

Hospital Liability and AIDS Treatment: The Need for a National Standard of Care

Donald H.J. Hermann* & Robert D. Gorman**

This Article examines the current rules governing hospital liability in relation to the potential liability arising from Acquired Immunodeficiency Syndrome (AIDS). Traditional limitations on hospital liability have eroded while doctrines of corporate negligence and apparent agency have increased the basis for hospital liability. At the same time, the use of the locality rule, which established a standard of care based on community practice, increasingly has been replaced by the adoption of a national standard of care. With no existing precedent concerning the standard of care in AIDS treatment, both hospitals and courts require an authoritative basis for establishing the appropriate national standard of care. The authors contend that the guidelines established by the Centers for Disease Control (CDC) provide the most appropriate basis for establishing a national standard of care for AIDS treatment.

INTRODUCTION

Hospital administrators providing care for patients with Acquired Immune Deficiency Syndrome (AIDS)¹ increasingly have expressed

* Professor of Law and Philosophy, Director of the Health Law Institute, DePaul University. A.B., Stanford University, 1965; J.D., Columbia University, 1968; LL.M., Harvard University, 1974; M.A., Northwestern University, 1979; Ph.D., Northwestern University, 1981.

**B.A., Michigan State University, 1984; J.D., DePaul University, 1986.

¹ The Centers for Disease Control (CDC) has defined AIDS as "a reliably diagnosed disease that is at least moderately indicative of an underlying cellular immunodeficiency in a person who has had no known underlying cause of cellular immunodeficiency nor any other cause of reduced resistance reported to be associated with that disease." *Acquired Immunodeficiency Syndrome (AIDS) Update - United States*, 32 MORBIDITY AND MORTALITY WEEKLY REP. 309, 310 n.1 (1983) [hereafter *1983 AIDS Update*].

concern about potential tort liability.² They fear lawsuits both from AIDS patients, and from other patients, visitors, and staff accidentally infected with the AIDS-related virus while in hospitals.³ Since the disease was first reported in the United States in June 1981,⁴ over 28,000 persons have been diagnosed with AIDS.⁵ Experts predict that this number will increase at slightly less than exponential rates over the coming years.⁶ The fear of AIDS-related liability is due not only to the

² See generally *AIDS: A Time Bomb at Hospitals' Door*, HOSPITALS, Jan. 5, 1986, at 54 [hereafter *AIDS Time Bomb*]. The article predicts that a wave of lawsuits against hospitals will soon hit the courts; these suits will likely involve allegations of "hospital negligence over the failure to inform patients of positive test results, failure to protect workers and patients from contracting AIDS, failure to protect the confidentiality of AIDS victims, and inadvertent use of AIDS-contaminated blood." *Id.* at 61.

³ See Williams, *CDC Guidelines for the Prevention and Control of Nosocomial Infections, Guideline for Infection Control in Hospital Personnel*, 12 INFECTION CONTROL 34 (1984), observing that: "In the United States, about 5 million persons work in more than 7,000 hospitals. These personnel may become infected by patients if proper precautions are not used, or acquire infection outside the hospital. They may then transmit the infection to susceptible patients or other hospital personnel, members of households, or other community contacts." See also Jonsen, Cooke & Koenig, *AIDS and Ethics*, 2 ISSUES IN SCIENCE AND TECHNOLOGY 56, 59 (1986), in which the authors report:

In June 1983 when we asked interns the general question, 'How did you respond to the AIDS epidemic?' . . . [Most] spoke of more medical concerns, such as fear of being accidentally stuck by a needle contaminated with AIDS virus, or the inadequacy of the isolation of AIDS patients, or the threat of having to do mouth-to-mouth resuscitation on an AIDS patient. Nurses and medical technicians, in more frequent and intimate physical contact with patients than physicians, were even more anxious.

⁴ In 1981, The United States Department of Health and Human Service, Public Health Service, Center for Disease Control first published information on Kaposi's sarcoma and *Pneumocystis carinii* pneumonia occurring in young homosexual men. See *Kaposi's Sarcoma and Pneumocystis Pneumonia Among Homosexual Men - New York City and California*, 30 MORBIDITY AND MORTALITY WEEKLY REP. 305 (1981) [hereafter *Kaposi's Sarcoma*]; *Pneumocystis Pneumonia - Los Angeles*, 30 MORBIDITY AND MORTALITY WEEKLY REP. 250 (1981). The accounts given by the medical researchers, whose work provided the basis for these reports on what are now regarded as opportunistic infections associated with AIDS, are now considered to be the first cases of AIDS in the United States. See V. DEVITA, *AIDS: ECOLOGY, DIAGNOSIS TREATMENT AND PREVENTION IX* (1985).

⁵ The CDC has reported 28,098 cases of AIDS diagnosed as of December 8, 1986. Of this number, 27,704 were adults and 394 were children. See *Update: Acquired Immunodeficiency Syndrome - United States*, 35 MORBIDITY AND MORTALITY WEEKLY REP. 1, 49 (1986) [hereafter *1986 AIDS Update*].

⁶ See, e.g., INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, *MOBILIZING AGAINST AIDS 2* (1986) [hereafter *MOBILIZING AGAINST AIDS*] commenting on the rate of increase of AIDS cases: "The rate of increase in the number of cases ap-

disease's near-exponential spread,⁷ but also to uncertainties about the medical, economic, and social consequences of contracting the AIDS-related virus.⁸ Because of these problems, and their rising institutional accountability,⁹ hospitals are concerned about limiting their liability in the care and control of AIDS.

There are documented reports of hospitals refusing to accept patients with AIDS and of other hospitals that have accepted patients with AIDS and permitted them to go untreated and unattended.¹⁰ To date,

appears to be slowing down gradually. In 1983 the number of cases was doubling about every six months; the most recent doubling took 11 months, and public health experts predict that the next doubling will take about 13 months. Nonetheless, the absolute number of cases continues to rise sharply."

⁷ See 1986 AIDS Update, *supra* note 5, at 757. The report shows the following increase in cumulative cases reported in the United States, through December 8, 1986:

CHART I

| Cumulative Cases Reported | Date | Doubling Time (months) |
|---------------------------|----------------|------------------------|
| 112 | September 1981 | — |
| 220 | January 1982 | 5 |
| 439 | June 1982 | 6 |
| 878 | December 1982 | 6 |
| 1,756 | July 1983 | 7 |
| 3,512 | February 1984 | 8 |
| 8,025 | December 1984 | 9 |
| 14,249 | October 1985 | 11 |
| 28,098 | December 1986 | 13 |

⁸ See generally MOBILIZING AGAINST AIDS, *supra* note 6, at 4, 41-58.

⁹ See, e.g., Southwick, *The Hospital as an Institution — Expanding Responsibilities Changed Its Relationship with the Staff Physicians*, 9 CAL. W.L. REV. 429 (1973).

¹⁰ See N.Y.C. COMMISSION ON HUMAN RIGHTS: REPORT ON DISCRIMINATION AGAINST PEOPLE WITH AIDS — NOVEMBER 1983 TO APRIL 1986 (1986). The commission reports a December 1985 case in which a man with AIDS needed kidney dialysis. When he arrived at the hospital for his treatment, they refused to put him on the dialysis machine because he had AIDS. As a result of not being able to obtain the treatment, he had to be rushed to the emergency ward of a hospital two weeks later. *Id.* at 36. The report includes a February 1985 case involving failure to attend to the needs of an AIDS patient. It was reported by the GMHC (Gay Mens' Health Clinic) "buddy" of a person with AIDS that a man was kept waiting for 18 hours in a hospital emergency room. The next day when his family visited, they found him lying in his own excrement in a bed that had no covers. He was very sick and had not been fed. *Id.* at 31. The report also includes a May 1984 case involving inattention and lack of

no courts have determined the medical duty a hospital owes to persons with AIDS, whether patients or staff, and to those who come in contact with patients and staff diagnosed with AIDS, including other patients, health care workers, and visitors. The resulting uncertainty over liability threatens to skew hospital policy and treatment programs. The need to control this uncertainty, as well as the disease itself, favors developing a national standard defining a hospital's duty of care. A national standard of care could reduce the likelihood of extraordinary institutional liability, limit escalating treatment costs for AIDS, and ensure uniform, consistent court decisions. This Article argues that courts should base the national standard of care on the Centers for Disease Control (CDC)¹¹ guidelines.¹² The CDC guidelines could be used to define a hospital's duty to patients,¹³ health care

treatment of AIDS patient. The uncle of a man with AIDS called regarding the treatment to which his nephew was being subjected in the hospital where he had been for several weeks. The uncle is a retired hospital administrator and described the situation as "shocking and getting worse." His nephew's room had not been cleaned during the time he was there, nor had his bedding been changed. Food was not brought into his room (although he was bedridden) and medication was not administered. He complained repeatedly to every level of hospital staff to no avail. *Id.* at 29.

¹¹ The Centers for Disease Control (CDC) was established on July 1, 1973, by the Secretary of Health, Education and Welfare to be the operating health agency concerned with contagious diseases within the Public Health Service. At present, the CDC is a department of the Public Health Service, which is a part of the Department of Health and Human Services. The CDC is the federal agency charged with protecting the public health of the nation by responding to public health emergencies and by providing direction and leadership in the control and prevention of communicable diseases. THE 1983/1984 UNITED STATES GOVERNMENT MANUAL 273 (1983).

¹² See generally CENTERS FOR DISEASE CONTROL, RECOMMENDATIONS AND GUIDELINES CONCERNING AIDS PUBLISHED IN THE MORBIDITY AND MORTALITY WEEKLY REPORT, NOVEMBER 1982 THROUGH DECEMBER 1985 (1986).

¹³ See generally *Immunization of Children Infected with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus*, 35 MORBIDITY AND MORTALITY WEEKLY REP. 595 (1986); *Diagnosis and Management of Mycobacterial Infection and Disease in Persons with Human T-lymphotropic Virus Type III/Lymphadenopathy-Associated Virus Infection*, 35 MORBIDITY AND MORTALITY WEEKLY REP. 448 (1986); *Recommendations for Providing Dialysis Treatment to Patients with Human T-lymphotropic Virus Type III/Lymphadenopathy-Associated Virus*, 35 MORBIDITY AND MORTALITY WEEKLY REP. 376 (1986) [hereafter *Dialysis Treatment*]; *Recommendations for Assisting in the Prevention of Perinatal Transmission of Human T-Lymphotropic Virus, Type III/Lymphadenopathy-Associated Virus and Acquired Immunodeficiency Syndrome*, 34 MORBIDITY AND MORTALITY WEEKLY REP. 721 (1985); *Provisional Public Health Service Inter-Agency Recommendations for Screening Donated Blood and Plasma for Antibody to the Virus Causing Acquired Immunodeficiency Syndrome*, 34 MORBIDITY AND MORTALITY WEEKLY REP. 1 (1985) [hereafter *Recommendations for Screening Blood*]; *Update: Acquired Immu-*

workers,¹⁴ and others who may, at the hospital, come into contact with AIDS patients or be exposed to bodily fluids or tissue potentially infected with the AIDS-associated virus.¹⁵

For two reasons, the CDC is the most authoritative entity to which courts can look for standards. First, it provides the most current and comprehensive regularly disseminated data on the disease. The CDC consults with medical researchers, treating physicians and institutions, public health authorities, and various medically related associations in developing guidelines for treatment and institutional policy. Second, adopting the CDC guidelines as a national standard of care would enable hospitals to adopt policies and procedures which, if followed, could provide needed assurance of protection from liability.

I. ACQUIRED IMMUNE DEFICIENCY SYNDROME: THE DISEASE

AIDS results from a virus that destroys a person's immune system, leaving the person prone to infection from opportunistic diseases.¹⁶ The AIDS-associated virus, human immunodeficiency virus (HIV),¹⁷ is

nodeficiency Syndrome (AIDS) in Persons with Hemophilia, 33 MORBIDITY AND MORTALITY WEEKLY REP. 589 (1984); *Prevention of Acquired Immune Deficiency Syndrome (AIDS): Report of Inter-Agency Recommendations*, 32 MORBIDITY AND MORTALITY WEEKLY REP. 101 (1983).

¹⁴ See generally *Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy - Associated Virus in the Workplace*, 34 MORBIDITY AND MORTALITY WEEKLY REP. 682 (1985) [hereafter *Preventing Transmission of Infection in the Workplace*]; *Acquired Immunodeficiency Syndrome (AIDS): Precautions for Health-Care Workers and Allied Professionals*, 32 MORBIDITY AND MORTALITY WEEKLY REP. 450, 450 (1983) [hereafter *Precautions for Health-Care Workers*]; *Acquired Immune Deficiency Syndrome (AIDS): Precautions for Clinical and Laboratory Staffs*, 31 MORBIDITY AND MORTALITY WEEKLY REP. 577 (1982) [hereafter *AIDS Precautions*].

¹⁵ See generally *Preventing Transmission of Infection in the Workplace*, *supra* note 14; *Update: Revised Public Health Service Definition of Persons Who Should Refrain From Donating Blood and Plasma - United States*, 34 MORBIDITY AND MORTALITY WEEKLY REP. 547 (1985); *Testing Donors of Organs, Tissues, and Semen for Antibody to Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus*, 34 MORBIDITY AND MORTALITY WEEKLY REP. 294 (1985); *Recommendations for Screening Blood*, *supra* note 13.

¹⁶ An opportunistic disease is one to which a person becomes susceptible because of an impaired immune system. *Pneumocystis carinii* pneumonia (PCP) and Kaposi's sarcoma (KS) are the most frequently found opportunistic diseases associated with AIDS. See *1983 AIDS Update*, *supra* note 1.

¹⁷ The virus that has been identified as causing damage to the immune system, and thus inducing AIDS, has been named differently by various researchers. There is a growing consensus to identify the virus by the name "human immunodeficiency virus,"

transmitted through infected persons' bodily fluids, such as semen, urine, whole blood, and its particulates.¹⁸ Medical studies indicate that casual contact with an infected person is not likely to transmit the virus.¹⁹ Although researchers have found the AIDS-related virus in saliva and tears, there are no reported incidences of transmission through these fluids.²⁰ Nor have researchers reported transmission through close

or HIV. It is also known as human T-cell lymphotropic virus type III (HTLV-III), lymphadenopathy-associated virus (LAV), and AIDS-associated retrovirus (ARV). *See* INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, *CONFRONTING AIDS: DIRECTIONS FOR PUBLIC HEALTH, HEALTH CARE, AND RESEARCH* 5-6 (1986); *see also Human T-Cell Leukemia Virus Infection in Patients with Acquired Immune Deficiency Syndrome: Preliminary Observations*, 32 MORBIDITY AND MORTALITY WEEKLY REP. 233 (1983); Elliott, *AIDS Research in France: Different Culture, Same Virus?*, 125 SCIENCE NEWS 55-86 (May 5, 1984); Norman, *HTLV-III and LAV: Similar, or Identical?*, 230 SCIENCE 643 (Nov. 8, 1985).

¹⁸ HIV has been detected in at least ten bodily fluids including semen, blood, saliva, urine, feces, breastmilk, tears, cerebrospinal fluid, brain tissue, and cervical secretions, and is likely to be present in other bodily fluids, secretions, and tissues of infected persons. Studies reveal that it is unlikely that the virus can be transmitted by saliva, and no case has been documented of transmission by saliva or tears. The virus has not been detected in perspiration fluids. Semen and blood have proven to be effective transmitters. The most likely ways to transmit the virus are: transfusions of infected blood or blood products; shared use of needles by intravenous drug users; childbirth by an infected mother; and most commonly, sexual intercourse. Although normal heterosexual intercourse is a likely means of transmission, the most prevalent method of transmission from male to male and male to female is anal intercourse. *See generally* UNITED STATES PUBLIC HEALTH SERVICES, *AIDS INFORMATION BULLETIN: THE PUBLIC HEALTH SERVICE RESPONSE TO AIDS 2* (Sept. 1985) [hereafter 1985 PUBLIC HEALTH SERVICES BULLETIN].

¹⁹ *See, e.g., Preventing Transmission of Infection in the Workplace [Summary]*, *supra* note 14, at 681. Certain groups of people are naturally at higher risk of being infected with HIV. These high risk groups include:

- (1) homosexual and bisexual men;
- (2) past or present IV drug abusers;
- (3) persons with clinical or laboratory evidence of infection, such as those with signs or symptoms compatible with AIDS or AIDS-related complex (ARC);
- (4) persons born in countries where heterosexual transmission is relatively common (e.g., Haiti, Central African countries);
- (5) male or female prostitutes and their sex partners;
- (6) sex partners of infected persons or persons at increased risk;
- (7) all persons with hemophilia who have received clotting-factor products; and
- (8) newborn infants of high-risk or infected mothers.

Additional Recommendations to Reduce Sexual and Drug Abuse-Related Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus, 35 MORBIDITY AND MORTALITY WEEKLY REP. 152, 152-53 (1986).

²⁰ *See* Fujikawa, Salahuddin, & Palestine, *Isolation of Human T-cell Leukemia/Lymphotropic Virus Type III (HTLV-III) From Tears of a Patient With Acquired Immunodeficiency Syndrome (AIDS)*, LANCET (Sept. 7, 1985); 2 (8454): 529-30; *see also*

contact, such as shaking hands or using common restroom facilities.²¹ Transmission primarily occurs through receiving infected blood or through sexual intercourse.²²

About ninety percent of persons with AIDS are homosexuals, bisexuals, or intravenous drug users.²³ However, a growing number of heterosexual men, women, and children have contracted the disease.²⁴ At first, experts believed AIDS was confined to the dense population centers of New York and California.²⁵ However, the disease has spread to large and small communities in all fifty states, the District of Columbia, and three United States territories.²⁶

Persons with AIDS suffer a very high mortality rate; according to the CDC, approximately one-half of those people diagnosed with AIDS have died.²⁷ Further, of the 28,098 persons diagnosed with AIDS between June 1981 and December 1986, 15,757 (fifty-six percent of the adults and sixty-one percent of the children) have died. Seventy-nine percent of those diagnosed before January 1985 have died.²⁸ This percentage may change over time since experts are unsure of both the incubation period of HIV, and the body's potential for developing natural defenses to AIDS.²⁹ The effect of HIV infection depends upon the specific opportunistic infections that develop from the patient's weakened immune system.³⁰ Thus, people do not die of AIDS itself, but rather of

Recommendations for Preventing Possible Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus from Tears, 34 MORBIDITY AND MORTALITY WEEKLY REP. 533-34 (1986).

²¹ See Marwick, *AIDS-Associated Virus Yields Data to Intensifying Scientific Study*, 254 J. A.M.A. 2865-69 (1985), which reports: "[T]here's no evidence whatever that AIDS is transmitted through casual contact or through non-blood and blood product contact. It has not been transmitted by sneezing, coughing, touching or otherwise socially interacting with someone who has AIDS. This is true despite the fact that the virus has been found in the saliva of patients with AIDS" (emphasis added).

²² See Fischinger, *Prospects for Diagnostic Test, Interventions, and Vaccine Development in AIDS*, in V. DEVITA, *supra* note 4, at 56.

²³ See 1986 AIDS Update, *supra* note 5, at 18.

²⁴ See generally Selik, Haverkos & Curran, *Acquired Immune Deficiency Syndrome (AIDS) Trends in the United States, 1978-1982*, 76 AM. J. MED. 493 (1984).

²⁵ See, e.g., *Kaposi's Sarcoma*, *supra* note 4; see also Issacson, *Hunting for the Hidden Killers*, TIME 122:50-55, July 4, 1983.

²⁶ See 1986 AIDS Update, *supra* note 5, at 757; see also BULLETIN: THE PUBLIC HEALTH SERVICE RESPONSE TO AIDS 2 (1986) [hereafter AIDS INFORMATION BULLETIN].

²⁷ See 1986 AIDS Update, *supra* note 5, at 1.

²⁸ See 1986 AIDS Update, *supra* note 5, at 21.

²⁹ See *id.* at 757.

³⁰ See Update on Acquired Immune Deficiency Syndrome (AIDS)-United States, 31

one or more infections or diseases that invade the body after its immune system is weakened or eliminated.³¹

The prognosis for a person exposed to HIV or diagnosed with AIDS is presently unknown. Medical researchers do not know why some individuals apparently can carry HIV without actually contracting the disease. There remain uncertainties about the precise methods of transmission. Since much is still unknown about this relatively new disease, the basis for establishing a standard of care as a matter of law must be flexible enough to encompass new discoveries.

II. EROSION OF THE LIMITATIONS ON HOSPITAL LIABILITY

Traditionally, courts considered hospitals merely as offering facilities in which health care workers could provide their services, rather than as themselves providing treatment. Moreover, hospitals bore little or no responsibility for the conduct of their staff physicians or for their staff members.³² Courts held negligent staff members individually responsible, or held the physician who directed them responsible under *respondeat superior*, but not the hospital.³³ The doctrines of sovereign immunity³⁴ and charitable immunity,³⁵ and the inapplicability of *respondeat superior*³⁶ shielded hospitals from liability. Courts regarded health professionals as independent contractors. However, over time the courts have either eliminated or severely restricted these protections, judging them to be unfair.

MORBIDITY AND MORTALITY WEEKLY REP. 507 (1982). The CDC has stated that death is caused by the opportunistic disease itself. *Pneumocystis carinii* pneumonia (PCP) is much more deadly a disease than Kaposi's sarcoma (KS). The mortality rate for AIDS patients with PCP is 47%, for those with KS it is 21%, for those with both PCP and KS the mortality rate is 68%. For other opportunistic diseases the mortality rate is 48%.

³¹ See *id.*

³² See *Moore v. Board of Trustees of Carson - Tahoe Hosp.*, 88 Nev. 207, 495 P.2d 605, *cert. denied*, 409 U.S. 879 (1972) (describing hospital as doctors' workshop); see also *Alden v. Providence Hosp.*, 382 F.2d 163, 166 (D.C. Cir. 1967) (Burger dissenting) (noting that "a hospital, as its name implies, is a hostel with special services, but it is nonetheless essentially a custodial institution, albeit a very high form of custody.").

³³ See, e.g., *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914) (holding that doctrine of *respondeat superior* does not impose liability upon health care institution for negligent acts of physicians and employees in exercise of their professional judgment).

³⁴ See *infra* notes 37-60 and accompanying text.

³⁵ See *infra* notes 61-70 and accompanying text.

³⁶ See *infra* notes 96-110 and accompanying text.

A. Sovereign Immunity

At the turn of the century the United States Supreme Court adopted the doctrine of governmental sovereign immunity, even though an individual sovereign did not exist.³⁷ Under the sovereign immunity doctrine, federal and state governments' agencies and employees are immune from tort liability. The Court reasoned that "[a] sovereign is exempt from suit . . . on the logical and practical ground that there can be no legal right as against the authority that makes the law on which the right depends."³⁸ Thus, courts considered hospitals owned or operated by a governmental entity exempt from civil liability.³⁹ However, with judicial modification of the sovereign immunity doctrine, federal and state run hospitals, as well as local hospitals operated by municipal authorities, are immune from liability only to the extent that their operation can be characterized as governmental rather than proprietary in nature.⁴⁰

The modern trend is to abrogate the doctrine of sovereign immunity. For example, the Federal Torts Claims Act (FTCA)⁴¹ greatly restricts federal sovereign immunity. Under the Act, an eligible claimant may sue for the negligence of a federal employee,⁴² and the government will be liable if a similarly situated individual would be liable for such actions under the laws of the state where such incident occurred.⁴³ An

³⁷ See *Kawananakoa v. Polyblank*, 205 U.S. 349 (1907) (denying motion to enjoin territory of Hawaii in suit for foreclosure on mortgage; court stated that a political entity cannot be subordinate to courts and laws it created).

³⁸ *Id.* at 353.

³⁹ In a minority of jurisdictions, courts consider state and local government hospitals governmental in nature, and thus not liable for torts committed. See, e.g., *Washington v. City of Columbus*, 222 S.E.2d 583 (Ga. 1975); *City of Leland v. Leach*, 227 Miss. 558, 86 So. 2d 363 (Miss. 1956); *Jerauld County v. St. Paul-Mercury Indemnity Co.*, 76 S.D. 1, 71 N.W.2d 571 (S.D. 1955); *Crowe v. John W. Harton Memorial Hosp.*, 579 S.W.2d 888 (Tenn. 1979).

⁴⁰ See, e.g., *Stein v. Regents of the Univ. of Minn.*, 282 N.W.2d 552, 555 (Minn. 1979) (court will consider several factors in determining whether hospital is governmental or proprietary in nature: (1) if indigents are primary objects of hospital care; (2) source of operating revenues: public funding or payment by patients; (3) similarity to and competition with private institutions; and (4) whether hospital makes a profit).

⁴¹ 28 U.S.C. §§ 2671-2680 (1982).

⁴² *Id.* § 2675.

⁴³ Generally, state law rather than federal law defines whether a duty is owed by a hospital or other governmental body. See, e.g., *Schindler v. United States*, 661 F.2d 552, 561 (6th Cir. 1981) (suit against United States under FTCA for wrongfully granting license to manufacture polio vaccine). However, if state law recognizes such sources, federal statutes may impose a duty upon governmental entities. See, e.g., *Griffin v. United States*, 500 F.2d 1059 (3d Cir. 1974) (suit for injury caused by negligent

FTCA action against the federal government is the exclusive remedy for damages by an injured party in cases of negligence or malpractice by federal government health care personnel acting within the scope of their employment.⁴⁴ However, federal statutes continue to provide immunity for certain medical employees of the federal government.⁴⁵

The FTCA allows several important exceptions to its limited doctrine of sovereign immunity for federal hospitals. One significant exception involves claims against government employees performing a discretionary function.⁴⁶ The rationale behind the discretionary function exception is that judicial control over certain legislative or executive governmental functions would violate the separation of powers doctrine.⁴⁷ Judges determine what constitutes a discretionary function. Generally, if the government hospital employee's action involves "planning" or policy judgment, the action merits immunity.⁴⁸ For example, a court held that refusing to treat an ill person was a discretionary function of a government hospital, since such a decision is in part policy-related.⁴⁹ However, once treatment has begun, the discretionary function exception no longer shields a government hospital from liability for its employees' negligence.⁵⁰ The discretionary function exception does not insulate the federal government from liability in ordinary doctor-patient relationships, since providing such treatment is within a physi-

release of production lot of polio vaccine that paralyzed plaintiff).

⁴⁴ See 28 U.S.C. § 2679(a) (1982).

⁴⁵ See 38 U.S.C. § 4116(a) (1982), which grants immunity to physicians, dentists, podiatrists, optometrists, nurses, physician assistants, expanded-function dental auxiliaries, pharmacists, paramedics, technicians, nursing assistants, and therapists.

⁴⁶ See 28 U.S.C. § 2680(a) (1982), which provides the exception for discretionary function.

⁴⁷ See, e.g., *Dalehite v. United States*, 346 U.S. 15 (1953) (cabinet-level decision to institute fertilizer export program held to be discretionary act and thus not subject to FTCA).

⁴⁸ See, e.g., *Swanson v. United States*, 229 F. Supp. 217 (N.D. Cal. 1964) (exception applies when victim claims that conduct at planning level was cause of damages, but not when claim is based on conduct at operational level).

⁴⁹ See, e.g., *Denny v. United States*, 171 F.2d 365 (5th Cir. 1948), *cert. denied*, 337 U.S. 919 (1949); (finding that providing medical care to pregnant woman was discretionary act); see also *United States v. Gray*, 199 F.2d 239 (10th Cir. 1952) (finding that initial admission to government hospital was a discretionary function under the FTCA, but decision to post guard to protect safety of depressed woman was not discretionary).

⁵⁰ See, e.g., *Rise v. United States*, 630 F.2d 1068 (5th Cir. 1980) (holding that treatment and subsequent referral of aneurysm victim to private facility by Army was not policy decision and, therefore, not protected under discretionary exception to FTCA).

cian's scope of employment.⁵¹

In addition, government hospitals are not liable under the FTCA for their staffs members' intentional torts.⁵² In a hospital setting, intentional tort lawsuits most frequently result from failure to obtain informed consent, which courts have construed as a battery. When a staff member fails to obtain informed consent or commits some other intentional tort, the patient's only recourse is to sue the individual tortfeasor.⁵³

While under the FTCA the federal government's liability for its employees' acts is a question of state law, whether an individual is a United States employee or an independent contractor is a question of federal law.⁵⁴ The plaintiff has the burden of proving that the tortfeasor was a governmental employee.⁵⁵ For many hospital employees, this standard is fairly simple to apply. However, the distinction between employees and nonemployees blurs when considering the status of doctors. In determining whether a physician is a government employee, a primary factor is the government's power to control her day-to-day activities.⁵⁶ At least one court has rejected finding an indepen-

⁵¹ See, e.g., *Jackson v. Kelley*, 557 F.2d 735 (10th Cir. 1977) (court held that status of military physician who negligently treated condition of pregnant patient does not fall within narrow category of federal officials entitled to absolute immunity; treatment of patients involves medical discretion and not governmental discretion protected under FTCA).

⁵² See 28 U.S.C. § 2680(h) (1982), providing an exception for intentional torts; the section proscribes actions against the government for any claim arising out of assault, battery, false imprisonment, false arrest, malicious prosecution, abuse of process, libel, slander, misrepresentation, deceit, or interference with contract rights.

⁵³ See *id.*; see also, e.g., *Hernandez v. United States*, 465 F. Supp. 1071 (D. Kan. 1979) (holding that patient is without recourse under FTCA for surgery without consent pursuant to assault and battery exception).

⁵⁴ See, e.g., *Wood v. Standard Prods. Co.*, 671 F.2d 825 (4th Cir. 1982) (in action for malpractice injury, court applied federal common law and found that doctor contracting to supply medical assistance in little used ports was independent contractor and not employee of United States).

⁵⁵ See, e.g., *Duncan v. United States*, 562 F. Supp. 96 (E.D. La. 1983) (in suit for damages instituted under FTCA, in which truck used to carry United States mail collided with plaintiff's automobile, court concluded that plaintiff had burden of proof that driver was government employee).

⁵⁶ See, e.g., *United States v. Orleans*, 425 U.S. 807, 814 (1976) (court held that critical element in distinguishing agent from contractor is government's power to control detailed physical performance of contractor); see also *Walker v. United States*, 549 F. Supp. 973 (W.D. Okla. 1982) (court considered such factors as limits on physician's authority to employ assistants, methods of billing time, control of work area, and payment of taxes on physician's income in determining that he was not federal employee). The rule with regard to physicians follows the general rule that when persons have

dent contractor relationship solely because the person is a physician.⁵⁷ Factors that courts consider in determining whether a physician is a government employee include the method of paying the physician for services rendered, the physician's authority to select an assistant, and whether the parties intended to create a master-servant relationship.⁵⁸ Once a court determines that an individual is a federal employee, applicable state law determines the scope of employment⁵⁹ and the extent of liability.⁶⁰

B. Charitable Immunity

The doctrine of charitable immunity for many years allowed private hospitals to escape liability for their employees' torts. Charitable immunity developed as a common law doctrine⁶¹ that was first adopted in the United States by Massachusetts in 1876.⁶² The doctrine immunized

authority and control over their activity, they will be regarded as independent contractors. *See, e.g.*, *Wollman v. Gross*, 484 F. Supp. 598 (D.S.D.), *aff'd*, 637 F.2d 544 (8th Cir. 1980), *cert. denied*, 454 U.S. 893 (1981) (fact that federal employee was allowed to select precise time and route he would travel was not sufficient independent authority to change his status to independent contractor when driving the car was within the ordinary scope of his employment).

⁵⁷ *See Henderson v. Bluemink*, 511 F.2d 399 (D.C. Cir. 1974) (finding army physician, who improperly diagnosed patient's condition, to be federal employee).

⁵⁸ *See Bernie v. United States*, 712 F.2d 1271 (8th Cir. 1983) (court considered method of payment for physician's services in determining extent of control of hospital over physician); *Wood v. Standards Prods. Co. Inc.*, 671 F.2d 825 (4th Cir. 1982) (the court examined whether physician and hospital intended to create master/servant relationship in contract between the parties); *Walker v. United States*, 549 F. Supp. 973 (W.D. Okla. 1982) (court considered physician's independent authority to employ assistants as factor in determining federal employee status).

⁵⁹ *See, e.g.*, *Proietti v. Civiletti*, 603 F.2d 88 (9th Cir. 1979) (holding that state law determines whether air force sergeant involved in automobile accident when returning to duty office from base hospital was acting within scope of his employment).

⁶⁰ *See, e.g.*, *Haas v. United States*, 492 F. Supp. 755 (D. Mass. 1980) (holding that Massachusetts medical malpractice law governs malpractice claim brought under the FTCA for alleged anoxic episode caused by oxygen deprivation during knee surgery); *Johnson v. United States*, 409 F. Supp. 1283 (M.D. Fla. 1976) (holding that Georgia medical malpractice law governs action brought under FTCA for negligent treatment and release by Army physicians); *Riddlesperger v. United States*, 406 F. Supp. 617 (N.D. Ala. 1976) (holding that law of state in which negligent act occurs determines liability in action under FTCA alleging negligent misdiagnosis of brain tumor).

⁶¹ *See Feoffees of Heriot's Hosp. v. Ross*, 8 Eng. Rep. 1508 (1846). The doctrine in England was overturned twenty years later by "The Mersey Docks and Harbour Bd." Trustees v. Gibbs, 11 Eng. Rep. 1500 (1866).

⁶² *See McDonald v. Massachusetts General Hosp.*, 120 Mass. 432 (1876), *overruled in Colby v. Carney Hosp.*, 356 Mass. 527, 254 N.E.2d 407 (1969).

charitable hospitals from liability for their employees' torts to protect the hospitals' sources of funding.⁶³ Courts feared that without such protection, hospital donations would decline because donors do not wish their money to pay court awards for workers' negligence.⁶⁴ Also, the courts felt they should not allow those benefiting from a charitable institution to sue the institution for negligence.⁶⁵

Similar to governmental immunity, the modern trend is toward abrogating the charitable immunity doctrine due to the inherent unfairness of allowing some hospitals to evade liability simply because they are charitable organizations.⁶⁶ Although once in widespread use, only two jurisdictions retain the doctrine in its pure form today.⁶⁷ Some jurisdictions have abrogated hospital charitable immunity to the extent that insurance covers tort liability.⁶⁸ Other jurisdictions have limited liability to the charity's nontrust assets.⁶⁹ A few jurisdictions have statutorily limited the doctrine by narrowly defining "charitable" hospitals.⁷⁰

⁶³ American courts continued to recognize charitable immunity for many years based on one of four grounds: that imposing liability would divert trust funds for purposes outside the donor's intent, that the doctrine of *respondeat superior* should not apply to impose liability on nonprofit charities, that a charity beneficiary assumes the risk of the charity's negligence, or that allowing liability for charities would discourage donations. W. KEETON, D. DOBBS, R. KEETON & D. OWEN, PROSSER AND KEETON ON TORTS § 133, at 1070 (5th ed. 1984).

⁶⁴ See, e.g., *Jensen v. Maine Eye and Ear Infirmary*, 107 Me. 408, 409, 78 A. 898, 899 (1910) (in negligence action against hospital for fatal injuries sustained when patient fell out of hospital window, the court stated "it is not difficult to discern that private gift and public aid would not alone be contributed to feed the hungry law of litigation, and charitable institutions of all kinds would ultimately cease or become greatly impaired in their usefulness").

⁶⁵ See, e.g., *Powers v. Massachusetts Homeopathic Hosp.*, 109 F. 244 (1st Cir.), cert. denied, 183 U.S. 695 (1901).

⁶⁶ See, e.g., *Adkins v. St. Francis Hosp.*, 149 W. Va. 705, 143 S.E.2d 154 (1965) (action for negligence in allowing paralyzed patient to fall upon hot radiator, thereby sustaining serious burns; court overruled charitable immunity doctrine noting apparent trend toward making charity liable for negligence of its employees).

⁶⁷ See generally RESTATEMENT (SECOND) OF TORTS § 895E (1965).

⁶⁸ Arkansas and Wyoming have not abolished hospital charitable immunity. See, e.g., *Williams v. Jefferson Hosp. Ass'n*, 246 Ark. 1231, 442 S.W.2d 243 (1969); *Lutheran Hosps. and Homes Soc'y of Am. v. Yepsen*, 469 P.2d 409 (Wyo. 1970).

⁶⁹ See, e.g., ME. REV. STAT. ANN. tit. 14, § 158 (1964); MD. HEALTH - GEN. CODE ANN. § 419-354 (1968). Several jurisdictions have limited the immunity to the actual funds held in trust for the hospital, but permit recovery against the hospitals nontrust assets, including insurance. See, e.g., *Tidwell v. Smith*, 27 Ill. App. 2d 63, 169 N.E.2d 157 (1960); *O'Quin v. Baptist Memorial Hosp.*, 184 Tenn. 570, 201 S.W.2d 694 (1947).

⁷⁰ Some jurisdictions have limited application of the immunity by narrowing the

C. *The Emergence of a National Standard of Care*

The duty of a hospital toward a patient is generally defined as the reasonable care required by the patient's known or apparent condition.⁷¹ Some jurisdictions have imposed a duty to take reasonable steps to discover the patient's physical and mental status.⁷² However, the standard of reasonable care for treating a patient differs among jurisdictions. Courts have particularly struggled in defining the measure of diligence and expertise required of a hospital. Initially courts looked to the practices within the hospital's particular community or locality to determine the appropriate standard of care.⁷³ However, courts have increasingly employed a national standard of reasonable care in determining the hospital's duty to its patients.⁷⁴ In defining a national standard of care, some courts have looked to the standards and guidelines developed by national health organizations.⁷⁵

1. Locality Rule

Under the locality rule, which defined a hospital's standard of care by looking to local practices,⁷⁶ expert testimony was necessary to establish the local standard of care at a particular time for a given procedure or illness.⁷⁷ While some local precedent developed under this approach,

definition of a charity. *See, e.g.,* Avellone v. St. John's Hosp., 165 Ohio St. 467, 135 N.E.2d 410 (1956).

⁷¹ *See, e.g.,* Lutheran Hosp. and Homes Soc'y of Am. v. Yepson, 469 P.2d 409 (Wyo. 1970) (holding hospital not entitled to immunity from suit for employees' negligence because hospital generally made charges in connection with services rendered and substantial payments were made on behalf of charity patients by government agencies from public funds); *see also* J.W. Resort, Inc. v. First Am. Nat'l Bank, 3 Ark. App. 290, 625 S.W.2d 557 (1981) (holding that hospital must in fact supply such charitable services for which it was ostensibly created).

⁷² *See, e.g.,* Emerick v. Raleigh Hills Hosp.-Newport Beach, 133 Cal. App. 3d 575, 184 Cal. Rptr. 92 (1982).

⁷³ *See, e.g.,* Mason v. Geddes, 258 Mass. 40, 154 N.E. 519 (1926).

⁷⁴ *See, e.g.,* Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 349 A.2d 245 (1975).

⁷⁵ *See, e.g.,* Smith v. John C. Lincoln Hosp., 118 Ariz. 549, 578 P.2d 630 (1978).

⁷⁶ *See, e.g.,* Greenberg v. Michael Reese Hosp., 83 Ill. 2d 282, 415 N.E.2d 390 (1980). *See generally* Dornette, *The Legal Impact of Voluntary Standards in Civil Actions Against the Health Care Provider*, 22 N.Y.L. SCH. L. REV. 925 (1977).

⁷⁷ *See, e.g.,* Copeland v. Robertson, 236 Miss. 95, 110, 112 So. 2d 236, 241 (1959) (holding that "a physician is bound to bestow such reasonable diligence as physicians and surgeons in good standing in the same neighborhood, in the same general line of practice, ordinarily have and exercise in like cases."); *see also* Mason v. Geddes, 258 Mass. 40, 154 N.E. 519 (1926).

court decisions in one jurisdiction provided little guidance to courts or hospitals in other jurisdictions. Each case was relevant only in the community involved.

The locality rule defined a hospital's duty of care by the standard accepted by other similarly situated institutions in the community where the action arose.⁷⁸ The experts testifying as to the common practice in the locality for the procedure in question were usually local doctors.⁷⁹ Generally, courts would not consider national standards published through various sources or available through expert testimony from outside the community.⁸⁰ However, when there was a flagrant departure from well-established medical practice, plaintiffs could show that particular medical standards of a community were not a fit standard of care.⁸¹

The locality rule's purpose was to prevent unfair comparison between small rural hospitals and better financed urban hospitals.⁸² Urban hospitals were not only wealthier, they also provided much greater opportunity for learning state-of-the-art procedures.⁸³ However, advanced communication systems and broadening educational opportunities have weakened this latter argument.⁸⁴ Today, a myriad of medical

⁷⁸ See, e.g., *Krause v. Bridgeport Hosp.*, 169 Conn. 1, 362 A.2d 802 (1975).

⁷⁹ The "locality rule" apparently was first extended to medical care by *Small v. Howard*, 128 Mass. 131 (1880), *overruled*, *Brune v. Belinkoff*, 354 Mass. 102, 235 N.E.2d 793 (1968). The *Small* court, in contemplating a fractured wrist that was allegedly given improper treatment, stated that the physician "was bound to possess that skill only which physicians and surgeons of ordinary ability and skill, practicing in similar localities, with opportunities for no larger experience, ordinarily possessed" 128 Mass. at 136; see also *Avey v. St. Francis Hosp. & School of Nursing, Inc.*, 201 Kan. 687, 442 P.2d 1013 (1968); *Walker v. North Dakota Eye Clinic, Ltd.*, 415 F. Supp. 891 (D.N.D. 1976).

⁸⁰ See, e.g., *Chandler v. Neosho Memorial Hosp.*, 223 Kan. 1, 574 P.2d 136 (1977).

⁸¹ See, e.g., *Townsend v. Kiracoff*, 545 F. Supp. 465 (D. Colo. 1982).

⁸² See, e.g., *Small*, 128 Mass. 131.

⁸³ See *Pederson v. Dumouchel*, 72 Wash. 2d 73, 79, 431 P.2d 973, 977 (1967), in which the Washington Supreme court discussed the original reasoning for the locality rule:

When there was little inter-community travel, courts required experts who testified to the standard of care that should have been used to have a personal knowledge of the practice of physicians in that particular community where the patient was treated. It was accepted theory that a doctor in a small community did not have the same opportunities and resources as did a doctor practicing in a large city to keep abreast of advances in his profession; hence, he should not be held to the same standard of care and skill as that employed by doctors in other communities or in larger cities.

⁸⁴ See, e.g., *Brune v. Belinkoff*, 354 Mass. 102, 108-09, 235 N.E.2d 793, 798

publications disseminate information about modern procedures and treatments are available to health care personnel in even the smallest communities. Similarly, more advanced information systems, such as videotaped surgical procedures, are widely available.

In its original form, the locality rule produced significant administrative problems. In smaller, rural communities, qualified experts on local practices were often difficult to obtain.⁸⁵ Also, the defendant hospital was often a community's *only* hospital, allowing it to set its own standards.⁸⁶ Critics further attacked the locality rule for promoting a "conspiracy of silence" among physicians in the same locality, allowing doctors and hospitals to evade liability.⁸⁷ When only a few experts resided in rural communities, and they all refused to testify or would only testify in favor of the hospital, it was easy to intuit collusion. These problems unfairly disadvantaged injured patients.

Thus, many jurisdictions have modified or abolished the locality rule. Some courts have adopted a "same or similar" locality standard that allows comparison to hospitals in the same community *or* in communities with similar characteristics.⁸⁸ This modification reduces some of the original locality rule's problems by allowing comparison between a larger number of hospitals. It also provides a greater number of expert witnesses and decreases the opportunity for collusion between health

(1968), in which the Massachusetts Supreme Court observed:

The time has come when the medical profession should no longer be Balkanized by the application of varying geographic standards in malpractice cases The present case affords a good illustration of the inappropriateness of the "locality" rule to existing conditions. The defendant was a specialist practicing in New Bedford, a city of 100,000, which is slightly more than fifty miles from Boston, one of the medical centers of the nation, if not the world.

Id. at 108-09.

⁸⁵ See, e.g., *King v. Murphy*, 424 So. 2d 547, 549-50 (Miss. 1982), *modified*, *Hall v. Hilbun*, 466 So. 2d 856 (Miss. 1985) (expert witness' testimony not admitted into evidence because of lack of knowledge about local practices; plaintiff asserted that all doctors are equally trained today in same schools).

⁸⁶ See, e.g., *Shilkret v. Annapolis Emergency Hosp. Ass'n*, 276 Md. 187, 194; 349 A.2d 245, 253 (1975) (stating that locality rule would not apply to hospital); see also *In re Eastern Transp. Co.*, 60 F.2d 737, 740 (2d Cir. 1932) (holding that body may not set its own standard to exclusion of court's scrutiny because that standard may be negligent).

⁸⁷ See, e.g., *Faris v. Doctors Hosp., Inc.*, 18 Ariz. App. 264, 501 P.2d 440 (1972); *Belshaw v. Feinstein*, 258 Cal. App. 2d 711, 65 Cal. Rptr. 788 (1968).

⁸⁸ See, e.g., *Avey v. St. Francis Hosp. and School of Nursing, Inc.*, 201 Kan. 687, 442 P.2d 1013 (1968); *Segreti v. Putnam Community Hosp.*, 88 A.D.2d 590, 449 N.Y.S.2d 785 (1982); *Little v. Cross*, 217 Va. 71, 225 S.E.2d 387 (1976).

care workers.

2. A National Standard of Care

Jurisdictions that have rejected the locality rule altogether⁸⁹ have replaced it with a national standard of care.⁹⁰ Under this approach, courts look to the standards adopted by that class of health care persons or institutions engaged in the area of practice or providing a particular treatment.⁹¹ This standard was first articulated in *Shilkret v. Annapolis Emergency Hospital Association*,⁹² in which the Maryland Supreme Court stated, "a physician is under a duty to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances."⁹³ Under this standard, liability arises when a medical care professional departs from the standards applicable to the average member of the profession practicing the specialty in issue.⁹⁴ By considering evidence of the procedures and treatments available in the best qualified hospitals, the courts are establishing national standards that require the highest level of care and treatment available.⁹⁵

A national standard of care eliminates many of the substantive and administrative problems associated with the locality rule. Furthermore, case law based on a national standard provides precedent for the entire nation, not just individual localities. The trend toward a national standard will likely continue as courts in all jurisdictions become aware of its

⁸⁹ See, e.g., *Speed v. State*, 240 N.W.2d 901 (Iowa 1976); *Blair v. Eblen*, 461 S.W.2d 370 (Ky. 1970); *Taylor v. Hill*, 464 A.2d 938 (Me. 1983); *Shilkret v. Annapolis Emergency Hosp. Ass'n*, 276 Md. 187, 349 A.2d 245 (1975); *Pederson v. Dumouchel*, 72 Wash. 2d 73, 431 P.2d 973 (1967).

⁹⁰ See, e.g., *Pederson v. Dumouchel*, 72 Wash. 2d 73, 78, 431 P.2d 973, 977 (court adopts national standard of care because even same or similar community rule could not alleviate problem of small group of physicians in community, who establish standard of care below legal minimum).

⁹¹ See, e.g., *Brune v. Belinkoff*, 354 Mass. 102, 108, 235 N.E.2d 793, 798 (1968) (physician or surgeon who holds self out as specialist should be held to standard of skill and care of average physician practicing such specialty, taking into account advances in profession and permitting consideration of medical resources available to her); see also *Buck v. St. Clair*, 108 Idaho 743, 702 P.2d 781 (1985).

⁹² 276 Md. 187, 349 A.2d 245 (1975).

⁹³ *Id.* at 196, 349 A.2d at 251 (citing *Blair v. Eblen*, 461 S.W.2d 370, 372-73 (Ky. 1970) and *Pederson*, 72 Wash. 2d at 79, 431 P.2d at 978).

⁹⁴ See, e.g., *Moultrie v. Medical Univ.*, 280 S.C. 159, 311 S.E.2d 730 (1984).

⁹⁵ See, e.g., *Pederson*, 72 Wash. 2d at 79, 431 P.2d at 979 (reversing judgment of lower court for improper jury instruction on local standard of care, thereby denying admittance of evidence of national standards).

benefits.

III. EXPANSION OF HOSPITAL LIABILITY

A. *Elimination of the Hospital Exception to the Doctrine of Respondeat Superior*

The doctrine of *respondeat superior* holds that generally employers are accountable for their employees' torts committed in the ordinary scope of their employment.⁹⁶ For many years, hospitals were not liable for their employees' actions under an exception to the *respondeat superior* doctrine. This exception arose in *Schloendorff v. Society of New York Hospital*.⁹⁷ The *Schloendorff* court characterized nurses and physicians as independent contractors, placing them outside the doctrine's scope.⁹⁸ This exception freed hospitals from liability for most negligent actions of health care workers.⁹⁹ The court found that holding the hospital liable for failing to maintain control over a physician's medical decisions was improper because the hospital lacked the necessary knowledge and expertise to practice medicine and could not effectively control the medical staff.¹⁰⁰

The *Schloendorff* decision distinguished between providing a place where a patient could receive care and treatment as opposed to actually administering medical care or treatment.¹⁰¹ In cases of negligence related to providing health facilities, a hospital was responsible since such health care activity was "administrative" rather than "medical."¹⁰²

⁹⁶ See Seavey, *Speculations as to "Respondeat Superior,"* HARV. LEG. ESSAYS 433 (1934). The doctrine of *respondeat superior* imputes upon an otherwise faultless employer responsibility for the injury causing actions of its employees. Based upon the control theory, the employer must have control over the person's actions for the person to be an employee, and such an employee must be acting within the scope of the employment for the doctrine to be effective.

⁹⁷ 211 N.Y. 125, 105 N.E. 92 (1914) (plaintiff-patient's doctors surgically removed, without patient's consent, fibroid tumor; patient later developed gangrene in her arm, necessitating removal of several fingers; court of appeals held that hospital was not liable for doctor's malpractice).

⁹⁸ *Id.*

⁹⁹ *Id.* at 126-27, 105 N.E. at 93-94.

¹⁰⁰ *Id.* at 127, 105 N.E. at 94. The court reasoned that, "[t]he wrong was not that of the hospital; it was that of physicians, who were not the defendant's servants, but were pursuing an independent calling . . . safeguarded by stringent penalties. If, in serving their patient, they violated her commands, the responsibility is not the [hospital's]; it is theirs." *Id.* at 131-32, 105 N.E. at 94.

¹⁰¹ *Id.* at 128-29, 105 N.E. at 93.

¹⁰² *Id.* at 131-32, 105 N.E. at 94-95 (administrative actions of hospital involve furnishing safe and adequate facilities to care for patient, and to provide routine daily

Consequently, a hospital was responsible for only a small fraction of the negligent actions occurring within the institution. However, since courts could not neatly categorize all provider actions as administrative or medical, the distinction often caused problems of characterization.¹⁰³

In 1957 New York first rejected the hospital exception to *respondeat superior* in *Bing v. Thunig*.¹⁰⁴ The *Bing* court reasoned that a hospital does far more than merely provide facilities for curing illnesses.¹⁰⁵ The court noted that a hospital employs many physicians, nurses, administrators, and other laborers for the purpose of operating the facility.¹⁰⁶ Because hospitals hold themselves out as being engaged in the process of treating patients, they could not argue that they merely provided a place for health care providers to work and that the staff acted entirely on its own responsibility.¹⁰⁷ The *Bing* court reasoned that a hospital should "shoulder the responsibilities borne by everyone else."¹⁰⁸ The court held that the "[t]est should be, for these institutions, whether charitable or profit-making, as it is for every other employer, was the person who committed the negligent injury-producing act one of its employees and, if he was, was he acting within the scope of his employment."¹⁰⁹ According to *Bing*, the dichotomy between administrative and medical actions involved an unworkable doctrine creating confusion and uncertainty.¹¹⁰

B. The Doctrine of Corporate Negligence

The doctrine of corporate negligence has greatly expanded hospital liability. Under this doctrine, hospitals are liable if they fail to ensure the competence of health care providers, and/or to properly supervise

care; however, court held that actions carried out by nurses pursuant to doctor's orders, so-called medical actions, were not responsibility of hospital).

¹⁰³ See, e.g., *Bing v. Thunig*, 2 N.Y.2d 656, 660-61, 143 N.E.2d 3, 4-5 (1957) (particular actions, such as blood transfusions, may have characteristics that are both administrative and medical).

¹⁰⁴ *Id.* (patient, during surgery, was burned when sheeting surrounding patient, on which alcohol-based antiseptic had been spilt, caught fire from electric cautery used by surgeon; nurse failed to use care in applying antiseptic and failed to inspect linen for spills as instructed to do; court held that hospital is far too involved in care and treatment of patients to be exempt from liability).

¹⁰⁵ See *id.* at 666, 143 N.E.2d at 8.

¹⁰⁶ See *id.*

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ See *id.* at 666-67, 143 N.E.2d at 8.

the care provided.¹¹¹ The corporate negligence doctrine extends hospital liability to encompass the actions of independent practitioners who belong to the hospital staff.¹¹²

The landmark case recognizing the corporate negligence doctrine is *Darling v. Charleston Community Memorial Hospital*.¹¹³ In *Darling*, a high school football player broke his leg and was taken to a hospital emergency room. Without calling for an orthopedic specialist, the attending physician applied traction and a plaster cast.¹¹⁴ Following the application of the cast, signs that the treatment was improper, including complaints of pain by the plaintiff and swollen, discolored toes, were not brought to the doctor's attention.¹¹⁵ When he finally became aware of his patient's condition, the doctor attempted to remedy the problem by notching the cast. Two days later the cast was totally removed, the leg having telltale signs of massive infection. A specialist was not called in until the young man was admitted to a different hospital eleven days later. The leg had to be amputated. In determining the hospital's standard of care, the court considered the Standards for Hospital Accreditation, state licensing regulations, and the defendant hospital's by-laws.¹¹⁶ The court imputed to hospitals an independent duty of care for monitoring patients' treatment and duty of care to avoid harm.¹¹⁷ The court found the defendant hospital negligent for failing to supervise the attending physician and for failing to require consultation with an orthopedic specialist, particularly after complications developed.¹¹⁸

The doctrine of corporate negligence does not make hospitals absolute insurers of patients' health, but it does require that hospitals create committees to ensure that treatment is proper, and to review the competence of each individual staff member.¹¹⁹ A number of jurisdictions

¹¹¹ See generally Southwick, *The Hospital's New Responsibility*, 17 CLEV.-MAR. L. REV. 146 (1968).

¹¹² See generally Copeland, *Hospital's Responsibility for Basic Care Provided by Medical Staff Members: "Am I My Brother's Keeper?"*, 5 N. KY. L. REV. 27 (1978).

¹¹³ 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966) (holding hospital liable for negligently failing to review treatment given to patient by staff physician).

¹¹⁴ *Id.* at 328, 211 N.E.2d at 255.

¹¹⁵ *Id.*

¹¹⁶ See *id.*

¹¹⁷ See *id.* at 332, 211 N.E.2d at 256-57.

¹¹⁸ See *id.* at 333, 211 N.E.2d at 258. "That the defendant corporation [hospital] then owed to the said plaintiff a duty to use that degree of skill in the care of such patient as would be exercised by institutions of like kind and character. . . ." *Id.*

¹¹⁹ *Id.*

have followed *Darling's* lead in recognizing the doctrine of corporate negligence.¹²⁰ However, *Darling* only found hospital liability for staff employee negligence. The opinion left open the question of whether its rule extended to nonemployee physicians. The opinion also left unanswered the question of whether liability extends to actions that do not involve gross negligence. Several jurisdictions have held that a hospital's duty to supervise extends to all physicians and health care providers, including independent contractors administering medical care within the institution.¹²¹ Although *Darling* involved gross negligence by a physician, another state court extended the doctrine to cases not involving gross negligence.¹²²

C. *The Ostensible Agency Doctrine*

Under the doctrine of ostensible agency, a hospital is held vicariously responsible for the acts, errors, and omissions of independent contractor physicians and other health professionals if, considering all the facts and circumstances surrounding the case, the patient reasonably believes that the physician is an employee of the hospital.¹²³ Three elements have been identified by courts as supporting a finding of ostensible agency: that there was a reasonable basis to conclude that the physician providing hands-on care to the patient was controlled by the hospital;¹²⁴ that this impression was created by the general behavior of the hospital either through public relations or through the ways and means by which the patient is referred to the hospital;¹²⁵ and that the patient

¹²⁰ See, e.g., *Joiner v. Mitchell County Hosp. Auth.*, 125 Ga. App. 1, 186 S.E.2d 307 (1971) (holding hospital liable under corporate negligence doctrine for patient's wrongful death when it negligently gave doctor staff privileges without investigating his professional qualifications).

¹²¹ See, e.g., *Tucson Medical Center, Inc., v. Misevch*, 113 Ariz. 34, 545 P.2d 958 (1976) (considered corporate negligence doctrine in holding that medical review documents and testimony not subject to subpoena); *Elam v. College Park Hosp.*, 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982); *Pedroza v. Bryant*, 101 Wash. 2d 226, 677 P.2d 166 (1984) (adopting corporate negligence doctrine and holding that hospital's duty to monitor does not extend to physician's private practice outside hospital).

¹²² See, e.g., *Elam v. College Park Hosp.*, 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982) (extending liability to nonstaff surgeons); *Ravenis v. Detroit General Hosp.*, 63 Mich. App. 79, 234 N.W.2d 411 (1976); *Pedroza v. Bryant*, 101 Wash. 2d 226, 677 P.2d 166 (1984) (extending liability to negligence of nonstaff physicians); *Pederson v. Dumouchel*, 72 Wash. 2d 73, 431 P.2d 973 (1967) (extending liability to hospital staff for failing to forward medical records).

¹²³ See *Mehlman v. Powell*, 281 Md. 269, 378 A.2d 1121 (1977).

¹²⁴ See *Hill v. Citizens Nat'l Trust & Sav. Bank*, 9 Cal. 2d 172, 69 P.2d 853 (1937).

¹²⁵ See *Howard v. Park*, 37 Mich. App. 496, 195 N.W.2d 39 (1972).

reasonably relied upon the mistaken impression.¹²⁶

The doctrine had its beginnings in the emergency room and among hospital-based physicians. In one of the earliest cases, *Stanhope v. Los Angeles College of Chiropractic*,¹²⁷ the California Appellate Court found that a radiologist was the ostensible agent of the hospital, even though he conducted an independent practice and billed in his own name. The court held that because a sign over the door to the physician's laboratory read "Los Angeles X-Ray Laboratory," the patient had no duty to conduct an investigation to determine whether the physician was an employee or an independent contractor, especially considering that the plaintiff was in pain and in critical need of health care services.

Courts have looked to a variety of factors to determine whether the impression of ostensible agency has been sufficiently strong. A primary consideration is the method of referral. If the hospital made the referral and arranged for the physician to treat the patient, courts are predisposed to find an agency relationship, especially if all health care treatment was rendered at the hospital.¹²⁸

Some courts have held that lack of meaningful choice of physician, especially in emergencies, gives rise to a finding of agency.¹²⁹ Courts will also carefully evaluate posted signs to ascertain whether they create the impression that the purported independent office is in reality an integral part of the hospital's operations.¹³⁰ Some courts have held hospital public relations efforts describing the hospital as a "full service facility" to be determinative on the issue of whether emergency room services were being provided by the hospital.¹³¹ Wearing of garments similar to those worn by hospital employees, displaying the hospital insignia, and failing to inform a patient in the consent form as to the physician's independent contractor status have been considered relevant to the conclusion that an ostensible agency relationship has been

¹²⁶ See *Brownsville Medical Center & Valley Community Hosp. v. Garcia*, 84-369-CV, slip. op. (Tex. App. Corpus Christi, June 28, 1985) as reported in Note, *Medical Malpractice — Ostensible Agency and Corporate Negligence — Hospital Liability May Be Based on Either Doctrine of Ostensible Agency or Doctrine of Corporate Negligence*, 17 ST. MARY'S L.J. 551 (1986).

¹²⁷ 54 Cal. App. 2d 141, 128 P.2d 705 (1942).

¹²⁸ See *Howard*, 37 Mich. App. 496, 195 N.W.2d 39.

¹²⁹ See *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 426 N.E.2d 1187 (1980).

¹³⁰ 54 Cal. App. 2d 141, 128 P.2d 705 (1942).

¹³¹ See *Adamski v. Tacoma General Hosp.*, 20 Wash. App. 98, 579 P.2d 970 (1978).

created.¹³²

The impression created in the patient by these factors, which may establish an agency by estoppel, is a central element considered by courts applying the doctrine.¹³³ Courts usually presume that a patient comes to a hospital expecting to receive health care from the hospital.¹³⁴ They will also presume that the patient was not aware of the status of a hospital-based physician as an independent contractor, refusing to hold that a patient has a duty to inquire as to the nature of the relationship between the hospital and the physician.¹³⁵ In some cases the courts have determined that any requirement that the patient make such inquiry into the status of the physician would be unreasonable.¹³⁶

D. Extension of Hospital Liability

Expanding hospitals' liability is supported by several lines of reasoning. First, modern health care institutions are far more than providers of medical facilities; they hold themselves out as "full service facilities" or as a source of emergency and other special care.¹³⁷ Commensurate with the increased public reliance upon hospitals for health services, a corresponding increase in the scope of liability is warranted.¹³⁸ Second, the hospital is best able to supervise physicians' actions. The hospital can make observations on site and can control physicians in awarding and withdrawing staff privileges.¹³⁹ Finally, *respondeat superior*, with liability often depending on whether an individual was engaged in administrative rather than treatment activity, has proven insufficient in providing an appropriate basis for determining hospital liability for staff negligence.¹⁴⁰ Often, minute distinctions in the status of health care workers, under the guise of whether they were performing administrative tasks or providing medical treatment, have determined whether a hospital was liable.¹⁴¹

¹³² See *Green v. Rogers*, 147 Ill. App. 3d 1009, 498 N.E.2d 867 (1986).

¹³³ See *Hill v. Citizens Nat'l Trust & Sav. Bank*, 9 Cal. 2d 172, 69 P.2d 853 (1937).

¹³⁴ See *Mehlman v. Powell*, 281 Md. 269, 373 A.2d 1121 (1977).

¹³⁵ See *Arthur v. St. Peters Hosp.*, 169 N.J. Super. 575, 405 A.2d 443 (1979).

¹³⁶ See *Capan v. Divine Providence Hosp.*, 287 Pa. Super. 364, 430 A.2d 647 (1980).

¹³⁷ See *Pedroza v. Bryant*, 101 Wash. 2d 226, 231, 677 P.2d 166, 169 (1984).

¹³⁸ *Id.* (increased public reliance favors adoption of corporate negligence).

¹³⁹ *Id.* at 231-32, 677 P.2d at 169.

¹⁴⁰ See, e.g., *Bost v. Riley*, 44 N.C. App. 638, 647, 262 S.E.2d 391, 396 (1980) (recognizing corporate negligence doctrine as basis of liability apart and distinct from *respondeat superior*).

¹⁴¹ The unworkability of the administrative and treatment activities distinction is

Thus, the courts acted properly in abrogating the exception to *respondere superior* and adopting the doctrines of corporate negligence and ostensible agency. This judicial action not only recognizes hospitals' representations of themselves as providers of care and treatment, but also accommodates the public's reasonable perception of them as such. *Darling* and its progeny, as well as the ostensible agency cases, are significant because they impose a responsibility to the patient independent of the duty owed by physicians. Thus, the courts have established a clear basis for hospital accountability.

IV. PROPOSAL FOR ADOPTION OF A NATIONAL STANDARD OF CARE IN MANAGEMENT AND TREATMENT OF PERSONS WITH AIDS

A national standard of care for hospitals can be derived from many sources. Statutes and regulations can serve as evidence of the standard of care required. Federal statutes regulating hospitals provide evidence of national policy as to the acceptable level of care.¹⁴² Similarly, standards of recognized professional associations or accrediting bodies may establish a national standard of care.¹⁴³ Courts adopting a national standard of care have accepted such materials as evidence of the national norm.¹⁴⁴

Although no cases have yet arisen regarding the standard of care for treating persons with AIDS, or for hospital policy on matters related to patient or health care workers diagnosed with AIDS, such cases will inevitably arise in the near future.¹⁴⁵ The CDC policies and guidelines

illustrated by the experience of the New York courts. *Compare* *Iacono v. New York Polyclinic Med. School & Hosp.*, 296 N.Y. 502, 68 N.E.2d 450 (1946) (placing an improperly capped hot water bottle on patient found to be administrative) *with* *Sutherland v. New York Polyclinic Med. School & Hosp.*, 289 N.Y. 682, 82 N.E.2d 583 (1948) (keeping hot water bottle on patient for too long found to be medical).

¹⁴² *See, e.g.*, statutes creating Medicare (42 U.S.C. §§ 1395-1395xx (1982)) and Medicaid (42 U.S.C. §§ 1396-1396p (1982)); *see also* Hill Burton Act, 42 U.S.C. §§ 291-291o (1982) (part of the Health Program Extension Act of 1973).

¹⁴³ *See, e.g.*, AMERICAN HOSP. ASSOCIATION (AHA), STATEMENT ON THE PATIENT BILL OF RIGHTS (1975); JOINT COMMISSION ON ACCREDITATION OF HOSPITALS (JCAH), ACCREDITATION MANUAL (1985).

¹⁴⁴ *See, e.g.*, *Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966) (accepting hospital licensing regulations, accreditation standards, and hospital by-laws as evidence of standard of care applicable to hospital's conduct); *see also* *Sullivan v. Sisters of St. Francis*, 374 S.W.2d 294 (Tex. Ct. Civ. App. 1963) (hospital's liability rested on its failure to employ licensed pharmacist as required by standards of JCAH and AHA).

¹⁴⁵ *See generally* Tarr, *The Legal Issues Under AIDS*, 11 NAT'L L.J. 1 (1985).

could provide a proper national standard of care in AIDS-related¹⁴⁶ matters. These policies and guidelines could provide the appropriate standard for conducting invasive procedures,¹⁴⁷ and health care workers' treatment of AIDS patients.¹⁴⁸

The CDC guidelines, as reported in the *Morbidity and Mortality Weekly Report* (MMWR) and other intermittent CDC publications, provide the most current, accurate standards available for treating and caring for AIDS patients.¹⁴⁹ Courts' use of these guidelines in determining the standard of care in AIDS-related litigation would provide an efficient, clear, and authoritative basis for determining liability. Adopting these guidelines would also accommodate advances in medical knowledge and treatment of AIDS, since they are modified as CDC research advances the understanding of AIDS' transmission and treatment.¹⁵⁰

Thus, the proposed standard of care would not be fixed in time by a particular state of medical knowledge. Courts could make hospitals responsible for implementing new guidelines as they are disseminated by the CDC. Moreover, these guidelines would provide exact standards as of the date of any incident. The court would thus have a definite and manageable reference in determining whether a hospital had breached its duty at any particular time. Failing to follow the CDC standards would create a rebuttable presumption of breach by a hospital. The onus of proof would then fall upon the hospital to show good cause for the staff's deviation from the standard.

Along with the other considerations discussed, the particular charac-

¹⁴⁶ See, e.g., *Diagnosis and Management of Mycobacterial Infection and Disease in Persons with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus Infection*, 35 MORBIDITY AND MORTALITY WEEKLY REP. 448 (1986) [hereafter *Diagnosis of Infection*].

¹⁴⁷ See, e.g., *Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus During Invasive Procedures*, 35 MORBIDITY AND MORTALITY WEEKLY REP. 221 (1986).

¹⁴⁸ See, e.g., *Diagnosis of Infection*, *supra* note 146; *Dialysis Treatment*, *supra* note 13.

¹⁴⁹ The MORBIDITY AND MORTALITY WEEKLY REPORT (MMWR) is published weekly for Centers for Disease Control and the Department of Health and Human Services. MMWR's publish the latest discoveries concerning the spread and treatment of various communicable diseases including AIDS. MMWR is available from the Public Inquiries Office, Information Distribution Services Branch, Management Analysis and Service Office, Centers for Disease Control (CDC), Atlanta, Georgia.

¹⁵⁰ The CDC conducts independent research on the transmission, spread, and treatment of the disease. The MMWR's report this research as well as the findings of research conducted by physicians and scientists around the country.

teristics of AIDS necessitate adopting national guidelines. AIDS can no longer be viewed as a disease limited to the major coastal cities where there are large homosexual communities, in which hospitals' liability can be determined by reference to sophisticated local levels of practice.¹⁵¹ AIDS has become a national epidemic, affecting men, both homosexual and heterosexual, women, and children.¹⁵² Although less than 30,000 people have been diagnosed with AIDS, HIV has infected an estimated 500,000 to 1,000,000 Americans, indicating the potential increase in the number of persons who will ultimately contract AIDS.¹⁵³ With the rise in AIDS cases, the probability that transmission will occur in a hospital rises. Since the CDC guidelines entail the measures most effective in limiting the transmission of AIDS in the hospital setting, using the guidelines will limit the possibility of such transmission. Courts' adoption of the guidelines as proof of the standard of care for hospitals in AIDS treatment will provide added incentives to bring policies and practices into conformity with the CDC guidelines. Further, AIDS patients will more likely receive appropriate treatment if hospitals conform to the CDC guidelines. Without the guidelines as a standard of care, hospitals might capitulate to the unreasoned fear of those who are unsophisticated in the treatment of AIDS patients.

A. *Benefits of a National Standard of Care*

A number of benefits would result from adopting the CDC guidelines on AIDS as a national standard of care. This section discusses how such action would address concerns about transmission of AIDS in a health care setting, provide cost containment for hospitals saddled with the cost of treating uninsured patients, and ensure consistency and uniformity in court decisions.

Adopting the CDC guidelines as a national standard of hospital care will reduce the likelihood of accidental transmission of AIDS by mandating procedures governing the care of AIDS patients and the disposal of waste products. Although most large urban hospitals already follow

¹⁵¹ See Baum, *AIDS Epidemic Continues, Moving Beyond High-Risk Groups*, 63 CHEMICAL AND ENGINEERING NEWS 19 (1985); see also Ismach, *AIDS: Can the Nation Cope?*, 26 MED. WORLD NEWS 46-71 (1985).

¹⁵² See generally INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, *MOBILIZING AGAINST AIDS: THE UNFINISHED STORY OF A VIRUS* 10-40 (1986) [hereafter *THE UNFINISHED STORY*].

¹⁵³ See 1985 PUBLIC HEALTH SERVICE BULLETIN, *supra* note 18. Note that not everyone who is infected by the HIV virus actually contracts the disease, but they may be capable of transmitting the virus to other persons who may later contract the disease.

proper contamination procedures, small rural hospitals may not, since they likely encounter relatively few AIDS patients and in the past may have had few if any patients requiring infection control measures. A health care worker is most likely to contract AIDS due to substandard anticontamination procedures.

A further benefit would be uniform and improved care in treating patients. By requiring all health care institutions to follow the most authoritative care procedures, fewer patients would be injured or have their conditions worsened through substandard care. The few that might be injured would at least have appropriate legal remedies.

Cost containment is a real concern in the highly competitive area of hospital care.¹⁵⁴ Estimates of the cost of treating AIDS patients during the course of the disease average up to \$140,000.¹⁵⁵ Many of the persons hospitalized with AIDS are underinsured or totally uninsured.¹⁵⁶ At present, the burden of paying for their treatment often falls upon the hospital or the government.¹⁵⁷ By following a national standard based on the CDC guidelines, hospitals can curb costs by eliminating the need for excessive precautions to insulate themselves from liability. Precautions for AIDS contamination presently run from nothing in some hospitals, to requirements in others that dietitians and service personnel wear gloves, gowns, masks, and other such apparel just to hand a patient a tray of food.¹⁵⁸ Through a unified standard of required safety measures, hospitals can avoid excessive expense in preventing transmission and foreclosing liability.

¹⁵⁴ See THE UNFINISHED STORY, *supra* note 152, at 138, reporting that: The IOM/NAS [Institute of Medicine of the National Academy of Science] committee will explore the difficult problem of how to organize and finance clinical and supportive services for AIDS patients. A sudden influx of AIDS patients can throw a single hospital department or an entire medical center into disarray. Hospitals need to develop specific plans that will allow them to provide comprehensive care for AIDS patients without disrupting other services.

¹⁵⁵ *Id.* (reporting that estimated costs of hospitalization for each AIDS patient runs from \$42,000 to \$147,000).

¹⁵⁶ *Id.* at 139 (reporting that in some areas, fastest growing segment of AIDS population consists of intravenous drug abusers likely to be indigent and to require great range of services).

¹⁵⁷ *Id.* at 138 (reporting that costs of hospitalization are being met through combination of sources: private health insurance, direct out-of-pocket payments by patients, Medicare, Medicaid, state and local funds, and public hospitals).

¹⁵⁸ See D. ALTMAN, AIDS IN THE MIND OF AMERICA 62 (1986) (some health care workers take precautions far beyond those necessary to avoid contamination by bodily fluids, including wearing gloves and masks to enter an AIDS patient's room, causing psychological and emotional problems for patients and their visitors).

Adopting a national standard would benefit the judicial system as well. The courts have shown a strong and continuing general concern that their decisions be uniform and consistent.¹⁵⁹ By using a national standard based on the CDC guidelines, courts would produce consistent rulings on the liability of health care institutions. These rulings would in turn provide clear and authoritative precedent for subsequent courts to follow. Given the large number of diagnosed AIDS cases, a substantial amount of AIDS-related litigation involving hospitals is on the horizon. This consideration makes the need for consistent decisions compelling.¹⁶⁰

B. Judicial Incrementalism

The courts, acting alone, are ill-equipped to establish an autonomous standard of care without information provided by the medical community. The trier of fact has only a lay knowledge of medical practices and requires expert testimony to develop informed opinions.¹⁶¹ More-

¹⁵⁹ See S. MERMIN, *LAW AND THE LEGAL SYSTEM* 6 (2d ed. 1982) (observing that "[T]he legal system constitutes a framework within which certain common expectations about the transactions, relationships, planned happenings, and accidents of daily life can be met (and this force for predictability and regularity can itself be viewed as a species of maintenance of order)" (emphasis in original)).

¹⁶⁰ See, e.g., Tarr, *AIDS: The Legal Issues Widen*, NAT'L L.J., Nov. 25, 1985, at 1, col. 2; see also *AIDS Time Bomb*, *supra* note 2.

¹⁶¹ See P. MISHKIN & C. MORRIS, *ON LAW IN COURTS* 143-45 (1965), discussing the problem of judicial determination of "policy facts":

How does a court learn such 'policy facts' [i.e., general factual considerations bearing on questions of policy]? Most often, they rely on their general knowledge, judgment or intuition. Obviously, this is undesirable whenever greater precision and objectivity are possible. The advance of the behavioral sciences [and applied science] has opened up the possibility by being better informed from these sources. . . . With further advances, greater use of such materials may be expected, although substantial procedural, legal problems will have to be solved to achieve optimum benefit from them. Among the easier of these is development of adequate techniques for receiving such data, whether through testimony, other evidentiary means, or 'judicial notice' (citation omitted).

* * * *

Legislatures may have easier access to policy facts than courts. Legislative committees can employ experts, hold hearings at which experts are asked to testify, ask public administrative bodies to make studies, and so on. Judges sometimes recognize this legislative superiority and prefer to withhold action in hope that the legislature will deal with a problem beyond the competence of courts. . . . Of course if a judge has adequate knowledge of policy facts to act, the fact that the legislature can acquire more reliable data should not inhibit the judge from making the proper judicial

over, the court system tends to operate under a process of judicial incrementalism.¹⁶² By judicial incrementalism, we mean the process by which courts, through a series of decisions related to a particular problem, decide in a piecemeal manner how the various aspects of that problem will be dealt with, rather than by adopting a general standard or by specifying the manner in which the identifiable aspects of a problem are to be resolved. In the case of AIDS, to determine the required hospital standard of care, the courts would resolve the issue of liability by deciding whether liability would attach to particular practices, activities, or failings, rather than specifying a source or standard to which individuals or courts could look for determining the proper standard of care in AIDS-related matters. The state and federal constitutions require that individual litigants have a case or controversy presenting the proper issues in order to make a judicial determination.¹⁶³ This justiciability requirement impedes establishing general rules to govern an area of activity. In the absence of adopting a set of standards as the basis for reference for determination of the standard of care in an area of practice, a court must wait for the proper case to arise before ruling on issues, even if a present social need exists for a definitive standard of conduct in a particular area of activity.¹⁶⁴ Because judicial rulings are discontinuous,¹⁶⁵ a standard of care will develop only gradually or incrementally in response to the individual lawsuits if the matter is left to

decision (citation omitted).

¹⁶² See Shapiro, *Stability and Change in Judicial Decision Making: Incrementalism or Stare Decisis?*, 2 L. IN TRANSITION Q. 134 (1964), describing incrementalism as a form of decision making:

The decision-maker starts from the status quo and compares alternatives which are typically marginal variations from the status quo. Formulation and choice among alternatives is derived largely from historical and contemporary experience. It follows that only a restricted number, rather than all rationally conceivable, alternatives are considered. Moreover only a restricted number of the consequences of any given alternative are considered. And those that are chosen for consideration are not necessarily the most immediate or important but those that fall most clearly within the formal sphere of competence of the analyst and with which he feels most technically competent to deal.

¹⁶³ See, e.g., U.S. CONST. art. III, § 2 (power of judicial branch extends only to suits containing true "case or controversies"); see also *Baker v. Carr*, 369 U.S. 186, 204 (1962) (to have standing to sue, plaintiff must allege "such a personal stake in the outcome of the controversy as to assure that concrete adverseness which sharpens the presentation of issues").

¹⁶⁴ See, e.g., Gunther, *The Subtle Vices of the 'Passive Virtues' — A Comment on Principle and Expediency in Judicial Review*, 64 COLUM. L. REV. 1 (1964).

¹⁶⁵ See generally Shapiro, *supra* note 162.

develop out of judicial precedent established by individual cases. Moreover, if courts define the standard of care for AIDS-related activity through case-by-case determinations, the standard will inevitably lag behind the rapidly changing standards of medical practice. A piecemeal process will react much too slowly to allow hospitals, health care providers, and AIDS patients a standard providing appropriate protection and guidance.

The sluggishness of the judiciary's traditional method of *stare decisis* may go beyond slowing down the development of a standard of care; it may prevent *any* development of an appropriate standard for several years.¹⁶⁶ Courts are reluctant to overrule prior decisions.¹⁶⁷ A court may hesitate to set a new standard, even in light of changed medical technology. Such a situation exists regarding abortion. The United States Supreme Court established standards for various stages of pregnancy, and the appropriateness of state limitations on abortions, based on current medical technology and the ability to sustain a fetus.¹⁶⁸ Quickly the medical technology outstripped that on which the court based its opinion.¹⁶⁹ Nevertheless, the courts continue to use outdated rules applied to the various trimesters of pregnancy.

A similar result in AIDS-related litigation could cause delay in adopting a revised standard of care based on the latest in medical knowledge. Adopting a national standard subject to continuing revision, such as the CDC guidelines, would ensure appropriate and informed judicial determination, and would prevent hospitals from evading liabil-

¹⁶⁶ See generally Keeton, *Judicial Law Reform — A Perspective on the Performance of Appellate Courts*, 44 TEX. L. REV. 1254 (1966).

¹⁶⁷ See *Roe v. Wade*, 410 U.S. 113 (1973). In setting out its holding, the court reasoned that the state's interest in the health of the mother justifies reasonable regulations, such as where and by whom the abortion may be performed after the end of the first trimester. The Court based its reasoning on (1) the "established medical fact . . . that until [then] mortality in abortion may be less than mortality in normal childbirth," *id.* at 163, and (2) the state's interest in potential life, which becomes compelling at viability "because the fetus then presumably has the capability of meaningful life outside the mother's womb," *id.* The Court further observed that viability occurs when the fetus is "potentially able to live outside the mother's womb, albeit with artificial aid." *Id.* at 160. It is this latter point which ties the Court's decision to the capabilities of medical science at the time of the *Roe* decision.

¹⁶⁸ See generally Rhoden, *Trimester and Technology: Revamping Roe v. Wade*, 95 YALE L.J. 639 (1986).

¹⁶⁹ *Id.* at 670-71; see also *Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 458 (1983) (O'Connor, J., dissenting), in which Justice O'Connor suggested that the trimester framework established in *Roe v. Wade* is no longer workable; she observed that the trimester framework was so linked to medical technology that it would be antiquated by medical advances.

ity through claiming reliance on outdated standards. Judicial incrementalism in this area based on "piecemeal litigation [would] . . . culminate[] in a crazy quilt of rules defying intelligent restatement or coherent application."¹⁷⁰

C. Implementing the National Standard of Care

A standard of care for AIDS-related litigation based on the CDC guidelines could be implemented in several ways, all with equal effect. The courts could adopt it, acting on their own initiative; legislatures could pass statutes giving the judiciary the power to promulgate a standard of care; or legislatures could directly adopt the standard by passing statutes that bind on the courts.

In the past, courts have regularly promulgated new legal standards when modifying or changing a common law rule.¹⁷¹ In the health care field, several jurisdictions have expressly rejected the common law locality rule and have adopted a national standard of care without legislative intervention.¹⁷² Similarly, courts have inherent power to promulgate a standard of care to govern a particular area of activity. For example, the court in *Darling v. Charleston Memorial Hospital*¹⁷³ imposed an independent duty on the hospital to oversee the quality of care provided, when none had existed before. Judges have long recognized their inherent power to adopt rules and standards guided by considerations of expediency and public policy.¹⁷⁴ In at least two instances, the Supreme Court of Minnesota admitted the JCAH Accreditation Manual as evidence of accepted medical practices and of the hospital's applicable duty of care based on its common law power to promulgate standards of care.¹⁷⁵ Courts may determine that judicial adoption of the

¹⁷⁰ See Traynor, *Reasoning in a Circle of Law*, 56 VA. L. REV. 739, 741 (1970).

¹⁷¹ See, e.g., *Scurti v. City of New York*, 40 N.Y.2d 433, 354 N.E.2d 794, 387 N.Y.S.2d 55 (1976) (discarding antiquated distinctions between trespassers, licensees, and invitees; adopting modern standard of care). See generally MCCORMICK ON EVIDENCE 928-30 (E. Cleary 3d ed. 1984) (discussing use of social and economic data in judicial lawmaking).

¹⁷² These jurisdictions have expressly rejected the locality rule and have adopted a national standard of care without state legislature ratification. See *Shilkret v. Annapolis Emergency Hosp. Ass'n*, 267 Md. 187, 349 A.2d 245 (1975); *Brune v. Belinkoff*, 354 Mass. 102, 235 N.E.2d 793 (1968); *Pederson v. Dumouchel*, 72 Wash. 2d 73, 431 P.2d 973 (1967).

¹⁷³ 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966).

¹⁷⁴ B. CARDOZO, *THE NATURE OF THE JUDICIAL PROCESS* 113-25 (1921); J. FRANK, *LAW AND THE MODERN MIND* 32-41 (1930).

¹⁷⁵ See *Cornfeldt v. Tongen*, 262 N.W.2d 681 (Minn. 1977) (appellate court admit-

CDC guidelines as a standard of care is desirable in the face of slow or nonexistent legislative action.

While courts have the inherent power to adopt a standard of care for the determination of liability, they will be more likely to do so if directed by the legislature to address the matter. If the legislature itself determines that the judiciary is best equipped to apply the standard of care, it may pass legislation specifically affording courts such power. With the Rules Enabling Act of 1934, Congress granted the United States Supreme Court the power to promulgate rules on civil procedure to ensure orderly conduct in the federal courts.¹⁷⁶ The Supreme Court adopted the rules recommended by an advisory committee.¹⁷⁷ Subject to the Enabling Act's provisions, the Court submitted the adopted rules of procedure to Congress.¹⁷⁸ However, only a concurrent action by both houses could veto their adoption.¹⁷⁹ The CDC guidelines could be adopted in a similar fashion if a legislature, cognizant of its own limitations, were to empower its high court to take such action.

As a third alternative, the legislature could directly impose the CDC guidelines as a standard of care. State legislatures regularly promulgate laws that are binding on the courts.¹⁸⁰ In the area of health law and medical malpractice, several jurisdictions have enacted legislation that imposes procedures and establishes measures of damages in such suits.¹⁸¹ Legislative enactment may limit the occasions for judicial law-making and avoid problems of prospectivity. However, courts will soon be faced with suits presenting the issue of standard of care and health and safety precautions for hospitals, and, if the legislature has not acted to set standards or rules, courts should feel empowered to do so.

Although all three alternatives are viable, judicial promulgation is the preferable method. The issue is pressing and the judiciary can act

ted JCAH standards for invasive procedures and anesthesiology despite "same or similar jurisdiction" doctrine then in force).

¹⁷⁶ See 28 U.S.C. § 2072 (1982) (subsequently revised). See generally C. WRIGHT, *THE LAW OF FEDERAL COURTS* 402-08 (1983).

¹⁷⁷ See Order of December 20, 1937, 302 U.S. 783 (orders regarding rules of procedure).

¹⁷⁸ 28 U.S.C. § 2072 (1982).

¹⁷⁹ *Id.*

¹⁸⁰ See *People v. Green*, 96 Ill. 2d 334, 338, 450 N.E.2d 329, 331 (1983) (court stated that there is a strong presumption that legislative enactments are constitutional).

¹⁸¹ See, e.g., *Gronne v. Abrams*, 743 F.2d 74 (2d Cir. 1986) (New York statute providing for malpractice panel for liability hearing was upheld and binding on the court's decision); see also *Benier v. Burris*, 113 Ill. 2d 219, 497 N.E.2d 763 (1986) (after constitutional test, court upheld damage recovery statute, ILL. REV. STAT. ch. 110, ¶ 2-1719 (1985), and found it binding on court in calculating damages).

more expeditiously. However, the precise method of adoption will necessarily vary from jurisdiction to jurisdiction based on a state's constitution, the interplay between the state's judiciary and its legislature, and the exigency with which a need for a standard of care arises.

Adequate notice of a court's adoption of a standard of care is necessary to overcome due process objections.¹⁸² A court could adopt a time schedule for publishing and disseminating the CDC guidelines, and could make the guidelines binding upon the hospital as establishing its duty of care according to the schedule.¹⁸³ Alternatively, a legislature could enact a statute providing that in future cases the CDC guidelines will be the standard for state-licensed health care providers, and that failing to adhere to the guidelines would be negligence per se.¹⁸⁴

The CDC has approached the development of guidelines on AIDS issues with care; it has consulted a broad range of experts and conducted regional and national conferences devoted to the development and review of its guidelines. Hospitals are generally aware of forthcoming guidelines. With an additional period of notice of ninety days or six months, hospitals should be able to conform their practices to the guidelines without undue burden. Generally, revisions of the guidelines have been made over a reasonable period of time. Hospitals should not fear that use of the guidelines would result in excessive revision of procedures or protocols. Finally, to date, the guidelines have required practices which hospitals should already be employing in other areas of treatment; therefore, there is little basis for concern that compliance with the guidelines will impose an undue administrative or economic burden.

¹⁸² See, e.g., *Bouie v. City of Columbia*, 378 U.S. 347 (1964) (holding that due process applies to construction of statutes by courts and principles similar to those involved in application of the ex post facto doctrine). In *Bouie*, the Court found an unforeseeable enlargement of a trespass statute to violate due process.

¹⁸³ This approach would be consistent with the judicial procedure of prospective overruling. With this procedure a court can depart from stare decisis in future cases arising from facts occurring after some date specified by the court. See, e.g., *England v. Louisiana State Bd. of Medical Examiners*, 375 U.S. 411 (1964); *Great N. Ry. Co. v. Sunburst Oil & Ref. Co.*, 287 U.S. 358 (1932).

¹⁸⁴ See, e.g., *Martin v. Herzog*, 228 N.Y. 164, 126 N.E. 814 (1920) (holding that once statute is determined applicable and harm results from its violation, issue of negligence is conclusively proved). See generally RESTATEMENT (SECOND) OF TORTS § 288B (1965).

D. Other National Standards of Care

Judicial adoption of a government agency's guidelines as a standard of care is not new to the law. Indeed, establishing national standards based upon guidelines set by governmental agencies is a growing trend. For example, in the area of employee safety, courts have admitted regulations promulgated under the Occupational Safety and Health Administration Act (OSHA)¹⁸⁵ as evidence of a standard of care¹⁸⁶ for employers required to maintain a safe workplace.¹⁸⁷ Some courts have found that juries can consider OSHA regulations as evidence of negligence.¹⁸⁸ Other courts have found OSHA violations to be negligence per se.¹⁸⁹

Similarly, courts have established aviation standards of care utilizing Federal Aviation Administration (FAA) regulations and publications. Some courts hold violations of FAA and other government safety regulations to be negligence per se.¹⁹⁰ Other courts construe FAA advisory circulars as evidence of a negligence standard of care.¹⁹¹

¹⁸⁵ See Occupational Safety and Health Administration Act of 1970, 29 U.S.C. §§ 651-678 (1982) (OSHA). See generally Morey, *The General Duty of the Occupational Safety and Health Act of 1970*, 86 HARV. L. REV. 988 (1973).

¹⁸⁶ See, e.g., *Buhler v. Marriott Hotels, Inc.*, 390 F. Supp. 999, 1000 (E.D. La. 1974) (violation of OSHA standards admissible as evidence of negligence against defendant-hotel corporation); see also *Knight v. Burns, Kirkland & Williams Const. Co.*, 331 So. 2d 651, 654 (Ala. 1976); *Dunn v. Brimer*, 259 Ark. 855, 856-57, 537 S.W.2d 164, 166 (1976); *Mingachos v. CBS Inc.*, 196 Conn. 91, 491 A.2d 368, 379 (1985); *Disabatino Bros., Inc. v. Baio*, 366 A.2d 508, 511 (Del. 1976); *Taira v. Oahu Sugar Co.*, 1 Haw. App. 208, 213, 616 P.2d 1026, 1030 (Haw. App. 1980).

¹⁸⁷ See, e.g., CONN. GEN. STAT. ANN. § 31-370(a) (1977) (providing in part: "[each] employer shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employee").

¹⁸⁸ See, e.g., *Wendland v. Ridgefield Const. Servs., Inc.*, 184 Conn. 173, 181, 439 A.2d 954, 958 (1981).

¹⁸⁹ See, e.g., *Carroll v. Getty Oil Co.*, 498 F. Supp. 409, 413 (D. Del. 1980) (applying a negligence per se analysis to alleged OSHA violations of defendant oil company); see also *Rabar v. E.I. duPont de Nemours & Co.*, 415 A.2d 499, 502-05 (Del. Super. Ct. 1980); *Koll v. Manatt's Transp. Co.*, 253 N.W.2d 265, 270 (Iowa 1977); *Kelley v. Howard S. Wright Constr. Co.*, 90 Wash. 2d 323, 336, 582 P.2d 500, 508 (1978).

¹⁹⁰ See, e.g., *Gatenby v. Altoona Aviation Corp.*, 407 F.2d 443, 446 (3d Cir. 1969) (state substantive law holds that common carrier owes its passengers duty of exercising highest degree of care; this duty is subject to negligence per se treatment when there is a violation of governmental safety regulation, such as the FAA); see also *Hunziker v. Scheidemantle*, 543 F.2d 489, 498 (3d Cir. 1976) (if violation of FAA regulation was substantial factor in causing accident, court can find negligence per se).

¹⁹¹ See *Muncie Aviation Corp. v. Party Doll Fleet, Inc.*, 519 F.2d 1178, 1181 (5th

In upholding the admissibility of government safety codes, the Fifth Circuit Court of Appeals observed:

In holding admissible advisory materials promulgated by a governmental agency, this Court's decision is in accord with the modern trend of cases finding national safety codes representative of 'a consensus of opinion carrying the approval of a significant segment of an industry' and offerable as exemplifying safety practices prevailing in the industry.¹⁹²

The Fifth Circuit noted that "[c]ourts have become increasingly appreciative of the value of national safety codes and other guidelines issued by governmental and voluntary associations to assist the trier of facts in applying the standard of due care in negligence cases."¹⁹³ Just as courts have accepted governmental agency guidelines as standards for aviation and workplace safety, they should accept such guidelines in the medical field as establishing a standard of care for health care providers. The CDC is a governmental agency coordinated under the United States Public Health Service and the Department of Health and Human Services; courts should consider its guidelines impartial and authoritative.

The CDC guidelines would establish a higher standard of care than some hospitals now exercise, especially those in rural areas. Although implementing the CDC guidelines would necessarily involve an increased burden, the guidelines would not be financially prohibitive. The current CDC guidelines do not involve heavy capital expenditures for research or equipment, but merely define procedures for treating AIDS patients and preventing transmission or contamination in the hospital setting.¹⁹⁴ For example, the protective gowns and gloves required under the CDC guidelines in particular situations are inexpensive. Indeed, they are already available in most hospitals for use in other treatment contexts.¹⁹⁵ For those hospitals that overreacted to the disease, adopting the guidelines will save money.¹⁹⁶ Although operating costs for some hospitals may rise slightly, the costs are small compared to the potential liability that could arise under inadequate procedures.

Cir. 1975) (finding FAA advisory materials to evidence standard of care concerning nature, behavior, and danger of wake turbulence from aircraft); *Thinguldstad v. United States*, 343 F. Supp. 551 (S.D. Ohio 1972).

¹⁹² *Muncie Aviation*, 519 F.2d at 1183.

¹⁹³ *Id.*

¹⁹⁴ See CENTERS FOR DISEASE CONTROL, RECOMMENDATIONS AND GUIDELINES CONCERNING AIDS (Apr. 1986).

¹⁹⁵ See *Preventing Transmission of Infection in the Workplace*, *supra* note 14, at 684.

¹⁹⁶ *Id.* at 690-91.

E. Appropriateness of the Centers for Disease Control Guidelines

The CDC guidelines are the most current, authoritative guidelines available concerning AIDS, and provide the most appropriate standard of care. The CDC has primary responsibility in the United States for tracking the spread and control of AIDS. The CDC played a primary role in identifying the AIDS virus, and also assisted in developing an antibody test to determine HIV virus infections. The CDC performs an active national surveillance of the AIDS epidemic, and promotes national and international epidemiologic studies to identify new risk factors and to determine the means of transmission.¹⁹⁷ The CDC also disseminates technology and techniques for controlling AIDS to the medical community¹⁹⁸ and works with private industry to produce drugs for treating the opportunistic diseases that attack AIDS patients.¹⁹⁹ Finally, the CDC takes part in the continuing effort to develop a vaccine for AIDS. The CDC clearly plays a primary role in AIDS research and prevention.

Many legal and medical authors look to the CDC for accurate data concerning AIDS. The American Hospital Association's infection control recommendations on AIDS were prepared with the CDC's assistance.²⁰⁰ Law review articles and monographs addressing AIDS issues repeatedly refer to the CDC guidelines as authority for technical data.²⁰¹ Courts have often looked to CDC information on other diseases as expert evidence in negligence cases.²⁰²

¹⁹⁷ See UNITED STATES PUBLIC HEALTH SERVICE, AIDS INFORMATION BULLETIN: THE PUBLIC HEALTH SERVICE RESPONSE TO AIDS 5 (Feb. 1980).

¹⁹⁸ *Id.* at 5-6. For example, the CDC provides funding for workshops relating to the use of HIV antibody test across the nation and gives information to high risk groups.

¹⁹⁹ *Id.* The CDC also tracks variations among HIV isolates from different geographic areas, provides communication between different government agencies concerning AIDS, and is developing of an animal model for AIDS for vaccination evaluation.

²⁰⁰ See AMERICAN HOSPITAL ASSOCIATION, MANAGEMENT OF HTLV-III/LAV INFECTION IN THE HOSPITAL: AIDS, THE RECOMMENDATIONS OF THE ADVISORY COMMITTEE ON INFECTIONS WITHIN HOSPITALS (1986) [hereafter AHA, MANAGEMENT OF INFECTION]. The report notes that the recommendations have been prepared by the Advisory Committee on Infections and the Hospitals of the AHA, with assistance from the CDC. *Id.* at 1.

²⁰¹ See, e.g., Comment, *AIDS: A Legal Epidemic?*, 17 AKRON L. REV. 717 (1984); COMMERCE CLEARING HOUSE, INC., AIDS: EMPLOYERS RIGHTS AND RESPONSIBILITIES (1985).

²⁰² See, e.g., *Hightower v. Brammal, Inc.*, 435 So. 2d 1295, 1297 (Ala. Civ. App. 1982) (court considered CDC reports as evidence on possible cause of Raynaud's Disease in construction worker); *West v. Johnson & Johnson Prods., Inc.*, 174 Cal. App. 3d 831, 220 Cal. Rptr. 437 (1985) (CDC statistical evidence of link between Toxic

Other organizations could serve as the source for a standard of care. For example, the Joint Commission on Accreditation of Hospitals (JCAH)²⁰³ regularly sets standards for operations of hospitals.²⁰⁴ However, the JCAH accreditation manual does not contain specific guidelines on matters related to AIDS or HIV. The American Medical Association (AMA) is another organization that could provide an authoritative standard of care. However, like the JCAH, the AMA currently has no published AIDS guidelines. Neither the AMA or the JCAH will likely develop standards in this area, since the CDC is already actively engaged in doing so.

Another organization that could possibly provide a standard of care in AIDS treatment is the American Hospital Association (AHA). The AHA has published guidelines concerning the HIV.²⁰⁵ However, the CDC guidelines offer several advantages over the AHA guidelines. First, the CDC guidelines are more extensive than are the AHA's. For example, the CDC has separate guidelines for clinical and laboratory staff,²⁰⁶ dental care personnel,²⁰⁷ morticians' services,²⁰⁸ and personnel

Shock Syndrome and use of tampons admitted to court along with CDC's recommendations to Food and Drug Administration); *Kearl v. Lederle Labs.*, 172 Cal. App. 3d 812, 835, 218 Cal. Rptr. 453, 467 (1985) (CDC recommendations used as evidence of medical standards of an accepted vaccination); *State v. Joint Comm'n in Accreditation of Hosps.*, 470 So. 2d 169, 172 (La. Ct. App. 1985) (CDC reported failure of purification system in kidney dialysis machine causing unusually high levels of aluminum accepted as evidence); *Matter of Tara H.*, 129 Misc. 2d 508, 513, 494 N.Y.S. 2d 953, 957 (1985) (accepting testimony of CDC employee as to presence of infectious gonorrhea as evidence); *City of Rome v. New York State Health Dept.*, 411 N.Y.S.2d 61 (1978) (accepting as evidence CDC confirmation of outbreak of water-borne disease from sample); *Wilson v. State*, 697 S.W.2d 83 (Tex. Ct. App. 1985) (CDC personnel testified as to accuracy of machine designed to test for controlled substances).

²⁰³ See generally JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS (1986). The JCAH is the only organization that grants accreditation to entire hospitals. The Commission is governed by a committee selected by the American Medical Association, the American College of Surgeons, and the American College of Physicians. The JCAH's primary purpose is to establish standards for the operation of health care facilities in the task of promoting efficient, high quality care in all areas of hospital administration. It recognizes compliance with their standard through on-site surveys, employee interviews, and examination of hospital records before issuance of certificates of accreditation.

²⁰⁴ See, e.g., *Niven v. Siqueira*, 109 Ill. 2d 357, 487 N.E.2d 937 (1985). The AMA's continued activity in issues relating to AIDS is documented in its publications. See generally H. COLE & G. LUNDBURG, AIDS FROM THE BEGINNING (1986).

²⁰⁵ See AHA, MANAGEMENT OF INFECTION, *supra* note 200.

²⁰⁶ See AIDS Precautions, *supra* note 14, at 577-80.

²⁰⁷ See Precautions For Health-Care Workers, *supra* note 14, at 451.

²⁰⁸ See *id.*

service workers;²⁰⁹ whereas the AHA does not. Second, the CDC provides greater detail on suggested precautions and sets out the underlying theories for its recommendations. Third, the CDC updates its guidelines much more frequently in response to changing AIDS technology than does the AHA.²¹⁰ Fourth, the AHA relied heavily upon the CDC's recommendations in developing its guidelines, indicating that the CDC guidelines are the dominant authority.²¹¹ Finally, the CDC is a government agency that observers view as impartial and lacking any appearance of self-interest. By contrast, the AHA is an association representing hospitals. Even though its guidelines may be unbiased, there is an apparent lack of the neutrality that judges and legislators highly value.

CONCLUSION

Every hospital in the United States must be conscious of the unlimited liability they face with the possibility of AIDS-related litigation. Courts, too, face the possibility of unprecedented litigation involving assertions of hospital liability for failure to protect persons who may be exposed to infected patients or health care workers. With no existing precedent concerning AIDS, courts will require guidance from the medical and scientific community for their decisions in AIDS-related lawsuits to which hospitals are a party. To ensure consistency and fairness, a national standard should be adopted. Hospital administrators are searching for ways to care properly for patients while limiting their institution's liability. Developing a recognized standard of care will reduce the possibility of accidental transmissions of the disease, lower treatment costs, and ensure better care for persons with AIDS. To meet this need, courts should recognize the CDC guidelines and recommendations on matters relating to AIDS as establishing a national standard of care owed by hospitals. Adopting a national standard of care based on CDC guidelines should influence hospitals to follow safe procedures in the care and treatment of AIDS patients, while actually decreasing

²⁰⁹ *Preventing Transmission of Infection in the Workplace*, *supra* note 14, at 693.

²¹⁰ The Center for Disease Control guidelines are updated periodically in the *Morbidity and Mortality Weekly Report*. See, e.g., *Cryptosporidiosis: Assessment of Chemotherapy of Males with Acquired Immune Deficiency Syndrome (AIDS)*, 31 MORBIDITY AND MORTALITY WEEKLY REP. 589 (1982); see also *Update: Treatment of Cryptosporidiosis in Patients with Acquired Immunodeficiency Syndrome (AIDS)*, 33 MORBIDITY AND MORTALITY WEEKLY REP. 117 (1984). The AHA guidelines were only updated in 1986, three years after its original guidelines were issued in 1983.

²¹¹ See AHA, *MANAGEMENT OF INFECTION*, *supra* note 200.

the likelihood of liability.

A continuing trend is to replace local standards for medical treatment with national standards of care. The courts have adopted standards of care promulgated by government agencies in other areas of the law, such as employment safety and aviation. Recognizing that another strong trend is to abrogate the doctrines providing them immunity from liability, hospitals need to have authoritative sources for determining their standard of care. In the context of treating AIDS patients, this need would be met by adopting the Center for Disease Control guidelines on matters related to AIDS as a national standard of care for hospitals.

