97 S.Ct. 319, 50 L.Ed.2d 289 (1976) And recently, the Michigan Supreme Court also rejected the argument that the distinction "between acts that artificially sustain life and acts that artificially curtail life" is merely a "distinction without constitutional significance—a meaningless exercise in semantic gymnastics," insisting that "the Cruzan majority disagreed and so do we." *Kevorkian*, 447 Mich., at 471, 527 N.W.2d, at 728.

Similarly, the overwhelming majority of state legislatures have drawn a clear line between assisting suicide and withdrawing or permitting the refusal of unwanted lifesaving medical treatment by prohibiting the former and permitting the latter. *Glucksberg*, at 708-711, 713-720, 117 S.Ct., 2262-2263, 2264-2267. And "nearly all states expressly disapprove of suicide and assisted suicide either in statutes dealing with durable powers of attorney in health-care situations, or in 'living will' statutes." *Kevorkian*, *supra*, at 478-479, and nn. 53-54, 527 N.W.2d, at 731-732, and nn. 53-54. Thus, even as the States move to protect and promote patients' dignity at the end of life, they remain opposed to physician-assisted suicide.

New York is a case in point. The State enacted its current assisted-suicide statutes in 1965 (citations omitted). In so doing, however, the State has neither endorsed a general right to "hasten death" nor

approved physician-assisted suicide. Quite the opposite: The State has reaffirmed the line between “killing” and “letting die.” See N.Y. Pub. Health Law s. 2989 (3) (McKinney 1993) (“This article is not intended to permit or promote suicide, assisted suicide, or euthanasia”); New York State Task Force on Life and the Law, *Life-Sustaining Treatment: Making Decisions and Appointing a Health Care Agent* 36–42 (July 1987); *Do Not Resuscitate Orders: The Proposed Legislation and Report of the New York State Task Force on Life and the Law* 15 (Apr.1986). More recently, the New York State Task Force on Life and the Law studied assisted suicide and euthanasia and, in 1994, unanimously recommended against legalization. *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* vii (1994). In the Task Force’s view, “allowing decisions to forgo life-sustaining treatment and allowing assisted suicide or euthanasia have radically different consequences and meanings for public policy.” *Id.*, at 146.

This Court has also recognized, at least implicitly, the distinction between letting a patient die and making that patient die. In *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 278, 110 S.Ct. 2841, 2851, 111 L.Ed.2d 224 (1990), we concluded that “[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions,” and we assumed the existence of such a right for purposes of that case, *Id.*, at 279, 110 S.Ct., at 2851-2852. But our assumption of a right to refuse treatment was grounded not, as the Court of Appeals supposed, on the proposition that patients have a general and abstract “right to hasten death,” 80 F.3d, at 727-728, but on well-established, traditional rights to bodily integrity and freedom from unwanted touching, *Cruzan*, 497 U.S., at 278-279, 110 S.Ct., at 2851-2852; *Id.*, at 287-288, 110 S.Ct., at 2856-2857 (O’CONNOR, J., concurring). In fact, we observed that “the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide.” *Id.*, at 280, 110 S.Ct., at 2852. *Cruzan* therefore provides no support for the notion that refusing life-sustaining medical treatment is “nothing more nor less than suicide.”

For all these reasons, we disagree with respondents’ claim that the distinction between refusing lifesaving medical treatment and assisted suicide is “arbitrary” and “irrational.” Brief for Respondents 44. Granted, in some cases, the line between the two may not be clear, but certainty is not required, even were it possible. Logic and contemporary practice support New York’s judgment that the two acts are different, and New York may therefore, consistent with the Constitution, treat them differently. By permitting everyone to refuse unwanted medical treatment while prohibiting anyone from assisting a suicide, New York law follows a longstanding and rational distinction.

New York’s reasons for recognizing and acting on this distinction—including prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians’ role as their patients’ healers; protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible slide towards euthanasia—are discussed in greater detail in our opinion in *Glucksberg*, ante. These valid and important public interests easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end.

The judgment of the Court of Appeals is reversed.

It is so ordered.

### **9.3 Baxter v. State, 224 P.3d 1211 (State Constitution)**

JUSTICE W. WILLIAM LEAPHART delivered the Opinion of the Court.

The State of Montana appeals from the Order of the First Judicial District Court granting summary judgment in favor of Robert Baxter, Stephen Speckart, M.D., C. Paul Loehnen, M.D., Lar Autio, M.D., George Risi, Jr., M.D., and Compassion & Choices; and from the District Court's decision that a competent, terminally ill patient has a right to die with dignity under Article II, Sections 4 and 10 of the Montana Constitution, which includes protection of the patient's physician from prosecution under the homicide statutes. We affirm in part and reverse in part.

We rephrase the following issues on appeal:

I. Whether the District Court erred in its decision that competent, terminally ill patients have a constitutional right to die with dignity, which protects physicians who provide aid in dying from prosecution under the homicide statutes.

#### **BACKGROUND**

This appeal originated with Robert Baxter, a retired truck driver from Billings who was terminally ill with lymphocytic leukemia with diffuse lymphadenopathy. At the time of the District Court's decision, Mr. Baxter was being treated with multiple rounds of chemotherapy, which typically become less effective over time. As a result of the disease and treatment, Mr. Baxter suffered from a variety of debilitating symptoms, including infections, chronic fatigue and weakness, anemia, night sweats, nausea, massively swollen glands, significant ongoing digestive problems and generalized pain and discomfort. The symptoms were expected to increase in frequency and intensity as the chemotherapy lost its effectiveness. There was no cure for Mr. Baxter's disease and no prospect of recovery. Mr. Baxter wanted the option of ingesting a lethal dose of medication prescribed by his physician and self-administered at the time of Mr. Baxter's own choosing.

Mr. Baxter, four physicians, and Compassion & Choices, brought an action in District Court challenging the constitutionality of the application of Montana homicide statutes to physicians who provide aid in dying to mentally competent, terminally ill patients. The complaint alleged that patients have a right to die with dignity under the Montana Constitution Article II, Sections 4 and 10, which address individual dignity and privacy.

In December 2008, the District Court issued its Order and Decision, holding that the Montana constitutional rights of individual privacy and human dignity, together, encompass the right of a competent, terminally ill patient to die with dignity. The District Court held that a patient may use the assistance of his physician to obtain a prescription for a lethal dose of medication. The patient would then decide whether to self-administer the dose and cause his own death. The District Court further held that the patient's right to die with dignity includes protection of the patient's physician from prosecution under the State's homicide statutes. The State appeals

#### **DISCUSSION**

The parties in this appeal focus their arguments on the question of whether a right to die with dignity—including physician aid in dying—exists under the privacy and dignity provisions of the Montana

Constitution. The District Court held that a competent, terminally ill patient has a right to die with dignity under Article II, Sections 4 and 10 of the Montana Constitution. Sections 4 and 10 address individual dignity and the right to privacy, respectively. The District Court further held that the right to die with dignity includes protecting the patient's physician from prosecution under Montana homicide statutes. The District Court concluded that Montana homicide laws are unconstitutional as applied to a physician who aids a competent, terminally ill patient in dying.

While we recognize the extensive briefing by the parties and amici on the constitutional issues, this Court is guided by the judicial principle that we should decline to rule on the constitutionality of a legislative act if we are able to decide the case without reaching constitutional questions. *State v. Adkins*, 2009 MT 71, para. 12, 349 Mont. 444, 447, 204 P.3d 1, 5; *Sunburst Sch. Dist. No. 2 v. Texaco, Inc.* 2007 MT 183, para. 62, 228 Mont. 259, 279, 165 P.3d 1079, 1093. Since both parties have recognized the possibility of a consent defense to a homicide charge under section 45-2-211(1), MCA, we focus our analysis on whether the issues presented can be resolved at the statutory, rather than the constitutional, level.

We start with the proposition that suicide is not a crime under Montana law. In the aid in dying situation, the only person who might conceivably be prosecuted for criminal behavior is the physician who prescribes a lethal dose of medication. In that the claims of the plaintiff physicians are premised in significant part upon concerns that they could be prosecuted for extending aid in dying, we deem it appropriate to analyze their possible culpability for homicide by examining whether the consent of the patient to his physician's aid in dying could constitute a statutory defense to a homicide charge against the physician.

The consent statute would shield physicians from homicide liability if, with the patients' consent, the physicians provide aid in dying to terminally ill, mentally competent adult patients. We first determine whether a statutory consent defense applies to physicians who provide aid in dying and, second, whether patient consent is rendered ineffective by section 45-2-211(2)(d), MCA, because permitting the conduct or resulting harm "is against public policy."

Section 45-5-102(1), MCA, states that a person commits the offense of deliberate homicide if "the person purposely or knowingly causes the death of another human being." Section 45-5-211(1), MCA, establishes consent as a defense, stating that the "consent of the victim to conduct charged to constitute an offense or to the result thereof is a defense." Thus, if the State prosecutes a physician for providing aid in dying to a mentally competent, terminally ill adult patient who consented to such aid, the physician may be shielded from liability pursuant to the consent statute. This consent defense, however, is only effective if none of the statutory exceptions to consent applies. Section 45-2-211(1), MCA, codifies the four exceptions:

Consent is ineffective if: (a) it is given by a person who is legally incompetent to authorize the conduct charged to constitute the offense; (b) it is given by a person who by reason of youth, mental disease or defect, or intoxication is unable to make a reasonable judgment as to the nature or harmfulness of the conduct charged to constitute the offense; (c) it is induced by force, duress, or deception; or (d) it is against public policy to permit the conduct or the resulting harm, even though consented to.

The first three statutory circumstances rendering consent ineffective require case-by-case factual determinations. We therefore confine our analysis to the last exception and determine whether, under Montana law, consent to physician aid in dying is against public policy. For the reasons stated below,



we find no indication in Montana law that physician aid in dying provided to terminally ill, mentally competent adult patients is against public policy.

Section 45-2-211(2)(d), MCA, renders consent ineffective if “it is against public policy to permit the conduct or the resulting harm, even though consented to.” We addressed the applicability of this provision in *State v. Mackrill*, 2008 MT 297, 345 Mont. 469, 191 P.3d 451. This Court held that the consent of a victim is not a defense to the charge of aggravated assault under section 45-5-202(1), MCA. *Mackrill*, para. 33. The *Mackrill* decision, while not limiting the exception’s reach, applied the “against public policy” exception to situations in which violent, public altercations breach public peace and endanger others in the vicinity. Physician aid in dying, as analyzed below, does not fall within the scope of what this Court has thus far identified as “against public policy.”

The *Mackrill* case arose from a particularly violent altercation between Jason Mackrill and Robert Gluesing outside a Livingston bar. Mackrill, who had been drinking heavily, spent the better part of the evening disrupting other bar-goers, including Gluesing. When a bartender refused to serve Mackrill, Gluesing offered Mackrill a few dollars and encouraged him to go elsewhere. Mackrill became obstinate and refused to leave. When the bartender picked up the phone to call the police, Gluesing escorted Mackrill out of the bar. Once outside, Mackrill began punching Gluesing, including a “very solid shot” that caused Gluesing’s feet to come off the ground and the back of his head to hit the pavement. A witness called 9–1–1 and paramedics arrived on the scene. They found Gluesing unconscious and bleeding in the street. He was transported to the hospital and treated for head injuries, including a skull fracture.

The State charged Mackrill with one count of aggravated assault, a felony under section 45-5-202, MCA. He pleaded not guilty and filed a Notice of Affirmative Defenses, in which he stated he would argue consent as a defense at trial. The jury found Mackrill guilty. He then filed a post-trial motion claiming the State failed to introduce evidence upon which the jury could conclude Gluesing did not consent to the fight. After a hearing on the matter, the district court denied the motion. Mackrill appealed. This Court concluded that consent is not an effective defense against an assault charge under section 45-5-202(1), MCA. *Mackrill*, para. 33.

The *Mackrill* decision is the only Montana case addressing the public policy exception to consent. It demonstrates one set of circumstances in which consent as a defense is rendered ineffective because permitting the conduct or resulting harm is “against public policy.” This “against public policy” exception to consent applies to conduct that disrupts public peace and physically endangers others. Clearly, under *Mackrill*, unruly, physical and public aggression between individuals falls within the parameters of the “against public policy” exception. The men were intoxicated, brawling in a public space, and endangering others in the process.

A survey of courts that have considered this issue yields unanimous understanding that consent is rendered ineffective as “against public policy” in assault cases characterized by aggressive and combative acts that breach public peace and physically endanger others.

The State of Washington is home to an unusual volume of these “public policy” exception cases. Washington courts have consistently held that the “public policy” exception applies only to brutish, irrational violence that endangers others. In *State v. Dejarlais*, the Supreme Court of Washington held that consent is not a defense to violations of a domestic-violence protection order. 136 Wash.2d 939, 942, 969 P.2d 90 91 (Wash. 1998). In *State v. Hiott*, the court determined that consent is not a defense to a game in which two people agreed to shoot BB guns at each other because it was a breach of the

public peace. 97 Wash.App. 825, 828, 987 P.2d 135, 137 (Wash.App. Div. 2 1999). In *State v. Weber*, the court held consent is not a defense to the charge of second degree assault between two incarcerated persons. 137 Wash. App. 852, 860, 155 P.3d 947, 951 (Wash.App. Div. 3 2007). The court noted there “is nothing redeeming or valuable in permitting fighting and every reason to dissuade it.” *Weber*, 155 P.3d at 951.

In *State v. Fransua*, the Court of Appeals of New Mexico held that one person’s taunting invitation to “go ahead” and shoot him did not establish a valid consent defense for another person who took him up on the offer. 85 N.M. 173, 174, 510 P.2d 106, 107 (N.M.App. 1973). In the Superior Court of New Jersey, a defendant claimed he was not guilty of assault and battery because he and his wife agreed that if she consumed alcohol he would physically assault her as punishment. *State v. Brown*, 143 N.J. Super. 571, 580, 364 A.2d 27, 32 (Law Div. 1976) He argued consent as a defense after the state charged him with assault and battery. *Brown*, 364 A.2d at 28. The court held that failing to punish *Brown* “would seriously threaten the dignity, peace, health and security of our society.” *Brown*, 364 A.2d at 32.

The above acts—including the Mackrill brawl—illustrate that sheer physical aggression that breaches public peace and endangers others is against public policy. In contrast, the act of a physician handing medicine to a terminally ill patient, and the patient’s subsequent peaceful and private act of taking the medicine, are not comparable to the violent, peace-breaching conduct that this Court and others have found to violate public policy.

The above cases address assaults in which the defendant alone performs a direct and violent act that causes harm. The bar brawler, prison fighter, BB gun-shooter, and domestic violence aggressor all committed violent acts that directly caused harm and breached the public peace. It is clear from these cases that courts deem consent ineffective when defendants directly commit blatantly aggressive, peace-breaching acts against another party.

In contrast, a physician who aids a terminally ill patient in dying is not directly involved in the final decision or the final act. He or she only provides a means by which a terminally ill patient himself can give effect to his life-ending decision, or not, as the case may be. Each stage of the physician-patient interaction is private, civil, and compassionate. The physician and terminally ill patient work together to create a means by which the patient can be in control of his own mortality. The patient’s subsequent private decision whether to take the medicine does not breach public peace or endanger others.

Although the “against public policy” exception of section 45-2-211(2)(d), MCA, is not limited to violent breaches of the peace as discussed in the above cases, we see nothing in the case law facts or analysis suggesting that a patient’s private interaction with his physician, and subsequent decision regarding whether to take medication provided by a physician, violate public policy. We thus turn to a review of Montana statutory law.

We similarly find no indication in Montana statutes that physician aid in dying is against public policy. The Montana Rights of the Terminally Ill Act (Terminally Ill Act) and the homicide statute’s narrow applicability to “another” human being, do not indicate that physician aid in dying is against public policy.

Under section 45-2-102, MCA a “person commits the offense of deliberate homicide if: (a) the person purposely or knowingly causes the death of another human being.” In physician aid in dying, the physician makes medication available for a terminally ill patient who requests it, and the patient would

then choose whether to cause his own death by self-administering the medicine. The terminally ill patient's act of ingesting the medicine is not criminal. There is no language in the homicide statute indicating that killing "oneself," as opposed to "another," is a punishable offense, and there is no separate statute in Montana criminalizing suicide. There is thus no indication in the homicide statutes that physician aid in dying—in which a terminally ill patient elects and consents to taking possession of a quantity of medicine from a physician that, if he chooses to take it, will cause his own death—is against public policy.

There is similarly no indication in the Terminally Ill Act that physician aid in dying is against public policy. The Terminally Ill Act, by its very subject matter, is an apt statutory starting point for understanding the legislature's intent to give terminally ill patients—like Mr. Baxter—end-of-life autonomy, respect and assurance that their life-ending wishes will be followed. The Terminally Ill Act expressly immunizes physicians from criminal and civil liability for following a patient's directions to withhold or withdraw life-sustaining treatment. Section 50-9-204, MCA. Indeed, the legislature has criminalized the *failure* to act according to the patient's wishes. Section 50-9-206, MCA. Other parts of the Terminally Ill Act also resonate with this respect for the patient's end-of-life preferences. Section 50-9-205, MCA. explicitly prohibits, "for any purpose," calling the patient's death a "suicide or homicide," and section 50-9-501, MCA, charges the Montana Attorney General with creating a "declaration registry" and waging a statewide campaign to educate Montanans about end-of-life decisionmaking. The statute even establishes a specialized state fund account specifically for the registry and education program. Section 50-9-502(b), MCA.

The Rights of the Terminally Ill Act very clearly provides that terminally ill patients are entitled to autonomous, end-of-life decisions, even if enforcement of those decisions involves direct acts by a physician. Furthermore, there is no indication in the Rights of the Terminally Ill Act that an additional means of giving effect to a patient's decision—in which the patient, without any direct assistance, chooses the time of his own death—is against public policy.

The Montana Legislature codified several means by which a patient's life-ending request can be fulfilled. The Terminally Ill Act authorizes an individual "of sound mind and 18 years of age or older to execute at any time a declaration governing the withholding or withdrawal of life-sustaining treatment." Section 50-9-103, MCA. The Terminally Ill Act defines "life-sustaining treatment" as any medical procedure or intervention that "serves only to prolong the dying process." Section 50-9-102(9), MCA. The declaration is operative when it is communicated to the physician or registered nurse and the declarant is determined to be in a terminal condition and no longer able to vocalize his end-of-life wishes. Section 50-9-105, MCA.

The Terminally Ill Act, in short, confers on terminally ill patients a right to have their end-of-life wishes followed, even if it requires *direct* participation by a physician through withdrawing or withholding treatment. Section 50-9-103, MCA. Nothing in the statute indicates it is against public policy to honor those same wishes when the patient is conscious and able to vocalize and carry out the decision himself with self-administered medicine and no immediate or direct physician assistance.

The Terminally Ill Act contains declaration forms a patient may use to legally ensure his end-of-life instructions will be followed. The forms shed critical light on the end-of-life roles of terminally ill Montanans and their physicians, as envisioned and codified by the legislature. The first declaration states:

If I should have an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician or attending advanced practice registered nurse, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician or attending advanced practice registered nurse, pursuant to the Montana Rights of the Terminally Ill Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.

Section 50-9-103(2), MCA. The declaration language of section 50-9-103, MCA not only highlights the legislature's intent to provide terminally ill patients with various means to express (and have followed) their autonomous end-of-life preferences, but also authorizes physician involvement in both the terminal diagnosis and the act of withdrawing or withholding treatment.

The legislature, in creating this legally-enforceable declaration, also immunized physicians and medical professionals who act in accordance with the patient's wishes. The statute shields physicians from liability for following a patient's instructions to stop life-sustaining treatment, or refrain from treating him altogether. Section 50-9-204, MCA. The Dissent states that the Terminally Ill Act only allows the "taking away of, or refraining from giving" life-sustaining medical treatment. The Dissent's definition of "withdraw" confirms that this "taking away" is, itself, a direct act by the physician. "Withdrawal" is "*the act of taking back or away*" something that was granted. *Webster's Third New International Dictionary of the English Language* 2627 (Philip Babcock Gove ed., G. & C. Merriam Co. 1971) (emphasis added). The "giving" is an act, as is the "taking away." The Terminally Ill Act authorizes physicians to commit a direct *act* of withdrawing medical care, which hastens death. In contrast, the physician's involvement in aid in dying consists solely of making the instrument of the "act" available to the terminally ill patient. The patient himself then chooses whether to commit the act that will bring about his own death. The legislature codified public policy by expressly immunizing physicians who commit a direct act that gives effect to the life-ending wishes of a terminally ill patient. Section 50-9-204, MCA. There is no suggestion in the Act that a lesser physician involvement (making available a lethal dose of medicine)—which is then vetted by a terminally ill patient's intervening choice and subsequent self-administered ingestion—is against public policy.

The Terminally Ill Act explicitly shields physicians from criminal, civil or professional liability for the act of withdrawing or withholding life-sustaining treatment from a terminally ill patient who requests it. Section 50-9-204, MCA. The legislature devoted an entire section to codifying this immunity, ensuring that physicians and nurses will not be held liable for acting consistent with a terminally ill patient's decision to die. Section 50-9-204, MCA, provides an extensive list of medical professionals and others exempt from prosecution:

(a) a physician or advanced practice registered nurse who *causes* the withholding or withdrawal of life-sustaining treatment from a qualified patient; (b) a person who participates in the withholding or withdrawal of life-sustaining treatment under the direction or with the authorization of the physician or advanced practice registered nurse; (c) emergency medical services personnel who *cause or participate* in the withholding or withdrawal of life-sustaining treatment under the direction of or with the authorization of a physician or advanced practice registered nurse or who on receipt of reliable documentation follow a living will protocol.

Section 50-9-204, MCA. (emphasis added). The section also immunizes health care facilities, health care providers, and the patient's designee. Section 50-9-204 (e), MCA. The Terminally Ill Act's second enactment expands this immunity to include emergency medical service personnel. Section 50-9-204(c), MCA. The statute explicitly states that the above individuals are "not subject to civil or criminal liability or guilty of unprofessional conduct." Section 50-9-204 (1), MCA. This encompassing immunity for medical professionals reinforces the terminally ill patient's right to enforce his decision without fear that those who give effect to his wishes will be prosecuted.

Further, the legislature criminalized the failure to follow a patient's end-of-life instructions. A physician "who willfully fails to record the determination of terminal condition or the terms of a declaration" is punishable by a maximum \$500 fine, a maximum one year in jail, or both. Section 50-9-206(2), MCA. A person who "purposely conceals, cancels, defaces, or obliterates the declaration of another without the declarant's consent" is punishable by the same. Section 50-9-206(3), MCA. The statute's message is clear: failure to give effect to a terminally ill patient's life-ending declaration is a crime.

Other parts of the Terminally Ill Act similarly reflect legislative respect for the patient's end-of-life autonomy and the physician's legal obligation to comply with the patient's declaration. Section 50-9-205, MCA, prohibits, *for any purpose*, treating the death as either "suicide or homicide." The legislature, by prohibiting anyone from deeming the act a homicide or suicide, ensured that insurance companies cannot punish a terminally ill patient and his family for the patient's choice to die.

The provision also lists behaviors not supported by the statute. Notably, physician aid in dying is not listed. Section 50-9-205(7), MCA, reads: "This chapter does not condone, authorize, or approve mercy killing or euthanasia." Physician aid in dying is, by definition, neither of these. Euthanasia is the "intentional putting to death of a person with an incurable or painful disease intended as an act of mercy." Stedman's Medical Dictionary 678 (28th ed., Lippincott Williams & Wilkins 2006). The phrase "mercy killing" is the active term for euthanasia defined as "a mode of ending life in which the intent is to cause the patient's death in a single act." Stedman's Medical Dictionary at 678. Neither of these definitions is consent-based, and neither involves a patient's autonomous decision to self-administer drugs Section 50-9-204, MCA. Section 50-9-204, MCA. that will cause his own death.

The final part of the Terminally Ill Act orders the Montana Attorney General to "establish and maintain a health care declaration registry" in which declarations are stored and updated. Section 50-9-501, MCA. The provision also creates a health care declaration account in the state special revenue fund, which the Attorney General must use to "create and maintain the health care declaration registry" and to create an education and outreach program. Section 50-9-502 (b), MCA. The program must pertain to "advance health care planning and end-of-life health care decisionmaking." Section 50-9-505 (1), MCA. The program must also "explain the need for readily available legal documents that express an individual's health care wishes." Section 50-9-505(c), MCA. The registry requirement, outreach and education provisions, and state funding for both, indicate legislative intent to honor and promulgate the rights of terminally ill patients to autonomously choose the direction of their end-of-life medical care. There is no indication in the statutes that another choice—physician aid in dying—is against this legislative ethos of honoring the end-of-life decisions of the terminally ill.

There is no indication in the Rights of the Terminally Ill Act that physician aid in dying is against public policy. Indeed, the Act reflects legislative respect for the wishes of a patient facing incurable illness. The Act also indicates legislative regard and protection for a physician who honors his legal obligation to the patient. The Act immunizes a physician for following the patient's declaration even

if it requires the physician to directly unplug the patient's ventilator or withhold medicine or medical treatment that is keeping the patient alive. Physician aid in dying, on the other hand, does not require such *direct* involvement by a physician. Rather, in physician aid in dying, the final death-causing act lies in the patient's hands. In light of the long-standing, evolving and unequivocal recognition of the terminally ill patient's right to self-determination at the end of life in Title 50, chapter 9, MCA, it would be incongruous to conclude that a physician's indirect aid in dying is contrary to public policy.

In conclusion, we find nothing in Montana Supreme Court precedent or Montana statutes indicating that physician aid in dying is against public policy. The "against public policy" exception to consent has been interpreted by this Court as applicable to violent breaches of the public peace. Physician aid in dying does not satisfy that definition. We also find nothing in the plain language of Montana statutes indicating that physician aid in dying is against public policy. In physician aid in dying, the patient—not the physician—commits the final death-causing act by self-administering a lethal dose of medicine.

Furthermore, the Montana Rights of the Terminally Ill Act indicates legislative respect for a patient's autonomous right to decide if and how he will receive medical treatment at the end of his life. The Terminally Ill Act explicitly shields physicians from liability for acting in accordance with a patient's end-of-life wishes, even if the physician must actively pull the plug on a patient's ventilator or withhold treatment that will keep him alive. There is no statutory indication that lesser end-of-life physician involvement, in which the patient himself commits the final act, is against public policy. We therefore hold that under s 45-2-211, MCA, a terminally ill patient's consent to physician aid in dying constitutes a statutory defense to a charge of homicide against the aiding physician when no other consent exceptions apply.

The District Court's ruling on the constitutional issues is vacated, although the court's grant of summary judgment to Plaintiffs/Appellees is affirmed on the alternate statutory grounds set forth above.