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Immunity of Volunteer Health Care Providers in Texas: Bartering Legal Rights for Free Medical Care Comment

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IMMUNITY OF VOLUNTEER HEALTH CARE PROVIDERS IN TEXAS: BARTERING LEGAL RIGHTS FOR FREE MEDICAL CARE

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* This comment is dedicated to the memory of my abuelito; to my mother, whose undying faith in me continues to inspire me, and to my father, who survived his own struggles with poverty to provide a better life for his children.

I. INTRODUCTION

On a lazy Sunday afternoon many years ago, I sat at the kitchen counter, gazing at my grandfather's tanned, wrinkled face through the mist of tears that coated my eyes. My *abuelito,*[1] in his early seventies, was recounting stories of his childhood - everything from tragedies to *milagros.*[2] His voice quivered and his gray eyes brimmed with tears as he spoke of the day he lost his mother.

At only sixteen years of age, my *abuelito* stumbled through his poor hometown, cradling his dying mother in his arms, desperately searching for a doctor or healer to cure his mother's asthma. The staunch poverty that had pervaded his sixteen years of life would not allow for his mother's salvation. My *abuelito* was left poorer than he had ever been – without a mother. As time passed and new families blossomed, my *abuelito* escaped poverty and created a better life for himself and his children. His generous spirit was all that remained of his early life of poverty. He translated the foreign life of poverty into a compelling story even the privileged could comprehend. I will forever remember that day because my *abuelito* exposed the everyday afflictions that poverty subsumes.

Today, death from asthma seems absurd. Death from any medical illness is an unspeakable tragedy. As a society, we exhaust every possible avenue to avoid confronting illness and are armed with advanced medical technology when faced with illness. Yet, under the umbrella of poverty, these confrontations are commonplace. Poverty requires the poor to rely on charity as their only defense against dangerous diseases that threaten to steal their well-being.

The ideology that the poor must rely on charity denies the existence of inherent human rights, granted simply because of an individual's humanity. The United States of America, founded on principles of individuality and freedom,[3] has failed to regard health care as a fundamental human right.[4] The American aversion to governmental intrusion has created a

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1. *Abuelito* is Spanish for grandfather.

2. *Milagros* is Spanish for miracles.

3. *See* U.S. CONST. Preamble (declaring that one of the purposes of the United States Constitution is to "secure the Blessings of Liberty"); *see also* THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776) (stating that "all men are created equal" and endowed with particular unalienable rights such as liberty). *See generally* Dieter Giesen, *A Right to Health Care?: A Comparative Perspective*, 4 HEALTH MATRIX 277, 278 (1994) (noting that in the United States, individualism has prevailed over general obligations of universal humanity and solidarity).

4. *See* Randall R. Bovbjerg & William G. Kopit, *Coverage and Care for the Medically Indigent: Public and Private Options*, 19 IND. L. REV. 857, 874 (1986) (commenting that no general federal obligation to provide health care exists); Satvinder Juss, *Global Environmental Change: Health and the Challenge for Human Rights*, 5 IND. J. GLOBAL LEGAL

staggering 44.3 million uninsured Americans.[5] In Texas, a peculiarly independent state, 1.4 million children have no health insurance, the second highest number in the nation.[6] Overall, Texas leads the nation with 4.88 million uninsured citizens.[7] Nevertheless, despite recent proposals to create a unified health care system,[8] the United States continues to allow the welfare of its poor citizens to ride the wave of the free market.[9]

In the most recent surge of tort reform, Texas passed new legislation, effective September 1, 1999, that affords civil immunity to volunteer

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STUD. 121, 148 (1997) (recalling that in 1983, the Commission for the Study of Ethical Problems in the Medical and Biomedical and Behavioral Research, appointed by the President of the United States, rejected the recognition of a right to health based on the lack of reference to such a right in the Bill of Rights of the United States Constitution). *See generally* Kenneth R. Wing, *The Right to Health Care in the United States*, 2 ANNALS HEALTH L. 161, 161 (1993) (indicating that there is nothing in the United States Constitution that could be defined as a constitutional right to health care).

5. *See* Carlos Guerra, *Texas Needs Health Care for Its Citizens*, SAN ANTONIO EXPRESS-NEWS, Oct. 7, 1999, at 1B. The United States Census Bureau revealed that one in every six Americans is uninsured. *See id.*; *see also* Susan J. Landers, *Groups Seek Common Ground on Uninsured* (visited Jan. 26, 2000) <http://www.ama-assn.org/sci-pubs/amnews/pick_00/gvsa0131.htm> (relating health care proposals to cover forty-four million uninsured Americans); Susan J. Landers, *Physician Volunteers "Reach Out" to Care for Thousands of Uninsured* (visited Jan. 25, 2000) <http://www.ama-assn.org/sci-pubs/amnews/pick_00/gvsb0131.htm> (relating the efforts of a program funded by Robert Wood Johnson Foundation to serve some of the forty-four million uninsured Americans); Robin Toner, *Health Care Brings Out Contrast in Candidates*, N.Y. TIMES, Nov. 8, 1999, at A18.

6. *See* Cindy Tumiel, *Texas Seen Near Bottom in Insuring Kids*, SAN ANTONIO EXPRESS-NEWS, Feb. 26, 1999, at 4B. In Texas, nearly one in every four children lack heath insurance. *See id.*

7. *See* Guerra, *supra* note 5, at 1B.

8. *See* Ann C. McGinley, *Aspirations and Reality in the Law and Politics of Health Care Reform: Examining a Symposium on (E)qual(ity) Care for the Poor*, 60 BROOK. L. REV. 7, 18-27 (1994) (discussing the details of several Democratic health care proposals, including President Bill Clinton's and then Senate majority leader George Mitchell's universal health care plans); Hallye Jordan & Robert A. Rankin, *$65 Billion Health Plan Proposed by Bradley*, SAN ANTONIO EXPRESS-NEWS, Sept. 29, 1999, at 6A (describing Democratic presidential candidate Bill Bradley's universal health plan proposal); Toner, *supra* note 5, at A18 (contrasting the different health care plans of the presidential candidates).

9. *See* Carlo V. DiFlorio, Comment, *Assessing Universal Access to Health Care: An Analysis of Legal Principle and Economic Feasibility*, 11 DICK. J. INT'L L. 139, 151 (1992) (describing how the United States' allegiance to economic independence and individualism rejects the right to health care as a civic axiom); Juss, *supra* note 4, at 149 (suggesting that the American ideology towards health care is that individuals who can afford health care deserve health care); *see also* Jason B. Saunders, Note, *International Health Care: Will the United States Ever Adopt Health Care for All? - A Comparison Between Proposed United States Approaches to Health Care and the Single-Source Financing Systems of Denmark and the Netherlands*, 18 SUFFOLK TRANSNAT'L L. REV. 711, 731 (1995).

health care professionals providing free medical services.[10] By limiting the liability of volunteer health care providers to gross negligence and intentional torts,[11] the Texas legislature seems to anticipate an amelioration of the availability of adequate health care for the indigent.[12]

This comment will explore the ramifications of recent Texas legislation affecting the indigent beneficiaries of free health care services and why we elect this particular option of caring for the poor. This comment will delve into the idea of health care as a fundamental human right and how this idea relates to the American definition of poverty. The problem of inadequate access to health care among the poor will be examined, with a discussion of the recent creation of volunteer immunity in Texas and similar legislation in other states. This comment will also evaluate the reliance of the poor on charity. Finally, alternative solutions will be proposed to the problem of indigent access to health care.

II. HEALTH CARE AS A FUNDAMENTAL HUMAN RIGHT?

A. *The International Community*

The Texas legislature's offer of immunity for volunteer health care providers is an implicit denial of a universal, fundamental right to health care that has been widely recognized in international law.

Historically, several international declarations have acknowledged the inherent human right to health. In 1946, the World Health Organization (WHO), an international organization responsible for the formulation of standards to protect and promote human health,[13] defined the fundamental right to health in its Constitution as the "enjoyment of the highest

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10. *See* TEX. CIV. PRAC. & REM. CODE ANN. § 84.004(c) (Vernon Supp. 2000) (detailing the conditions of volunteer immunity).

11. *See id.* § 84.007(a) (Vernon Supp. 2000).

12. This recent legislation will affect those that benefit from free medical services. I use the terms "indigent," "poor," and "medically indigent" interchangeably to refer to this affected group: a growing number of Americans who are uninsured, ineligible for Medicaid, and unable to afford self-pay for medical care, regardless of whether they are employed or not. *See* Giesen, *supra* note 3, at 283 (recognizing the emergence of a new class of excluded individuals whose incomes are insufficient to cover the costs of private insurance, but sufficient to place them beyond Medicaid eligibility guidelines); McGinley, *supra* note 8, at 12 (acknowledging that many individuals ineligible for Medicaid are the employed or their dependents who work for employers that pay enough to disqualify them for Medicaid, but do not offer private medical insurance); *see also* Aïssatou Sidimé, *Many Doing without Health Coverage*, SAN ANTONIO EXPRESS-NEWS, Jan. 23, 2000, at J1 (describing the plight of uninsured Americans who are ineligible for Medicaid and unable to self-pay for medical care).

13. *See* Katarina Tomasevski, *Health*, in 2 UNITED NATIONS LEGAL ORDER 859, 859 (1995); *see also* Saunders, *supra* note 9, at 714-15.

attainable standard of health."[14] Two years later, in 1948, the United Nations adopted the Universal Declaration of Human Rights[15] (Universal Declaration), regarded as one of the primary sources of international standards of fundamental rights.[16] Article 25 of the Universal Declaration contends that all individuals have the "right to a standard of living adequate for the health and well-being of himself and his family, including . . . medical care and the right to security in the event of . . . sickness . . . ."[17] Despite its originally non-binding nature, the Universal Declaration has achieved international customary law status and has become legally binding in many countries; even United States' case law has recognized that the Universal Declaration contains norms that are internationally binding.[18]

Following the Universal Declaration, the United Nations adopted the Covenant on Economic, Social, and Cultural Rights (The Covenant).[19] The Covenant reiterated the Universal Declaration's commitment to fundamental rights, such as the right to health care, but noted those rights with more specificity than the Universal Declaration.[20] Article 12 of the Covenant instructs ratifying states to undertake, at minimum, four initiatives to secure the right to health for their citizens: investing in public health measures; providing preventive health care; adopting measures to prevent the spread of epidemic and endemic diseases; and assuming responsibility for the critical health care of the poor and underserved.[21]

Notwithstanding this international recognition of a fundamental right to health,[22] the formal declaration and enforcement of such a right remains stifled by an extraordinary deference for the sovereignty of individ-

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14. Juss, *supra* note 4, at 149-50. *See* World Health Organization, *Health and Human Rights* (last modified Dec. 14, 1999) <http://www.who.int/inf/human_rights.html>. Health as referred to within the WHO's constitution is defined by the organization as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Audrey R. Chapman, *Conceptualizing the Right to Health: A Violations Approach*, 65 TENN. L. REV. 389, 391 (1998).

15. *See* W. Kent Davis, *Answering Justice Ginsburg's Charge That the Constitution Is "Skimpy" in Comparison to Our International Neighbors: A Comparison of Fundamental Rights in American and Foreign Law*, 39 S. TEX. L. REV. 951, 976 (1998).

16. *See id.* at 977.

17. *The Universal Declaration of Human Rights*, G.A. Res. 217 A (III), U.N. GAOR, 3d Sess., at art. 25(1), U.N. Doc. A/810 (1948); Giesen, *supra* note 3, at 278; Juss, *supra* note 4, at 164.

18. *See* Davis, *supra* note 15, at 977.

19. *See id.*

20. *See* Chapman, *supra* note 14, at 390.

21. *See id.* at 410-11.

22. *See id.* at 389; Juss, *supra* note 4, at 149-50.

ual countries.[23] During the drafting of Article 12 of the Covenant, the WHO refused to endorse a state obligation to assure access to medical care.[24] The WHO was reluctant to force states to adopt a particular method of providing health care.[25] As a result, the WHO has never advocated a right to health care services based simply on individual entitlement.[26]

Despite the success of the inclusion of a right to health care in the Universal Declaration and the Covenant, there is still no international agreement on the particular obligations of the states to provide health care access to its populations, or whether states are obliged to assume the responsibility of providing health care.[27] A vast majority of ratifying nations of the Covenant do not treat health care as a fundamental human right.[28] Thus, although the right to health care has been consistently acknowledged by the international community, the ultimate security of such a right depends on the actions of individual nations.

B. *The United States*

Despite the sophistication with which the United States has defined individual rights, the right to health care has never been defined as "fundamental" and remains dependent on an individual's economic status.[29] Under the United States Constitution, no right to health care has ever been found by the United States Supreme Court, nor is there an affirmative governmental obligation to provide health care.[30] Among industrialized nations, the United States is one of the few that does not grant its citizens health care as a fundamental right.[31] Among democracies, the

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23. *See* Tomasevski, *supra* note 13, at 874 (commenting on the approach of International developmental agencies, such as the WHO, which fails to address governmental duties or obligations).

24. *See id.* at 874-75.

25. *See id.* at 874. The WHO refused to force States to guarantee access to medical care, with the exception of maternity and child care. *See id.*

26. *See id.* at 874-75 (describing the struggle of the human rights movement to define access to health care as a human right to be guaranteed by the governments of states and the WHO's refusal to promote such an obligation).

27. *See id.* at 875.

28. Overall, among ratifying countries, few offer a constitutional or legal recognition of the right to health care. *See* Chapman, *supra* note 14, at 411. Of the 130 countries that are parties to the covenant, very few systematically monitor or amass data on the treatment of health as a human right. *See id.* at 395.

29. *See* Juss, *supra* note 4, at 149 (recognizing how many Americans dismiss the idea of an unqualified right to medical care because they prefer to reserve health care for those who can afford to pay for it).

30. *See* Saunders, *supra* note 9, at 741-42; *see also* Wing, *supra* note 4, 161-62.

31. *See* Saunders, *supra* note 9, at 711 & n.1. The constitutions of more than thirty other nations guarantee the right to health care to their citizens. *See id.*

United States stands alone in its failure to recognize universal entitlement to medical care.[32]

This failure is rooted in our unique American political tradition. The adoption of the United States Constitution was largely premised on the idea that certain individual rights exist as "natural" or inherent rights not given by society or government.[33] This political ideology resulted in the creation of "negative" Constitutional rights that prevent, rather than require, any action by the government.[34] The United States has typically defined only civil and political rights as fundamental.[35] Indeed, the United States has never ratified the Covenant on Economic, Social, and Cultural Rights because of the framing of such rights as fundamental.[36]

The American ignorance of a universal health care right occurs despite American public sentiment that health care should be regarded as fundamental.[37] In 1938, a Gallup poll revealed that eighty-one percent of Americans believed that the government had a duty to provide health care to those who could not afford it.[38] Nearly fifty years later, in 1987, a Harris poll concluded that approximately ninety-one percent of Americans supported the 1938 statement.[39] In 1944, in an effort to realize such sentiment, President Franklin D. Roosevelt proposed the adoption of a second Bill of Rights[40] that included "the right to adequate medical care and the opportunity to achieve and enjoy good health . . . "[41] Unfortunately, President Roosevelt's noteworthy attempt failed.[42]

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32. *See* Chapman, *supra* note 14, at 390.

33. *See* DiFlorio, *supra* note 9, at 151. These inherent individual rights are not derived from the Constitution, but antecede the Constitution. *See id.* The government was viewed as not being obliged to provide for the welfare of its citizens, but instead to allow them to pursue it for themselves. *See id.*

34. *See* Giesen, *supra* note 3, at 279; *see also* Wing, *supra* note 4, at 162 (asserting that the United States Constitution does not require either the federal or state government to ensure the health of its citizens). The United States Constitution does not actually require the government to provide any benefits relating to domestic or social welfare. *See id.* at 162-63.

35. *See* Davis, *supra* note 15, at 966 (noting that fundamental rights do not encompass social and economic rights); *see also* Theodore R. Marmor, *The National Agenda for Health Care Reform: What Does it Mean for Poor Americans?*, 60 BROOK. L. REV. 83, 97 (1994). Aside from education, an individual's status as an American has never legitimized an entitlement to the "public provision of services". *See id.*

36. *See* DiFlorio, *supra* note 9, at 144-45.

37. *See generally id.* at 151-52 (indicating that polls demonstrate that Americans do not think that citizens should go without health care simply because they cannot afford it).

38. *See* Chapman, *supra* note 14, at 393.

39. *See id.*

40. *See* Davis, *supra* note 15, at 965; *see also* Saunders, *supra* note 9, at 721 n.46.

41. Davis, *supra* note 15, at 991.

42. *See id.* at 965.

Notwithstanding the lack of a fundamental right to health care for all American citizens, health care providers in the United States have long recognized a duty to care for all. The American Medical Association (AMA) has acknowledged a physician's ethical obligation to help make health care available to needy patients.[43] The AMA's first code of ethics provided for the accordance of professional services to indigent individuals.[44] Today, AMA's policy states that "[t]he patient has a basic right to have available adequate health care."[45] This policy was founded on the AMA's recognition of society's responsibility to provide all people with access to medical care, regardless of their financial circumstances.[46]

In 1987, the AMA House of Delegates approved a policy urging all doctors to "share in the care of indigent patients."[47] In 1990, the AMA further encouraged all physicians to continue their traditional responsibility for the health care of those who cannot afford it.[48] The American Medical Student Association (AMSA) also recognized a patient's basic right to health care regardless of the ability to pay.[49] Thus, in addition to American public sentiment, there appears to be an implicit understanding of an individual's right to health care among health care providers.

C. *Ramifications of the Failure to Define Health Care as a Fundamental Right*

The failure of the United States to recognize health care as a fundamental right has created an almost pure model of a private health care system.[50] The United States health care system consists of three tiers: the

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43. *See* American Medical Association, The Council on Ethical and Judicial Affairs, *Caring for the Poor*, 269 JAMA 2533, 2533 (1993).

44. *See id.*

45. American Medical Association, The Council on Ethical and Judicial Affairs, *Ethical Issues in Health Care System Reform: The Provision of Adequate Health Care*, 272 JAMA 1056, 1056 (1994) [hereinafter *Ethical Issues in Health Care System Reform*].

46. *See id.*

47. George D. Lundberg & Laurence Bodine, *Fifty Hours for the Poor*, 262 JAMA 3045, 3045 (1989).

48. *See* American Medical Association, *supra* note 43, at 2533 & n.5; *see also* Eli Ginzberg, *Medical Care for the Poor: No Magic Bullets*, 259 JAMA 3309, 3311 (1988) (encouraging physicians to enforce the medical ethic that all men and women have access to health care); John Glasson & David Orentlicher, *Caring for the Poor and Professional Liability: Is There a Need for Tort Reform?*, 270 JAMA 1740, 1741 (1993) (stating that caring for the needy remains a "cardinal principle of the helping professions").

49. *See Principles Regarding Health Care Delivery and Delivery Systems* (visited Jan. 25, 2000) <http://www.amsa.org/about/ppp/19.html>.

50. *See* Dana Derham-Aoyama, Comment, *U.S. Health Care Reform: Some Lessons from Japanese Health Care Law and Practice*, 9 TEMP. INT'L & COMP. L.J. 365, 368-70 (1995) (detailing the three-tier system of health care coverage in the United States); *see also* Saunders, *supra* note 9, at 732 (concluding that the primary difference between the

first level is comprised of approximately 166 million Americans covered by private insurance;[51] the second level consists of approximately eighteen million Americans covered by government programs, such as Medicaid and Medicare;[52] the third level consists of approximately thirty-seven million uninsured Americans.[53]

Individuals in the first tier, with the "luxury" of private insurance, still do not fare well. In comparison with the twenty-three other countries belonging to the Organization for Economic Cooperation and Development (OECD), "[t]he United States spends almost twice as much on each person's health care than OECD countries, yet allots almost the same amount of financial support to hospitals, doctors, and drugs."[54]

These discrepancies in efficacy between the United States and the other OECD countries exist because health care providers in the United States are permitted to charge more for their medical services than is allowed in other OECD countries.[55] Additionally, due to the domination of private health insurance companies, health care providers in the United States are opting for a steady source of income and are not consumer driven as in other countries.[56] Consequently, the American health care system has achieved a status as the most expensive system in the world with the least efficiency and satisfaction.[57]

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health care systems of the United States, Denmark and the Netherlands is the fact that the United States' system is almost entirely a private system).

51. *See* Derham-Aoyama, *supra* note 50, at 368. The majority of the 166 million Americans in this first level obtain private insurance through their employers; the remaining pay for it themselves or obtain it through other sources. *See id.* at 368-69. Unfortunately, many individuals with lucrative health care benefits from their employers become "insurance hostages" and are reluctant to seek other employment for fear of losing their invaluable insurance benefits. *See id.* at 369.

52. *See id.* at 369. Medicare provides coverage for the elderly, but is not a comprehensive program. *See id.* As a result, many elderly Medicare recipients also purchase additional private insurance to help cover costs Medicare will not cover. *See id.* Medicaid, on the other hand, provides insurance coverage for low-income earners who meet certain requirements and income guidelines. *See id.*

53. *See id.* at 369-70. Many individuals in this category are either employees of small businesses that cannot afford insurance plans or are ineligible for Medicaid. *See id.* Additionally, the statistics for this third level are outdated. The current estimate of uninsured third-tier Americans is approximately 44.3-45 million. *See* Guerra, *supra* note 5, at 1B; Jordan & Rankin, *supra* note 8, at 6A; Toner, *supra* note 5, at A18.

54. Derham-Aoyama, *supra* note 50, at 370.

55. *See id.*

56. *See id. See generally* Marmor, *supra* note 35, at 100 (addressing the United States' "flirtation with competitive models of health reform"). Such "flirtation" has created a sorry combination of an overwhelmingly expensive health care system with largely dissatisfied contractors and recipients. *See id.*

57. *See* Marmor, *supra* note 35, at 100; *see also* Saunders, *supra* note 9, at 733-36. *See generally* Kelli D. Back, *Rationing Health Care: Naturally Unjust?*, 12 HAMLINE J. PUB. L.

The medically indigent, those without the luxury of private insurance, are forced into the second and third tiers of this highly ineffective health care system. At best, the indigent can hope to meet their health care needs through Medicaid.[58] Unfortunately, the American aversion to social rights has maintained Medicaid as a safety net program rather than a sustenance program.[59] As a result, Medicaid often suffers from cutbacks in eligibility due to rising medical care costs;[60] in 1986, only forty percent of individuals below the poverty level were covered by Medicaid.[61] Ironically, funds for Medicaid are deducted from the paychecks of employed individuals, some of whom are ineligible for Medicaid, yet unable to afford medical care or insurance themselves.[62]

The Texas Medicaid program fails to reach a large proportion of the poor.[63] In Texas, Medicaid is limited to recipients of Aid to Families with Dependent Children and covers only one-third of individuals whose income is below the poverty level.[64] Because providers of Medicaid patients are not reimbursed at the level of reimbursement as insured patients,[65] the poor continue to be treated as second-class patients.[66]

& POL'Y (1991) 245, 245. "The United States spends more on health care than on education or national defense." *Id.*

58. *See* DiFlorio, *supra* note 9, at 148-49. Medicaid is a state program subsidized by the federal government. *See id.* Each state determines eligibility, with funds from the federal government subsidizing funds a portion of the state's expenses depending on the state's own resources. *See id.* Consequently, Medicaid coverage varies from state to state. *See id.* Throughout the 1980's, Medicaid suffered severe cutbacks due to reduced federal funding and rising medical costs, and by 1989, only forty percent of the poor in America were covered by Medicaid. *See id.*

59. *See* Back, *supra* note 57, at 252 (describing how the poverty line determinations of Medicaid coverage fluctuate with each state depending on the amount they desire to spend on Medicaid).

60. *See* Bovbjerg & Kopit, *supra* note 4, at 861 (indicating that Medicaid cutbacks in eligibility were encouraged by shortfalls in expected revenues to states and federal changes to Medicaid in 1981); *see also* Derham-Aoyama, *supra* note 50, at 369.

61. *See* Bovbjerg & Kopit, *supra* note 4, at 861.

62. *See* Derham-Aoyama, *supra* note 50, at 369; *see also* Sidimé, *supra* note 12, at J1.

63. *See* Eli Ginzberg, *Improving Health Care for the Poor: Lessons from the 1980's*, 271 JAMA 464, 465 (1994) [hereinafter *Improving Healthcare for the Poor*].

64. *See id.* at 465. The Texas Medicaid ratio ranks among the lowest in the nation. *See id.*

65. *See* Giesen, *supra* note 3, at 283 (doubting the effectiveness of Medicaid if physician reimbursement levels are low and services to Medicaid recipients are reduced); *Improving Health Care for the Poor, supra* note 63, at 465. *See generally* Sylvia A. Law, *A Right to Health Care That Cannot Be Taken Away: The Lessons of Twenty-Five Years of Health Care Advocacy*, 61 TENN. L. REV. 771, 774 (1994) (relating how federal law grants a great deal of discretion to states in determining how much to reimburse physicians for their care of Medicaid beneficiaries). As a result of states' discretion, many states reimburse at such a low level that physicians elect not to provide services to Medicaid beneficiaries. *See id.*

Providers who do accept Medicaid patients at this low level of reimbursement are often "Medicaid mills" that thrive on quantity rather than quality.[67] Therefore, beyond the failure of the private insurance health care system, public assistance programs also fail in their purpose of reaching out to the poor.

III. REDEFINING POVERTY

A. *Historical Treatment of the Poor*

United States public policy and legislation addressing poverty arose from English Poor Laws.[68] The colonization of America by the English was undertaken for profit and property, and poverty and idleness were not tolerated.[69] Colonial poor laws developed from English legal tradition, which were heavily influenced by Puritan theology, and were executed through public-private partnerships.[70]

In response to the growth of cities and the resulting poverty during colonization, colonial poor laws were enacted to define the type of relief afforded to the indigent.[71] Much like the antecedent English Poor Laws, colonial poor laws distinguished the indigent into two groups: 1) those who were unable to work, and 2) those who were able to work but did not.[72] Among those two groups, the poor were further distinguished into

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66. *See* Law, *supra* note 67, at 775 (discussing the failed promises of Medicaid and Medicare, when implemented in 1965, to integrate the poor and elderly into the American mainstream of health care).

67. *See Improving Health Care for the Poor, supra* note 63, at 465 (suggesting that because of the low reimbursement levels of state Medicaid programs, physicians must provide services to a high number of patients in order to make a profit). "Medicaid mills" refers to groups of providers "with questionable standards" that financially thrive on treating a large volume of Medicaid beneficiaries. *See id.*

68. *See* WALTER I. TRATTNER, FROM POOR LAW TO WELFARE STATE: A HISTORY OF SOCIAL WELFARE IN AMERICA 17 (5th ed. 1994); *see also* William P. Quigley, *Work or Starve: Regulation of the Poor in Colonial America*, 31 U.S.F. L. REV. 35, 42 (1996) (commenting that English Poor Laws were the most important source contributing to the development of American poverty legislation). Early public policy and statutes of Rhode Island, Maryland, New Plymouth, and Virginia referred to an adherence to English law regarding the treatment of the poor. *See id.* at 43-44.

69. *See* TRATTNER, *supra* note 68, at 23; Quigley, *supra* note 68, at 36 (emphasizing that poverty and idleness were considered sinful).

70. *See* Michael B. Katz, IN THE SHADOW OF THE POORHOUSE: A SOCIAL HISTORY OF WELFARE IN AMERICA 47 (10th ed. 1996); Quigley, *supra* note 68, at 42.

71. *See* TRATTNER, *supra* note 68, at 17; Quigley, *supra* note 68, at 42.

72. *See* TRATTNER, *supra* note 68, at 56; Quigley, *supra* note 68, at 55 (illustrating the importance in colonial law of not rewarding voluntary idleness).

1) those who were neighbors, and 2) those who were strangers.[73] Colonial poor laws only allowed for assistance to the "worthy poor," neighbors who were incapable of working.[74]

Implicit in poor laws was a work ethic that adhered to the belief that poverty was a result of idleness.[75] Because many Puritans believed a divine order declared that some would be rich and others poor, charity to the needy allowed the wealthy to fulfill a religious responsibility.[76] The donation of private property to public officials for charity was a common form of philanthropy.[77]

The concept of Puritan charity, however, did not reflect a giving of alms, but rather an opportunity for the poor to work their way out of poverty.[78] During the early colonial period, assistance to the poor was provided by placing the poor in private homes of others where their needs for shelter and food were satisfied at public expense.[79]

As the colonies developed, the population of the poor expanded and other methods of poor relief were explored.[80]

Poorhouses and workhouses were created which assisted the poor at the price of stigmatization and shame.[81] Poorhouses housed the "worthy poor,"[82] while workhouses or almshouses housed the "unworthy poor" and forced the "idle" to work.[83] Forcing the poor into these public institutions also reflected a prevalent belief in England and the colonies, that the poor should be shamed into self-improvement.[84] To further encourage self-improvement, many New England cities required the poor

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73. *See* Quigley, *supra* note 68, at 65. Settlement laws determined which individuals were neighbors and which were strangers. *See id.* Strangers generally included the newly arrived or immigrants. *See id.*

74. *See id.*

75. *See* TRATTNER, *supra* note 68, at 23-24; Quigley, *supra* note 68, at 44-45.

76. *See* Quigley, *supra* note 68, at 44.

77. *See id.* at 46; *see also* Mark Schlesinger, *Paradigms Lost: The Persisting Search for Community in U.S. Health Policy*, 22 J. HEALTH POL. POL'Y & L. 937, 944 (1997) (describing the combination of public and private sources of support for community services).

78. *See* Quigley, *supra* note 68, at 45.

79. *See* TRATTNER, *supra* note 68, at 19; Quigley, *supra* note 68, at 60. Another form of aid to the poor used by British colonies was farming out. *See* Phillip Harvey, *Joblessness and the Law Before the New Deal*, 6 GEO. J. ON POVERTY L. & POL'Y 1, 21-22 (1999). "Farming out" referred to the placement of paupers in the private home of the highest bidder. *See id.* Private parties would house and feed the paupers in exchange for a fee and labor. *See id.*

80. *See* Quigley, *supra* note 68, at 61.

81. *See id.* at 63. *See generally* Harvey, *supra* note 79, at 21.

82. Quigley, *supra* note 68, at 62 (stating the "worthy poor" refers to those unable to work).

83. *Id.* at 62 (1996).

84. *See id.* at 63.

wear badges in public.[85] Badging served as another form of stigmatization and emphasized the common moral assumption that if the poor remained poor, it was simply because of their own personal decisions that "squandered God-given opportunities."[86]

B. *Historical Views of Health Care*

Health care in the United States shares a similar history. Traditionally, health care for the poor was provided by charitable organizations, such as churches and public hospitals, as well as through private philanthropy.[87] Some cities provided for medical care to the poor through the collection of a poor tax which helped pay for the services of medical practitioners and midwives.[88] In the early 1900's, medical education was redefined and medical schools became affiliated with universities and charity hospitals.[89] As a result, medical care for the poor was also provided as a component of the medical educational process.[90]

During the 1930's, the economic hardship created by the Great Depression precluded many Americans from obtaining health care. This lack of access was viewed as being responsible for the poor health of a substantial portion of the American population.[91] Given that advances in medical technology and knowledge had improved physicians' abilities to treat disease, the problem of distribution of health care became a responsibility of the federal government.[92]

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85. *See id.* at 63-64. The cities of New York, Pennsylvania, and New Jersey required the poor to wear a badge with the letter "P" on it. *See id.* at 64. The state of Maryland required residents of poorhouses and workhouses wear a badge with a large Roman P on it. *See id.* Violations of the law warranted suspension of relief, twenty lashes, or a maximum punishment of twenty-one days of hard labor. *See id.*

86. *See* Quigley, *supra* note 68, at 64.

87. *See* American Medical Association, *supra* note 43, at 2533; *see also* James E. Davis, *National Initiatives for Care of the Medically Needy*, 259 JAMA 3171, 3171 (1988)[hereinafter *Care of the Medically Needy*].

88. *See* Nissa M. Strottman, Note, *Public Health and Private Medicine: Regulation in Colonial and Early National America*, 50 HASTINGS L.J. 383, 390 & n.61 (1999) (citing the example of Philadelphia poor laws). The incentive for cities to provide medical care to the poor was to prevent the spread of disease. *See id.*

89. *See* American Medical Association, *supra* note 43, at 2533 (1993) (stating that in the early 1900's, care of the poor became part of the medical educational process); *Care of the Medically Needy*, *supra* note 87, at 3171 (describing the affiliation of medical schools with universities in the early part of the twentieth century).

90. *See* American Medical Association, *supra* note 43, at 2533 (1993); *Care of the Medically Needy*, *supra* note 87, at 3171.

91. *See* American Medical Association, *supra* note 43, at 2533 (discussing the effects of the Great Depression on health care).

92. *See id.*

The federal government responded to the health care crisis by passing the Hill-Burton Act following World War II.[93] Under the Hill-Burton Act, the federal government created a loan program that encouraged the construction of hospitals in areas of underserved populations by allowing the hospitals to repay their construction loans through the provision of charity care.[94] Although the availability of hospitals in low-income states reached that of high-income states, the greatest gains occurred in middle-income communities.[95]

In 1965, the federal government established Medicaid as part of a number of health care initiatives that signified a remarkable shift in responsibility for providing health care to the poor from private or charitable organizations to the federal government.[96] Medicaid promised to "integrate the poor . . . into the mainstream of medical care".[97]

The 1970's brought the creation of numerous other endeavors, such as community health centers, the Veterans Administration, the National Health Service Corps, and the Indian Health Services, aimed at providing access to health care to distinct groups of individuals.[98]

By the 1980's, these several components suffered from a severe lack of internal communication and an inability to provide the comprehensive care promised.[99] Perhaps the most damaging result of such a multi-faceted system was the perception propagated that health care was solely the responsibility of the federal government; this perception discouraged the development of state and local initiatives to provide health care to the poor.[100]

C. *Contemporary Poverty & Health Care*

In contemporary society, not only have the present federal and state initiatives of providing health care to the poor failed, but the past stigma-

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93. *See id.*; *Care of the Medically Needy*, *supra* note 87, at 3171.

94. *See* American Medical Association, *supra* note 43, at 2533 (1993); *Care of the Medically Needy*, *supra* note 87, at 3171; *see also* Joel Weissman, *Uncompensated Hospital Care: Will It Be There if We Need It? (Caring for the Uninsured and Underinsured)*, 276 JAMA 823, 824 (1996). Unfortunately, the number of hospitals under the Hill-Burton Act has decreased. *See id.* at 824. In 1980, 4,090 hospitals participated, but by 1990, only 1,544 chose to participate in the Hill-Burton Act. *See id.* at 827.

95. *See* American Medical Association, *supra* note 43, at 2533.

96. *See id.*; *Care of the Medically Needy*, *supra* note 87, at 3171.

97. Law, *supra* note 65, at 775.

98. *See* American Medical Association, *supra* note 43, at 2533; *Care of the Medically Needy*, *supra* note 87, at 3171.

99. *See* American Medical Association, *supra* note 43, at 2534; *Care of the Medically Needy*, *supra* note 87, at 3171.

100. *See* American Medical Association, *supra* note 87, at 2534; *Care of the Medically Needy*, *supra* note 87, at 3171 (1988).

tization of the poor lingers in the expectation that the poor be appreciative of free care provided. As a pre-med student in college, I volunteered weekly at a community clinic that provided free prenatal care to indigent women. The women who visited the clinic endured long hours of waiting only to visit briefly with a physician or nurse practitioner. Nevertheless, the rare opportunity to have some health care eased their worries for the well being of their unborn.

One memorable evening, the clinic closed particularly late. I offered the last patient of the evening, a woman eight months pregnant and with four young children, a ride home. As I arrived at the humble home of the woman and her children, she kindly touched my arm and without the slightest hesitation, offered me her home. This kind, soft-spoken woman, with barely enough to feed her children, offered me a place to stay should I ever encounter a time of need.

As I drove home that evening, I was troubled by the woman's display of gratitude. The presumption that an indigent individual should be grateful for spending her entire evening in a homely clinic, waiting for a brief visit with a tired, volunteer physician was absurd. I felt as if I should have apologized to her for the shortcomings of a nation that cannot ensure its citizens equal opportunities to health care.

The gracious women I encountered in my experiences at the clinic were deprived of a guarantee to health care. Remnants of the Puritan work ethic have instilled in our culture the idea that the health of individuals, like these women, flows only from their individual prosperity.[101] In order to develop autonomous life-styles and fulfill personal goals, however, all individuals require a bare minimum basis of physical health and well-being.[102]

American economic productivity is severely hampered if the workplace includes an increasing number of uninsured.[103] The uninsured are more likely to be absent from work due to illness, stay home to care for sick family members, and spread what ails them to co-workers.[104] The combination of the prevailing work ethic and the current American health care system thus breed inefficiency; a vicious cycle of Social Darwinism, in which the lack of health care allows illness to flourish, leads to the inability to work and ultimately, poverty.[105]

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101. *See generally* Saunders, *supra* note 9, at 731 (noting that the United States allows the marketplace to determine the price of health care and ultimately who can afford it).

102. *See* Giesen, *supra* note 3, at 280 (claiming that if individual autonomy is valued, health should be viewed as a "condition of human flourishing").

103. *See* Emily Friedman, *The Torturer's Horse*, 261 JAMA 1481, 1482 (1999).

104. *See id.*

105. *See* Derham-Aoyama, *supra* note 50, at 365 (describing the troubling condition of the United States' health care system).

IV. The Problem of Indigent Access to Health Care

A. *Barriers Facing the Indigent*

A multitude of existing barriers preclude the indigent from obtaining adequate health care. The poor are more likely to be seriously ill when admitted to the hospital, yet they receive less aggressive medical care or specialized care upon hospitalization.[106] The poor are also more likely to receive and be injured by substandard health care and to die during hospitalization.[107] The health and well-being of indigent patients who rely on government programs for medical benefits are dramatically affected by government budget cuts.[108] Health care facilities often avoid treatment of the indigent by removing or closing paths of entry for poor people, such as emergency rooms and obstetrical care units.[109]

The privatization of public and non-profit hospitals also excludes the poor, as do limitations on the size of emergency rooms and restrictive hospital admission policies.[110] Many indigent patients are hustled through a maze of referrals only to end up in a teaching hospital that refuses treatment for fear of malpractice claims.[111]

Still other hospitals refuse to treat patients unless substantial deposits are paid or refuse to deliver babies unless the expectant mother has received a particular amount of prenatal care.[112] Those forced to seek hospital-based care must endure long waiting times and a lack of

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106. *See* Bovbjerg & Kopit, *supra* note 4, at 864; Tom Stacy, *The Courts, the Constitution, and a Just Distribution of Health Care*, 3 Kan. J.L. & Pub. Pol'y 77, 79 (1993); American Medical Association, *supra* note 43, at 2534.

107. *See* American Medical Association, *supra* note 43, at 2533 (1993); *see also* Stacy, *supra* note 106, at 79 (discussing a study revealing that uninsured patients suffer from higher rates of in-hospital death and are at a greater risk for negligent care).

108. *See* American Medical Association, *supra* note 43, at 2533.

109. *See* Marianne L. Engelman Lado, *Breaking the Barriers of Access to Health Care: A Discussion of the Role of Civil Rights Litigation and the Relationship Between Burdens of Proof and the Experience of Denial*, 60 Brook. L. Rev. 239, 248-49 (1994).

110. *See id.* at 249; *see also* Peter P. Budetti, *Malpractice and Access to Care*, 36 St. Louis U. L. J. 879, 891 (1992).

111. *See* Dorothy M. Allison, *Physician Retaliation: Can the Physician-Patient Relationship Be Protected?*, 94 Dick. L. Rev. 965, 966 (1990) (stating that high-risk indigent patients often undergo several referrals because of the liability risk they pose for physicians).

112. *See* Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination – It Shouldn't Be So Easy*, 58 Fordham L. Rev. 939, 941 (1990) (describing the ways in which minorities are excluded from obtaining health care). The ways in which health care institutions exclude minority patients ultimately result in the exclusion of indigent patients because of the intersection of socioeconomic status and ethnicity. *See id. See also Care of the Medically Needy*, *supra* note 87, at 3171. In 1977, a study conducted by the National Medical Care Expenditure Survey revealed that 96% of high-income mothers have access to prenatal care as opposed to only 65% of low-income mothers. *See id.*

continuity.[113] Most indigent patients never see the same physician twice.[114]

In the United States, one out of ten Americans reported that they were in fair or poor health in 1995.[115] In 1988, a study conducted by the Robert Wood Johnson Foundation revealed that the uninsured reported higher rates of illness, but fewer physician visits and hospitalizations than the insured.[116] Additionally, approximately one million individuals report attempting to obtain necessary medical care, but not receiving it for economic reasons.[117]

Fears of medical malpractice and invidious stereotypes of the medically indigent preclude the development of relationships between physicians and poor patients.[118] The philosophy of benevolence and altruism associated with a physician's oath[119] is often not realized because indigent care ultimately depends on an individual physician's choice.[120]

In order to encourage physicians to choose to provide free indigent care, the AMA, much like the American Bar Association, recommends a

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113. *See* Bovbjerg & Kopit, *supra* note 4, at 864 (stating the uninsured generally do not have a consistent source of care); *see also Improving Health Care for the Poor, supra* note 63, at 465.

114. *See Improving Health Care for the Poor, supra* note 63, at 465.

115. *See* Center for Disease Control and Prevention, *Fastats* (last modified Sep. 9, 1999) <http://www.cdc.gove/nchs/fastats/hstatus.htm>.

116. *See* Robert J. Blendon, *What Should Be Done About the Uninsured Poor?*, 260 JAMA 3176, 3176 (1988).

117. *See id.*; Bovbjerg & Kopit, *supra* note 4, at 864 (stating that uninsured individuals are often turned away or discouraged by some health care providers).

118. *See* Glasson & Orentlicher, *supra* note 48, at 1741 (suggesting that doctors, like others in society, may be too willing to accept stereotypes about the poor). In a survey of family medicine physicians, researchers discovered the physicians held false and unfavorable beliefs about the indigent. *See id.* In particular, the physicians believed indigent women have children as a means of collecting welfare benefits and that the poor abusively overused the health care system. *See id.*

119. *See* John A. Siliciano, *Wealth, Equity, and the Unitary Medical Malpractice Standard*, 77 VA. L. REV. 439, 450 (1991) (noting a physician's long-standing ethical commitment to serving those in need); *see also The Oath of Hippocrates* (visited Nov. 13, 1999) <http://www.humanities.ccny.cuny.edu/history/reader/hippoath.htm>. An excerpt from the Hippocratic oath states: "Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption . . . ." *Id.*; *see also The World Medical Association Declaration of Geneva (1948) Physician's Oath* (last modified Dec. 16, 1998) <http://www.cirp.org/library/ethics/geneva/> (referring to the physician's oath adopted by the World Medical Association immediately prior to the United Nations' adoption of the Universal Declaration).

120. *See* Friedman, *supra* note 103, at 1481 (referring to the vulnerability of the indigent in relying on the whims of providers).

physician offer fifty hours per year of charity care.[121] Although a substantial number of physicians offer charity care, a disproportionate share of charity care is provided by physicians who already serve high levels of Medicaid patients. Thus, the responsibility to serve the poor is unequally distributed.[122] The AMA estimates that one-quarter to one-third of physicians fail to provide medical care to the poor.[123] Unfortunately, until health care is acknowledged as an essential human right, the status of indigent care will remain contingent upon personal choices by individual physicians.[124]

B. *Vulnerability of Charitable Programs*

There is inherent inequality in a society that requires its less fortunate to rely on the charity of others. Programs that only serve the poor have a tendency to be poor programs.[125] For example, Aid to Families with Dependent Children, a program exclusively serving the poor, is subject to drastic cutbacks due to its political vulnerability.[126] Furthermore, welfare programs are often characterized by severe denials of privacy and dignity.[127] Social Security, on the other hand, has remained politically strong because it serves individuals of all economic classes.[128] Social Security benefits increase with increases in living costs and the program avoids any intrusion into the privacy of its beneficiaries.[129]

The vulnerability of welfare programs is exacerbated by the fact that the poor have almost no participation in the process of creating legislation that will govern their lives.[130] The poor lack the finances to contribute to the political campaigns of elected officials and vote in disproportionately low numbers.[131] There are few organizations that

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121. *See* American Medical Association, *supra* note 43, at 2536; *see also* Lundberg & Bodine, supra note 47, at 3045 (encouraging fellow physicians to give a minimum of 50 hours per year, or one week, of charity care).

122. *See* American Medical Association, *supra* note 43, at 3535 (reporting that physicians responded to the increase in uninsured Americans by providing a greater amount of charity care, but the charity care was not equally distributed among physicians).

123. *See id.*

124. *See* Friedman, *supra* note 103, at 1481 (stating that health care inevitably becomes charity that is doled out sporadically, subject to when providers are moved to do so, and every provider is not so moved).

125. *See* Law, *supra* note 65, at 773 (explaining the inefficacy of charitable programs).

126. *See id.*

127. *See id.*

128. *See id.*

129. *See id.*

130. *See* Laurence E. Norton, II, *Not Too Much Justice for the Poor*, 101 DICK. L. REV. 601, 601 (1997) (describing how laws affecting the poor are unfairly enacted).

131. *See id.*

lobby on behalf of the interests of the poor, and lawyers available to the poor, through legal services organizations, are precluded from advocating for the poor in the legislative process.[132] The poor are thus relegated to rely on a legal system that has typically been indifferent to the plight of the poor.[133]

C. *Consequences for the Whole Community*

The consequences of the lack of access for the medically indigent reach beyond the poor.[134] Because the medically indigent do not have a continuous relationship with a general physician, the indigent seek primary care in hospital emergency rooms, inappropriate and costly sites for routine care.[135] Providing primary care in an emergency room is "equivalent to tending a rose garden with a bulldozer."[136] By the time indigent patients reach the emergency room, they often present severe health problems and as a result, suffer worse outcomes.[137] Because indigent patients rarely see the same physician twice, medical procedures are often duplicated and the quality of care is inferior.[138] Consequently, health care costs rise, resources are misappropriated, and indigent patients' medical outcomes suffer.[139]

Society's failure to adequately provide health care for individuals may result in a threat to public health.[140] Moreover, failure to adequately protect the community against individuals with contagious diseases breaches a society's duty of collective protection to all members.[141] The health

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132. *See id.*

133. *See id.* at 604.

134. *See* American Medical Association, *supra* note 43, at 2534 (discussing the ramifications of the lack of health care for the poor).

135. *See id.*; *Ethical Issues in Health Care System Reform, supra* note 45, at 1056; *see also* Stacy, *supra* note 106, at 78.

136. American Medical Association, *supra* note 43, at 2534.

137. *See id.* (suggesting that indigent patients without primary care visit the emergency room as a last resort); *see also* Stacy, *supra* note 106, at 78 (noting that a disproportionate number of the uninsured visit hospitals with conditions that could have been prevented if treated earlier).

138. *See Improving Health Care for the Poor, supra* note 63, at 465 (listing the hallmarks of primary care based in hospitals, such as long waiting times and a lack of continuity).

139. *See* American Medical Association, *supra* note 43, at 2534.

140. *See generally Ethical Issues in Health Care System Reform, supra* note 45, at 1057 (commenting that "the health of the community is no better than the health of its members"). For example, individuals with highly contagious diseases present an enormous threat to the rest of the community. *See id.*; *see also* Friedman, *supra* note 103, at 1481-82 (describing the effects of not treating the poor on the whole American community).

141. *See Ethical Issues in Health Care System Reform, supra* note 45, at 1057 (describing social contract theory as a basis for the duty of collective protection).

status of the poor, therefore, has broad implications for the health of the entire community.

V. The Proposal of Immunity for Volunteer Health Care Providers

A. *Texas*

Texas once held the title of the "lawsuit capital of America" due to the generosity of jury awards.[142] During the last decade, Texas has undergone a drastic transformation of its legal system through a movement of tort reform.[143] The now Republican Texas Supreme Court rules against plaintiffs seventy-five percent of the time, compared with only thirty percent in the mid-1980's.[144] The political action committee of Texans for Lawsuit Reform is currently one of the largest in the state, donating over one million dollars to state political candidates.[145]

In the recent wave of tort reform and in response to the health care needs of the indigent community, the Texas legislature has recently passed legislation that provides the following:

> A volunteer health care provider who is serving as a direct service volunteer of a charitable organization is immune from civil liability for any act or omission resulting in death, damage, or injury to a patient if: (1) the volunteer was acting in good faith and in the course and scope of the volunteer's duties or functions within the organization; (2) the volunteer commits the act or omission in the course of providing health care services to the patient; (3) the services provided are within the scope of the license of the volunteer; and (4) before the volunteer provides health care services, the patient, or if the patient is a minor or is otherwise legally incompetent, the patient's parent, managing conservator, legal guardian, or other person with legal responsibility for the care of the patient signs a written statement that acknowledges: (A) that the volunteer is providing care that is not administered for or in expectation of compensation; and (B) the limitations on the recovery of damages from the volunteer in exchange for receiving the health care services.[146]

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142. William Glaberson, *Texas, Once U.S. 'Lawsuit Capital,' Now Leads Judicial 'Reform' Effort Courts Overturn Damage Awards Seen As Excessive*, The Palm Beach Post, June 14, 1999, at 12A.

143. *See id.*

144. *See id.*

145. *See id.*

146. Tex. Civ. Prac. & Rem. Code Ann. § 84.004(c) (Vernon Supp. 2000).

The volunteer immunity granted in the legislation is quite expansive, encompassing physicians, physician assistants, registered and licensed vocational nurses, pharmacists, podiatrists, dentists, dental hygienists, and optometrists in its definition of "volunteer health care provider."[147] However, volunteer immunity is inapplicable to any acts or omissions that are "intentional, willfully or wantonly negligent, or done with conscious indifference or reckless disregard for the safety of others."[148]

The legislation, effective September 1, 1999, is an expansion of Good Samaritan legislation that provides for the rewarding of good deeds with limited liability.[149] Currently, each state in the United States, as well as Washington, D.C., has enacted some form of Good Samaritan law.[150] Despite the lack of data supporting the effectiveness of Good Samaritan legislation,[151] many states are expanding the doctrine to include volunteer and charitable immunity legislation.[152] Texas legislators apparently expect that volunteer immunity will overcome the obstacles of potential medical malpractice claims and encourage health care professionals to engage in benevolent volunteerism. An increasing number of states have adopted similar legislation[153] despite the lack of empirical data to

147. *Id.* at § 84.003(5)A-J (Vernon Supp. 2000).

148. *Id.* at § 84.007(a) (Vernon Supp. 2000).

149. *See id.* at § 74.001 (Vernon 1999). Good Samaritan legislation in Texas provides immunity to any person who administers emergency care, in good faith, at the scene of an emergency. *See id.* Good Samaritan immunity extends to civil damages for any act performed during the emergency so long as the act was not willful or wantonly negligent. *See id.*

150. *See* Bridget A. Burke, *Using Good Samaritan Acts to Provide Access to Health Care for the Poor: A Modest Proposal*, 1 ANNALS HEALTH L. 139, 140 (1992).

151. *See* Giesen, *supra* note 3, at 288-89. There has been no case of malpractice in the United States where a physician was sued for medical aid rendered at the site of an emergency. *See id.*

152. *See* Burke, *supra* note 150, at 141. In fact, some studies have revealed that physicians volunteerism has been completely unaffected by Good Samaritan legislation. *See id.*; *see also* American Medical Association, *supra* note 43, at 2533.

153. *See* ARIZ. REV. STAT. ANN. § 12-571 (West 2000); D.C. CODE ANN. § 2-1345 (1999); FLA. STAT. ANN. § 768.1345 (West 1999); GA. CODE ANN. § 51-1-29.1 (1999); HAW. REV. STAT. ANN. § 662D-2 (Michie Supp. 1999); 745 ILL. COMP. STAT. ANN. 49/30 (West 1999); N.D. CENT. CODE § 32-03.1-02.2 (1999); S.C. CODE ANN. § 33-56-180 (West Supp. 1999); VA. CODE ANN. § 32.1-127.3 (Michie 1997); VA. CODE ANN. § 54.1-106 (Michie 1998); Fred Wurlitzer & Robert McCool, Editorial, *Liability Immunity for Physician Volunteers*, 272 JAMA 31, 31 (1994). *See generally Legal Immunity for Uncompensated Medical Care Providers* (visited Jan. 25, 2000) <http://www.ama-assn.org/ama/pub/feature/0,1127,304/23,FF.html>.

support the causal connection between statutory immunity and volunteerism.[154]

B. *Other States*

The District of Columbia, North Dakota, and Arizona have adopted similar legislation to protect volunteer health care providers.[155] In the District of Columbia, volunteer immunity legislation was passed in 1991, in response to the need for gynecological and obstetrical care among indigent women.[156] The volunteer immunity legislation amended the District's Good Samaritan Act[157] and met with little opposition.[158] Proponents of the amendment, including the Coalition Against Lawsuit Abuse and the American Tort Reform Association, argued it would promote volunteerism and create access to health care for the indigent.[159] The only opponent to the amendment, the District of Columbia Trial Lawyers Association, voiced its concern that the poor should not be stripped of their inalienable right to sue simply because they are poor.[160]

North Dakota passed similar legislation, amending its Good Samaritan Act to provide for "immunity for physicians who volunteer with no compensation at a free clinic."[161] The only opposition to the legislation came from the North Dakota Trial Lawyers Association, whose representative stated that economically deprived people should not be subject to "anything less than the rest of us in our society expect and demand from our medical community."[162]

Similarly, in Arizona, volunteer immunity legislation[163] met with little opposition, except for the Arizona Trial Lawyers Association.[164] An attorney for the Association voiced the organization's concerns that the

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154. *See* John Brown, Comment, *Statutory Immunity for Volunteer Physicians: A Vehicle for Reaffirmation of the Doctor's Beneficent Duties – Absent the Rights Talk*, 1-SPG WIDENER L. SYMP. J. 425, 443 (1996).

155. *See* D.C. CODE ANN. § 2-1345 (1999); N.D. CENT. CODE. § 32-03.1-02.2 (1999); ARIZ. REV. STAT. ANN. § 12-571 (West 2000); *see also Legal Immunity for Volunteer Doctors*, WASH. POST, May 31, 1990, at B6.

156. *See* Brown, *supra* note 154, at 441.

157. *See id.*; *see also Legal Immunity for Volunteer Doctors*, THE WASH. POST, May 31, 1990, at B6.

158. *See* Brown, *supra* note 154, at 443.

159. *See* Burke, *supra* note 150, at 145.

160. *See id.*

161. Brown, *supra* note 154, at 444; *see also* N.D. CENT. CODE § 32-03.1-02.2 (1999).

162. Brown, *supra* note 154, at 445 (referring to comments made by the Trial Lawyers' Association that were never debated).

163. *See* ARIZ. REV. STAT. ANN. § 12-571 (West 1999).

164. *See* Brown, *supra* note 154, at 444-46 (discussing the ease with which such legislation passed).

legislation would result in a taking of the rights to sue for personal injuries "in an effort to give protection to a certain segment of society."[165] Despite the opposition, the legislation is in effect today.

When analyzing the efforts of other states to provide immunity for volunteer health care providers, the most disconcerting aspect of their legislative processes is the ease with which such legislation has been created. Opposition to the legislation was voiced only by attorneys, a group trained in protecting the legal rights of individuals.[166] The lack of substantial opposition suggests that the idea of rewarding volunteerism, regardless of the effects on the indigent, is widely accepted. Furthermore, as other states follow the trend of adopting volunteer immunity legislation,[167] the opportunity to delve into the status of indigent health care in this country slowly diminishes.

VI. An Unsuitable Solution

A. *Myth of the Litigious Poor*

Volunteer immunity legislation is predicated on the assumption that health care providers do not volunteer their services simply because of liability concerns.[168] This simplified explanation, however, does not rely on accurate premises.

The poor, contrary to persistent myth, are not a litigious group.[169] Indigent patients rarely pursue their right to sue in court.[170] In a case-control study of fifty-one hospitals in New York State, poor patients were found to be significantly less likely to file a malpractice claim, even after

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165. *Id.* at 446.

166. *See id.* at 444-46 (referring to opposition voiced by North Dakota and Arizona Trial Lawyers' Associations).

167. *See generally American Medical Association, Legal Immunity for Uncompensated Medical Care Providers* (visited Jan. 25, 2000) <http://www.ama-assn.org/ama/pub/feature/0,1127,304/23,FF.html> (listing the states that passed immunity legislation for uncompensated health care providers between the years of 1993-1997).

168. *See* Burke, *supra* note 150, at 142 (explaining that the expansion of Good Samaritan legislation is premised on the assumption that liability concerns are responsible for lack of medical access to the indigent).

169. *See* American Medical Association, *supra* note 43, at 2535 (referring to the conclusions of a case-study on lawsuits by the indigent); Brown, *supra* note 154, at 444-47 (referring to the discussions surrounding the passage of immunity legislation in North Dakota and Arizona); Burke, *supra* note 150, at 147-48; Helen R. Burstin, et al., *Do the Poor Sue More? A Case-Control Study of Malpractice Claims and Socioeconomic Status*, 270 JAMA 1697, 1697 (1993); Glasson & Orentlicher, *supra* note 48, at 1740. In fact, the likelihood of the poor bringing lawsuits is only "10% to 20% that of wealthier patients." *Id.*

170. *See* Burke, *supra* note 150, at 147; Burstin, *supra* note 169, at 1697.

controlling for the presence and severity of medical injury.[171] The indigent maintain a lower likelihood of suing despite the fact that they are more likely to suffer negative medical outcomes or injury because of general ill health and lack of continuity of health care.[172] Furthermore, because of a generally lower educational status among the indigent, many indigent patients may not be aware of their right to sue for medical malpractice or have access to legal assistance.[173] Legal aid lawyers available to the poor generally do not or cannot pursue medical malpractice claims.[174]

Given the inadequacy of health care, indigent patients are not likely to sue the few physicians who treat them for fear of alienation.[175] Lastly, medical malpractice claims of indigent patients are not lucrative to plaintiff attorneys because of the patients' reduced expected future earnings.[176]

B. *Cost of Free Care*

"The problem of tort liability when treating the indigent is not really a problem with the tort system so much as it is a problem with the health care insurance system."[177] If malpractice liability concerns among physicians are unfounded, then volunteer immunity legislation proposes a solution to the wrong problem.

Under volunteer immunity legislation, the indigent population is forced to relinquish their rights to sue for negligent care in exchange for access to care, thus maintaining the status quo and "stratify[ing] the 'haves' from the 'have nots.'"[178] The infringement on the indigent individual's right to sue for injuries is disguised as a necessary sacrifice for the good of the

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171. *See* Burstin, *supra* note 169, at 1697 (discussing the results of a study of indigent patients). Similarly, indigent patients rarely sue for breast cancer malpractice, the second most common basis for litigation and the most expensive to indemnify. *See generally* Kenneth A. Kern, Editorial, *Do the Poor Sue More?*, 271 JAMA 503, 504 (1994).

172. *See* American Medical Association, *supra* note 43, at 2536 (disputing any relation between the poor medical outcomes of indigent patients and malpractice suits); *see also* Glasson & Orentlicher, supra note 48, at 1740 (negating the myth that the poor are litigious).

173. *See* Burke, *supra* note 150, at 147; Burstin, *supra* note 169, at 1697.

174. *See* Burke, *supra* note 150, at 147-48.

175. *See id.* at 147 (disputing myths that the poor are litigious).

176. *See id.* at 148 (discussing an indigent's probable law earning power); *see also* Glasson & Orentilcher, *supra* note 48, at 1740.

177. Glasson & Orentilcher, *supra* note 48, at 1740.

178. Burke, *supra* note 150, at 147.

overall public.[179] The donation of an individual's right to sue to the public is as unjust as a compulsory donation to a charity.[180] In analogous situations, such as the doctrine of eminent domain,[181] the seizure of an individual's right to life, health or property requires just compensation.[182]

Furthermore, a duty of due care in emergencies exists on behalf of the health care provider regardless of whether compensation is involved; there is no plausible relationship between payment and liability.[183] When a patient-physician relationship is established, a physician is required to exercise the same level of care to the patient, regardless of whether the patient can compensate the physician.[184] The duty of due care does not vary with the financial status of the duty-holder, nor does it require a contractual relationship exist.[185] In fact, a duty of due care may exist between strangers who have no contractual relationship because the duty of due care is derived from the power of individuals to do or avoid doing harm.[186] Thus, both rich and poor duty-holders should be held accountable for their negligence.[187]

"Immunity statutes fail to make good public policy, not only because they eliminate a patient's right to recover for injuries, but because they remove an effective deterrent to substandard medical care by physicians."[188]

With the recent passing of a bill that will allow insured patients to sue their health maintenance organizations (hereinafter HMO),[189] the United States House of Representatives recognizes what volunteer immunity legislation has ignored: the deterrent effect of litigation. Removing a pa-

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179. *See* Note, *The Quality of Mercy: 'Charitable Torts' and Their Continuing Immunity*, 100 HARV. L. REV. 1382, 1389 (1987) [hereinafter *The Quality of Mercy*] (criticizing the premise of immunity legislation).

180. *See id.*

181. *See* BLACK'S LAW DICTIONARY 523 (6th ed. 1990). Eminent domain is defined as the power of the government to take private property for public use. *See id.* The power of eminent domain is found in both the Fifth Amendment of the Constitution and state constitutions. *See id.* The taking of property under the Fifth Amendment requires just compensation. *See id.*

182. *See The Quality of Mercy, supra* note 179, at 1389.

183. *See id.* at 1393 (discussing the fact that a contractual obligation does not normally exist between the provider of charitable health care and the recipient of that care, that would create a plausible relationship between payment and liability).

184. *See* Bovbjerg & Kopit, *supra* note 4, at 876.

185. *See The Quality of Mercy, supra* note 179, at 1393. *See generally* Bovbjerg & Kopit, *supra* note 4, at 1393.

186. *See The Quality of Mercy, supra* note 179, at 1393.

187. *See id.*

188. Glasson & Orentlicher, *supra* note 48, at 1740.

189. *See* Jon Frandsen, *House OKs Right to Sue HMO Plans*, SAN ANTONIO EXPRESS-NEWS, Oct. 8, 1999, at 1A.

tient's right to sue for malpractice may potentially eliminate any monitoring of health care standards. Such harsh ramifications are not worth legislation that has never been shown to be particularly useful.[190]

C. *Myth of Malpractice Liability*

The danger in adopting volunteer immunity legislation is an ignorance of a more realistic explanation: health care providers' decisions not to treat the indigent are heavily influenced by the lack of reimbursement.[191] This is especially evident when considering that Medicaid beneficiaries, indigent patients with state and federally funded medical coverage,[192] still cannot find physicians willing to care for them.[193] For physicians treating Medicaid patients or the medically indigent, the either low or nonexistent reimbursement does not cover the costs of providing medical care, much less the costs of malpractice liability.[194] Therefore, even if a small percentage of the indigent pursue malpractice claims, the fact that any sue at all is a disincentive for physicians to provide charity care.[195] If the goal of volunteer immunity legislation is to provide health care for the medically indigent, a universal health care plan will have a much greater influence than tort reform.[196]

By addressing the reality that medical professionals may not volunteer their services to the indigent because it does not pay, solutions aimed at the training of medical professionals can be explored. Until alternative explanations are considered, the complexity involved in indigent access to

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190. *See* Burke, *supra* note 150, at 142; *see also The Quality of Mercy, supra* note 179, at 1394 (commenting that there is a lack of evidence supporting the idea that liability deters volunteerism).

191. *See* Brown, *supra* note 154, at 439 (suggesting that with volunteer work, unlike emergency care, a physician weighs the financial consequences of providing free care).

192. *See* Derham-Aoyama, *supra* note 50, at 369; DiFlorio, *supra* note 9, at 148-49. Medicaid is a state health insurance program, subsidized in part by the federal government, and available to low-income men, women, children, and individuals with specific disabilities. Each state defines its own scales of eligibility and the federal government funds a portion of the state's expenses depending on the state's own resources. Consequently, Medicaid coverage varies from state to state. *See id.*

193. *See* Law, *supra* note 65, at 773-74 (discussing the barriers indigent patients face in attempting to obtain health care); McGinley, *supra* note, at 12. A quarter of physicians nationwide refuse treating Medicaid patients. *See* Sidney Dean Watson, *In Search of the Story: Physicians and Charity Care*, 15 ST. LOUIS PUB. L. REV. 353, 359 (1996) [hereinafter *Physicans and Charity Care*]. Additionally, two thirds of physicians who treat Medicaid patients, limit the number of patients they treat. *See id.*

194. *See* Glasson & Orentlicher, *supra* note 48, at 1740 (explaining the financial risks physicians undertake when treating the indigent).

195. *See id.*

196. *See id.* (suggesting that the health care system be reformed rather than passing temporary remedies like immunity legislation).

health care will be severely undermined by the simplicity of volunteer immunity legislation.[197]

D. *Creation of a Dual Standard of Care*

Inherent risks exist in a system where indigent patients rely on the benevolence of health care professionals for their health care needs.[198] Under such a system, indigent patients are subject to a dual standard of care because health care services are not readily available and are typically of lesser quality.[199] The expansion of charity care and charitable immunity are not, therefore, adequate solutions to the problem of access.[200]

In Texas, volunteer immunity legislation threatens to redefine the standard of indigent care.[201] Implicit in Texas volunteer immunity legislation is the idea that "beggars can't be choosers." Because health care is not a fundamental right, the indigent seem to be forced to accept the services available to them, regardless of the quality, because they are free. Thus, volunteer immunity legislation maintains the status quo, and further removes the nation from the possible recognition of an equal, fundamental right to health care.[202]

The creation of a dual standard of care is exacerbated by the denial of a legal remedy to indigent patients injured by a volunteer health care provider. The poor are forced to trade "their right to sue in exchange for health care."[203] Volunteer immunity legislation thus effectuates a differential impact among patients: those who can afford medical care are granted the right to sue for personal injuries, while indigent patients are

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197. *See* Burke, *supra* note 150, at 144 (recommending a careful consideration of all factors affecting the availability of medical care).

198. *See id.* at 146.

199. *See* Stacy, *supra* note 106, at 78-79 (detailing the discrepancies in the quality of care received by the insured versus the uninsured).

200. *See* Burke, *supra* note 150, at 146; *see also* Bonnie Booth, *Wake-up Call on a Growing Problem*, AM. MED. NEWS, July 5, 1999, at 19 (describing the AMA President's visits to over 20 free clinics in the United States). The AMA President called for an understanding that ". . . free clinics cannot be the answer to the issue of the uninsured," and that although free clinics will always be needed, ". . . they cannot be relied upon as a solution to a problem of this magnitude." *See id.*

201. *See generally* TEX. CIV. PRAC. & REM. CODE ANN., § 84.004 (Vernon Supp. 2000). This provision of immunity seems to have the potential to result in substandard care because it serves as a disincentive for physicians to practice cautiously.

202. *See* Burke, *supra* note 150, at 146-47.

203. *See id.* at 146.

denied their right to sue in exchange for free medical care.[204] The right to sue for medical malpractice thus becomes a right by purchase.

VII. Alternative Solutions

As the debates over health care reform continue, the likelihood that this nation will agree on a plan for universal health care seems bleak. In the meantime, there are more feasible alternatives to volunteer immunity legislation.

A. *Mandatory Volunteerism*

1. As a Requirement for Licensing

A proposal to increase the number of volunteer health care professionals is to require volunteerism as a condition of licensing.[205] Since 1846, the original Code of Ethics of the American Medical Association has declared that "to individuals in indigent circumstances, professional services should be cheerfully and freely accorded."[206]

In 1992, in order to ensure health care professionals would donate their services, a proposal was made to the AMA that would have required physicians donate ten percent of their income or fifty hours per year to health care for the indigent.[207] The proposal was rejected due to the prevailing belief that charitable work should be done because of genuine concern and kindness for the patient, and not forced.[208]

The idea of mandatory volunteerism is particularly appealing when considering the debt a graduating physician owes to society.[209] A physician's training is financed by state investments derived from taxing state citizens; a physician's clinical experience is gained by practice on willing patients.[210] Furthermore, physicians are subject to the licensing powers

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204. *See* Brown, *supra* note 154, at 446 (stating that volunteer immunity bills "take[s] those rights in an effort to give protection to a certain segment of society"); Burke, *supra* note 150, at 146.

205. *See* Lewis D. Solomon & Tricia Asaro, *Community-Based Health Care: A Legal and Policy Analysis*, 24 Fordham Urb. L. J. 235, 276 (1997); *see also Improving Health Care for the Poor*, *supra* note 63, at 276 (advancing the idea that the promise of universal access may stem from the requirement of mandatory service for all medical school graduates following completion of residency training).

206. *See* Solomon & Asaro, *supra* note 205, at 276.

207. *See id.* at 277.

208. *See id.* at 277-78.

209. *See* Giesen, *supra* note 3, at 285.

210. *See id. See generally Ethical Issues in Health Care System Reform*, *supra* note 45, at 1057. Society invests large amounts of money in the training of physicians, the construction of medical faculties, and in medical research. *See id.*

of different state authorities.[211] Thus, a mutually beneficial relationship exists between society and physicians and physicians should repay society for what society has invested in them.

Nevertheless, a proposal for mandatory volunteerism as a condition of licensing would ensure a steady flow of free health services for the poor around the country. Perhaps a proposal with less stringent requirements, such as five percent of income or twenty-five hours per year, might gain approval among physicians. The effect of such a proposal would be invaluable and ensure a steadfast supply of health care.

2. As a Requirement for Medical School Graduation

Mandatory volunteerism as a requirement for medical school graduation would not only ensure a steady flow of free services, but would also teach future physicians the importance of serving indigent communities before they are personally exposed to the financial gain of the practice of medicine.

By requiring volunteerism *before* graduation, this proposal addresses the pitfalls of mandatory volunteerism as a condition of licensing. First, physicians generally do not practice in areas of greatest need.[212] Medical students, on the other hand, can be placed in these areas and their volunteer work can be incorporated as part of their clinical training prior to graduation. Secondly, there is a high saturation of specialists compared to general physicians.[213] Because of the need for primary health care among the indigent, and the fact that only two percent of medical students choose to pursue an area of general medicine upon graduation,[214] it would be advantageous to utilize medical students prior to their specialization.

This proposal is particularly effective because of the possible short and long-term benefits. The immediate benefits are the availability of pools of medical professional students providing free health care services, and the emphasis of volunteerism in medical education. The long-term benefit is the potential impact volunteerism may have on these physicians-to-be to donate their time once in private practice.

B. *Government-Paid Insurance Premiums*

A more feasible solution may lie in government-paid malpractice insurance premiums.[215] Although taxpayer dollars may be required to pay the

211. *See* Giesen, *supra* note 3, at 285.
212. *See* Solomon & Asaro, *supra* note 205, at 278.
213. *See id.*
214. *See id.*
215. *See id.* at 281.

premiums, the savings incurred in providing primary and preventive care for the cost of malpractice insurance are invaluable.[216] Furthermore, by providing preventive and primary care to the indigent population, the poor would no longer be forced to obtain their primary care in hospital emergency rooms, thus lowering the overall costs of health care.

In 1995, Kentucky attempted a version of this proposal by enacting a law that required the state's physicians and attorneys to pay one dollar per year to help purchase malpractice insurance for the state's free health care clinics.[217] The legislation was declared unconstitutional by the Attorney General because the statute was ambiguous, arbitrary, and considered "special legislation" because it singled out attorneys and physicians.[218] Nevertheless, even opponents of the legislation did not attack the premise of the legislation, and only argued that all taxpayers should contribute financially.[219] This particular proposal was passed instead of the volunteer immunity lobbied for by a local hospital.[220] Although not successful in Kentucky, government paid insurance premiums collected from taxpayers could be an efficient, feasible means of generating income immediately.

This proposal would also be particularly effective in tapping into a specific pool of volunteers: retired physicians. Because retired physicians are generally financially secure, they can devote their time to volunteer. Unfortunately, although many retired physicians would like to volunteer, many have liability concerns since their malpractice insurance terminates upon their retirement.[221] By arranging for the government to pay their insurance premiums, a pool of experienced physicians could be utilized to serve the poor.

VIII. Conclusion

The wave of tort reform sweeping Texas has created an aversion to liability and has clashed with the movement for health care reform. Volunteer immunity legislation is a product of the desire to reduce the liability of volunteer health care providers in hopes of solving the problem of indigent access to health care. This proposed solution, however, grossly oversimplifies the problem of indigent health care.

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216. *See id.* 281-82.

217. *See* Gil Lawson, *Dollar-for-Clinics Law Is Ruled Illegal*, The Courier-J., May 27, 1995, at 1A.

218. *See id.*

219. *See id.* Physicians did not challenge the legislation and over $10,000 had already been collected at the time of the Attorney General's decision. *See id.*

220. *See id.*

221. *See* Solomon & Asaro, *supra* note 205, at 282 (recognizing the vast amount of retired physicians willing to volunteer their services and reasons they do not).

Volunteer immunity legislation is particularly dangerous because it creates a façade that the indigent are litigious and are the cause of their own lack of health care. Such legislation allows for the emergence of a dual standard of health care among those who can afford remuneration and those who cannot. This dual standard of care chastises the indigent for their economic status and forces them to depend on the whims of charity.

There are intrinsic inequalities in a society that allows the dependence of the indigent on charity. Until there is substantial evidence that this form of Good Samaritan legislation improves access to health care, Texas should avoid relying on this legislation to cure the problem of indigent access. The elitist implication manifested in this legislation - that the indigent must forfeit their legal rights in exchange for "free" care - exacerbates the hardships of poverty. Poverty should not require such degradation.

The right to wellness should not be a right contingent upon economic status. In this nation premised on self-reliance, the indigent are struggling to survive in a scheme of Social Darwinism disguised as a health care system. In this nation premised on individual freedoms, the indigent that succeed in obtaining health care are stripped of their inalienable rights to sue. The misfortunes of poverty should not justify such robbery.