

The Right to Medical Treatment

TAUNYA LOVELL BANKS

The public's fear of contracting AIDS is escalating as the syndrome spreads. Unfortunately, this fear of AIDS is also high among members of the medical profession and is a special concern of health care workers in hospitals across the nation.¹ The term "medical professionals" includes nurses, doctors, lab technicians, ambulance drivers, paramedics, as well as people in other professions, such as funeral directors and embalmers. Many medical professionals are refusing to treat people with AIDS, even though current medical studies indicate that the occupational risk of transmission of the Human Immunodeficiency Virus (HIV) is minimal.² Medical treatment has even been denied to some merely because they are members of AIDS high-risk groups.³

Until recently, fear of AIDS within the medical community did not create a serious problem, because most of the early AIDS cases were confined to established, active, urban gay communities. Initially, the primary health care providers for most people with AIDS were physicians close to the gay community. However, many other physicians with highly developed ethical standards feel an obligation to treat patients with AIDS.⁴

As the number of AIDS cases increases, however, the general medical community will be forced to become more involved in the care of people with AIDS. As AIDS spreads beyond large coastal cities, and becomes more commonplace, people with the disease will come into contact not just with sophisticated, cosmopolitan physicians, but with general practitioners and a wide variety of ordinary health care workers. Further, with improved understanding of other illnesses such as AIDS-Related Complex (ARC) and progress in ability to detect the presence of HIV, more demands will be made on the medical community for treatment and counseling of people who have been exposed to the virus but have not developed AIDS.

Several commentators, relying on anecdotal information, suggest that fear of infection has caused the general medical community to be reluctant in

treating patient with AIDS and ARC.⁵ For example, two paramedics in Los Angeles were sued for allegedly not providing proper medical assistance to a heart attack victim because they believed he had AIDS. In another instance, a nationally known heart surgeon refused to operate on anyone infected with HIV.⁶

Since unlike other terminal illnesses such as cancer, AIDS is contagious, physicians are forced by AIDS to decide how much personal risk they are willing to assume. Two writers recently noted, "[h]istorically, physicians have tacitly accepted an occupational risk of exposure to fatal infectious diseases. . . . Only the current generation of physicians, trained after the development of effective antibiotics, has never confronted this potential occupational risk."⁷ Some physicians choose not to work with AIDS patients, while others elect to care for people with AIDS only when necessary.⁸

As the epidemic grows, these fears of infection are likely to result in an increase in refusals to treat. The problem, then, is to determine what legal obligation, if any, the medical community has to provide care to people who are ill with AIDS or ARC, or infected with HIV.

OBLIGATIONS OF PRIVATE PHYSICIANS AND HEALTH CARE PROVIDERS

While people with AIDS undoubtedly deserve access to adequate medical care, the law does not ensure such access. Because the law views the relationship between a private physician and her patient as consensual, a physician has no legal duty to treat.⁹ The reasoning behind this rule is that a private physician is not responsible for a stranger's misfortune she did not cause.

The American Medical Association's Code of Ethics states that "in an emergency [a physician] should render service to the best of his ability." Nevertheless, most courts refuse to impose on physicians a broad legal duty to treat, even in an emergency.¹⁰ A rather limited duty to treat has been recognized and is the subject of the following section.

The Duty to Treat under Common Law and Statute

A physician-patient relationship rests upon an express or implied contract, with most relationships created by implication.¹¹ Making an appointment with a physician, receiving an examination, and beginning treatment imply the existence of a contract between physician and patient.¹² This contract, however, does not guarantee future care. Even where the physician has previously treated a patient for an illness and may be considered the family physician, she may be under no legal duty to treat a patient for a new illness.¹³ A physician may, by notice or by special agreement, limit the extent and scope of her practice, excluding certain diseases or medical conditions.¹⁴ Thus a person with AIDS or ARC may have difficulty obtaining medical care

from private physicians, even those with whom she has some preexisting relationship.

A patient affiliated with a health maintenance organization (HMO) may have more rights than a person with a private physician.¹⁵ By paying regular fees for the right of access to the HMO's services, members establish an ongoing contractual relationship with the HMO. Unless the contract specifically excludes treatment for AIDS or ARC, the HMO may be liable if its health care professionals refuse to treat members with those conditions. This liability does not necessarily extend to health care personnel employed by the HMO. Their individual duty to treat may depend upon the terms of their employment contracts with the HMO rather than their relationship with the patient.

Recently, many courts have suggested that a legal duty to treat may be created in another manner. Based on tort rather than contract theory, this duty is commonly referred to as "personal encounters or undertakings." A physician may incur the duty by agreeing to treat a specific, as opposed to an unspecified, illness.¹⁶ Thus, a duty to treat may arise 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.¹⁷ However, at least one court has held that no legal duty was created where an associate of the treating doctor was consulted by telephone over a decision to hospitalize a patient.¹⁸ Similarly, where a doctor merely converses with the treating physician about the treatment of a patient, a duty to treat may not exist.

Physicians who contemplate refusing to treat people with AIDS or ARC should be aware that while the courts have not imposed any general duty to treat on private physicians in the absence of some close connection to the patient, whether they will continue to adhere to the traditional "no duty" view is open to question.

Common law obligations fashioned by courts are not the only means by which physicians may be obliged to render care. Statutes may also address the rights and obligations of physicians. Several states, for example, have enacted "good Samaritan laws" that limit the liability of people who provide emergency assistance. These laws do not require physicians to treat all persons in life threatening circumstances,¹⁹ but their purpose is to encourage qualified individuals to provide emergency care by protecting them from lawsuits. Where she chooses to treat, the physician is not legally liable for injuries to the victim unless she is grossly negligent. In the few states that require treatment in emergency situations, the physician is required to treat only if she was at the scene when an accident occurred.²⁰ Thus even the most demanding good Samaritan law rarely imposes any legal duty to treat.

Duty to Treat under Antidiscrimination Legislation

Of greater potential benefit to persons with AIDS are antidiscrimination statutes. Although a growing number of cities²¹ and states²² have specifically

prohibited various kinds of discrimination against people with AIDS, many more cities and states have not acted to prevent such discrimination. However, forty-seven states and many cities have general antidiscrimination laws, many of which prohibit discrimination against the physically disabled.²³ Twenty-one states have formally declared that their handicap-discrimination provisions will be construed to include AIDS as a handicap, and five states have unofficial policies to that effect.²⁴ Where state antidiscrimination laws prohibit discrimination in public accommodations—places or services representing themselves as open to the general public—they may be interpreted to include the provision of medical and dental care.²⁵ Washington state, for example, has interpreted its statute concerning discrimination based on handicap in public accommodations to apply to AIDS-based discrimination in dental offices, doctors' offices, hospitals, and nursing homes.²⁶ Under such a statute, a physician who refused to treat a person with AIDS or ARC would be acting illegally.

Recently, several California cities have enacted laws prohibiting discrimination against people with AIDS. These laws are exemplary and will probably be used as models for future local ordinances. They cover discrimination in medical and dental treatment and clearly include people with ARC, people harboring the virus, and people suspected of having AIDS.²⁷ Protection for people in the first two categories is also important because they may suffer discrimination when they seek ordinary medical and dental services which are not related to illnesses associated with AIDS. It would also be capricious for a statute to mandate that those who are gravely ill with full-blown AIDS should be treated while those who are mildly ill with ARC and more responsive to treatment can be ignored by physicians.

One state (Wisconsin)²⁸ and several localities²⁹ have laws prohibiting discrimination based on sexual preference that can be used to combat discrimination against healthy people in high-risk categories because of the connection, real or imagined, between AIDS and their life style. For example, a dentist who refuses appointments to gay men because she fears AIDS could be charged with discrimination against gay men.³⁰ Sexual preference laws could not, of course, be used by heterosexual people faced with AIDS-based discrimination.

Termination of the Relationship

A physician often agrees to treat a patient for a specific illness. But as with any consensual relationship, either party is free to end the relationship before treatment is completed. Nevertheless, public policy considerations have led to certain limits on the physician's right to terminate the relationship. The physician may not leave a critically ill patient without making provisions for her care. Such conduct would constitute abandonment, and the physician would be legally liable for any resulting damage.³¹

Unlawful abandonment can take many forms: the outright refusal to treat a patient further; the premature discharge by the physician of a patient from the hospital; the refusal to treat a patient on a timely basis.³² Even the patient's failure to pay the physician's fee may not be an adequate basis for the abandonment of a patient in need of medical care.³³

Since liability will attach to a physician who abandons a patient at a critical stage of an illness or disease, and the course of AIDS and ARC is so unpredictable, it might be difficult for a physician treating a person with AIDS or ARC to terminate unilaterally an on-going relationship with the patient without risking legal liability. Therefore, a physician should be careful to ensure that the patient has obtained other competent medical care before ending the relationship.

Hospital Staff

The law treats physicians working in hospitals differently from independent physicians. A physician employed by a hospital is generally required to treat any patient the hospital admits.³⁴ In agreeing to work for the hospital, the physician waives the right to choose her patients.³⁵ Likewise, medical students, nurses, and other health care workers affiliated with hospitals or health care organizations are obligated to care for all admitted patients.³⁶

Hospital employees' obligation to treat may be modified by hospital regulation or labor agreement, either of which may restore to staff the right to select patients.³⁷ Furthermore, employees covered by the Occupational Health and Safety Act may refuse to do anything that threatens their safety.³⁸ As mentioned previously, however, current medical research indicates that the risk of HIV transmission to health care workers in hospitals is negligible. Thus health care workers probably could not successfully assert a threat to their safety as a valid basis for refusing to treat an AIDS patient admitted to the hospital.³⁹ (For more information on employment law, see Chapter 8.) Some hospitals assign to AIDS patients only those staff members who volunteer to care for them, reasoning that willing professionals are likely to provide better and more sensitive treatment.⁴⁰ The use of volunteers also allows hospitals to avoid the problem of firing employees who refuse to care for persons with AIDS.

HOSPITALS' DUTY TO TREAT

The treatment of AIDS patients places greater burdens on hospitals than the treatment of most other patients. People with AIDS tend to be hospitalized frequently, often for long periods.⁴¹ The cost of treating people with AIDS exceeds the average cost of treating many catastrophic illnesses,⁴² and many AIDS patients lack full insurance coverage for hospitalization.⁴³ AIDS patients also require almost twice as much nursing care as patients with other terminal

illnesses.⁴⁴ As a result, institutional pressures to prohibit or severely limit the hospitalization of people with AIDS are strong. In addition, many private hospitals strive to avoid the "stigma" of being characterized as AIDS hospitals, fearing that other patients will not be referred to them.⁴⁵

Private Hospitals

As a general rule, a private hospital is under no legal duty to admit and treat all who seek care.⁴⁶ Even the receipt of federal funds does not substantially affect the discretion of private hospitals in selecting patients.⁴⁷ Some jurisdictions recognize an exception to this rule in the case of private hospitals with "well established" emergency facilities,⁴⁸ and some states have passed statutes requiring every hospital to admit persons in need of emergency care.⁴⁹ And while, in the absence of such requirements, most private hospitals act on what they perceive as a professional obligation to treat people in life threatening circumstances, the provision of emergency care creates no obligation to treat the patient further, and private hospitals may refuse comprehensive treatment without liability.⁵⁰ This practice, although legally permissible, is frowned upon by many in the medical profession.

The antidiscrimination laws discussed earlier may apply to private hospitals either directly or indirectly in their capacity as places of public accommodation.⁵¹ If covered by such laws, a hospital that refused to treat a person with, or suspected of having, AIDS or ARC, could be liable for any resulting injury. Liability for discrimination might prove costly, since many of the relevant statutes provide not only for compensatory damages, including emotional injury, but also for punitive damages.⁵² Thus antidiscrimination laws will effectively impose greater duties on private hospitals than does the common law, although even under the common law, a court might be persuaded to impose a higher duty on a hospital that was the only accessible facility in the community.

Nonprofit hospitals may be exempt from taxation as charitable organizations.⁵³ Hospitals that refuse to treat AIDS patients risk losing their tax exempt status. In defining "charitable" in this context, the federal government has suggested that "charitable" hospitals must "provid[e medical care] for all those persons in the community able to pay the cost thereof." One ruling also stressed the importance of a hospital operating an emergency room open to all community members, even those who cannot pay.⁵⁴ The force of these rulings may be diminished in practice by the fact that individuals cannot sue to revoke an organization's tax exempt status.⁵⁵ The initiative can be taken only by the government.

Public Hospitals

At common law, even a public hospital supported by public tax funds had no duty to accept and treat everyone nor any duty to maintain an emergency

room. However, if a public hospital does maintain an emergency room, the hospital cannot refuse to provide emergency treatment to a person because that person has or is suspected of having a specific disease.⁵⁶

Furthermore, courts enforcing federal antidiscrimination laws would most likely forbid a public hospital to refuse nonemergency care to a person solely because she had ARC or AIDS. The equal protection clause of the Fourteenth Amendment requires that any classification by government imposing different benefits or burdens on people must be rationally related to a legitimate government objective. (For a detailed discussion of the equal protection clause, see Chapter 4.) Since AIDS cannot be transmitted through casual contact, neither other patients nor health care personnel are endangered by AIDS patients,⁵⁷ so denying care to people with AIDS cannot rationally be related to protecting a hospital's staff and patients from risk of infection. A city, county, or state with a policy denying access to publicly financed health care services by people with or suspected of having AIDS may violate those persons' right to equal treatment, especially in life threatening circumstances. The governmental entity would have to demonstrate that denying people with AIDS equal access to public life-saving facilities was rationally related to some legitimate governmental objective.

OTHER RELATED SERVICES

Ambulance Service

Very little law exists in this area. Most cases involve situations where the ambulance service provided transportation and was sued for operating the ambulance in a negligent manner. In assessing liability the courts look at the ambulance service and determine whether it is gratuitous, operated for a profit, or owned and operated by the city, county, or state.⁵⁸

At least one lawsuit has been filed involving the refusal to provide city ambulance service to a person wrongly suspected of having AIDS.⁵⁹ Until September 1985, the District of Columbia permitted posting the names of people with AIDS on the chalkboards of city firehouses, reasoning that it had an obligation to inform ambulance personnel of persons with contagious diseases so that precautionary measures could be taken. Only protest from the local gay community forced the discontinuation of this practice.⁶⁰ Whether an ambulance service may refuse to transport a person suspected of having AIDS or ARC depends on whether the service has a legal duty to provide service to all in need. Privately owned and operated services would probably not be found to have a duty to provide services to all who requested them. Like private physicians, they are free to select their customers/patients.

If the ambulance could be classified as a common carrier, however, a duty to provide services to all might follow. As one court defines them,

“[c]ommon carriers of passengers are those who undertake to carry all persons indifferently who apply for passage.”⁶¹ The common carrier characterization is important because most antidiscrimination laws cover common carriers.⁶² Where antidiscrimination laws prohibit discrimination based on disability, a refusal to transport an AIDS or ARC patient would probably be illegal. Antidiscrimination laws cover private services classified as common carriers as well as ambulance services that provide their services to the general public for no charge.

Some ambulance services provide transportation only to persons who are “members” of the service, that is, those who pay a membership fee entitling them to access to the service. These services are not considered common carriers. Therefore they could refuse to provide service to a nonmember suspected of having AIDS. However, the membership ambulance service would probably be liable for refusing to provide services to a member with AIDS or suspected of having AIDS, on a breach of contract theory. Of course, membership ambulance services could, by contract, restrict the type of cases for which they would provide service, thereby avoiding legal liability for refusing to transport a member who had AIDS.

Many jurisdictions have laws requiring a publicly owned and operated ambulance service to transport any person to or from the hospital in an emergency. These laws may also apply to services that are operated only partly at public expense.⁶³

Residential Health Care Facilities

Most residential health care facilities or nursing homes are privately operated and not open to all who request admittance. Many of these facilities have refused to accept people with AIDS.⁶⁴ Legally there is not much one can do to force them to admit people with AIDS since the facilities are free to determine what types of medical cases they will admit. This refusal of residential health care facilities to admit people with AIDS creates a problem for hospitals: It means they are unable to discharge people with AIDS who no longer require specialized hospital care but are unable to care for themselves.

Generally hospitals have a duty not to discharge prematurely a patient who has been admitted for treatment. Thus it may be unlawful to discharge involuntarily a person not well enough to care for herself.⁶⁵ The absence of alternative residential care makes discharge planning very difficult and also increases the costs for both patient and hospital. Recently, special hospices and residential health care facilities for people with AIDS have been established in cities with a high incidence of AIDS. Most often these centers are small and designed to serve only local AIDS patients. Thus persons from areas with relatively low numbers of AIDS cases may be the most harmed by discriminatory practices of residential health care facilities.

Funeral Homes and Cemeteries

Many funeral homes are reluctant to handle the remains of AIDS patients. A few homes have refused to even accept the bodies of persons who have died from AIDS, but more have discriminated in the provision of services—refusing to embalm and charging extra for handling people with AIDS.⁶⁶ Because the embalming process may result in the release of contaminated body fluids, the Centers for Disease Control has issued guidelines for funeral homes that handle the remains of AIDS patients.⁶⁷ However, as one embalmer stated, these precautions are no greater than those taken with other bodies.⁶⁸

Since funeral homes are privately operated, they have a measure of discretion in whom they serve, though they are subject to regulation by the state.⁶⁹ However, where funeral homes are classified as public accommodations, as they are in several states,⁷⁰ and where laws forbid discrimination based on disability, the refusal to provide services might be held illegal, depending on whether the court believes that the antidiscrimination laws apply only to living persons. A New York state court has held that legal protections “are not extinguished with the end of life,” in giving the New York City Commission on Human Rights authority to prosecute funeral homes which discriminated on the basis of AIDS.⁷¹

The right to “decent burial” according to the usual custom in the neighborhood has long been recognized at common law, although the decedent may not necessarily be buried in the plot of her choice.⁷² Religious or other institutions can place restrictions on who will be interned in their burial grounds.⁷³ Advocates for the deceased AIDS patient has several legal arguments to ensure that she is properly buried. A number of cases hold that cemeteries cannot discriminate in the sale of burial plots on the basis of race, since federal law prohibits discrimination based upon race in the sale or rental of property.⁷⁴ An analogous claim might be brought by an AIDS patient. Ownership of a lot in a cemetery gives a right to burial therein that, subject to certain religious considerations, the cemetery may not unreasonably abridge.⁷⁵ If a plot owner were to develop AIDS after purchasing the plot, her disease may not alter her right to be buried in her plot. Furthermore, courts may give some weight to the deceased’s wishes concerning the disposition of her body.⁷⁶

Some AIDS and disability antidiscrimination laws apply to cemeteries directly, or indirectly as public accommodations.⁷⁷ Under these laws a privately operated cemetery that was selling burial plots to the general public but refused to sell a plot to a person with AIDS, or to the family of a person who died from AIDS, would be acting illegally. Refusals by public cemeteries owned and operated by some unit of the government to bury a person solely because that person had AIDS would be of doubtful legality since the government would have to show some rational basis for AIDS-based discrimination.

Unfortunately, the law does not automatically require all health care providers to care for people with AIDS. It seems strange that innkeepers and taxicab drivers may owe more of a duty to strangers than physicians, even though the latter provide life-saving and life sustaining services. But the law regarding the physician's duty to treat is unlikely to change in the near future. To require a physician to provide medical care in a nonemergency situation is perceived as akin to requiring involuntary servitude.

Nevertheless, in light of the growing AIDS epidemic, states need to reexamine existing antidiscrimination and good Samaritan laws. These laws should prevent AIDS-based discrimination in medical treatment. No one should be allowed to go without medical treatment simply because she has a terminal illness. To allow this would demonstrate total disregard for the value of human life.