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## AIDS and the Right to Health Care

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# *AIDS and the Right to Health Care*

Taunya Lovell Banks, J.D.\*

*Nothing more exposes a physician's true ethics than the way he or she balances his or her own interests against those of the patient.<sup>1</sup>*

A 1987 New York Times editorial noted that the refusal of physicians and dentists to treat patients infected with the AIDS virus<sup>2</sup> is the most painful symptom produced by the fear of AIDS.<sup>3</sup> An editorial in the Journal of the American Medical Association (JAMA) echoed this concern.<sup>4</sup> C. Everett Koop, the Surgeon General of the United States, admitted that he is getting more reports of health care providers refusing to treat people infected with the AIDS virus.<sup>5</sup> In November, 1987, the American Medical Association, a national voluntary asso-

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<sup>1</sup>Pellegrino, *Altruism, Self-Interest, and Medical Ethics*, 258 JAMA 1939 (1987).

<sup>2</sup>AIDS stands for Acquired Immune Deficiency Syndrome. AIDS is believed to be caused by the Human Immunodeficiency Virus (HIV). ARC stands for Aids Related Complex.

<sup>3</sup>*When Doctors Refuse to Treat AIDS*, N.Y. Times, Aug. 3, 1987, at A16, col. 1 (late ed.). See, e.g., *Refusal to Treat AIDS Infant Sparks Debate*, Tulsa World, Jan 18, 1988, at A5, col. 1 (Firefighters in Annapolis, California refused to help an infant with AIDS who appeared to be choking, claiming that no one present was trained in emergency care for persons with AIDS); *Surgeon Won't Operate on Victims of AIDS*, N.Y. Times, March 13, 1987, at A21, col. 4 (late ed.); *Doctor Bars AIDS Patients*, Tulsa World, Oct. 22, 1987, at D2, col. 5 (Surgeons in Milwaukee and Mountain View, California have refused to operate on persons infected with AIDS).

<sup>4</sup>See generally Pellegrino, *supra* note 1.

<sup>5</sup>Boffey, *Doctors Who Shun AIDS Patients Are Assailed by Surgeon General*, N.Y. Times, Sept. 10, 1987, at A1, col. 4 (late ed.). Koop also said that some health care providers are refusing to treat persons suspected of having AIDS. *Id.*

ciation of physicians, declared that physicians have an ethical duty to treat people infected with the AIDS virus.<sup>6</sup> Shortly thereafter, the Texas Medical Association and the Arizona State Board of Medical Examiners adopted policies which said that physicians can refuse to treat persons infected with the AIDS virus as long as they refer the patients to other physicians.<sup>7</sup>

Both Surgeon General Koop and the American Medical Association believe that only a small number of physicians are refusing to treat persons with AIDS.<sup>8</sup> Health care providers also refuse to treat patients with other diseases.<sup>9</sup> Nevertheless, current cases have stimulated discussion within the medical community about the legal, ethical, and moral obligations of physicians toward people in need of medical care.<sup>10</sup> These questions are not new and there are few clear-cut answers.

As the number of persons with AIDS increases,<sup>11</sup> new trends emerge. Since 1981, most adults in the United States infected with AIDS have been homosexual or bisexual men without a history of intravenous (IV) drug abuse.<sup>12</sup> However, a second group of infected persons, which includes intravenous drug users, their sexual partners and offspring, has emerged.<sup>13</sup> This group of patients, unlike the initial

<sup>6</sup>Pear, *A.M.A. Rules That Doctors Are Obligated To Treat AIDS*, N.Y. Times, Nov. 13, 1987, at A14, col. 1 (late ed.). The A.M.A.'s Council on Ethical and Judicial Affairs Report states: "A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive [to the AIDS antibody]." A.M.A. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, *ETHICAL ISSUES INVOLVED IN THE GROWING AIDS CRISIS* (Dec. 1987) [hereinafter *AIDS REPORT*] reprinted in Freedman, *Health Professions, Codes, and the Right to Refuse to Treat HIV-Infectious Patients*, HASTINGS CENTER REP., Apr.-May 1988, at 20, 24 (Special Supp.).

<sup>7</sup>*TMA Policy Lets MDs Refuse AIDS Patients If They Refer*, Amer. Med. News, Dec. 4, 1987, at 3, col. 4; *Ariz. MDs Can Refuse AIDS Patients*, Amer. Med. News, Nov. 6, 1987, at 37, col. 2.

<sup>8</sup>Boffey, *supra* note 5; Pear, *supra* note 6.

<sup>9</sup>*See, e.g., 9 Fla. Hospitals Refuse Emergency Victim*, Am. Med. News, Oct. 16, 1987, at 31, col. 1 (physicians reluctant to accept trauma cases, such as critically injured gunshot victim, because of skyrocketing insurance premiums).

<sup>10</sup>Zuger & Miles, *Physicians, AIDS, and Occupational Risk: Historic Traditions and Ethical Obligations*, 258 JAMA 1924 (1987).

<sup>11</sup>Curran, Jaffe, Hardy, Morgan, Selik, and Dondero, *Epidemiology of HIV Infection and AIDS in the United States*, 239 SCIENCE 610 (1988) (By the end of 1987, 49,793 cases of AIDS had been reported in the United States).

<sup>12</sup>*Id.* at 610. This group represents 65% of the total reported cases. *Id.*

<sup>13</sup>*Id.* Intravenous drug users account for 17% of all reported AIDS cases. Seventy percent of the 2.3% heterosexual transmission cases involved sexual partners of IV drug users, and 70% of perinatally acquired AIDS cases are related to IV drug abuse by the child's mother or her sexual partner. *Id.* at 610-11.

group of middle class gay and bisexual men, are primarily black and Hispanic.<sup>14</sup> They are generally indigent, have little or no health insurance, and have traditionally been denied access to adequate health care.<sup>15</sup> If a small number of physicians are refusing to treat infected persons who can pay and are responsive to medical counselling, then it is foreseeable that an even larger number of physicians will refuse to treat minority individuals who are not able to pay and who may be more resistant to medical counselling. Within the next five years there is a real possibility that hundreds of thousands of people infected with HIV will have severely limited access to health care.<sup>16</sup>

This article examines both the legal and ethical duty of physicians to treat persons in need of medical care. It also reviews the arguments for and against recognition of any right to health care. These issues will be examined to determine if either the legislature or the courts need to modify current law in this area in light of the AIDS epidemic.

### Legal Duty to Treat

#### *Creating a Duty*

Early English law treated physicians like other business persons offering services to the public.<sup>17</sup> This view changed over time and the relationship between physician and patient became more selective.<sup>18</sup> Thus, the law evolved that a private physician owes no duty to treat all sick people.<sup>19</sup> Ethically and morally, a private physician is free to

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<sup>14</sup>*Id.* at 610-11.

<sup>15</sup>PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBS. IN MED. BIOMED. BEHAVIORAL RES., SECURING ACCESS TO HEALTH CARE: A REPORT ON THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES, 97-98 (vol. I) (1983) [hereinafter PRESIDENT'S COMM'N].

<sup>16</sup>Walters, *Ethical Issues in the Prevention and Treatment of HIV Infection and AIDS*, 239 SCIENCE 597, 600-601 (1988). Estimates of personal medical costs for AIDS patients in 1991 range from \$3.5 billion to \$9.4 billion, and there are already shortages in health care facilities, home care programs and counseling services for infected persons. *Id.* at 601.

<sup>17</sup>Marsh, *Health Care Cost Containment and the Duty to Treat*, 6 J. LEGAL MED. 157, 159-60 (Chicago 1985).

<sup>18</sup>*Id.* at 160.

<sup>19</sup>*Davis v. Weiskopf*, 108 Ill. App. 3d 505, 439 N.E.2d 60 (1982); *Lyons v. Grether*, 218 Va. 630, 239 S.E.2d 103 (1977); *Childs v. Weis*, 440 S.W.2d 104 (Tex. Civ. App. 1969); *Hurley v. Eddingfield*, 156 Ind. 416, 59 N.E. 1058 (1901). See also Berg & Hirsch, *The Physician's Duty To Treat*, 11 LEGAL ASPECTS OF MED. PRAC. 4 (1983); Annotation, *What Constitutes Patient-Physician Relationship for Malpractice Purposes*, 17 A.L.R. 4th 132 (1982).

choose whom he will treat.<sup>20</sup> Even the Hippocratic Oath, often cited as mandating a duty to treat, assumes a preexisting relationship between patient and physician.<sup>21</sup>

Usually the physician-patient relationship arises by contract, either expressed or implied, with most relationships created by implication.<sup>22</sup> Where the physician previously treated a patient for an illness and is considered the family physician, there may be no legal duty to treat that patient for a new illness.<sup>23</sup> In fact, a physician may, by notice or special agreement, limit the scope of his practice, thereby excluding certain diseases or medical conditions from his scope of responsibility.<sup>24</sup> Thus, a person with HIV seropositivity, ARC, or AIDS may have difficulty obtaining medical care from private physicians, even when a prior relationship exists.

Medical students, interns, residents, or physicians employed by a hospital have no choice and must treat any patient assigned to them.<sup>25</sup> Physicians who work for health maintenance organizations (HMOs)<sup>26</sup> or public health clinics also do not have the same right as

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<sup>20</sup>*Childs*, 440 S.W.2d at 107; *Agnew v. Parks*, 172 Cal. App. 2d 756, 764, 343 P.2d 118, 123 (1959); *Hiser v. Randolph*, 126 Ariz. 608, 610, 617 P.2d 774, 776 (1980). See generally Note, *Emergency Care: Physician Should Be Placed Under an Affirmative Duty to Render Essential Medical Care in Emergency Circumstances*, 7 U.C. DAVIS L. REV. 246 (1974).

<sup>21</sup>*Agnew*, 172 Cal. App. 2d at 764, 343 P.2d at 123. For example, a physician-patient relationship may be implied where a person has an appointment and the physician has examined and begun treatment. *Osbourne v. Frazer*, 58 Tenn. App. 15, 425 S.W.2d 768 (1968).

<sup>22</sup>*Berg & Hirsch*, *supra* note 19, at 4.

<sup>23</sup>*Hurley*, 156 Ind. at 417, 59 N.E. at 1058. However, in some cases of preexisting relationships, a refusal to treat by a physician may constitute abandonment. See *infra* notes 43-47 and accompanying text.

<sup>24</sup>*Childers v. Frye*, 201 N.C. 42, 158 S.E. 744, 746 (1931) (refusal to treat injured man who had been drinking). For example, a number of ob/gyn specialists have refused to deliver babies because of rising malpractice insurance rates. See Sandroff, *When the Obstetrician Says "No,"* HEALTH, Nov. 1987, at 52. See also Note, *'Claims-Made' Liability Insurance: Closing The Gaps With Retroactive Coverage*, 60 TEMPLE L.Q. 165, 174 n.56 (1987) (citing a Philadelphia newspaper article about obstetricians and gynecologists refusing to deliver babies because of high malpractice insurance rates); G.L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521, 1568 (1987) (discussing the decline in the availability of obstetrical services).

<sup>25</sup>Volberding and Abrams, *Clinical Care and Research in AIDS*, HASTINGS CENTER REP., Aug. 1985, at 17 (Special Supp.).

<sup>26</sup>The term Health Maintenance Organization is used here to refer to three general types of prepaid medical services: those that are created by independent groups; those organized by individual physicians (group practice); and HMOs established by local medical associations. All of these organizations share some common characteristics: They work on a contractual basis to provide an organized health care delivery system to a voluntarily enrolled population. The patient/member contracts

private physicians to refuse to treat a person. Physicians in these categories are contractual employees who probably contracted away all or most of their freedom to select patients.<sup>27</sup>

Recently some courts have suggested that a physician-patient relationship may be created independent of any contract. Under the legal theory of undertaking, a duty to treat may arise where a physician manifestly undertakes to treat a patient.<sup>28</sup> Such an undertaking may be implied where a physician advises patients or attempts to diagnose a condition over the telephone.<sup>29</sup> However, telephone consultations in the absence of other connections to the patient usually will not give rise to a legal duty to treat.<sup>30</sup> A physician-patient relationship may be created when a physician accepts an appointment to see a patient for a specific illness, which creates a duty to perform specific medical services.<sup>31</sup> And a relationship may also be established when a patient is referred by one physician to a second physician for treatment of a specific problem and the second physician accepts the referral.<sup>32</sup>

The courts are still a long way from imposing any general duty to treat in the absence of some close relationship between the private physician and the alleged patient. Nevertheless, when groups of phy-

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in advance with the HMO for her health care needs. Ludlam, *Health Maintenance Organizations HMOs: Do They Really Work?* 10 FORUM 405, 406 (1974).

<sup>27</sup>*Contractual Theories of Recovery in the HMO Provider-Subscriber Relationship: Prospective Litigation for Breach of Contract*, 36 BUFFALO L. REV. 119, 123 (1987) (HMO physicians are either direct employees or independent contractors; see, e.g., *Texas Fires Prison Dentist Who Refused AIDS Cases*, Washington Post, Aug. 25, 1987 (Health Section), at 5 (staff dentist in a Texas prison was dismissed for refusing to treat prisoners suspected of having AIDS)).

<sup>28</sup>Bianco, *The Physician-Patient Relationship*, 11 LEGAL ASPECTS OF MED. PRAC. 1, 2 (1983).

<sup>29</sup>*Id.* See *O'Neill v. Montefiore Hospital*, 11 A.D.2d 132, 202 N.Y.S.2d 436 (1960) (held that the jury could have concluded that the physician undertook by telephone to diagnose the condition of the patient).

<sup>30</sup>*Buckroyd v. Burten*, 237 N.W.2d 808 (Iowa 1976) (associate of the treating physician consulted by telephone regarding hospitalization of patient); *Oliver v. Brock*, 342 So.2d 1 (Ala. 1977) (physician consulted by treating physician over the telephone). This rule may apply to consultations in general when there is no sufficient connection between the physician and the patient to create a duty to treat. For example, in *Rainier v. Grossman*, 31 Cal. App. 3d 539, 107 Cal. Rptr. 469 (1973), the court held that a medical school professor who advised the patient's physician at a medical staff conference owed no duty to the patient.

<sup>31</sup>*Lyons v. Grether*, 218 Va. 630, 633-34, 239 S.E.2d 103, 105 (1977) (patient with appointment to treat vaginal infection ejected from waiting room before seeing the physician because she would not remove her seeing eye dog).

<sup>32</sup>*Davis v. Weiskopf*, 108 Ill. App. 3d 505, 512, 439 N.E.2d 60, 64-65 (1982).

sicians in an area agree not to treat persons with AIDS, they may be violating federal antitrust laws.<sup>33</sup> In general, a private physician cannot be forced under most existing laws to treat all sick persons, even those with life threatening illnesses.<sup>34</sup>

Under most good samaritan laws, there is no duty to treat.<sup>35</sup> Good samaritan laws simply limit the physician's legal liability if he voluntarily assists someone in an emergency situation. In the one state that requires physicians to treat in emergency situations, a physician is only required to treat if he is at the scene of the accident.<sup>36</sup> The operation of good samaritan laws suggests that state legislatures are reluctant to force private physicians to treat all sick people, even when a patient is able to pay for medical services. Legislatures would therefore be even more reluctant, from a business perspective, to force private physicians to treat persons who are indigent.

A few California cities have laws prohibiting discrimination against persons with AIDS. These laws cover discrimination in medical treatment, as well as other services.<sup>37</sup> These AIDS-specific antidis-

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<sup>33</sup>Antitrust laws were applied to the "learned professions" in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975). In *National Society of Professional Engineers v. U.S.*, 435 U.S. 679 (1978), the Court focused on whether the challenged practice promoted or suppressed competition. More recently, the Court applied antitrust laws to peer review of a hospital physician. *Patrick v. Burget*, No. 86-1145 (U.S. May 16, 1988) (held that state action does not protect Oregon physicians from federal antitrust liability for their activities on hospital peer-review committees). However, federal antitrust laws do not apply to acts that have an unsubstantial effect on interstate commerce. Heitler, *Antitrust, Restraint of Trade, and Unfair Business Practices: Impact on Physicians*, 3 J. LEGAL MED. 443, 448-49 (Chicago 1982). Of course the conduct still may be covered by state antitrust laws. At least one court has ruled that antitrust laws may apply when a group of doctors conspired to boycott a patient who regularly brought malpractice suits. *Williams v. St. Joseph Hospital*, 629 F.2d 448 (7th Cir. 1980).

<sup>34</sup>See 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* §14 (1981).

<sup>35</sup>See generally Note, *Good Samaritans and Liability For Medical Malpractice*, 64 COLUM L. REV. 1301 (1964). Note too that Massachusetts' medical licensing board requires physicians to render emergency treatment to anyone, anywhere. Annas, *Legal Risks and Responsibilities of Physicians in the AIDS Epidemic*, HASTINGS CENTER REP., Apr.-May 1988, at 26, 27 (Special Supp.).

<sup>36</sup>VT. STAT. ANN. tit. 12, § 519 (1972). Vermont alone prescribes a statutory penalty for consciously failing to aid. *Id.* at § 519(c). See Note, *Duty to Aid the Endangered Act: The Impact and Potential of the Vermont Approach*, 7 VT. L. REV. 143 (1982).

<sup>37</sup>The Los Angeles ordinance covers discrimination in medical and dental services as well as businesses and public accommodations. Los Angeles, Cal., Ordinance 160289 (Aug. 16, 1985), 3 EMPL. PRAC. GUIDE (CCH) ¶ 20,950A. The San Francisco ordinance prohibits discrimination on the basis of AIDS and AIDS related conditions and includes business establishments and public accommodations. San Francisco, Cal., Ordinance 49985 (Dec. 20, 1985) 3 EMPL. PRAC. GUIDE (CCH) ¶¶ 20,950B, 20,9595.05.

crimination statutes cover persons with HIV seropositivity, ARC, and AIDS, as well as persons merely suspected of having AIDS.<sup>38</sup> These provisions are exceptional but seem to apply only to persons with HIV seropositivity, ARC, or AIDS who have the ability to pay for medical services. There appears to be nothing in these laws to prohibit a private physician from refusing to treat a person with AIDS if that person is unable to pay for the medical services rendered. To date there are no recorded decisions challenging these provisions.

Many states prohibit discrimination based on physical disability.<sup>39</sup> Courts and administrative agencies interpret some of these laws to include persons with HIV seropositivity, AIDS, and ARC within the definition of physically handicapped.<sup>40</sup> However, in all but a few states, these laws do not cover medical services. To be covered under most state laws, physicians' offices would have to be considered public accommodations.<sup>41</sup>

<sup>38</sup>Section 3801 of the San Francisco Ordinance states: "It is the policy of the City and County of San Francisco to eliminate discrimination based on the fact that a person has AIDS or any medical signs or symptoms related thereto." 3 EMPL. PRAC. GUIDE (CCH) ¶ 20,950B.01. Article 5.8 of the Los Angeles Ordinance is titled: Prohibition Against Discrimination Based On A Person Suffering From The Medical Condition AIDS, Or Any Medical Signs or Symptoms Related Thereto, Or Any Perception That A Person Is Suffering From The Medical Condition AIDS Whether Real Or Imaginary. 3 EMPL. PRAC. GUIDE (CCH) ¶ 20,950A.001.

<sup>39</sup>Most states have antidiscrimination laws which generally prohibit discrimination in employment, although many cover discrimination in other areas as well. See Leonard, *Employment Discrimination Against Persons with AIDS*, 10 U. DAYTON L. REV. 681, 690 (1985).

<sup>40</sup>Agencies in Texas, New York, Massachusetts, New Jersey, California and the District of Columbia have announced that AIDS-based discrimination violates laws prohibiting discrimination based on disability. 1985 LESBIAN/GAY LAW NOTES 53 (Dec.). The statutory language in the laws in Alaska, Maine, Montana, Maryland, Nebraska and New Jersey seem likely to encompass AIDS-based discrimination. Leonard, *supra* note 39, at 692. See also *Shuttleworth v. Broward Co. Office of Budget and Management*, 54 U.S.L.W. 2330 (1985) *decided on other grounds*, 639 F. Supp. 654 (D.C. Fla. 1986); *Raytheon Company v. FEHC*, No. 167995 (Cal. Super. Ct. 1988); *Cronan v. New England Telephone Company*, 41 FAIR EMPL. PRAC. CASES 1273 (Mass. Sup. Ct. 1986) *aff'd on other grounds*, 41 FAIR EMPL. PRAC. CASES 1268 (D.C. Mass. 1986); Parry, *AIDS As a Handicapping Condition* (pt. 2), 10 MENTAL PHYSICAL DISABILITY L. REP. 2, 3-4 (1986).

<sup>41</sup>Many of the antidiscrimination statutes prohibit discrimination against the handicapped and other classifications in public accommodations. Generally, the offices of private physicians and dentists are not considered public accommodations. *Rice v. Rinaldo*, 119 N.E.2d 657 (Ohio Ct. App. 1951). *But cf.* *Lyons v. Grether*, 218 Va. 630, 634, 259 S.E.2d 103, 106 (1977) (held that defendant's office was within the intentment of the state's White Cane Act defining the rights of the disabled to public accommodations, but did not address whether the Act covered "all physicians' offices under all circumstances."). Note too that the refusal to provide professional services due



Since the nature of the relationship between physician and patient is considered contractual and voluntary, it is unlikely that state legislatures or courts would characterize physicians' offices as places of public accommodation as a means of forcing physicians to treat all sick persons who can pay. Any state legislation mandating that physicians treat financially able persons with AIDS must address why the law should apply to AIDS but not other serious and deadly diseases. Legislation which forces private professionals to provide services for those who the professionals prefer not to treat is fraught with constitutional problems.<sup>42</sup>

#### *Terminating the Relationship*

A private physician usually agrees to treat a patient for a specific illness. But as with any consensual relationship, either the physician

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to race has been viewed in some states as professional misconduct. *See, e.g.*, N.Y. EDUC. LAW § 6509 (McKinney 1985). Arguably this type of provision is not analogous to the AIDS discrimination cases since a refusal to provide services based solely on race is not discrimination relating to type of illness. Rather the discrimination is based on something totally unrelated to the practice of medicine, i.e. the race of the patient. Perhaps some similarity might be found between the professional misconduct statute and a physician who refuses to treat homosexual or bisexual males, but if the physician also refuses to treat any person with AIDS, there is probably little that can be done in the absence of a statute creating some obligation to treat.

<sup>42</sup>Physicians fear that excessive government involvement in health care will result in loss of autonomy. While autonomy is a component of the right to privacy, case law suggests that the autonomy protected applies to highly personal matters like freedom of choice in marital, sexual, and reproductive matters. *See Zablocki v. Redhail*, 434 U.S. 374 (1978); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Roe v. Wade*, 410 U.S. 113 (1973); *but cf.*, *Bowers v. Hardwick*, 106 S. Ct. 2841 (1986) (held that the Federal Constitution does not confer a fundamental right upon homosexuals to engage in sodomy). It is doubtful that physicians could successfully assert a right to privacy to challenge legislation which mandated a duty to treat. Even a due process argument that such legislation interfered with the physician's liberty of contract might not be successful since government merely needs to assert some legitimate governmental interest to support the restriction. *Schweiker v. Wilson*, 450 U.S. 221 (1981); *U.S. R.R. Retirement Board v. Fritz*, 449 U.S. 166 (1980). Here the legitimate governmental interest is protection of the public's health. The thirteenth amendment prohibition of involuntary servitude may be asserted, but the Court cases recognize that the prohibition does not apply to those duties citizens owe to the state. *Butler v. Perry*, 240 U.S. 328 (1916) (public works jobs); *Arver v. U.S.*, 245 U.S. 366 (1918) (military draft). The Court also ruled that interfering with business activities, like labor disputes, does not violate the thirteenth amendment. *International Union v. Wisconsin Employment Relations Board*, 336 U.S. 245 (1949). Finally, physicians may argue that mandatory treatment laws violate the guarantee of equal protection of the laws. However, such claims would only have to satisfy a rational basis standard of review since they relate to economic matters. *U.S. v. Carolene Products. Co.*, 304 U.S. 144 (1938).

or the patient is free to end the relationship unilaterally or by mutual consent before treatment is completed.<sup>43</sup> Nevertheless public policy considerations place certain limits on the physician's right to unilaterally terminate the relationship. A physician probably cannot leave a critically ill patient unless the patient either is out of danger or is entrusted to the care of another competent physician. To leave a critically ill patient without making provisions for his care or without his consent would constitute abandonment.<sup>44</sup> Under this theory the physician could be legally liable for any damage resulting from the abandonment.

The law seems well settled that a physician can terminate the relationship for any reason, provided the patient is given reasonable notice.<sup>45</sup> Even in those cases where the physician has neither provided adequate notice nor provided for the transfer of care for a critically ill patient, the physician would only be liable where any injury suffered by the patient was directly related to the abandonment by the physician.<sup>46</sup> Nevertheless, at least one court ruled that failure to pay a physician's fees is not grounds for terminating the patient-physician relationship.<sup>47</sup> Thus, a physician who undertakes the treatment of a person with AIDS may not be legally able to terminate the relationship solely because of the patient's inability to pay for medical services.

#### *The Right to Health Care*

In 1948, the United Nations General Assembly issued the Universal Declaration of Human Rights.<sup>48</sup> Article 25 of that document recognized a right to medical care.<sup>49</sup> This document serves as a model or ideal goal and in no way reflects current "rights" in most countries, including the United States.<sup>50</sup> Twenty-one years later the House of Delegates of the American Medical Association issued a statement

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<sup>43</sup>Norton v. Hamilton, 92 Ga. App. 727, 89 S.E.2d 809 (1955). See generally, Annotation, *Liability of Physician Who Abandons Case*, 57 A.L.R. 2d 432 (1958).

<sup>44</sup>Norton, 92 Ga. App. at 731, 89 S.E.2d at 812.

<sup>45</sup>Groce v. Myers, 224 N.C. 165, 29 S.E.2d 553. (1944); Capps v. Valk, 189 Kan. 287, 369 P.2d 238 (1962); McManus v. Donlin, 23 Wis. 2d 289, 127 N.W.2d 22 (1964).

<sup>46</sup>Baulsir v. Sugar, 266 Md. 390, 293 A.2d 253 (1972).

<sup>47</sup>Ricks v. Budge, 91 Utah 307, 64 P.2d 208 (1937).

<sup>48</sup>*Universal Declaration of Human Rights*, reprinted in HUMAN RIGHTS: A COMPILATION OF INTERNATIONAL INSTRUMENTS OF THE UNITED NATIONS 1 (1973).

<sup>49</sup>*Id.* at 2-3.

<sup>50</sup>Beauchamp, *The Status of the Right to Health Care*, 12 Soc. RESP.: BUS., L., JOURNALISM, MED. 47, 48 (1986). "Its [the Declaration] preamble suggests that the document is to be read as a blueprint for future actions and declarations of rights rather than as an assertion of rights that persons in their native countries now possess." *Id.*

declaring that "it is a basic right of every citizen to have available to him adequate health care."<sup>51</sup> However, the AMA views this right as a societal obligation and not an obligation of individual physicians, or the AMA.<sup>52</sup>

The Supreme Court has ruled that there is no constitutional right to medical care.<sup>53</sup> Recently, the United States Court of Appeals for the Eleventh Circuit discussed this point in *Wideman v. Shallowford Community Hospital*.<sup>54</sup> The court noted that if a right exists at all, it must derive from the due process clause of the fourteenth amendment, which prohibits state deprivation of fundamental rights without due process of law.<sup>55</sup> However, the court asserted that while the Constitution places restraints on what the government can do, it does not impose any specific obligations.<sup>56</sup> The only instance where government has any duty to provide medical care is where a special custodial or other relationship exists between the individual and government.<sup>57</sup>

<sup>51</sup>*Id.* quoting American Medical Association, House of Delegates (Chicago 1969).

<sup>52</sup>Zuger & Miles, *supra* note 10, at 1926.

<sup>53</sup>Kinney, *Making Hard Choices Under Medicare Prospective Payment System: One Administrative Model for Allocating Medical Resources Under a Government Health Insurance Program*, 19 IND. L. REV. 1151, 1157 (1986). "[I]t is clear that one does not have an enforceable, legal 'right' to health care. The Supreme Court has ruled that the federal Constitution does not recognize any such 'right' to medical care. The federal Constitution does protect the entitlement interest of beneficiaries in the federal and state Medicare and Medicaid programs, but only to the extent outlined in the enabling legislation for these programs." (footnotes omitted) *Id.* This conclusion is also supported by the holding and language in two United States Supreme Court decisions, *Maier v. Roe*, 432 U.S. 464, 470-71 (1977) (upholding a state regulation prohibiting funding of therapeutic abortions for indigent women): "In a sense, every denial of welfare to an indigent creates a wealth classification as compared to nonindigents who are able to pay for the desired goods or services. But this Court has never held that financial need alone identifies a suspect class for purposes of equal protection analysis." *Id.* at 471; and *Harris v. McRae*, 448 U.S. 297, 308-9 (1980) (upholding a government provision denying the use of public funds for necessary abortions): "[A]bsent an indication of contrary legislative intent by a subsequent Congress, Title XIX does not obligate a participating State to pay for those medical services for which federal reimbursement is unavailable." (footnote omitted) *Id.* at 309. *But see* *Memorial Hospital v. Maricopa County*, 415 U.S. 250 (1974) where Justice Thurgood Marshall writing for the majority referred to medical care as a "basic necessity of life." *Id.*, at 259; *Mariner, Access to Health Care and Equal Protection of the Law: The Need for a New Heightened Scrutiny*, 12 AM. J. L. MED. 345 (1986) (arguing that unequal claims in health care should be subject to heightened scrutiny).

<sup>54</sup>826 F.2d 1030 (11th Cir. 1987).

<sup>55</sup>*Id.* at 1032-33.

<sup>56</sup>*Id.* at 1033 (citing *Bradberry v. Pinellas County*, 789 F.2d 1513, 1517 (11th Cir. 1986)).

<sup>57</sup>*Id.* at 1034-35. For example, the court has held that the government has a duty to provide medical care to a prisoner on the grounds that denial of such care is cruel and unusual punishment which is prohibited by the eighth amendment. *Estelle v.*

The courts interpret this to mean that when the government acts affirmatively to limit an individual's freedom or impair his ability to act on his own, it is constitutionally required to provide medical care.<sup>58</sup>

While there is no constitutional right to medical care, there is no legal obstacle to prevent the creation of the right legislatively. In 1970, Senator Edward Kennedy introduced the Health Security Act.<sup>59</sup> Although the measure was never enacted into law, it is the closest Congress has come to recognizing health care as a right. The federal government provides some limited health insurance benefits under Medicare and Medicaid, but neither program can be considered comparable to a right to medical care.<sup>60</sup>

The federal government has tried to expand access to medical care through measures like the Hill-Burton construction program,<sup>61</sup> and federal income tax exemptions for charitable institutions.<sup>62</sup> Nevertheless, neither the federal legislature nor the courts have been willing to formally recognize any right to medical care.

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Gamble, 429 U.S. 97 (1976). The Court has also held that an involuntarily committed mental patient retains certain constitutional substantive liberty interests under the fourteenth amendment including rights "to adequate food, shelter, clothing, and medical care." *Youngberg v. Romeo*, 457 U.S. 307, 315 (1982). A duty to provide care and treatment has further been imposed for custodial relationships less extreme than permanent incarceration or institutionalization. *See, e.g., Hamm v. DeKalb County*, 774 F.2d 1567 (11th Cir. 1985), *cert. denied*, 106 S. Ct. 1492 (1986) (pretrial detainment) and *City of Revere v. Massachusetts General Hosp.*, 463 U.S. 239 (1983) (persons injured while being apprehended by police).

<sup>58</sup>The Court stated that a duty will arise if the government "places [the] person in a worse situation than he would have been had the government not acted at all. Such a situation could arise by virtue of the state affirmatively placing an individual in a position of danger, effectively stripping a person of her ability to defend herself, or cutting off potential sources of private aid." *Wideman*, 826 F.2d at 1035.

<sup>59</sup>Kennedy, *Introduction of the Health Security Act*, 116 CONG. REC. 30142 (1970).

<sup>60</sup>Medicare covers some of the health costs for older persons. 42 U.S.C. §§ 1305, 1395-1396(d) (1982) (recipients under Health Insurance for the Aged and Disabled). Medicaid covers some health costs for indigent persons. 42 U.S.C. §§ 1381-1383, 1396-1396(p) (1982) (recipients under Aid to Families with Dependent Children and Supplemental Security Income Programs).

<sup>61</sup>42 U.S.C. § 291 (1982). Under this program hospitals receiving federal monies to construct facilities must provide "a reasonable volume of services to persons unable to pay. . . ." 42 U.S.C. § 291c(e)(2) (1982). But the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research noted that "the Hill-Burton program illustrate[s] the reluctance of government to place significant constraints on providers' freedom of action, even where large sums of public money are involved. . . . Although the Hill-Burton Act was designed to get hospital beds to places with the greatest need, it did not provide the means to force the issue." PRESIDENT'S COMM'N, *supra* note 15, at 128.

<sup>62</sup>26 U.S.C. § 501(c)(3) (1982).

At the state level one state trial court ruled that a right to certain health care is guaranteed by that state's constitution.<sup>63</sup> Three states—Connecticut, Hawaii, and Minnesota—enacted comprehensive health insurance statutes in the 1970s.<sup>64</sup> Recently, Massachusetts became the first state to mandate universal health insurance for all state residents.<sup>65</sup> Nevertheless, this legislation does not create any duty of physicians to treat all persons who are sick.

### Ethical Duty to Treat

There is a difference between law and ethics. Law sets forth the minimal standards of performance required by society whereas ethics set forth the ideal standards of performance, "the best performance the individual can, by virtue of training and natural endowment, deliver."<sup>66</sup> Nevertheless, law and medical ethics reinforce each other in that the law protects patients from unethical physicians while ethics insure that physicians will carry out those obligations not mandated by law.<sup>67</sup>

Medical practice laws date back to the Code of Hammurabi (1792-1750 B.C.),<sup>68</sup> but the Hippocratic Oath, developed around 400 B.C., represents the first attempt to develop a code of medical ethics.<sup>69</sup> In the early nineteenth century, Thomas Percival, a British physician, modernized Greek medical ethics<sup>70</sup> and his version was adopted by the Medical Society of Boston in 1808.<sup>71</sup> The American Medical As-

<sup>63</sup>Kinney, *supra* note 53, at 1157, citing Callahan v. Carey, N.Y.L.J., Dec. 11, 1979, at 10, col. 5 (N.Y. Co. Sup. Ct. 1979), and Malone, *Homelessness in Modern Urban Setting*, 10 FORDHAM URB. L. J. 749, 769 (1982). Article I of the New Jersey constitution was used to support a right to a publicly funded abortion. Right to Choose v. Byrne, 165 N.J. Super. 443, 398 A.2d 587 (N.J. Super. Ct. Ch. Div. 1979); *new regulations reviewed in* 169 N.J. Super. 543, 405 A.2d 427 (N.J. Super. Ct. Ch. Div. 1979), *modified on other grounds*, 91 N.J. 287, 450 A.2d 925 (1982). These cases suggest that state constitutions could be used to create a right to health care. See generally *The Emergence of State Constitutional Law*, 63 TEX. L. REV. 959-1338 (1986).

<sup>64</sup>Connecticut Health Care Act of 1975, CONN. GEN. STAT. ANN. §§ 38-371 to -381 (West 1987 & Supp. 1988); Hawaii Prepaid Health Care Act, HAW. REV. STAT. § 393-1 to -51 (1985); Minnesota Comprehensive Health Insurance Act of 1976, *as amended*, MINN. STAT. ANN. 62E.01-612E.18 (West 1986 & Supp. 1988).

<sup>65</sup>Radding and Carlsen, *Mass. Lawmakers Approve Universal Health Coverage*, HEALTH WEEK, April 25, 1988, at 25.

<sup>66</sup>C. CHAPMAN, PHYSICIANS, LAW AND ETHICS 2 (1984).

<sup>67</sup>Pellegrino, *Hospitals as Moral Agents*, in MEDICAL ETHICS: A CLINICAL TEXTBOOK AND REFERENCE FOR THE HEALTH CARE PROFESSIONS 195 (N. Abrams & M.D. Buckner eds. 1983). [hereinafter Abrams & Buckner].

<sup>68</sup>C. CHAPMAN, *supra* note 66, at 4.

<sup>69</sup>*Id.* at 20.

<sup>70</sup>See *id.* at 77-86.

<sup>71</sup>*Id.* at 86.

sociation (AMA) formed and adopted a code of ethics in 1847.<sup>72</sup> This code, the *Principles of Medical Ethics*, was revised in 1903, 1912, 1957, and 1980.<sup>73</sup> Nevertheless, the AMA represents only 50% of the nation's physicians.<sup>74</sup> As one commentator wrote: "We live in a democratic society in which there is no uniformity of opinion on most medio-moral issues and no recognized authority to settle differences in ethical beliefs."<sup>75</sup>

A code of ethics does not necessarily constitute a clear mandate of public policy<sup>76</sup> and the breach of medical ethics is not enforceable in a court of law.<sup>77</sup> The primary focus of traditional medical ethics is the duty the physician owes to the medical profession.<sup>78</sup> The duty owed to the patient is largely determined by the physician.<sup>79</sup> Breach of a voluntary association's ethical standards carries no formal sanctions other than loss of membership in the association.<sup>80</sup> But state medical boards control the licensing of physicians and breach of their standards can result in loss or revocation of one's license.<sup>81</sup> Further, courts often use ethical standards as proof of the requisite duty of care since a physician's legal duty is often determined by the prevailing medical custom.<sup>82</sup>

Until the AMA amended the canons of ethics in November, 1987, the only instance under the modern code in which a physician had an ethical duty to treat was an emergency. Section Six of the 1980 *Principles of Medical Ethics* states: "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate and the environment in which to provide medical services."<sup>83</sup> Although the first AMA code in 1847 pro-

<sup>72</sup>*Id.* at 111.

<sup>73</sup>*Id.* at 112-24.

<sup>74</sup>Arras, *The Fragile Web of Responsibility: AIDS and the Duty to Treat*, HASTINGS CENTER REP., Apr.-May 1988, at 10, 20 n.38 (Special Supp.).

<sup>75</sup>Abrams and Buckner, *supra* note 67, at 197.

<sup>76</sup>*Warthen v. Toms River Comm. Memorial Hosp.*, 199 N.J. Super. 18, 488 A.2d 229, *cert. denied*, 101 N.J. 255, 501 A.2d 926 (1985) (held that the nurses' code of ethics did not represent a clear mandate of public policy so as to override an employer's policy to the contrary). For further discussion of this principle, see Davis, *Defining the Employment Rights of Medical Personnel Within the Parameters of Personal Conscience*, 3 DETROIT COLL. L. REV. 847 (1986).

<sup>77</sup>*Quarles v. Sutherland*, 215 Tenn. 651, 657, 389 S.W.2d 249, 251 (1965) *cited with approval* in *Bryson v. Tillinghast*, 749 P.2d 110, 114 (Okla. 1988).

<sup>78</sup>C. CHAPMAN, *supra* note 66, at 88-89.

<sup>79</sup>*Id.*

<sup>80</sup>Annas, *supra* note 35, at 29.

<sup>81</sup>*Id.* at 30.

<sup>82</sup>*Id.* at 29.

<sup>83</sup>PRINCIPLES OF MEDICAL ETHICS §VI (American Medical Association 1980), *quoted*

vided that a physician's ethical duty during epidemics was to "continue his labors without regard to the risk to his own health,"<sup>84</sup> this provision is not part of the present code.

The AMA's first statement on AIDS did not impose any obligation to treat HIV-infected people. While recognizing the profession's long tradition of treating patients with contagious diseases, the AMA asserted that where the physician is "emotionally" unable to care for HIV infected patients other arrangements should be made.<sup>85</sup> The 1987 amendment does not explicitly revoke this earlier statement and, as one commentator noted, it actually "subsumes . . . the prior exemption for 'emotional inability'."<sup>86</sup> In general, though, the amendment implies an obligation to treat HIV-infectious patients.<sup>87</sup>

The prestige of the medical profession is due in part to the public's perception that physicians are willing to endanger themselves to fulfill their obligations to persons who are sick.<sup>88</sup> However, at least one commentator suggests that this notion is no longer part of medical ethics.<sup>89</sup> There have been radical changes in medical ethics over the last twenty years.<sup>90</sup> Some of these changes, especially the entry of

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in *Unethical to Refuse to Treat HIV-infected Patient AMA says*, *Amer. Med. News*, Nov. 20, 1987, at 1, col. 1.

<sup>84</sup>AIDS REPORT, reprinted in Freedman, *supra* note 6, at 24.

<sup>85</sup>The 1986 statement read:

Physicians and other health professionals have a long tradition of tending to patients afflicted with infectious disease with compassion and courage. However, not everyone is emotionally able to care for patients with AIDS. If the health professional is unable to care for a patient with AIDS, that individual should ask to be removed from the case. Alternative arrangements for the care of the patient must be made.

A.M.A. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, STATEMENT ON AIDS (Dec. 1986), reprinted in Freedman, *supra* note 6, at 22.

<sup>86</sup>Freedman, *supra* note 6, at 24. The amendment refers to the physician's obligation to treat a condition within his "realm of competence" and states that he should "respond to the best of [his] abilities in cases of emergency. . . ." It also states that "[a] physician who is not able to provide the services required by persons with AIDS should make an appropriate referral to those physicians or facilities that are equipped to provide such services." *Id.*, quoting *AIDS Report*, *supra*, note 6. The author notes that emotional incapacity may be one source of inability. *Id.*

<sup>87</sup>*Id.*

<sup>88</sup>Jonsen, *Ethics and AIDS*, 70 BULL. AMER. C. SURGEONS, June 1985 at 16, 17.

<sup>89</sup>*Id.* Jonsen suggests that the idea of physicians' willingness to endanger their lives to help those who are sick is being revived in light of the AIDS epidemic. *Id.*

<sup>90</sup>Two radical changes are: (1) the shift to more patient autonomy in health care decisionmaking; and (2) the tremendous expansion of medical technological capability. Pellegrino & Thomasma, *The Conflict Between Autonomy and Beneficence in Medical Ethics: Proposal for a Resolution*, 3 J. CONTEMP. L. POLICY 23 (1987).

economic considerations as a primary force in health care decisions, create conflicts with the traditional canons of ethics.<sup>91</sup>

Several models have been used to describe the ethical obligation physicians owe patients.<sup>92</sup> The prevailing view of this obligation is best represented by the contractual model. Under this model physician and patient are bound by a voluntary agreement governing the patient's care.<sup>93</sup> Absent this agreement there is no duty to treat.<sup>94</sup> While this model has come under attack,<sup>95</sup> even those who accept it consider the physician-patient relationship as a social or fiduciary contract.<sup>96</sup>

Abigail Zuger and Steven H. Miles, writing for the Center for Clinical Medical Ethics at The University of Chicago Hospitals and Clinics, assert that "an ethic stressing traditional professional duties may not be ideal for defining the optimal relation of the medical professions to patients with acquired immunodeficiency syndrome. A new professional ethic to guide physicians in the [AIDS] pandemic is needed."<sup>97</sup> They point out that neither the rights nor contract ethical models of medical care require physicians to treat persons with HIV seropositivity, ARC, and AIDS.<sup>98</sup> They argue that the virtuous physician or a virtue-based ethical model of medical care is the only model that mandates a clear ethical duty to treat.<sup>99</sup>

The notion of the virtuous physician was popular in the United States and Britain in the eighteenth and nineteenth centuries.<sup>100</sup> Sam-

<sup>91</sup>*Id.* See also Emanuel, *Do Physicians Have an Obligation to Treat Patients With AIDS?*, 318 *NEW ENG. J. MED.* 1686 (1988).

<sup>92</sup>Some of the ethical models are: (1) the priestly model in which the patient is obligated to do whatever the physician recommends; (2) the engineering model in which the physician is viewed as a technical expert; and (3) the collegial model in which physician and patient are viewed as equals in all respects. Brody, *The Physician-Patient Contract: Legal and Ethical Aspects*, *J. LEGAL MED.*, July-Aug. 1976, at 25, 26. There is also the rights model in which "a patient's right to health care creates a correlative duty on the part of physicians, institutions, or society to provide health care." Zuger & Miles, *supra* note 10, at 1927.

<sup>93</sup>Zuger & Miles, *supra* note 10, at 1927.

<sup>94</sup>*Id.*

<sup>95</sup>See, e.g., Masters, *Is Contract An Adequate Basis For Medical Ethics*, *HASTINGS CENTER REP.*, Dec. 1975, at 24; May, *Code, Covenant, Contract, or Philanthropy*, *HASTINGS CENTER REP.*, Dec. 1975, at 29.

<sup>96</sup>Brody, *supra* note 92, at 26-27. See also Veatch, *Models For Ethical Medicine In A Revolutionary Age*, *HASTINGS CENTER REP.*, incomplete cite 1972, at 5.

<sup>97</sup>Zuger & Miles, *supra* note 10, at 1924.

<sup>98</sup>*Id.* The rights model imposes an obligation on the profession, not on individual physicians. Thus, except in emergencies, an individual physician has no ethical duty to treat under this model. *Id.* at 1927.

<sup>99</sup>*Id.* at 1927-28.

<sup>100</sup>McCullough, *Justice and Health Care: Historical Perspectives and Precedents*, in *JUSTICE AND HEALTH CARE* 51, 60 (E.E. Shelp ed. 1981). James Gregory in Scotland and



uel Bard, one of the founders of Kings College medical school in New York City, contended that the virtuous physician has an obligation to treat sick indigent persons without charge.<sup>101</sup> Bard said that a refusal to treat them without remuneration would be contrary to benevolence.<sup>102</sup>

Bard's virtuous physician owed a duty not only to his patients, but to the public at large.<sup>103</sup> He owed these duties not because of any basic right of the individual to health care or because of any duty owed government to protect the public health. Rather the virtuous physician should treat sick indigent persons without charge because this duty is freely taken on and defines him as a physician.<sup>104</sup> Since some would contend that many of today's practitioners no longer believe this and are more concerned about economic considerations, Zuger and Miles' ethical model seems unrealistic.

The ideals underlying the concept of the medical police seems more consistent with the historic position of physicians during the plagues. The medical police concept was developed by the Germans in the eighteenth century.<sup>105</sup> According to this concept, government needs to regulate medical education and practice to prevent quacks and charlatans and to insure a large, sturdy, healthy population.<sup>106</sup> Physicians are considered medical police because their primary obligation is to insure that society remains healthy—that is, they are to police the public's health. This obligation is owed to government and not to the patient.<sup>107</sup>

In reviewing the history of the medical profession's response to contagious diseases, Daniel Fox, a professor of humanities in medicine, has concluded that "there has been remarkable continuity in how the profession has responded to the threat of contagion."<sup>108</sup> Fox notes that plague doctors usually negotiated with civic leaders to treat the sick, often in exchange for money and prestige.<sup>109</sup> Thus, the obligation

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Samuel Bard in the United States were the two leading proponents of this theory. *Id.* at 61.

<sup>101</sup>*Id.* at 63-64.

<sup>102</sup>*Id.* at 64.

<sup>103</sup>*Id.*

<sup>104</sup>*Id.* at 61-64.

<sup>105</sup>*Id.* at 58.

<sup>106</sup>*Id.*, citing G. ROSEN, FROM MEDICAL POLICE TO SOCIAL MEDICINE: ESSAYS ON THE HISTORY OF HEALTH CARE (1974). Rosen credits this concept to Wolfgang T. Raw who first coined the term medical police. *Id.*

<sup>107</sup>*Id.* at 59.

<sup>108</sup>FOX, *The Politics of Physicians' Responsibility in Epidemics: A Note on History*, HASTINGS CENTER REP., Apr.-May 1988, at 5 (Special Supp.).

<sup>109</sup>*Id.* at 9.

to treat in times of epidemics was still based in contract, except that the contract was between the physician and society and not the patient.

Another commentator has asserted that the ethical obligation to treat arises either by virtue of the social contract or reciprocity resulting from the physician's monopolistic privilege to practice medicine.<sup>110</sup> Even though this obligation is imposed on the medical profession collectively, it can and should be imposed on the individual physician.<sup>111</sup>

An editorial in the *Journal of the American Medical Association* argues that the virtue-based ethical model of health care is not sufficient to address the problem of refusals to treat patients with AIDS.<sup>112</sup> The author asserted that "an obligation of effacement of self-interest" is imposed by three things which distinguish medicine from other businesses: the nature of the illness itself; the fact that a physician's knowledge about medical matters is not proprietary; and the physician's covenant that is publicly acknowledged upon graduation.<sup>113</sup> Most medical students and many physicians disagree with the author's premise that altruism is obligatory.<sup>114</sup> Even if they agreed, existence of an ethical obligation to treat does not necessarily translate into access to health care since breaches of ethics are rarely punished.<sup>115</sup> Thus, medical ethics provide little help for people with AIDS who are seeking adequate health care unless courts are willing to convert these ethical principles into law. Nevertheless, the ethical issues raised by AIDS concerning the duty to treat are important not only for those HIV-infected persons but for future generations faced with different, but no less alarming, epidemics.<sup>116</sup>

### Right to Health Care Revisited

In 1983, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research asserted that "[a] sufficient supply of health personnel and facilities does not ensure that health care resources are available to all members of a

<sup>110</sup>Arras, *supra* note 74, at 11.

<sup>111</sup>*Id.* at 11-12.

<sup>112</sup>Pellegrino, *supra* note 1.

<sup>113</sup>*Id.*

<sup>114</sup>Arras, *supra* note 74, at 18-19.

<sup>115</sup>Two medical licensing boards have adopted two different approaches to physicians' refusals to treat HIV-infected persons. New Jersey prohibits such conduct and Arizona allows it. Arras, *supra* note 35, at 30.

<sup>116</sup>One author has written: "If and when such future epidemics strike, and such diseases turn out not to be respectors of race and social class, what kind of medical profession will the public want then?" Arras, *supra* note 74, at 19.

community."<sup>117</sup> The Commission found that there was such a high demand for physicians in the United States that physicians could be selective in accepting patients.<sup>118</sup> Experience shows that we cannot always rely on individual physicians to make fair and just choices. For example, the Commission pointed out that racial and ethnic minorities in this country still have limited access to health care because of discriminatory practices.<sup>119</sup> The Commission also found that many physicians feel no responsibility to treat indigent persons.<sup>120</sup> Since many AIDS patients are among the indigent as well as various racial and ethnic minorities, and generally have little or no health insurance, their access to adequate health care is a concern.<sup>121</sup>

Some physicians assert that medical care is neither a right nor a privilege, but simply a service provided by physicians to people who wish to purchase it.<sup>122</sup> They say that nothing in the Hippocratic Oath suggests that physicians should treat indigent persons without charge.<sup>123</sup>

The key issue here is whether a right to health care should be legislated to insure that the sick have access to adequate health care, regardless of their ability to pay. Members of the medical community contend that a right to health care would seriously threaten physician autonomy.<sup>124</sup> Proponents of a legislative right to health care argue that creation of a general right might lower the overall health of the population.<sup>125</sup> Among the proponents, Robert M. Veatch, a noted medical

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<sup>117</sup>PRESIDENT'S COMM'N, *supra* note 15, at 85.

<sup>118</sup>*Id.* at 88.

<sup>119</sup>*Id.* at 89, citing INSTITUTE OF MEDICINE, HEALTH CARE IN A CONTEXT OF CIVIL RIGHTS 35 (1981).

<sup>120</sup>*Id.* For more recent confirmation, see Lundberg & Bodine, *Fifty Hours for the Poor*, 258 JAMA 3157 (1987) and Hilfiker, "Unconscious on a corner, . . ." 258 JAMA 3155 (1987). These authors suggest that physicians should donate a portion of their practice to the poor. In reply, one writer objected: "Let me tell you, buddy, I don't do anything in this business without financial remuneration. . . . They're (the poor) drunks, addicts, illiterates, beggars [sic], and thieves. They're unemployed simply because they're unemployable. They procreate prolifically and illegitimately, saddling future generations of responsible citizens with more of their kind." Letters, 259 JAMA 2236-37 (1988).

<sup>121</sup>See *supra* notes 14-15 and accompanying text.

<sup>122</sup>Sade, *Medical Care as a Right: A Refutation*, 285 NEW ENG. J. MED. 1288, 1289 (1971).

<sup>123</sup>Letter from E. Reinhardt to Dr. Arnold S. Relman, Institute of Medicine, Nat'l Academy of Science, FOR-PROFIT ENTERPRISE IN HEALTH CARE 210, 211, 213 (1986) reprinted in HEALTH LAW, CASES AND MATERIALS (FUTROW, JOHNSON, JOST, SCHWARTZ eds. 1987).

<sup>124</sup>See generally Pellegrino & Thomasma, *supra* note 90.

<sup>125</sup>See, e.g., Veatch, *Ethical Aspects of the Right to Health Care* in MEDICAL ETHICS AND THE LAW: IMPLICATIONS FOR PUBLIC POLICY 53, 55 (Hiller ed. 1981).

ethicist, contends that a legislated right to health cannot be delivered, but that a right to access to certain kinds of health care should be legislated.<sup>126</sup> Justice, he argues, must be a conscious goal of our health policy planning and a legislated right to health care short of a blank check for "every imaginable kind of desired medical intervention at government expense" is only fair.<sup>127</sup>

A recent article in the *New England Journal of Medicine* noted that the number of uninsured Americans increased from 26 to 35 million between 1977 and 1984.<sup>128</sup> Most of the uninsured are poor and approximately 23 million are children and their young parents,<sup>129</sup> the same group that is at a high risk for heterosexual transmission of HIV. The article noted that lack of insurance means lack of access to health care and results in increased financial burdens for society as a whole.<sup>130</sup>

A few states are trying to increase access to health care by pressuring private nonprofit hospitals to carry a larger percentage of charity cases. Although publicly supported hospitals traditionally had no duty to accept and treat everyone,<sup>131</sup> today few public hospitals would risk refusing to treat persons infected with HIV. However, private hospitals, as a general rule, are under no legal obligation to admit and treat all who need medical care.<sup>132</sup> Even the receipt of federal funds does not substantially alter the legal obligation of private hospitals in selecting patients.<sup>133</sup> The only possible exception to this rule is where the private hospital maintains an emergency room. In this case the hospital must provide emergency treatment<sup>134</sup> but is under no obligation to treat the patient further and may refuse comprehensive treatment without liability.<sup>135</sup>

Recently, private nonprofit hospitals have come under attack for not providing sufficient charity care to warrant a tax exemption. The

<sup>126</sup>*Id.* at 54.

<sup>127</sup>*Id.* at 71-72.

<sup>128</sup>Freedman, Klepper, Duncan & Bell, *Coverage of the Uninsured and Underinsured: A Proposal for School Enrollment Based Family Health Insurance*, 318 *NEW ENG. J. MED.* 843, 844 (1988).

<sup>129</sup>*Id.* at 845.

<sup>130</sup>*Id.* at 844.

<sup>131</sup>*Williams v. Hospital Authority of Hall County*, 119 Ga. App. 626, 627, 168 S.E.2d 336, 337 (1969).

<sup>132</sup>*Le Juene Road Hospital v. Watson*, 171 So.2d 202 (Fla. Dist. Ct. App. 1965); *Fabian v. Matzko*, 236 Super. 267, 344 A.2d 569 (1975). See generally Annotation, *Liability of Hospital for Refusal to Admit or Treat Patient*, 35 A.L.R. 3d 841 (1971).

<sup>133</sup>*Stanturf v. Sipes*, 224 F. Supp. 883 (W.D. Mo. 1963); *Doe v. Bellin Memorial Hospital*, 479 F.2d 756 (7th Cir. 1973).

<sup>134</sup>*Wilmington General Hospital v. Manlove*, 54 Del. 15, 25, 174 A.2d 135, 140 (1961).

<sup>135</sup>*Harper v. Baptist Medical Center-Princeton*, 341 So.2d 133 (Ala. 1976).

issue is whether the hospitals are providing the services for which the charitable tax exemption is intended.

Tax exemptions are a form of subsidy, similar to cash grants in the amount of taxes the organization would otherwise have paid. Like deductions and other special exclusions, they constitute the tax expenditure budget. Tax expenditure budget items, as opposed to direct budget outlays, represent the revenue losses attributable to provisions of the federal income tax laws that are intended to encourage certain economic activities, such as support of charitable institutions.<sup>136</sup>

In 1985, the Utah Supreme Court upheld a Utah county's challenge to the state tax commission grant of a tax exemption to two private nonprofit hospitals.<sup>137</sup> The county questioned whether the hospital provided sufficient charity care and community service to justify the state tax exemption for nonprofit hospitals.<sup>138</sup> The state supreme court held that the hospital has the burden of proving annually that they are engaged in sufficient charitable activities.<sup>139</sup>

The court set forth six factors to be considered in determining whether a hospital is used for charitable purposes. These factors are: (1) whether the hospital's stated purpose is to provide significant medical care without expectation of material reward; (2) whether patients are required to pay in whole or part for services rendered by the hospital; (3) whether the beneficiaries of the charities are restricted or unrestricted; (4) whether the hospital is supported by donations and gifts; (5) whether accumulated capital results in a profit in the sense that income from gifts, donations and payment from recipients of the charity exceeds operating and maintenance costs; and (6) whether some form of financial benefit such as dividends is available to private interests, and whether commercial activities are subordinate to charitable activities.<sup>140</sup>

While the Utah decision remains a minority view, several other states—California, Vermont, and Tennessee—are considering or already implementing similar policies.<sup>141</sup> One congressional committee is examining certain operational aspects of these private nonprofit

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<sup>136</sup>*Developments Regarding the Charitable Tax Exemption for Hospitals*, 19 CLEARINGHOUSE REV. 472, 473 (1985) [hereinafter *Developments*].

<sup>137</sup>*Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265 (Utah 1985).

<sup>138</sup>*Id.* at 274.

<sup>139</sup>*Id.* at 273.

<sup>140</sup>*Id.* at 269–70.

<sup>141</sup>Tolchin, *Hospitals Use Charity to Fend Off Tax Collectors*, N.Y. Times, May 3, 1988, at C3, col. 1 (Science Section).

hospitals.<sup>142</sup> Even the current medical literature has addressed this issue.<sup>143</sup> Many reasons are given for a closer examination of the charitable activities of these private hospitals,<sup>144</sup> but without a doubt, a major reason is the growing concern about the 37 million medically indigent people denied access to health care because they do not qualify for Medicaid or private health insurance plans.<sup>145</sup>

This attack on private nonprofit hospitals is not new. In *Simon v. Eastern Kentucky Welfare Rights Organization*, low-income plaintiffs unsuccessfully challenged a change in the charitable obligation of federally tax-exempt hospitals.<sup>146</sup> The United States Supreme Court avoided the issue by ruling that the plaintiffs lacked standing to sue.<sup>147</sup>

The Utah decision questioning a hospital's right to tax exemptions should not seem surprising. Many hospitals are granted tax-exemptions by federal and state internal revenue services<sup>148</sup> based on the prerequisite that these hospitals are to be operated for charitable purposes.<sup>149</sup> "The term 'charitable' traditionally has been tied to the provision of free care to poor uninsured persons who are unable to pay for necessary medical care."<sup>150</sup> However, there is still much confusion at the federal level over the meaning of the term "charitable" as used in Internal Revenue Code section 501(c)(3),<sup>151</sup> and federal courts are reluctant to entertain suits raising the issue.<sup>152</sup> Thus, the focus has shifted to the states.

<sup>142</sup>*Id.*

<sup>143</sup>Relman, *Are Voluntary Hospitals Caring for the Poor?*, 318 NEW ENG. J. MED. 1198 (1988); Lewin & Eckels, *Setting The Record Straight: The Provision of Uncompensated Care by Not-for-Profit Hospitals*, 318 NEW ENG. J. MED. 1212 (1988).

<sup>144</sup>These include the perception that hospitals have become businesses and should be treated as such, the need for revenue in states and cities, and complaints from small businesses concerned with competition from nonprofit hospitals engaged in commercial activities. Tolchin, *supra* note 141.

<sup>145</sup>*Id.*

<sup>146</sup>*Id.* 426 U.S. 26 (1976).

<sup>147</sup>*Id.*

<sup>148</sup>*Developments, supra* note 136, at 472, citing Schwartz & Rose, *Opening the Doors of the Non-Profit Hospital to the Poor*, 7 CLEARINGHOUSE REV. 655 (1974).

<sup>149</sup>*Id.*, citing 26 U.S.C. § 501(c)(3) (Supp. 1984). Under § 501(c)(3), a hospital must also use no part of its net earnings to benefit any private individual or shareholder and it must refrain from substantial lobbying or political activities. *Id.* at 473.

<sup>150</sup>*Id.*, citing Rose, *The Implications of the Charitable Deduction and Exemption Provisions of the Internal Revenue Code Upon the Service Required of a Voluntary Hospital to Treat the Poor*, 4 CLEARINGHOUSE REV. 183 (1970); Bromburg, *The Charitable Hospital*, 20 CATH. U.L. REV. 24 (1970).

<sup>151</sup>*See generally Developments, supra* note 136, 473-76.

<sup>152</sup>*See, e.g., Lugo v. Simon*, 453 F. Supp. 677 (N.D. Ohio 1978), *rev'd sub. nom.*, *Lugo v. Miller*, 640 F.2d 823 (6th Cir. 1981) (plaintiffs denied standing even though they had sued specific tax-exempt hospitals as well as Treasury officials). Compare *Simon*

A number of state laws require that charitable, tax-exempt institutions provide free care to persons who are indigent.<sup>153</sup> Alabama and Mississippi specifically refer to the obligation of tax exempt hospitals to provide free medical care to persons who are indigent.<sup>154</sup> Other states prohibit tax-exempt hospitals from discriminating in their admissions policies,<sup>155</sup> and still "[o]ther states interpret their tax laws to confer charitable exemption upon facilities that are caring for those who would otherwise become government charges."<sup>156</sup>

Legal scholars and others have questioned the casual conferral of nonprofit tax-exempt status on private hospitals and other nonprofit organizations.<sup>157</sup> It is surprising that legal services lawyers and others who traditionally represent persons who are indigent have not challenged state tax commissions for not requiring private nonprofit hospitals to provide a significant percentage of free care or provide other comparable charitable services.<sup>158</sup>

Imposing a duty to treat on hospitals, both public and private, seems consistent with the medical police theory of health care with the hospital substituted for the individual physician. One could argue that in light of the tremendous advances in medical science since the eighteenth century, hospitals rather than individual physicians are the more appropriate health caretakers for the public.

Since tax exemptions are public subsidies, as are tax deductions given to donors to nonprofit hospitals, it is not unreasonable in light of the large number of people denied access to health care to require the private sector to carry a portion of the load. The predicted increase

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*v. Eastern Kentucky Welfare Rights Organization*, 426 U.S. 26 (1976) (plaintiffs denied standing because no specific hospital was named as defendant).

<sup>153</sup>*See, e.g.,* *Burgess v. Four States Memorial Hospital*, 250 Ark. 485, 465 S.W.2d 693 (1971); *United Presbyterian Association v. Board of County Commissioners*, 167 Colo. 485, 448 P.2d 967 (1968); *Haines v. St. Petersburg Methodist Home*, 173 So.2d 176 (Fla. 1965); *Georgia Osteopathic Hospital v. Alford*, 217 Ga. 663, 124 S.E.2d 402 (1962); *Iowa Methodist Hospital v. Board of Review*, 252 N.W.2d 390 (Iowa 1977); *Ruston Hospital v. Riser*, 191 So.2d 665 (La. 1966).

<sup>154</sup>ALA. CODE 40-9-1(2) (Supp. 1987); MISS. CODE ANN. § 27-31-1(f) (Supp. 1987).

<sup>155</sup>ILL. ANN. STAT. ch. 120, § 500.7 (Smith-Hurd Supp. 1988); OKLA. STAT. ANN. tit. 68, § 2405(j) (West Supp. 1988); TENN. CODE ANN. § 67-5-212(e)(2) (Supp. 1987); *see also Developments, supra* note 136, at 478.

<sup>156</sup>*Developments, supra* note 136, at 477.

<sup>157</sup>*Id.* *See also* Clark, *Does the Nonprofit Form Fit the Hospital Industry*, 93 HARV. L. REV. 1416 (1980); Hopkins & Beckwith, *The Federal Tax Law of Hospitals; Basic Principles and Current Developments*, 24 DUQUESNE L. REV. 691 (1985).

<sup>158</sup>*But cf. Cook v. Rose*, 299 S.E. 2d 3 (W. Va. 1982) (held that, pursuant to the state's "charitable purpose" requirement, guidelines for determining tax-exempt status had to require tax-exempt hospitals to provide free and below-cost services to patients unable to pay). *Id.* at 8. *See also Developments, supra* note 136, at 477.

in the number of indigent AIDS-related cases may force more state to require greater accountability of private nonprofit hospitals.

Nevertheless, this approach to increasing indigent persons' access to health care does not prevent these hospitals from denying treatment to HIV-infected persons who can pay. Such a denial may be barred by federal and state handicap antidiscrimination laws prohibiting discrimination on the basis of disability. Further, if the charity burden becomes too great, private nonprofit hospitals may decide to become for-profit hospitals in an attempt to avoid this burden.<sup>159</sup> If this tactic becomes commonplace, states may end up with decreased rather than increased access to health care.

### Conclusion

The AIDS crisis may force society to rethink the issue of a right to health care. Should such a right be recognized and on whom should a duty to treat be imposed? Shifting the focus of the duty from individual physicians to public or private hospitals may result in greater access to health care for all. Forcing private hospitals to shoulder some of the burden of care for the indigent and other groups traditionally denied adequate care will expand access to medical care even more. However, a recognized right to medical care should not be anticipated. Not only is there no constitutional right to health care, but attempts at regulating such a right have not been successful. Furthermore, despite pressure on private nonprofit hospitals to provide an adequate amount of charity care to warrant their tax exempt status, the enforcement of tax-exempt requirements at the state level will not result in the recognition of a right to health care. At best, a piecemeal approach to solving the health care crisis is likely, particularly in view of the medical community's negative attitude toward government sponsored health care. With no end in sight to the AIDS crisis, such an approach is unfortunate.

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<sup>159</sup>See Lewin & Eckels, *supra* note 143. The authors contend there is little difference between the amount of charity care provided by private nonprofit and private for-profit hospitals. They cite a recent study showing substantial differences in the amount of such care provided at state and local levels where not-for-profit and investor-owned hospitals are in competition. *Id.* at 1213.